BACKGROUND PAPER FOR THE BOARD OF PODIATRIC MEDICINE

(Oversight Hearing, March 12, 2012, Senate Committee on Business, Professions and Economic Development)

IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS FOR BPM OF PODIATRIC MEDICINE

BRIEF OVERVIEW OF THE BOARD OF PODIATRIC MEDICINE

Function of the Board

The Board of Podiatric Medicine (BPM) in the Department of Consumer Affairs (DCA) is responsible for licensing and regulating doctors of podiatric medicine (DPM). Although the BPM functions in an independent manner, similar to other boards under DCA, the BPM is within the jurisdiction of the Medical Board of California (MBC), and it is the MBC that officially issues licenses to these practitioners upon the "recommendation" of the BPM.

The BPM licenses approximately 2,000 doctors of podiatric medicine. The BPM issues some 55 licenses each year, and approximately 1,000 licenses are renewed each year.

The doctor of podiatric medicine license as defined in the Business and Professions Code (BPC) and in the regulations of the BPM are specialists in the foot and ankle. Some DPMs specialize in conservative care while others practice mostly as surgeons. They are unmatched in their understanding of the foot's biomechanics. Many DPMs specialize in care and preservation of the diabetic foot. DPMs also assist other doctors in non-podiatric surgeries, because of their special skills and doctor-patient relationships. DPMs are the only medical specialty limited to its area of expertise by the license itself, which enhances patient protection.

The current BPM mission statement, as stated in its Strategic Plan 2011-2014, is as follows:

The mission of the Board of Podiatric Medicine is to ensure protection of consumers under the laws of California through the setting and enforcement of contemporary standards and the provision of accurate and timely information that promotes sound consumer decision-making.

Currently, the BPM is composed of seven members. It has a professional majority with three public members, and four professional members.

The Governor appoints five members of the BPM. The Senate Rules Committee and the Assembly Speaker each appoints one public member. The BPM is required to meet at least three times each calendar year and meets at various locations throughout the state. Board meetings are open and give the public the opportunity to testify on agenda items and on other issues.

The following table lists all members of the BPM, including: Background on each member, when appointed, term expiration date, and appointing authority.

Name	Appointment Date	Term Expiration Date	Appointing Authority
Dr. Neil Mansdorf, President Professional Member. A sole practitioner since 2000. Practiced with Cupertino Podiatry Group from 1999 to 2000. Member of the Radiologic Technology Certification Committee's Board of Directors and California Podiatric Medical Association. Fellow with the American College of Foot and Ankle Surgeons; an associate with the American Academy of Podiatric Sports Medicine. Past president of Orange County Podiatric Medical Association.	January 2010	June 1, 2012	Governor
Dr. James Longobardi, Vice President Professional Member. Has been in private practice since 1990. Served as podiatric physician for the Indian Health Service, Rincon Clinic from 1990 to 2007. Fellow of the American College of Foot and Ankle Orthopedics, and American Professional Wound Care Association. Member of the San Diego County Podiatric Medical Society, California Podiatric Medical Association and American Podiatric Medical Association. Past president of the San Diego County Podiatric Medical Society, and obtained an MBA in 2006.	January 2010	June 1, 2012	Governor
Edward E. Barnes Public Member. A labor consultant and medical gas inspector, serves as chair of the advisory board of the Los Angeles Career Technical Education Board; previously served on advisory boards of the North Hollywood High School Home Engineering Academy, Granada Hills High School Construction Academy, and on the steering committee of the A to G Community Coalition for Youth and Work Force Development Alliance of Los Angeles. Previously served as a member of the Contractors State License Board.	June 2011	June 1, 2015	Senate Rules
Kristina M. Dixon Public Member. A Staff Accountant for First 5 LA. Holds a BA in Sociology from UC Berkeley; a dual MBA in Finance and Management & Leadership from the University of La Verne, over eight years of professional experience working within the nonprofit industry and over 20 years of experience serving the communities where she has lived and worked. A 2007 graduate of Los Angeles African American Women in Public Policy Institute, and Project B.U.I.L.D. (Blacks United In Leadership Development). Co-Chair/Co-Founder of the Southern Cal Alumni Coalition. Serves as a Library Commissioner to the City of Moreno Valley and the Chair of the Los Angeles Urban League Young Professionals, Civic Engagement and Political Action Committee.	June 2010	June 1, 2014	Assembly Speaker
Dr. Karen Wrubel Professional Member. Has been in private medical practice as owner of Far West Podiatric Medical Group since 1985. Board certified by the American Board of Podiatric Surgery; a member of the American Podiatric Medical Association, California Podiatric Medical Association, Los Angeles County Podiatric Medical Society, American College of Foot and Ankle Surgeons, American Professional Wound Care Association and Hear My Voice.	May 2007	June 1, 2014	Governor
Vacancy Public Member.			Governor
Vacancy Professional Member.			Governor

The BPM currently has five committees that perform various functions:

- **Public Outreach Committee** – external communication & public liaison.
- **Enforcement Committee** – enforcement procedures.
- **Legislative Committee** – legislative liaison.
- **Licensing & Medical Education Committee** – licensing, exams, approval of schools & residencies.
- **Professional Practice Committee** – guides & advises staff on practice matters.

The executive officer is appointed by the BPM. The current executive officer, Jim Rathlesberger, was appointed in 1989, and holds the longest tenure of any executive officer in the Department of Consumer Affairs.

As a Special Fund agency, the BPM receives no General Fund support, relying solely on fees set by statute and collected from licensees and applicants. The total revenues anticipated by the BPM for FY 2011/12 is $918,000. The total expenditures anticipated for BPM for FY 2011/12 are $960,000, and for FY 2012/13, $979,000. Based upon these figures, the BPM would have approximately 10 months in reserve in FY 2011/12, and 9.3 months in reserve in FY 2012/13. Following standard financial planning practices, DCA projects full budget expenditure by the BPM. With that assumption, the BPM's reserve is shown to decline. However, the BPM tightly manages its budget every year to stay under budget and return money to its fund for long-term solvency and avoidance of fee increases. The BPM spends approximately 70% of its budget on enforcement-related functions.

The BPM has a staff level of five authorized positions and currently has no vacancies. Historically, there has been little turnover in staff for the BPM. The BPM's recent enforcement coordinator served for 17 years until pursuing other career opportunities. Following the BPM's last sunset review, the BPM's office technician left for a promotion just before a hiring freeze. Vacant for more than six months, the position was abolished automatically by law. The BPM struggled for a couple years to win support for a freeze exemption before being able to reestablish and fill this position. According to the BPM, during this time, customer service was maintained but some programs were temporarily interrupted.

Enforcement By The Medical Board

As noted above, the BPM is part of the Medical Board and DPM licenses are in fact issued by the MBC. The Medical Board also handles the BPM complaint and enforcement cases under an annual Shared Services agreement, funded through the BPM's budget. The MBC does the following under the Shared Services agreement:

- Receives, processes, coordinates and tracks DPM complaints in its Central Complaint Unit.
- Sends cases to DPM consultants, in coordination with the BPM's Enforcement Coordinator, in quality/standard of care cases.
- Sends cases to Medical Board investigators, as appropriate.
- Sends cases to the BPM's DPM expert reviewers/witnesses when DPM consultants determine in-depth review is indicated.
- Refers cases to the Attorney General, as appropriate.
- Processes and manages proposed decisions, stipulated agreements, mails ballots to the BPM Board Members, and final decisions, and coordinates petitions and court appeal documents.

- Reports data to the BPM in the Enforcement Matrix Report
- Reports the BPM Accusations, Statements of Issue, and final decisions in its MBC Action Report.

The BPM's Enforcement Coordinator assists, facilitates and expedites this entire process. Central to the BPM's mission is an emphasis on the quality and appropriateness of case handling, in addition to moving cases expeditiously. The Enforcement Coordinator monitors cases to ensure adherence to the minimum disciplinary standards in the BPM's adopted Regulations (*Manual of Disciplinary Guidelines*).

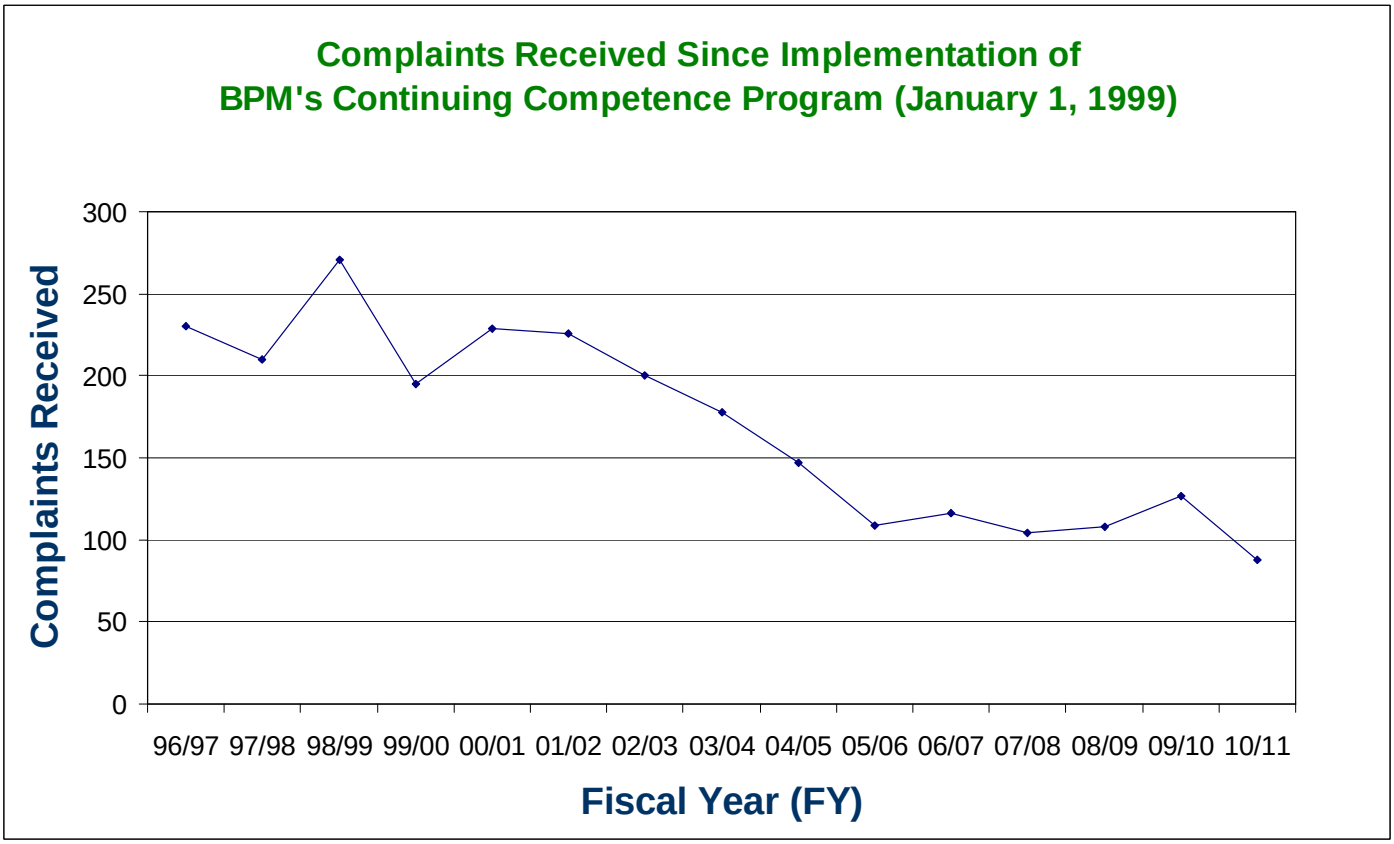
With DCA's Consumer Protection Enforcement Initiative (CPEI), the Medical Board was to receive authority to hire non-sworn investigators to help expedite investigations. One-half of one of these positions was to be dedicated to DPM cases and funded by the BPM's budget. This .5 non-sworn addition, beginning after July 1, 2010, is to assist the Medical Board's ability to move the BPM cases. The BPM Enforcement Coordinator will monitor and assist the MBC's non-sworn investigators in these efforts.

Continuing Education / Continuing Competency

The BPM requires each licensee to complete 50 hours of continuing medical education (CME) at each two-year renewal. In addition, the law further requires compliance at each renewal with at least one of several peer-reviewed pathways for the Continuing Competence requirement. The Continuing Competence requirement was enacted in 1998 through SB 1981 (Greene, Chapter 736, Statutes of 1998) at the BPM's recommendation during the BPM's first Sunset Review.

While CME remains important, the BPM contends that it is the Continuing Competence requirement that defines the professional culture of which CME is now a part. The BPM proposed the first, and still only, Continuing Competency program of any doctor-licensing board in the Nation in its first Sunset Review. The Continuing Competence program was further refined by SB 1955 (Joint Committee, Chapter 1150, Statutes of 2002).

Since implementation of the Continuing Competency program in 1999, there has been a steady, longitudinal decline in complaints of more than 50 percent. The 90 complaints in FY 2010/11 is an all-time low for the BPM. The BPM attributes this steady decline to the success of the Continuing Competency program.



(For more detailed information regarding the responsibilities, operation, and functions of the BPM please refer to the BPM *of Podiatric Medicine, Sunset Review Report, 2011*.)

PRIOR SUNSET REVIEW

The BPM was last reviewed by the former Joint Legislative Sunset Review Committee (JLSRC) ten years ago (2001-2002). During the previous Sunset Review, the JLSRC made eight final recommendations regarding BPM. The following are actions which the BPM took since the last Sunset Review to address these issues. For those which were not addressed and which may still be of concern to the Committee, they are addressed and more fully discussed under "Current Sunset Review Issues."

In November 2011, the BPM submitted its required Sunset Review Report to the Committee. In this report, the BPM described actions that have been taken since the BPM's prior review to address the recommendations of the JLSRC. The following are some of the more important programmatic and operational changes and enhancements which the BPM has taken and other important policy decisions or regulatory changes it has adopted, as well as some highlighted accomplishments:

- **Increase Residency Training From One to Two Years.** In 2002, the JLSRC recommended that the BPM should thoroughly assess the need for this additional training. The BPM provided evidence that the American Podiatric Medical Association (APMA) and its affiliates had conducted an occupational analyses demonstrating that two-years of postgraduate residency

training is the minimum required to achieve entry-level competence. Subsequently, BPC § 2484 was amended to reflect the two-year requirement by AB 932 (Koretz, Chapter 88, Statutes of 2004).

- **Model Law Adoption.** Neither the JLSRC nor DCA had a recommendation regarding adoption of a Model Law as had been proposed by the BPM. The JLSRC emphasized that a model law should reflect the consumer protection goals of this state. Accordingly, the BPM was instrumental in legislation which enacted many Model Law provisions, following further documentation and justification (AB 1777, Assembly B&P Committee, Chapter 586, Statutes of 2003; AB 932, Koretz, Chapter 88, Statutes of 2004).

- **Renewal Fee Increase Extension.** The BPM instituted a temporary license renewal fee increase, of from $800 to $900, effective January 1, 2000, on a four-year basis (AB 1252, Wildman, Chapter 977, Statutes of 1999; extended by SB 724, Senate B&P Committee, Chapter 728, Statutes of 2001). The JLSRC recognized that the demands on the BPM's operating fund suggested continuation of the fee increase to maintain the BPM's licensing and enforcement activities, and enable the BPM's fund condition to stabilize. Since that time, the fee level was extended through 2005, and SB 1549 (Figueroa, Chapter 691, Statutes of 2004) removed the sunset date and the renewal fee has remained $900. The fee level has been supported by the California Podiatric Medical Association.

- **Audits of Continuing Medical Education (CME).** Faced with fiscal challenges, the BPM discontinued its contract with the Medical Board to conduct random audits of CME. The JLSRC recommended that the BPM resume conducting random audits of CME courses and providers to guarantee that licensees are receiving CME courses of quality and relevance to the profession. The BPM resumed the annual Continuing Competence/CME random audit in 2004, however the audits have been interrupted by staffing limitations, furloughs, and budget constraints. The annual random audit is of one percent of licensees. It verifies self-certification under penalty of perjury in the current renewal for compliance with the Continuing Competence and 50-hour CME requirements. The BPM has recently completed its 2011 random compliance audit of 20 licensees and found a 95% compliance rate with 19 providing documentation of CME (50 hours) and the required Continuing Competence. One licensee was granted a one-time waiver by the BPM.

- **Review of Complaints by Board Members.** In 2002, the JLSRC emphasized that Board members should not review complaints and the BPM should continue to contract with subject matter experts to do so. Board staff should conduct initial complaint review and forward select complaints to a panel of experts when technical expertise is needed. The BPM agrees and complies with this recommendation.

- **Transition to a National Examination.** SB 1955 (Figueroa, Chapter 1150, Statutes of 2002) amended BPC § 2486 to reflect a transition from the state oral clinical licensing examination to Part III of the National Board of Podiatric Medical Examiners (NBPME) examination.

- **Refine Continuing Competency Program.** The JLSRC recommended that the BPM's continuing competency program should be refined to provide additional pathways and ease compliance. Accordingly, SB 1955 (Figueroa, Chapter 1150, Statutes of 2002) amended BPC §2496 to provide that upon renewing a license, the DPM may show continued competency in

practice by passing within the past 10 years Part III of the examination administered by the National Board of Podiatric Medical Examiners. The BPM deems this as landmark legislation, to reinforce lifelong learning. The BPM believes that the complaint data over time showing a steady 50-percent decline reflects that patient harm is being prevented by these changes.

- **Headquarters Relocation.** In 2008, moved The BPM's headquarters from the Howe Avenue complex to the Evergreen Street location along with the MBC and other boards.

CURRENT SUNSET REVIEW ISSUES

The following are issues pertaining to the BPM, or those which have been raised by the BPM, and other areas of concern for the Committee to consider along with background information concerning the particular issue. There are also recommendations the Committee staff have made regarding particular issues or problem areas which need to be addressed. The BPM and other interested parties, including the professions, have been provided with this Background Paper and can respond to the issues presented and the recommendations of staff.

LICENSING, EXAMINATION AND PRACTICE ISSUES

ISSUE # 1: Should the reference to ankle certification after January 1, 1984 be removed from the Code, thereby confirming a single scope of licensure for doctors of podiatric medicine?

Background: Article 22 (Podiatric Medicine) of the Medical Practice Act essentially provides for a two-tier license system, depending on whether a DPM was ankle certified "on or after January 1, 1984," the date that legislation took effect (Chapter 305, Statutes of 1983) to clarify that a podiatrist may treat the ankle as part of the licensed scope of practice.

Joint Committee staff discussed in 1997 whether this two-tiered system could be eliminated, upon receipt of BPM's first Sunset Review report. The BPM staff commented then it was probably premature. In 1998, SB 1981 (Greene, Chapter 736, Statutes of 1998) repealed the requirement that licensed podiatrists obtain a certificate from BPM in order to perform ankle surgery, and instead, simply authorized a DPM certified by the BPM after January 1, 1984 to perform ankle surgery.

Now, a decade and a half later, and approaching three decades since 1984, the BPM states in its Report that it would support a single scope of practice for DPMs. The useful life of the 1984 two-tier licensing has run its course, according to the BPM.

More than 80-percent of the BPM's licensees are "ankle licensed" and this percentage continues to increase. According to the BPM, it is a small number of older licensees who do not perform ankle surgery, amputations or surgical assisting to MD and DO surgeons that the "ankle license" now allows.

Doctors licensed prior to 1984 were able under the law to become ankle licensed if certified by the American Board of Podiatric Surgery (ABPS) or by passing a sophisticated, rigorous oral ankle examination administered by the BPM. The BPM has discontinued that examination because there is no longer any demand to take the examination. Following enactment of

AB 932 (Koretz, Chapter 88, Statutes of 2004), there was renewed interest in taking the examination because that bill in practice disenfranchised some non-ankle-licensed doctors who had previously performed digital amputations as part of their practices to preserve diabetic limb and life. Those doctors were provided opportunities to take this "Section 2499.5(k) exam," and most who did so passed the examination:

Examination Date	Candidate Number	Pass Rate
12/11/2004	52	75%
10/1/2005	13	73%
2/3/2007*	7	57%
2/18/2010	2	100%

According to the BPM, a single-scope licensure would simplify the statute and its administration without harm to the public.

Staff Recommendation: ***The Committee should consider amending BPC Section 2472(d)(1) to remove reference to "ankle certification by the BPM on and after January 1, 1984" thereby confirming a single scope of licensure for doctors of podiatric medicine.***

ISSUE # 2: Should the provision prohibiting a DPM from conducting an admitting history and physical examination of a patient in an acute care hospital be repealed?

Background: BPC Section 2472(f) provides that "A doctor of podiatric medicine shall not perform an admitting history and physical examination of a patient in an acute care hospital where doing so would violate the regulations governing the Medicare program." In 2010, a California Attorney General Opinion No. 09-0504, regarding the effect of these provisions regarding the ability of a doctor of podiatric medicine to perform an admitting history and physical (H&P) at an acute care hospital found that "not only is a podiatrist not precluded from performing an admitting H&P by Business and Professions Code section 2472, but failing to do so may fall below the standard of care expected of podiatrists generally."

In stating this opinion, the AG points out that the prohibition of Section 2472 is for performing a H&P "where doing so would violate the regulations governing the Medicare program" and was placed in the statute in response to a former federal rule, which imposed restrictions on federal reimbursements of podiatric services under Medicare. The federal restriction was superseded by 42 C.F.R. Section 410.25 to provide that "Medicare Part B pays for the services of a doctor of podiatric medicine acting within the scope of his or her license, if the services would be covered as physician's services when performed by a doctor of medicine or osteopathy."

Therefore, the BPM points out, Medicare regulations no longer restrict DPM history and physical examinations, thereby making Section 2472(f) obsolete. The BPM states that the provision is confusing to the public and should be deleted from the Code.

Committee staff agrees with the BPM that the Code should be clarified by removing this obsolete provision from the law.

Staff Recommendation: ***Section 2472 of the Business and Professions Code should be amended to repeal paragraph (f), thereby removing an obsolete provision prohibiting a DPM from performing an admitting history and physical exam at an acute care hospital.***

ISSUE # 3: Should the four-year limit on postgraduate training be eliminated for graduates of podiatric medicine with a residence license.

Background: The law provides that a graduate of an approved school of podiatric medicine may apply for and obtain a resident's license from the BPM, authorizing them to practice podiatric medicine, as specified. A resident's license may be renewed annually for up to four years.

The BPM is proposing that the four-year limitation of the resident's license be deleted, thus ending the four-year cap on DPM postgraduate training. According to the BPM, few individuals may participate in residency and fellowship training for more than four years, but the limit on education is unnecessary. The BPM argues that this limitation is the only known statutory cap on education anywhere in this country for any profession or group. Ultimately, the BPM believes that the four-year cap will interfere with advanced training of some leading practitioners. The BPM states that it is a principle of medical education that there is no such thing as too much education and training.

Committee staff believes that the BPM's recommendation to eliminate the four-year cap may have merit; however, it is unclear from the BPM's Report whether this recommendation would instead authorize a person to simply practice as a resident and not progress into full licensure as a doctor of podiatric medicine. The BPM should provide more information to the Committee on this issue.

Staff Recommendation: ***The BPM should provide more information regarding the proposal to amend BPC Section 2475 to remove the four-year cap on DPM postgraduate resident's license.***

ISSUE # 4: Should the law be amended to clarify that a medical license is needed to diagnose and prescribe corrective shoes and appliances for medical conditions?

Background: The BPM has proposed that BPC Section 2477 be amended to clarify that a medical license is required in order to diagnose and prescribe corrective shoes or appliances (called orthotics) for the foot.

Orthotics typically refers to custom-made shoe inserts prescribed by a licensed doctor of podiatric medicine, an osteopathic doctor, or a medical doctor after a medical examination and diagnosis. Orthotics are designed to accommodate or correct an abnormal or irregular walking pattern, and ultimately make standing, walking, and running more comfortable and efficient by altering the angles at which the foot strikes the ground. Orthotics placed inside of an individual's shoes can absorb shock, improve balance, and take pressure off sore spots.

The BPM has recommended amending the law to clarify that anyone may offer special shoes and inserts without a license to aid comfort and athletic performance, but that a medical license is needed to diagnose and prescribe for medical conditions. The BPM's recommended amendment is as follows:

> 2477. Nothing in this chapter prohibits the manufacture, the recommendation, or the sale of either corrective shoes or appliances for the human feet **to enhance comfort and**

performance, or, following diagnosis and prescription by a licensed practitioner in any case involving medical conditions.

From the materials supplied by the BPM, the necessity of this proposed change is unclear. Committee staff recommends that the BPM document the necessity for this change and further explain the reasons behind its proposal.

Staff Recommendation: ***The BPM should more thoroughly discuss with the Committee the need for this proposed change. The BPM should document the necessity for this change and further explain the reasons behind its proposal.***

ISSUE # 5: Should the law be amended to no longer require applicants to obtain a specific score on the licensing examination?

Background: Following the BPM's 2001-2002 sunset review, BPC §2484 was amended to reflect the two-year residency requirement by AB 932 (Koretz, Chapter 88, Statutes of 2004). That bill, sponsored by the California Podiatric Medical Association, additionally amended BPC § 2493 to correspond to the changes made in § 2484 by requiring "a passing score one standard error of measurement higher than the national passing scale score" on the American Podiatric Medical Licensing Examination (APMLE) Part III, the national examination administered by the National Board of Podiatric Medicine Examiners (NBPME).

This technical language was added by AB 932 pursuant to Association negotiations with input from the BPM, the National Board of Podiatric Medical Examiners, and the Department's Office of Examination Resources (OER), which raised concern about such technical language being included in the statute.

According to the BPM, NBPME utilizes a national passing scale score of 75, after converting actual raw scores on individual exams to scaled scores allowing comparison with the scores of applicants taking previous administrations of the exam. The scale passing score corresponds to a level of achievement judged by NBPME to represent entry-level competence.

Nationally, passing rates on Part III have ranged between 80-90 percent. During its history from November 1984 to May 2002, the BPM's oral clinical licensing examination had a 76 percent pass rate (1,269 of 1,667).

In the BPM's experience, the California score, one standard error of measurement higher than the national scale passing score, raises the passing score from 75 one or two points, e.g., to 77, and slightly lowers the overall pass rate percentage. Numerically, this means that for each bi-annual Part III exam, one or two California candidates might achieve the national scale passing score of 75, but fall just below California's one standard error of measurement higher, and must retake the examination.

The BPM's requirement by law for a higher score than the national passing score confuses and disappoints applicants, and delays or blocks their entering practice, sometimes losing job offers in the process. In the judgment of the BPM's professional staff it has a marginal if any effect on the quality of licensees and patient care.

In June 2011, the Executive Director of the NBPME informed the BPM that it was revising the Part III examination to reflect the level of competence expected following one year of graduate medical education (residency training), an upgrade from the previous competency level reflecting graduation from podiatric medical school.

In August 2011, NBPME reported to the BPM: "The June 2011 examination and all subsequent forms will include a board-adopted passing score that reflects entry-level competence by a podiatric physician with one year of post-graduate training." The Fall 2011 NBPME Reports (Vol. 21 No.1) states: "The culmination of an effort begun in 2008, with an updated practice analysis survey followed by revised test specifications was the administration of a revised Part III examination in June 2011. The examination is now directed toward the competencies expected of a candidate with at least one year post graduate training."

With this step, the BPM recommends amending BPC Section 2493 to delete paragraph (b) as follows:

> 2493. (a) An applicant for a certificate to practice podiatric medicine shall pass an examination in the subjects required by Section 2483 in order to ensure a minimum of entry-level competence.
> ~~**(b) BPM shall require a passing score on the National Board of Podiatric Medical Examiners Part III examination that is consistent with the postgraduate training requirement in Section 2484. BPM, as of July 1, 2005, shall require a passing score one standard error of measurement higher than the national passing scale score until such time as the National Board of Podiatric Medical Examiners recommends a higher passing score consistent with Section 2484. In consultation with the Office of Professional Examination Services of the Department of Consumer Affairs, BPM shall ensure that the part III examination adequately evaluates the full scope of practice established by Section 2472, including amputation and other foot and ankle surgical procedures, pursuant to Section 139.**~~

Committee staff concurs with the BPM's recommendation, and notes the BPM's citation that DCA's *Examination Validation Policy* developed under BPC §139, requires a licensing examination testing for "entry-level competence."

Staff Recommendation: ***As recommended by the BPM, BPC Section 2493 should be amended to repeal subdivision (b).***

ENFORCEMENT ISSUES

ISSUE # 6: Should BPC Section 2335 be amended to remove the two-vote requirement for a disciplinary decision to be discussed by the BPM as a whole?

Background: The BPM licenses doctors of podiatric medicine under the authority of the Medical Board of California. The law creates the Health Quality Enforcement Section within the Department of Justice with the primary responsibility of prosecuting proceedings against licensees and applicants within the jurisdiction of MBC and various other boards, including the BPM. Under these provisions, a panel of administrative law judges, the Medical Quality Hearing Panel (MQHP) within the Office of Administrative Hearings, conducts disciplinary proceedings against a DPM. BPC Section 2335

provides that all proposed decisions of the MQHP are transferred to the executive officer of the BPM, and sent by Board staff to each Board member within 10 days. The BPM staff then polls each member regarding his or her vote on the proposed decision. By majority vote, the BPM may do any of the following: approve the decision, approve the decision with an altered penalty, refer the case back to the administrative law judge in order to take additional evidence, defer final decision pending discussion of the case by Board as a whole, or non-adopt the decision.

The law provides that the votes of two members of the BPM are required to defer a final decision pending discussion of the case by the BPM as a whole. If two or more members vote to defer the final decision until after a discussion of the entire Board, then the BPM must engage in that discussion before 100 calendar days of the date the proposed decision is received by the BPM.

In its Report, the BPM states that the requirement that, "The votes of two members of the panel or board are required to defer a final decision pending discussion of the case by the panel or board as a whole," effectively prevents the BPM Board Members from discussing a case in closed session as a jury even when one member of the BPM identifies an issue and wishes to have discussion with her or his colleagues prior to voting. The BPM states that there is no such obstacle to jury deliberation in civil or criminal courts, nor was there a problem with too many cases being held by the BPM prior to enactment of the two-votes rule. The BPM has recommended deleting this provision as it relates to the BPM, and believes that doing so, could empower the BPM as a jury in disciplinary matters and make its role more meaningful.

Committee staff believes that the BPM's proposal may have merit relating to the operations of the BPM, and suggests that the BPM provide more information to the Committee on this issue.

Staff Recommendation: ***The BPM should provide more information regarding the proposal to amend BPC Section 2335 to remove the two-vote requirement for a disciplinary decision to be discussed by the BPM as a whole.***

ISSUE # 7: Should the BPM be given authority to increase costs when the BPM does not adopt a proposed ALJ decision, and finds grounds to increase the assessed costs?

Background: As part of the Medical Board, and utilizing MBC staff for enforcement, the BPM has cost recovery authority through BPC § 2497.5. The BPM's *Manual of Disciplinary Guidelines and Model Disciplinary Orders* provides that cost recovery is a standard condition for all cases.

According to the BPM, Administrative Law Judges (ALJs) are inconsistent in the amount of cost recovery they propose from one case to another. In stipulated agreements, the BPM's staff and the Attorney General always seek cost recovery as part of the negotiation.

In its Report, the BPM recommends amending BPC § 2497.5(b) to give the BPM discretion to increase cost recovery in disciplinary cases when it non-adopts a proposed decision from an administrative law judge "and in making its own decision finds grounds for increasing the costs to be assessed." The BPM indicates that it is unusual to non-adopt an ALJ's proposed decision and for the BPM to make its own decision. However, the BPM contends that it should not be prohibited from ordering actual and reasonable cost recovery in such cases.

The BPM argues that Section 2497.5 prevents it from increasing the cost recovery proposed by an ALJ "in any event" and also prohibits an ALJ from increasing the cost recovery when the BPM remands cases. There is no apparent rationale for these provisions other than to restrict recovery of costs. This undercuts the role of the BPM Members in making the final decision and ultimately has the effect of inflating licensing fees, according to the BPM.

The BPM recommends amending BPC § 2497.5 as follows:

> (b) The costs to be assessed shall be fixed by the administrative law judge and shall not ~~**in any event**~~ **be increased by the BPM unless the BPM does not adopt a proposed decision and in making its own decision finds grounds for increasing the costs to be assessed, not to exceed the actual and reasonable costs of the investigation and prosecution of the case. ~~When BPM does not adopt a proposed decision and remands the case to an administrative law judge, the administrative law judge shall not increase the amount of any costs assessed in the proposed decision.~~**

Committee staff concurs with the BPM's recommendation to authorize the BPM to increase costs assessed to a disciplined licensee when a proposed decision is not adopted by the BPM and the BPM finds grounds for increasing the costs.

Staff Recommendation: ***BPC Section 2497.5 should be amended to authorize the BPM to increase costs assessed when a proposed decision is not adopted by the BPM and the BPM finds grounds for increasing the assessed costs.***

TECHNOLOGY ISSUES

ISSUE # 8: What is the status of BReEZe implementation by the BPM?

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

BreEZe will provide all DCA organizations with a solution for all applicant tracking, licensing, renewal, enforcement, monitoring, cashiering, and data management capabilities. In addition to meeting these core DCA business requirements, BreEZe will improve DCA's service to the public and connect all license types for an individual licensee. BreEZe will be web-enabled, allowing licensees to complete applications, renewals, and process payments through the Internet. The public will also be able to file complaints, access complaint status, and check licensee information. The BreEZe solution will be maintained at a three-tier State Data Center in alignment with current State IT policy.

BreEZe is an important opportunity to improve the BPM operations to include electronic payments and expedite processing. Staff from numerous DCA boards and bureaus have actively participated with the BreEZe Project. Due to increased costs in the BreEZe Project, last year SB 543 (Steinberg, Chapter 448, Statutes of 2011) was amended to authorize the Department of Finance (DOF) to augment the budgets of BPMs, bureaus and other entities that comprise DCA for expenditure of non-General Fund moneys to pay BreEZe project costs within the 2011-2012 Budget Year.

The BPM indicates in its Report that in August 2011, DCA advised the BPM that the BPM budget and fund will be charged assessments of $4,000 in FY 2011-12 followed in succeeding FYs by $11,000, $9,000, $8,000, $9,000 and $9,000 consecutively through FY 2016-17 for BreEZe SPR Funding.

The BPM is scheduled to begin using BreEZe in the Summer of 2012. It would be helpful to update the Committee about BPM's current work to implement the BreEZe project.

Staff Recommendation: ***The BPM should update the Committee about the current status of its implementation of BreEZe. What have been the challenges to implementing this new system? What are the costs of implementing this system? Is the cost of BreEZe consistent with what the BPM was told the project would cost?***

ISSUE # 9: Are the costly credit card fees associated with the BreEZe system justified for the BPM?

Background: The BPM Report states that DCA has advised that it projects deducting another $15,000 annually for BreEZe credit card convenience fees beginning in FY 2012-13. The BPM states that the additional $15,000 annual assessment is problematic.

The $15,000 annual charge is based upon an assumption of a two-percent transaction fee on average for each online renewal fee payment. The BPM states, "Whereas this fee for a Registered Nurse, with a $140 renewal fee, will be $2.80, the transaction fee for each the BPM renewal will be $18.00 (two percent of the $900 renewal fee)."

With fewer than 2,000 licensees, the BPM has less than 1,000 renewals each year. DCA assumes 80 percent will renew online via a credit card, i.e., 833 online renewals annually, times $900, times two percent. That calculation results in the $15,000 that DCA projects being charged to the BPM's budget annually. The BPM argues that the $15,000 amount stands out as difficult to justify for only 833 renewals.

The BPM has the highest professional renewal fee ($900) and one of the smallest budgets and funds in DCA ($960,000 for FY 2011/12). The BPM states that for two decades the BPM has kept its fund in the black by careful, thrifty under-spending of its budget and returning money to its fund for future use. The BPM has kept its fund solvent by cutting expenditures for 20 years, developing a lean operation with minimum staff. Given the small size of the BPM's budget, and the potential volatility of enforcement costs, this budget flexibility remains instrumental, according to the BPM.

With the BPM a high renewal fee, which has been the case for two decades, there may be little if any support for raising the fee to cover the credit card costs. The BPM does not support raising the renewal fee or cutting licensing or enforcement programs.

The BPM Report states that the BPM unanimously approved initiating having BreEze give the licensee the option of online renewal with credit card payments of both the $900 renewal fee and the amount DCA charges to cover the average convenience fee (currently 2 percent, or $18). The current mail-in renewal with check payment will continue to be available for licensees. According to the BPM, this will cover the $15,000 convenience fee assessment that DCA projects being charged to the BPM's budget, and help preserve the BPM's fund balance.

Committee staff recognizes the concerns of the BPM and understands desire to pass the credit card convenience fee on to those licensees renewing their license online. As consumers, licensees are often used to making electronic payments via credit card for online purchases and making other electronic purchase and payments online. No doubt it would be of great benefit to the licensing population and be more efficient for the BPM to be able to make credit card payments for fees online.

Committee staff is concerned whether the BPM has adequate authority to charge a separate convenience fee for renewing a license online by credit card. The BPM should more fully discuss this issue with the Committee.

Staff Recommendation: ***The BPM should discuss with the Committee its authority to charge additional fees such as the convenience fees contemplated by the BPM. Does the BPM currently have sufficient authority to charge such a fee? Is any legislative change needed to clarify the authority of the BPM to charge an additional fee to cover the cost of a credit card convenience fee? Should or can the fee be reduced?***

BUDGET ISSUES

ISSUE # 10: Should the fees for services other than for license renewals be increased?

Background: Aside from the BPM's renewal fee, which accounts for more than 90 percent of the BPM's revenue, the fees for other specified services have not been adjusted in two decades. They are at their statutory limits. DCA Budget Office recommended in 2004, when the $900 renewal fee was made permanent, that the BPM's other fees be adjusted to reflect actual costs of service. This was to stabilize the BPM special fund and relieve pressure on the renewal fee, which has been the highest professional renewal fee in DCA for decades.

The BPM recommends following changes to bring fees more in line with current costs:

- Increase the application fee from $20 to $100 (BPC § 2499.5 (a)).
- Delete application and renewal fee discounts for recent graduates (BPC § 2499.5 (c)).
- Add authority to waive the renewal fee for doctors working only as volunteers consistent with MBC statute (Section 2442) (BPC § 2499.5 (d)).
- Increase the duplicate wall certificate fee from $40 to $100 (BPC § 2499.5 (f)).
- Increase the duplicate renewal receipt fee from $40 to $50, and clarify statute to include the issuance of pocket licenses under this provision so that it is consistent with current practice (BPC § 2499.5 (g)).
- Increase the endorsement fee from $30 to $100, and clarify statute to include all of the services that are currently provided under this subsection (BPC § 2499.5 (h), (i)).
- Increase the resident's license fee from $60 to $100 (BPC § 2499.5 (j)).
- Sunset authorization and fees for ankle licensure examination for pre-1984 licensees (BPC § 2499.5 (k)).
- Increase the examination appeal fee from $25 to $100 (BPC § 2499.5 (l)).
- Increase the continuing education course approval fee from $100 to $250 (BPC § 2499.5 (m)).

Given the BPM's close budget management and lean operation, these fees should not require further adjustment for some years. While the renewal fee is the highest professional fee within the Department, DPMs support it to ensure the fiscal and enforcement integrity of a Board dedicated to standards reflecting well on the profession, according to the BPM.

Committee staff agrees that the stability of the BPM's special fund is essential to the long-term regulatory activities of the BPM. However, to this point, the BPM has not sufficiently demonstrated the need for the proposed increases.

Staff Recommendation: ***The BPM should discuss its fund projections, and whether the current fee structure will generate sufficient revenues to cover its administrative, licensing and enforcement costs and to provide for adequate staffing levels for critical program areas into the foreseeable future. The BPM should demonstrate the level of need for the proposed fee increase by completing the Committee's "Fee Bill Worksheet."***

CONTINUED REGULATION OF THE PROFESSION BY THE CURRENT MEMBERS OF THE BPM

ISSUE # 11: Should the licensing and regulation of podiatric medicine be continued, and should the profession continue to be regulated by the BPM of Podiatric Medicine under the jurisdiction of the Medical Board of California?

Background: The health, safety and welfare of consumers are protected by a well-regulated medical profession, including podiatric medicine. Podiatric doctors make independent medical judgments with patients including diagnosis, prescription medication, and method of treatment. The BPM continues to be an effective mechanism for licensure and oversight of podiatrists and should be continued. The BPM has shown over the years a strong commitment to improve the BPM's overall efficiency and effectiveness and has worked cooperatively with the Legislature and this Committee to bring about necessary changes. The BPM should be continued under the jurisdiction of the MBC with a four-year extension of its sunset date so that the Committee may review once again if the issues and recommendations in this Paper and others of the Committee have been addressed.

Staff Recommendation: ***Recommend that doctors of podiatric medicine continue to be regulated by the current the BPM members under the jurisdiction of the MBC in order to protect the interests of the public and be reviewed once again in four years.***

TECHNICAL CLEANUP OF PODIATRIC ACT

ISSUE # 12: Technical cleanup of the Podiatric Medicine Act proposed by the BPM.

Background: The BPM has raised several cleanup provisions in its Report which should be made to clarify the law.

The following are technical corrections recommended by the BPM:

2465. No person who directly or indirectly owns any interest in any college, school, or other institution engaged in podiatric medical instruction shall be appointed to the BPM ~~**or**~~ **nor** shall any incumbent member of the BPM have or acquire any interest, direct or indirect, in any such college, school, or institution.

2484. In addition to any other requirements of this chapter, before a certificate to practice podiatric medicine may be issued, each applicant shall show by evidence satisfactory to the BPM, submitted directly to the BPM by the sponsoring institution, that he or she has satisfactorily completed at least two years of postgraduate podiatric medical and podiatric surgical training in a general acute care hospital approved by the Council ~~**of**~~ **on** Podiatric Medical Education.

The BPM states that Section 2496 duplicates provisions found in Section 2470 and other provisions of law, and recommends amendments to remove the duplicative wording. Committee staff recommends also amending Section 2470 to more fully cite the Administrative Procedures Act.

2496. In order to ensure the continuing competence of persons licensed to practice podiatric medicine, the BPM shall adopt and administer regulations ~~in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code)~~.

2470. The BPM may adopt, amend, or repeal, in accordance with the provisions of the Administrative Procedure Act **(Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code)**, regulations necessary to enable BPM to carry into effect the provisions of law relating to the practice of podiatric medicine.

Staff Recommendation: ***Amendments should be made to make the technical cleanup changes identified by the BPM and recommended by Committee staff.***