

CURRENT SUNSET REVIEW ISSUES FOR THE MEDICAL BOARD OF CALIFORNIA - 2017

MBC ADMINISTRATION ISSUES

ISSUE #1: (BreEZe.) MBC transitioned to BreEZe in October 2013 as one of the first entities at DCA utilizing the new system. MBC has faced challenges in meeting timeline goals and implementing processes and has paid vast sums of money for the project, in addition to countless hours of staff resources. What is the status of BreEZe? How many of MBC's service requests are still pending? Does BreEZe track enforcement statistics in a meaningful way for MBC?

Background: The DCA has been working since 2009 on replacing multiple antiquated standalone IT systems with one fully integrated system. In September 2011, the DCA awarded Accenture LLC with a contract to develop and implement a commercial off-the-shelf customized IT system, which it calls BreEZe. BreEZe is intended to provide applicant tracking, licensing, renewals, enforcement, monitoring, cashiering, and data management capabilities. In addition, BreEZe is web-enabled and designed to allow licensees to complete and submit applications, renewals, and the necessary fees through the internet. The public also will be able to file complaints, access complaint status, and check licensee information if/when the program is fully operational.

The project plan called for BreEZe to be implemented in three releases. The first release was scheduled for July 2012 but delayed until late 2013. MBC transitioned to BreEZe during Release One in October 2013. MBC reports that since 2013, there have been 118 releases that included major, minor, and emergency service request changes, which have been implemented. Unlike many other entities at DCA, MBC is fortunate to have its own Information System Branch (ISB) which is able to work with the DCA Office of Information Services and vendor analysts and developers to define, prioritize, test, and implement service requests for MBC.

MBC reports that once the system went live, MBC's Consumer Information Unit received requests for BreEZe support from applicants, licensees and consumers, leading to ISB's internal technical support Help Desk to also provide technical support for BreEZe online users. In FY 2013/2014, the ISB Help Desk received 14,403 public support requests via phone or email; in FY 2014/2015, 16,678 requests; and in FY 2015/2016, 17,353 requests.

Like other DCA entities transitioning to the new BreEZe system, MBC staff adjusted to new business processes and requirements which delayed timeframes. Licensing processing timelines grew as the initial deployment of BreEZe resulted in a need for all business processes to be reviewed. Changes were required for staff activity as well as the BreEZe system itself, all of which impacted every facet of processing of applications, from the receipt of initial fees and application forms through the final issuance of a license. MBC reports that staff is now trained and more comfortable with the system and new business processes and timeframes have since stabilized.

MBC's ability to access monthly caseload reports and track complaint processing and enforcement timelines was significantly impacted by BreEZe. Staff at MBC's Central Complaint Unit were not able to receive these reports, an important tool for MBC to effectively monitor the progress and timeframe for cases.

MBC CME audits have also been impacted by BreEZe. The prior tools utilized to automate the process for CME auditing and tracking CME audit information for a licensee were not initially available in BreEZe, resulting in MBC's inability to perform CME audits. MBC did not conduct **any** CME audits until May 2016 when the system change went into effect.

MBC reports that ISB and other MBC staff are working on requests for system updates to further streamline the processes for applicants, licensees, consumers and staff and to make more transactions available online.

It would be helpful for the Committees to understand the continuing cost impacts of BreEZe to MBC's budget as well as the status of requests for technical fixes and larger change improvements.

Staff Recommendation: *MBC should advise the Committees how much it is projected to pay in BreEZe costs for FY 2017/18. MBC should update the Committees on the number of pending tickets and how swiftly MBC requests for system upgrades and changes are being processed. MBC should advise the Committees of any major updates anticipated based on the passage of recent legislation.*

Board Response (March 2017):

The Medical Board of California (Board) is projected to spend at least \$2.235 million in fiscal year (FY) 17/18 on the BreEZe project. This figure includes the credit card fees associated with online payments. In FY 18/19, the Board is projected to spend \$2.342 million.

BreEZe Release R2.1.6.0 went into effect on February 21, 2017. As part of BreEZe Release R2.1.6.0, the Board had eight Board-specific updates implemented in BreEZe. Some of these updates included changes due to the passage of Senate Bill (SB) 1478, which waived the CURES \$12 fee at renewal for physician and surgeon licensees in inactive, retired, or disabled status. Since January 11, 2017 (Breeze's R2.1.5.0 release date), the Board has submitted eleven additional BreEZe service requests. As the Board continues to work with the Department of Consumer Affairs' (DCA) Office of Information Services (OIS) to enhance BreEZe to streamline processes, while maintaining the system based on legislative and business process changes, new BreEZe service requests will most likely outpace implemented BreEZe services requests during most release cycles. There are many enhancements that the Board is pursuing via pending service requests and others that still need to be documented and submitted, but are awaiting changes to business processes and resources. With each release, the Board continues to work with OIS to enhance BreEZe and improve it for applicants, licensees, consumers, and staff.

As of February 17, 2017, the Board had 52 Board-specific service requests and there were 115 GLOBAL service requests pending assignment to a release. Along with the service requests closed as they were implemented in recent releases, the Board consolidated several service requests and also transferred ownership of several service requests to the California Board of Optometry (CBO) when the Registered Dispensing Optician (RDO) program was transferred. The criteria for an emergency release is strictly defined by OIS. Most requests do not qualify for an emergency release and therefore go through the normal BreEZe Maintenance and Operations Release Lifecycle. The Board's priorities for the next BreEZe Release R2.1.7.0, which is tentatively scheduled for release on March 29, 2017, were due to OIS on January 17, 2017. This means that a minimum of 10 weeks was required to develop, implement, test, and deploy the service requests for this release cycle once it was assigned to a release based on the Board's priority and BreEZe development resources. The Board bases the

prioritization of service requests on legislative requirements and business process needs. Some service requests can sit in queue for months waiting for the space to be prioritized into the scope of a release.

The BreZE system does not have the same check and balance capabilities available in the legacy system, which was a custom coded solution. As enforcement statistical reports are developed by Board and OIS staff, data quality issues are discovered. Quality assurance reports are developed to assist in the cleaning of the data so it can be extracted in a meaningful way. This quality assurance report development and data cleanup may slow down the process of developing enforcement statistical reports and generating meaningful data. Board enforcement staff and the OIS reports team are constantly testing and updating enforcement performance measure reports. There is still a queue of reports that are waiting to be developed, but the Board and OIS staff are working on these requests with all available resources.

Recent and upcoming legislation can result in additional, high priority service requests being created. The priority of these new service requests could cause pre-existing service requests to be delayed to later releases because of resource limitations. However, at this time, the Board does not have any major updates pending due to recent legislation.

ISSUE #2: (DATA SHARING WITH OTHER STATE AGENCIES.) Data collected by other state agencies impacts MBC's knowledge of its licensee population. MBC is supposed to receive data from a number of state agencies yet does not always receive the information necessary for MBC to do its job. What is the status of MBC's efforts to obtain important data from other state agencies?

Background: Various state agencies collect and receive health related data that may be connected to activities of MBC licensees. For example, the Department of Public Health (DPH) Office of Vital Records maintains certificates for vital events in California, including death certificates. The Department of Health Care Services (DHCS) and Department of Social Services (DSS) work together to track psychotropic medication prescription data for children in foster care. DPH's Laboratory Field Services program is supposed to inspect and subsequently track information related to the outcome of inspections of laboratories.

In each of these instances, MBC's work may be improved by having access to data from other agencies. For example, MBC could gauge prescribing trends for certain populations and conditions if it has timely access to psychotropic medication prescriptions for foster youth. With data, MBC can both set guidelines and advise on best practices as well as take enforcement action when necessary in events of demonstrated overprescribing. MBC's receipt of death certificates for deaths involving prescription drug overdose, could similarly allow MBC to assess trends that may inform best practices for controlled substances prescribing, or lead MBC to conduct investigations in instances where a death could be connected to the prescribing by an MBC licensee. If MBC received timely information from DPH about laboratories providing inducements to physicians, it would be better positioned to take action against those licensees violating Business and Professions Code Section 650 which prohibits these activities.

While MBC does have data use agreements with some agencies for information, there have historically been delays in MBC receiving information that could in turn allow MBC to make administrative decisions to inform its licensees of best practices or in some cases, allow MBC to take important enforcement action.

It would be helpful for the Committees to understand what state agencies MBC could benefit from receiving data from, what state agencies MBC has data use agreements with and where challenges persist for MBC to gain often critical information about the role of its licensees.

Staff Recommendation: *MBC should advise the Committees of its data sharing efforts and relationships with other state agencies. MBC should provide information to the Committees about necessary statutory changes that would enhance MBC's ability to safely and securely access data related to its licensees.*

Board Response (March 2017):

In the last two years, the Board has entered into data use agreements (DUA) with other state agencies in order to receive information that will assist the Board in obtaining data regarding physicians who may be violating the law or to obtain information that assists the Board in its regulatory functions. The Board entered into a data use agreement with the California Department of Public Health (CDPH) to receive death certificate data when the death was related to opioids. The Board received the data from CDPH and is in the process of analyzing the information to identify physicians who may be inappropriately prescribing opioids. In addition, the Board has a long standing agreement with CDPH to receive death certificate information on deceased physicians on an ongoing basis in order to update physician license records.

The Board also entered into a DUA with the Department of Health Care Services (DHCS) and Department of Social Services (DSS) to receive information on physicians who had prescribed three or more psychotropic medications to foster care children for 90 days or more during July 1, 2014 to December 31, 2014. This data was received by the Board and is going through the enforcement process. This DUA was codified in statute (SB 1174, McGuire, Statutes of 2016) and the data is now required to be provided to the Board on an ongoing basis for ten years. The updated DUA was recently finalized and the Board received data for calendar year 2015 on March 2, 2017. This information will be sent to our expert reviewer(s) to review the data to identify physicians who may be inappropriately prescribing. Through a review of the data received from DHCS and DSS for the 2014 time frame, the Board identified numerous patients who may have been inappropriately prescribed psychotropic medications that needed further investigation. The next step in this process is for the Board to obtain authorization to request medical records for the patients identified. The Board has requested the assistance of DSS in obtaining the medical records for these patients. At this time, Board staff is awaiting assistance from DSS and the counties to identify who needs to be contacted to request authorization for the records and to establish a process to receive these records. Without receiving authorization to obtain the medical records, the Board will not be able to move forward with investigating these physicians.

In addition to these agreements, there are other state agencies and other data that could be obtained to assist the Board with its enforcement role. DHCS Audits and Investigations Unit (AIU) performs billing audits and may identify physicians who may be violating the law. The Board needs to receive enough information to be able to pursue an investigation and these should always be sent to the Board.

On December 9, 2016, the Board, the DCA's Health Quality Investigative Unit (HQIU), and the Physician Assistant Board provided a presentation to the DHCS AIU on the Board's enforcement process, including its investigation and disciplinary process. During this presentation, the Board identified the information that would be necessary in order to open a complaint and perform an investigation. In addition, on March 10, 2017, the DHCS AIU provided a presentation to staff of the Board and the HQIU on the AIU's investigation process and its review process. During the meeting,

discussions began regarding a DUA between DHCS AIU and the Board. The Board will work with DHCS to determine what information should be provided to the Board in order for the Board to be able to perform an appropriate investigation of a physician who may be violating the law.

CDPH audits hospitals and other facilities and during an audit may obtain information regarding a physician who may be in violation of the law. In addition, CDPH, through its review of laboratories, may identify a physician who is receiving inducements. While the Board does receive some referrals from CDPH, there is no requirement to provide this information to the Board. If information is obtained by CDPH regarding a physician who may be in violation of the law, that information should be provided to the Board with enough background information and evidence that the Board can pursue an investigation.

The Board agrees with the Committees that this information is useful to the Board. The Board would support any legislation that would require data sharing between state agencies, thereby assisting the Board in identifying physicians who may be violating the Medical Practice Act. Such legislation should also ensure that the Board receives enough information to perform an adequate investigation.

ISSUE #3: (RESEARCH PSYCHOANALYST REGISTRATION.) As noted previously, MBC registers Research Psychoanalysts (RPs), individuals who practice psychoanalysis for fees for no more than one third of the individual's total professional time (which includes time spent in practice, teaching, training or research). Psychoanalysis is a discipline of psychology. Why does MBC administer the RP registration program rather than the Board of Psychology which oversees those practicing in psychology and has experience administering registration programs?

Background: According to the American Psychological Association (APA), psychoanalysis is a specialty in psychology that is distinguished from other specialties by its body of knowledge and its intensive treatment approaches. It aims at structural changes and modifications of a person's personality. Psychoanalysis promotes awareness of unconscious, maladaptive and habitually recurrent patterns of emotion and behavior, allowing previously unconscious aspects of the self to become integrated and promoting optimal functioning, healing and creative expression. The APA states that psychoanalytic training typically requires four to eight years of advanced study after completion of a doctoral degree in psychology acceptable to the American Board of Professional Psychology and further requires specialized training at free-standing psychoanalytic institutes, postdoctoral university programs, or an equivalent training secured independently that is acceptable to the American Board and Academy of Psychoanalysis.

In California, the Board of Psychology licenses psychologists and registers psychologists and psychological assistants. Licensed psychologists may practice independently in any private or public setting. Psychological assistants are those individuals who have an advanced degree in psychology and provide limited psychological services under direct supervision. Registered psychologists are authorized to engage in psychological activities under direct supervision only at nonprofit community agencies that receive a minimum of 25 percent of their funding from a governmental source.

The Board of Psychology previously had a member who served as president of the Northern California Society for the Psychoanalytic Psychology Board of Directors and was an assistant editor for a psychoanalytic publication. It appears that the Board of Psychology may have more expertise in this discipline and may be a more appropriate entity to register RPs who engage in a psychology based practice.

Staff Recommendation: *MBC should advise the Committees why it registers RPs rather than the Board of Psychology. Upon receipt of information from MBC and the Board of Psychology, the Committees may wish to transfer registration of RPs to the Board of Psychology, which already successfully administers registration programs for individuals practicing psychology.*

Board Response (March 2017):

In 1977, when the research psychoanalysts were established in law, the Board, then the Board of Medical Quality Assurance, was comprised of three sections, the Division of Medical Quality, the Division of Licensing, and the Division of Allied Health Professions. Several allied health professions were within the jurisdiction of the Division of Allied Health Professions, including audiologists, acupuncturists, hearing aid dispensers, physical therapists, medical assistants, physician assistants, podiatrists, *psychologists*, registered dispensing opticians, and speech pathologists. In 1990 when the Board of Psychology came into existence, the research psychoanalysts remained under the Board's oversight.

Although the Board has not fully discussed this issue, Board staff does not believe there would be any adverse effect to transfer this program to the Board of Psychology. The Board looks forward to working with the Board of Psychology, the Committees, and interested parties to determine the impact of this transfer and to draft any language necessary for the transition.

ISSUE #4: (LICENSED MIDWIVES.) **MBC regulates licensed midwives. Are certain clarifications to the law necessary to reflect these providers' role? How does MBC work with LMs and LM stakeholder groups?**

Background: MBC received regulatory authority over licensed midwives in 1994. A licensed midwife (LM) is an individual who has been issued a license to practice midwifery by MBC. The Midwifery Practice Act, contained in BPC Sections 2505 to 2521, authorizes a licensee to attend cases of normal pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother and immediate care for the newborn. LMs can practice in a home, birthing clinic or hospital environment.

MBC receives guidance on midwifery issues through a Midwifery Advisory Council (MAC). The MAC is made up of LMs (pursuant to BPC 2509, at least half of the MAC members are LMs), a physician, and two non-physician public members. MBC is working with stakeholders through the MAC and a specified task force in order to define "normal" in regulations, for purposes of clarifying births an LM can attend, as required under AB 1308. Until MBC adopts regulations, LMs are not able to be a "comprehensive perinatal provider" for purposes of providing comprehensive perinatal services to Medi-Cal beneficiaries in the Comprehensive Perinatal Services Program (CPSP). SB 407 (Morrell, Chapter 313, Statutes of 2015) authorized a health care provider to employ or contract with licensed midwives for the purpose of providing comprehensive perinatal services in the CPSP.

Certain areas of the law have been identified as potentially benefitting from amendments to better reflect the role of LMs.

Professional Corporations. Corporations Code 13401.5 authorizes the formation of various healing arts professional corporations and establishes which healing arts licensees who are not of the same license type as the corporation may be shareholders, officers, and directors of that corporation. Any person licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act may be employed by these professional corporations. Thus, the services of professional corporations

are not limited to the named profession. For example, a nursing corporation may have a director who is a chiropractor, a shareholder who is an acupuncturist, and employ an accountant, podiatrist, and a marriage and family therapist, none of which would traditionally be seen as providing the professional services of nursing.

Current law authorizes a medical corporation to have a number of health licensees as officers, directors, and shareholders. *LMs should be added to the list.*

Peer Review. Under BPC Section 805, specified health-related professional societies, duly-appointed committees of a medical specialty society, duly-appointed committees of a state or local health related professional society or duly-appointed members of a committee of a professional staff of a licensed hospital that undertakes peer review, must provide reports to the MBC or other state licensing board under certain circumstances. LMs are not currently included in this requirement and should be added. Existing law also provides that there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, specified health professional societies, members of a duly appointed committee of a medical specialty society, or any member of a duly appointed committee of a state or local health professional society, or duly appointed member of a committee of a professional staff of a licensed hospital for acts performed within the scope of the functions of peer review.

Existing law also provides that the proceedings and actions of specified health professional societies, committees of a medical specialty society or other health professional society, or a committee of the professional staff of a licensed hospital, that have responsibility for the evaluation and improvement of the quality of care provided by the members of the professional society, are not subject to discovery in civil actions. Likewise, persons in attendance at any meeting of any such committee cannot be compelled to testify regarding what transpired at the meeting. *LM professional societies and LM review committees are not included and should be added. Peer review provisions should include LMs.*

Staff Recommendation: *The Committees should amend provisions in the law as noted above. MBC should advise the Committees on outreach efforts to LMs and LM stakeholders and should update the Committees on the ongoing relationship between MBC and LMs. MBC should provide an update to the Committees on the AB 1308 regulations, as delays in promulgating these regulations impact the implementation of SB 407 and ability for LMs to provide services under the CPSP.*

Board Response (March 2017):

Although the Board has not discussed the issues in the background paper related to changes in the corporations code and the peer review section relating to licensed midwives, these suggestions are in the interests of consumer protection. Regarding outreach to licensed midwives, as issues arise, the Board solicits input from licensed midwives on certain issues. For example, they were contacted to provide input into the Licensed Midwife Annual Report (LMAR) and sent a letter regarding authorized testing. The Board notifies all subscribers of MAC meetings and reaches out to LM stakeholders on specific issues. In addition, the MAC Chair provides an update to the Board at each Board meeting after a MAC meeting.

The Board has held several interested parties meetings on the regulations to implement Assembly Bill (AB) 1308. In addition, the Board has been working with both the California Association of Midwives/California Association of Licensed Midwives (CAM/CALM) and the American College of Obstetricians and Gynecologists (ACOG) on these regulations. However, there has not been agreement on the issue of putting prior cesarean sections on the list of preexisting conditions requiring a physician

and surgeon examination and determination that the risk factors presented by the woman's disease or condition are not likely to significantly affect the course of pregnancy and childbirth prior to the licensed midwife continuing to provide care pursuant to Business and Professions Code section 2507. Therefore, the Board established a Midwifery Task Force, made up of two Board Members to assist with these regulations. The Midwifery Task Force met on Monday, March 6, 2017, with representatives from ACOG and CAM/CALM to discuss the current status of regulations to define "preexisting maternal disease or condition likely to affect the pregnancy," and "significant disease arising from the pregnancy" under Business and Professions Code section 2507.

At the meeting, the parties discussed the challenges created by the current language under 2507(b)(2) requiring a licensed midwife to refer a client with a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy to a physician and surgeon for an examination and a determination by the physician that the risk factors presented by the woman's disease or condition are not likely to significantly affect the course of pregnancy and childbirth. It was acknowledged that this issue could not be resolved through regulations.

The Midwifery Task Force determined that a legislative fix is necessary, so that if the woman has a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy, the midwife will still be required to refer the woman to a physician trained in obstetrics for an assessment of the risk factors that may adversely affect the outcome of the pregnancy or childbirth. The midwife would have to include the assessment in evaluating whether the woman's disease or condition are likely to significantly affect the course of the pregnancy or childbirth. Thus, it would be the midwife making that determination within the midwifery standard of care, rather than the physician, as to whether the woman should continue with midwifery care. If the woman does have a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy likely to significantly affect the course of pregnancy or childbirth, the midwife would have to refer the woman to a physician and surgeon for care, with the midwife providing collaborative care, as appropriate.

Should the statute be changed, the Board will move forward with proposed regulations to define "preexisting maternal disease or condition likely to affect the pregnancy," and "significant disease arising from the pregnancy." Conditions falling within the definitions put forth in regulations would prompt the referral to the physician for the assessment of the risk factors, and when appropriate, for the transfer of care.

The Midwifery Task Force will provide the proposed legislative amendment to the Board at its next meeting in April 2017. If the language is approved, the Board will provide the language to the Committees. This change should resolve the issue that has been hindering the regulations moving forward.

ISSUE #5: (BOARD OF PODIATRIC MEDICINE [BPM].) While the BPM was once housed within the MBC, it has been a board since 1986 and relies on the MBC only for contractually specified duties, which the MBC provides for other boards as well. The BPM is independently responsible for determining the eligibility of its licensees and making final disciplinary decisions. Should statutory clarifications be made to reflect the actual nature of MBC and BPM's relationship?

Background: MBC provides certain services to other entities at the DCA that were formerly committees under MBC. MBC provides shared services for the BPM and the Physician Assistant

Board, smaller programs that do not have near the infrastructure and administrative wherewithal that a large board like MBC does, in order to assist these boards in efficiently conducting their business. Confusion has arisen as to the exact nature of MBC's role with regards to BPM operations as outlined in BPM presentations and discussions at its public meetings.

Through shared services agreements, MBC solely performs administrative functions for independent boards like BPM. In essence, MBC is contracted to do certain work and MBC in turn charges BPM for the time MBC staff work on behalf of BPM to do tasks like processing complaints and handling other disciplinary functions.

When the Podiatry Examining Committee was first created under MBC, terminology describing the relationship between the two entities, as well as the relationship itself was entirely different. In 1980, BPC Section 2460 "created within the jurisdiction of the Division of Allied Health Professions of the Board of Medical Quality Assurance, a Podiatry Examining Committee." BPC 2460 today reads that there is "created within the jurisdiction of the Medical Board of California the California Board of Podiatric Medicine." It appears that the Act has not always been updated to reflect changes in both the relationship, as well as terminology of these two entities, but rather has only been amended over the years to acknowledge changed names of the two entities and sunset dates and extensions.

Historically, MBC issued certificates to practice podiatric medicine to qualified applicants because the committee was under MBC's jurisdiction. The only changes to BPC 2479 related to the issuance of certificates (since the codes were restructured in 1980 and Article 22 related to Podiatric Medicine was placed where it is in the Act) reflect MBC internal reorganization, specifically that that MBC's Division of Licensing issues licenses on MBC's behalf instead of prior language that referred to MBC. This code section does not appear to have been updated at all to reflect the creation of BPM as a board in 1986. The Act defines "podiatric medicine" as all medical treatment of the foot, ankle, and tendons that insert into the foot, including diagnosis, surgery, and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot. Therefore, a DPM's scope of practice is similar to that of a physician and surgeon who specializes in the foot and ankle. However, unlike a physician and surgeon, whose scope is only limited by the licensee's own area of competence, a DPM's scope is statutorily limited to the foot and ankle.

BPM determines the qualifications for licensure, reviews applications and subsequently makes all decisions about DPM licensure and until 2016, issued its own licenses to its own licensees. However, for these licensees, the actual pieces of paper included a Medical Board of California seal, despite being separate from the licenses issued by MBC for physicians and surgeons due to the lack of proper code cleanup recognizing BPM as an independent entity. Once this proposal was discussed and concerns were raised it was determined that MBC staff, again through a shared services agreement, would update the BreZE system to issue a DPM license on behalf of BPM. MBC does nothing more than update the system to reflect the independent licensure decision made by BPM. For instance, existing law specifies that the MBC issues the podiatric medicine license.

MBC has requested, and legislation was proposed last year (SB 1039, Hill), to clarify that BPM is its own board that performs its own licensing functions so that the law accurately reflects the true nature of each independent entity and each board's actual responsibilities. In response to concerns raised by the BPM, California Podiatric Medical Association and California Medical Association, SB 1039 was amended in the Assembly to remove the provisions related to BPM. CPMA advised the Committees this year that any changes stemming from those conversations last year should continue to place BPM in the Act. CPMA also noted that "there are various rules, regulations and codes that refer to

‘licensees of the Medical Board’, which have included DPM licensees...CPMA would ask that any new laws consider this and address wording to include DPMs where appropriate.”

It does not appear that technical statutory changes to the Act will impact the two boards’ shared services agreement, as that is separate from statute and clarifies the contractual services MBC provides to BPM. Further, it does not appear that any code cleanup will impact either of the boards’ role in effectively operating, nor does it appear that additional cost will arise from changes to the Act, since the administrative shared services agreement delineates the services MBC provides on behalf of BPM and specifically outlines the cost to BPM for those services.

Staff Recommendation: *The Act should be amended according to the following below, in addition to other code sections identified that clarify the nature of DPM licensure by BPM:*

BPC 2423. (a) Notwithstanding Section 2422:

(1) All physician and surgeon’s ~~certificates, certificates to practice podiatric medicine, registrations of spectacle lens dispensers and contact lens dispensers,~~ **certificates** and certificates to practice midwifery shall expire at 12 midnight on the last day of the birth month of the licensee during the second year of a two-year term if not renewed.

(2) Registrations of dispensing opticians will expire at midnight on the last day of the month in which the license was issued during the second year of a two-year term if not renewed.

(b) The ~~Division of Licensing~~ **board** shall establish by regulation procedures for the administration of a birth date renewal program, including, but not limited to, the establishment of a system of staggered license expiration dates such that a relatively equal number of licenses expire monthly.

(c) To renew an unexpired license, the licensee shall, on or before the dates on which it would otherwise expire, apply for renewal on a form prescribed by the licensing authority and pay the prescribed renewal fee.

2460. (a) There is created within the ~~jurisdiction of the Medical Board of California~~ the **Department of Consumer Affairs** a California Board of Podiatric Medicine.

(b) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

Notwithstanding any other provision of law, the repeal of this section renders the California Board of Podiatric Medicine subject to review by the appropriate policy committees of the Legislature.

2461. As used in this article:

(a) ~~“Division” means the Division of Licensing of the Medical Board of California.~~

(b)

(a) “Board” means the California Board of Podiatric Medicine.

(c)

(b) “Podiatric licensing authority” refers to any officer, board, commission, committee, or department of another state that may issue a license to practice podiatric medicine.

2475. Unless otherwise provided by law, no postgraduate trainee, intern, resident postdoctoral fellow, or instructor may engage in the practice of podiatric medicine, or receive compensation therefor, or offer to engage in the practice of podiatric medicine unless he or she holds a valid, unrevoked, and unsuspended certificate to practice podiatric medicine issued by the ~~division.~~ **board**. However, a graduate of an approved college or school of podiatric medicine upon whom the degree doctor of

podiatric medicine has been conferred, who is issued a resident's license, which may be renewed annually for up to eight years for this purpose by the ~~division upon recommendation of the board~~, and who is enrolled in a postgraduate training program approved by the board, may engage in the practice of podiatric medicine whenever and wherever required as a part of that program and may receive compensation for that practice under the following conditions:

(a) A graduate with a resident's license in an approved internship, residency, or fellowship program may participate in training rotations outside the scope of podiatric medicine, under the supervision of a physician and surgeon who holds a medical doctor or doctor of osteopathy degree wherever and whenever required as a part of the training program, and may receive compensation for that practice. If the graduate fails to receive a license to practice podiatric medicine under this chapter within three years from the commencement of the postgraduate training, all privileges and exemptions under this section shall automatically cease.

(b) Hospitals functioning as a part of the teaching program of an approved college or school of podiatric medicine in this state may exchange instructors or resident or assistant resident doctors of podiatric medicine with another approved college or school of podiatric medicine not located in this state, or those hospitals may appoint a graduate of an approved school as such a resident for purposes of postgraduate training. Those instructors and residents may practice and be compensated as provided in this section, but that practice and compensation shall be for a period not to exceed two years.

2479. ~~The division shall issue, upon the recommendation of the board,~~ **board shall issue** a certificate to practice podiatric medicine to each applicant who meets the requirements of this chapter. Every applicant for a certificate to practice podiatric medicine shall comply with the provisions of Article 4 (commencing with Section 2080) which are not specifically applicable to applicants for a physician's and surgeon's certificate, in addition to the provisions of this article.

2486.

~~The Medical Board of California shall issue, upon the recommendation of the board,~~ **board shall issue** a certificate to practice podiatric medicine if the applicant has submitted directly to the board from the credentialing organizations verification that he or she meets all of the following requirements:

(a) The applicant has graduated from an approved school or college of podiatric medicine and meets the requirements of Section 2483.

(b) The applicant, within the past 10 years, has passed parts I, II, and III of the examination administered by the National Board of Podiatric Medical Examiners of the United States or has passed a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States.

(c) The applicant has satisfactorily completed the postgraduate training required by Section 2484.

(d) The applicant has passed within the past 10 years any oral and practical examination that may be required of all applicants by the board to ascertain clinical competence.

(e) The applicant has committed no acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475).

(f) The board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.

(g) A disciplinary databank report regarding the applicant is received by the board from the Federation of Podiatric Medical Boards.

2488. Notwithstanding any other ~~provision of law, the Medical Board of California shall issue, upon the recommendation of the board,~~ **board shall issue** a certificate to practice podiatric medicine by

credentialing if the applicant has submitted directly to the board from the credentialing organizations verification that he or she is licensed as a doctor of podiatric medicine in any other state and meets all of the following requirements:

- (a) The applicant has graduated from an approved school or college of podiatric medicine.
- (b) The applicant, within the past 10 years, has passed either part III of the examination administered by the National Board of Podiatric Medical Examiners of the United States or a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States.
- (c) The applicant has satisfactorily completed a postgraduate training program approved by the Council on Podiatric Medical Education.
- (d) The applicant, within the past 10 years, has passed any oral and practical examination that may be required of all applicants by the board to ascertain clinical competence.
- (e) The applicant has committed no acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475).
- (f) The board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.
- (g) A disciplinary databank report regarding the applicant is received by the board from the Federation of Podiatric Medical Boards.

2492. (a) The board shall examine every applicant for a certificate to practice podiatric medicine to ensure a minimum of entry-level competence at the time and place designated by the board in its discretion, but at least twice a year.

(b) Unless the applicant meets the requirements of Section 2486, applicants shall be required to have taken and passed the examination administered by the National Board of Podiatric Medical Examiners.

(c) The board may appoint qualified persons to give the whole or any portion of any examination as provided in this article, who shall be designated as examination commissioners. The board may fix the compensation of those persons subject to the provisions of applicable state laws and regulations.

(d) The provisions of Article 9 (commencing with Section 2170) shall apply to examinations administered by the board except where those provisions are in conflict with or inconsistent with the provisions of this article. ~~In respect to applicants under this article any references to the "Division of Licensing" or "division" shall be deemed to apply to the board.~~

2499. There is in the State Treasury the Board of Podiatric Medicine Fund. Notwithstanding Section 2445, the ~~division~~ **board** shall report to the Controller at the beginning of each calendar month for the month preceding the amount and source of all revenue received by ~~it on behalf of~~ the board, pursuant to this chapter, and shall pay the entire amount thereof to the Treasurer for deposit into the fund. All revenue received by the board ~~and the division~~ from fees authorized to be charged relating to the practice of podiatric medicine shall be deposited in the fund as provided in this section, and shall be used to carry out the provisions of this chapter relating to the regulation of the practice of podiatric medicine.

Section 2499.7 is added to the Business and Professions Code, to read:

2499.7. (a) Certificates to practice podiatric medicine shall expire at 12 midnight on the last day of the birth month of the licensee during the second year of a two-year term.

(b) To renew an unexpired certificate, the licensee, on or before the date on which the certificate would otherwise expire, shall apply for renewal on a form prescribed by the board and pay the prescribed renewal fee.

Board Response (March 2017):

The Board agrees with the Committees' recommendation and the legislative changes proposed by the Committees.

ISSUE #6: (PANEL MEMBERSHIP.) MBC is authorized to create panels pursuant to BPC 2008 to evaluate appropriate disciplinary actions. The structure of these panels is potentially hindered by a statutory prohibition for the MBC president to serve as a panel member unless MBC has a vacancy, while at the same time providing that the number of physicians on a panel cannot outweigh the number of public members. Should the law be clarified to account for the realities of MBC membership?

Background: MBC is comprised of 15 members, eight physicians and seven public members. In addition, BPC Section 2004(c) states that MBC's responsibilities include carrying out the disciplinary actions appropriate to the findings made by a panel or an administrative law judge. BPC Section 2008 authorizes MBC to establish panels to fulfill section 2004(c). In establishing panels, the law specifies that the panel must be comprised of a minimum of four members, with the number of public members not to exceed the number of licensed physician and surgeon members, but that the MBC president can only be a member of a panel if there is a vacancy in MBC membership.

According to MBC, this inability for the MBC president to serve on a panel has caused a conflict. Depending on the MBC's appointed membership at any given time, the number of individuals on a panel could vary from four to seven. When all MBC members have been appointed, MBC should have two panels, each comprised of seven members. However, if the MBC president happens to be a physician member, and the president is prohibited from sitting on a panel, the result is more public members than physician members, also specifically prohibited under the law. One resolution could be to prohibit a public member from serving on a panel during the tenure of a physician MBC president. However, eliminating the physician member from eligibility as a panel member due to their appointment as president then leaves only seven physicians and seven public members to be divided between two panels. One panel could be made up of four physicians and four public members, but the other panel would be made up of four public members and three physicians, thus violating of the requirement in BPC 2008 that the number of public members not exceed the number of physician members on a panel.

Staff Recommendation: *The Act should be amended to allow the MBC president to be on a panel to resolve this unintended conflict according to the following:*

BPC 2008. 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.

Board Response (March 2017):

The Board agrees with the Committees' recommendation and the legislative changes proposed by the Committees.

ISSUE #7: (ROLE OF MBC AND HEALTH PROFESSIONALS AND EDUCATION FOUNDATION [HPEF].) MBC has always played a formal role in the administration of the Steven M. Thompson Physician Corps Loan Repayment Program but currently does not have authority to appoint members to the board of the HPEF. Should MBC once again be able to appoint members to the board of the entity that administers this important program?

Background: The Steven M. Thompson Physician Corps Loan Repayment Program (Program) exists within the Health Professions Education Fund, administered by the Office of Statewide Health Planning and Development (OSHPD), as a means of providing educational loans repayment for physicians and surgeons who practice in medically underserved areas of the state. The program was established through legislation in 2002, (AB 982, Firebaugh, Chapter 1131, Statutes of 2002) in response to the physician shortage problem in underserved areas. The program encourages recently licensed physicians to practice in health professional shortage areas (HPSA) in California, repaying up to \$105,000 in educational loans in exchange for full-time service for at least three years. To be considered eligible for an award, applicants must:

- Be an allopathic or osteopathic physician
- Be free of any contractual service obligations (i.e. the National Health Service Corps Federal Loan Repayment Program or other financial incentive programs)
- Have outstanding educational debt from a government or commercial lending institution
- Have a valid, unrestricted license to practice medicine in California
- Be employed or have accepted employment in a HPSA in California and commit to providing full-time direct patient care in a HPSA.

Currently, up to 20 percent of the available Program funds may be awarded to program applicants from specialties outside of the primary care specialties.

The Program was previously housed at MBC until legislation in 2005 (AB 920, Aghazarian, Chapter 317, Statutes 2005) moved the Program to the Health Professions and Education Foundation (HPEF), a 501(c)(3) public benefit corporation, which receives administrative support from OSHPD. 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 enabled it to grow and increase access to care for Californians.

Although the Program moved to the HPEF, AB 920 also required that two members of the HPEF Board be appointed by MBC. However, that bill also provided a sunset date of January 1, 2011 for the provision related to MBC appointees. AB 1767 (Hill, Chapter 451, Statutes of 2010) extended the date for MBC to appoint members to the HPEF from January 1, 2011, to January 1, 2016, but there was no subsequent legislation to extend the sunset date from January 1, 2016. As a result, MBC's HPEF appointees were removed effective January 1, 2016.

MBC believes that representation on the HPEF is still necessary, noting that physician licensees each provide a mandatory \$25 to the HPEF to fund the program and the assistance MBC staff provides in the award process.

Staff Recommendation: *The Health and Safety Code statutes governing the Program should be amended to ensure participating by MBC in the Program according to the following:*

HSC 128335. (a) The office shall establish a nonprofit public benefit corporation, to be known as the Health Professions Education Foundation, that shall be governed by a board consisting of nine members appointed by the Governor, one member appointed by the Speaker of the Assembly, and one member appointed by the Senate Committee on Rules and two members appointed by the Medical Board of California. The members of the foundation board appointed by the Governor, Speaker of the Assembly, and Senate Committee on Rules may include representatives of minority groups which are underrepresented in the health professions, persons employed as health professionals, and other appropriate members of health or related professions. All persons considered for appointment shall have an interest in health programs, an interest in health educational opportunities for underrepresented groups, and the ability and desire to solicit funds for the purposes of this article as determined by the appointing power. The chairperson of the commission shall also be a nonvoting, ex officio member of the board.

(b) The Governor shall appoint the president of the board of trustees from among those members appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules, and Medical Board of California.

(c) The director, after consultation with the president of the board, may appoint a council of advisers comprised of up to nine members. The council shall advise the director and the board on technical matters and programmatic issues related to the Health Professions Education Foundation Program.

(d) Members of the board and members of the council shall serve without compensation but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the board or the council. Members appointed by the Medical Board of California shall serve without compensation, but shall be reimbursed by the Medical Board of California for any actual and necessary expenses incurred in connection with their duties as members of the foundation board.

(e) The foundation shall be subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), except that if there is a conflict with this article and the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), this article shall prevail.

(f) This section shall become operative January 1, 2016.

Board Response (March 2017):

The Board agrees with the Committees' recommendation and the legislative changes proposed by the Committees.

ISSUE #8: (NOTICE TO CONSUMERS.) Business and Professions Code Section 138 requires DCA entities to adopt regulations requiring licensees to provide notice to consumers that the individual is licensed by the State of California. MBC is concerned that this notification does not accurately represent information consumers may need. Should the notification be expanded?

Background: Pursuant to legislation passed in 1998 (SB 2238, Senate Committee on Business and Professions, Chapter 879, Statutes of 1998), DCA entities were required to promulgate regulations outlining how licensees should provide notice to consumers that the individual is licensed. BPC Section 138 states:

138. Every board in the department, as defined in Section 22, shall initiate the process of adopting regulations on or before June 30, 1999, to require its licentiates, as defined in Section 23.8, to provide notice to their clients or customers that the practitioner is licensed by this state. A board shall be exempt from the requirement to adopt regulations pursuant to this section if the board has in place, in statute or regulation, a requirement that provides for consumer notice of a practitioner's status as a licensee of this state.

MBC advises that the regulations it adopted only reflect this limited notification that an individual is licensed and notes in its Sunset Report “that consumer protection will be furthered by expanding the statutory language as to what is to be included in the notice, and how it is to be delivered to consumers.” Specifically, MBC notes that BPC 138 does not necessarily provide consumers with sufficient information about what MBC does. MBC is concerned this this limited notice does not encourage consumers to access information from MBC or to contact MBC.

While the general provisions of BPC could be enhanced for improved notification to consumers by all DCA licensees, for purposes of MBC, it may be appropriate to include language in the Act to outline the notification MBC licensees should provide consumers.

Staff Recommendation: *The Committees may wish to amend the Act to specify additional information about MBC and how to access MBC services that should be provided to patients and the public. MBC should work with the Committees and stakeholders in order to determine the information consumers should receive and provide suggested statutory language to fulfill this important mission of arming the public with information about MBC.*

Board Response (March 2017):

Language was submitted on March 10, 2017 to Senate Business, Professions, and Economic Development (B&P) Committee staff that would amend the notice that is required to be posted, thereby providing consumers with more information.

ISSUE #9: (PHYSICIAN HEALTH AND WELLNESS PROGRAM.) **MBC is considering implementing a Physician Health and Wellness Program. MBC’s prior program faced significant shortfalls and raised concerns about patient protection. How will MBC ensure the program will successfully assist physicians while ensuring patients are not harmed?**

Background: SB 1177 (Galgiani, Chapter 591, Statutes of 2016) authorizes MBC to establish a Physician and Surgeon Health and Wellness Program (PHWP) for the early identification and appropriate interventions to support a licensee in his or her rehabilitation from substance abuse and authorizes MBC to contract with an independent entity to administer the PHWP. The bill requires MBC, if it establishes a PHWP, to contract for administration with an independent administering entity selected by MBC through a request for proposals process. SB 1177 also establishes requirements for a PHWP and provides that MBC shall determine the appropriate fee that a participant shall pay to cover all costs for participating in the PHWP, including any costs to administer the PHWP.

Proponents of the bill were concerned that California physicians are the only licensed medical professionals without a wellness and treatment program aimed at providing support and rehabilitation for substance abuse, stress, and other health issues. The MBC previously administered a Physician Diversion Program (PDP), created in 1980 to rehabilitate doctors with mental illness and substance abuse problems without endangering public health and safety. Under this concept, physicians who abuse drugs and/or alcohol or who are mentally or physically ill may be “diverted” from the disciplinary track into a program that monitors their compliance with terms and conditions of a contract that is aimed at ensuring their recovery. The PDP monitored participants’ attendance at group meetings, facilitated random drug testing, and required reports from work-site monitors and treatment providers. Many of the physicians in the PDP retained full and unrestricted medical licenses during their participation and enjoyed complete confidentiality. In recognition that patient safety could not continue to be compromised, as numerous audits pointed out about the PDP, the MBC voted unanimously on July 26, 2007 to end the PDP. The PDP was allowed to sunset on June 30, 2008.

While MBC housed its diversion program, other boards outsource these functions. The DCA currently manages a master contract with MAXIMUS, Inc. (MAXIMUS), a publicly traded corporation for the healing arts boards that have a diversion program. Under this model, the individual boards oversee the programs, but services are provided by MAXIMUS. These diversion programs generally follow the same general principles of the MBC’s former PDP. Health practitioners with substance abuse issues may be referred in lieu of discipline or self-refer into the programs and receive help with rehabilitation. After an initial evaluation, individuals accept a participation agreement and are regularly monitored in various ways, including random drug testing, to ensure compliance.

SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) required the DCA to develop uniform and specific standards that shall be used by each healing arts board in dealing with substance-abusing licensees in 16 specified areas, including requirements and standards for: (1) clinical and diagnostic evaluation of the licensee; (2) temporary removal of the licensee from practice; (3) communication with licensee’s employer about licensee status and condition; (4) testing and frequency of testing while participating in a diversion program or while on probation; (5) group meeting attendance and qualifications for facilitators; (6) determining what type of treatment is necessary; (7) worksite monitoring; (8) procedures to be followed if a licensee tests positive for a banned substance; (9) procedures to be followed when a licensee is confirmed to have ingested a banned substance; (10) consequences for major violations and minor violations of the standards and requirements; (11) return to practice on a full-time basis; (12) reinstatement of a health practitioner’s license; (13) use and reliance on a private-sector vendor that provides diversion services; (14) the extent to which participation in a diversion program shall be kept confidential; (15) audits of a private-sector vendor’s performance and adherence to the uniform standards and requirements; and (16) measurable criteria and standards to determine how effective diversion programs are in protecting patients and in assisting licensees in recovering from substance abuse in the long term. The Uniform Substance Abuse Standards (Uniform Standards) were finally adopted in early 2010, with the exception of the frequency of drug testing which was finalized in March 2011. The MBC formally implemented the Uniform Standards in July 2015.

Currently, impaired physicians with substance abuse issues must find their own treatment facility for assistance. MBC is not made aware that the physician received treatment unless a complaint is received, and the physician may present the treatment as evidence in a disciplinary proceeding only if he or she wishes. When MBC is made aware of substance abuse, licensees are placed on formal probation, with terms customized to fit the licensee’s individual need. Typical terms include participation in support group meetings, random testing for drug and alcohol use, practice restrictions,

and/or medical or psychiatric treatment, including psychotherapy. MBC still retains the power to currently order biological fluid testing as a condition of probation. If the physician tests positive, MBC issues a cease practice order, if allowed in the condition of probation, until MBC investigates and takes subsequent action. If the condition does not authorize a cease practice order, MBC investigates whether the physician is safe to practice medicine. If not, MBC staff will seek an ISO or ask the physician to agree not to practice via a stipulated agreement.

It appears that MBC is preparing to implement a PHWP. MBC held an interested parties meeting in January to discuss regulatory steps necessary for any program. The Governor's 2017/2018 budget includes a request for MBC to add one position to its staff dedicated to administration of a program (despite a program not being in place). It would be helpful for the Committees to understand what steps MBC is taking to implement a PHWP, how the PHWP will conform to the Uniform Standards, how MBC will assure robust accountability for and oversight of the PHWP and how MBC will ensure there are no conflicts of interest in the administration a PHWP should MBC implement a program.

Staff Recommendation: *MBC should update the Committees on the implementation of a PHWP, including the status of implementation and steps MBC plans to take to ensure the PHWP does not repeat the mistakes of the former PDP.*

Board Response (March 2017):

SB 1177 authorized the Board to establish a Physician Health and Wellness Program. At the October 2016 Board Meeting, the Board approved moving forward with a Physician Health and Wellness Program. On January 11, 2017, the Board held an interested parties meeting to obtain stakeholder input on language for the regulations for the program. The Board is drafting these regulations and will hold another interested parties meeting to discuss these regulations. Once the language has been finalized, it will be provided to the Board for approval. Once the language is approved, the Board will proceed with the regulatory process. Once the regulations are approved, the Board will send out a request for proposal for a third-party vendor. After the contract is awarded, the Board will have to do regulations to set the participation fee. The Board anticipates having all the activities completed so a program could start in the fall of 2018.

This program, as established in the law, is very different than the Board's prior Diversion Program. Physicians will not be able to divert the disciplinary process by entering and successfully completing this program. In addition, the program will have to comply with regulations that are based upon the law, as well as the Uniform Standards. These regulations are going to follow the Uniform Standards as written, which in most circumstances does not allow for deviations. The program will also be run by a third-party entity, not Board staff. This third-party entity will have more expertise and will not be under civil service requirements. The Board will be able to have an independent auditor review the program at least every three years. This will provide the Board with information as to the compliance of this program with the regulations and Uniform Standards. Lastly, the program will provide updates to the Board on the status of individuals in the program. Reports have not yet been established, but this will be part of the process to establish this program. All of these safeguards will assist the Board in ensuring that the program is in compliance with the regulations and Uniform Standards and in line with the Board's mission of consumer protection.

ISSUE #10: (INPUT FROM INTERESTED PARTIES.) **MBC invites stakeholders to participate in meetings and provides formal opportunities for representatives of various state agencies, organizations and professions to present to MBC. Should representatives for the Naturopathic Medicine Committee be allowed to provide information to MBC in a formal MBC**

meeting setting to better inform members and staff about the role of naturopathic physicians as licensees in California?

Background: According to the Naturopathic Medicine Committee (NMC), naturopathic medicine is a distinct and comprehensive system of primary health care that uses natural methods and substances to support and stimulate the body's self-healing process. Naturopathic medicine includes the combination of a variety of natural medicines and treatments. Naturopathic doctors (NDs) are clinically trained in both natural and conventional approaches to medicine and can prescribe all natural and synthetic hormones, epinephrine, and vitamins, minerals, and amino acids independent of physician supervision. California NDs complete 72 pharmacology course hours in school and are required to complete a minimum of 20 hours of pharmacotherapeutic training every two years as part of their 60 hour continuing education requirement. NDs attend four year, graduate-level, accredited naturopathic medical schools, are trained as primary care providers, and take a national, standardized licensing examination. NDs have limited opportunities to complete hospital residencies, but perform at least 1500 hours of clinical rotations at clinics and private doctors' offices during their education program. California is one of 17 states that license NDs, and over 500 ND licenses have been issued to date.

Stemming from complaints received by MBC about NDs, NMC believes it could be helpful for MBC to receive a presentation about the legal abilities for NDs to practice in California. The NMC cites a 2010 case that MBC dedicated enforcement staff resources and eventually arrested a ND for practicing medicine without a license, however, charges were dropped when a better understanding of the Naturopathic Doctors Act was gained by both MBC investigators and OAG.

It would be helpful for MBC members and their staff to learn more about the legal practices NDs are authorized to perform in California.

Staff Recommendation: *MBC should have representatives of NMC attend an upcoming MBC meeting to better inform MBC staff and members about the profession.*

Board Response (March 2017):

The Board always welcomes other boards and state agencies to provide presentations at Medical Board meetings on areas of interest to the Board. The Board was unaware of the concerns about enforcement actions or a desire to provide a presentation by the Naturopathic Medicine Committee (NMC). The Board will contact the NMC to request a presentation be provided to the Board at either the April or July 2017 Board meeting. In addition, the Board will recommend that the NMC provide a presentation to the Board's Enforcement and HQUI's staff.

ISSUE #11: (BOARD CERTIFICATION.) BPC Section 651 requires MBC to review and approve specialty boards who are not approved by the American Board of Medical Specialties (ABMS) but believe they have equivalent requirements. The law also prohibits a physician from advertising that he or she is "board certified" unless the individual holds a certification from 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 MBC. MBC is required, then, to approve or disapprove these specialty boards based upon their equivalency. The discussion of MBC's continued role in approving specialty boards has been raised in previous reviews of MBC and remains an issue. Is MBC really the most appropriate entity to determine board

certification equivalency? What is the impact to California patients if MBC no longer performs these reviews?

Background: The role of MBC in evaluating specialty boards not affiliated with or certified by ABMS has been a source of discussion, legislation and contention for many years. In 1990, SB 2036 (McCorquodale, Chapter 1660, Statutes of 1990), sponsored by the California Society of Plastic Surgeons, among others, sought to prohibit physicians from advertising board certification by boards that were not member boards of the American Board of Medical Specialties (ABMS). It added BPC Section 651(h) to prohibit physicians from advertising they are “board certified” or “board eligible” unless they are certified by any of the following:

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

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

To implement the law, MBC adopted regulations which are substantially based on the requirements of ABMS, including number of diplomates certified, testing, specialty and subspecialty definitions, bylaws, governing and review bodies, etc. The most notable requirement relates to the training provided to those certified by the specialty boards. In MBC’s regulations, training must be equivalent to an ACGME postgraduate specialty training program in “scope, content, and duration”.

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

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

MBC has denied approval to the American Academy of Pain Management and American Board of Cosmetic Surgery.

The purpose of the law and regulation is to provide protection to consumers from misleading advertising. Board certification is a major accomplishment for physicians, and while board certification does not ensure exemplary medical care, it does guarantee that physicians were formally trained and tested in a specialty, and, with the ABMS’ Maintenance of Certification (MOC)

requirements to remain board-certified, offers assurances that ongoing training, quality improvement, and assessment are 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.

The law 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. Health insurance companies typically only choose board-certified physicians for their panels or those physicians whose credentials they have vetted. Hospitals grant privileges to physicians after conducting a review of qualifications through a process called "credentialing" which includes determining a physician's accredited training and board certification. Thus, most physicians granted hospital privileges are board-certified in the specialty for which they are granted privileges, or similarly highly, formally trained.

The "board certification" advertising prohibition is primarily meaningful for elective procedures – those procedures that are not reimbursed by insurance or those performed outside of hospitals or hospital clinic settings.

MBC does not appear to face significant cost pressure for its actual review of these boards, as there have been few applications in recent years. Non-ABMS certifying boards may be deterred from filing applications due to the law, the strict regulations, the demanding review process and MBC's \$4030 application fee. While processing an application to determine if the minimum information has been provided can be completed by an MBC analyst, the actual evaluation of the medical training must be performed by an expert physician consultant 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.) MBC then must pay for the services of a medical education expert to perform a review of the specialty board's formal training program, cost for which varies but runs in the general range of \$5,000 to \$11,000. MBC has statutory authority to increase the application fee as necessary to cover its review costs.

However, MBC has incurred significant costs related to litigation over MBC board denials. The American Academy of Pain Management was denied and filed four suits against the MBC, 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. To date, MBC has prevailed in these cases but at considerable costs, conservatively estimated in excess of \$200,000 due in large part to the very high charges for OAG attorneys to represent MBC in these matters.

The ABMS is a well-established, large organization with tremendous resources, both in revenue, infrastructure, and expertise, far beyond those of MBC. The Act basically tasks MBC with performing the same duties, with regards to the work MBC undertakes to approve non-ABMS boards, as the tasks of ABMS, the ACGME and the specialty boards and their residency review committees, yet MBC has only a fraction of their resources. Unlike the ABMS process, the MBC is not a part of developing 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 MBC regulation.

MBC has maintained through prior review and again this year that three entities have the expertise to review and evaluate the quality of medical specialty boards' training and certification criteria: (1) ABMS, (2) ACGME, and to a lesser degree (3) medical schools that provide ABMS designed and ACGME accredited residency training programs. MBC acknowledges, though, that it would be inappropriate for any of these entities to judge a competing specialty board training program. MBC has advised the Legislature that provisions in the BPC related to MBC approval of non-ABMS specialty board should be deleted and instead, physicians should only be allowed to advertise as board certified if they have been certified by ABMS boards and the four additional boards currently approved by the MBC.

The California Society of Plastic Surgeons (CSPS) agrees with this request by MBC, noting that MBC does not have the resources or expertise to determine equivalency, that this role should be eliminated but also agrees that boards that have already been approved by MBC should be grandfathered into law as recognized. CSPS notes that the law does not restrict the ability for a physician to state they have a specialty in a certain area of their practice but rather is specific to advertisements using the term "board certified".

According to the American Society of Plastic Surgeons (ASPS), MBC's objectives of reducing its legal exposure and protecting patients by prohibiting diplomats of substandard board from advertising their certification to consumers can be continued through changes to BPC 651 proposed by ASPS.

The American Board of Pain Medicine (ABPM), one of the current MBC approved non-ABMS entities states that "the existing MBC process has served as an important tool for the state in weeding out less rigorous certification entities." ABPM would like to ensure that non-ABMS boards approved by MBC remain approved by being grandfathered and states concerns that the elimination of MBC's role, "without an appropriate process to vet alternate boards may lower the bar for use of the term 'board certified' which will ultimately put patients at risk for negative health outcomes."

It would be helpful for the Committees to better understand ramifications for patients as well as the potential impact to licensed California physicians in terms of their ability to safely and effectively treat patients if BPC 651 is amended to remove MBC from the review of non-ABMS specialty boards.

Staff Recommendation: *The Committees may wish to amend the Act, as proposed through legislation in 2013, to deal with this issue. MBC should advise the Committees on the impact to patients if MBC no longer approves non-ABMS specialty boards for equivalencies and what it means for patients if they no longer see advertisements for services from a physician who is board certified by a non-ABMS board that MBC has not already approved.*

Board Response (March 2017):

The Board is recommending that the statute be amended to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the Board. On March 8, 2017, the Board submitted language to Senate B&P Committee staff to amend the statutes in this regard. Due to the fact Business and Professions Code section 651 only pertains to advertising, and since the advertisement requirements will remain the same, the Board does not believe there will be any impact to patients if the Board does not approve non-ABMS specialty boards for equivalency.

ISSUE #12: (ACCESS TO CARE.) California law prohibits physicians from being directly employed by corporations as a means of ensuring that corporations are not practicing medicine, and in order to preserve the independence of physician judgment while preventing an employer's interests from interfering with physician decisions or the physician-patient relationship. Healthcare has evolved significantly since the inception of this ban and it is unclear whether these legal prohibitions are still achieving the original purpose. Is the ban on the corporate practice of medicine still appropriate for healthcare today?

Background: The ban on the corporate practice of medicine, or CPM doctrine, is usually referred to in the context of a prohibition, banning hospitals from employing physicians. The ban on CPM evolved in the early 20th century when mining companies had to hire physicians directly to provide care for their employees in remote areas. However, problems arose when physicians' loyalty to the mining companies conflicted with patients' needs. Eventually, physicians, courts and legislatures prohibited CPM in an effort to preserve physicians' autonomy and improve patient care.

Over the years, various state and federal statutes have weakened the CPM prohibition. According to a 2007 report prepared by the California Research Bureau (CRB), "California's CPM doctrine has been defined largely through lawsuits and Attorney General opinions over decades, and then riddled by HMO and other legislation; its power and meaning are now inconsistent.... Although some non-profit clinics may employ physicians, California applies the CPM doctrine to most other entities.... Teaching hospitals may employ physicians, but other hospitals, including most public and non-profit hospitals, may not employ physicians. Professional medical corporations are expressly permitted to engage in the practice of medicine, and may employ physicians. [However, t]hese medical corporations may operate on a for-profit basis, although the profit motive was one of the original rationales of the CPM prohibition."

A 2016 CRB report notes that "since 2007, the provision of healthcare has undergone changes in California. The Affordable Care Act is responsible for an increase in insured patients across the state. In 2016-2017, 13.5 million Californians are expected to have enrolled in Medi-Cal, up from 7.9 million in 2012-2013, and 1.5 million people will be enrolled in Covered California at the end of 2015-2016. As a result, more insured patients than ever are accessing healthcare services without a commensurate increase in healthcare practitioners." The report suggested assessing changing financial incentives; considering whether other methods of protecting physician autonomy are sufficient; increasing patient access to data about physician-hospital relationships and hospital metrics; determining whether the current alignment strategies used by physicians and hospitals are more costly than direct employment models; and collecting additional data to better understand the impact of CPM.

Throughout the years, a number of exceptions to the CPM ban have been established statutorily, thereby allowing certain types of facilities to employ physicians, including:

- Clinics operated primarily for the purpose of medical education by a public or private nonprofit university medical school, to charge for professional services rendered to teaching patients by licensed physicians who hold academic appointments on the faculty of the university, if the charges are approved by the physician in whose name the charges are made;
- Certain nonprofit clinics organized and operated exclusively for scientific and charitable purposes, that have been conducting research since before 1982, and that meet other specified requirements, to employ physicians and charge for professional services. Prohibits, however, these clinics from interfering with, controlling, or otherwise directing a physician's

professional judgment in a manner prohibited by the CPM prohibition or any other provision of law;

- A narcotic treatment program regulated by the Department of Alcohol and Drug Programs to employ physicians and charge for professional services rendered by those physicians. Prohibits, however, the narcotic clinic from interfering with, controlling, or otherwise directing a physician's professional judgment in a manner that is prohibited by the CPM prohibition or any other provision of law; and,
- A hospital that is owned and operated by a licensed charitable organization that offers only pediatric subspecialty care, as specified.
- Until 2024, a federally certified critical access hospital which is a small (25 or less beds) hospital located in a remote, rural area.

California currently has a physician shortage. As the 2016 CRB report notes, "AMA figures show that, on average, California has 80 primary care physicians and 138 specialty physicians per 100,000 residents. This is in the upper range for primary care physicians (60-80) and above the range for specialty care physicians (85-105) recommended by the Department of Health and Human Services. However, when disaggregated by region, there is a coverage disparity. California's rural regions have lower numbers of physicians than its urban areas. For instance, the San Joaquin Valley has only 45 primary care physicians and 74 specialty physicians per 100,000 residents, compared with the Bay Area's 78 primary care physicians and 155 specialists per 100,000 residents. The number of healthcare providers, including primary care physicians, in California is not anticipated to dramatically increase soon."

The nationwide trend in healthcare is toward direct employment. According to a 2011 survey from the consulting firm Accenture:

"U.S. physicians continue to sell their private practices and seek employment with healthcare systems, according to a new survey from Accenture. As physicians migrate from private practice to larger health systems, the new landscape will require healthcare information technology (IT), medical device manufacturers, pharmaceutical companies and payers to revise their business models and offerings. At the same time, hospitals will need to determine how to retain and recruit the correct mix of physicians, especially in high-growth service lines, including cardiovascular care, orthopedics, cancer care and radiology. Patients will increasingly move to large health systems, as opposed to the current trend of visiting doctors in private, small practice settings.

"Health reform is challenging the entire system to deliver improved care through insight driven health," said Kristin Ficery, senior executive, Accenture Health. "We see an increasing number of physicians leaving private practice to join hospital systems, which will force all stakeholders to revise and refine their business models, product offerings and service strategies."

Benefits to direct employment include:

- Relief from administrative responsibilities, especially those relating to insurance billing.

- Malpractice insurance.
- Greater access and support for healthcare IT tools, facilities, and medical equipment.
- A predictable work week.
- Economic stability.

The law provides for protections against retaliation for health care practitioners who advocate for appropriate health care for their patients, pursuant to *Wickline v. State of California* (192 Cal. App. 3d 1630): (BPC Section 510) by stating:

- It is the public policy of the State of California that a health care practitioner be encouraged to advocate for appropriate health care for his or her patients. For purposes of this section, “to advocate for appropriate health care” means to appeal a payer’s decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer, or to protest a decision, policy, or practice that the health care practitioner, consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care, reasonably believes impairs the health care practitioner’s ability to provide appropriate health care to his or her patients.
- The application and rendering by any individual, partnership, corporation, or other organization of a decision to terminate an employment or other contractual relationship with or otherwise penalize a health care practitioner principally for advocating for appropriate health care consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care violates the public policy of this state.
- This law shall not be construed to prohibit a payer from making a determination not to pay for a particular medical treatment or service, or the services of a type of health care practitioner, or to prohibit a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff, hospital governing body, or payer from enforcing reasonable peer review or utilization review protocols or determining whether a health care practitioner has complied with those protocols.

As noted in the 2016 CRB report and reflected in broad legislative discussion on the topic, stakeholder groups have weighed in on CPM. The report cites a 2007 document from the California Medical Association (CMA) which notes that the CMA considers the CPM doctrine “a fundamental protection against the potential that the provision of medical care and treatment will be subject to commercial exploitation.” The report noted that in this document, CMA’s Legal Counsel defines the CPM bar broadly, as a prohibition on lay entities hiring or employing physicians or other health care practitioners, or interfering with physicians or other health care practitioners’ practice of medicine. Lay entities are also prohibited from contracting with health care professionals to render services. The CMA further notes that the CPM Bar “...is designed to protect the public from possible abuses stemming from the commercial exploitation of the practice of medicine,” and that California’s courts and legislature have upheld the CPM Bar to protect physicians from the “pressures of the commercial marketplace”.

Staff Recommendation: *The Committees may wish to discuss changes for greater patient access to care. The Committees may wish to consider the pros and cons for patients if physicians were permitted to be employed by corporations.*

Board Response (March 2017):

Current law under Business and Professions Code section 2400 (commonly referred to as the "ban on the corporate practice of medicine"), generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine. This prohibition ensures that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians.

The purpose of the ban on the corporate practice of medicine is to minimize the undue influence or interference with physician's judgment and the physician-patient relationship. Physicians should not be forced to choose between the dictates of the employer and the best interest of the patient. The ban protects consumers so that those physicians who make decisions that affect the provision of medical services understand the medical implications of those decisions, have an ethical obligation to place the patient's interests ahead of their own, and are subject to the enforcement powers of the Board. The Board has always believed that the ban on the corporate practice of medicine provides a very important protection for patients and physicians from inappropriate intrusions into the practice of medicine.

The Board believes that removal of the ban on the corporate practice of medicine would have a significant impact on consumer protection. While the Board has taken a neutral position on bills that have allowed certain hospitals to hire physicians, an overall removal of this ban outside of these settings would not be in the interest of consumer protection.

ISSUE #13: (PRESCRIBER GUIDELINES). **Current, appropriate guidelines outlining safe prescribing practices for certain types of medication, or medication prescribed to certain patient populations, are an important tool for physicians and MBC alike. While MBC recently updated its guidelines for prescribing pain medication, it is unclear what MBC does to ensure physicians read and use these guidelines. Guidance to physicians about prescribing psychotropic medication to foster youth and recommending medical cannabis could also be beneficial. How has MBC promoted its guidelines for prescribing controlled substances? Is MBC issuing guidelines related to the appropriate prescribing of psychotropic medication to foster youth or medical cannabis?**

Background: MBC licensees issue prescriptions to patients for medication through the course of care, according to professional judgment and within the appropriate standard of care. For certain types of medication, and certain types of medication prescribed to certain types of patients, guidelines on appropriate and safe prescribing practices can serve as a helpful tools for the providers, patients and MBC alike.

Prescription medicine used to treat pain has been the focus of ongoing discussions in the Legislature, particularly in the years since MBC's last review as California and the nation face an epidemic of prescription drug abuse and related overdose deaths. In 1994, MBC unanimously adopted a policy statement entitled "Prescribing Controlled Substances for Pain." Stemming from studies and discussions about controlled substances, this policy statement was designed to provide guidance to improve prescriber standards for pain management, while simultaneously undermining opportunities for drug diversion and abuse. The guidelines outlined appropriate steps related to a patient's examination, treatment plan, informed consent, periodic review, consultation, records, and compliance

with controlled substances laws. Subsequent to MBC's 1994 action, legislation that took effect in 2002 (AB 487, Aroner, Chapter 518, Statutes of 2001) created a task force to revisit the 1994 guidelines to develop standards assuring competent review in cases concerning the under-treatment and under-medication of a patient's pain and also required continuing education courses for physicians in the subjects of pain management and the treatment of terminally ill and dying patients. The intent of the bill was to broaden and update the knowledge base of all physicians related to the appropriate care and treatment of patients suffering from pain, and terminally ill and dying patients. The passage of AB 2198 in 2006 (Houston, Chapter 350, Statutes of 2006) updated California law governing the use of drugs to treat pain by clarifying that health care professionals with a medical basis, including the treatment of pain, for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances, may do so without being subject to disciplinary action or prosecution.

MBC currently encourages all licensees to consult the policy statement and Guidelines for Prescribing Controlled Substances for Pain which were updated in 2014 based on input from a MBC Prescribing Task Force that held multiple meetings to identify best practices. According to the MBC website, "The board strongly urges physicians and surgeons to view effective pain management as a high priority in all patients, including children, the elderly, and patients who are terminally ill. Pain should be assessed and treated promptly, effectively and for as long as pain persists. The medical management of pain should be based on up-to-date knowledge about pain, pain assessment and pain treatment. Pain treatment may involve the use of several medications and non-pharmacological treatment modalities, often in combination. For some types of pain, the use of medications is emphasized and should be pursued vigorously; for other types, the use of medications is better de-emphasized in favor of other therapeutic modalities. Physicians and surgeons should have sufficient knowledge or utilize consultations to make such judgments for their patients. Medications, in particular opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedures, or cancer." MBC intends for the guidelines to educate physicians on effective pain management in California by avoiding under treatment, overtreatment, or other inappropriate treatment of a patient's pain. Reduction of prescription overdose deaths is also an objective of the updated guidelines. *It would be helpful for the Committees to understand what steps MBC takes to ensure licensees consult the updated guidelines.*

Concern over the use of psychotropic medications among children have also been the subject of recent Legislative consideration and discussion, and have been well-documented in research journals and the mainstream media for more than a decade. The category of psychotropic medication is fairly broad, intending to treat symptoms of conditions ranging from attention deficit hyperactivity disorder (ADHD) to childhood schizophrenia. Some of the drugs used to treat these conditions are U.S. Food and Drug Administration (FDA)-approved, however only about 31 percent of psychotropic medications have been approved by the FDA for use in children or adolescents. It is estimated that more than 75 percent of the prescriptions written for psychiatric illness in this population are "off label" in usage, meaning they have not been approved by the FDA for the prescribed use, though the practice is legal and common across all manner of pharmaceuticals. Studies have found that the off-label use of these anti-psychotics among children is high, particularly among foster children.

In 2012, the DHCS and DSS convened a statewide Quality Improvement Project (QIP) to design, pilot, and evaluate effective practices to improve psychotropic medication use among children and youth in foster care. The QIP's Clinical Workgroup released a set of guidelines to assist prescribers and caregivers in maintaining compliance with State and county regulations and guidelines pertaining to Medi-Cal funded mental health services and psychotropic prescribing practices for foster homes, group

homes, and residential treatment centers. In addition, the guidelines include prescriber and caregiver expectations regarding developing and monitoring treatment plans for behavioral health care, principles for informed consent to medications, and governing medication safety. These guidelines are designed as a statement of best practice for the treatment of children and youth in out-of-home care.

MBC reported during conversations about SB 1174 (McGuire, Chapter 840, Statutes of 2016) that it has made the QIP's Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care available to all licensees on its website as well as through an email to its licensee listserv. MBC's responsibilities in overseeing their licensees' prescribing habits of psychotropic medications to foster youth were also a component of an audit conducted by the California State Auditor pertaining to the oversight and monitoring of children in foster care who have been prescribed psychotropic medications. The audit revealed that some foster children were prescribed psychotropic medications in amounts and dosages that exceeded state guidelines and counties did not follow up with prescribers to ensure the appropriateness of these prescriptions. The audit also found that many foster children did not receive follow-up visits or recommended psychosocial services in conjunction with their prescriptions for psychotropic medications. *It would be helpful for the Committees to understand what additional steps MBC takes to ensure licensees consult the QIP's guidelines.*

MBC licensees are also authorized to recommend the use of cannabis for medical purposes. Since the approval of the Compassionate Use Act (contained in Proposition 215) by voters in 1996, state law has allowed Californians access to marijuana for medical purposes, and prohibited punitive action against physicians for making medical marijuana recommendations. The CUA established the right of patients to obtain and use marijuana to treat specified illnesses and any other illness for which marijuana provides relief. Three laws enacted in 2015 (AB 243, Wood, Chapter 688 Statutes of 2015; AB 266, Bonta, Chapter 689, Statutes of 2015 and; SB 643, McGuire, Chapter 719, Statutes of 2015), known collectively as the Medical Cannabis Regulation and Safety Act (MCRSA), provide a statutory framework to regulate medical cannabis. Under MCRSA, MBC is required to consult with the California Marijuana Research Program, known as the Center for Medicinal Cannabis Research, in order to develop and adopt medical guidelines for the appropriate administration and use of medical marijuana. MBC has a page on its website titled *Marijuana for Medical Purposes* which MBC notes was adopted by the full MBC in 2004 and amended in October 2014. This information page refers to the former CUA in defining the role of physicians and surgeons related to medical marijuana, but does note that MBC "developed this statement since marijuana is an emerging treatment modality. The Medical Board wants to assure physicians who choose to recommend marijuana for medical purposes to their patients, as part of their regular practice of medicine, that they WILL NOT be subject to investigation or disciplinary action by the Medical Board if they arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility. The mere receipt of a complaint that the physician is recommending marijuana for medical purposes will not generate an investigation absent additional information indicating that the physician is not adhering to accepted medical standards." MBC clarifies that a physician's written recommendation to a patient will not trigger action by MBC and notes that a patient need not have failed on all standard medications in order for a physician to recommend or approve the use of marijuana for medical purposes. Rather than direct licensees and the public to MBC guidelines, it refers physicians to links for other organizations' websites. It appears that the FSMB developed model policy guidelines regarding the recommendation in patient care for state boards to utilize, but those are also not provided to California physicians. *While MBC reports that it has a Marijuana Task Force, it would be helpful for the Committees to understand the status of the Task Force's work, the status of MBC guidelines and MBC's plan for dissemination of guidelines when they are adopted.*

Staff Recommendation: *MBC should update the Committees on its efforts related to guidelines for prescriptions of controlled substances for pain, psychotropic medication to foster youth and medical cannabis.*

Board Response (March 2017):

The Board released its new Guidelines for Prescribing Controlled Substances for Pain in November 2014. Upon approval by the Board, the Board emailed a link to this document to all licensed physicians and applicants encouraging them to review the document and use it when prescribing controlled substances. The Board also prominently displayed this link on its website. In addition, the Board sent it out to all subscribers on the Board's subscription list. The Board also enlisted the assistance of the Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup, which is made up of numerous state agencies, to disseminate the guidelines via their distribution lists and on their websites. The Board also discussed the guidelines in an article in the Board's Newsletter that came out in January 2015. This Newsletter is not only emailed out to physicians who have an email, but it is mailed to all physicians who do not have an email. The guidelines have also been discussed and provided in other organization's and association's newsletters. Most importantly, the Board has made numerous presentations on the guidelines to physician groups across California. All of these efforts are conducted to ensure physicians consult these updated guidelines.

When DHCS and DSS' Quality Improvement Project released its California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, the Board followed a similar release format. This information was emailed to all physicians and applicants, a link was posted on the Board's website and a subscriber's email was sent. In addition, the Board wrote an article in its summer 2015 Newsletter about the guidelines with a link to the document. The Board also has a page devoted to these guidelines on its website. Based upon the information in these guidelines and the process this document went through, including significant input from experts in the field, the Board did not develop its own guidelines.

In 2004, the Board developed a statement on recommending marijuana for medicinal purposes, which is on the Board's website. In 2014, the Board updated this statement to make some edits related to the use of telemedicine. Last year, the Federation of State Medical Boards released its guidelines on recommending marijuana. Upon release of these guidelines, the Board directed staff to review the Board's current statement and determine if changes needed to be made. In addition, SB 643, authored by Senator McGuire, also directed the Board to develop guidelines.

The Board has established a Marijuana Task Force to develop these guidelines with assistance from experts in this field. The Task Force held an interested parties meeting on February 8, 2017, to review the current statement and the Federation guidelines, and to hear input from experts on needed changes to the document. Board staff is in the process of updating its current statement and turning it into Board guidelines for recommending marijuana for medicinal purposes. The Board anticipates a completed document by fall of 2017. Once the document is finalized, the Board will follow the same dissemination process as conducted with the other guidelines.

MBC BUDGET ISSUES

ISSUE #14: (COST RECOVERY.) **MBC is statutorily prohibited from seeking reimbursement from physicians for costs related to disciplinary action. MBC is only prohibited from collecting reimbursement from physicians and has the ability to seek cost recovery for other allied health professionals it may take disciplinary action against. In general, DCA boards are authorized to**

collect payment from licensees for the high costs a board pays related to disciplinary action, as investigation and prosecution charges significantly impact fund conditions. Should MBC once again be authorized to seek cost recovery from physicians for disciplinary action?

Background: MBC has been prohibited from recovering costs for administrative prosecution of physicians since 2006 when SB 231 (Figueroa, Chapter 674, Statutes of 2005) went into effect. Specifically, BPC Section 125.3 (k) states that MBC “shall not request nor obtain from a licentiate, investigation and prosecution costs for a disciplinary proceeding against the licentiate. The board shall ensure that this subdivision is revenue neutral with regard to it and that any loss of revenue or increase in costs resulting from this subdivision is offset by an increase in the amount of the initial license fee and the biennial renewal fee, as provided in subdivision (e) of Section 2435.”

It would be helpful for the Committees to better understand the impact of this inability to recover costs on MBC’s fund. With OAG costs rising and charges higher for OAG efforts today than in 2005, it would be helpful for the Committees to determine whether MBC still has the ability to pay for, without the option of reimbursement, disciplinary action. It would be helpful for the Committees to see a breakdown of charges for an average case that results in disciplinary action. It would also be helpful for the Committees to learn whether the inability to recover costs drives MBC’s and OAG’s decision to settle certain cases that would otherwise continue to accrue costs.

Staff Recommendation: *MBC should advise the Committees on the impact its inability to seek reimbursement for costly disciplinary action has on MBC’s fund. MBC should provide a projected fund condition to reflect MBC’s fund if MBC were again authorized to seek cost recovery.*

Board Response March 2017):

Most boards within DCA do not obtain full cost recovery on their enforcement cases. Prior to the elimination of the Board’s ability to obtain cost recovery, the Board was not receiving full costs on their cases. This occurred for two reasons: 1) cost recovery was used as a negotiation tool during the settlement process; and 2) Administrative Law Judges would not order full costs in most cases. Therefore, the Board was not receiving full cost recovery.

In 2006, when the Board’s ability to obtain cost recovery was eliminated, the Board was able to adopt regulations to increase the physician and surgeon fee to make this elimination cost neutral. At that time, the Board determined that the renewal fee would be increased by \$15 to recuperate the funds that were eliminated due to cost recovery. This \$15 fee increase was not based upon what the Board had spent, nor was it based upon the amount that had been ordered. It was based upon what the Board had received in cost recovery each year for the prior three fiscal years.

Based upon this fee increase of \$15, last year the Board received approximately \$927,585 in funds due to the elimination of cost recovery. Since 2006, the Board’s budget has increased from 42 million to 62 million dollars. Therefore, the Board’s current \$15 fee may not be commensurate with what the Board would have received in cost recovery should it be available. Attached is the Board’s fund condition, as reported at the January 2017 Board Meeting (Attachment 1). In addition, the Board estimated the amount of cost recovery it would receive, if authorized, and added this line item to the current fund condition (Attachment 2).

Because of the \$15 fee increase, the elimination of cost recovery did not have a significant impact to the Board’s budget. However, based upon the increase in the Board’s budget, this amount may need to be increased. The committee may wish to either authorize the Board to increase licensing fees to

obtain the difference in cost recovery from 2006 to 2017 or again allow the Board to obtain cost recovery from those physicians found in violation of the law.

The inability to receive cost recovery has not impacted the case outcomes. It was thought that more cases would go to hearing with the elimination of cost recovery; however, the Board still continues to settle approximately 70-80% of its cases. The inability to recover costs has no impact on whether the Board determines to settle a case or not. The Board reviews the violations the physician has committed, reviews the disciplinary guidelines, and on a case-by-case basis, offers a settlement that ensures consumer protection and rehabilitation of the physician. The Board does not resist going to hearing based upon the costs that may be incurred should the matter go to hearing. If the physician does not agree to the recommended settlement from the Board, the matter will proceed to hearing.

MBC LICENSING ISSUES

ISSUE #15: (MEXICO PILOT PROGRAM.) Legislation passed in 2002, established a pilot program aimed at addressing primary care and dental practitioner shortages by authorizing MBC and the Dental Board of California to issue licenses for three years to physicians and dentists from Mexico who meet specified criteria. The program has not been implemented. What are the barriers to MBC implementing this program? What steps has MBC taken since 2003 to put the program in place?

Background: As noted in a Senate Business and Professions Committee analysis in 2002, The Licensed Physicians and Dentists Program established by AB 1045 (Firebaugh, Chapter 1157, Statutes of 2002) was designed to bring physicians and dentists from Mexico who have rural experience, speak the language, understand the culture and know how to apply this knowledge in serving the large Latino communities in rural areas who have limited or no access to primary health care services. Bill proponents were concerned about addressing primary care physician and dentist shortages while maintaining a high quality of care. The bill authorized up to 30 licensed physicians specializing in family practice, internal medicine, pediatrics and obstetrics and gynecology and up to 30 licensed dentists from Mexico to practice medicine or dentistry in California for up to three years and required the individuals to meet certain requirements related to training and education. Program participants are required to undergo a six month orientation program approved by MBC addressing medical protocol, community clinic history and operations, medical administration, hospital operations and protocol, medical ethics, the California medical delivery system, health maintenance organizations and managed care practices and pharmacology differences.

AB 1045 tasked MBC with oversight review of both the implementation of the program and an evaluation of the program. MBC was supposed to consult with medical schools applying for funding to implement and evaluate this program, executive and medical directors of nonprofit community health centers wanting to employ program participants and hospital administrators who would have program participants practicing in their hospital. The bill specified that any funding necessary for the implementation of the program, including the evaluation and oversight functions, was to be secured from nonprofit philanthropic entities and stated that implementation of the program could not move forward unless appropriate funding was secured from nonprofit philanthropic entities. AB 1045 also required MBC to report to the Legislature every January during which the program is operational regarding the status of the program and the ability of the program to secure the funding necessary to carry out its required provisions.

At its October 2016 quarterly meeting, MBC's E.D. reported on discussions surrounding implementation of the pilot program. The E.D. outlined the program as defined in BPC Section 853 and informed MBC that there had been several discussions regarding the program for the past 13 years but that funding had remained a barrier to implementation. The E.D. noted that when funds became available, MBC staff would begin implementing the program.

Given access to care issues, particularly those related to residents of rural communities and stemming from language barriers, remain a concern these many years following passage of the bill, it would be helpful for the Committees to understand remaining barriers to program implementation. It would also be helpful for the Committees to understand where program funding will come from and whether statutory changes are necessary to allow MBC to receive funding to implement the program.

Staff Recommendation: *MBC should update the Committees on the status of The Licensed Physicians and Dentists Program, including remaining barriers to implementation and funding options. MBC should advise the Committees of statutory changes necessary to the Act in order for the program to be implemented, considering the significant passage of time since its statutory creation and potential implementation.*

Board Response (March 2017):

Business and Professions Code section 853 became effective in 2003 and established the Licensed Physicians and Dentists from Mexico Pilot Program (Program). This Program allows up to 30 licensed physicians from Mexico specializing in family practice, internal medicine, pediatrics, and obstetrics and gynecology to practice medicine in California for a period not to exceed three years, if they meet specified requirements. The Program is also required to be affiliated with a medical school in California.

The Board's role in this Program is to provide oversight review of the implementation, as specified. However, this law requires that all of the funding necessary for the implementation of this Program, including the evaluation and oversight functions, to be secured from nonprofit philanthropic entities. This law expressly states that implementation of this Program shall not proceed unless appropriate funding is secured from nonprofit philanthropic entities. Funding has never been secured for this Program, so it has not yet been implemented. Once funding is secured and other requirements are met, the Board will begin the process of establishing this Program.

The Board had meetings last year with interested parties and provided a fiscal estimate of the funding that would be needed to implement the Program from the Board's perspective, but to the Board's knowledge, that funding has not yet been secured. In order to implement this Program without funding from nonprofit philanthropic entities, the law would need to be amended to delete this requirement and identify a new funding source.

ISSUE #16: (POSTGRADUATE TRAINING AND MBC APPROVAL OF INTERNATIONAL MEDICAL SCHOOLS.) **The Act specifies requirements for postgraduate training that MBC physician applicants must undertake and outlines what graduates of international medical schools must do in terms of postgraduate training. MBC approves all schools applicants for licensure must attend, including medical schools located in other countries. Are there amendments to the Act to ensure proper clinical training? Should MBC be in the business of approving international medical schools?**

Background: The Act treats graduates of international medical schools and those located in the U.S. differently in terms of the clinical training required for MBC licensure. Applicants for licensure who graduated from an LCME-approved domestic medical school (domestic includes the U.S. and Canada) are required to complete one year of either ACGME (U.S.) or Royal College of Physicians and Surgeons of Canada (RCPSC) (Canada) accredited postgraduate training. Applicants for licensure who graduated from a MBC approved international medical school must complete two years of ACGME or RCPSC accredited postgraduate training. ACGME and RCPSC accredited schools must meet the same educational and experience requirements, all programs are accredited by the same entity, all programs undergo specified re-accreditation assessments, and all programs are judged by the same standards. According to MBC, graduates of domestic medical schools meet the minimum undergraduate clinical requirements (4 weeks psychiatry, 4 weeks family medicine, 8 weeks medicine, 6 weeks obstetrics and gynecology, 6 weeks pediatrics, 8 weeks surgery, plus another 4 weeks from one of the clinical core subjects, and 32 weeks of electives) by virtue of attending a LCME-approved medical school.

Graduates of international medical schools must meet the same undergraduate clinical requirements, however, due to the lack of any international accreditation organization like the LCME, and lack of an LCME-like organization in many countries, MBC has attempted to recognize postgraduate training of these applicants but many are still not eligible for licensure by MBC. MBC has proposed solving this problem by amending the Act to require all applicants, regardless of school of graduation, to satisfactorily complete a minimum of three years of ACGME/RCPSC postgraduate training prior to the issuance of a full unrestricted license to practice. MBC proposes issuing training permits and identifying the scopes of practice for each training year, in conjunction with the postgraduate training programs. Three years comes from the industry-recognized standard of three years of training required for board certification by ABMS boards in specialties family medicine, internal medicine, pediatrics and others. According to MBC, this equitable evaluation process ensures the programs set the same criteria, requirements and standards and ensures that all participants in these programs meet the same criteria, requirements, and standards. MBC believes this approach will result in a more effective assessment of an applicant's eligibility for licensure than where he or she attended medical school and completed undergraduate clinical rotations. According to MBC, this new process will ensure physicians satisfactorily completing three years of ACGME or RCPSC postgraduate training, in any specialty, have developed and demonstrated competency in the same skill sets of patient care in a monitored and structured setting.

The Act currently requires MBC to approve all medical schools it accepts graduate applicants for licensure from. MBC approves medical schools in the U.S. and Canada that are accredited by the LCME. For schools not located in the U.S., MBC recognizes schools with historic approval from the World Health Organization and schools MBC itself approves, as there is no foreign equivalent to LCME.

In 2003, MBC adopted regulations establishing a standard review process and minimum standards for international medical schools whose graduates wish to apply for licensure in California. Medical schools located in another country are divided into two categories: schools that are owned and operated by the government of the country in which the school is domiciled whose primary purpose is to educate citizens to practice medicine in that country (also known as "(a)(1) schools") and schools with a primary purpose of educating non-citizens to practice medicine in other countries ("(a)(2) schools"). MBC's evaluation and assessment process for all international schools includes many steps, various protocols and copious amounts of staff time. "(a)(1)" schools are not required to undergo the same in-depth individual review of "(a)(2)" schools, as MBC has determined that free-standing for profit

medical schools are less likely to satisfy MBC’s minimal quality standards. MBC states that it relies on the expertise of individuals experienced in medical academies to determine whether or not “(a)(2)” schools are sufficient to meet quality requirements. Many “(a)(2)” schools are required to undergo a MBC staff site visit which allows MBC to verify information a school submits to MBC in its initial application and self-assessment report. According to MBC, the process can take as little as 30 days or as long as three or more years, depending on factors like when documentation is received, when staff is approved to travel out of the country for inspection and when a site visit report is completed.

MBC currently recognizes 1,882 international medical schools, some of which require a reassessment every seven years, modeled after LCME requirements for domestic schools. Yet MBC reports that it is not able to conduct these reviews due to a lack of staffing and the fact that only a very limited number of MBC staff have the experience to review international medical schools. According to MBC, it does not have sufficient resources with appropriate knowledge of how medical education is developed and delivered, nor sufficient numbers of highly-trained and educated medical consultants to properly and adequately conduct these assessments and render decisions. Given the historic challenges for MBC to conduct quality review of international medical schools and the high cost for this activity, MBC suggests in its 2016 Sunset Report that the Act should be amended to eliminate requirements for MBC recognition of international medical schools and that MBC should instead require individuals to have graduated from a medical school listed in the World Health Organization’s directory as an approved school. MBC advises that this change will speed up the timeframe for applications from graduates of foreign schools to be processed. MBC asserts that this will also allow the staff dedicated to international school approval to work on assisting with the processing of postgraduate training authorization letters and issuing licenses.

Staff Recommendation: *The Committees should consider MBC’s suggestion to eliminate requirements for approval of international medical schools by MBC. Given that other states rely on MBC approval of international medical schools in lieu of there being an international organization equivalent to LCME, MBC should advise the Committees of any potential impacts.*

Board Response (March 2017):

As a consumer protection agency, the Board does not believe that one year (for US/Canadian medical school graduates) or two years (for international medical school graduates) of postgraduate training is sufficient. Therefore, the Board recommended changing the postgraduate training requirements for licensure from one or two years of postgraduate training to three years of postgraduate training. With this change, the Board also recommended a change to the school recognition/approval process.

The Board does not believe that the elimination of the Board’s review of international schools would have an impact on other states due to the fact that changes are being made to the approval process under the World Federation for Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER) who, in collaboration with the World Health Organization and the University of Copenhagen, develop the World Directory of Medical Schools. All states should be able to use the World Directory. Because this change would enhance consumer protection with the increase in the number of years of postgraduate training, the Board supports it and will work with interested parties to eliminate any unforeseen issues that have been brought forward. The Board will provide suggested statutory language to Committee staff on this issue by April 3, 2017.

ISSUE #17: (LICENSE CYCLES.) Concerns have been raised about the way that MBC determines when licenses expire. Does it make more sense for MBC to issue two-year term licenses rather than having licenses expire based on a physician’s date of birth?

Background: The birth date renewal system is used by many DCA boards to establish licensure cycle. Licenses are issued for a period of time ranging between 12 and 24 months depending on the licensee's birth month. If, for example, a licensee has a February birth date and his or her license is issued in March 2014, the license will expire at midnight on February 29, 2016. If, however, a licensee has a March birthday and his or her license is issued in March 2014, the license will expire at midnight on March 31, 2015.

In these examples, the license in the first scenario will expire after nearly 2 years, but in the second scenario, the license will expire after 12 months and 5 days. Despite the varying expiration dates, both licensees would need to pay the same initial license fee. This system has been perceived as unfair to first-time licensees because all licenses pay the same fee, regardless of how long the license lasts.

MBC uses a physician's birth date to calculate license expiration dates. According to MBC, the purpose of the birth date renewal initially was to ensure that the MBC did not have to process a large number of applications or renewals during peak times. However, now that MBC conducts outreach to medical school graduates and potential applicants, licenses are issued throughout the year. MBC advises that it offers applicants the option of waiting until their birth month for their physician and surgeon license to be issued but some applicants cannot wait until their birth month, resulting in a license not being valid for a full two years and overpayment of licensure fees to MBC. MBC has requested that the Act be amended to clarify it can issue licenses on a two-year cycle.

Staff Recommendation: *The Act should be amended to reflect changes to the way MBC establishes license cycles.*

Board Response (March 2017):

Language was submitted on March 10, 2017 to Senate B&P Committee staff that would amend the Board's expiration date for its licensees.

ISSUE #18: (RETURNING TO PRACTICE AFTER A LAPSE IN LICENSURE.) MBC continues to study the issue of whether allowing a physician to return to practice after a lapse in licensure or practice for more than 18 months without completing additional training provides adequate public protection. MBC held an interested parties meeting to discuss this issue and is continuing to explore, along with partners and stakeholders throughout the nation, whether statutory changes are necessary to require additional training past a certain timeframe of practice inactivity.

Background: During the prior review of MBC, the Committees believed there should be consistency in the amount of time a physician and surgeon should be allowed to remain out of practice without receiving additional clinical training before renewing their license and/or allowing them to continue practice.

For a physician who has let his or her license expire, BPC Section 2456.3 states, in part, "a license which has expired may be renewed at any time within 5 years after its expiration." In order to renew the license, the physician must simply submit the renewal paperwork, CME verifications and pay the fees and penalties. This can result in a licensee returning 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. That physician who has not practiced

for eight years can just renew, pay fees, demonstrate that CME has been obtained and go back into practice. MBC is still looking into this issue of how long an individual should be eligible to remain out of practice before having to undergo training.

MBC states that it continues to receive applications for medical licensure from individuals who have not practiced clinical medicine for many years. In addition, BPC Section 2428 authorizes a previous California licensee to apply for issuance of the former license, provided all requirements and criteria set forth in the statute are met. MBC states that most applicants satisfy these requirements yet not all of these applicants have updated their clinical competency by practicing in a monitored or supervised clinical setting. While MBC requires individuals who have not practiced medicine for five or more years to undertake a recognized national assessment of their knowledge and clinical skills, California does not have a provision requiring clinical practice in a monitored and/or supervised setting.

MBC believes it could be helpful to issue a Limited Educational Permit for a certain time period to allow individuals to receive a limited license to practice while they continue to undergo important clinical work. During the time an individual holds this permit, patient encounters would need to be supervised, patient records would need to be audited and a formal assessment of clinical skills would need to be provided to MBC by a supervisor at the end of the time period of this permit, with a determination of whether the applicant is safe to practice medicine or if additional clinical training is needed. MBC believes that this will ensure it has oversight for these individuals and will also ensure that the applicant has met minimum requirements to safely and competently practice as an independent physician.

Staff Recommendation: *MBC should provide an update to the Committees on the length of time an individual should be eligible to remain out of practice without additional training. MBC should advise the Committees of stakeholder meetings it has held on the Limited Educational Permit proposal and advise the Committees whether this is a trend other states are following. Based on a review of proposed statutory language and additional information about the impact such a permit would have on physicians and the public, the Committees may wish to amend the Act to allow MBC to implement this option.*

Board Response (March 2017):

The Committees may want to consider separating this issue into two different issues. The first issue is the length of time a licensee should be allowed to be out of practice before some type of refresher course is necessary. At this time, the Board does not have any statutory authority that limits the amount of time a licensee can be out of practice before an additional requirement is met. As stated in the background paper, should a physician not renew their license for five years, then the license is automatically canceled. However, during any of the preceding years before their license is automatically cancelled, they can pay fees and renew that license, even if they have not been practicing. The Board would need to ask the licensee at the time of renewal whether they have been practicing and if not, the licensee would need to do some type of refresher course. What is required by the individual to come back into practice may need to be determined by the length of time the individual is out of practice. For example, a licensee who has not been practicing for three years may need to just take a clinical competence assessment and training, while a licensee who has been out of practice over five years may need to have not only an assessment, but also may need to be required to perform clinical practice in a monitored or supervised setting. While the Board held one interested parties meeting regarding physician reentry (2015) the attendance was not sufficient to obtain input. Therefore, this will be an item on the Board's Licensing Committee agenda for the April 2017

meeting. After that time, the Board can provide language to the Committees on the length of time and the assessment needed.

The second issue relates to individuals who have either let their license lapse or are applying for licensure in California for the first time and have not been in practice for three to four years preceding the application. The individual may apply for licensure, and the Board can request a clinical competence assessment, however, the Board is unable to have this individual actually perform proctored, monitored or supervised training because they cannot practice on a patient in California without a license. Currently, the only way the Board can ensure this individual can practice safely while re-entering the practice of medicine would be to place the individual on probation, which carries negative connotations. Therefore, the Board is recommending a limited educational permit to allow individuals to come into California to begin working again and practice in a supervised setting. Once the individual has shown that he/she can practice safely, the Board would issue a full and unrestricted license. The Board has not held an interested parties meeting specifically on the limited educational permit. However, there are other states that have a similar limited educational permit. The Board believes that consumer protection would be improved by ensuring that physicians who are applying to the Board and who have not practiced medicine within the last three to four years are required to be in a proctored, supervised and monitored setting for a length of time prior to being able to have a full and unrestricted license. The Board will provide suggested statutory language to Committee staff on this issue by April 3, 2017.

MBC ENFORCEMENT ISSUES

ISSUE #19: (UTILIZATION REVIEW.) In the workers' compensation system, an insurer or self-insured employer is entitled to retain a physician to conduct "utilization review" of treatment recommendations made by the injured worker's physician, which can determine what treatment the injured worker will receive. Concerns about standard of care by UR physicians have been raised over the years, complaints for which MBC should have jurisdiction and should take action when necessary. Is MBC properly investigating complaints it receives based on UR decisions?

Background: California's workers' compensation system requires employers to secure the payment of workers' compensation for injuries incurred by their employees. Employers are required to establish a medical treatment utilization review (UR) process, in compliance with specified requirements, either directly or through its workers' compensation insurer or an entity with which the employer or insurer contracts for these services. UR refers to reviewing whether recommended treatment by physicians, based on medical guidelines, should be approved, modified, delayed or denied. The law specifies that only a licensed physician who is competent to evaluate the specific clinical issues involved in medical treatment services (and where these services are within the scope of the physician's practice) requested by the physician may modify, delay or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

The MBC has for many years publicly asserted that when a medical director of a health plan or a utilization review physician in the workers' compensation system uses medical judgment to delay, deny or modify treatment for an enrollee or injured worker, that act constitutes the practice of medicine. This position, expressly stated on the MBC's website, has been presumed to be a correct interpretation of the Medical Practice Act by Legislators, regulators, physicians, and others involved with the Board. If a decision is contrary to the standard of care, the MBC should have clear authority to investigate the matter to determine whether the physician has engaged in unprofessional conduct.

As such, MBC notes that a decision to delay, modify or deny a medical treatment constitutes the practice of medicine under MBC's jurisdiction. The issue of who then can legally perform UR has been raised, specifically whether, because the treatment at issue is to be provided (in most cases) to a California resident, only a California-licensed physician can do UR. Proponents of legislation on this topic argued that physicians conducting UR who are not licensed in California may be unfamiliar with the specifics of California workers' compensation law and/or the details of the requirements of UR and in turn could be more likely to not properly follow California workers' compensation law. Proponents argued that out-of-state utilization review physicians made inappropriate decisions and thus a physician conducting UR should be licensed in California so that in the event practice standards are violated, MBC could take action against the physician.

During the prior review of MBC, the Committees questioned whether MBC should investigate complaints related to UR decisions, noting that complaints alleging UR decisions made by California-licensed physicians that violate the standard of care and cause significant harm had been rejected by MBC staff as being outside MBC's jurisdiction. In response, MBC placed this issue on the agenda for several MBC meetings and confirmed that UR is the practice of medicine. MBC asserts that it does not close UR-related complaints as non-jurisdictional and has worked to inform physicians and the public of this authority.

Staff Recommendation: *MBC should advise the Committees of remaining barriers to timely enforcement of UR cases related to the standard of care.*

Board Response (March 2017):

From the Board's perspective, the remaining barriers to enforcement of utilization review (UR) cases are that all UR physicians are not required to be licensed in California. While the Board believes that UR is the practice of medicine and that a physician providing UR for California patients should be licensed in California, the systems that utilize UR do not require all UR physicians to be licensed in California. In addition, the Board sometimes has difficulty obtaining patient authorization for release of medical records for UR cases. Lastly, there are some cases where the Board does not know the identity of the physician performing the UR, as Independent Medical Reviewers are not required to include their names on UR reports.

ISSUE #20: (MANDATORY REPORTING TO MBC.) MBC receives reports related to physicians from a variety of sources. These reports are critical tools that ensure MBC maintains awareness about its licensees and provide important information about licensee activity that may warrant further MBC investigation. MBC may not be receiving reports as required and enhancements to the Business and Professions Code may be necessary to ensure MBC has the information it needs to effectively do its job.

Background: There are a significant number of reporting requirements outlined in BPC designed to inform MBC about possible matters for investigation. MBC includes information in its Newsletter regarding mandatory reporting, conducts presentations regarding requirements for reporting and posts information on its website regarding the submission of required reports. Mandatory reports to MBC include:

BPC 801.01 requires MBC to receive reports of settlements over \$30,000 or arbitration awards or civil judgments of any amount. The report must be filed within 30 days by either the insurer providing professional liability insurance to the licensee, the state or governmental agency that

self-insures the licensee, the employer of the licensee if the award is against or paid for by the licensee or the licensee if not covered by professional liability insurance.

MBC reports that in general, these reports appear to be submitted to MBC within the 30 day timeframe. MBC states that it has reminded insurers of the reporting requirements and the importance of providing correct data. During the last four fiscal years the average settlement amount was \$478,112.

BPC 802.1 requires physicians to report indictments charging a felony and/or any convictions of any felony or misdemeanor, including a guilty verdict or plea of no contest.

MBC states that it appears to be receiving these incidents as required. MBC confirms that licensees are reporting these criminal charges through its receipt of arrest and conviction notifications that come to MBC from DOJ. MBC states that it also conducts Lexis/Nexis searches to identify any arrests reported in the media. Failure to report a criminal conviction to MBC results in a citation – MBC issued 36 citations in FY 2012/2013, 17 citations in FY 2013/2014, zero citations in FY 2014/2015 (due to the transfer of sworn investigators to HQIU and MBC's inability to issue citations until it promulgated regulations in 2015) and 4 citations in FY 2015/2016.

BPC 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 MBC. The coroner must provide relevant information, including the name of the decedent and attending physician as well as the final report and autopsy.

As was the case during the prior review, MBC reports that it is not receiving these reports as required, citing the submission of only 11 total reports between FY 2013/2014 and 2015/2016. Gross negligence may be a hard cause of death for a coroner to determine, which may lead to the low number of reports MBC receives. However, increased reporting by coroners to MBC when cause of death may be related to a physician could enhance MBC's enforcement efforts. The issue of coroners' reports is particularly salient for deaths related to prescription drug overdose. In those instances where a coroner determines cause of death is drug toxicity, and where the coroner findings deal with a young person, who is not a cancer patient on hospice or someone in a health facility setting, who was found dead in possession of various opioid combinations, the prescribing doctor and his or her practices may need to be looked into. MBC should receive coroner's reports as required by law and may benefit from receiving coroners reports where cause of death is expanded, beyond just gross negligence.

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

MBC does not believe that it is receiving reports from the court clerks as required by statute. The total number of reports filed pursuant to 803 and 803.6 between FY 2013/2014 and 2015/2016 is 31.

BPC Section 805 is one of the most important reporting requirements that allows MBC to learn key information about a physician or surgeon. 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 a health facility peer review body.

In FY 2015/2016, MBC received 127 reports. However, MBC compared the reports it received to information contained in the National Practitioners Databank and determined it is likely receiving reports when a facility believes a report should be issued. MBC has attempted to enhance knowledge of this requirement.

MBC notes that a number of explanations may account for the observed decline in 805 reporting, including: hospitals finding problems earlier and sending physicians to remedial training prior to an event occurring that would require an 805 report; with the implementation of electronic health records and the mining of medical record data by the health entities, early identification is a real possibility; the growing use of hospitalists providing care to hospitalized patients, concentrating the care in the hands of physicians who specialize in inpatient care and who are less prone to errors than physicians who provide the care on only an occasional basis; or health facilities may simply just not be reporting information.

However, because the MBC does not have jurisdiction over the hospitals, it has no way of knowing the exact reason it does not receive reports. As CDPH and other hospital accrediting agencies have the authority to review hospital records and conduct inspections of the hospitals, MBC could benefit from being provided reportable peer review incidents detected during an inspection by CDPH or a hospital accrediting agency.

BPC Section 805.01 is a similarly extremely important requirement. The law requires the chief of staff and chief executive officer, medical director, or administrator of a licensed health care facility to file a report within 15 days after the peer review body makes a final decision or recommendation to take disciplinary action which must be reported pursuant to section 805. This reporting requirement became effective January 2011 and is only required if the recommended action is taken for the following reasons:

- Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public.
- The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in BPC Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

- Repeated acts of clearly excessive prescribing, furnishing or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.
- Sexual misconduct with one or more patients during a course of treatment or an examination.

The purpose of 805.01 reports is to provide MBC with early information about these serious charges so that MBC may investigate and take appropriate action to further consumer protection at the earliest possible moment. Accordingly, for any allegations listed above, the Legislature determined that an 805.01 report must be filed once a formal investigation has been completed, and a final decision or recommendation regarding the disciplinary action to be taken against a physician has been determined by the peer review body, even when the physician has not yet been afforded a hearing to contest the findings.

The statistics below show the incredibly low number of 805.01 reports that have been filed per FY since the requirement came into place:

| FY 2011/2012 | FY 2012/2013 | FY 2013/2014 | FY 2014/2015 | FY 2015/2016 |
|-----------------|-----------------|-----------------|-----------------|-----------------|
| 16 | 9 | 2 | 4 | 5 |

MBC has attempted to enhance knowledge of this requirement but is not receiving reports as required. In FY 2015/2016, five reports were received pursuant to B&P 805.01, while in this same fiscal year, 127 B&P Code section 805 reports were received.

According to MBC, it writes an article every January in its Newsletter, “Mandatory Reporting Requirements for Physicians and Others,” that reminds entities they required to file 805.01 reports. MBC reports that it also wrote a separate article for the Fall 2015 Newsletter, “Patient Protection is Paramount: File Your 805.01 Reports,” in an effort to boost compliance with the requirement.

In addition to amending the law to require MBC to receive peer review reports, MBC believes that enhanced penalties for not providing 805.01 reports to MBC may yield additional compliance. MBC notes that if an entity fails to file an 805 report, they could receive a fine of up to \$50,000 per violation, or \$100,000 per violation if it is determined that the failure to file the 805 report was willful. In contrast, there is no penalty for an entity’s failure to file an 805.01 report, despite the serious nature of the charges involved. MBC recommends amending BPC Section 805.01 to allow MBC to fine an entity up to \$50,000 per violation for failing to submit an 805.01 report, or \$100,000 per violation if it is determined that the failure to report was willful.

BPC Section 2216.3 requires accredited outpatient surgery settings to report an adverse event to MBC no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected.

In FY 2014/2015 the Board received 104 adverse event reports. In FY 2015/2016 the Board received 111 adverse event reports. Adverse events appear to be reported as required, with the number of reports received by MBC increasing, as outpatient surgery settings became familiar with the law and gained an understanding of the types of events that should be reported. Enhancements to this requirement are discussed in Issue # ___ below.

BPC Section 2240(a) requires a physician and surgeon who performs a medical procedure outside of a general acute care hospital that results in the death of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, to report, in writing, on a form prescribed by the MBC, that occurrence to MBC within 15 days after the occurrence.

In FY 2014/2015 the Board received nine patient death reports and in FY 2015/2016, ten reports were received. MBC has worked with the Legislature to ensure that deaths from all procedures, rather just scheduled procedures, are reported.

Staff Recommendation: *The Committees should amend the Act to enhance MBC's ability to receive important reports that inform MBC about its licensees.*

Board Response (March 2017):

Language was submitted on March 10, 2017 to Senate B&P Committee staff that would implement penalties for failure to notify the Board pursuant to Business and Professions Code section 805.01 and would require state agencies and hospital accrediting agencies to report to the Board any peer review incidents subject to Business and Professions Code sections 805 or 805.01 reporting that are found during an inspection of a health care facility or clinic.

ISSUE #21: (OUTPATIENT SETTINGS.) California law prohibits physicians from performing some outpatient procedures unless they are performed in an accredited, licensed or certified setting. MBC approves agencies that accredit outpatient settings. MBC is required to receive information about incidents in these settings. Should MBC be provided additional data and should additional reporting be required to ensure MBC has the best information, provided in a timely manner, about incidents in these settings?

Background: Physicians are prohibited from performing some outpatient surgeries unless they are performed in an accredited, licensed, or certified setting. Specifically, the law specifies that 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. This exclusion includes certain outpatient surgery settings, 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 various sections of law in the Act and Dental Practice Act.

MBC is required to approve accreditation agencies that accredit outpatient settings. As such, MBC adopted standards for the approval of these accreditation agencies. MBC has approved five

accreditation agencies, the American Association for Accreditation of Ambulatory Surgery Facilities Inc., the Accreditation Association for Ambulatory Health Care, the Joint Commission, the Institute for Medical Quality and the American Osteopathic Association/Healthcare Facilities Accreditation Program. An 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 MBC.

MBC posts information regarding outpatient surgery settings on its website. The information on the website includes whether the outpatient setting is accredited or whether the setting's accreditation has been revoked, suspended, or placed on probation, or if the setting has received a reprimand by the accreditation agency. The website data also includes the name, address, medical license number and telephone number of any owners, the name and address of the facility, the name and telephone number of the accreditation agency and the effective and expiration dates of the accreditation.

Accrediting agencies approved by MBC are required to notify and update MBC on all outpatient settings that are accredited. If MBC receives a complaint regarding an accredited outpatient setting, the complaint is referred to the accrediting agency for inspection. Once the inspection report is received, MBC reviews the findings to determine if any deficiencies were identified in categories that relate to patient safety and if patient safety deficiencies are detected, the complaint may be referred for formal investigation.

Per existing law (Health and Safety Code Section 1216), clinics licensed by CDPH, including surgical clinics, are required to report aggregate data to the Office of Statewide Health Planning and Development (OSHPD). This data includes number of patients served and descriptive background, number of patient visits by type of service, patient charges, and any additional information required by CDPH and OSHPD. Both a June 2013 report by the California Health Care Foundation (“Ambulatory Surgery Centers: Big Business, Little Data”) and CHCF’s 2015 follow-up report, (“Outpatient Surgery Services in California: Oversight, Transparency and Quality”) noted that physician-owned outpatient settings, which fall under the jurisdiction of MBC, are not providing this important data as that required by CDPH and OSHPD.

MBC believes that it is important to require both accredited and licensed outpatient settings to report data to OSHPD, as this data will provide important information on procedures being done in ambulatory surgery centers and will allow MBC and other regulatory agencies to be aware of any issues or areas of concern. Language was contained in 2015 legislation (SB 396 (Hill, Chapter 287, Statutes of 2015) that would have required the same data reporting for accredited outpatient settings as what is required for surgical clinics. However, due to concerns raised by stakeholders that the proposed data requirement was too broad and would not provide the appropriate health outcome information, the language was removed. MBC believes this information is still necessary and important to be reported.

MBC also believes that enhancements are necessary to current mandatory reporting by accredited outpatient settings of adverse events, as outlined in BPC Section 2216.3 and discussed above. These adverse events required to be reported are the same adverse events that hospitals are required to report to CDPH. The issue is that while accredited outpatient settings have been reporting these adverse events to MBC, just pointing to the hospital adverse events reporting section as the law does has proven to be problematic. Some of the adverse events hospitals have to report do not necessarily apply to accredited outpatient settings. MBC also believes that there are adverse events that occur in

accredited outpatient settings that do not apply to hospitals, but should be added to the adverse event reporting requirements for accredited outpatient settings.

MBC states that there is confusion for some outpatient settings in terms of what adverse events should then be reported to MBC, particularly when an adverse event doesn't really fit into a specific category outlined in HSC 1279.1. MBC believes clarifications may be necessary.

Staff Recommendation: *MBC should update the Committees on its efforts to engage stakeholders and interested parties about the information MBC needs to receive from and about outpatient settings. Consideration should be granted to ensuring MBC has the information it needs about outpatient settings in order to protect patients and that the law is clear on what adverse events need to be reported to MBC.*

Board Response (March 2017):

In order to provide more information on outpatient surgery settings (OSS), accredited OSSs should be required to report data to OSHPD, as this data will provide important information on procedures being done in OSSs and will make the Board and other regulatory agencies aware of any issues of concern so that consumer protection enhancements can be addressed if they are needed. Language to require data reporting was included in SB 396 (Hill) from 2015, however it was taken out because of concerns raised by interested parties. An interested parties meeting was held on May 26, 2016, to discuss this issue and suggested language was provided to the interested parties that included changes addressing the concerns raised. The interested parties were asked to submit suggested amendments and language on this issue, however, no language was submitted. The Board provided the language from the interested parties meeting to Senate B&P Committee staff on March 10, 2017.

In addition, the Board is suggesting changes to the reporting requirements for adverse events, as the law currently requires an OSS to report the same adverse events as hospitals, which in some cases may not pertain to an OSS and results in confusion regarding what should be reported. On December 13, 2016, Board staff met with the California Ambulatory Surgery Association to develop proposed amendments to the adverse event reporting. The Board provided the statutory language to Senate B&P Committee staff on March 20, 2017.

ISSUE #22: (ENFORCEMENT ENHANCEMENTS.) Various enhancements to the Act may be necessary for MBC to ensure public protection from dangerous physicians.

Background: MBC may be assisted in its ability to take swift disciplinary action when necessary and warranted through amendments to the Act.

Challenges Revoking the License of Physician Required to Register as a Sex Offender. BPC Section 2232 requires the “prompt revocation” of a physician and surgeon’s license when a licensee has been required to register as a sex offender based on a conviction for certain sexual offenses. MBC notes in its 2016 report to the Legislature that allowing physicians who are sex offenders to continue to practice medicine is contrary to its public protection mandate.

Specifically, as BPC 2232 is currently written, obtaining a prompt revocation has proven to be difficult for MBC. Once MBC learns that a doctor has been convicted of a crime requiring that he or she register as a sex offender, the MBC requests OAG to file an accusation on its behalf. This accusation, along with several other documents, is served on the respondent physician, and he or she has 15 days

to file a Notice of Defense (NOD). MBC and OAG are then required to wait to receive that NOD before requesting to set a hearing with the Office of Administrative Hearings (OAH). Once the hearing is set, pursuant to the APA, OAG is then required to send the respondent physician a Notice of Hearing no less than 10 days prior to the date of the hearing. Therefore, over a month will have passed before a hearing can even be set from the time MBC is notified that a physician has registered as a sex offender. If OAH does not quickly set the hearing after a request has been filed, a prompt revocation can actually turn into a several-month delay. In the meantime, because there are no restrictions on the license, the offending doctor may practice medicine and the public is at risk for possible further harm, unless MBC has been able to successfully take other action like obtaining an Interim Suspension Order.

MBC notes that without a definition of “prompt” in the Act and without tools for “prompt revocation”, MBC is actually not able to take quick action. According to MBC, an automatic revocation of a license would make more sense for these situations. MBC notes that automatic revocations are not new to professional licensees and cites the example of teachers who have been convicted of certain sex offenses who are suspended by the Commission on Teacher Credentialing, without having a hearing beforehand. Once the conviction becomes final, the teacher’s license is revoked. Specifically, Education Code Section 44425(a) provides that when a holder of a teacher credential has been convicted of certain sex offenses as defined in Education Code section 44010, the Commission on Teacher Credentialing immediately shall suspend the credential. When the conviction becomes final or when imposition of sentence is suspended, the commission immediately shall revoke the credential. Subdivision (c) provides that the revocation shall be final without possibility of reinstatement of the credential if the conviction is for a felony sex offense as defined in section 44010.

MBC believes that when it receives notification that a physician has been ordered to register as a sex offender, rather than filing an accusation and going through the lengthy administrative process, MBC should instead be able to file a pleading that immediately revokes the physician’s license. The respondent would still be eligible for due process consideration and a hearing if they make a request in writing. MBC notes that physicians who are ordered to register as sex offenders have already had their due process rights satisfied at the criminal level. In addition, if the physician requests a hearing at OAH after the revocation, their due process rights will be satisfied at the administrative level by allowing review of MBC’s decision.

Challenges to Obtain Patient Records and Key Documents. BPC Section 2225 provides that “Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon...and his or her patients a privileged communication, those provision shall not apply to investigations or proceedings conducted under this chapter.”

According to MBC, it relies on this section to obtain medical records either through patient authorization or via subpoena. Recently, MBC faced a challenge to its authority to obtain records from a physician who practiced psychiatry and was accused of inappropriately prescribing medications. The patient authorized MBC to obtain his medical records, but then rescinded the authorization and objected to MBC’s subpoena for his medical records out of fear that the physician would stop prescribing to him. The superior court ultimately granted MBC’s motion for subpoena enforcement. The appellate court, however, initially determined that BPC Section 2225 did not allow MBC to obtain psychotherapy records when the patient objected and invoked the psychotherapist-patient privilege provided by Evidence Code Section 1014.

MBC notes in its 2016 report to the Legislature that it is concerned that similar challenges will be made in the future, and if successful, MBC's ability to investigate physicians who declare themselves to be psychiatrists will be significantly hampered, especially in the area of overprescribing controlled substances where the patient may refuse to sign an authorization and object to a subpoena for records due to issues with addiction and/or financial gain (in cases of diversion of prescription medications).

MBC's ability to investigate and protect the public depends upon its ability to enforce investigational subpoenas with a proper showing of good cause, regardless of the physician's specialty. MBC believes that amendments to BPC 2225 should be made to make it clear that invocation of the psychotherapist-patient privilege is not a barrier to MBC obtaining psychotherapy records via a subpoena upon a showing of good cause.

ISO filing versus Petition to Revoke Probation. Provisions in the APA, specifically contained within Government Code Section 11529, provide that if MBC pursues and obtains an ISO, it has 30 days to file an accusation. However, in some instances MBC may not file an accusation, but instead file a petition to revoke probation. MBC is concerned that this section of law does not treat an order to revoke probation the same as an accusation, despite the fact that a petition to revoke probation is very similar to an accusation. A petition to revoke probation serves as the charging document identifying what a physician has done to violate the law when a physician is on probation. MBC would like to add petitions to revoke probation to this section of the APA for needed clarification.

Staff Recommendation: *Consideration should be given to amending the Act and APA to ensure MBC has the necessary authority to process enforcement actions.*

Board Response (March 2017):

Language was submitted on March 10, 2017 to Senate B&P Committee staff that would amend the Business and Professions Code and Government Code to enhance the Board's enforcement authority and provide clarification to the law.

ISSUE #23: (EXPERT WITNESS REPORTS.) **MBC may be hindered by provisions in the Administrative Procedure Act related to discovery, specifically the ability of MBC to receive expert witness reports prepared for a respondent. Are amendments necessary to ensure MBC can respond in a timely fashion to information provided in expert witness reports?**

Background: As noted during the prior MBC review and raised in MBC's 2016 report to the Legislature, MBC is concerned that provisions outlined in the Administrative Procedure Act (APA) limit MBC's ability to access, through discovery, information provided by experts who are used by a licensee, or his or her attorney, who is the subject of disciplinary action. A key tool for accessing information used in civil action is to depose individuals, however, APA provisions (Government Code Section 11511) only authorize depositions in extreme circumstances, circumstances that typically do not apply to MBC cases. While it may not be appropriate to amend and expand general discovery provisions under the APA, as the APA applies to all administrative hearings and any amendments could impact disciplinary proceedings of other administrative agencies and perhaps add costs or delay proceedings, it may be appropriate to amend the Act to deal specifically with expert testimony for MBC cases.

BPC Section 2334 specifically relates to expert testimony for MBC disciplinary cases. According to MBC the provisions in this section are beneficial to DAGs prosecuting MBC cases for a number of reasons. Upon receipt of an expert witness disclosure, DAGs can assess the qualifications of the

respondent's expert in relation to the expert MBC may be using. Further, DAGs are able to provide a respondent's expert's narrative for a case and opinions to the expert used by MBC to determine whether the expert's previously expressed opinions change. Information contained in the expert witness reports can also assist MBC in determining necessary next steps for a case or can assist MBC's own expert in their testimony before an ALJ. Since discovery is so limited in proceedings governed by the APA, this section of the BPC provides at least some information to MBC and DAGs that impact proceedings in these important quality-of-care cases.

According to MBC, in some instances, once MBC receives these reports, amendments to an initial accusation filed may be necessary, thus increasing the timeframe for disciplinary action to be taken and that consumer protection can be enhanced through changes to this section in the Act.

Staff Recommendation: *The Committees should consider amending the Act to ensure MBC has important information related to an enforcement case, according to a timeline that assists MBC in taking swift action.*

Board Response (March 2017):

In an effort to enhance consumer protection, section 2334 of the Business and Professions Code should be amended. The Board submitted language on March 10, 2017 to Senate B&P Committee staff to clarify the date and require the complete expert report be produced by the respondent.

ISSUE #24: (CEASE PRACTICE ORDERS.) **MBC has the authority to seek an Interim Suspension Order from an Administrative Law Judge when MBC believes the public may be at risk due to physical or mental impairment. Does the Act need to be amended to ensure MBC can take swift action when physicians delay or refuse to comply with orders to undergo a physical or mental examination?**

Background: BPC Section 820 authorizes MBC to order a physician to undergo a physical or mental health examination when MBC determines, through the course of an investigation, that a licensee's ability to practice may be impaired by physical or mental illness. Failure to comply with an examination order constitutes grounds for suspension or revocation of the individual's certificate or license (pursuant to BPC Section 821). However, the process for suspension or revocation for refusal to submit to a duly-ordered examination can be lengthy, as demonstrated by a recent court case in which a Board of Registered Nursing licensee refused a psychiatric examination yet continued to practice for months thereafter (see *Lee v Board of Registered Nursing*, 209 Cal. App. 4th 793; 147 Cal. Rptr. 3d 269; Sept. 26, 2012).

As noted during the prior MBC review and raised in MBC's 2016 report to the Legislature, to refuse or delay compliance with an examination order poses risks for consumers because of the possibility that a mentally or physically ill practitioner could continue to see patients until the MBC completes suspension or revocation proceedings. Public protection would be better served if MBC is authorized to issue a cease practice order in cases where compliance with an examination order under BPC Section 820 is delayed beyond a reasonable amount of time (the exact timeframe that constitutes "reasonable" could be determined through stakeholder discussions with MBC, interested parties and the Committees).

Staff Recommendation: *The Act should be amended to provide MBC the authority to issue a cease practice order in cases where a licensee delays or all together does not comply with an order to undergo a physical or mental health examination.*

Board Response (March 2017):

The Board agrees with Committees' staff's recommendation. Public protection will be better served if the statute is amended to give the Board the authority to issue a cease practice order in cases where the licensee delays or fails to comply with an order issued under Business and Professions Code section 820 within the specified time frame as set forth in the order. Language was submitted on March 10, 2017 to Senate B&P Committee staff to address this issue.

ISSUE #25: (DISPARITY IN ENFORCEMENT ACTIONS.) MBC commissioned a third-party study to identify whether disparity in its enforcement actions were present. What is the status of MBC's efforts in the wake of the study's release?

Background: In response to concerns raised by members of the African American physician community and a formal request from the Golden State Medical Association (GSMA), MBC contracted with CRB to conduct a study aimed at determining if disparity exists in MBC's enforcement efforts. Anthony Jackson, M.D., an anesthesiologist from Southern California and GSMA raised the issue to MBC over the course of a number of meetings that African-American physicians were targeted and received discipline from MBC in higher numbers than other comparable ethnic groups.

MBC is required to collect certain demographic information from licensees on a voluntary basis. According to MBC, about 70 percent of licensees voluntarily provide this information.

CRB's study was released in January. Using archival data provided by MBC of complaints, investigations and discipline that occurred from July 2003 through June 2013, CRB determined that there is a correlation between physician race and the pattern of complaints, investigations and discipline. Latino and black physicians were both more likely to receive complaints and more likely to see those complaints escalate to investigations. According to the study, Latino physicians were also more likely to see those investigations result in disciplinary outcomes. CRB noted that the findings "should be taken with the caveat that this is an observational study, and many variables affecting the perception of physician performance (for instance, "bedside manner") could not be taken into account." CRB further determined that while there is evidence of disparate outcomes, there is no evidence that any actor has specifically applied racial bias to achieve these outcomes.

MBC discussed the study at its January meeting and formed a Demographic Study Task Force to further explore this issue and provide additional direction to MBC. MBC also noted that it would promptly begin training for members and all staff to ensure equity in its work.

Staff Recommendation: *MBC should provide an update to the Committees on its efforts to ensure that bias and disparities do not exist in any of its programs. MBC should establish a formal policy against racial discrimination.*

Board Response (March 2017):

The California Research Bureau's report on Demographics of Disciplinary Action by the Medical Board of California 2003 – 2013 was requested by the Board in response to concerns about bias in the Board's disciplinary process. It is important to note that, due to limitations in the study's design and methodology, the CRB was not able to draw definitive conclusions regarding the drivers and scope of the disparities highlighted in its report. Despite the limitations, the Board takes the disparities highlighted in the CRB's report very seriously and is taking proactive steps to investigate and address them.

In response to the report, the Board established a Disciplinary Demographics Task Force made up of one physician and one public Board Member to review the report and deliver specific recommendations on how best to proceed. This Task Force had its first meeting on February 24, 2017. During this meeting, the Members began to identify available training and possible next steps.

The Board has been looking at available training on implicit bias that is already being provided to other entities. The training on implicit bias will be provided to all individuals in the enforcement process, from Board staff and Members to investigators, experts, prosecutors and judges, if not already required.

The Task Force will also review existing complaint, investigation, and disciplinary processes to better understand the institutional and procedural issues that may have contributed to the disparities outlined in the report. The Task Force's recommendations are going to be presented at the Board's next meeting.

The Board currently utilizes the DCA's Non-Discrimination Policy and Complaint Procedures, which must be reviewed and signed by all employees. This policy states that the DCA enforces a zero tolerance policy against discrimination, harassment, and retaliation. Every year, all employees must review this policy and indicate that they will comply with the policy. Due to this current policy that is already in place for all DCA boards and bureaus, the Board does not believe a separate policy is necessary. However, this will be discussed with the Disciplinary Demographics Task Force to determine if a separate policy should be developed.

ISSUE #26: (COMPLAINTS.) Complaints are the heart of MBC's enforcement program. Successfully processing complaints can ensure that patients and the public are protected. Delays in complaint processing can have grave effects on patients and the public and compound MBC's efforts to protect consumers. In consumer satisfaction surveys, MBC consistently receives unfavorable feedback and response for its handling of complaints. What efforts is MBC taking to process complaints, particularly with a rise in the number of complaints received?

Background: Accepting, processing and acting on complaints from patients, the public, MBC staff, other agencies and other sources is a primary mechanism by which MBC can ensure that licensees are in compliance with the Act and that patients have options for action in the event that their physician violates the law. The timely processing of complaints provides MBC with critical information about their licensees and assists in prioritizing workloads.

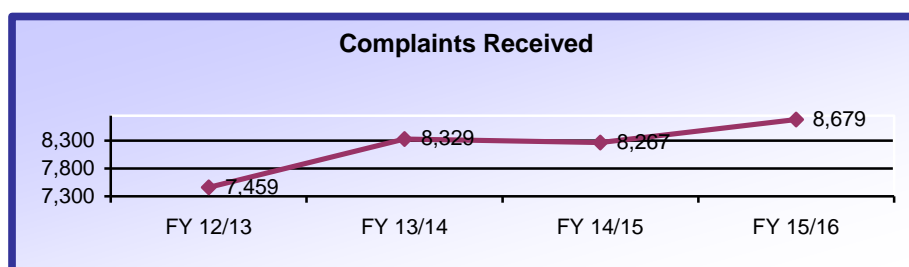
The law establishes MBC's prioritization for complaints and outlines the following as the highest priority for MBC:

- Complaints related to gross negligence, incompetence or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public
- Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient

- Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor
- Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation
- Sexual misconduct with one or more patients during a course of treatment or an examination
- Practicing medicine while under the influence of drugs or alcohol
- Repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith examination of the patient and medical reason therefor.

Complaints are treated as confidential until such time as a complaint and investigation result in some type of formal, public action.

MBC reports there has been a continual increase in the number of complaints since the prior review. The average complaints received for the three fiscal years of the prior sunset report (FY 2009/2010 to FY 2011/2012) was 6,861 complaints received; whereas the average of the three fiscal years included in this report (FY 2013/2014 to FY 2015/2016) is 8,425, an increase of 1,564. Between FY 2014/2015 and FY 2015/2016 there was an increase of 412 complaints, which shows the numbers are continuing to increase.



It would be helpful for the Committees to better understand what MBC is doing to handle the influx of complaints. It would be helpful for the Committees to understand whether MBC treats complaints received by patients any differently than complaints generated by MBC staff in response to a report or news media article. It would be helpful for the Committees to better understand how MBC follows up on complaints, particularly how MBC contacts individuals who file complaints about their physicians to either gain additional information or to alert the individual of the status of a case.

Staff Recommendation: *MBC should update the Committees on its complaints process, giving particular attention to the work MBC does to ensure that patients have an opportunity to provide information that may be critical in determining what next steps to take and whether they are ever proactively informed when a complaint leads to formal disciplinary action.*

Board Response (March 2017):

Complaints are brought to the Board's attention through a variety of sources, including patients, family members, licensees, other state agencies, media, mandated reporters, other state's disciplinary actions, and any other means of receiving information about a physician who may be violating the law. While the steps to process a complaint may be different based upon the type of complaint, all complaints go through the same process of triage and initial review by the Board's Central Complaint Unit (CCU), investigation, if warranted by either the Board's non-sworn investigators or the DCA's sworn investigators, and prosecution by the Attorney General's Office. As indicated in the Board's Sunset Review report and pointed out in this background paper, over the past four years the Board has seen an increase in the number of complaints received. Accordingly, the Board also saw an increase in the timeframe to process complaints within CCU. Due to this increase, in FY 15/16, the Board was able to obtain one additional staff member through the budget change proposal process to assist in the complaint triage. Further, the Board is seeking two more analysts this year, through the budget change proposal process, to review and process complaints within this unit. In addition to requesting additional staff, the Board has made business process improvements to assist in decreasing the timeframe. Such process improvements include performing quarterly case reviews on all complaints pending within the unit and reviewing pending reports to follow up on complaints that are not moving forward in a timely manner. These pending reports were just recently able to be obtained and have greatly improved the follow up on complaints.

It is the Board's policy that individuals who file a complaint with the Board are notified at various stages within the enforcement process. Upon receipt and opening of a complaint, an acknowledgement letter is sent to the complainant. This letter informs the complainant that the Board received their complaint and that if they have additional information they may submit it to CCU for review. This letter provides examples of what type of additional information this may include.

In addition, the Board recently developed a letter that is sent to patients or plaintiffs in malpractice cases who may be unaware that the Board received a mandated report complaint. This letter informs them that the Board received this report, asks them to provide additional information they may have, and outlines the Board's statute of limitations.

When the Board sends a request to the complainant for their release of medical records the Board also informs the complainant that they can provide additional information to the Board regarding their complaint. During the complaint review process, if the complainant calls the Board, staff also informs them that additional information can be provided.

For quality of care cases, the complainant is notified that all the medical records have been received and that the complaint is going to be sent to an expert for review. For all cases, if it is determined that the complaint is moving to formal investigation then the complainant is sent a letter notifying them of this transition of the case. Once the complaint goes to formal investigation, the complainant will be contacted by the investigator. If the matter is referred to the Attorney General's Office, the complainant receives a letter notifying them the matter has been referred and also receives a letter and a copy of the accusation, if one is filed. Lastly, if disciplinary action is taken, the complainant also receives a copy of the final decision in the matter. Therefore, the complainant is made aware that the complaint they filed with the Board has led to disciplinary action.

For complaints that are closed at CCU, the Board sends the complainant a link to a consumer satisfaction survey. However, through this sunset review process and feedback from interested parties, the Board identified that not all complainants have received the survey link, including those whose complaints went to investigation and proceeded to disciplinary action. The Board is ensuring that this

link will be added to all closing letters from the Board, including those sent after a formal investigation and after disciplinary action is taken.

ISSUE #27: (VERTICAL ENFORCEMENT.) Originally implemented as a tool to bring about efficiencies in MBC enforcement efforts, VE does not appear to have reduced timeframes for disciplinary action and appears saddled with administrative challenges that significantly impact the ability for effective prosecution of administrative cases against physicians. Given that the initial intent and structure of the VE model does not appear to be functioning the way it was intended and given that timeframes for disciplinary action have actually increased, should VE be continued?

Background: Following the 2004 release of a statutorily mandated report by an independent monitor, MBC implemented VE, requiring DAGs to be involved in MBC’s investigation activities as well as its prosecution activities. As initially drafted, SB 231 would have transferred MBC investigators to HQE to ensure seamless coordination, however, only the VE provisions became effective requiring the utilization of a VE model, with MBC investigators still housed at MBC and not transferred to OAG. At the time, MBC supported the transfer of investigators to the OAG’s HQE.

Despite VE and other enhancements, MBC’s enforcement activities were still called into question during the prior review of MBC by the Committees in 2013. MBC was seen as continuing to fail to aggressively investigate and pursue actions against dangerous physicians. In response, SB 304 of 2013 again proposed the transfer of MBC investigators to HQE but ultimately required MBC to transfer its investigators to DCA’s DOI, establishing the framework for the current HQIU.

HQIU performs investigative services for the MBC, the Osteopathic Medical Board, the Board of Podiatric Medicine, the Board of Psychology, the Physician Assistant Board and all of the other allied health professions within MBC’s jurisdiction. However, only MBC cases follow the VE model.

DOI and OAG worked to establish formal policies and procedures for VE following the transfer of investigators to DOI as of July 1, 2014. In July 2015, the VE Prosecution Protocol manual was finally formalized, providing guidelines for staff members conducting investigations and strategies to resolve disagreements between investigators and HQE DAGs. The manual also outlined cooperation and communication expectations between the two offices. The manual emphasized collaboration and conflict resolution between HQIU and HQE, stemming from strained personnel issues between the two offices. The manual sought to address disagreements by providing clarified definitions regarding the roles of each office and the expected amounts of direction and supervision HQE should provide HQIU.

Yet problems still persist and MBC enforcement timelines continue to grow.

The initial intent and structure of the VE model does not appear to be upheld, as cases are being conducted with the “handoff method”. The entire purpose of the VE model was to eliminate this handoff method by aligning investigators and legal staff to handle cases together, instead of the traditional route of investigator gathering information and “handing” the case off to legal staff. With high levels of staff turnover in HQIU and shifting assignments in HQE, cases are not handled by the same investigator and same DAG from start to finish.

There are still significant working relationship challenges between HQIU and HQE, despite completion of the protocol manual. HQE DAGs may direct investigators to seek out certain information that could prove beneficial in an administrative licensure case but that impacts the

independence trained peace officer investigators need in order to effectively investigate cases. Government Code provisions related to VE (GC 12529.6(b)) specifically use the word “direction,” stating that an investigator shall, “under the direction but not the supervision of the deputy attorney general,” be responsible for obtaining evidence in a matter. This no doubt impacts the team approach and may result in the expertise of both the investigator and DAG not being effectively utilized. Not every case should result solely in administrative action as initiated by a DAG, as investigations may bring criminal violations to light as well. HQIU faces an almost 40 percent vacancy in investigators, numbers that are not the same for other DOI investigators whose cases are not required to be coordinated with a DAG from the outset, and who may have independence in how they put their investigative skills to use.

A March 2016 MBC report on VE showed that MBC has spent \$18.6 million to implement the program and provided statistical data showing that the average investigation timeframe has increased. In FY 2014/2015 the timeframe was 382 days and during FY 2015/2016 the timeframe increased to 426 days. Data from the first half of FY 2016/2017 presented at a January MBC meeting indicate an average HQIU investigative case cycle time of 473 days.

Staff Recommendation: *Discretion is clearly needed in terms of determining when a case should be investigated under a VE model. In some instances, VE may not necessarily bring about enhanced action or results, yet all MBC cases must follow this process. Accessing and consulting DAGs may also prove to be beneficial for non-sworn MBC staff and HQIU investigators in other health board related cases may benefit from coordinating early on with a DAG. Strong consideration should be given to removing the requirement that all MBC cases follow a VE model or in the alternative eliminate the VE model entirely.*

Board Response (March 2017):

The Board agrees with Committees’ staff recommendation that changes are necessary to the vertical enforcement (VE) model. In the Board’s March 2016 report, the Board recommended that the Government Code authorizing this program be amended to more fully utilize the expertise of both the investigators and the prosecutors. In addition to that recommendation, Board staff agrees that there should be discretion in terms of determining which cases will be investigated under the VE model.

The Board has seen benefits to specific case types being placed in the VE model. If these specific case types were kept in the VE model, and all other cases were investigated through the normal investigation process, this would enable the prosecutors to focus on the highest priority matters from the perspective of consumer protection.

The Board looks forward to working with the Committees, the Attorney General’s Office, and the DCA to identify the needed changes to this program in order to enhance consumer protection and reduce the enforcement timeframes.

ISSUE #28: (PUBLIC NOTIFICATION OF DISCIPLINARY ACTION.) Access to timely, accurate information about MBC licensees is a fundamental means by which patients and the public are informed about medical services provided to them. MBC posts information on its website and has improved these efforts yet significant gaps remain in the ability for patients to have full awareness of disciplinary action taken against their physician. For the small number of physicians ordered on probation by MBC, requiring that patients are proactively notified of their probationary status can serve as a useful tool in patients’ efforts to know their physician and know when their physician has violated the Act. What steps should be taken to ensure

patients and the public are properly informed about MBC disciplinary action and about physician probationary status for the rare cases that result in MBC having to take such action to protect patients from harm?

Background: SB 231 referenced above in Issue #14 required the Little Hoover Commission to conduct a study and make recommendations on the role of public disclosure in the public protection mandate of the MBC. Those responsibilities were then transferred through SB 1438 (Figueroa, Chapter 223, Statutes of 2006) to the CRB of the California State Library. The study, *Physician Misconduct and Public Disclosure Practices at the Medical Board of California*, was completed in November 2008 and offered 11 policy options aimed at improving public disclosure access to information about physician misconduct, many of which were implemented by MBC and frame MBC's current requirements and practices for public disclosure of disciplinary action. As a follow up to the study, MBC sponsored legislation in 2014 (AB1886, Eggman, Chapter 285, Statutes of 2014) to update the length of time information is made available to the public on the MBC's website, allowing MBC to post the most serious disciplinary information on MBC's website for as long as it remains public, rather than just 10 years.

MBC reports that it exceeds the DCA recommended minimum standards for public information and is consistent with the requirement that boards post accusations and disciplinary actions. MBC states that in the event that the section of MBC's website which enables consumers to access information about a physician is not operational at any given time, MBC provides a phone number consumers can call to receive enforcement updates from MBC staff.

MBC's website provides the following information about physicians:

- Discipline taken by MBC (public reprimands and public letters of reprimand are only available for ten years on the website).
- Formal accusations by MBC of wrongdoing.
- Practice restrictions or practice suspensions pursuant to a court order.
- Discipline taken by a medical board of another state or federal government agency.
- Felony convictions MBC has reports of (for convictions after January 3, 1991).
- Misdemeanor convictions (for convictions after January 1, 2007) that resulted in a disciplinary action or an accusation being filed by MBC if the accusation is not subsequently withdrawn or dismissed.
- Citations received for a minor violation of the Act within the last three years (for citations that have not been withdrawn or dismissed).
- Public letter of reprimand issued at time of licensure within the last three years.
- Any hospital disciplinary actions that resulted in the termination or revocation of the physician's privileges to provide health care services at a healthcare facility for a medical disciplinary cause or reason reported to MBC after January 1, 1995.
- All malpractice judgments and arbitration awards reported to MBC 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 MBC).
- All malpractice settlements over \$30,000 reported to MBC after January 1, 2003 that meet certain criteria.

MBC also provides the following documents on its website for each licensee, as relevant, and unless specifically prohibited by law, allowing the public to see:

- The accusation or petition to revoke a license or amended accusation as filed by a DAG.
- The public letter of reprimand received by a licensee.
- The actual citation and fine received by a licensee.
- The suspension or restriction order issued by MBC.
- The administrative or disciplinary decision adopted by MBC.

While it is true that important information is available on MBC’s website, a key issue for the Committees remains how easily available it is for California patients to access easily understandable information about physicians who have been the subject of disciplinary action, placed on probation and are practicing. When the MBC places physicians on probation, generally they continue to practice medicine and see patients under restricted conditions. Terms of probation may include certain practice limitations and requirements, but most commonly physicians on probation are not required to provide any information to their patients regarding discipline taken by MBC.

A determination of probation is a step in a lengthy disciplinary process, conducted in accordance with the Administrative Procedures Act, and offering due process for accused licensees. Once an individual is placed on probation, they have already had an accusation filed against them which is publicly available on MBC’s website. The filing of an accusation alone requires significant justification that a violation of the Act has occurred. In reviewing MBC data for current physicians on probation, proven violations that result in probation include gross negligence or incompetence, substance abuse, inappropriate prescribing, sexual misconduct or conviction of a felony. Probationary status is not secret. MBC only orders probation for a licensee once multiple steps in the life of a case have been taken. Probation is not loosely issued for suspicions or complaints or facts gained during an investigation that lead to the filing of an accusation for which clear and convincing evidence is present.

According to MBC data, there are currently 635 physicians on probation (this includes those issued a probationary license at application and those with an out of state address of record, for a total of 497 on probation with an address in California, 83 on probation with an address in another state, 38 with a probationary license with an address in California and 17 with a probationary license with an address in another state.) These individuals represent only a fraction of overall MBC licensees. (See Appendix in this report attached for a listing of those physicians and surgeons currently on probation.)

The MBC posts information regarding probation on its website and distributes the information to its email list, which includes media and interested persons who have signed up to receive it, relying on members of the public to take the steps to access important information. According to a recent Pew Research Center U.S. analysis, seniors, the most likely group to seek healthcare, are also the group most likely to say they never go online. About four-in-ten adults ages 65 and older (39 percent) do not use the internet, compared with only 3 percent of 18- to 29-year-olds. One-in-five African Americans, 18 percent of Hispanics and 5 percent of English-speaking Asian Americans do not use the internet, compared with 14 percent of whites.

Patients may be especially deserving of greater access to information about a physician on probation given the potential for future disciplinary action. The 2008 CRB study reported that physicians who have received serious sanctions in the past are far more likely to receive additional sanctions in the future. According to the CRB report, “These findings strongly imply that disciplinary histories provide patients with important information about the likely qualities of different physicians.” The CRB cited research that examined physician discipline data provided by FSMB. The researchers split their sample into two periods, Period A 1994 - 98 and Period B 1999 - 2002. They classified physicians by whether

they had no sanctions in the period, or had been assessed with one or more mild, medium or severe sanctions. Severe sanctions encompassed disciplinary actions that resulted in the revocation, suspension, surrender, or mandatory retirement of a license or the loss of privileges afforded by that license. The medium sanctions included actions that resulted in probation, limitation, or conditions on the medical license or a restriction of license privileges. The study found that less than 1 percent of physicians who were unsanctioned during Period A were assessed a disciplinary action during Period B. However, physicians sanctioned during the earlier period were much more likely to be assessed additional sanctions in the second period; for example, 15.7% of those who received a medium sanction in Period A went on to receive either a medium or a severe sanction in Period B; physicians who received a medium sanction in Period A were 28 percent more likely to receive a severe sanction in Period B than someone who received no sanction in period A; and, physicians who received a medium sanction in Period A were 32 percent more likely to receive another medium sanction in Period B than someone who received no sanction in Period A.

In October, 2012 MBC staff made a proposal to the MBC to require physicians to inform their patients when the physician is on probation and required to have a monitor. In its recommendation staff said, “This would insure the public has the ability to make informed decisions regarding their healthcare provider.” MBC did not approve the staff proposal.

In 2015, a petition filed before the MBC by Consumers’ Union Safe Patient Project called on MBC to amend its Manual of Model Disciplinary Orders and Disciplinary Guidelines by requiring physicians on probation to notify patients about their status as a probationer. Specifically, the petition asked MBC to require physicians who continue to see patients to inform their patients of their probationary status and take steps accordingly, including; (1) notifying patients of probationary status when the patient contacts a physician’s office to make an appointment; (2) disclosing probationary status in writing; (3) having patients sign an acknowledgment that they received information from their physician about his or her probation; (4) posted a disclosure about probation in a physician's office in a place readily apparent to patients; (5) ensuring that disclosures include at least a one-paragraph description of the offenses that led the MBC to place the physician on probation as well any practice restrictions placed on the physician; (6) referring a patient to MBC’s website to access the actual documents related to a physician’s probation; and (7) maintaining a log of all patients who were provided notification.

MBC voted to deny the petition based on concerns about the impact this would have to the patient-physician relationship and concerns raised about the lack of exemptions of the requirement in certain settings like emergency rooms. Instead, MBC established a task force to explore a variety of suggestions for enhancing and improving the public’s awareness of MBC’s regulation of physicians. At the January 2016 MBC meeting, the task force discussed improving MBC’s online license lookup function, modifying the consumer notice posted in physician waiting rooms, increasing public outreach regarding physicians on probation and revising MBC’s Disciplinary Guidelines. MBC did not take action on the option for health care providers on probation to notify their patients. MBC held an interested parties meeting in January 2017 and sought stakeholder feedback on two possible amendments to the Manual of Model Disciplinary Orders and Disciplinary Guidelines, requiring notice of probationary status via a posted sign in a prominent place in a physician’s office and requiring physician notification of probationary status to patients in writing. MBC did not take further action on these options.

Staff Recommendation: The Act should be amended to ensure that patients receive timely notification of their physician’s probationary status, that patients are easily able to obtain understandable information about violations leading to probation, and that MBC makes changes to

the disciplinary enforcement information displayed on its website to allow for easier public access and understanding of actions MBC has taken.

Board Response (March 2017):

After the Board denied the petition for rulemaking from the Consumer’s Union, the Board established a Patient Notification Task Force. After a meeting of the Task Force, the Board determined that the issues raised during the Patient Notification Task Force meeting would be pursued within other standing Board committees. The improvements recommended for outreach and changes to the website were pursued within the Board’s Public Outreach, Education, and Wellness Committee. The signage and changes in legislation to allow the Board to require more information on the sign a physician must post are being addressed in this sunset report. The issue of a possible change to the disciplinary guidelines to have an optional condition that would require a physician to notify their patients they are on probation is being discussed and an interested parties meeting was held on January 11, 2017, to obtain public input.

The Board took a neutral if amended position on the bill proposed last year, SB 1033, regarding patient notification. The Board looks forward to working with Committee staff and interested parties on this issue.

TECHNICAL CHANGES

ISSUE #29: (TECHNICAL CHANGES MAY IMPROVE EFFECTIVENESS OF THE MEDICAL PRACTICE ACT AND MBC OPERATIONS.) There are amendments to the Act that are technical in nature but may improve MBC operations and the enforcement of the Medical Practice Act.

Background: There are instances in the Medical Practice Act where technical clarifications may improve MBC operations and application of the statutes governing the MBC’s work.

Staff Recommendation: *The Committees may wish to amend the Act to include technical clarifications.*

Board Response (March 2017):

The Board submitted language to Senate B&P Committee staff on March 10, 2017 to make some technical changes to laws pertaining to the Board’s licensing program as identified in the Board’s Sunset Review Report.

CONTINUED REGULATION OF PHYSICIANS AND SURGEONS, LICENSED MIDWIVES AND VARIOUS OTHER HEALTH PROFESSIONALS BY THE MEDICAL BOARD OF CALIFORNIA

ISSUE #30 (CONTINUED REGULATION BY MEDICAL BOARD OF CALIFORNIA.) Should the licensing and regulation of physicians and surgeons, licensed midwives and other allied health professionals be continued and be regulated by the current MBC membership?

Background: Patients and the public are best protected by a strong regulatory board with oversight for physicians and surgeons and associated allied professions. MBC needs to take swift enforcement action and needs to improve timelines for case processing, particularly for complaints and cases with a high risk of patient and public harm. The MBC should be continued with a 4-year extension of its

sunset date so that the Legislature may once again review whether the issues and recommendations in this Background Paper have been addressed.

Staff Recommendation: *The licensing and regulation of physicians and surgeons and allied health professions should continue to be regulated by the current board members of the Medical Board of California in order to protect the interests of the public. MBC should be reviewed again in four years.*

Board Response (March 2017):

The Board appreciates the opportunity of the sunset review process and looks forward to working with both the Senate and the Assembly B&P Committees and their staff on issues that have been identified for future consideration. The Board is pleased that Committee staff has recommended that the licensing and regulation of physicians and surgeons and allied health professions continue to be regulated by the Medical Board of California in order to protect the interests of the public and be reviewed once again in four years.

0758 - Medical Board

Analysis of Fund Condition

(Dollars in Thousands)

Fund Condition with General Fund Loan Repayments

| | ACTUAL 2015-16 | CY 2016-17 | BY 2017-18 | BY+1 2018-19 | BY+2 2019-20 |
|---|-------------------|---------------|---------------|-----------------|-----------------|
| BEGINNING BALANCE | \$ 28,087 | \$ 27,001 | \$ 26,227 | \$ 27,856 | \$ 19,060 |
| Prior Year Adjustment | \$ 282 | \$ - | \$ - | \$ - | \$ - |
| Adjusted Beginning Balance | \$ 28,369 | \$ 27,001 | \$ 26,227 | \$ 27,856 | \$ 19,060 |
| REVENUES, TRANSFERS AND OTHER ADJUSTMENTS | | | | | |
| Revenues: | | | | | |
| 125600 Other regulatory fees | \$ 385 | \$ 388 | \$ 388 | \$ 388 | \$ 388 |
| 125700 Other regulatory licenses and permits | \$ 7,388 | \$ 7,194 | \$ 7,194 | \$ 7,194 | \$ 7,194 |
| 125800 Renewal fees | \$ 48,728 | \$ 47,828 | \$ 48,799 | \$ 48,799 | \$ 48,799 |
| 125900 Delinquent fees | \$ 124 | \$ 136 | \$ 136 | \$ 136 | \$ 136 |
| 131700 Miscellaneous revenue from local agencies | \$ 2 | \$ - | \$ - | \$ - | \$ - |
| 141200 Sales of documents | \$ 25 | \$ 10 | \$ 10 | \$ 10 | \$ 10 |
| 142500 Miscellaneous services to the public | \$ - | \$ - | \$ - | \$ - | \$ - |
| 150300 Income from surplus money investments | \$ 139 | \$ 52 | \$ 53 | \$ 53 | \$ 53 |
| 160400 Sale of fixed assets | \$ - | \$ - | \$ - | \$ - | \$ - |
| 160800 Escheat of unclaimed property | \$ 1 | \$ - | \$ - | \$ - | \$ - |
| 161000 Escheat of unclaimed checks and warrants | \$ 23 | \$ 10 | \$ 10 | \$ 10 | \$ 10 |
| 161400 Miscellaneous revenues | \$ 1 | \$ 1 | \$ 1 | \$ 1 | \$ 1 |
| Totals, Revenues | \$ 56,816 | \$ 55,619 | \$ 56,591 | \$ 56,591 | \$ 56,591 |
| Transfers and Other Adjustments: | | | | | |
| Proposed GF Loan Repayment (Budget Act of 2008) | \$ - | \$ 6,000 | \$ - | \$ - | \$ - |
| Proposed GF Loan Repayment (Budget Act of 2011) | \$ - | \$ - | \$ 9,000 | \$ - | \$ - |
| TOTALS, REVENUES, TRANSFERS AND OTHER ADJUSTMENTS | \$ 56,816 | \$ 61,619 | \$ 65,591 | \$ 56,591 | \$ 56,591 |
| TOTAL RESOURCES | \$ 85,185 | \$ 88,620 | \$ 91,818 | \$ 84,447 | \$ 75,651 |
| EXPENDITURES AND EXPENDITURE ADJUSTMENTS | | | | | |
| Expenditures: | | | | | |
| 1111 Program Expenditures (State Operations) | \$ 58,077 | \$ 59,956 | \$ 61,396 | \$ 62,579 | \$ 63,733 |
| <u>2016-17 and Ongoing Approved Costs</u> | | | | | |
| BreEZe Costs | \$ - | \$ 2,403 | \$ - | \$ - | \$ - |
| Staff Augmentation | \$ - | \$ 113 | \$ 105 | \$ 105 | \$ 105 |
| Expert Reviewer | \$ - | \$ 206 | \$ 206 | \$ 206 | \$ 206 |
| Registered Dispensing Opticians | \$ - | \$ (39) | \$ (39) | \$ (39) | \$ (39) |
| Department of Justice | \$ - | \$ 577 | \$ 577 | \$ 577 | \$ 577 |
| <u>Anticipated Future Costs</u> | | | | | |
| Staff Augmentation - Enforcement | \$ - | \$ - | \$ 187 | \$ 161 | \$ 161 |
| Implement SB 1177 | \$ - | \$ - | \$ 114 | \$ 356 | \$ 356 |
| BreEZe Costs | \$ - | \$ - | \$ 2,235 | \$ 2,342 | \$ 1,188 |
| 1111 Program Expenditures (State Operations) Subtotal | \$ 58,077 | \$ 63,216 | \$ 64,781 | \$ 66,287 | \$ 66,287 |
| Expenditure Adjustments: | | | | | |
| 0840 State Controller (State Operations) | \$ - | \$ - | \$ - | \$ - | \$ - |
| 8880 Financial Information System for California (State Operations) | \$ 107 | \$ 77 | \$ 81 | \$ - | \$ - |
| TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS | \$ 58,184 | \$ 63,293 | \$ 64,862 | \$ 66,287 | \$ 66,287 |
| Unscheduled Reimbursements | \$ - | \$ 900 | \$ 900 | \$ 900 | \$ 900 |
| FUND BALANCE | | | | | |
| Reserve for economic uncertainties | \$ 27,001 | \$ 26,227 | \$ 27,856 | \$ 19,060 | \$ 10,264 |
| Months in Reserve | 5.1 | 4.9 | 5.0 | 3.5 | 1.9 |

NOTES:

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

0758 - Medical Board

Analysis of Fund Condition

(Dollars in Thousands)

Fund Condition with General Fund Loan Repayments including Cost Recovery

| | ACTUAL 2015-16 | CY 2016-17 | BY 2017-18 | BY+1 2018-19 | BY+2 2019-20 |
|---|-------------------|---------------|---------------|-----------------|-----------------|
| BEGINNING BALANCE | \$ 28,087 | \$ 27,001 | \$ 26,227 | \$ 27,703 | \$ 19,536 |
| Prior Year Adjustment | \$ 282 | \$ - | \$ - | \$ - | \$ - |
| Adjusted Beginning Balance | \$ 28,369 | \$ 27,001 | \$ 26,227 | \$ 27,703 | \$ 19,536 |
| REVENUES, TRANSFERS AND OTHER ADJUSTMENTS | | | | | |
| Revenues: | | | | | |
| 125600 Other regulatory fees | \$ 385 | \$ 388 | \$ 388 | \$ 388 | \$ 388 |
| 125700 Other regulatory licenses and permits | \$ 7,388 | \$ 7,194 | \$ 7,194 | \$ 7,194 | \$ 7,194 |
| 125800 Renewal fees | \$ 48,728 | \$ 47,828 | \$ 47,864 | \$ 47,864 | \$ 47,864 |
| 125900 Delinquent fees | \$ 124 | \$ 136 | \$ 136 | \$ 136 | \$ 136 |
| 131700 Miscellaneous revenue from local agencies | \$ 2 | \$ - | \$ - | \$ - | \$ - |
| 141200 Sales of documents | \$ 25 | \$ 10 | \$ 10 | \$ 10 | \$ 10 |
| 142500 Miscellaneous services to the public | \$ - | \$ - | \$ - | \$ - | \$ - |
| 150300 Income from surplus money investments | \$ 139 | \$ 52 | \$ 53 | \$ 53 | \$ 53 |
| 160400 Sale of fixed assets | \$ - | \$ - | \$ - | \$ - | \$ - |
| 160800 Escheat of unclaimed property | \$ 1 | \$ - | \$ - | \$ - | \$ - |
| 161000 Escheat of unclaimed checks and warrants | \$ 23 | \$ 10 | \$ 10 | \$ 10 | \$ 10 |
| 161400 Miscellaneous revenues | \$ 1 | \$ 1 | \$ 1 | \$ 1 | \$ 1 |
| 161900 Other - Cost Recovery | \$ - | \$ - | \$ 782 | \$ 1,564 | \$ 1,564 |
| Totals, Revenues | \$ 56,816 | \$ 55,619 | \$ 56,438 | \$ 57,220 | \$ 57,220 |
| Transfers and Other Adjustments: | | | | | |
| Proposed GF Loan Repayment (Budget Act of 2008) | \$ - | \$ 6,000 | \$ - | \$ - | \$ - |
| Proposed GF Loan Repayment (Budget Act of 2011) | \$ - | \$ - | \$ 9,000 | \$ - | \$ - |
| TOTALS, REVENUES, TRANSFERS AND OTHER ADJUSTMENTS | \$ 56,816 | \$ 61,619 | \$ 65,438 | \$ 57,220 | \$ 57,220 |
| TOTAL RESOURCES | \$ 85,185 | \$ 88,620 | \$ 91,665 | \$ 84,923 | \$ 76,756 |
| EXPENDITURES AND EXPENDITURE ADJUSTMENTS | | | | | |
| Expenditures: | | | | | |
| 1111 Program Expenditures (State Operations) | \$ 58,077 | \$ 59,956 | \$ 61,396 | \$ 62,579 | \$ 63,733 |
| <u>2016-17 and Ongoing Approved Costs</u> | | | | | |
| BreEZe Costs | \$ - | \$ 2,403 | \$ - | \$ - | \$ - |
| Staff Augmentation | \$ - | \$ 113 | \$ 105 | \$ 105 | \$ 105 |
| Expert Reviewer | \$ - | \$ 206 | \$ 206 | \$ 206 | \$ 206 |
| Registered Dispensing Opticians | \$ - | \$ (39) | \$ (39) | \$ (39) | \$ (39) |
| Department of Justice | \$ - | \$ 577 | \$ 577 | \$ 577 | \$ 577 |
| <u>Anticipated Future Costs</u> | | | | | |
| Staff Augmentation - Enforcement | \$ - | \$ - | \$ 187 | \$ 161 | \$ 161 |
| Implement SB 1177 | \$ - | \$ - | \$ 114 | \$ 356 | \$ 356 |
| BreEZe Costs | \$ - | \$ - | \$ 2,235 | \$ 2,342 | \$ 1,188 |
| 1111 Program Expenditures (State Operations) Subtotal | \$ 58,077 | \$ 63,216 | \$ 64,781 | \$ 66,287 | \$ 66,287 |
| Expenditure Adjustments: | | | | | |
| 0840 State Controller (State Operations) | \$ - | \$ - | \$ - | \$ - | \$ - |
| 8880 Financial Information System for California (State Operations) | \$ 107 | \$ 77 | \$ 81 | \$ - | \$ - |
| TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS | \$ 58,184 | \$ 63,293 | \$ 64,862 | \$ 66,287 | \$ 66,287 |
| Unscheduled Reimbursements | \$ - | \$ 900 | \$ 900 | \$ 900 | \$ 900 |
| FUND BALANCE | | | | | |
| Reserve for economic uncertainties | \$ 27,001 | \$ 26,227 | \$ 27,703 | \$ 19,536 | \$ 11,369 |
| Months in Reserve | 5.1 | 4.9 | 5.0 | 3.5 | 2.1 |

NOTES:

- A. Assumes workload and revenue projections are realized for FY 16/17 and beyond.
- B. Interest on fund estimated at .361%.
- C. \$6 million was loaned to the General Fund in FY 08/09 and \$9 million was loaned to the General Fund by the Board in FY 11/12.
\$6 million will be repaid in FY 16/17 and \$9 million in FY 17/18. If partial payment is made, the remainder will be paid when the fund is nearing its minimum mandated level.
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- E. Unscheduled reimbursements result in a net increase in the fund balance.