BACKGROUND PAPER FOR THE MEDICAL BOARD OF CALIFORNIA

Joint Oversight Hearing, March 11, 2013

Senate Committee on Business, Professions and Economic Development and Assembly Committee on Business, Professions and Consumer Protection

IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS REGARDING THE MEDICAL BOARD OF CALIFORNIA

BRIEF OVERVIEW OF THE MEDICAL BOARD OF CALIFORNIA

The Medical Practice Act (Act) was first enacted in 1876. In 1901, the Act was rewritten to combine the former California Medical Society Board, Eclectic Medical Society Board and Homeopathic Medical Society Board into a nine-member Board of Examinations. From 1950 to 1976, the Board expanded its role beyond physician licensing and discipline to oversee various allied health professionals, such as physical therapists and psychologists.

In 1976, the Medical Practice Act was significantly changed; creating the Board of Medical Quality Assurance (BMQA). It was also the year that the Medical Injury Compensation Reform Act (MICRA) was established. MICRA created a cap of $250,000 "general damages" for pain and suffering, emotional distress, and loss of companionship and limited attorney contingency fees. "Special" or "economic" damages, such as lost wages, extra costs, and repair or replacement, remained unlimited. The BMQA increased to 19 members with 7 being public members. Other changes included authorizing the BMQA to employ its own enforcement team of trained peace officers to investigate complaints. Another change that was a significant step towards consumer protection was the establishment of mandatory reporting of hospital discipline and malpractice awards.

In 1990, the BMQA's name was changed to Medical Board of California (MBC); coroners were required to report deaths to the MBC that were a result of physician involvement; county courts were required to report felony convictions of physicians; and physician license applicants were required to submit fingerprints. In addition, in 1990 changes were made to require MBC cases to be prosecuted by a specialized unit within the Attorney General's (AG) Office – Health Quality Enforcement Section (HQES). Legislation further established a Medical Quality Hearing Panel within the Office of Administrative Hearings, requiring specially trained and experienced Administrative Law Judges (ALJ) to hear MBC disciplinary cases.

The Division of Allied Health was eliminated in 1993 through legislation and its duties were assigned to the Division of Licensing. The MBC was consolidated from three to two Divisions, the Division of Licensing and the Division of Medical Quality. Greater transparency of public information was also mandated, including information about disciplinary actions taken in California (and other jurisdictions), malpractice judgments, specific hospital peer review discipline and criminal convictions. A "Public Letter of Reprimand" was also created as an enforcement tool.

The MBC received regulatory authority over licensed midwives in 1994. Growing out of the issue of surgery being performed without safeguards in settings outside of a hospital, in 1996, outpatient surgery settings were required to be accredited and the MBC had to approve accrediting agencies.

In 1997, a telemedicine law was signed that required California licensure if the physician was in another state. More improvements to public disclosure occurred in 1998, including a requirement for licensing information to be posted on the MBC's Website, thus providing immediate access to a physician's license profile, thereby increasing consumer protection. The statute of limitations law passed in 1999 and limited the timeframe in which an accusation could be filed by the MBC.

In 2000, additional laws were passed, including required reporting of specified outcomes in outpatient surgery settings, revising laws pertaining to misleading and deceptive advertising, and requiring pain management and end of life care to be added to medical school curriculum. In 2003, to meet the need for physicians in underserved areas, the MBC sponsored the physician loan repayment program, which allowed the repayment of student loans for physicians who were willing to serve three years in an underserved area. This program continues to fulfill its purpose (through the Health Professions Education Fund (HPEF)) of placing physicians in underserved areas.

In 2004, a legislatively mandated Enforcement Monitor report was released. The report was the result of an in-depth review of the MBC's Enforcement and Diversion Programs, and included significant recommendations for improvement. A Final Enforcement Monitor report was issued in 2005 making additional recommendations. A number of those recommendations were placed into legislation, including establishing a vertical prosecution model (now called vertical enforcement/prosecution, or VE). VE requires the AG's Office to be involved in the MBC's investigation activities as well as its prosecution activities. In order to fund this program, a physician's initial license and renewal fees were increased; however, the ability to order cost recovery for investigating and prosecuting an administrative case was eliminated.

Structural changes were further made to the MBC in 2008 to eliminate the Division of Licensing and the Division of Medical Quality and establish a single unified MBC. The MBC was reduced from 21 to 15 members. The MBC's Diversion Program was eliminated that same year. (See below: "Major Changes to the Board Since the Last Sunset Review.")

In 2010, the Department of Consumer Affairs (DCA) launched the Consumer Protection Enforcement Initiative (CPEI) to overhaul the enforcement process of healing arts boards. According to the DCA, the CPEI is a systematic approach designed to address three specific

areas: Legislative Changes, Staffing and Information Technology Resources, and Administrative Improvements. Once fully implemented, the DCA expected the healing arts boards to reduce the average enforcement completion timeline to between 12 -18 months. The DCA requested an increase of 106.8 authorized positions and $12,690,000 (special funds) in FY 2010-11 and 138.5 positions and $14,103,000 in FY 2011-12 and ongoing to specified healing arts boards for purposes of funding the CPEI. As part of CPEI, the MBC was authorized to hire 22.5 positions, including 20.5 (non-sworn) special investigators and 2 supervisors/managers. However, the MBC has eliminated these positions based upon the 5% salary savings reduction.

Function of the Medical Board of California

The primary purpose of the MBC is to protect consumers, much like the other boards and committees under the DCA. While the MBC does engage in a number of activities to educate, or assist physicians, the primary purpose of the MBC is to benefit consumers, through the appropriate licensing of physicians and surgeons and through enforcement of the Medical Practice Act.

Under the Medical Practice Act in the Business and Professions Code (BPC), the MBC has jurisdiction over physicians licensed by the state. The MBC licenses and regulates approximately 132,000 physicians and surgeons. The MBC issues some 5,300 licenses each year, and approximately 64,000 licenses are renewed each year.

The MBC also has statutory and regulatory authority over licensed midwives, medical assistants, registered contact lens dispensers, registered dispensing opticians, registered non-resident contact lens sellers, registered spectacle lens dispensers, registered polysomnographic trainees, registered polysomnographic technicians, registered polysomnographic technologists, research psychoanalysts, student research psychoanalysts, special program registrants and special faculty permits.

The MBC approves accreditation agencies that accredit outpatient surgery settings and issues Fictitious Name Permits to physicians practicing under a name other than their own. The MBC, with a few exceptions, does not have jurisdiction over facilities, business practices, reimbursement rates, or civil malpractice matters.

The current mission statement of the MBC is:

> ***"To protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care professions and through the vigorous, objective enforcement of the Medical Practice Act, and, to promote access to quality medical care through the Board's licensing and regulatory functions."***

Board Membership and Committees

Currently the MBC is composed of 15 members. It has professional majority with 7 public members and 8 physician and surgeon members.

The Governor appoints 13 members of the MBC. The Senate Rules Committee and the Assembly Speaker each appoints one public member. Four of the physician members must also hold faculty appointments in a clinical department of an approved medical school in the state.

MBC members receive a $100-a-day per diem. The full MBC holds quarterly meetings throughout the State. All meetings are subject to the Bagley-Keene Open Meetings Act. There are currently 4 vacancies on the MBC. The following is a listing of the current MBC members:

Name and Short Bio	Appointment Date	Term Expiration Date	Appointing Authority
Sharon Levine, M.D, President, Physician Member First appointed by Governor Schwarzenegger and reappointed by Governor Brown. An associate executive director of The Permanente Medical Group and served as a pediatrician from 1977 to 1991. Served as staff pediatrician for the Georgetown University Community Health Plan; a clinical associate in infant nutrition at the National Institutes of Health; and director of pediatric services for Montgomery Georgetown Pediatric Clinic. Member of many professional associations and sits on the boards of directors of the Reagan Udall Foundation, the Integrated Healthcare Association, Women's Foundation of California, California Hospital Association, and the Public Health Institute.	02/11/09	06/01/15	Governor
Gerrie Schipske, R.N.P., J.D., Vice President, Public Member Licensed as both a registered nurse practitioner and an attorney, serves as general counsel to the Teachers Association of Long Beach. In 2006, was elected to a four-year term on the Long Beach City Council. The founder of Long Beach Cares, a non-profit organization that raises funds for the City of Long Beach's Department of Health and Human Services and other organizations providing public health and human services. Served on the Long Beach Board of Health and Human Services from 1985-1993. Was elected to the Long Beach Community College District Board of Trustees from 1992-1996.	06/12/07	06/01/15	Senate Rules Committee
Silvia Diego, M.D., Secretary, Physician Member First appointed by Governor Schwarzenegger and reappointed by Governor Brown. The chief medical officer at Golden Valley Health Centers, where she was previously an associate medical officer. Served as assistant clinical professor at the University of California, Davis Department of Family and Community Medicine. A clinical committee member of the California Primary Care Association and a fellow at the California HealthCare Foundation.	07/30/10	06/01/14	Governor
Michael Bishop, M.D, Physician Member Director of anesthesia for same-day surgery at the University of California, San Diego Medical Center in Hillcrest since 2008. An attending anesthesiologist and clinical professor of anesthesiology at the University of California, San Diego and serves as quality officer for the Department of Anesthesiology. Worked as a private practice anesthesiologist from 1992 to 2006.	12/21/11	06/01/13	Governor

Dev GnanaDev, M.D., Physician Member Serves as the president of the Arrowhead Regional Medical Center and chair of the Department of Surgery, since 1989. Clinical professor of surgery at Western University for Health Sciences and an associate professor of surgery at Loma Linda University. Served as president of the California Medical Association from 2008 to 2009. Received numerous honors and recognition for work and commitment to those who utilize public health programs, including the MBC's Physician Recognition Award in February 2005.	12/21/11	06/01/14	Governor
Reginald Low, M.D., Physician Member Serves as professor of medicine and chief of the Division of Cardiovascular Medicine at the University of California, Davis. Is an interventional cardiologist and also serves as director of the Heart Center at the University of California, Davis Medical Center. Was previously in private practice and medical director of the Mercy Heart Institute in Sacramento, California.	08/10/06	06/01/13	Governor
Denise Pines, Public Member Responsible for strategic planning and business development for Denise Pines Inc. Served as President for The Smiley Group from 1998 to 2010. Launched Pines One Publications in 1993. Prior to starting her business over 15 years ago, she held management positions at AT&T, Neiman Marcus, Louis Vuitton, and The Gap.	08/29/12	06/01/16	Governor
Janet Salomonson, M.D., Physician Member A plastic surgeon in private practice and medical director of the Cleft Palate Center at Saint John's Health Center in Santa Monica. A diplomate of the American Board of Plastic Surgery and clinical assistant professor of surgery, Division of Plastic Surgery at U.S.C. A member of the American Society of Plastic Surgeons, California Society of Plastic Surgeons and the American Cleft Palate - Craniofacial Association. Serves as the CSPS representative to the California Access to Specialty Care Coalition and the Saint John's representative to the Coalition of California Cleft and Craniofacial Teams. Has published articles on cleft reconstruction and is an invited reviewer for the Cleft Palate Journal. Volunteers on international missions providing cleft team care.	08/10/06	06/01/13	Governor
David Serrano Sewell, J.D., Public Member A Deputy City Attorney for the City and County of San Francisco since 2003. Prior to practicing law, was an Assistant to the Director at the Department of Building Inspection for the City and County of San Francisco from 1998 to 1999. Was Special Assistant to Mayor Willie L. Brown Jr. from 1996 to 1998. Served for seven years as a founding member of the state Governing Board for the California Institute for Regenerative Medicine, the state agency responsible for awarding $3 billion for stem cell research and facilities. Earned a Juris Doctorate degree from Golden Gate University School of Law, and was a member of Law Review. Worked as an extern for Judge Maxine M. Chesney at the United States District Court, Northern District of California in 2002.	08/29/12	06/01/16	Governor
Barbara Yaroslavsky, Public Member Involved in many community projects in Southern California, primarily in the areas of health care and education. Serves on the boards of a number of nonprofit agencies, including the Los Angeles Free Clinic; LA's Best, which provides a quality program	09/24/03	06/01/15	Assembly Speaker

for over 10,000 students in Los Angeles City-area elementary public schools; the Undergraduate Student Scholarship Committee at U.C. San Diego; the Jewish Public Affairs Committee; and the Executive Board of the Jewish Community Relations Council. Heads a special projects group for the Zimmer Children's Museum and participates in the Jewish Community's response to literacy through the Koreh Los Angeles Task Force. Is a board member of Executive Service Corps (ESC), a management consulting group that provides mentoring and staffing services by retired executives to nonprofit organizations.			
Felix C. Yip, M.D. Physician Member A board certified urologist in private practice and currently the Chief of Surgery at Garfield Medical Center and Pacific Alliance Medical Center. Serves clinical professor of urology at the Keck School of Medicine, University of Southern California and has previously served as clinical assistant professor of surgery at UCLA School of Medicine and Western University of Health Sciences. A UCLA Foundation Governor and member of the Board of Counselors at UCLA School of Dentistry. Holds a medical degree from the University of Wisconsin - Madison, School of Medicine and Public Health, and an M.B.A. in health care management from the University of California, Irvine.	02/01/13	06/01/14	Governor
Vacant – Public Member		06/01/14	Governor
Vacant – Public Member		06/01/16	Governor
Vacant – Public Member		06/01/14	Governor
Vacant – Physician Member		06/01/16	Governor

The MBC has nine Committees, eight Subcommittees, two Panels, and one Council. Three of the MBC's Committees, the two Panels, and the Council are statutorily mandated, while others are established by the MBC to meet specific needs.

- **Executive Committee** (non-statutory) – Oversees various administrative functions of the MBC, such as budgets and personnel, the strategic plan, and the review of legislation.
- **Licensing Committee** (non-statutory) – Serves as an expert resource and advisory capacity to the MBC and its Licensing Program; identifies program improvements and reviews licensing regulations, policies, and procedures.
- **Enforcement Committee** (non-statutory) – Serves as an expert resource and advisory capacity to the MBC and its Enforcement Program; identifies program improvements to enhance protection of healthcare consumers and reviews, via a task force, the MBC's VE Model.
- **Application Review Committee** (BPC § 2099) – Evaluates the credentials of certain licensure applicants regarding eligibility for licensure, and makes recommendations to the Chief of Licensing.
- **Special Faculty Permit Review Committee** (BPC § 2168.1) – Evaluates the credentials of applicants proposed by a California medical school to meet the requirements of being an academically eminent physician, or an outstanding physician in an identified area of need.
- **Special Programs Committee** (BPC §§ 2072-2073, 2111-2113, 2115) – Provides guidance, recommendations and expertise regarding special program laws and regulations, specific

applications, medical school site visits, and issues of concern, and makes recommendations to the Chief of Licensing.

- **Access to Care Committee/Cultural & Linguistic Competency Committee** (non-statutory) – Identifies opportunities to promote and assist physician involvement in access to care issues, and to promote the cultural and linguistic competency of physicians. A subcommittee of this committee addresses the cultural and linguistic competency of physicians.
- **Education and Wellness Committee** (non-statutory) – Develops informational materials on issues for publication and Internet posting; monitors the MBC's strategic communication plan; develops physician wellness information regarding activities and resources that renew and balance a physician's personal and professional life. A subcommittee of this committee assists with the development of physician wellness information and wellness resources.
- **Committee on Physician Supervisory Responsibilities** (non-statutory) – Discusses physician availability in non-traditional settings, including settings where cosmetic procedures take place; develops regulatory language related to physician availability in cosmetic surgery settings that use laser impulse light, and discusses issues relating to physician supervision and its definition.
- **Midwifery Advisory Council** (BPC § 2509) – Develops solutions to various regulatory, policy, and procedure issues regarding the midwifery program, including physician supervision, challenge mechanisms, and examinations; makes recommendations to the full MBC.
- **Panel A & Panel B** (BPC § 2008) – Disciplinary panels which carry out disciplinary actions as stated in BPC § 2004 (c).
- **Budget Subcommittee** (Appointed as needed) – Reviews budget documents, expenditures, and revenues.
- **Legislation Subcommittee** (Appointed as needed) – Reviews legislative amendments and pending legislation.
- **Strategic Plan Subcommittee** (Appointed as needed) – Assists in drafting and revising the Strategic Plan every three to four years.
- **Full MBC Evaluation/Sunset Subcommittees** (3 subcommittees appointed as needed) – Meets with the Executive Director and Deputy Director to review sunset review questions and responses.

Board Meeting and Quorum Issues

Although the full MBC has not had any meetings that had to be canceled due to a lack of a quorum, there have been items at these meetings that had to be tabled to a later time due to lack of a quorum at the time. In addition, the MBC has held a Committee meeting (April 2012) where no action could be taken because a Member had to cancel attendance resulting in the lack of a quorum of the Committee. At the May 2012 meeting, one of the MBC's disciplinary Panels had to cancel an oral argument that was scheduled due to the lack of a quorum. This caused additional expense to the MBC for an ALJ and a DAG, and caused expense and delay for the Respondent.

Currently, the MBC has four vacancies in its membership, all appointees of the Governor.

Staffing Levels

The MBC's Executive Director is appointed by the MBC and serves as the executive officer of the MBC. The current Executive Director, Linda Whitney, was appointed by the MBC in 2010, and previously had been employed by the MBC since 1994 in a variety of capacities, including administrative management and as Chief of Legislation for the MBC. For FY

2012/13, the MBC has 271 authorized positions. Of those positions, 147 are allocated to enforcement, 6 to Operation Safe Medicine, 25 to probation monitoring, and 53 to licensing. The other staff are allocated to executive functions, administrative services, and information systems.

The Board had some staffing issues in recent years. Prior to the budget crisis, the Board had difficulty in filling some positions. The Board employs its own sworn investigative staff, and these positions have been difficult to fill due to a variety of issues, including: salary inequities, substantial workload, and lack of geographical pay. Under the state's fiscal crisis, the three-day furloughs resulted in an almost 15% reduction in pay, and several of these staff either retired or went to other agencies that did not impose the pay reduction. When the hiring freeze was imposed, a number of positions were vacant, resulting in a significant vacancy rate in the enforcement field staff. In addition, these positions require an extensive background investigation be performed prior to hiring the individual, which must be conducted in accordance with Peace Officer Standards and Training (POST) requirements, and can take four to six months to complete. The investigator may also have to attend a 16-week academy. Simply stated, these positions are difficult to recruit and difficult to retain once hired.

The Board commissioned a study to examine the need to reclassify these positions. The outcome was that the positions did not need to be reclassified, but should have "deeper classes" for those with advanced training, experience, and skills. The study also recommended geographical and field training officer pay differentials. Lastly, the study stated the minimum qualifications for the investigator classification should be expanded from the limited types of degrees that can be used to meet the qualifications (e.g. criminal justice, administration of justice, police science, etc.).

Despite the prior hiring challenges, when the hiring freeze lifted at the end of 2011, the Board was able to identify individuals to fill almost every investigator vacancy. This was due, in large part, to layoffs by other agencies. The MBC indicates that since the hiring freeze lifted, the Board has had good success in recruiting and retaining employees across all Board programs.

The MBC has been further impacted by the reduction in the Board's fleet of cars for its investigative and inspector staff. Currently, with the fleet reduction, the Board does not have enough vehicles for staff that perform investigative and probation monitoring duties. As a result cars must be rented or staff is limited in performing their duties.

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

Fiscal and Fund Analysis

As a Special Fund agency, the MBC receives no General Fund support, relying solely on fees set by statute and collected from the licensing of physician and surgeons, and other licensees

and registrants and biennial renewal fees. Currently, the license fee for a physician and surgeon is $783 and the renewal fee is $783.

The fees for the allied health programs have remained the same over the last six years; however, the physician's renewal fee has changed several times within this timeframe. As previously stated, in order to financially support VE, the physician initial license and renewal fees were increased from $600 to $790 effective January 1, 2006 (first fee increase since 1994). Included in the statutory language to increase the fee to $790, was language that stated the MBC may, by regulation, increase the renewal fee by an amount required to offset the elimination of reimbursement of investigation and prosecution costs. Therefore, through the regulatory process, the MBC increased the physician initial license and renewal fees by $15 based upon the average amount of cost recovery that the MBC had received in the prior three fiscal years that would no longer be received by the MBC (fee increased from $790 to $805).

With the elimination of the MBC's Diversion Program in 2008, the MBC was required to reduce the initial license and renewal fees based upon the reduced expenditures from the elimination of that program. Therefore, in 2009, the license and renewal fees were decreased by $22 to the current $783 level. The MBC has no intentions of increasing or decreasing the license renewal fee at this time.

Physician License: Fee Schedule and Revenue

Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2012/13 Revenue	% of Total Revenue
Application (B&P 2435)	442.00	442.00	2,719,137	2,625,899	2,697,296	2,958,876	5.62%
Initial License (B&P 2435) (Title 16, CCR 1351.5)	783.00	790.00	1,512,442	1,285,555	1,408,668	1,492,531	2.84%
Initial License (Reduced – 1/2) (B&P 2435)	391.50	395.00	1,319,034	1,428,937	1,374,825	1,467,768	2.79%
Biennial Renewal (B&P 2435) (Title 16, CCR 1352)	783.00	790.00	44,478,782	44,455,854	43,570,578	46,047,490	87.51%

The total revenues anticipated by the MBC for FY 2012/13, is $77 million and for FY 2013/14, $73 million. The total expenditures anticipated for the MBC for FY 2012/13, is $56.6 million, and for FY 2013/2014, $56.4. The MBC anticipates it would have approximately 4.4 months in reserve for FY 2012/13, and 3.6 months in reserve for FY 2013/14. In looking at the MBC's current and projected fund condition, it appears the Board will be at a deficit and in need of a fee increase in FY 2014/2015 or FY 2015/2016. However, with the uncertainty of the State's fiscal condition, it is unknown whether the projections for future fiscal years will remain as projected.

The MBC has had two loans made to the General Fund: $6 million in FY 2008/2009 and $9 million in FY 2011/2012. The MBC has not received any payments from the General Fund on these loans. If the MBC should fall below its statutory mandate of not less than 2 or more than 4 months reserve, then the MBC will request payment for the loans. However, the MBC is not projected to be at that level until FY 2014/2015. On the next page is the Fund Condition of the MBC for the past 4 years and the projected Fund Condition for the next 2 fiscal years.

Fund Condition

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

* Includes prior year adjustments, revenue, and reimbursements
** As of October 2012

The Enforcement Program (including the AG's Office and the Office of Administrative Hearings, and Probation Monitoring) makes up approximately 78% of the MBC's overall expenditures. The Licensing Program accounts for about 10% of the MBC's expenditures, while the Information Systems Branch (ISB) accounts for approximately 6%. The Executive and Administrative Programs make up about 6% of the MBC's overall expenditures. Although the MBC cannot order cost recovery for investigation and prosecution of a case, the MBC can order that probation monitoring costs be reimbursed.

Expenditures by Program Component

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

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

Budget Distribution (budgeted not actual)

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

In 2010, DCA launched the CPEI to overhaul the enforcement process of healing arts boards. According to the DCA, the CPEI was a systematic approach designed to address three specific areas: Legislative Changes, Staffing and Information Technology Resources, and Administrative Improvements. Once fully implemented, the DCA expected the healing arts boards to reduce the average enforcement completion timeline to between 12-18 months. The DCA requested an increase of 106.8 authorized positions and $12,690,000 (special funds) in FY 2010-11 and 138.5 positions and $14,103,000 in FY 2011-12 and ongoing to specified healing arts boards for purposes of funding the CPEI.

As part of CPEI, the MBC was authorized to hire 22.5 positions effective FY 2010/2011. The MBC hired a manager and an analyst in its Central Complaint Unit (CCU). Because the MBC conducted investigations for the Osteopathic Medical Board of California (OMBC) and the Board of Psychology (BOP), 2.5 of the CPEI positions authorized for the MBC were to assist in those boards' investigations. However, these boards determined that they would rather have the positions under their specific authority, and those 2.5 positions were moved to those boards, leaving MBC with 18 unfilled CPEI positions. According to the MBC, the statewide budget crisis severely impacted its efforts to fill the remaining CPEI positions. Workforce cap position reductions, statewide hiring freeze, elimination of position due to a statewide mandate for a 5% salary saving reduction effectively eliminated all of the remaining CPEI positions. In 2012, the MBC states that it was notified that it could reestablish the positions in the temporary help blanket as long as the Board always maintains a 5% vacancy rate to meet the required salary reduction level, and the MBC began the process of identifying positions to establish and hiring to fill those positions.

Licensing

The Licensing Program of the MBC provides public protection by ensuring licenses or registrations are issued only to applicants who meet the minimum requirements of current statutes and regulations and who have not committed acts that would be grounds for denial.

In addition to the licensure of physicians, the Board licenses and/or issues registrations or permits for the following professionals, although in smaller numbers:

- Special Faculty Permits – BPC § 2168
- Special Programs – BPC §s 2072, 2073, 2111, 2112, 2113, 2115; CCR § 1327
- 298 Licensed Midwives

- 1,360 Registered Dispensing Opticians (businesses)
- 3028 Spectacle Lens Dispensers
- 1204 Contact Lens Dispensers
- 10 Out-of-State Contact Lens Sellers
- 118 Research Psychoanalysts/Student Research Psychoanalysts
- Polysomnographic Trainees, Technicians, and Technologists (New program in 2012)
- Sponsored Free Health Care Event Out-of-State Physician Registration (regulations were finalized in August 2012 and no applications have been received to date)

The MBC also has responsibilities to:

- Determine if an international medical school will be recognized by the Board.
- Approves Outpatient Setting Accreditation Agencies.
- Evaluates physician specialty boards that are not affiliated with or certified by the AMBS but believe they have equivalent requirements.
- Issues Fictitious Name Permits (FNP).

The Board requires that all documentation, including the applicant's medical education and training, be primary source verified. This includes verification from all medical schools that the applicant attended and or graduated from, including completion of other specified forms to document education and training.

As part of the licensing process, all applicants are required to submit fingerprint images in order to obtain criminal history background checks from the DOJ and Federal Bureau of Investigation (FBI). Physician applicant fingerprinting was required beginning in 1991. The MBC reports that all physicians with a current license have been fingerprinted. Licenses are not issued until clearance is obtained from both DOJ and FBI. The Board receives subsequent reports from the DOJ following the initial submittal of fingerprints should there be any criminal occurrence. Subsequent arrest reports are reviewed by the Enforcement Program to determine if any action should be taken against the licensee.

The Board queries the National Practitioner Databank (NPDB) for certain applicants with issues of concern disclosed on the application or during the application process. The NPDB is a confidential information clearinghouse created by Congress to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S. The Board is also a member of the Federation of State Medical Boards (FSMB), and queries all applicants in the FSMB database for disciplinary actions taken by other states and jurisdictions. In addition, when disciplinary action is taken in another state and the FSMB receives notification, it automatically sends an email to the MBC indicating the action taken. This information is received by the Board's Enforcement Program which determines the appropriate action to take.

Physician Licensee Population					
		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Physician & Surgeon	Active	127,436	128,866	130,670	132,842
	Out-of-State	26,682	26,774	27,279	27,732
	Out-of-Country	854	837	830	830
	Delinquent	11,355	12,051	12,383	12,163
	Renewals	–	60,814	62,656	64,351

The MBC Licensing Program has set expectations and a Strategic Plan objective that U.S., International, and Postgraduate Training Authorization Letter (PTAL) applications be reviewed within 45 calendar days. The Program has met these goals for the 18 months and is currently reviewing all application types within 45 calendar days.

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

The Board has seen an increase in applications each year and anticipates that these numbers will continue to grow. The following chart identifies the licensure cycle times for each type of applicant as identified above. The average days are from the time of receipt of the application until licensure.

FY	2008/2009		2009/2010		2010/2011		2011/2012	
	Record Count	Average Days	Record Count	Average Days	Record Count	Average Days	Record Count	Average Days
US	3452	169	3849	188	3927	152	4013	142
International	1179	696	999	523	937	391	901	297
PTAL	56	800	262	1148	408	1271	437	1313*
Total	4687	--	5110	--	5272	--	5351	--
*If the two year required postgraduate training time of 730 days is subtracted, then the cycle time is 583 days, which includes time from issuance of a PTAL until postgraduate training begins.								

Since many areas are outside of the Board's control in the licensure cycle times, the goals for the Licensing Program in the Strategic plan are based on the length of time it takes to review an application and subsequent documents. This is an area where the Board has seen marked improvement over the last two years. The Licensing Program found efficiencies in the process and received additional staff. The improvements can be seen in the following chart. The Average Days is from the time of receipt of the application until the initial review (which results in licensure or a deficiency letter being sent to the applicant).

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

Continuing Education

Each physician is required to complete not less than 50 hours of approved continuing medical education (CME) during each 2-year period immediately preceding the expiration date of the license. However, any physician who takes and passes a certifying or recertifying examination administered by a recognized specialty board is granted credit for 4 consecutive years of CME for re-licensure purposes.

Physicians are required to certify under penalty of perjury upon renewal that they have met each of the CME requirements.

In the past, MBC conducted CME audits once a year; a largely labor-intensive manual process. Due to limited resources, the MBC did not perform CME audits between 2006 and 2011. In 2011, the MBC's Information Systems Branch (ISB) revamped the CME audit process into an automatic computer driven procedure. CME audits are performed on a monthly basis and randomly audits approximately 10% of the total number of renewing physicians per year. If selected for the audit, proof of attendance at CME courses or programs is required to be submitted. Upon receipt of documents a manual review is performed by staff to determine compliance with the law. Approximately 10% of the randomly selected physicians failed the audit in 2011.

Enforcement

Enforcement by the Board is far and away the Board's most critical public protection function. Indeed, physician safety and medical quality are among the most tangible and direct regulatory functions state government performs. Virtually everyone in California has contact with doctors and the medical establishment, and can identify the importance of safe medical practices.

BPC § 2319 requires the MBC to set goal of no more than 180 days average from the receipt of a complaint to the completion of an investigation, and for complex medical or fraud issues or complex business or financial arrangements the goal should be no more than one year to investigate.

Approximately 80% of complaints received are closed in the CCU. In FY 2011/2012 the average time in the CCU to either close a complaint or refer it to the district office for investigation was 83 days (Thus closing 80% of complaints within 180 days). The other 20% of the Board's complaints are referred to the field for investigation by a sworn peace officer.

In FY 2011/2012, the average time to complete an investigation was 264 days. Adding the average time in the CCU to the average time in the field for investigation, results in 347 days. (The goal of 180 days to complete an investigation has never been achieved by the MBC.)

Although the Board has no system to identify a case as complex or non-complex, the Board believes that the majority of the cases that are transmitted to the district offices for investigation are complex cases.

In FY 2007/2008, the Board established internal performance targets, including reducing case aging by 10-20% for investigations in the Board's district offices. This target was met, and since FY 2007/2008, the Board has reduced the average time to investigate a complaint from 324 days to 264 days, an average of 18.5% reduction.

The Board's 2012 strategic plan identifies an objective to reduce complaint processing average to less than 70 days, with 50-60% less than 50 days. At the time the MBC filed its Report in November 2012, this target had not been reached; however, the MBC pointed out at its February 1, 2013 board meeting that it had now met the goal.

The MBC is required to have an upfront review by a medical expert on almost all complaints involving quality of care (BPC § 2220.08). The CCU monitors the time it takes for a medical expert to review a complaint and, to reduce timeframes, CCU staff follows up with the experts to ensure they review the complaint in a timely manner.

Expert reviewers are critically important in the investigation and prosecution process, providing a resource in establishing violations or eliminating cases that should not be prosecuted. To improve the quality of expert reviewer work product and promote timely reviews, an 8-hour training course was developed in 2012. The training incorporates presentations from an ALJ, a district medical consultant, an attorney who represents physicians, and a Supervising DAG. Approximately 100 expert reviewers attended the training and the MBC was able to provide continuing medical education credit as inducement to attend. The MBC plans additional training sessions for expert reviewers. Training will also be provided on an ongoing basis to assist in training new experts as they sign contracts.

The MBC statistics reflect an increase of about 600 complaints in FY 2010/2011. Although it cannot verify the reason for the increase, the MBC has suggested it could be related to the Board's increased outreach efforts to inform the consumers of the Board through the "notice to consumers" requirement in 2010 that required physicians to notify their patients that they are licensed and regulated by the Board.

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

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

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

Fiscal Year	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Vacancy rate	9%	13%	15%	9%	18%

However, when compared to prior Sunset Reports, the number of investigations appears to have declined. The following is from the MBC's 2002 Sunset Report:

Enforcement Data: Physicians & Surgeons	FY 97/98	FY 98/99	FY 99/00	FY 00/01
Investigations Commenced	2,154	2,139	2,083	2,320

Note these numbers: in FY 00/2001 the MBC initiated 2,320 investigations, and in FY 11/12, 1,577 investigations were opened – a decrease of 42%.

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

Average times from complaint intake to the completion of the investigation, has also increased. In the Board's 2002 Report, in FY 00/01 it took 257 days on the average, and in FY 11/12 it took 347 – an increase of 74%.

Furloughs/Hiring Freeze – Staff were furloughed 2 days per month from February 2009 through June 2009. From July 2009 through June 2010, staff was furloughed 3 days per month. From April 2011 through April 2012, MBC's investigators were furloughed one day per month. This was a devastating loss of work force hours. Furthermore, the loss of pay caused some staff to retire prematurely, thus creating additional vacancies. In addition, the hiring freeze (effective August 2010) severely hindered the MBC's ability to fill vacant positions.

Vertical Enforcement Program – In 2005, stemming from an MBC Enforcement Monitor recommendation, SB 231 (Figueroa, Chapter 674, Statutes of 2005) created a pilot program establishing a vertical prosecution model, also known as vertical enforcement (VE) program to handle Board investigations and prosecutions. VE requires Board investigators and Attorney General (AG) Health Quality Enforcement Section (HQES) prosecutors to work together from the beginning of an investigation to the conclusion of legal proceedings.

The MBC and the HQES have used the VE program since 2006, and a number of modifications have been made since its inception to make the program more efficient. The MBC states that although the investigation timelines have shortened, it is unknown if this is due to VE, or if it is due to increased efficiencies in enforcement processes and procedures in general. In order to more fully determine the level of success of the VE program, the MBC and the AG have engaged in discussions of the accumulated data from the VE cases. At this time, the analysis of the VE program by the MBC and the AG has not been fully completed. The Committee anticipates greater detail to be furnished by the Board and the AG's office later in 2013.

What MBC has concluded thus far is that significant improvements in actions taken have occurred and are identified below. Comparing fiscal year (FY) 2006/2007 to FY 2011/2012:

- 47% more cases were referred to the AG;
- 74% more probation violation cases were referred to the AG;
- 49% more license restrictions/suspensions were imposed while administrative action was pending;
- 203% more cases were referred for criminal action;
- 35% more revocations were issued;
- 25% more cases resulting in probation were issued;
- 26% more disciplinary actions were issued.

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

A significant accomplishment in the Board's Report is the reduction of investigation times. The average time to complete an investigation in the field has been reduced from 324 days in 2008, to 264 in 2012 – an almost 20% reduction. The Board attributes this accomplishment to a number of factors, including the commitment of staff to perform at high levels, the ability to hire/replace staff, a reduction in furloughs, and the implementation of a Aged Case Council (cases that meet a chronologic milestone get the attention of the Chief and Deputy Chief of Enforcement for a case conference with the investigator to strategize on case resolution).

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

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

Mandatory Reporting – A number of reporting requirements are intended to inform the Board about possible matters for investigation. The MBC indicates that it engages in ongoing outreach efforts to educate and inform those who are required to submit mandatory reports to the Board.

BPC § 801.01– Requires reporting settlements over $30,000 and arbitration awards or civil judgments of any amount. The report must be filed within 30 days by either the insurer providing professional liability insurance to the licensee, the state or governmental agency

that self-insures the licensee, the employer of the licensee, or the licensee if not covered by professional liability insurance. The MBC believes that in general, it appears that these reports are being submitted as required, but the Board states that there is no way to verify if the Board receives 100% of the reports.

BPC § 802.1 – Requires physicians to report criminal charges; the bringing of an indictment charging a felony and any conviction of any felony or misdemeanor, including a verdict of guilty or a plea of no contest. These reports appear to be reported as required, according to the Board.

BPC § 802.5 – Requires a coroner who receives information, based on findings reached by a pathologist that indicates that a death may be the result of a physician's gross negligence, to submit a report to the MBC. The Board does not believe that it is receiving the reports as is required because the number of reports filed continues to decline. In FY 2006/2007 the Board received 22 reports compared to 4 in FY 2011/2012.

This is especially important because 2 of the Board's highest priorities involve cases of excessive prescribing and death. It appears the Board is not being notified of prescription drug overdose death cases because only one report was received in FY 2011/2012.

BPC §§ 803, 803.5 – Requires the clerk of a court that renders a judgment that a licensee has committed a crime, or is liable for any death or personal injury resulting in a judgment of any amount caused by the licensee's negligence, error or omission in practice, or his or her rendering of unauthorized professional services, to report that judgment to the board within 10 days after the judgment is entered. The court clerk is also responsible for reporting criminal convictions to the Board. The Board does not believe that it is receiving the reports from the court clerks as is required by statute because the number of reports filed pursuant to Section 803 continues to decline. In FY 2006/2007 the Board received 10 reports compared to 4 in FY 2011/2012.

BPC § 805 – Requires the Chief of Staff and Chief Executive Officer, Medical Director, or Administrator of a licensed health care facility to file a report when a physician's application for staff privileges or membership is denied or the physician's staff privileges or employment is terminated or revoked for a medical disciplinary cause. The reporting entities are also required to file a report when restrictions are imposed or voluntarily accepted on the physician's staff privileges for a cumulative total of 30 days or more for any 12-month period. The report must be filed within 15 days after the effective date of the action taken by the peer review body.

<u>Peer review reporting continues to be low</u>. In FY 2002/2003, the Board received 162 reports. In FY 2010/2011, the Board received 93 reports and in FY 2011/2012, 114 reports were received. A 2008 study by Lumetra titled *Peer Review in California Final Report, Comprehensive Study* evaluated the physician peer review process and reporting requirements. The report identified a number of concerns including inconsistencies in the way reporting entities conducted peer review and interpreted the law regarding reporting obligations.

In 2011, a new reporting requirement was established to deal with peer review actions taken by physicians and surgeons. *BPC § 805.01* – Requires the Chief of Staff and Chief Executive Officer, Medical Director, or Administrator of a licensed health care facility to file a report within 15 days after the peer review body makes a final decision or recommendation to take disciplinary action which must be reported under Section 805. This new reporting requirement was intended to provide the Board with earlier notification of disciplinary action being taken against a physician by a peer review body. The Board indicates that even though the reporting requirement is still new, it appears that the required reports are being submitted.

Another reporting requirement was established regarding outpatient surgery centers (surgical clinics). *BPC § 2240* – Requires a physician who performs a medical procedure in an outpatient surgery setting that results in the death of a patient to report the incident to the Board within 15 days after the occurrence. MBC is concerned that it may not be receiving the reports from physicians as is required by statute because the number of patient death reports filed each year is very low.

Allied Health Professions Regulated by the Medical Board

As noted above, the MBC also regulates other allied health professions through the following programs: Midwifery Program, Polysomnographic Program, Registered Dispensing Optician Program, Research Psychoanalyst Program. Attachments to the MBC Sunset Report contain an abbreviated sunset report for each of the Board's allied health professions. The following is a brief summary regarding each profession regulated by the MBC.

Midwifery Program

A licensed midwife is an individual who has been issued a license to practice midwifery by the MBC. The practice of midwifery authorizes the licensee, under the supervision of a licensed physician, in active practice, to attend cases of normal childbirth, in a home, birthing clinic, or hospital environment.

Pathways to midwife licensure include completion of a three-year postsecondary education program in an accredited school approved by the MBC or through a Challenge Mechanism. (BPC § 2513). Prior to licensure, all midwives must take and pass the North American Registry of Midwives (NARM) examination.

SB 1638 (Figueroa, Chapter 536, Statutes of 2006) required the MBC to create and appoint a Midwifery Advisory Council. The Council is made up of licensed midwives (at least half of the Council must be licensed midwives), a Board Member, a physician, and a member of the public (currently an individual who has used a licensed midwife). The Board specifies issues for the Council to discuss/resolve and the Council also identifies issues and obtains approval from the Board to develop solutions to the various matters. Some items that have been discussed include physician supervision, challenge mechanisms, required reporting, and student midwives.

SB 1638 also required licensed midwives to make annual reports to OSHPD on specified information regarding birth outcomes, and required the reported data to be consolidated by OSHPD and reported back to the Board for inclusion in the Board's annual report.

The fees collected for the Midwifery Program go into the Licensed Midwifery Fund. Although the Program began in 1994, the Fund does not have any approved budget appropriation. The MBC states that it will be seeking an augmentation to establish an appropriation in FY 2013/2014 to fund the personnel needed to administer the Midwifery Program. The Board would request repayment from the Midwifery Program for the staff resources to perform the licensing and enforcement functions of the Program. There have been no General Fund loans from the Licensed Midwifery Fund.

The Licensed Midwives submit an application and initial license fee of $300 and have a biennial renewal fee of $200. The renewal fee is about 70% of the fees received in the Licensed Midwifery Fund.

The table below shows the Midwifery Program licensee population, licenses issued and licenses renewed.

Licensee Population					
		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Licensed Midwife	Active	199	219	252	270
	Out-of-State	21	22	21	20
	Out-of-Country	0	0	0	0
	Delinquent	21	18	19	28
	Renewals	–	99	98	125

The Board approves midwifery schools by conducting a comprehensive assessment to evaluate the school's educational program curriculum and the program's academic and clinical preparation equivalent. Schools wishing to obtain approval must submit supporting documentation to verify that they meet the requirements of BPC § 2512.5. Currently there are 11 approved midwifery schools.

The Board requires each licensed midwife to document completion of 36 hours of CE every two years in areas that fall within the scope of the practice of midwifery as specified by the MBC.

The licensee population in the Midwifery Program is small and the number of disciplinary actions filed against licensees is also proportionally small with a total of 5 disciplinary actions being filed over the past 3 fiscal years. Of the 4 disciplinary actions that have been adjudicated, all have been resolved with either revocation or license surrender.

Although the licensee population is small, the MBC states that there have been complaints related to unlicensed practice. The Board states that it investigates and prosecutes, if appropriate, individuals providing midwifery services without the proper credentials. The Midwifery Program utilizes the Medical Board's disciplinary guidelines as a model for disciplinary actions imposed on midwives.

Polysomnographic Program

Polysomnography is the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. Polysomnography includes, but is not limited to, the process of analysis, monitoring, and recording of physiologic data during sleep and wakefulness to assist in the treatment of disorders, syndromes, and dysfunctions that are sleep-related, manifest during sleep, or disrupt normal sleep activities.

SB 132 (Denham, Chapter 635, Statutes of 2009) established the Polysomnographic Program, under the jurisdiction of the Board. This Program registers Polysomnographic technologists, technicians, and trainees that are involved in the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. In April 2012, the Board began accepting applications for the Polysomnographic Program.

Polysomnographic Trainee registration is required for individuals under the direct supervision of a supervising physician, Polysomnographic Technologist or other licensed health care professionals who provide specified supportive services. To qualify as a Polysomnographic Trainee, one must have either a high school diploma or GED and have completed at least 6 months of supervised direct polysomnographic patient care experience, or, be enrolled in a polysomnographic education program approved by the Board. Applicants must also possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association.

Polysomnographic Technician registration is required for individuals who may perform the services equivalent to that of a Polysomnographic Trainee under general supervision and may implement appropriate interventions necessary for patient safety. To qualify for a Polysomnographic Technician registration, an individual must meet the initial requirements for a Polysomnographic Trainee and have at least six months experience at a level of Polysomnographic Trainee.

Polysomnographic Technologist registration is required for individuals who under the supervision of a physician, are responsible for the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. Registration requirements include having a valid current credential as a Polysomnographic Technologist issued by the Board of Registered Polysomnographic Technologists, graduation from a polysomnographic educational program approved by the Board, and passage of the Board of Registered Polysomnographic Technologist examination given by the Board of Registered Polysomnographic Technologists.

When the MBC submitted its Report, in November 2012, the Program had not yet issued any registrations. According to the MBC's Website, verification of polysomnographic registration is not available on the MBC's license lookup function; verification of registrants may be obtained by contacting the MBC's Consumer Information Unit.

Registered Dispensing Optician Program

Regulation of Dispensing Opticians by the Board began in 1939, for individuals and firms filling prescriptions of physicians licensed by the Board for ophthalmic lenses and kindred products. Contact Lens Dispenser registration began in 1983, for individuals engaged in fitting and adjusting contact lenses at a registered dispensing optician business. Unregistered Individuals are allowed to perform these functions under the direct responsibility and supervision of a registered contact lens dispenser, who is present on the premises.

In 1986, legislation was enacted to require the registration of Spectacle Lens Dispensers (BPC § 2559.1). Unregistered Individuals are allowed to fit and adjust spectacle lenses under the direct responsibility and supervision of a registered spectacle lens dispenser, who is on the registered premises, as specified.

SB 640 (Craven, Chapter 853, Statutes of 1995) prohibited any person located outside of California from shipping, mailing, or delivering contact lenses to California residents unless registered with the Board. Registrants are referred to as Nonresident Contact Lens Sellers.

Currently, these 4 registrations make up the Registered Dispensing Optician (RDO) Program.

The fees collected for the RDO Program go into the Dispensing Opticians Fund. MBC carries out the investigative and prosecution functions and bills the Program for the costs of these services. According to the MBC: "In looking at the Program's reserve level, it appears the Program would need to seek a fee increase for FY 2013/2014. However, this Program has consistently underspent the budget appropriation over the last several years. Therefore, the Program should remain solvent in FY 2013/2014." There have been no General Fund loans from the Dispensing Opticians Fund.

According to the MBC, fees for the RDO Program have not increased since its inception. The registrants under this Program pay an initial registration fee and then a biennial renewal fee. The majority of the Program's revenue is received from the Registered Spectacle Lens Dispenser renewal fees. The RDO Program has budget authority for one position to perform the Program functions.

RDO Fee Schedule and Revenue

Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
Registered Dispensing Optician:							
Initial Registration	75.00	100.00	7,350	14,325	6,375	5,175	2.75%
Biennial Renewal	75.00	100.00	40,125	36,525	32,775	47,250	25.11%
Registered Contact Lens Dispenser:							
Initial Registration	75.00	100.00	7,950	7,650	5,775	6,075	3.23%
Biennial Renewal	75.00	100.00	26,250	26,250	30,225	30,225	16.06%
Registered Spectacle Lens Dispenser:							
Initial Registration	75.00	100.00	13,050	18,225	15,450	14,700	7.80%

Biennial Renewal	75.00	100.00	64,450	70,200	67,650	75,825	40.29%
Nonresident Contact Lens Seller:							
Initial Registration	100.00	100.00	200	200	--	--	0
Biennial Renewal Fee	100.00	100.00	300	200	500	400	94.12%

The tables below show the RDO registration population, RDO registrations issues and RDO registrations renewed.

Registration Population					
		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Registered Dispensing Optician	Active	1,165	1,146	1,161	1,170
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	205	210	205	190
	Renewals	–	485	421	582
Registered Contact Lens Dispenser	Active	827	874	902	948
	Out-of-State	7	9	9	8
	Out-of-Country	0	0	0	0
	Delinquent	239	255	253	256
	Renewals	–	366	384	420
Registered Spectacle Lens Dispenser	Active	2,045	2,130	2,182	2,258
	Out-of-State	35	32	29	36
	Out-of-Country	0	1	1	0
	Delinquent	832	818	802	770
		–	906	870	991
Nonresident Contact Lens Sellers	Active	11	12	11	10
	Out-of-State	11	12	11	10
	Out-of-Country	0	0	0	0
	Delinquent	0	0	0	0
	Renewals	–	3	5	3

The number of disciplinary actions filed against RDO Program registrants is small and generally results from notification that the registrant has been convicted of a crime. In all but one of the disciplinary actions filed as a result of conviction of a crime in the past two fiscal years, the registrant has been revoked or surrendered as an outcome of the action filed.

The majority of the complaints received regarding the RDO Program do not involve the inappropriate dispensing or furnishing of eyeglasses or contact lenses. Instead, the complaints typically involve business issues such as employing or advertising the services of an optometrist or physician to examine or treat the eyes. The MBC also receives complaints regarding unregistered businesses or registered business which do not have registered dispensers on staff. These complaints are considered urgent complaints, consistent with DCA guidelines. The RDO Program uses the MBC's disciplinary guidelines as a model for any disciplinary actions imposed on registrants.

The Board utilizes its citation authority to address and resolve complaints related to an unregistered practice. Of the nine citations issued within the past three fiscal years, six

informal conferences have been requested and held. The majority of the complaints involve either an unregistered employee working in a registered dispensing location or a business that is operating without being registered with the Board. The cases are resolved through an order of abatement requiring registration.

Research Psychoanalyst Program

The MBC began regulating Research Psychoanalysts (RP) in 1977. A registered Research Psychoanalyst is an individual who has graduated from an approved psychoanalytic institution and is registered with the MBC. A doctorate degree, or its equivalent, and graduation from a psychoanalytic institution approved by the Board is required prior to registration. Additionally, students who are currently enrolled in an approved psychoanalytic institution and are registered with the Board as a Student Research Psychoanalyst, may engage in psychoanalysis under supervision.

An RP may engage in psychoanalysis as an adjunct to teaching, training or research. "Adjunct" means that the Research Psychoanalyst may not render psychoanalytic services on a fee-for-service basis for more than an average of one-third of his or her total professional time, including time spent in practice, teaching, training or research.

Students and graduates are may not state or imply that they are licensed to practice psychology, nor may they hold themselves out by any title or description of services incorporating the words: psychological, psychologist, psychology, psychometrists, psychometrics or psychometry. The table below shows the RP registration population, registrations issued and registrations renewed.

Registration Population

		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Research Psychoanalyst	Active	86	87	92	87
	Out-of-State	7	6	6	5
	Out-of-Country	0	1	1	1
	Delinquent	24	26	25	31
	Renewals	–	79	4	80

An examination is not required prior to registration as an RP. Qualification for registration is based on educational requirements and training. An RP applicant must disclose on the application: (1) the names and locations of all schools where professional instruction was received; (2) the name and location of the school where psychoanalytic training was received. To verify this information, the applicant must request: (1) an official transcript verifying that a doctorate degree has been granted; (2) an official certification from the dean verifying the student's current status. The Board requires primary source verification and requires schools to send documents directly to the Board for review.

The MBC approves RP schools, and determines, based on documentation submitted by the institute, whether or not a school meets the mandated requirements. The MBC has approved 19 Research Psychoanalytic Institutions.

No disciplinary actions have ever been filed or taken against registered research psychoanalysts. Over the past three fiscal years, the Board has received only 4 complaints regarding research psychoanalysts who provide services under the auspice of their training program as an adjunct to teaching, training or research. The complaints received by the Board do not relate to the care and treatment being provided and instead relate to billing practices or other issues outside the jurisdiction of the Board. The RP Program utilizes the physician's disciplinary guidelines as a model for any disciplinary actions that would be imposed on registrants.

For more detailed information regarding the responsibilities, operation and functions of the Medical Board of California, please refer to the MBC's *Sunset Review Report 2012*. [1]

PRIOR SUNSET REVIEWS: CHANGES AND IMPROVEMENTS

The Medical Board of California (MBC) was last reviewed in 2005 by the Joint Committee on Boards, Commissions and Consumer Protection (JCBCCP).

During the previous sunset review, JCBCCP raised 12 issues. The final recommendations from JCBCCP contained a set of recommendations to address the issues. Below are actions which the MBC and the Legislature took over the past 8 years to address many of these issues, as well as significant changes to the MBC's functions. For those which were not addressed and which may still be of concern, they are addressed and more fully discussed under "Current Sunset Review Issues."

In November, 2012, the MBC submitted its required sunset report to this Committee. In this report, the MBC described actions it has taken since its prior review to address the recommendations of JCBCCP. According to the MBC, the following are some of the more important programmatic and operational changes, enhancements and other important policy decisions or regulatory changes made:

- **Continuation of the Medical Board of California.** The 2002 sunset review revealed numerous and significant problems with the MBC's enforcement and public disclosure practices, resulting in the enactment of SB 1950 (Figueroa, Chapter 1085, Statutes of 2002), which, among other things, required an independent enforcement monitor to be appointed to evaluate the MBC's enforcement system. The 2004 "Initial Report: Medical Board of California Enforcement Program Monitor" identified serious deficiencies in the MBC's enforcement program and in the MBC's "diversion" program. The Report suggested that the MBC should be continued. However, it made 65 specific recommendations, a number of which were appropriate for legislative consideration in 2005.

  Senate Bill 231 (Figueroa, Chapter 674, Statutes of 2005) enacted a number of the changes recommended by the Enforcement Monitor.

[1] Available on the MBC Website at http://www.mbc.ca.gov/publications/sunset_report_2012.pdf.

- **License fee increase.** Facing increased costs, and the loss of some 45 positions, including 29 in the enforcement program due to the 2001-03 statewide hiring freezes, the MBC's fund reserves had fallen to a critical level, and was headed for severe and increasing deficits. In 2005, SB 231 increased physician license fee limits, and the MBC increased the physician license and renewal fees from $600 to $790. The fee was decreased to $783 when the MBC's Diversion Program was eliminated in 2008. The current total fee received is $808, which includes a $25 mandatory fee for the Physician Loan Repayment Program. The MBC states that there is no current need to raise fees.

- **Vertical Prosecution.** The Enforcement Program Monitor and the JCBCCP recommended that the MBC should work with the AG's office and the DCA, and implement Vertical Prosecution.

  In 2005, SB 231 established a Vertical Enforcement and Prosecution (VE) pilot program in which DOJ attorneys are assigned to assist MBC investigators at the beginning of an investigation, and repealed that authority on January 1, 2008. Under this program, each complaint referred to a MBC's district office for investigation is simultaneously and jointly assigned to a MBC investigator and a DAG from the AG's Office. This team approach encourages early coordination and faster decisions, filings, and results. Subsequent legislation extended the sunset date several times. The current sunset date on the VE is January 1, 2014.

- **Physicians withholding records.** By statute (BPC § 2225), physicians have 15 days from the time they receive a patient's signed release to turn those medical records over to the MBC for its investigation of complaints. The JCBCCP noted that physicians routinely flout this legal mandate, and suffer almost no consequences for such violations. The JCBCCP recommended that the MBC must enforce existing law, and should be given additional tools so that investigations may proceed in a timely manner.

  SB 231 authorized the MBC to use its authority to cite and fine a physician for failure to provide requested records within the 15-day time period. AB 1070 Hill (Chapter 505, Statutes of 2009) further required all medical records requested by the MBC be certified. The MBC states that this has eliminated the need for investigators to request records a second time when the initial records received were not certified, thereby improving investigation timeframes.

  In addition, the MBC reports that in 2011, it trained all DAGs and MBC investigators regarding techniques for promptly acquiring medical records. Furthermore, the revision to the VE manual in July 2011 further specified the expected timeframe by which an investigatory task should be completed including standards for requesting medical records.

- **Remove Notice of Intent requirement (Code of Civil Procedure § 364.1).** The JCBCCP recommended that this requirement should be eliminated and replaced with a more effective provision. Section 364.1 required attorneys who wish to file a malpractice action against a physician to file a 90 day notice with the MBC of their

intent. The filed notices, however, were not helpful to the MBC. SB 231 repealed CCP § 364.1.

- **Reporting malpractice judgments.** The JCBCCP pointed out that BPC § 802 requires physicians to report settlements and arbitration awards against them, but not actual judgments, and recommend amending the law to also require reporting judgments to the MBC. SB 231 added the requirement to report malpractice judgments to BPC § 802.

- **Reporting misdemeanor convictions.** As recommended by the JCBCCP, SB 231 amended Section 802.1 to require a physician to report to the MBC all misdemeanor convictions substantially related to the qualifications, functions, or duties of a physician. Later, SB 1438 Figueroa (Chapter 223, Statutes of 2006) further amended these provisions to require all misdemeanor convictions to be reported to the MBC. Mandating that all misdemeanor convictions be reported requires the MBC rather than the licensee to make the determination whether a conviction is substantially related to the qualifications, functions, or duties of a physician.

- **Forum shopping.** The JCBCCP recommended that BPC § 2019 and Government Code § 11508 should be amended to minimize the problem of forum shopping. Together, these statutes permitted a defense attorney in an administrative case to look around the state for a judge that may be favorable to the defense's case, a practice known as "forum shopping."

  SB 231, amended the Government Code to require a case to be heard in a location selected by the state agency that is closer to the location where the transaction occurred or to where the respondent resides, unless the two parties agree to another location.

- **Study of the policy implications of public disclosure laws.** As recommended by JCBCCP, SB 231 required the Little Hoover Commission (Commission) to study and make recommendations on the role of public disclosure in the public protection mandate of the MBC. SB 1438 (Figueroa, Chapter 223, Statutes of 2006) placed the responsibility for the study on the California Research Bureau (CRB) of the California State Library.

  The CRB Report completed in 2008, suggested 11 policy options to improve public access to information about physician misconduct. The MBC indicates that some options require legislation to implement, but the MBC has implemented a couple of them without legislation. For example, the MBC expanded the physician profile on MBC's license lookup website to include information from the physician survey including board certification. The MBC also adopted a regulation in 2010 that requires a physician inform consumers where to go for information or where to file a complaint about a California physician.

- **Study of peer review.** The Legislature required the MBC to conduct a study of peer review reporting by November 2003 (BPC § 805.2). However, the study had not been conducted, at the time of the 2005 review because of the severe budgetary condition

of the MBC. SB 231 required a comprehensive study of the peer review process as it is conducted by peer review bodies, and to evaluate the continuing validity of the peer review laws (BPC §§ 805, 809-809.8). The July 2008 Lumetra report titled Peer Review in California Final Report, Comprehensive Study offered many recommendations of which most, if not all, would require legislation to implement. The report suggested redesigning the peer review process and creating an independent review organization; MBC posting of any action recommended by the independent organization on its Website; and revising the role of the MBC in the review process, including giving the responsibility of the 809 hearing to the MBC. SB 700 (Negrete McLeod, Chapter 505, Statutes of 2010) made enhancements to the peer review system related to the MBC.

- **Diversion Program.** As recommended by the JCBCCP, SB 231 called for the Bureau of State Audits to conduct a full review of the MBC's Diversion Program. BSA conducted the audit in 2007 and evaluated the effectiveness of the Program and made recommendations regarding its continuation, concluding that although the Diversion Program made a number of improvements, it must continue to improve its performance and procedures in order to adequately protect the public.

  In 2007, SB 761 (Ridley-Thomas) sought to extend the dates of the Diversion Program. Ultimately, the bill died and the Diversion Program law became inoperative and later repealed. The MBC no longer has a Diversion Program.

- **Board Restructuring.** AB 253 (Eng, Chapter 678, Statutes of 2007), sponsored by the MBC drastically changed the MBC's structure and membership. Previously, the MBC was made up of two Divisions, the Division of Licensing and the Division of Medical Quality. The Division of Licensing handled all policy decisions related to the MBC's licensing functions. The Division of Medical Quality dealt with all enforcement policy decisions. For the most part, each Division operated independently from the other Division. The MBC realized that this was not the best arrangement in order to meet its mission of consumer protection. AB 253 restructured the MBC to eliminate the two divisions, resulting in a single, unified MBC. The bill also reduced the membership from 21 Members, to 15 Members.

- **Adoption of certain decisions by Executive Director.** AB 253 also provided the authority for the Executive Director of the MBC to adopt default decisions and stipulated decisions for surrender. This was a significant change that created an expedited process for these decisions, thus improving consumer protection.

- **Headquarter Relocation.** In 2008, moved the MBC's headquarters from the Howe Avenue complex to the current Evergreen Street location along with other DCA boards.

- **Change in Leadership.** In April 2010, Linda Whitney was appointed as Executive Director of the MBC. Ms. Whitney was previously the MBC's Chief of Legislation.

- **Strategic Planning.** Since the last Sunset Review Report, the MBC has written and approved two Strategic Plans, in 2008 and 2012. Most recently, the Board adopted

the new 2012 Strategic Plan at its February 2012 meeting.

- **Information to the public.** The MBC developed a subscriber's list that allows any individual to go to the MBC's Website and sign up to receive "news" from the MBC via an email alert. Such information could be a disciplinary action taken against a physician, new proposed regulations, the release of the MBC's Newsletter, or notification of an upcoming meeting.

- **Application Status lookup.** The MBC implemented a system that allows any applicant to log into the MBC's secure Website and view the status of his/her application. This alleviates numerous applicant inquiries about the status of an application.

- **License lookup.** The MBC revamped its Website public disclosure screen (or license lookup). The public can verify that a physician's license is renewed and current, see any disciplinary action (or other actions, such as a conviction, malpractice judgment award, other state discipline, etc.), view the information physicians have provided in their physician survey (such as ethnicity, foreign language spoken, board certification, etc.), and view any disciplinary documents based upon the MBC's action.

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

- **Operation Safe Medicine.** The MBC established an enforcement unit solely devoted to the unlicensed practice of medicine (Operation Safe Medicine) in Southern California. The investigators within this unit are specially trained in undercover operations and take a proactive role in finding unlicensed individuals practicing medicine. This unit has conducted arrests, filed a number of cases with the district attorneys' offices, and actively works with other law enforcement agencies at the local, state, and federal levels.

- **Administrative Law Judge Training.** The MBC has coordinated with the Office of Administrative Hearings (OAH) to initiate training for the ALJs assigned to hear MBC cases (as specified in Government Code § 11371).

- **Steven M. Thompson Loan Repayment Program.** In 2005, the MBC worked with the California Medical Association on legislation to authorize a $50 voluntary fee for the Steven M. Thompson Loan Repayment Program. This program provides for the repayment of educational loans, up to $105,000, in exchange for an applicant's commitment to service in a designated underserved area for a minimum of three years. In 2008, AB 2439 (De La Torre, Chapter 640, Statutes of 2007) required an additional $25 on all initial and renewal licenses to fund the program.

- **Sponsored free healthcare events.** In compliance with BPC § 901, created by AB 2699 (Bass, Chapter 270, Statutes of 2010), the MBC was the first board in the DCA to adopt regulations to allow physicians who are licensed, but not in California, to participate in sponsored free health care events.

CURRENT SUNSET REVIEW ISSUES FOR THE MEDICAL BOARD OF CALIFORNIA

The following are unresolved issues pertaining to the MBC, or those which were not previously addressed by the Committee, and other areas of concern for this Committee to consider along with background information concerning the particular issue. There are also recommendations the Business, Professions and Economic Development Committee staff have made regarding particular issues or problem areas which need to be addressed. The MBC 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: (AB 2699 Implementation: Out-of-State Physicians Providing Free Health Care Services.) How many physicians and surgeons have been exempted from licensure pursuant to AB 2699?

Background: AB 2699 (Bass, Chapter 270, Statutes of 2010) exempts from California licensure specified health care practitioners who are licensed or certified in other states and who register with the board and who provide health care services on a voluntary basis to uninsured or underinsured persons in California, as specified.

The MBC states that it was the first board within DCA to enact regulations to implement these provisions set forth in BPC § 901. The regulations allow physicians who are licensed, but not in California, to participate in sponsored free health care events. The regulations provide the rules and documents for registration of sponsored free health care events and the physicians who volunteer their services. Physicians must hold a license in good standing in another state to register.

At the time of the writing of the Sunset Report, the MBC stated that since the regulations only became effective in August 2012, that no applications had yet been received.

Staff Recommendation: ***The MBC should inform the Committee how many physicians and surgeons have been exempted from licensure pursuant to the regulations adopted to implement AB 2699.***

ISSUE #2: Is a statutory change needed to accommodate changes to the United States Medical Licensing Examination?

Background: In its Sunset Report, the MBC has raised the following new issue. Individual state medical boards set their own rules, regulations and requirements for passage of examinations to demonstrate an applicant's qualifications for medical licensure. In California, the MBC receives examination results from the United States Medical Licensing Examination (USMLE) program, which is used to determine if an individual will be granted licensure to practice medicine in California.

The examination consists of three steps, which must be passed sequentially in order to be eligible to move on to the next examination step. The steps are defined as:

- Step 1: Focuses primarily on understanding and application of key concepts of basic biomedical sciences.
- Step 2: Focuses primarily on knowledge, skills, and understanding of clinical science that forms the foundation for safe and competent supervised practice.
- Step 3: Focuses primarily on the knowledge and understanding of the biomedical and clinical science essential for the unsupervised, general practice of medicine.

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

The USMLE Composite Committee and its parent organizations, the Federation of State Medical Boards (FSMB), and the National Board of Medical Examiners (NBME), have approved plans to change the structure of the USMLE. Step 3 is slated to be the first examination impacted. The USMLE has stated the changes to Step 3 will "occur no earlier than 2014". The plans call to divide Step 3 into two separate exams, one day in length each, and will focus on different sets of competencies. The two examinations will be scored separately and applicants must pass each. There may also be new testing formats to focus on competencies not currently addressed in Step 3. Step 3 of the USMLE will remain known as Step 3; however, it will be a two-part examination.

The MBC states that BPC § 2177 (c) may require legislative change to ensure the new testing format is addressed.

> BPC § 2177
> (a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the Board.
> (b) Applicants may elect to take the written examinations conducted or accepted by the Board in separate parts.
> (c)(1)An applicant shall have obtained a passing score on Step 3 of the United States Medical Licensing Examination within not more than 4 attempts in order to be eligible for a physician's and surgeon's certificate.
> (2) Notwithstanding paragraph (1), an applicant who obtains a passing score on Step 3 of the United States Medical Licensing Examination in more than 4

attempts and who meets the requirements of section 2135.5 shall be eligible to be considered for issuance of a physician's and surgeon's certificate.

MBC points out, that Board regulations may also require changes to ensure aspects of the new testing steps are addressed.

The MBC recommends that the language of BPC § 2177 be amended to accommodate two parts of the Step 3 examination, and any new evolving examination requirement.

Staff Recommendation: ***The MBC should submit to the Committee specific language to amend BPC § 2177 to accommodate two parts to Step 3 of the USMLE, and to accommodate future examination changes.***

ISSUE #3: (Physician Shortages Anticipated.) Should changes be made to allow Medical School Programs to utilize Accelerated 3-Year and Competency-Based Medical School Programs?

Background: The MBC has raised the following as a new issue in its Sunset Report. A nationwide physician shortage is projected to reach 90,000+ physicians by the year 2020. Nearly half of that shortage is projected for primary care doctors (family physicians, pediatricians, and family practitioners). The federal Affordable Care Act (ACA) contains provisions to relieve the projected shortage of primary care professionals. Combined with the Prevention and Public Health Fund and the American Recovery and Reinvestment Act, the ACA will provide for the training, development and placement of more than 16,000 primary care providers, including physicians, over the next five years.

A significant deterrent to becoming a physician is the substantial cost of medical education. At an estimate cost of $80,000 per year, a medical student can easily accrue a debt of up to $400,000 upon graduation.

In an effort to reduce the nationwide shortage of primary care doctors, as well as lessen burdens on medical students, there is a movement toward an accelerated 3-year curriculum. This curriculum would allow medical students to receive the same amount of education in a concentrated, modified year-round education schedule, by eliminating the existing summer breaks, which occur currently in the standard four-year program. Reducing or eliminating the summer breaks allows for an accelerated curriculum completion date.

One such example is the Texas Tech University Health Sciences Center School of Medicine which offers a Family Medicine Accelerated Track (F-MAT) curriculum that provides 10-12 medical students the opportunity to obtain a medical degree in 3 years with 149 contact weeks, as opposed to a traditional 4-year program of 160 weeks. In addition, the F-MAT does not require the medical school student to pass USMLE Step 2CS prior to graduation, unlike most Liaison Committee on Medical Education (LCME) accredited medical schools. However, the F-MAT students will be required to pass USMLE Step 2CS during their first year of postgraduate training. Normally, LCME accredited medical school graduates are required to pass USMLE Step 2CS as a graduation requirement and must pass USMLE Step 3 during residency training.

The F-MAT also has an incentive program where students are given a scholarship in their first year. It is estimated that approximately $50,000 can be saved by the student in an accelerated 3-year program. This is a substantial economic incentive to a potential medical student.

The MBC additionally indicates that other medical schools are proposing competency-based tracks for students that excel and can progress at a faster rate than the standard 4-year program. Other programs may also be examining major clinical instruction in clinical settings outside of a traditional hospital setting.

It remains unknown how many weeks of clinical training in each of the core subjects and the total number clinical training weeks are required for graduation. Therefore, the MBC states that it is currently unable to determine if these accelerated programs meet the requirements of BPC §§ 2089–2091.2.

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

Specifically:

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

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

The MBC points out that in addition to the expedited degree process, the practice of medicine has evolved such that the majority of clinical practice is no longer hospital based. The teaching of medicine must likewise be allowed to evolve with the practice.

The MBC recommends a review of the statutes to determine if increased flexibility is needed. If it is determined that a change is required, a provision to accommodate an accelerated medical degree program and other variations of clinical instruction outside of a hospital by an LCME accredited institution must be added.

Staff Recommendation: ***The MBC should commence, in cooperation with the appropriate stakeholders, a review of the applicable provisions of California law to determine if increased flexibility is needed in order to authorize LCME-accredited accelerated medical degree curriculum to meet the requirements for licensure in California. If it is determined that a legislative change is required, the MBC should submit to the Committee the appropriate amendment language.***

ISSUE #4: There should be consistency in the amount of time a physician and surgeon may be out of practice without receiving additional clinical training before renewing their license and/or allowing them to continue practice.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2229 mandates that protection of the public shall be the highest priority for the MBC, and that whenever possible disciplinary actions shall be calculated to aid in the rehabilitation of licensees.

In addition, the MBC's Disciplinary Guidelines provide that, in the event a licensee experiences a period of non-practice of more than 18 months while on probation, the licensee shall successfully complete a clinical training program prior to resuming the practice of medicine. This short timeframe (18 months) has been adopted because the licensee already is on probation, and an 18-month period of non-practice has been identified as the reasonable cut off point before a clinical training program is required.

However, for a physician who has let his or her license expire, BPC § 2456.3 states, in part, "a license which has expired may be renewed at any time within 5 years after its expiration." In order to renew the license, the physician must simply submit the renewal paperwork, CME verifications, and pay the fees and penalties. Hypothetically, the license can be returned to active status even if the physician has not practiced medicine for up to five or more years. For example, a physician who, during the last two renewal cycles, did not practice clinical medicine, and then allowed the license to lapse four years prior to renewing, could go back into some sort of clinical practice. The physician has not practiced for eight years, but can renew, pay fees, demonstrate that CME has been obtained, and go back into practice. Although the Board is not aware that this hypothetical ever has happened, it is a potential scenario that Board could face.

The Board recommends that legislation be considered to bring some consistency in the time that a physician may be out of practice before he/she has to show competency. If it is believed that five years is too long, then there may need to be a legislative change, but this is an issue worthy of study so it may be addressed. The study must include the availability of training programs to address re-entry training needs.

Staff Recommendation: ***The MBC should study the issue of whether allowing a physician to return to practice after a lapse in licensure or of practice of more than 18***

months without completing additional training provides adequate public protection. The MBC should make recommendations to the Committee on its findings.

ISSUE #5: Should there be a mandatory requirement for licensees to submit their Email address to the MBC, if they possess one?

Background: The MBC has raised the following as a new issue in its Sunset Report. The MBC believes it would be beneficial to require all licensees to provide the Board with an email address, if they possess one. Currently, providing an email address to the MBC is optional for applicants and licensees. An email address is requested on the application and renewal forms. When an email address is provided, it is considered confidential. When appropriate, the MBC sends some correspondence electronically instead of mailing to the physical address on record. This practice has proven to be a quicker, more convenient, and potentially more reliable delivery method while saving printing and postage costs. For example, the Board's Summer 2012 Newsletter was sent electronically via email to approximately 113,800 licensees and 6,800 applicants. In addition, when there is a FDA alert, it can be relayed in the same day the alert is released.

On rare occasions, licensee email addresses are used to send notices of important law changes, emergency regulations, as well as other urgent issues affecting licensees and public health. The MBC states that in such cases Executive and MBC staff review and approve these rare, relatively infrequent emails that are distributed.

The Board regularly posts information on its Internet Website to alert licensees of urgent issues. The Board also uses a subscriber list service to notify individuals about items of interest relating to the activities of the Board via email. Subscribers may choose to receive email alerts for some or all of the offered topics. This is a valuable tool to get important information to licensees and other interested parties, but it is not widely used by licensees. As of August 2012, there were less than 4,000 subscribers for each topic.

In addition, the MBC is moving to a new information technology (IT) system that will allow licensees to receive renewal notifications and other information via email. The new IT system will allow licensees the opportunity to choose the best method (i.e. electronically or U.S. Postal Service) of receiving information from the Board. SB 1575 Price (Chapter 799, Statutes of 2012) amended BPC § 2424 to allow the MBC to send email notifications for expired licenses. The Board wants to communicate with its licensees to provide the most current, meaningful, and important information in a 21st century manner, that is also respectful of the time that is taken going through email messages.

The MBC recommends a legislative change to require that licensees provide the Board with an email address, if they possess one. In addition, the language should state the email address provided will be confidential.

While Committee staff strongly agrees with the idea of using email addresses to communicate with licensees, staff questions the ultimate effectiveness of the proposed mandate. Since the MBC already requests email addresses on license renewal forms, and the proposed mandate is to require licensees to submit an email address, if they possess one. It leaves the possibility open of a licensee refusing or failing to submit an email address.

Furthermore, since the proposal to make it a requirement, licensees and violation of the law could be subject to disciplinary action unprofessional conduct under BPC § 2234 (a).

Staff Recommendation: ***The MBC should address the concerns of Committee staff stated above, and submit to the Committee appropriate amendment language regarding licensees providing email addresses to the Board, if they possess one. The language should additionally require the MBC to keep a provided email address confidential.***

ISSUE #6: Should the MBC continue to provide to the public information regarding a physician and surgeon's postgraduate training?

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 803.1 states the Board shall disclose a physician's approved postgraduate training; § 2027 further requires the MBC Website to contain everything required to be disclosed in section 803.1. The Board currently collects limited postgraduate training information, and will disclose it upon request, but only posts the number of years completed in postgraduate training. This information is based upon information self-certified by the physician. The names of all the postgraduate training taken are not easily obtained for posting, thus it is not disclosed on the Website.

The MBC states that this information is submitted by applicants for a physician license during the time in which most applicants are in the first or second year of postgraduate training. The Board only collects the postgraduate information at the time of licensure. Any additional training they receive is not collected by the Board.

Additionally, the Board does not currently request additional postgraduate training information that the applicant may have received. If the Board were to begin to require it, the Board might then be required to verify this additional information. The collection of this information and the posting would be a huge and costly task.

The Board is unsure of the added value to consumer protection with the addition of specific postgraduate training program information on a physician's profile. To most members of the public, postgraduate training information is not the important information to use to determine if this is the correct physician for the patient. What is important to the public is whether the individual is board certified and what the practice specialty is for the physician. This is the information most members of the public want to know and find valuable. This information is not required but most physicians do provide it on their survey.

The Board recommends that the law should be amended to eliminate the requirements for the Board to post a physician's approved postgraduate training.

Committee staff is cautious about reducing board disclosures about licensees. Such information is generally believed to be valuable for consumers to make informed choices about the licensed professionals that they deal with. However, the MBC has indicated that the information required to be posted may very well be outdated and irrelevant to the licensee's practice, and thus fall short of giving consumers sound choices based upon valid information.

Staff Recommendation: ***The MBC should further discuss this proposal with stakeholders, including those stakeholders representing consumer interests and advise the Committee of the results of those discussions, and if appropriate the MBC should submit to the Committee amendment language to eliminate the requirement for the MBC to post a physician's approved postgraduate training.***

ISSUE #7: Clarify that the employment of physicians and surgeons in Accredited Residency Training Programs and/or Fellowship Programs does not violate the prohibition against the Corporate Practice of Medicine.

Background: The MBC has raised the following as a new issue in its Sunset Report. A question has been raised regarding whether the employment of residents is a violation of the prohibition against the corporate practice of medicine.

BPC § 2052, provides in part:

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

BPC § 2400 provides in pertinent part:

> "Corporations and other artificial entities shall have no professional rights, privileges, or powers."

The policy in BPC § 2400 against the corporate practice of medicine is intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment. The MBC has a long standing interpretation that physicians in an ACGME accredited postgraduate training (accredited residency) and/or fellowships do not meet the criteria for the prohibition against the corporate practice of medicine for several reasons, including:

a. U.S. and Canadian medical school graduates training in California may practice medicine in an accredited residency program for up to 2 years before requiring a license to continue in the residency program. (BPC § 2065)

b. International medical school graduates training in California may practice medicine in an accredited residency program for up to 3 years. (BPC § 2066)

c. Residents do not practice medicine independently, since residents work under the supervision of a residency program director and other teaching faculty.

The MBC believes that the corporate practice of medicine issue regarding accredited residency programs and their residents should be clarified. The MBC has determined that the corporate practice of medicine as it relates to accredited residency and fellowship programs should be addressed as a specific exemption. The MBC states that there is clearly an emerging need to remove any possible misinterpretations regarding the corporate practice

of medicine for accredited residency programs. This will ensure California accredited residency/fellowship programs are not in danger of closing due to the concerns regarding the prohibition of the corporate practice of medicine.

The Board recommends that legislation be introduced to clarify that residents in California accredited resident/fellowship programs are exempt from corporate practice laws related to how they are paid.

Staff Recommendation: ***Committee staff agrees that the corporate practice of medicine issue regarding accredited residency programs and their residents should be clarified. The MBC should submit to the Committee specific language to clarify that participation in an accredited physician residency training program is not a violation of the prohibition against the corporate practice of medicine.***

ISSUE #8: Should the requirement for the MBC to approve non-American Board of Medical Specialties be eliminated?

Background: The MBC has raised the following as a new issue in its Sunset Report:

The Law and History. In 1990, SB 2036 (McCorquodale), sponsored by the California Society of Plastic Surgeons, among others, sought to prohibit physicians from advertising board certification by boards that were not member boards of the American Board of Medical Specialties (ABMS). It added BPC § 651(h) to prohibit physicians from advertising they are "board certified" or "board eligible" unless they are certified by any of the following:

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

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

To implement BPC § 651, the MBC adopted regulations which are substantially based on the requirements of ABMS, including number of diplomates certified, testing, specialty and subspecialty definitions, bylaws, governing and review bodies, etc. The most notable requirement relates to the training provided to those certified by the specialty boards. In the regulations, training must be equivalent to an ACGME postgraduate specialty training program in "scope, content, and duration."

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

- American Board of Facial Plastic & Reconstructive Surgery

- American Board of Pain Medicine
- American Board of Sleep Medicine
- American Board of Spine Surgery.

The MBC has also disapproved two boards:

- American Academy of Pain Management
- American Board of Cosmetic Surgery.

Consumer Protection Function. The purpose of the law and regulation is to provide protection to consumers from misleading advertising. Board certification is a major accomplishment for physicians, and while board certification does not ensure exemplary medical care, it does guarantee that physicians were formally trained and tested in a specialty, and, with the ABMS' Maintenance of Certification (MOC) requirements to remain board-certified, offers assurances that ongoing training, quality improvement, and assessment is occurring.

At the time the legislation was promoted, a number of television news programs covered stories from severely injured patients that were victims of malpractice from physicians who advertised they were board certified, when, in fact, they had no formal training in the specialty advertised. The law put an end to physicians' ability to legally advertise board certification if the certifying agency was not a member board of ABMS.

Is the Program Still Relevant? As explained, the law merely addresses advertising, and does not in any way require physicians to be board certified or formally trained to practice in a specialty or in the specialty of which they practice. Physicians only need to possess a valid physician's license to practice in any specialty. As prospective patients usually are covered by insurance, searching for a physician in most specialties is generally done through their insurance directory. At present, insurance companies generally only choose board-certified physicians for their panels, or those physicians whose credentials they have vetted.

The same is generally true for the granting of hospital privileges. Hospitals grant privileges after conducting a review of qualifications. This process, called "credentialing" will include looking into the background of a physician, including accredited training and board certification. For that reason, most physicians who are granted privileges will be board-certified in the specialty for which they are granted privileges, or similarly highly, formally trained.

Therefore, the "board certification" advertising prohibition is primarily meaningful for elective procedures; that is to say, those procedures that are not reimbursed by insurance or those performed outside of hospitals or hospital clinic settings.

Cost of Program. The cost for the MBC to administer the program has been minimal in recent years, since there has only been one recent application. It is likely that non-ABMS certifying boards have been deterred from filing applications due to the law, the strict regulations, the demanding review process, and the fee.

Processing the application for meeting the basic requirements can be done by an analyst. The evaluation of the medical training, however, must be performed by a physician consultant that is an expert with academic experience. Generally the consultant used is an emeritus professor of medicine and former training program director who has served on residency review committees. (Residency review committees are part of the ACGME/ABMS review process.)

Therefore, a medical education expert must be hired to perform a review of the specialty board's formal training program. The cost of the expert varies, but when the fee regulations were promulgated in the 1990s, it was estimated that such a review would require from 80 to 160 hours to complete. At present, the cost of hiring an expert would be from $5,000 to $11,000.

The current application fee for a specialty board application is $4,030. (The fee was determined not by hours, however, but by the average costs of all three boards at the time they had been reviewed.) By law, however, the Board has the authority to raise the fee to cover reasonable costs associated with processing the application.

Ultimately, the costs of processing specialty board applications has not been the major expense in this program. The cost comes when an application is denied, and litigation results, and thereby legal costs.

Risk of Lawsuits and Potential Payouts. Since the program's inception, the MBC has only denied two specialty boards. American Academy of Pain Management was denied, and filed four suits against the MBC, including one in Federal Court. American Board of Cosmetic Surgery applied for approval twice, was denied both times, and filed suit on the second denial.

The MBC states that it has prevailed in all litigation, but the cost has been considerable. While AG billing methods makes it difficult to ascertain the exact cost of legal representation specific to the suits, MBC estimates its litigation costs conservatively to be in excess of $200,000.

Use of Medical Consultants and Experts. When the original legislation was introduced in 1990, the MBC opposed the bill because it could see tremendous problems in implementation. The ABMS is a well-established, huge organization with tremendous resources, both in revenue, infrastructure, and expertise, far beyond the MBC’s resources.

The law asks the MBC to essentially perform most of the same tasks as the ABMS, the ACGME, and the specialty boards and their residency review committees – with a fraction of their resources. In contrast, the MBC must use academic medical training experts to conduct reviews and provide recommendations to the MBC. Unlike the ABMS process, the MBC is not a part of developing the curriculum or training programs, but is being required to consider whether or not the criteria for certification and the training provided is "equivalent" as defined by the regulation.

Other than the Board, Who Could Fulfill this Function? According to the MBC, three entities have the expertise to review and evaluate the quality of medical specialty boards'

training and certification criteria: (1) ABMS, (2) ACGME, and to a lesser degree (3) medical schools that provide ABMS designed and ACGME accredited residency training programs. Unfortunately, according to the MBC, it would be inappropriate for any of these entities to judge a competing specialty board training program.

Factors to Consider. To determine whether or not this program's benefits outweigh its cost, the MBC recommends consideration of the following:

1. The existing law is designed to prevent consumers from being misled by physician advertising – to deter physicians from advertising board certification. In that sense, the law has provided such a deterrent, and the MBC has the legal authority to combat this practice.

2. Physicians are not prohibited from advertising that they specialize in procedures for which they have little training or qualifications, and may advertise that they are members or "diplomates" of various boards that are not ABMS or the equivalent. The current law only relates to advertising, and does nothing to prevent physicians from practicing in specialties for which they are not certified.

3. The cost of processing applications has been minimal; however, the cost of litigation has been substantial. Should more specialty boards apply and be disapproved, it is likely that there will be future legal costs.

The Board recommends that the Legislature delete the provision requiring the MBC to approve non-ABMS specialty boards. For consumer protection, the law should continue to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the MBC. In addition, the law could be amended to prevent the use of other misleading terms.

Staff Recommendation: ***The MBC should submit a specific legislative proposal to the Committee to delete the provision requiring the MBC to approve non-ABMS specialty boards, and to prevent the use of other misleading terms. Consideration should be given to amending BPC § 651(h) to delete the MBC's authority to approve non-ABMS specialty boards, and to prevent the use of other misleading terms in physician and surgeon advertising, as recommended by the MBC.***

ENFORCEMENT ISSUES

ISSUE #9: Enforcement program shortfalls.

Background: In November and December of 2012, the *Los Angeles Times* published a series of four articles which were the outcome of an intensive review of the epidemic of prescription drug-related deaths in four Southern California counties. In the investigation, reporters examined coroners' records and interviewed doctors, regulators, law enforcement officials and relatives of those who died from overdoses. The investigators also created and

analyzed a searchable database of 3,700 drug related deaths during a 5-year span (2005-2011) in Southern California to identify those tied to doctors' prescriptions.

An examination of coroner records by the *Times* found that:

- In 47% of those cases (1,762 deaths) drugs for which the deceased had a prescription were the sole cause or a contributing cause of death.
- A small number of doctors were associated with a disproportionate number of those fatal overdoses. 0.1% of the practicing physicians (71 physicians) in the 4 counties wrote prescriptions for drugs that caused or contributed to 298 deaths. That is 17% of the total deaths linked to doctors' prescriptions.
- Each of the 71 physicians prescribed drugs to 3 or more patients who died.
- 4 of the physicians had 10 or more patients who fatally overdosed.
- One physician had 16 patients who died.

The *Times* found that the 71 physicians with 3 or more fatal overdoses among their patients are primarily pain specialists, general practitioners and psychiatrists. Four of the physicians have been convicted of drug offenses in connection with their prescriptions, and a fifth is awaiting trial on second-degree murder charges in the overdose deaths of 3 patients. The remaining physicians have clean records with the MBC, according to the *Times*.

[Note these numbers: in FY 00/2001 the MBC initiated 2,320 investigations, and in FY 11/12, 1,577 investigations were opened – a decrease of 42%.]

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

Average times from complaint intake to the completion of the investigation have also increased. In the Board's 2002 Report, in FY 00/01 it took 257 days on the average, and in FY 11/12 it took 347 – an increase of 74%.

The *Times* articles further stated that there are about 30 fewer investigators today than in 2001.

Historical background. Because of skyrocketing medical malpractice insurance costs, in 1975, AB 1 (Keene) enacted the Medical Injury Compensation Reform Act of 1975 (MICRA), a measure carefully designed to comprehensively address three issues — tort reform, medical quality control, and insurance regulation — that were of interest to the 4 sets of stakeholders "at the table" (physicians, lawyers, insurance companies, and patients).

MICRA created the cap of $250,000 for pain and suffering, emotional distress, and loss of companionship in malpractice suits, a cap that remains to this day and is unique to civil actions brought against professional licensees. In addition, attorney contingency fees were also limited.

As a trade-off in order to reach such a sweeping agreement, however, the medical profession had to make concessions too. The concession made was a new, improved, better equipped, less physician oriented and more publicly minded Medical Board. In addition, the Board would have its own enforcement team, trained peace officers that would investigate

complaints against doctors. Part of the Act required mandatory reporting to the Board of hospital discipline and malpractice awards.

The rationale of this compromise was simple. Punitive damages do not remedy injury. Prevention of malpractice that could occur, due to a more efficient Medical Board, would save lives and injury, and, after much debate, the bill was passed and a new Board was born.

The reforms of MICRA were balanced partially on the creation of a regulatory board which would engage in vigorous enforcement of the law against bad doctors in order to protect the safety of consumers.

In 2005, SB 231 (Figueroa) made a number of changes recommended by the MBC's Enforcement Monitor. Among those changes was the establishment of a Vertical Enforcement (VE) pilot program. Under VE, prosecutors from the Attorney General's (AG) Health Quality Enforcement Section (HQES) are paired with MBC investigators from the initial assignment of the case for investigation all the way through the final prosecution of the case. The idea is to bring about better cases and better outcomes for the safety of patients.

As initially drafted, the VE program in SB 231 in 2005 would have transferred the MBC's investigators to the HQES in the AG's office. This would have placed the investigator and prosecutor in the same office under the same agency, a practice, as is done in numerous other law enforcement shops throughout the country. Ultimately the transfer of investigators was taken out of the bill, but the idea of paring prosecutors and investigators from start to finish on a case remained.

Even though progress has been made in improving investigations and prosecution of disciplinary cases involving physicians and surgeons under VE over the last 6 years, there still is a long way to go to ensure the public is well protected.

Staff Recommendation: ***The VE program should be continued, and additional improvements should be identified which would further enhance the collaborative efforts of the MBC investigators and HQE prosecutors.***

ISSUE #10: (JURISDICTION OVER UTILIZATION REVIEW DECISIONS.) Should the Medical Board investigate complaints that relate to utilization review decisions in the workers' compensation system regarding physicians and surgeons who may have violated the standard of care?

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

In the workers' compensation system, an insurer or self-insured employer is entitled to retain a physician to conduct "utilization review" of treatment recommendations made by the injured worker's physician. This decision can have the effect of determining what treatment the injured worker will receive. The utilization review physician is supposed to exercise his or her independent medical judgment. However, concerns have been expressed by treating physicians that insurer or self-insured employer rules that violate the standard of care are being enforced by utilization review physicians. If this were the case, and a patient is harmed, it has been assumed that the utilization review physician's decision would be subject to MBC oversight. Recent actions and statements by the MBC staff contradict this assumption.

Complaints alleging that utilization review decisions made by California-licensed physicians that: (1) violate the standard of care, and (2) cause significant harm, have been rejected by MBC staff as being outside the Board's jurisdiction. Certainly, the MBC does not have the authority to direct an insurer to pay for treatment – that is within the authority of the Division of Workers' Compensation, but the existence of an administrative remedy for the harmed patient is no more a barrier to MBC jurisdiction over the physician than a medical malpractice award is to a patient harmed by standard of care violations in the group health care market.

Staff Recommendation: ***The MBC should have jurisdiction over medical decisions made by California-licensed physicians and surgeons who conduct utilization reviews. The MBC should also report to the Committee on its plan to direct enforcement staff to implement enforcement oversight over these decisions. The MBC should also make the worker' compensation system aware of this requirement.***

ISSUE #11: (PUBLIC DISCLOSURE PRACTICES OF THE MBC.) To what extent have the recommendations made by the California Research Bureau regarding public disclosure been implemented?

Background: SB 231 (Figueroa, Chapter 674, Statutes of 2005) required the Little Hoover Commission to conduct a study and make recommendations on the role of public disclosure in the public protection mandate of the MBC. SB 1438 (Figueroa, Chapter 223, Statutes of 2006) then transferred the responsibility to conduct the study to the California Research Bureau (CRB) of the California State Library. The study titled *Physician Misconduct and Public Disclosure Practices at the Medical Board of California* was completed November 2008 and offered 11 policy options for improving public access to information about physician misconduct.

Although some options required legislation to implement a couple of the recommendations, most could be implemented by the MBC without legislation. For example, the MBC expanded the physician profile on its license lookup Website to include items from the physician survey including board certification. In addition, the MBC adopted a regulation in 2010 that requires a physician inform consumers where to go for information or where to file a complaint about California physicians.

However, it is unclear to what extent that the other recommendations in the CRB Report have been implemented. Are there additional policy or regulatory changes that could be made by

the MBC to implement the recommendations? Are there statutory changes that should be made to implement recommendations in the report?

Staff Recommendation: ***The MBC should inform the Committee to what extent the 11 policy options recommendations made by the California Research Bureau have been implemented? In its response, the MBC should identify and recommend to the Committee whether additional MBC policies or regulations should be changed and whether additional legislation should be enacted to implement the recommendations made by the CRB.***

ISSUE #12: (SURGICAL CLINIC OVERSIGHT BY MBC.) Has MBC fully implemented all the provisions of SB 100? Are there functions that the MBC should continue to improve as it implements SB 100?

Background: SB 100 (Price, Chapter 645, Statutes of 2011) provided for greater oversight and regulation of surgical clinics, and other types of clinics such as fertility and outpatient settings, and to ensure that quality of care standards are in place at these clinics and checked by the appropriate credentialing agency. Accrediting agencies that accredit these outpatient settings are approved by the MBC. Specifically, SB 100 included the following provisions:

1. Laser or Intense Pulse Light Devices. On or before January 1, 2013, the MBC shall adopt regulations regarding the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures.

   In 2010 the MBC established the Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals (Advisory Committee) to determine the appropriate level of physician supervision at medical spa clinics. The Advisory Committee conducted several meetings on this issue; however, it is unclear whether recommendations were established and adopted. The MBC should update the Committee on the findings and recommendations of the Advisory Committee and whether the MBC has adopted the regulations relating to physician availability at clinics or settings that use laser or intense pulse light devices.

2. In vitro fertilization. The MBC shall adopt standards that it deems necessary for outpatient settings that offer in vitro fertilization.

   The MBC should inform the Committee how many outpatient settings that offer in vitro fertilization are currently accredited, and whether any new standards were adopted for outpatient settings that offer in vitro fertilization.

   Additionally, the MBC should inform its licensees that settings that offer in vitro fertilization must be accredited.

3. Clinics outside the definition of outpatient settings. The MBC may adopt regulations it deems necessary to specify procedures that should be performed in an accredited outpatient setting for facilities or clinics that are outside the definition of outpatient

setting.

The MBC should inform the Committee whether it has adopted regulations for clinics that are outside the definition of outpatient settings. Additionally, the MBC should inform its licensees of any regulations that are adopted.

4. Reporting Requirements. An outpatient setting shall be subject to specified adverse reporting requirements and penalties for failure to report.

   SB 100 subjected outpatient settings to the adverse event reporting requirements contained in Section 1279.1 of the Health and Safety Code. An outpatient setting must report to the Department of Public Health within 5 days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Adverse events include surgical events, product or device events, patient protection events, environmental events, criminal events, an adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. Civil penalties in the amount not to exceed $100 for each day that the adverse event is not reported may be assessed by DPH.

   The MBC should inform the Committee whether it has established an arrangement or a memorandum of understanding with DPH to obtain information on outpatient settings with adverse reports. Additionally, the MBC should notify all outpatient settings of this requirement and inform accrediting agencies of its obligation to report to the DPH adverse events that are found during inspections.

5. Information on the Internet Website. The MBC shall obtain and maintain a list of accredited outpatient settings from the information provided by the accreditation agencies approved by the MBC, and shall notify the public by placing the information on its Internet Website, whether an outpatient setting is accredited or the setting's accreditation has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency. Specifies the information that must be posted on the Internet Website.

   Committee staff tried searching the MBC's list of outpatient settings and encountered several flaws. First, the Internet page for Outpatient Surgery Settings is not easy or intuitively found on the MBC Website. Second, after accessing the Outpatient Surgery Setting Database, Committee staff found that you have to scroll through page after page of listings in order to find the information on the particular surgery center you are looking for. A consumer cannot just plug in the name of the surgery center they are looking for to get the information. Ultimately, the database is presented in such a way that it appears that the relevant information would at best be difficult for consumers to find. The MBC should update the database lookup so that consumers may more easily find useful information on an outpatient setting.

Staff Recommendation: *The MBC* should update the Committee on its efforts to implement SB 100, including: (1) The findings and recommendations of the Advisory Committee and whether the Board has adopted regulations relating to physician

availability at clinics or settings that use laser or intense pulse light devices; (2) How many outpatient settings that offer in vitro fertilization are currently accredited, and whether any new standards were adopted for outpatient settings that offer in vitro fertilization; (3) Whether the Board has adopted regulations for clinics that are outside the definition of outpatient settings; (4) Whether the Board has established an arrangement or a memorandum of understanding with DPH to obtain information on outpatient settings with adverse reports. The MBC should further do the following, and report back to the Committee: (1) Inform licensees and the public that settings that offer in vitro fertilization must be accredited. (2) Inform of any regulations for clinics that are outside the definition of outpatient settings that are adopted by the Board. (3) Notify all outpatient settings of the reporting requirement under Health and Safety Code § 1279.1 and inform accrediting agencies of its obligation to report adverse events that are found during inspections to the DPH. (4) Update the database lookup so that consumers may more easily find useful information on outpatient settings.

ISSUE #13: Implementation of peer review requirements pursuant to SB 700.

Background: In 2008 a study required by BPC § 805.2 was completed, which involved a comprehensive study of the peer review process. The study, performed by Lumetra, also included an evaluation of the continuing validity of BPC §§ 805 and 809 through 809.8 and their relevance to the conduct of peer review in California. The study found, among other things, that there were inconsistencies in the way entities conduct peer review, select and apply criteria, and interpret the law regarding BPC § 805 reporting and § 809 hearings. SB 820 (Negrete McLeod, 2009) sought to define the requirements and clarify the peer review process based on the results of the study; however the bill was vetoed. Subsequently, SB 700 (Negrete McLeod, Chapter 505, Statutes of 2010) was enacted, which focused on enhancements to the peer review system and made other improvements to peer review.

Staff Recommendation: ***The MBC should report to the Committee regarding the implementation of SB 700, and the extent to which it is receiving the reports required under SB 700.***

ISSUE #14: (BETTER USE OF HEALTH CARE INFORMATION.) Should the MBC engage stakeholders to identify areas in which alternative approaches may be used to analyze current data collected on healthcare facilities and practices in order to improve or enhance the practice of health care providers?

Background: The federal American Recovery and Reinvestment Act (ARRA), enacted by Congress in 2009, calls for the development of a nationwide health information technology infrastructure. To support its development, ARRA created the State Health Information Exchange Cooperative Agreement Program (HIE), which provides federal funding to states and "state-designated entities" to establish and implement statewide HIE networks.

HIE is defined as the mobilization of health care information electronically across organizations within a region, community or hospital system. The goal of the HIE is to

facilitate access to and retrieval of clinical data to provide safer and timelier, efficient, effective, and equitable patient-centered care. The HIE is also useful to public health authorities to assist in analyses of the health of the population. The systems also facilitate the efforts of physicians and clinicians to meet high standards of patient care through electronic participation in a patient's continuity of care with multiple providers.

In addition to the HIEs, various Federal agencies and insurance companies require hospitals to collect patient satisfaction data among other data. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) also requires hospitals to submit data on patient satisfaction as part of the re-accreditation process.

In light of the national focus on the use of health information technology, as well as the requirements of JCAHO and insurance companies, it is prudent that California begin to explore ways to utilize the aggregate data that is being collected to examine health care patterns across the state.

Staff Recommendation: ***Recommend that the MBC take steps toward creating a Task Force to discuss how aggregate data can be utilized for each task force member's respective purposes. The group would be requested to examine the aggregate data already required to be reported to federal government in order to identify trend lines across the state. Ultimately, these findings could be used to identify standards for best practices. Task force members may include the following:***

- ***Medical Board of California***
- ***California Hospital Association***
- ***Institute for Medical Quality***
- ***Joint Commission on Accreditation of Health Care Organizations***
- ***Department of Public Health***
- ***Institute for Population Health Improvement***
- ***Citizen Advocacy Center***
- ***Center for Public Interest Law***

ISSUE #15: (ADOPTION OF UNIFORM SUBSTANCE ABUSE STANDARDS.) Has the MBC adopted all of the Uniform Standards developed by the Department of Consumer Affairs Substance Abuse Coordination Committee? If not, why not?

Background: The Medical Board of California (MBC) operated a physician's substance abuse "Diversion Program" for 27 years, which utilized statutory authority granted to "divert" a physician into the Diversion Program for treatment and rehabilitation in lieu of facing disciplinary action. In 2007, the Diversion Program was terminated following the release of several audits exposing the egregious shortcomings of the program, which in many cases put patients at tremendous risk. Since the end of the diversion program, physicians dealing with alcohol or substance abuse issues, mental illness, or other health conditions that may interfere with their ability to practice medicine safely can seek private treatment and monitoring services. However, California is one of only 5 states in the United States that does not have a physician health program to coordinate and provide care and referral services for physicians suffering from these maladies.

The Legislature enacted SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) to establish within the DCA a Substance Abuse Coordination Committee (SACC) to develop uniform standards and controls for healing arts programs dealing with licensees with substance abuse problems by January 1, 2010. SB 1441 requires each healing arts board within the Department to use the uniform standards developed by SACC regardless of whether the board has a formal diversion program.

The SACC completed its work and developed uniform standards in 16 specific areas identified by SB 1441. The uniform standards were published in April 2011. Since that time various boards within DCA have struggled with the uniform standards. Some boards have been reluctant to adopt the standards, contending that the standards are optional, or that certain standards are not applicable.

However, the Legislative Counsel, in a written opinion titled Healing Arts Boards: Adoption of Uniform Standards (# 1124437) dated October 27, 2011, states: "[W]e think that the intent of the Legislature in enacting Section 315.4 was not to make the uniform standards discretionary but to 'provide for the full implementation of the Uniform Standards' . . . Accordingly, we think the implementation by the various healing arts boards of the uniform standards adopted under Section 315 is mandatory."

An Attorney General Informal Legal Opinion, February 29, 2012, and a DCA Legal Counsel Opinion, dated April 5, 2012 both agree with this opinion.

The MBC has not yet adopted the Uniform Standards. At its January 31, 2013 Enforcement Committee meeting, the staff assessment of the Uniform Standards was that 8 of the 16 standards did not apply to the MBC, since they specifically reference a diversion program or elements typically found in a diversion program. Ultimately, the Enforcement Committee did not move forward on the proposal, choosing instead to have staff draft a more complete plan to implement the Uniform Standards.

Staff Recommendation: ***The MBC should fully implement the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as required by SB1441. The MBC should report back to the Committee by July 1, 2013 of its progress in implementing the Uniform Standards.***

ISSUE #16: Stipulated settlements below the Disciplinary Guidelines.

Background: In October 2012, an investigative report by the *Orange County Register* (Register) found that from July 2008 to June 2011, the MBC settled with disciplined physicians for penalties or conditions which were below the MBC's own Disciplinary Guideline standards. In the negotiated settlements, which were the focus of the investigation, the *Register* found 62 of 76 cases in which patients had been killed or permanently injured had negotiated settlements with physicians. According to the *Register*, 63% of those cases were settled for penalties below the Board's own minimum recommendations under its Disciplinary Guidelines.

Often times licensing boards resolve a disciplinary matter through negotiated settlement, typically referred to as a "stipulated settlement." This may be done, rather than going to the

expense of lengthy administrative hearing on a disciplinary matter.

According to the Citizen Advocacy Center (a national organization focusing on licensing regulatory issues nationwide) "It is not uncommon for licensing boards to negotiate consent orders [stipulated settlements] 80% of the time or more."

A stipulated settlement is not necessarily good or bad from a public protection standpoint. However, it is important for a licensing board to look critically at its practices to make sure that it is acting in the public's interest when it enters into a stipulated settlement and that it is acting in the best way to protect the public in each of these stipulated decisions.

Each board adopts disciplinary guidelines through its regulatory process. Consistent with its mandated priority to protect the public, a board establishes guidelines that the board finds appropriate for specific violations by a licensee.

The disciplinary guidelines are established with the expectation that Administrative Law Judges hearing a disciplinary case, or proposed settlements submitted to the board for adoption will conform to the guidelines. If there are mitigating factors, such as a clear admission of responsibility by the licensee early on in the process, or clear willingness to conform to board-ordered discipline, or other legal factors, a decision or settlement might vary from the guidelines. At other times in a disciplinary case there can be problems with the evidence, but the licensee admits to wrongdoing in a matter and may be willing to settle a case without going to a formal hearing. However when there are factors that cause the discipline to vary from the guidelines, they should be clearly identified in order to ensure that the interest of justice is being served.

Staff Recommendation: ***The MBC should discuss with the Committee its policies regarding stipulated settlements and the reasons why it would settle a disciplinary case for terms less than those stated in the Board's Disciplinary Guidelines. What is the consumer protection rationale for settling administrative cases for terms that are below those in the Disciplinary Guidelines? Are these recommendations of the Attorney General's Office or decisions made by the MBC staff independent of the AG?***

ISSUE #17: (CPEI IMPLEMENTATION.) Why has the MBC not filled staffing positions provided under CPEI in FY 2010-11?

Background: In response to a number of negative articles about the length of time licensing boards take to discipline licensees who are in violation of the law, in 2010, the DCA launched the Consumer Protection Enforcement Initiative (CPEI) to overhaul the enforcement process of healing arts boards. According to the DCA, the CPEI is a systematic approach designed to address three specific areas: Legislative Changes, Staffing and Information Technology Resources, and Administrative Improvements. Once fully implemented, the DCA expects the healing arts boards to reduce the average enforcement completion timeline to between 12 - 18 months. The DCA requested an increase of 106.8 authorized positions and $12,690,000 (special funds) in FY 2010-11 and 138.5 positions and $14,103,000 in FY 2011-12 and ongoing to specified healing arts boards for purposes of funding the CPEI. As part of CPEI, the MBC was authorized to hire 22.5 positions, including 20.5 (non-sworn) special investigators and 2 supervisors/managers.

However, the MBC has had very little success in filling these positions. An MBC staff report dated January 11, 2013, indicates that of the 22.5, positions authorized in 2010, 2.5 allocated for the MBC performing investigations for the Osteopathic Medical Board and the Board of Psychology were transferred to those boards. Of the remaining positions, 2 were filled – a manager and an analyst in its CCU. This left the MBC with 18 unfilled CPEI positions.

According to the MBC the statewide budget crisis severely impacted its efforts to fill the remaining CPEI positions. Workforce cap position reductions, statewide hiring freeze, elimination of position due to a statewide mandate for a 5% salary saving reduction effectively eliminated all of the remaining CPEI positions.

In 2012, the MBC states that it was notified that it could reestablish the positions in the temporary help blanket as long as the Board always maintains a 5% vacancy rate to meet the required salary reduction level, and the MBC began the process of identifying positions to establish and hiring to fill those positions.

The MBC has determined that it will request the re-establishment of 14.5 positions in the following areas in order to improve the enforcement timeframes as originally planned in the CPEI. According to the staff report, the MBC has determined where those positions will be allocated to meet the demands of CPEI.

It is troubling to Committee staff that the MBC has not done more to fill these positions. It is the understanding of staff that the hiring freeze did not apply to filling the positions established by the CPEI BCP. If this is the case, why did the MBC not fill the positions or purse exemptions to the existing hiring restrictions?

In addition, the BCP authorized the MBC to hire 20.5 non-sworn special investigators. It is understood by the Committee that MBC staff may have some reluctance to hire non-sworn personnel to assist in investigations when the board's enforcement unit has been typically staffed with sworn (peace officer) investigators. However, if the reluctance to fill positions authorized by the Legislature is because the positions are not of the traditionally desired classification, it calls into question the management of the MBC, and whether the MBC is flaunting the will of the Legislature and undermining public protection. Clearly the Legislature expected that the boards would immediately fill these positions once approved by the Administration. Considering some of the major enforcement problems which have been identified regarding this Board , both in the media, by consumer advocates and by this Committee, and some of those problems being directly related to staffing issues, it seems completely inappropriate that this Board would stall for any reason in the hiring of additional investigators. It raises the question to what extent will the remaining CPEI positions, and the functions that the MBC intends for them to carry out, enable the MBC to achieve the goals established by CPEI?

Staff Recommendation: ***The MBC should update the Committee on the current status of its efforts to fill the CPEI positions. The MBC should further advise the Committee of the appropriate level of staffing necessary to implement the goals of CPEI.***

ISSUE #18: Reporting of Patient Deaths to the MBC.

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

In its Report, the MBC states that is concerned that it may not be receiving the reports from physicians as is required by statute because the number of patient death reports filed each year is very low. The MBC indicates that there is no way to currently verify if the Board receives 100% of the reports but those that are provided are submitted within the 15-day statutory timeframe. The Board has the authority to issue a citation to the physician for failing to file a report as required. The Board can also charge the failure to file the report as a cause of action in any administrative action being taken against the physician regarding the incident. The MBC states that it reminds physicians of their mandated reporting obligations in the quarterly Newsletter.

The MBC should inform the Committee how many deaths were reported pursuant to this section. Additionally, the MBC should take steps to inform, not only licensees but also accrediting agencies that accredit outpatient settings that this requirement exists. The Board should further coordinate with accrediting agencies how this requirement can be incorporated in the accrediting agencies' inspection reports of outpatient settings.

Staff Recommendation: ***The MBC should inform the Committee how many deaths were reported pursuant to Section 2240. Additionally, the MBC should take steps to inform, not only licensees but also accrediting agencies that accredit outpatient settings about the reporting requirement in Section 2240. MBC should also coordinate with accrediting agencies how this requirement can be incorporated in the accrediting agencies' inspection reports of outpatient settings.***

ISSUE #19: There appears to be a low use of the MBC's Interim Suspension Authority.

Background: Government Code § 11529 authorizes the administrative law judge of the Medical Quality Hearing Panel in the Office of Administrative Hearings to issue an interim order suspending a license of a physician, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare. When an ISO is issued, the MBC has 15 days to file and serve a formal accusation under the Government Code to revoke the license of the physician.

This interim suspension order (ISO) authority was the first of its kind for DCA's regulatory boards, and was established in 1990 by SB 2375 (Presley, Chapter 1597, Statutes of 1990). This provision was intended to immediately halt the practice of very dangerous physicians in egregious cases.

A number of the recent newspaper articles critical of the MBC's enforcement practices have highlighted the time it takes to remove a dangerous doctor from practice. Enforcement statistics from the MBC's sunset report show that for the last 3 fiscal years, an average of 23 ISOs or temporary restraining orders (TRO) have been issued.

	FY 2009/10	FY 2010/11	FY 2011/12
ISO & TRO Issued	19	22	28

In 2004, the MBC Enforcement Monitor's Initial Report stated: "MBC's enforcement output statistics indicate a troubling decline in the efforts to use the powerful ISO/TRO authority in the recent past. ISOs/TROs sought by HQE on behalf of the MBC diminished from a high of 40 in 2001–2002 to 26 in the 2003–04 fiscal year (a decline of 40%). Given the importance of these public safety circumstances, a decline in the use of these tools is a source of concern to the Monitor." Since that time, ISO/TROs have remained low. According to the MBC, it sought 36 ISOs in FY 2011/12 although there were only 28 granted.

In discussing the challenges faced with obtaining an ISO, regulatory boards often point out the level of standard that must be demonstrated to obtain the ISO, and the difficulty in filing a formal accusation within 15 days from the time the ISO is issued.

Committee staff raises the issue of whether there should be a lower standard in order for an ALJ to issue an ISO. Furthermore, should there be lengthier timeframes (longer than 15 days) for the filing of an accusation after an ISO has been issued? In addition, in cases where the MBC is seeking to simply restrict a physician's prescribing privileges (rather than suspend the entire license), it may be an appropriate consumer protection tool to lower the standard for obtaining an ISO and for lengthening the timeframes for filing an accusation against a physician.

Staff Recommendation: ***The MBC should inform the Committee of the reasons why it believes that the number of ISOs and TROs has remained low in recent years. The MBC should further advise the Committee on whether Government Code § 11529 should be amended to provide for changes to the ISO or TRO process, so that it may enhance its use by the MBC to quickly remove dangerous physicians from practice.***

ISSUE #20: Use of MBC's Authority to cite and fine physicians who fail to produce records within 15 days.

Background: In the 2005 JCBCCP review of the MBC, the issue of physicians withholding records in violation of BPC § 2225 was raised. Physicians have 15 days from the time they receive a patient's signed release to turn those medical records over to the MBC for its investigation of complaints. Subsequently, SB 231 amended Section 2225 to authorize the MBC to use its cite and fine authority for a physician for failure to provide requested records within the 15-day time period.

It is unclear whether the MBC has used this authority and whether this authority has proven helpful in obtaining physician compliance.

Staff Recommendation: ***The MBC should inform the Committee of its use of cite and fine authority under BPC § 2225. How many citations have been issued? What are the fine amounts that have been assessed? How has this authority worked to obtain compliance with the 15 day record production requirement?***

ISSUE #21: Require Coroner Reporting of Prescription Drug Overdose Cases to the MBC.

Background: The epidemic of prescription drug overdoses is plaguing the nation and the number of deaths related to prescription drugs is overwhelming. At a time when the Board believes it should be receiving more coroner reports than ever, the number of reports received is at an all-time low. Only four reports were received in FY 2011/2012, and only one of the reports indicated a drug related death.

A recent *LA Times* series that analyzed coroners' reports for over 3000 deaths occurring in four counties (Los Angeles, Orange, Ventura and San Diego) where the cause of death was overdose by prescription drugs. The analysis found that in nearly half of the cases where prescription drug overdose was listed as the cause of death, there was a direct connection to a prescribing physician. The report also found that more than 80 of the doctors whose names were listed on prescription bottles found at the home of or on the body of a decedent had been the prescribing physician for 3 or more dead patients, including one doctor who was linked to as many as 16 dead patients.

The Board has reason to believe numerous deaths have occurred in the state that are related to prescription drug overdoses. However, complaints regarding drug-related offences are often hard for the Board to obtain. In most instances, patients who are receiving prescription drugs in a manner that is not within the standard of practice are unlikely to make a complaint to the Board.

BPC § 802.5 requires a coroner to report to the Board when he/she receives information based on findings by a pathologist indicating that a death may be the result of a physician's gross negligence or incompetence.

This section requires the coroner to make a determination that the death may be the result of a physician's gross negligence or incompetence. In order to alleviate the coroners from making this determination in prescription drug overdose cases, all deaths related to prescription drug overdoses should be reported to the Board for further investigation. This would allow the Board to review the documentation to determine if the prescribing physician was treating in a correct or inappropriate manner. This would increase consumer protection and ensure the Board is notified of physicians who might pose a danger to the public so action can be taken prior to another individual suffering the same outcome.

The Board recommends that BPC § 802.5 be amended to require coroners to report all deaths related to prescription drugs to the Board.

SB 62 (Price) was introduced on January 8, 2013, and would expand the coroner reporting requirement to further require that a coroner to file a report with the MBC when the coroner receives information that is based on findings by, or documented and approved by a pathologist that indicates that a death may be the result of prescription drug use.

This proposed change would help to connect the dots and create a very necessary pathway for prescription drug overdose deaths to be reported directly to the MBC and other health care boards that can take necessary action against their licensees who may have been directly involved. If boards are receiving reports from coroners throughout the state, they will be better armed with the necessary tools to make a correlation to their licensees in overprescribing circumstances and take action.

The provisions of SB 62 are consistent with the recommendation made in the MBCs report.

Staff Recommendation: ***Statutory changes should be made to require a coroner to file a report with the MBC and any other relevant health care boards when the coroner receives information that is based on findings by, or documented and approved by a pathologist that indicates that a death may be the result of prescription drug use. MBC should also inform all coroners in the state about any statutory changes to the coroner reporting requirements.***

ISSUE #22: Controlled Substance Utilization Review and Evaluation System (CURES) and California Prescription Drug Monitoring Program (PDMP) Funding.

Background: In 1997, California established an automated prescription monitoring program (also known as CURES) within the DOJ, Bureau of Narcotic Enforcement, that required the electronic reporting of Schedule II drugs prescribed by physicians and dispensed by pharmacies. The goal was twofold; to assist law enforcement agencies in identifying possible drug diversion and to assist regulatory agencies in identifying prescribers who may be prescribing excessive medications to the public.

Since 2003, physicians have been able to obtain "patient history" or activity reports from DOJ to assist in identifying those patients who may be "doctor shopping" or may have altered the quantity of drugs prescribed from the original order. “Doctor shoppers” are prescription-drug addicts who visit dozens of physicians and emergency rooms to obtain multiple prescriptions for drugs. It was felt that if physicians and pharmacies had real-time access to controlled substance history information at the point of care it would help them make better prescribing decisions and cut down on prescription drug abuse in California. The Patient Activity Reports (PAR) were generated from DOJ after the physician made a written request for the report.

In 2005, SB 151 expanded the reporting to CURES to include any prescriptions dispensed for Schedules II and III. Reporting for Schedule IV prescriptions was added shortly thereafter. The CURES database grew to contain over 100 million entries of controlled substance drugs that were dispensed in California and DOJ responded to over 60,000 requests from practitioners and pharmacists for PARs.

In 2009, DOJ launched an online PDMP database to provide real-time access to PARs. The on-line system made it easier for physicians to track their patients' prescription-drug history and provided health professionals, law enforcement agencies, and regulatory boards with faster computer access to patients' controlled-substance records. Under the new system, a pain-management physician examining a new patient complaining of chronic back pain would be able to look up the patient's controlled-substance history to determine whether the patient legitimately needed medication or was a "doctor shopper". In the past, the physician's request would have taken several days for a response from DOJ. With the new on-line system, physicians should have been able to identify "doctor shoppers" and other prescription-drug abusers before they wrote them another prescription. Unfortunately, this system still needs to be upgraded to provide rapid response, made more user friendly, and available on the most up-to-date technology system (e.g. smartphone, tablet, iPad, etc.) in order to get the prescribers and dispensers who should be using the system, to actually use it in day-to-day practice.

The Budget Act of 2011 eliminated all general fund support of the CURES/PDMP, which included funding for system support, staff support, and related operating expenses. DOJ temporarily redirected 5 staff to maintain support for the system, which included such tasks such as processing new user applications, responding to emails and voicemails from users, etc. While 5 regulatory boards at the DCA provide some funding for system maintenance, the level of funding is inadequate to maintain a minimal functioning PDMP, and certainly not enough funding to enhance the system to meet today's demand.

With 7,500 pharmacies and 158,000 prescribers reporting prescription information annually, CURES is the largest online prescription-drug monitoring database in the U.S. Its goal is to reduce drug trafficking and abuse of dangerous prescription medications, lower the number of emergency room visits due to prescription-drug overdose and misuse, and reduce the costs to health care providers related to prescription-drug abuse.

Prescription-drug abuse costs the state and consumers millions of dollars each year and can have serious consequences for both abusers and the public. Each year, hundreds of people die from prescription-drug overdoses in California. A recent article published in the *American Medical News* indicates that real-time access to prescription drug monitoring program databases results in a sizeable drop in the number of inappropriate prescriptions written for opioids and benzodiazepines, according to a study in British Columbia.

The Board believes that maintaining and upgrading a CURES/PDMP is essential not only for the medical community utilizing the system but as a tool used by the regulatory boards to identify prescribers who are not providing California citizens with quality medical care and are contributing to the epidemic of prescription drug abuse in this State.

The MBC recommends that legislation be considered to provide an adequate funding source for CURES. The prescribers/dispensers should include physicians, dentists, pharmacists, veterinarians, nurse practitioners, physician assistants, osteopathic physicians, optometrists, podiatrists, pharmaceutical companies, and the public. This funding source should support the necessary enhancements to the computer system and provide for adequate staffing to run the system.

Staff Recommendation: ***The MBC should advise the Committee whether CURES is currently working for its investigatory and regulatory purposes. Does MBC query CURES as a tool in its investigations? Should it do so? MBC should provide an update on its usage by the Board, and how it can be improved. Does the MBC recommend that consideration should be given to using licensing fees of various health related boards to adequately funding CURES in the future and the these licensing boards have primary responsibility for any actions to be taken against its licensees?***

ISSUE #23: Exclude medical malpractice reports from requirements of a medical expert review by the MBC.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2220.08 requires that before a quality of care complaint is referred for investigation it must be reviewed by a medical expert with the expertise necessary to evaluate the specific standard of care issue raised in the complaint. While, the rationale for the up-front specialty review makes sense, it may not make sense in the case of Medical Malpractice cases that have been reported to the Board.

The Board believes that medical malpractice cases reported pursuant to section 801.01 after the civil action has been concluded would be appropriate to exclude from the upfront specialty review as well. Unlike complaints filed by the public, medical malpractice cases have had the benefit of review by a number of medical experts. Typically both the plaintiff and the defendant will obtain an expert to review the care provided by the physician and opine as to whether the standard of care was met.

Whether the case settles prior to trial or proceeds through the litigation process, it has been subjected to numerous reviews, all by medical experts. The outcome from the medical malpractice case is required to be reported to the Board by the insurance carrier or employer who pays the award on behalf of the physician. According to the MBC, there is little benefit to obtain an initial medical expert review on these cases and this additional review adds approximately two months to the time it takes to refer the case to investigation.

The Board recommends that medical malpractice reports be excluded from the requirements of section 2220.08 consistent with the exception made for reports filed pursuant to section 805.

Staff Recommendation: ***Legislation should be enacted to exclude medical malpractice reports from the requirements of a medical expert review under BPC § 2220.08.***

ISSUE #24: Require medical facilities to produce medical records within 15 days.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2225.5 (a) (1) requires a licensee to produce the certified medical records of a patient, pursuant to the patient's authorization, within 15 business days of the receipt of the request. However, subsection § 2225.5 (b) requires a facility 30 days to produce the certified records. This disparity may have been seen as appropriate prior to the implementation of Electronic Health Records (EHR).

However, today most facilities (hospitals) maintain EHRs, which reduces the time required to retrieve and prepare medical records in response to requests. In an effort to reduce investigation time, consideration should be given to whether there is a need to allow a facility twice the amount of time to produce records than is allowed for production from the office of a licensee.

Additionally, if a subpoena duces tecum were served, the facility would have 15 days to produce the same records that they would be allowed 30 days to produce if requested via patient authorization. Therefore, the disparity should be eliminated and consistency established by affording 15 days for production of medical records by both the licensee and facilities.

The Board recommends that the law be amended to allow a facility only 15 days to provide medical records, upon request, if the facility has EHRs.

Staff Recommendation: ***BPC § 2225.5 (b) should be amended to require a facility to produce medical records within 15 days, if the facility has implemented Electronic Health Records (EHR).***

ISSUE #25: Consider requiring the Department of Public Health and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility.

Background: The MBC has raised the following as a new issue in its Sunset Report. Pursuant to BPC § 805, certain peer review bodies must report actions pertaining to staff privileges, membership, or employment. Specifically, the chief of staff of a medical or professional staff or other a chief executive officer, a medical director or administrator of any peer review body, or a chief executive officer or administrator of any licensed health care facility or clinic must report the following within 15 days of the action:

- A peer review body denies or rejects a licensee's application for staff privileges or membership for a medical disciplinary cause or reason.
- A licensee's staff privileges, membership, or employment are revoked for a medical disciplinary cause or reason.
- Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a total of 30 days or more within any 12 month period for medical disciplinary reasons.

- A resignation, leave of absence, withdrawal or abandonment of the application or for the renewal of privileges occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason.
- A summary suspension of staff privileges, membership, or employment is imposed for a period in excess of 14 days.

The Board has noticed a decline in the number of 805 reports received, and indicated in the following chart:

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

The MBC suggests that the decline in reporting may be due to the fact the hospitals are finding problems earlier and sending physicians to remedial training prior to requiring 805 reporting. With the implementation of electronic health records and the mining of data, early identification is a real possibility. MBC further believes that the decline may also be due to hospitals not reporting.

However, because the Board does not have jurisdiction over the hospitals, it has no way of knowing the reason for the decline. The California Department of Public Health (CDPH) and other hospital accrediting agencies have the authority to review hospital records. In addition, these entities do inspections of the hospitals. If the CDPH had to send information to the Board based upon its inspections, it would allow the Board to review the information and determine if an 805 was received from the entity. If the Board did not receive the appropriate reporting, the Board would issue a fine to the entity and would also investigate the actions of the physician.

The MBC recommends amending existing law to require CDPH and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the MBC. The MBC also recommends a requirement that these entities notify the Board if a hospital is not performing peer review.

Staff notes that since MBC is the agency with jurisdiction to enforce the peer review provisions, it may be appropriate for MBC to enter into an arrangement such as a memorandum of understanding (MOU) with CDPH and hospital accrediting agencies to have this information referred to MBC.

Staff Recommendation: ***The MBC should further discuss with the Committee the proposal, and consideration should be given to MBC entering into an arrangement or a MOU with CDPH and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the MBC; and to further require that these entities notify the Board if a hospital is not performing peer review.***

ISSUE #26: Require that Expert Reviewer Reports be provided to the MBC in a timely fashion.

Background: The MBC has raised the following as a new issue in its Sunset Report. The Administrative Procedure Act (APA) includes limited discovery provisions that do not assist in discovering opposing expert information. The MBC states that in some instances, once the Board received this information, it has to amend the accusation and therefore increase the timeframe for administrative action. In the civil context, the best tool to find out information from opposing experts would be to depose the expert. However, the APA only allows depositions in extreme circumstances, which do not usually apply to Board cases (Government Code section 11511).

It may not be appropriate to amend and expand the discovery provisions under the APA, because the APA applies to all administrative hearings. Any modification to the APA exclusive discovery provisions would impact the disciplinary proceedings of other administrative agencies and perhaps add costs and delays to these proceedings. The MBC recommends that instead of making any changes to the APA, the best way to make changes regarding expert testimony as it relates to MBC disciplinary cases is to amend BPC § 2334 which relates to expert testimony in disciplinary cases before the Board.

The MBC states that since its implementation, Section 2334 has been beneficial to the DAGs prosecuting Board cases. First, upon receipt of an expert witness disclosure, the DAGs can assess the qualifications of the respondent's expert in relation to the Board's expert.

Second, based upon respondent's brief narrative of his/her expert's opinions, the DAGs can provide that to the Board's expert to see if it changes his/her previously expressed opinions in the case. If it does change the Board's expert's opinion in a material way, the DAGs can reassess the settlement recommendation in the case and, with client approval, make a revised settlement offer. In this manner, Section 2334 directly promotes settlement in Board cases, which can often result in imposition of public protection measures in advance of the case proceeding to hearing.

Third, where cases do not settle, the brief narrative required by Section 2334 is also helpful to DAGs in preparing the Board's expert to testify at the administrative hearing. Fourth, by requiring respondents to confirm that their experts have, in fact, agreed to testify, Section 2334 helps to prevent defense counsel from listing various experts, who have not actually agreed to testify at the hearing. Finally, in those cases where respondents fail to make the required disclosures, their experts are routinely excluded. Since discovery is so limited in proceedings governed by the APA, section 2334 provides at least some information to the DAGs and the Board on this most important aspect of quality-of-care cases.

While section 2334 has been beneficial, the MBC believes it could be improved. The legislative history of section 2334 reveals that, during the legislative process, consideration was given to requiring both sides to exchange expert witness reports. The Board requires its own experts to prepare expert witness reports that, under the APA, must be produced in discovery. Requiring respondents to produce expert reports addressing each of the quality-of-care issues raised in the pending accusation would be of enormous benefit to the entire disciplinary process. It is believed that more cases would settle prior to hearing, thus

avoiding the months of waiting by both sides while the parties await the commencement of hearings.

The deadline for both sides to make the required disclosures under section 2334 is only 30 calendar days prior to the commencement date of the hearing. That deadline is too late in the process and, as a result, can delay early settlement. If the date were, for example, 90 calendar days before the commencement date of the hearing or 180 calendar days after service of the accusation on respondent, then settlements may occur earlier, thus the imposition of public protection measures would occur sooner.

The term "commencement date" as used in Section 2334 should be defined and clarified. It should be the first hearing date initially set by OAH, regardless of any subsequent continuances of the hearing. There needs to be clarification on this term, since the MBC states that in one instance the Superior Court has construed the term to mean the date that opening statements are given. Such an interpretation makes the disclosure deadline a "moving target" when hearings are delayed. This prolongs the entire administrative disciplinary process and delays consumer protection.

The Board recommends amending Section 2334 to require the respondent to provide the full expert witness report. Additionally, there needs to be specificity in the timeframes for providing the reports, such as 90 days from the filing of an accusation. This would provide enhanced consumer protection, as the physician who is found to be in violation of the law would be placed on probation, monitored, or sanctioned in a more expeditious manner, according to MBC.

Staff Recommendation: ***Consideration should be given to amending BPC § 2334 to: (1) require a respondent to provide the full expert witness report; (2) clarify the timeframes for providing the reports, such as 90 days from the filing of an accusation.***

ISSUE #27: Licensed Midwives: Physician Supervision.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2057 authorizes a licensed midwife, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother and immediate care for the newborn. BPC § 2507(f) requires the MBC by July 1, 2003 to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery. Due to the inability to reach consensus on the supervision issue, the MBC bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery (CCR § 1379.19). Three previous attempts to resolve the physician supervision issue via legislation and/or regulation have been unsuccessful due to the widely divergent opinions of interested parties and their inability to reach consensus.

Although required by law, physician supervision is essentially unavailable to licensed midwives performing home births, as California physicians are generally prohibited by their malpractice insurance companies from providing supervision of licensed midwives who perform home births.

According to insurance providers, if physicians supervise, or participate, in a home birth they will lose their insurance coverage resulting in loss of hospital privileges. The physician supervision requirement creates numerous barriers to care, in that if the licensed midwife needs to transfer a patient/baby to the hospital, many hospitals will not accept a patient transfer from a licensed midwife as the primary provider who does not have a supervising physician. MBC states that California is currently the only state that requires physician supervision of licensed midwives. Among states that regulate midwives, most require some sort of collaboration between the midwife and a physician.

The MBC, through the Midwifery Advisory Council has held many meetings regarding physician supervision of licensed midwives and has attempted to create regulations to address this issue. The concepts of collaboration, such as required consultation, referral, transfer of care, and physician liability have been discussed among the interested parties with little success. There is disagreement over the appropriate level of physician supervision, with licensed midwives expressing concern with any limits being placed on their ability to practice independently. The physician and liability insurance communities have concerns over the safety of midwife-assisted homebirths, specifically delays and/or the perceived reluctance of midwives to refer patients when the situation warrants referral or transfer of care. MBC states that it appears the physician supervision requirement needs to be addressed through the legislative process.

In general, Committee staff agrees with the recommendation of MBC, noting that appropriate access to care, and patient safety would argue that an appropriate solution needs to be found regarding licensed midwife and physician supervision and/or collaboration.

Staff Recommendation: ***The MBC should reach a consensus with stakeholders on this important issue and then submit a specific legislative proposal to the Committee regarding the appropriate level of supervision required for the practice of midwifery.***

ISSUE #28: Allow Licensed Midwives to have Lab Accounts and obtain Medical Supplies.

Background: The MBC has raised the following as a new issue in its Sunset Report. Licensed midwifes have difficulty securing diagnostic lab accounts, even though they are legally allowed to have lab accounts. Many labs require proof of physician supervision. In addition, licensed midwives are not able to obtain the medical supplies they have been trained and are expected to use: oxygen, necessary medications, and medical supplies that are included in approved licensed midwifery school curriculum (CCR § 1379.30). The inability for a licensed midwife to order lab tests often means the patient will not obtain the necessary tests to help the midwife monitor the patient during pregnancy. In addition, not being able to obtain the necessary medical supplies for the practice of midwifery adds additional risk to the licensed midwife's patient and child.

The MBC, through the Midwifery Advisory Council held meetings regarding the lab order and medical supplies/medication issues and has attempted to create regulatory language to address this issue. However, based upon discussions with interested parties it appears the lab order and medical supplies/medication issues will need to be addressed through the legislative process.

Staff Recommendation: ***Legislation should be enacted to clarify that a licensed midwife may order laboratory tests, and obtain medical supplies. The MBC should submit a specific legislative proposal to the Committee regarding this recommendation.***

ISSUE #29: Clarify Midwifery education and clinical training.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2514 authorizes a "bona fide student" who is enrolled or participating in a midwifery education program or who is enrolled in a program of supervised clinical training to engage in the practice of midwifery as part of that course of study if: (1) the student is under the supervision of a physician or a licensed midwife who holds a clear and unrestricted California midwife license and who is present on the premises at all times client services are provided; and (2) the client is informed of the student's status. There has been disagreement between the MBC and some members of the midwifery community regarding what constitutes a "bona fide student." The MBC believes the current statute is very clear regarding a student midwife.

Some members of the midwifery community hold that an individual who has executed a formal agreement to be supervised by a licensed midwife but is not formally enrolled in any approved midwifery education program qualifies the individual as a student in apprenticeship training. Many midwives consider that an individual may follow an "apprenticeship pathway" to licensure.

The original legislation of the Midwifery Practice Act, included the option to gain midwifery experience that will then allow them to pursue licensure via the "Challenge Mechanism" detailed in BPC § 2513 (a) which allows an approved midwifery education program to offer the opportunity for students to achieve credit by examination for previous clinical experience. According to MBC, this provision was included to allow for those who had been practicing to meet the requirements for licensure. The statute clearly states a midwife student must be formally enrolled in a midwifery educational institution in order to participate in a program of supervised midwifery clinical training. A written agreement between a licensed midwife and a "student" does not qualify as a "program of supervised clinical training". Accordingly, these types of arrangements are not consistent with the provisions of BPC § 2514. A Task Force consisting of members of the Midwifery Advisory Council has recently been formed to examine this issue. However, the issue of students/apprenticeships may need to be addressed through the legislative process, according to MBC.

Staff Recommendation: ***Recommend legislation should be enacted to clarify when an individual is considered a bona fide student, and to clarify that a written agreement does not meet the requirement of a program of supervised clinical training. The MBC should submit a specific legislative proposal to the Committee regarding this recommendation.***

ISSUE #30: Clarify the role of a Midwife Assistant.

Background: The MBC has raised the following as a new issue in its Sunset Report. A concern revolves around the use of "assistants" by a licensed midwife and the duties the assistant may legally perform. It has been brought to the attention of the MBC that licensed midwives use midwife assistants. Currently, there is no definition for a midwife assistant, the specific training requirements or the duties that a midwife assistant may perform.

MBC states that the law does not address the use of a midwife assistant, the need for formal training or not, or the specific duties of an assistant. Current statute does not provide a licensed midwife with the authority to train or supervise a midwife assistant who is actually assisting with the delivery of an infant. The issue of a midwife assistant is not an issue that can be addressed with regulation with the current statutes that regulate the practice of midwifery. The issue of the midwife assistants should be addressed with legislation, according to MBC.

Staff Recommendation: ***The MBC should provide more information regarding the proposal to address the issue of midwife assistants in legislation.***

ISSUE #31: SB 122 implementation for Out-of-State Licensed Physicians.

Background: SB 122 (Price, Chapter 789, Statutes of 2012), among other things, made clarifications to the licensing by MBC of physicians who have attended foreign medical schools. The bill was intended to address a concern by the Author that physicians who have been practicing in other states in good standing for many years were being refused a license to practice in California because the foreign medical school they attended has not been recognized by the MBC, even though it may have been recognized in another state. The Author believed that the MBC should at least be able to have the discretion to review the practice and other qualifications of the physician and surgeon who has been practicing in another state, and make a determination whether they are competent to practice within California even though they may have attended a foreign medical school that is currently not on the MBC's approved list of medical schools.

The Author worked with the MBC in drafting the final amendments which went into the bill to provide the MBC with the tools it needs to license such physicians who had been practicing safely in other states for a number of years but who the MBC had refused to issue a license to because of attendance at an unrecognized medical school or at a disapproved medical school.

Ultimately the language identified by the MBC required a physician who had attended an unrecognized medical school must practice for 10 years in another state in order to become licensed in California, and a physician who had attended a disapproved medical school had to practice for 20 years in another state in order to become licensed in California.

Staff Recommendation: ***The MBC should advise the Committee of its implementation of SB 122. How many licenses have been issued under the new provisions? How does the MBC propose to handle those cases of physicians who have a mixed***

combination of medical education, having received part of their education at an unrecognized medical school, and part at a disapproved medical school? Does the MBC anticipate that regulations could authorize a physician with a mixed combination of education to become licensed under the 10 year requirement? Does the MBC think that further legislation is needed to clarify such cases?

ISSUE #32: Continued Utilization by the MBC of Vertical Enforcement Prosecution (VE).

Background: In 2005, SB 231 (Figueroa, Chapter 674, Statutes of 2005) created a pilot program establishing a vertical prosecution model, also known as vertical enforcement (VE) program to handle MBC investigations and prosecutions. VE requires Board investigators and Attorney General (AG) Health Quality Enforcement Section (HQES) prosecutors to work together from the beginning of an investigation to the conclusion of legal proceedings. The MBC and the HQES have used the VE program since 2006, and a number of modifications have been made since its inception to make the program more efficient.

In 2010, VE was extensively studied by Benjamin Frank, LLC. The report, titled *Medical Board of California – Program Evaluation* made several conclusions, including that the insertion of DAGs into the investigative process did not translate into more positive disciplinary outcomes or a decrease in investigation completion times, and recommended scaling back and optimizing DAG involvement in investigations. The AG's Office took great exception to certain portions of the report, namely the cost of VE in the investigation phase of the case and that greater DAG involvement under the VE model has not translated into greater public protection.

The MBC states that although the investigation timelines have shortened, it is unknown if this is due to VE or if it is due to increased efficiencies in enforcement processes and procedures in general. In order to more fully determine the level of success of the VE program, the MBC and the AG have engaged in discussions of the accumulated data from the VE cases. At this time, the analysis of the VE program by the MBC and the AG has not been fully completed. The Committee anticipates greater detail to be furnished by the Board and the AG's office later in 2013.

What MBC has concluded thus far is that significant improvements in actions taken have occurred and are identified below:

Comparing fiscal year (FY) 2006/2007 to FY 2011/2012:

- 47% more cases were referred to the Attorney General's Office,
- 74% more probation violation cases were referred to the Attorney General's Office,
- 49% more license restrictions/suspensions were imposed while administrative action was pending,
- 203% more cases were referred for criminal action,
- 35% more revocations were issued,
- 25% more cases resulting in probation were issued, and
- 26% more disciplinary actions were issued.

Committee staff anticipates hearing from the MBC and the AG as the sunset process moves forward. However, the VE program should continue and further ways should be explored to make the collaborative relationship between investigators and prosecutors more effective to carrying out a vigorous enforcement process to protect the public.

Staff Recommendation: ***Recommend continuing the VE program, and explore further ways to improve the collaborative relationship between investigators and prosecutors to improve the effectiveness of the MBC enforcement program.***

ISSUE #33: Should the MBC's authority to issue a cease practice order be expanded to situations where in the course of a fitness to practice investigation a licensee refuses to undergo a duly ordered physical or mental health examination?

Background: Under BPC § 820, the MBC may order a physical or mental health examination of a licensee whenever it appears that a licensee's ability to practice may be impaired by physical or mental illness. The examination order is part of the investigation phase, and allows the MBC to make a substantive determination that the licentiate's ability to practice his or her profession actually has become impaired because of mental or physical illness.

Failure to comply with an examination order constitutes grounds for suspension or revocation of the individual's certificate or license (BPC 821). However, the process for suspension or revocation for refusal to submit to a duly-ordered examination can be lengthy, as demonstrated by a recent court case in which a licentiate of the Board of Registered Nursing refused a psychiatric examination yet continued to practice for months thereafter (see *Lee v Board of Registered Nursing*, 209 Cal. App. 4th 793; 147 Cal. Rptr. 3d 269; Sept. 26, 2012).

To refuse or delay compliance with an examination order poses risks for consumers because of the possibility that a mentally or physically ill practitioner could continue to see patients until the MBC completes suspension or revocation proceedings under BPC § 821. Public protection would be better served if the MBC has the authority to issue a cease practice order in cases where compliance with an examination order under BPC § 820 is delayed beyond a reasonable amount of time (perhaps 15-30 days).

Staff Recommendation: ***Recommend amendments to the MBC's authority to issue a cease practice order to expand to situations where in the course of a fitness to practice investigation a licensee refuses to undergo a duly ordered physical or mental health examination.***

ISSUE #34: (REQUIREMENT FOR A FICTITIOUS NAME PERMIT.) Should the exemption for accredited outpatient settings to obtain a fictitious permit be removed?

Background: Current law requires that a physician and surgeon, whether as a sole proprietor, a partnership, group or professional corporation, who desires to practice in any other name must obtain and maintain a fictitious name permit that is issued by the MBC.

Additionally, BPC § 2285 provides that the use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit constitutes unprofessional conduct. This requirement does not apply to the following:

- Licensees who are employed by a partnership, a group, or a professional corporation that holds a fictitious name permit.
- Licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services, as specified.
- An outpatient surgery setting granted a certificate of accreditation from an accreditation agency approved by the MBC.
- Any medical school approved by the MBC or a faculty practice plan connected with the medical school.

SB 100 required that as part of the accreditation process, the accrediting agency shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest therein, to determine whether there have been any adverse accreditation decisions rendered against them. For the purposes of this section, "conducting a reasonable investigation" means querying the MBC and the Osteopathic Medical Board to ascertain if either the outpatient setting has, or, if its owners are licensed physicians and surgeons, if those physicians and surgeons have, been subject to an adverse accreditation decision. Additionally, SB 100 required the MBC to obtain and maintain a list of accredited outpatient settings and notify the public by placing the information on the Internet Website. The information to be posted includes the name, address, and telephone number of any owners and their medical license numbers, and the name and address of the facility.

Staff Recommendation: ***In order for the public to get accurate information on outpatient settings that do business under a fictitious name, BPC § 2285 (c) should be amended to delete the exemption for outpatient settings that are accredited.***

TECHNOLOGY ISSUES

ISSUE #35: What is the status of BReEZe implementation by the MBC?

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 MBC 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, SB 543 (Steinberg, Chapter 448, Statutes of 2011) was amended to authorize the Department of Finance (DOF) to augment the budgets of boards, bureaus and other entities that comprise DCA for expenditure of non-General Fund moneys to pay BreEZe project costs.

The MBC is scheduled to begin using BreEZe in the "Early Spring" of 2013. It would be helpful to update the Committee about MBC's current work to implement the BreEZe project.

Prior to the DCA BreEZe project, the Board determined that it was in need of a new information technology system that would allow data transfer with the Department of Justice (DOJ) as well as improve complaint processing. This Complaint Resolution Information Management System (CRIMS) would provide the Board with needed technological efficiencies that would assist in streamlining the enforcement process. The Board was beginning to develop requirements for this new system when the BreEZe project was initiated. Since the scope of the BreEZe project, which incorporated the requirements for CRIMS, was also a replacement of the Board's archaic licensing system, the Board stopped working on the CRIMS project and joined the DCA in working on the BreEZe project.

Staff Recommendation: ***The MBC should update the Committee about the current status of its implementation of BreEZe. What have been the challenges to implementing this new system? What are the costs of implementing this system? Is the cost of BreEZe consistent with what the MBC was told the project would cost? Will BreEZe interact with the AG's information technology to allow seamless and usable data to be transferred between the MBC and the DOJ?***

ISSUE #36: (PUBLIC DISCLOSURE.) The limited ten year posting requirement for the MBC's Website should be removed.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2027 was amended effective January 1, 2003 to require the Board to remove certain public disclosure information from its Website. Specifically, the amendment stated:

> "From January 1, 2003, the information described in paragraphs (1) (other than whether or not the licensee is in good standing), (2), (4), (5), (7), and (9) of subdivision (a) shall remain posted for a period of 10 years from the date the board obtains possession, custody, or control of the information, and after the end of that period shall be removed from being posted on the board's Internet Website. Information in the possession, custody, or control of the board prior to January 1, 2003, shall be posted for a period of 10 years from January 1, 2003."

The information contained in these subsections pertaining to a physician's license, that would require removal, include: any license or practice suspension/restriction; any enforcement actions (e.g. probation, public reprimand, etc.); any disciplinary action in California or any other state as described in BPC § 803.1; any current accusations; any malpractice judgment or arbitration award; any misdemeanor conviction that resulted in disciplinary action; and any information required pursuant to 803.1. The only items that would remain on a physician's profile on the Board's Website after ten years would be a felony conviction and hospital disciplinary action that resulted in termination or revocation of a physician's hospital staff privileges (unless those privileges were reinstated and then the information will only remain posted for 10 years from the date of restoration).

Although the statute requires the removal of the information from the Board's Website, these records are considered to be indefinitely public and therefore can be obtained from the Board's office via phone or in person. However, most members of the public would not know to call the Board unless they fully read and understood the Board's disclaimers. If the public does read the disclaimer and calls the Board, staff will copy the documents and provide them to the public.

The Board will begin the removal of the documents January 1, 2013. There are several concerns pertaining to the removal of this information. First, the MBC is unsure whether the removal of this information is beneficial to the public. In today's society, transparency is foremost in the public's mind. If the Board has information that it is not providing to the public in an easy to access format, the Board is not doing its due diligence related to transparency. No matter how many disclaimers the Board puts on its Website, and no matter how eye catching it may be, individuals have a tendency not to read the disclaimers. Therefore, the public will believe the physician he/she is looking up has never had any action taken by the Board. If a bad outcome occurs, and the individual subsequently finds that the Board had information but it wasn't posted on the physician's profile, this will raise concerns about the Board's effectiveness in protecting consumers.

Additionally, the MBC states that there is increased workload associated with the removal of this information. Currently, the Board receives very few requests for documents due to the fact the information is easily accessible and printable from the Board's Website. Once these documents are removed, if the public were to read the disclaimers, the Board's call volume will increase because the public will want to know whether there is information on a physician that "may" be available at the Board's headquarters, but cannot be posted on the Board's Website. This will result in additional inquiries to the MBC, and the workload associated with determining if there are documents available, making the copies, and either scanning and emailing the documents or mailing the documents (plus postage to mail).

While the MBC understands this information has an impact on a physician, the MBC also believes the public has the right to review the information and make its own decision regarding the physician based upon the circumstances of the case, including how long ago the action took place.

In addition, the statute provides that the information shall remain posted for 10 years from the date the MBC obtains possession, custody, or control of the information. However, this is vague. The MBC states that it is not sure if its interpretation of the law is what was intended

by the Legislature. For example, for individuals who are placed on probation, the Board has interpreted the law to mean that the 10 years begins from the effective date of the decision and that would be when the information was in the Board's possession. If an individual were on probation for 7 years, once probation was completed, the information would only be posted for those 3 additional years. The MBC states that it does not know if this was the Legislature's intention, or if the information should be posted for 10 years from the date the probation was completed. For malpractice judgments, the MBC interprets the law to mean the Board would keep this action on the Website for 10 years from the date the Board receives this information, not the date of the judgment. The MBC may not receive the information timely, and the judgment may have been issued a significant amount of time prior to the MBC's receipt, leading to inconsistency in how certain types of information is posted under the law.

The MBC recommends elimination of the 10 year posting requirement in order to ensure transparency to the public. The MBC further recommends that if the Legislature does not wish to eliminate the requirement for the 10 year posting, that it specify a date, or have the MBC do that in regulations, when the 10 years begins/ends for these cases.

Staff Recommendation: ***Recommend that in the interest of transparency and disclosure of information to the public, BPC § 2027 should be amended to remove the 10 year limit on how long information should be posted on the MBC's Internet Website.***

CONTINUED REGULATION OF THE PROFESSION BY THE CURRENT MEDICAL BOARD OF CALIFORNIA

ISSUE #37: Registered Dispensing Optician Program: Should the RDO Program be Transferred to Another State Agency?

Background: The MBC has raised the following as a new issue in its Sunset Report. The MBC regulates the allied health professions of registered contact lens dispensers, registered dispensing opticians, registered non-resident contact lens sellers, registered spectacle lens dispensers under the provisions of Chapter 5.5 of Division 2 of the BPC (Commencing with Section 2550) through the Registered Dispensing Optician Program (RDO Program).

In its Sunset Report, the MBC discusses transferring regulation of the RDO Program to another entity such as the State Board of Optometry (SBO) or to the Department of Consumer Affairs to be operated as a program, board or committee within the Department.

The MBC states that SBO reported it receives about 20-30 calls a month from consumers who believe they received services from an optometrist, when in reality they received services from an individual or business that is a registrant with the RDO Program. Almost all of these calls are complaint related and many times include a combination of issues which also involve an optometrist and optometric assistant. Further, many consumers do not understand that the functions of the optometrist and the RDO are different. Unfortunately,

consumers incorrectly assume that optometrists and registrants of the RDO Program are the same profession, resulting in confusion as to which agency a complaint should be submitted.

What may lead to further confusion is that current law does not allow optometrists and RDO registrants to have commingling business relationships. BPC § 655 provides that an optometrist shall not have any membership, proprietary, interest, co-ownership, landlord-tenant relationship, or any, profit-sharing arrangement in any form, directly or indirectly, with an RDO registrant and vice versa.

There have been lengthy legal battles regarding the validity of B&P Section 655; both the California State and United States Federal courts have made it clear that California law prohibits certain relationships between optometrists and RDO registrants and that these laws are valid and constitutional. The most recent ruling came from the United States Court of Appeals for the Ninth Circuit on June 13, 2012. The ruling affirmed the decision of April 2010 by a U.S. District Judge that the state acted well within its rights to prohibit these types of relationships. The Plaintiffs-Appellants, National Association of Optometrists & Opticians, LensCrafters, Inc., and Eye Care Centers of America, Inc., could seek review by an enlarged circuit panel or at the Supreme Court.

AB 778 (Atkins, 2011) would have authorized a registered dispensing optician, an optical company, a manufacturer or distributor of optical goods, or a non-optometric corporation to own a specialized health care service plan that provides or arranges for the provision of vision care services. It would have also allowed shared profits with the specialized health care service plan, contract for specified business services with the specialized health care service plan, and jointly advertise vision care services with the specialized health care service plan. This bill eventually died in the Senate Business, Professions and Economic Development Committee.

MBC has suggested that moving the RDO Program to the SBO might lead to more efficient investigation of complaints by eliminating the need for two agencies to investigate the same complaint when it involved an optometrist and an RDO Program registrant. The MBC has also suggested as another option to transfer the RDO Program to the Department of Consumer Affairs as a program or bureau.

Committee staff points out that The RDO Program has budget authority for one position to perform the Program functions. If the RDO Program were moved into its own program or bureau, it would no doubt demand more staff and thus, ultimately escalate costs and registration fees.

Staff does note, however, that there has been success over the last 20 years or more of combining related regulatory issues into a single board. Of particular note are the following:

- Combining of cosmetology regulation with barbering regulation into the Board of Barbering and Cosmetology.
- Combined regulation of the funeral home industry and the cemetery industry by the Cemetery and Funeral Bureau.
- Combined regulation of architects and landscape architects by the California Board of Architecture.

- Combined regulation of land surveyors, professionals engineers, geologists and geophysics by the Board for Professional Engineers, Land Surveyors and Geologists.
- Combined regulation of the electronic and appliance repair industry and the home furnishing and thermal insulation industry into the Bureau of Home Furnishings and Thermal Insulation, Electronic and Appliance Repair.
- Combined regulation of speech-language pathology and audiology along with the hearing aid dispenser regulation in the Speech-Language Pathology, Audiology and Hearing Aid Dispensers Board.

Although, practitioners have at times recoiled at the prospect of such combined regulation and fought against it, the successful combinations of related regulatory programs shown above demonstrate the reality that related professions may be successfully regulated together.

Staff Recommendation: ***Recommend the MBC to initiate discussions with the Department of Consumer Affairs, the State Board of Optometry, stakeholders from each of the interested professional groups, and interested consumer representatives to discuss the potential need, usefulness, or problems with transferring regulation of the RDO Program from the MBC to another board or program. The MBC should report its findings and recommendations back to the Committee by July 1, 2014.***

ISSUE #38: Consolidate the licensing and regulation of osteopathic physicians and surgeons under the MBC.

Background: Since the initiative establishing the Osteopathic Act and the Osteopathic Medical Board of California (OMBC) in 1922, California's public policy has been clear that osteopathic physicians and surgeons (DOs) are to be treated equally with physicians and surgeons (MDs) licensed under the MBC. BPC § 2453(a) states: "It is the policy of this state that holders of MD degrees and DO degrees shall be accorded equal professional status and privileges as licensed physicians and surgeons."

Moreover, this equality is so firmly established that it extends to a statutorily mandated rule of non-discrimination. BPC § 2453(b) states:

> Notwithstanding any other provision of law, no health facility subject to licensure under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, no health care service plan, nonprofit hospital service plan, policy of disability insurance, self-insured employer welfare benefit plan, and no agency of the state or of any city, county, city and county, district, or other political subdivision of the state shall discriminate with respect to employment, staff privileges, or the provision of, or contracts for, professional services against a licensed physician and surgeon on the basis of whether the physician and surgeon holds an MD or DO degree.

This equality, as well as the vastly coextensive education and training of MDs and DOs, and the exact parity of their unrestricted licenses and scopes of practice, raise a perennial question: Is there a continual need to have two separate regulatory bodies for these virtually

identical professions? The question is particularly timely in light of the Governor's well-publicized desire to eliminate redundancies and inefficiencies in state government, and particularly in the structure of the state's boards and commissions.

The primary difference between DOs and MDs appears to be essentially one of emphasis. According to the Osteopathic Board, DOs have a different philosophy of medicine, focused on the interrelationship of the body's systems, a focus MDs do not share. Aside from that, both professions apparently have identical licenses, identical scopes of practice, and must be treated by insurers, hospitals, and government entities identically. They are held to apparently virtually identical standards of practice by hospital Peer Review Organizations and liability insurers, and, both the Osteopathic Board and the MBC use the same prosecutors when their licensees are subject to formal accusations. MBC already conducts all investigations and HQE conducts all prosecutions for the Osteopathic Board. OMBC simply has too few licensees to support a separate enforcement program — at least one of the physicians highlighted in the *LA Times* series (Dr. Lisa Tseng) is an osteopath, and it took the OMBC many years to suspend her license.

Is there a continuing need for two separate boards to regulate those who hold unrestricted licenses as physicians and surgeons?

If DO regulation were transferred to the MBC, it would appear appropriate to include osteopathic physician membership on the MBC.

Staff Recommendation: ***The MBC should discuss with the Committee the possibility of consolidating the OMBC into the MBC to provide a single regulatory authority over all physicians and surgeons in California.***

ISSUE #39: (CONTINUED REGULATION BY THE BOARD.) Should the licensing and regulation of physicians and surgeons be continued and be regulated by the current Board membership?

Background: The public interest is best protected by the presence of a strong licensing and regulatory board with oversight over physicians and surgeons and the associated allied professions. Since the inception of MICRA in 1975, a strong and vigorous enforcement agency has been demanded in order to represent the interests of patients, their families and the people of California.

The MBC faces considerable challenges to being the consumer protection agency that is needed in the coming years. Sharp criticism has been levied against the board in recent years. However, the MBC has faced a number of challenges in seeking to fulfill its consumer protection mission: Budget crises, budget restrictions, hiring freezes, vacancies, staff furloughs have all contributed to limiting the Board's operations. However the Board needs be proactive in its approach; finding new ways to use technology to accomplish its consumer protection purposes.

The MBC should be continued with a 4-year extension of its sunset date so that the Legislature may once again review whether the issues and recommendations in this Background Paper have been addressed.

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