LEGISLATIVE PROPOSALS 2015

805 Reporting

Pursuant to Business and Professions (B&P) Code Section 805, certain peer review bodies must report actions pertaining to staff privileges, membership, or employment. Specifically, the chief of staff of a medical or professional staff or other chief executive officer, medical director or administrator of any peer review body, or a chief executive officer or administrator of any licensed health care facility or clinic must report the following within 15 days of the action:

- A peer review body denies or rejects a licensee's application for staff privileges or membership for a medical disciplinary cause or reason;
- A licensee's staff privileges, membership, or employment are revoked for a medical disciplinary cause or reason;
- Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a total of 30 days or more within any 12 month period for medical disciplinary reasons;
- A resignation, leave of absence, or a withdrawal or abandonment of an application for, or renewal of, privileges that occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason; or
- A summary suspension of staff privileges, membership, or employment is imposed for a period in excess of 14 days.

In the Board's Sunset Report, the Board included information regarding a decline in 805 reporting. The following chart identifies the decline in reporting:

	FY 01/02	FY 02/03	FY 03/04	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
805 reports received	151	162	157	110	138	126	138	122	99	93	114

To address this decline in reporting, Board staff is proposing that the Board sponsor legislation that would require physicians to report to the Board when reportable actions occur (as identified in the above list). This will enable the Board to ensure that peer review bodies are reporting appropriately, and also ensure that the Board is aware when these actions are taken. This will allow for verification in 805 reporting. **The Board would need to approve this legislative proposal.**

Licensed Midwives (LMs) – Midwife Assistants

This issue was included in the Board's 2012 Sunset Report. It has been brought to the attention of the Board that LMs need to use assistants. Currently, there is no definition for a midwife assistant in statute, or the specific training requirements or duties that a midwife assistant may perform. Some LMs use other LMs as assistants, while some use a midwife student who is enrolled in a recognized midwifery school and who has an official agreement with the student

and midwifery school to provide clinical training to the student midwife. Other LMs use someone who may or may not have formal midwifery training and/or someone that the LM has trained. The duties that a midwife assistant performs also varies greatly from LM to LM. Board staff believe that this is a serious consumer protection issue and that legislation should be pursued to define midwife assistants and define the services they can provide. Board staff is proposing that language be pursued to ensure that midwife assistants meet minimum training requirements, the same requirements for medical assistants, pursuant to BPC Section 2069. The statute should also set forth the duties that a midwife assistant could perform, which should be at the same level as duties that a medical assistant can perform; technical support services only. The language should also allow the Board, through the Midwifery Advisory Council, to adopt regulations and standards for any additional midwife technical support services. **The Board would need to approve this legislative proposal.**

Outpatient Settings Legislative Proposals

- Per existing law, Health and Safety Code Section 1216, clinics licensed by the California Department of Public Health (CDPH), including surgical clinics, are required to report aggregate data to the Office of Statewide Health Planning and Development (OSHPD). This data includes number of patients served and descriptive background, number of patient visits by type of service, patient charges, and any additional information required by CDPH and OSHPD. Before *Capen v. Shewry*, this data was being collected for the majority of outpatient settings, as they were licensed as surgical clinics. However, when physician-owned outpatient settings fell under the jurisdiction of the Board, this reporting was no longer required, which resulted in a serious deficiency of outpatient settings data. Board staff is suggesting that the data collection requirements be put into place for accredited outpatient settings; the data required for reporting would be very similar to the data that surgical clinics are required to report to OSHPD. **The Board would work closely with OSHPD on this proposal. This was previously approved by the Board.**

- Currently, inspections performed by the Accreditation Agencies are announced and initial certificates of accreditation are good for three years. The Board is proposing that the inspections be unannounced and that the initial accreditation only be valid for up to two years. This will help to ensure consumer protection as it will ensure that outpatient settings will not know when their inspections will occur. In addition, newly accredited settings will get renewed in a shorter period of time, so the renewal inspection will occur sooner. **This proposal was previously approved by the Board.**

- Currently, a physician who owns his or her own outpatient setting may choose not to have peer review of his or her practice. The Board is suggesting language to require peer review evaluations for all outpatient settings to ensure that all physicians who are performing procedures in an outpatient setting are subject to peer review. **This proposal was previously approved by the Board.**

- Currently, a CMS-certified ambulatory surgical center (ASC) is considered a peer review body that is required to report specified actions to the Board. However, a CMS-certified ASC is not authorized to request peer review reports from the Board prior to granting or

renewing staff privileges for a physician. In addition, accredited outpatient settings are not required to report to the Board nor are they authorized to request peer review reports. Board staff is suggesting language that would consider accredited outpatient settings as a peer review body and require these settings to report specified actions to the Board. The language would also allow both CMS-certified ASCs and outpatient settings to be authorized to request peer review reports from the Board prior to granting or renewing staff privileges for a physician, since they are or would be reporting these actions to the Board. This will enhance consumer protection. **The Board would need to approve this legislative proposal.**

Technical Clean-Up (Potential Omnibus)

The following provisions are technical in nature and are potential candidates for the Board's omnibus bill, meaning the changes are purely technical and not controversial. **The Board would need to approve staff going forward with these technical changes.**

- Allied Health – Numerous clarifying changes are needed for the allied health licensure sections to allow the Board to take similar discipline for these license types, as it does for physician and surgeons. The Board has recently had obstacles in taking actions because the statute is not clear in the Board's authority pertaining to unlicensed practice, probation, cite and fine, etc. There also some clarifying changes needed regarding reinstatement for these license types. If approved, the Board would model the wording on existing law in the code sections related to physicians and surgeons.

- For physicians and surgeons, there are a few technical, clarifying changes that are needed related to using "M.D.", denials, public letters of reprimand, etc. The changes needed are purely technical in nature.