OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Board Meeting, Thursday, May 18, 2017
9:30 a.m.

Chino Valley Medical Center
5451 Walnut Avenue
Conference Center
Chino, CA 91710

OMBC Phone (916) 928-8390

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STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

OSTEOPATHIC MEDICAL BOARD OF CALIFONIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991
P (916) 928-8390 F (916) 928-8392 | www.ombc.ca.gov

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

BOARD MEETING

Date: Thursday, May 18, 2017
Time: 9:30 a.m. – 5:00 p.m. (or until the end of business)

Location(s): Chino Valley Medical Center
5451 Walnut Avenue
Conference Room
Chino CA 91710
(916) 928-8390

AGENDA

(Action may be taken on any items listed on the agenda and may be taken out of order, unless noticed for a certain time.) The Board plans to webcast this meeting on its website at https://thedcapage.wordpress.com/webcasts/ . Webcast availability cannot, however, be guaranteed due to limited resources or technical difficulties. The meeting will not be cancelled if webcast is not available. If you wish to participate or to have a guaranteed opportunity to observe, please plan to attend at a physical meeting location. Adjournment, if it is the only item that occurs after a closed session, may not be webcast.

Open Session

1. Call to Order and Roll Call / Establishment of a Quorum

2. Public Comment for Items Not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section except to decide whether to place the matter on the agenda of a future meeting [Government Code Sections 11125, 11125.7(a)]

3. Review and Approval of Minutes

   - January 20, 2017 Board Meeting

4. President's Report

   - Annual Federation of State Medical Boards (FSMB) Meeting
     - Forum Highlights
   - Clearinghouse for Continuing Medical Education by the American Osteopathic Association (AOA) for Non-AOA members for purposes of renewal of licensure

5. Administrative Hearing

   - 10:30 a.m. Brenda Steinberg, D.O. – Petition for Early Termination of Probation

6. Closed Session

   - The Board will meet in closed session pursuant to Government Code Section 11126(c)(3) to discuss disciplinary matters including the above petitions, petitions for reconsideration, stipulations, and proposed decisions.
   - Performance evaluation of the Executive Director pursuant to Government Code Section 11126(a)(1).
   - Adjourn Closed Session

   Return to Open Session

7. Presentation – Vincent DiCianni, Esq., Affiliated Monitors Inc.

   - Practice Monitoring for Probationers

8. Executive Director's Report – Angie Burton

   - Licensing – Statistical update/performance measure
   - Budget - Update
   - CURES – Statistical and Survey updates
   - Enforcement Report / Discipline – Corey Sparks

9. Legislation – Discussion and Possible Action

   - **SB 798** Healing arts: boards (Sunset Bill)
     - Osteopathic Medical Board specific:
       Amendments to B&P Code sections 114 and 2454.5
     - Other sections which affect Osteopathic Medical Board:
       B&P Code sections 803.1, 2064.5, 2065, 2082, 2096, 2135.5, 2143, 2228.1
   - **SB 572** Healing arts licensees: violations: grace period
   - **SB 715** Department of Consumer Affairs: regulatory boards: removal of board members
   - **SB 762** Healing arts licensees: activation fee: waiver
   - **SB 790** Health care providers: gifts and benefits
   - **AB 40** CURES database: health information technology system
   - **AB 505** Physicians and surgeons: probation
   - **AB 703** Professions and vocations: licenses: fee waivers
   - **AB 715** Workgroup review of opioid pain reliever use and abuse
   - **AB 845** Cannabidiol
   - **AB 1002** Center for Cannabis Research

10. Title 16 California Code of Regulations: Discussion and possible action to consider amendments to California Code of Regulations sections

    - 1635 Required Continuing Medical Education
    - 1636 Continuing Medical Education Progress Report
    - 1641 Sanctions for Noncompliance
    - 1661.2 Diversion Evaluation Committee Duties and Responsibilities
    - 1663 Disciplinary Guidelines (Senate Bill 1441 Uniform Standards)

11. Agenda Items for Next Meeting

12. Future Meeting Dates

13. Adjournment

For further information about this meeting, please contact Machiko Chong at 916-928-7636 or in writing 1300 National Drive, Suite 150 Sacramento CA 95834. This notice can be accessed at www.ombc.ca.gov

Government Code section 11125.7 provides the opportunity for the public to address each agenda item during discussion or consideration by the Board prior to the Board taking any action on said item. Members of the public will be provided appropriate opportunities to comment on any issue before the Board, but the Board President may, at his or her discretion, apportion available time among those who wish to speak. Individuals may appear before the Board to discuss items not on the agenda; however, the Board can neither discuss nor take official action on these items at the time of the same meeting. (Gov. Code, sections 11125, 11125.7(a).)

In accordance with the Bagley Keene Open Meeting Act, all meetings of the Board are open to the public and all meeting locations are accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting, may make a request by contacting Machiko Chong, ADA Liaison, at (916) 928-7636 or via e-mail at Machiko.Chong@dca.ca.gov or may send a written request to the Board's office at 1300 National Drive, Suite 150, Sacramento, CA 95834-1991. Providing your request at least five (5) business days before the meeting will help to ensure availability of the requested accommodation.

TAB 2

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991
P (916) 928-8390 F (916) 928-8392 | www.ombc.ca.gov

BOARD MEETING
MINUTES

Friday, January 20, 2017

BOARD MEMBERS PRESENT: Joseph Zammuto, D.O., President
Keith Higginbotham, Esq., Vice President
Cyrus Buhari, D.O., Board Member
Claudia Mercado, Board Member
Alan Howard, Board Member
Cheryl Williams, Board Member

STAFF PRESENT: Angelina Burton, Executive Director
Jason Hurtado, Esq., Legal Counsel, DCA
Machiko Chong, Executive Analyst
Corey Sparks, Lead Enforcement Analyst

BOARD MEMBERS ABSENT: James Lally, D.O., Board Member
Elizabeth Jensen, D.O., Board Member

The Board meeting of the Osteopathic Medical Board of California (OMBC) was called to order by President, Joseph Zammuto, D.O. at 10:00 a.m. at Department of Consumer Affairs (HQ2) - 1747 North Market Blvd., Sacramento CA 95834.

Dr. Zammuto called for a moment of silence to acknowledge the unexpected passing of the board's receptionist Susan Johnston.

Dr. Zammuto also acknowledged and thanked Michael Feinstein, D.O. who served on the board from 2012 through 2016, prior to voluntarily renouncing his board appointment due to health issues.

On behalf of the Business, Consumer Services and Housing Agency and the California Department of Consumer Affairs, Dr. Zammuto presented Dr. Lally with an award for his designation as the Physician of the Year by the American Osteopathic Foundation.

Dr. Krpan graciously accepted the award in Dr. Lally's absence and noted that he was proud of Dr. Lally's many achievements throughout his career.

1. Roll Call

Mrs. Chong called roll and Dr. Zammuto determined that a quorum was present.

2. Public Comment for Items Not on the Agenda

No Public Comment was received by the board.

3. Election of Officers

Board President

- Dr. Zammuto asked if there were any motions/nominations for election of Board President.
- Joseph Zammuto, D.O. was nominated for President

  Motion – C. Mercado, **Second** – C. Buhari.
- Dr. Zammuto opened the floor to additional nominations, none were given.
- Roll Call Vote was taken
  - **Aye** – Mrs. Blair, Dr. Buhari, Mr. Howard, Ms. Mercado, Mrs. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – None
  - **Absent** – Dr. Lally, Dr. Jensen
- Dr. Zammuto was unanimously elected for Board President.

Vice President

- Dr. Zammuto asked if there were any motions/nominations for election of Board Vice President.
- James Lally, D.O. was nominated for Vice President

  Motion – A. Howard, **Second** – C. Buhari.
- Dr. Zammuto opened the floor to additional nominations, none were given.
- Roll Call Vote was taken
  - **Aye** – Mrs. Blair, Dr. Buhari, Mr. Howard, Ms. Mercado, Mrs. Williams, Dr. Zammuto

- **Nay** – None
- **Abstention** – None
- **Absent** – Dr. Lally, Dr. Jensen

- Dr. Lally was unanimously elected for Board Vice President.

Secretary/Treasurer

- Dr. Zammuto asked if there were any motions/nominations for election of Secretary/Treasurer

- Cyrus Buhari, D.O. was nominated for Secretary/Treasurer
  Motion – J. Zammuto, **Second** – C.Mercado.
- Dr. Zammuto opened the floor to any additional nominations, none were given.
- Roll Call Vote was taken
  - **Aye** – Mrs. Blair, Dr. Buhari, Mr. Howard, Ms. Mercado, Mrs. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – None
  - **Absent** – Dr. Lally, Dr. Jensen
- Dr. Buhari was unanimously elected as Secretary/Treasurer.

4. Review and Approval of Minutes

Dr. Zammuto called for a motion regarding approval of the Board Meeting minutes of October 7, 2016.

- **Motion to approve the October 7, 2016 Board meeting minutes with no corrections. Motion** – Mr. Howard, **Second** – Mrs. Williams
- Roll Call Vote was taken
  - **Aye** – Dr. Buhari, Mr. Howard, Ms. Mercado, Mrs. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – Mrs. Blair
  - **Absent** – Dr. Lally, Dr. Jensen
- Motion carried to approve minutes with no corrections.

5. Executive Director's Report

Angie Burton updated the Board on licensing statistics, staffing, Board budget activity, and diversion program statistics.

Staffing - Mrs. Burton informed the board that the staffing level remained at 11.5 staff leaving no current vacancies. In late November, the board advertised to refill the office receptionist vacancy following the unexpected passing of Ms. Johnston. The board received 90 applications in response to the advertisement and after careful consideration and review of all submissions; interviews were conducted in late December. The board is happy to announce that Dina Ruprecht was selected to join the staff, and has also attended her first BreEZe training. Mrs. Burton also made note that the board is currently reviewing the budget to see if there is adequate funding to create a permanent intermittent position to assist both the licensing and enforcement units.

Ms. Mercado inquired on the amount that would be necessary to fund an additional position within staffing, and was informed by Mrs. Burton that the amount would be predicated on the position classification added. The board is looking to possibly hire a permanent intermittent Office Technician (OT) which has a starting salary of roughly $2,800 monthly. Permanent intermittent positions are only able to work a maximum of 1,500 hours per fiscal year, however the board would need to assess how many hours it would be able to absorb prior to implementing the new position.

CURES - DOJ estimates that as of November 15, 2016, roughly 4,262 Osteopathic Physicians and Surgeons have registered with the new CURES 2.0 database since it went live. Between August 15 - September 15, 2016 CURES was accessed 12,030 times solely by osteopathic physicians and the prescribing history reports of 24,017 patients were ran.

Mrs. Burton advised the board of impending fee changes that would be taking place on July 1, 2017 pursuant to the SB 1478 Omnibus Bill. The amended bill would no longer require physicians renewing as inactive status to pay the annual $6 fee for the CURES program. In addition to the fee change, the board also submitted a request to the BreEZe team to update the renewal form to accurately reflect the amendments. The first set of renewals to reflect the fee change would be those licenses expiring July 2017.

Mrs. Burton informed the board of the CURES survey that had been compiled and distributed by UC Davis Medical Center to those osteopathic physicians that were renewing in the month of December. She made note that at least 20% of the osteopathic physicians renewing during the specified timeframe participated in the survey, and added that the Medical Board of California received roughly a 23% participation rate.

Ms. Mercado questioned what the overall goal of the survey was, and was advised by Mrs. Burton that it was administered so that the researchers could gain a better understanding of the database and see how it has been utilized by physicians and their counterparts thus far.

Mrs. Blair inquired about the postage costs incurred to administer the survey, and was informed by Mrs. Burton that the board only utilized paper and copier resources during the transmittal process. All other fees were paid by UC Davis.

Enforcement/ Discipline - The boards Lead Enforcement Analyst Corey Sparks presented the enforcement report to the board.

Mr Howard inquired about the timeframe of the average field investigations and why the closure rates drastically fluctuated throughout the year. He also asked if there was a way to obtain or compile a matrixs that further detailed the board's open cases that are older than the 1 year goal and subsequently over 2 or 3 years to better understand why the cases were taking longer to close. He was informed by Mr. Sparks that many of the cases once opened are either routed to DOI or HQIU, and that many of the cases were still in HQIU awaiting processing due to low staffing which has made it a little difficult to close the cases that have been routed over in a timely manner.

Mr. Sparks also noted that twelve (12) of the boards Expert Reviewers have attended the training that was put on by the Medical Board of California in an effort to better assist them in completion of their reports of the enforcement cases reviewed. The board's training attendees were:

Rolf Knapp, D.O., Family Medicine; Richard Bond, D.O., Geriatrics; Shirley Wong, D.O., OB-GYN; John Kowalczyk, D.O., Urology; Gary Gramm, D.O., Family Medicine; Donna Marino, D.O., Pediatrics; Dan Miulli, D.O., Neurosurgery; Geraldine O'Shea, D.O., Internal Medicine; Marc Lynch, D.O., Pain Management; Deborah Arsenault, D.O., OB-GYN; Brian Loveless, D.O., OPP; & Eric Lindvall, D.O., Orthopedics.

6. Administrative Hearing(s)

10:35 a.m.

- Janet Pragit, D.O. - Petition for Early Termination of Probation

The Office of Administrative Hearing (OAH) Administrative Law Judge (ALJ) Marcia Larson conducted the above hearing.

7. Closed Session

The Board met in closed session to deliberate on the petition for early termination of probation of license listed above pursuant to Government Code section 11126(c)(3).

Return to Open Session

8. Budget Report – Mark Ito, DCA Budgets Office

Mr. Ito provided the board with an updated analysis of the board's current budget and gave an in-depth explanation of the budget report and projected expenditures.

9. Board Outreach - Veronica Harms, DCA Deputy Director of Communications

Ms. Harms introduced herself to the board and gave a brief overview of her employment background highlighting some of the campaigns that she had previously worked on throughout her career. She provided the board with an example of an outreach video that had been created by her staff for the Medical Board, and made note that the board would be tasked with creating a script for the video and the videographer would piece together the content and make additional edits as needed prior to dissemination. She explained that all of the services that would be offered to produce the outreach content are included in the monthly pro rata paid by the board. Ms. Harms included that the unit would also be willing to create a Facebook and Twitter page at the board's request which they would put online to assist in the boards outreach efforts. Ms. Harms briefly discussed the other services that the Communications Unit offered for publication and design, as well as offering editing and digital print services.

Dr. Zammuto asked about the timeline of developing outreach content and was advised by Ms. Harms that it would be immediate once request was made by the board.

Ms. Mercado inquired what metrics were used to track the progress of the outreach campaign and was advised by Ms. Harms that currently there were no metrics in use. However, Google analytics and Facebook post analytics may be used to better gauge outreach progress.

Dr. Zammuto asked the students in attendance what they felt the best mode of communication would be in terms of outreach and was informed that facebook posts and the mini videos that are utilized in the timeline feeds would be a great way to increase outreach regarding osteopathic physicians and surgeons. With the videos you are able to play them on your screen without having to open an alternate site. Although the videos are short they convey enough information for the viewer to gain a better understanding of the content provided.

10. Title 16 California Code of Regulations: Section 1636 Continuing Medical Education Progress Report

Discussion and possible amendments to Business and Professions Code 2454.5

Mrs. Burton informed the board members of the meetings that she held with both board appointed legal counsel and the Senate Business and Professions Committee regarding the proposed regulatory changes that would be made to the board's Continuing Medical Education (CME) requirement. It was decided that it would be in the best interest of the board to revise the current CME statutes to ensure that the proposed language would be enforceable once the regulatory changes occur. The board members were presented with the proposed statutory language that would be amended the Business and Profession Code statute 2454.5 regarding the CME cycle. The amendments would align the CME and license renewal cycles. The CME requirement would be changed from 150 hours every 3 years to 100 hours every 2 years to align with the 2 year license renewal.

Dr. Zammuto called for a motion to accept the proposed statutory language which would amend Business and Professions Code 2454.5.

- **Motion to accept the proposed language which would amend Business and Professions Code 2454.5. Motion** – Mr. Howard, **Second** – Dr. Buhari.

Dr. Zammuto called for public comment.

Kathleen Creason, Director of Osteopathic Physician and Surgeons of California (OPSC) made note that the association is in strong support of the proposed amendments being made to the current CME structure. Mrs. Creason included that the current statute verbiage has created a lot of confusion among licensees regarding the timeframe in which all CME must be submitted in accordance to the renewal cycle.

- Roll Call Vote was taken
  - **Aye** – Mrs. Blair, Dr. Buhari, Mr. Howard, Ms. Mercado, Mrs. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – None
  - **Absent** – Dr. Lally, Dr. Jensen
- Motion carried to accept proposed language.

Regulations Section(s):

- **1635 Required Continuing Medical Education;**
- **1636 Continuing Medical Education Progress Report;**
- **1641 Sanctions for Noncompliance**

The board members reviewed the proposed language which would amend California Code of Regulations Section(s) 1635, 1636, and 1641 regarding implementation of the audit process and self-certification of CME to the board by licensees. Mrs. Burton

explained that further dialogue took place with the CME compliance coordinators in office after the October 2016 board meeting, during which time the board discussed possible implementation of a hybrid audit process. After the meetings conclusion board staff informed management that utilization of a hybrid audit would increase workload. The hybrid audit would require review of AOA hours and trigger a subsequent review of allopathic CME submitted to the compliance coordinators well after the initial pre-cursory review of osteopathic CME, resulting in workload duplication.

The proposed regulatory language would require the staff complete a 100% audit at a later time. It would also require that every osteopathic physician who is up for licensure renewal complete the proposed self-certification form that will be included with every renewal application. The physician would need to report the number of hours completed during the specified reporting cycle, indicate whether the pain management criteria has been completed and also require that the physician sign under penalty of perjury acknowledging that all requirements have been met as detailed.

The board would divide the audit process into two phases upon conclusion of the CME reporting cycle. The CME Compliance Coordinators would select a random population of physicians to audit that equaled 50% in the first year, leaving the remaining 50% to be audited after conclusion of the 4 year cycle. This change would prevent further backlogs as the office averages roughly 750 renewals every other month.

Dr. Zammuto wanted to further relay that the self-reporting form will in fact be a legally enforceable document which may result in disciplinary action such as penalties and fines, and noted that the physicians will ultimately be held responsible. Mrs. Burton added that the board does currently have a mechanism in place to issue a citation and fine which is set at roughly $1,000 for any physician who fails to comply with the CME requirement. In the event that a physician fails to comply with the audit request for submission of renewal documentation, the board will then have the ability to cite and fine the physician and require s/he to also submit the deficient CME requirement.

Mr. Howard inquired on how the board would complete CME audit selections, and how they would ensure that the same person is not erroneously selected twice to complete the audit. Mrs. Burton informed him that the audit would be random and that the BreEZe database may have the ability to randomly generate a report of physicians that would be selected to submit documentation at the time of renewal. Additionally, Mrs. Burton was not entirely sure of the BreEZe databases' ability to prevent duplicate data extraction for audit requests and stated that it may have to be done manually. However, she stated that it would be looked into prior to implementation.

Mr. Howard also inquired whether the regulatory language would specify the percentage of physicians who would be audited throughout the year, and was advised by Mrs. Burton and Mr. Hurtado that it was not necessary to include that in the proposed

language. Inclusion of the CME audit process in the regulatory language would allow the board to audit the CME requirement at its discretion. Omission of the audit percentage would prevent processing constraints from being placed on the board. Mrs. Burton added that the board would then have the ability to add an audit percentage amount to its in-house policies and procedures which would also allow the board to amend the number of CME reports that are audited throughout the year when necessary.

Mr. Hurtado noted that making a motion to approve the regulatory language regarding the CME would be too premature as the board is requesting that legislative amendments be made to align the CME reporting cycle with the renewal cycle. The language would need to be brought back to the board for further discussion at a later time and date.

Dr. Zammuto called for public comment.

Dr. Krpan noted that although the board currently reviews 100% of the CME completed by each physician, he agrees with the board staff's recommendation of going to an audit system as the board does not have ample staff to both continue processing renewals in a timely manner and review 100% of the CME submitted. Those licensed physicians who are also members of the American Osteopathic Association (AOA) have always had the ability to submit their documents to the AOA to have them reviewed and inputted into a spreadsheet format; however the physicians that are not members are submitting excessive amounts of documentation equaling 150 hours to the board for staff review. Because of these submissions the board's CME compliance coordinators are having a hard time keeping up with the review demands.

Mrs. Creason, OPSC, expressed concerns about the board's choice to not indicate the percentage of licenses to be audited within its regulatory language. Mrs. Creason recommended that language be added to indicate a minimum of 50% of licensees would be audited per renewal cycle.

Mrs. Blair asked if there was a way to ensure that the system will automatically capture all inadvertently unnoticed physicians who had not yet complied with the audit process at sometime within the 4 years. She also inquired on the board's ability to include verbiage in the proposed language that would ensure that those missed physicians be made to comply with the board's request prior to conclusion of the 4th year. Mrs. Burton informed Mrs. Blair that Mr. Sparks should have the ability to run a report that would allow the board to better identify those physicians who had not yet been selected for the audit process and certify that they do complete the audit in a timely manner. The board can create a spreadsheet or utilize QBIRT, however either way there should not be an issue of duplicate audits or forgotten physicians.

Dr. Zammuto called for adoption of the Osteopathic Medical Board CME Self-Certification form for renewal.

- **Motion to adoption the CME Self-Certification form.**
- **Motion** – Mr. Howard, **Second** – Mrs. Blair.

Dr. Zammuto called for public comment.

Kathleen Creason, OPSC, wanted to clarify whether the motion was to adopt the regulatory language as adopted or just the concept, and was advised that the motion was only to adopt the concept of the Self-Reporting form.

- Roll Call Vote was taken
  - **Aye** – Mrs. Blair, Dr. Buhari, Mr. Howard, Ms. Mercado, Mrs. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – None
  - **Absent** – Dr. Lally, Dr. Jensen
- Motion carried to accept the CME Self-Certification form.

11. 2016/2017 Oversight Report - Assembly Business and Professions Committee and Senate Business, Professions and Economic Development Committee: Discussion and Possible Approval

Mrs. Burton informed the board that the agenda item had been added in anticipation of committee response to the submitted oversight report, however to date staff had not yet received any questions or comments from either committee.

12. Agenda Items for Next Board Meeting

- 2016/2017 Oversight Report - Review of Hearing
- Legislative report of the CME process

15. Future Meeting Dates

- Thursday, May 18, 2017 @ 10:00 am - TBD
- Thursday, October 19, 2017 @10:00 am - Sacramento, CA

16. Adjournment

There being no further business, the Meeting was adjourned at 1:15 p.m.

TAB 3

Guidelines for the Chronic Use of Opioid Analgesics

Adopted as policy by the Federation of State Medical Boards
April 2017

INTRODUCTION

In April 2015, the Federation of State Medical Boards (FSMB) Chair, J. Daniel Gifford, MD, FACP, appointed the Workgroup on FSMB's *Model Policy for the Use of Opioid Analgesics in the Treatment of Chronic Pain* to review the current science for treating chronic pain with opioid analgesics and to revise the Model Policy as appropriate.

To accomplish this charge, the workgroup conducted a thorough review and analysis of FSMB's existing policy document and other state and federal policies on the prescribing of opioids in the treatment of pain, including the March 2016 *CDC Guideline for Prescribing Opioids for Chronic Pain* (https://www.cdc.gov/drugoverdose/prescribing/guideline.html)

In updating its existing policy, the FSMB sought input from a diverse group of medical and policy stakeholders that ranged from experts in pain medicine and addiction to government officials and other thought leaders. Over the course of the last 12 months, the workgroup met on several occasions to examine and explore the key elements required to ensure FSMB's policy document remains relevant and is sufficiently comprehensive to serve as a prescribing guideline and resource for state medical and osteopathic boards and clinicians.

This policy document includes relevant recommendations identified by the workgroup, and is in keeping with recent releases of advisories issued by the CDC and FDA. This policy is intended as a resource providing overall guidance to state medical and osteopathic boards in assessing physicians' management of pain in their patients and whether opioid analgesics are used in a medically appropriate manner.

FSMB GUIDELINES FOR THE CHRONIC USE OF OPIOID ANALGESICS

Section 1 – PREAMBLE

The diagnosis and treatment of pain is integral to the practice of medicine. In order to implement best practices for responsible opioid prescribing, clinicians must understand the relevant pharmacologic and clinical issues in the use of opioid analgesics and should obtain sufficient targeted continuing education and training on the safe prescribing of opioids and other analgesics as well as training in multimodal treatments.

Section 2 – FOCUS OF GUIDELINES

The focus of the Guidelines that follow is on the general overall safe and evidence-based prescribing of opioids and treatment of chronic, non-cancer pain with the specific **limitation**

and restriction that these Guidelines do not operate to create any specific standard of care, which standard must depend upon fact-specific totality of circumstances surrounding specific quality-of-care events. The Guidelines recognize that there is not just one appropriate strategy to accomplish the goals of these Guidelines. Effective means of achieving the goals of these Guidelines vary widely depending on the type and causes of the patient's pain, the preferences of the clinician and the patient, the resources available at the time of care, and other concurrent issues beyond the scope of these Guidelines.

These Guidelines that follow do not encourage the prescribing of opioids over other pharmacological and nonpharmacological means of treatment but rather the Guidelines recognize the responsibility of clinicians to view pain management as essential to quality of medical practice and to the quality of life for patients who suffer from pain.

Finally, the Guidelines that follow are not intended for the treatment of acute pain, acute pain management in the perioperative setting, emergency care, cancer-related pain, palliative care, or end-of-life care. These Guidelines may apply most directly to the treatment of chronic pain lasting more than three months in duration or past the time of normal tissue healing, however many of the strategies mentioned here are also relevant to responsible prescribing and the mitigation of risks associated with other controlled substances in the treatment of pain.

Section 3 – DEFINITIONS

For the purposes of this Model Policy, the following terms are defined as shown.

Aberrant Behaviors: Certain behaviors may constitute aberrant behaviors. For example, obtaining prescriptions for the same or similar drugs from more than one clinician or other health care provider without the treating clinician's knowledge is aberrant behavior, as is use of illicit drugs.

Abuse: Abuse has been described as a pattern of drug use that exists despite adverse consequences or risk of consequences. Abuse of a prescription medication involves its use in a manner that deviates from accepted medical, legal, and social standards, generally to achieve a euphoric state ("high") or that is other than the purpose for which the medication was prescribed. Please also see "Substance Use Disorder".

Addiction: A common definition of addiction is that it is a primary, chronic, neurobiologic disease, whose development and manifestations are influenced by genetic, psychosocial, and environmental factors. Addiction often is said to be characterized by behaviors that include impaired control over drug use, craving, compulsive use, and continued use despite harm. A newer definition, adopted by the American Society of Addiction Medicine in 2011, describes addiction as "a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional

emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death." (As discussed below, physical dependence and tolerance are expected physiological consequences of extended opioid therapy for pain and in this context do not indicate the presence of addiction.) Please also see "Substance Use Disorder".

Controlled Substance: A controlled substance is a drug that is subject to special requirements under the federal Controlled Substances Act of 1970 (CSA), which is designed to ensure both the availability and control of regulated substances. Under the CSA, availability of regulated drugs for medical purposes is accomplished through a system that establishes quotas for drug production and a distribution system that closely monitors the importation, manufacture, distribution, prescribing, dispensing, administering, and possession of controlled drugs. Civil and criminal sanctions for serious violations of the statute are part of the government's control apparatus. The Code of Federal Regulations (Title 21, Chapter 2) implements the CSA. The CSA provides that responsibility for scheduling controlled substances is shared between the Food and Drug Administration (FDA) and the DEA. In granting regulatory authority to these agencies, the Congress noted that both public health and public safety needs are important and that neither takes primacy over the other. To accomplish this, the Congress provided guidance in the form of factors that must be considered by the FDA and DEA when assessing public health and safety issues related to a new drug or one that is being considered for rescheduling or removal from control.

The CSA does not limit the amount of drug prescribed, the duration for which it is prescribed, or the period for which a prescription is valid (although some states do impose such limits).

Most potent opioid analgesics are classified in Schedules II under the CSA, indicating that they have a significant potential for abuse and a currently accepted medical use in treatment in the U.S. (with certain restrictions), and that abuse of the drug may lead to severe psychological or physical dependence. Although the scheduling system provides a rough guide to abuse potential, all controlled medications have some potential for abuse.

Dependence: Physical dependence is a state of biologic adaptation that is evidenced by a withdrawal syndrome when the drug is abruptly discontinued or the dose rapidly reduced, and/or by the administration of an antagonist. It is important to distinguish addiction from the type of physical dependence that can and does occur within the context of good medical care, as when a patient on long-term opioid analgesics for pain becomes physically dependent on the analgesic. This distinction is reflected in the two primary diagnostic classification systems used by health care professionals: the International Classification of Mental and Behavioral Disorders, 10th Edition (ICD-10) of the World Health Organization, and the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. In the DSM-IV-TR, a diagnosis of "substance dependence" meant addiction. In the DSM-5, the term dependence is reestablished in its original meaning of physiological dependence. When symptoms are sufficient to meet criteria for substance misuse or addiction, the term "substance use disorder" is used, accompanied by severity ratings.

It may be important to clarify this distinction during the informed consent process, so that the patient (and family) understands that physical dependence and tolerance are likely to occur if opioids are taken regularly over a period of time, but that the risk of addiction is relatively low, although estimates do vary. Discontinuing chronic opioid therapy may be difficult, even in the absence of addiction. According to the World Health Organization, “The development of tolerance and physical dependence denote normal physiologic adaptations of the body to the presence of an opioid.” Consequently, physical dependence alone is neither necessary nor sufficient to diagnose addiction. Please also see "Substance Use Disorder".

Diversion: Drug diversion is defined as the intentional transfer of a controlled substance from authorized to unauthorized possession or channels of distribution. The federal Controlled Substances Act (21 U.S.C. §§ 801 et seq.) establishes a closed system of distribution for drugs that are classified as controlled substances. Records must be kept from the time a drug is manufactured to the time it is dispensed. Health care professionals who are authorized to prescribe, dispense, and otherwise control access to such drugs are required to register with the DEA.

Pharmaceuticals that make their way outside this closed distribution system are said to have been “diverted”, and the individuals responsible for the diversion (including patients) are in violation of federal law, and often corresponding state laws as well.

Experience shows that the degree to which a prescribed medication is misused depends in large part on how easily it is redirected (diverted) from the legitimate distribution system.

Misuse: The term misuse (also called nonmedical use) encompasses all uses of a prescription medication other than those that are directed by a clinician and used by a patient within the law and the requirements of good medical practice. Please also see "Substance Use Disorder".

Opioid: An opioid is an opium-like compound that binds to one or more of the three opioid receptors of the body. The class includes naturally occurring and synthetic or semi-synthetic opioid drugs or medications, as well as endogenous opioid peptides. Most clinicians use the terms “opiate” and “opioid” interchangeably, but toxicologists (who perform and interpret drug tests) make a clear distinction between them. “Opioid” is the broader term because it includes the entire class of agents that act at opioid receptors in the CNS, whereas “opiates” refers to natural compounds derived from the opium plant but not semisynthetic opioid derivatives of opiates or completely synthetic agents. Thus, drug tests that are “positive for opiates” have detected one of these compounds or a metabolite of heroin, 6-monoacetyl morphine (MAM). Drug tests that are “negative for opiates” have found no detectable levels of opiates in the sample, even though other opioids that were not tested for—including the most common currently used and misused prescription opioids—may be present in the sample that was analyzed.

Pain: An unpleasant and potentially disabling sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. *Acute pain* is the normal, predictable physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. Acute pain

generally is time limited, lasting six weeks or less. *Chronic pain* is a state in which pain persists beyond the usual course of an acute disease or healing of an injury (e.g., more than three months). It may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over a period of months or years. *Chronic non-cancer related pain* is chronic pain that is not associated with cancer and does not occur at the end of life. *Opioid-induced hyperalgesia* may develop as a result of long-term opioid use in the treatment of pain. *Primary hyperalgesia* is pain sensitivity that occurs directly in the damaged tissues, while *secondary hyperalgesia* occurs in surrounding undamaged tissues. Human and animal studies have demonstrated that primary or secondary hyperalgesia can develop in response to both chronic and acute exposure to opioids. Hyperalgesia can be severe enough to warrant discontinuation of opioid treatment.

Prescription Drug Monitoring Program: As a patient safety tool, almost all states have enacted laws that establish prescription drug monitoring programs (PDMPs) to facilitate the collection, analysis, and reporting of information on the prescribing and dispensing of controlled substances. Most such programs employ electronic data transfer systems, under which prescription information is transmitted from the dispensing pharmacy to a state agency, which collates and analyzes the information. After analyzing the efficacy of PDMPs, the Government Accountability Office (GAO) concluded that such programs have the potential to help law enforcement and regulatory agencies rapidly identify and investigate activities that may involve illegal prescribing, dispensing or consumption of controlled substances. Where real-time data are available, PDMPs also can help to prevent prescription drug misuse, overdose, and diversion by allowing clinicians to determine whether a patient is receiving prescriptions for controlled substances from other clinicians, as well as whether the patient has filled or refilled an order for an opioid the clinician has prescribed.

Substance Use Disorder: In the DSM-5, Substance Use Disorder encompasses what was previously classified as abuse, dependence, misuse, and tolerance. Under the DSM-5 definition of Substance Use Disorder a patient needs to meet any 2 of 11 criteria in the same 12 months. The severity is based on the number of criteria (i.e., mild is 2-3 criteria, moderate is 4-5 criteria, and severe is 6 or more criteria). Criteria are grouped into impaired control (i.e., taken in larger amounts or over longer time than was intended; persistent desire or unsuccessful efforts to cut down or control use; great deal of time spent in activities to obtain, use or recover from its effects; craving or strong desire to use); social impairment (i.e., use resulting in a failure to fulfill major role obligations at work, school, or home; continued use despite persistent or recurrent social or interpersonal problems caused by the use; important social, occupational, or recreational activities are given up or reduced due to use); risky use (i.e., recurrent use in situations in which it is physically dangerous; use despite knowledge of having a persistent physical or psychological problem that is caused or exacerbated by use); and pharmacological properties (i.e, tolerance; withdrawal).

Tolerance: Tolerance is a state of physiologic adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time. Tolerance is common in opioid treatment and is not the same as addiction. Please also see "Substance Use Disorder".

Section 3 - FSMB GUIDELINES

State medical boards may adopt the following criteria for use in evaluating a clinician's management of a patient with pain, including the clinician's prescribing of opioid analgesics. Such adoption is subject to the **Guidelines, Limitations and Restrictions** previously set forth.

Patient Evaluation and Risk Stratification

The medical record should document the presence of one or more recognized medical indications and absence of psychosocial contraindications for prescribing an opioid analgesic and reflect an appropriately detailed patient evaluation. An evaluation should be completed and documented concurrent with the decision of whether to prescribe an opioid analgesic.

The nature and extent of the evaluation depends on the type of pain and the context in which it occurs. Assessment of the patient's pain should include the nature and intensity of the pain, past and current treatments for the pain, any underlying or co-occurring disorders and conditions, and the effect of the pain on the patient's physical and psychological functioning.

For every patient, the initial assessment and evaluation should include a systems review and relevant physical examination, as well as objective markers of disease or diagnostic markers as indicated. Also, functional assessment, including social and vocational assessment, is useful in identifying supports and obstacles to treatment and rehabilitation.

Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for substance use disorder also should be part of the initial evaluation, and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics. This can be done through a careful clinical interview, which should also inquire into any history of physical, emotional or sexual abuse, because those are risk factors for substance use disorder. Use of validated screening tools for substance use disorder may be used for collecting and evaluating information and determining the patient's level of risk.

Patients who have a history of substance use disorder as defined by DSM-5 are at an elevated risk for failure of opioid analgesic therapy to achieve the goals of improved comfort and function, and also are at high risk for relapse. Treatment of a patient who has a history of substance use disorder may involve consultation with an addiction specialist before opioid therapy is initiated (and follow-up, as needed). Additionally, patients who have a substance use disorder as defined by the DSM-5, require additional support if opioid therapy is necessitated and should not receive opioid therapy until they are established in a treatment/recovery program or alternatives are established, such as co-management with an addiction professional. Clinicians who treat patients with chronic pain are encouraged to also be knowledgeable about the identification and treatment of substance use disorder, including the role of replacement agonists such as methadone and buprenorphine. Some non-addiction specialist clinicians may choose to directly treat patients with substance use disorder. This may include becoming eligible to treat substance use disorder using office-based buprenorphine as part of medication-assisted treatment.

Assessment of the patient's personal and family history of mental health disorders should be part of the initial evaluation, and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics. All patients should be screened for depression and other mental health disorders, as part of risk evaluation. Patients with untreated depression and other mental health disorders are at increased risk for misuse or abuse of controlled medications, including addiction and overdose. Additionally, untreated depression can interfere with the resolution of pain.
The patient evaluation may include information from family members and/or significant others. It is strongly recommended that the state prescription drug monitoring program (PDMP) be consulted prior to initiating opioid therapy and at appropriate intervals thereafter to determine whether the patient is receiving prescriptions from any other clinicians, and the results obtained from the PDMP should be reviewed.

In working with a patient who is taking opioids prescribed by another clinician—particularly a patient on high doses—the evaluation and risk stratification assume even greater importance. Therefore, to ensure a smooth transition of care, clinicians are encouraged to collaborate with the primary prescriber.

Caution should be used with the administration of chronic opioids in women of childbearing age, as chronic opioid therapy during pregnancy increases risk of harm to the newborn. Opioids should be administered with caution in breastfeeding women, as some opioids may be transferred to the baby in breast milk. When chronic opioid therapy is used for an elderly patient, clinicians should carefully consider the initial dose, titrating slowly upwards if necessary, using a longer dosing interval, and monitoring more frequently. Patients at risk for sleep disordered breathing are at increased risk for harm with the use of chronic opioid therapy. Clinicians should consider the use of a screening tool for obstructive sleep apnea and refer patients for proper evaluation and treatment when indicated.

The patient evaluation should include most of the following elements:

- Medical history and physical examination targeted to the pain condition
- Nature and intensity of the pain
- Current and past treatments, including interventional treatments, with response to each treatment
- Underlying or co-existing diseases or conditions, including those which could complicate treatment (i.e. obesity, renal disease, sleep apnea, COPD, etc.)
- Effect of pain on physical and psychological functioning
- Personal and family history of substance use disorder
- History of psychiatric disorders (bipolar, ADD/ADHD, sociopathic, borderline, major depressive disorder)
- Post-traumatic stress disorder (PTSD)
- Medical indication(s) for use of opioids
- Review of the PDMP results
- Obtain consultation with other clinicians when applicable
- Urine, blood or other types of biological samples and diagnostic markers

Development of a Treatment Plan and Goals

The goals of pain treatment include reasonably attainable improvement in pain to decrease suffering and to increase function; improvement in pain-associated symptoms such as sleep disturbance, depression, and anxiety; screening for side effects of treatment; and avoidance of unnecessary or excessive use of medications. There should be a balance between monitoring for efficacy and side effects with the use of medications for the shortest duration appropriate.

The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly, so as to provide clear-cut, individualized objectives to guide the choice of therapies for both the clinician and the patient.

The treatment plan may contain information supporting the selection of therapies, both pharmacologic (medications other than opioids to include anti-inflammatories, acetaminophen, and selected antidepressants and anticonvulsants) interventional, and non-pharmacologic therapies such as cognitive behavioral therapy, massage, exercise, multimodal pain treatment, and osteopathic manipulative treatment. The plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered to the extent they are available.

Informed Consent and Treatment Agreement

The decision to initiate chronic opioid therapy is a shared decision between the clinician and the patient. The clinician should discuss the risks and benefits of the treatment plan (including any proposed use of opioid analgesics) with the patient. If opioids are prescribed, the patient (and possibly family members) should be counseled on the potential risks and anticipated benefits, adverse effects of opioids, including but not limited to dependence, substance use disorder, overdose and death, as well as the safe ways to store and dispose of medications.

Use of a written informed consent and treatment agreement is recommended for long-term chronic opioid therapy. Treatment agreements outline the joint responsibilities of the clinician and patient, including the patient's agreement to periodic and unannounced drug testing for opioids and other medications when deemed appropriate by the clinician with potential for substance use disorder as well as discuss with the patient how and when the PDMP will be reviewed as part of the patient's care.

Informed consent may address:

- Limited evidence as to the benefit of opioids or other pharmaceutical therapies in the management of chronic pain (except for cancer)
- Potential risks and benefits of opioid therapy
- Potential side effects (both short and long term), such as cognitive impairment and constipation
- The likelihood that tolerance to and physical dependence on the medication will develop

- Risk of drug interactions and over-sedation
- Risk of impaired motor skills (affecting driving and other tasks)
- Risk of substance use disorder, overdose and death
- The clinician's prescribing policies and expectations, including the number and frequency of prescription refills, early refills and replacement of lost or stolen medications
- Reasons for which drug therapy may be changed or discontinued (including violation of the treatment agreement) or that treatment may be discontinued without agreement by the patient.
- Education of the patient that the complete elimination of pain is not to be expected.

Treatment agreements outline the joint responsibilities of the clinician and patient and are indicated for opioid or other medications with potential for substance use disorder. It is strongly recommended that treatment agreements include:

- Treatment goals in terms of pain management, restoration of function and safety
- Patient's responsibility for safe medication use (not taking more than prescribed; dangers of using in combination with alcohol, cannabis, or other substances like benzodiazepines unless closely monitored by the prescriber, etc.)
- Secure storage and safe disposal
- Patient's responsibility to obtain prescribed opioids from only one clinician or practice
- Patient's responsibility of getting the prescriptions filled at only one pharmacy
- Patient's agreement to periodic drug testing
- Clinician's responsibility to be available or to have a covering clinician available to care for unforeseen problems and to prescribe scheduled refills.

Clinicians are recommended to refrain from referring patients to the emergency department to obtain prescriptions for opioids for chronic pain that is not cancer-related or as part of palliative care or end-of-life care.

Initiating an Opioid Trial

Non-opioid and non-pharmacologic treatments should be considered before initiating opioid therapy for chronic or acute pain lasting beyond the expected duration.

When a decision is made to initiate opioid therapy, it should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 30 days) and with specified evaluation points including improvement in pain and function.

The clinician should explain that progress will be carefully monitored for both benefit and harm in terms of the effects of opioids on the patient's level of pain, function, and quality of life, as well as to identify any adverse events or risks to safety.

As noted by the FDA, when initiating opioid therapy for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment, it is highly recommended that

the lowest dose possible be given, beginning with a short acting opioid and/or rotating to a long acting/extended release, if indicated. Prescribers may download a medication guide of all extended-release opioids for patients at http://www.accessdata.fda.gov/scripts/cder/daf/. A patient counseling document available in English and Spanish through the extended-release, long-acting Risk Evaluation and Mitigation Strategy (REMS) is also available for download at http://www.er-la-opioidrems.com/IwgUI/rems/pcd.action.
The concurrent use of benzodiazepines and opioids, recently added as a Black Box warning by the FDA, greatly increases the risk of adverse events including death. Given this increased risk, clinicians should avoid prescribing opioid pain medication and benzodiazepines concurrently whenever possible.

While there is clinical variation in response by patients to opioid therapy at any given dosage, the CDC and some states have recommended specific dosing guidelines for opioids. Clinicians need to be aware that increasing opioid dosage beyond the current recommended guidelines may result in increased risk for substance use disorder and/or diversion. A clinician should clearly state in the medical records the rationale for using higher dosages than the current recommended guidelines, recognizing that genetic variations can significantly alter drug response, and monitor those patients prescribed such a dose with increased vigilance to assure the risks of diversion and/or overdose are minimized. The clinician should also be aware that maximum benefit to the patient may have already been obtained and increasing the dosage may not result in further therapeutic benefit, and can result in harm to the patient. Referral to, or consultation with a pain specialist for patients on higher than recommended dosages, may be considered, and dosages should not be escalated without re-evaluation of the benefits and risks.

Before prescribing methadone for its analgesic effect, it is strongly recommended that clinicians have specific training and/or experience as individual responses to methadone vary widely increasing the risk of overdose. There is a complex relationship between dose, half-life, duration of analgesic effect, and duration of respiratory depression. Specifically, the duration of analgesic effect is generally shorter than the duration of respiratory depression. The long half-life of methadone and the longer duration of respiratory depression relative to analgesia places patients at risk for overdose when titrating methadone dose for pain management.

Clinicians should consider co-prescribing naloxone for home use for all patients with opioid prescriptions in case of accidental or intentional overdose by the patient or household contacts. Patients at greatest risk of overdose include patients with a history of substance use disorder, history of prior overdose, clinical depression, patients who are taking opioids with other central nervous system depressants, or when evidence of increased risk by other measures exists (behaviors, family history, PDMP, risk assessment results).

Ongoing Monitoring and Adapting the Treatment Plan

The clinician should regularly review the patient's progress, including any new information about the etiology of the pain or the patient's overall health and level of function. When possible, collateral information about the patient's response to opioid therapy may be obtained from family members or other close contacts, as well as review of the state PDMP. The patient

may be seen more frequently while the treatment plan is being initiated and the opioid dose adjusted. As the patient is stabilized in the treatment regimen, follow-up visits may be scheduled as indicated by stability and risk level. Monitoring plans for a given patient should take into account the generally increased risk for dependence developing a substance use disorder and misuse the longer the patient uses them.

Continuation, modification or termination of opioid therapy for pain is contingent on the clinician's evaluation of (1) evidence of the patient's progress toward treatment objectives and (2) the absence of substantial risks or adverse events, such as signs of substance use disorder and/or diversion. A satisfactory response to treatment would be indicated by a reduced level of pain, increased level of function, and/or improved quality of life. Information from family members or other caregivers may be considered in evaluating the patient's response to treatment. Use of measurement tools to assess the patient's level of pain, function, and quality of life may be helpful in documenting therapeutic outcomes.

Periodic and Unannounced Drug Testing

Periodic and unannounced drug testing (including chromatography) are useful in monitoring adherence to the treatment plan, as well as in detecting the use of non-prescribed drugs. Drug testing is an important monitoring tool because self-reporting of medication use is not always reliable and behavioral observations may detect some problems but not others. It is strongly recommended that patients being treated for addiction be tested as frequently as necessary to ensure therapeutic adherence, but for patients being treated for pain, clinical judgment trumps recommendations for frequency of testing.

Urine may be the preferred biologic specimen for testing because of its ease of collection and storage and the cost-effectiveness of such testing. When such testing is conducted as part of pain treatment, forensic standards are generally not necessary and not in place. Collection is preferably observed especially in pain clinics; however, chain-of-custody protocols are not followed. To help ensure a valid specimen, the urine should be warm and urine specific gravity and creatinine should be measured. Initial testing may be done using class-specific immunoassay drug panels (point-of-care or laboratory-based), which typically do not identify particular drugs within a class unless the immunoassay is specific for that drug. If necessary, this can be followed up with a more specific technique, such as gas chromatography/mass spectrometry (GC/MS) or other chromatographic tests to confirm the presence or absence of a specific drug or its metabolites. In drug testing in a pain practice, it is important to identify the specific drug and metabolites, not just the class of the drug.

Clinicians need to be aware of the limitations of available tests (such as their limited sensitivity for many opioids) and take care to order tests appropriately. For example, when a drug test is ordered, it is important to specify that it include the opioid being prescribed. Because of the complexities involved in interpreting drug test results, it is advisable to confirm significant or unexpected results with the laboratory toxicologist or a clinical pathologist.

While immunoassay, point of care (POC) testing has its utility in the making of temporary and "on the spot" changes in clinical management, its limitations with regard to accuracy have

recently been the subject of study. These limitations are such that point of care testing may not be appropriate for making definitive changes in medication management in populations at high risk for adverse outcomes until the results of confirmatory testing with more accurate methods such as liquid chromatography tandem mass spectrometry (LC-MS/MS) are obtained. A recent study on LC-MS/MS results following immunoassay POC testing in substance use disorder treatment settings found very high rates of "false negatives and positives."
Test results that suggest opioid misuse should be discussed with the patient. It is helpful to approach such a discussion in a positive, supportive fashion, so as to strengthen the physician-patient relationship and encourage healthy behaviors (as well as behavioral change where that is needed). It is recommended that both the test results and subsequent discussion with the patient be documented in the medical record.

Adapting Treatment

As noted earlier, clinicians are encouraged to consult the state's PDMP before initiating opioids for pain and during ongoing therapy. A PDMP is important in monitoring compliance with the treatment agreement as well as identifying individuals obtaining controlled substances from multiple prescribers, and patients who may be at increased risk for overdose.

If the patient's progress is unsatisfactory, the clinician must decide whether to revise or augment the treatment plan, whether other treatment modalities should be added to or substituted for the opioid therapy, or whether a different approach—possibly involving referral to a pain specialist or other health professional—should be employed.

Evidence of misuse of prescribed opioids demands prompt evaluation by the clinician, including assessment for opioid use disorder or referral to a substance use disorder treatment specialist for such assessment, and arranging for evidence-based treatment of opioid use disorder if present. Patient behaviors that require such intervention typically involve recurrent early requests for refills, multiple reports of lost or stolen prescriptions, obtaining controlled medications from multiple sources without the clinician's knowledge, intoxication or impairment (either observed or reported), and pressuring or threatening behaviors.

When a drug test shows the presence of illicit drugs or drugs not prescribed by a clinician, this requires action on the part of the clinician. Some aberrant behaviors are more closely associated with substance use disorder. Of greatest concern is a pattern of behavior that suggests substance use disorder, such as unsanctioned dose escalations, deteriorating function, and failure to comply with the treatment plan.

Documented drug diversion or prescription forgery, and abusive or assaultive behaviors require a firm, immediate response, which may include properly discharging a patient from the clinician's practice. Indeed, failure to respond can place the patient and others at significant risk of adverse consequences, including accidental overdose, suicide attempts, arrests and incarceration, or even death.

Consultation and Referral

It is important to consider referral to an interdisciplinary pain management program which includes modalities such as interventional pain management, physical and occupational therapy, acupuncture, or other non-pharmacologic therapies to avoid unnecessary reliance on opioids as the sole therapy for chronic or complex pain issues.

Specialty consultation should be considered if diagnosis and/or treatment for the condition manifesting as pain is outside the scope of the clinician's comfort with dosing requirements. Opioid dose level, in and of itself, does not indicate a referral. However, there is some risk associated with higher doses, and therefore, that may be an indication for consultation, depending on the clinician's training, resources and comfort level. The treating clinician, if possible, should seek a consultation with, or refer the patient to a pain, psychiatric, addiction or mental health specialist as needed.

Clinicians should be aware of treatment options for opioid use disorder and addiction (including those available in licensed opioid treatment programs [OTPs]) and those offered by an appropriately credentialed and experienced clinician through office-based opioid treatment [OBOT]), so as to make appropriate referrals when needed.

Discontinuing Opioid Therapy

Throughout the course of opioid therapy, the clinician and patient should regularly weigh the potential benefits and risks of continued treatment and determine whether such treatment remains appropriate.

If opioid therapy is continued, the treatment plan may need to be adjusted to reflect the patient's changing physical status and needs, as well as to support safe and appropriate medication use.

Discontinuing or tapering of opioid therapy may be required for many reasons, and ideally, clinicians will have an end strategy for patients receiving opioids at the outset of treatment. Reasons for discontinuing opioid therapy include resolution of the underlying painful condition, emergence of intolerable side effects, inadequate analgesic effect, failure to improve the patient's quality of life despite reasonable titration, failure to achieve expected pain relief or functional improvement, failure to comply with the treatment agreement, or significant aberrant medication use, including signs of addiction. Additionally, clinicians should not continue opioid treatment unless the patient has received a benefit, including demonstrated functional improvement.

If opioid therapy is discontinued, the patient who has become physically dependent should be provided a safely structured tapering regimen. Withdrawal can be managed either by the prescribing clinician or by referring the patient to an addiction specialist. The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other health care specialists, as appropriate.

Discontinuing opioids is not an easy process for some patients; therefore, a referral may be needed as clinicians have an obligation to provide transition therapy in order to minimize adverse outcomes.

Medical Records

Every clinician who treats patients for chronic pain must maintain accurate and complete medical records. Information that should appear in the medical record includes the following:

- Copies of the signed informed consent and treatment agreement.
- The patient's medical history.
- Results of the physical examination and all laboratory tests.
- Results of the risk assessment, including results of any screening instruments used.
- A description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity).
- Instructions to the patient, including discussions of risks and benefits with the patient and any significant others.
- Results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management and functional improvement.
- Notes on evaluations by and consultations with specialists.
- Results of queries to the state PDMP.
- Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors. These may include actual copies of, or references to, medical records of past hospitalizations or treatments by other providers.
- Authorization for release of information to other treatment providers.

The medical record must include all prescription orders for opioid analgesics and other controlled substances, whether written or telephoned. In addition, written instructions for the use of all medications should be given to the patient and documented in the record. The name, telephone number, and address of the patient's primary pharmacy should also be recorded to facilitate contact as needed. Records should be up-to-date and maintained in an accessible manner so as to be readily available for review.

Compliance with Controlled Substance Laws and Regulations

To prescribe, dispense or administer controlled substances, the clinician must be registered with the DEA, licensed by the state in which he or she practices, and comply with applicable federal and state regulations.

Clinicians are referred to the Physicians' Manual of the U.S. Drug Enforcement Administration (and any relevant documents issued by the state medical Board) for specific rules and regulations governing the use of controlled substances. Additional resources are available on the DEA's website (at www.deadiversion.usdoj.gov), as well as from (any relevant documents issued by the state medical board).

Section 4 – CONCLUSION

The goal of this Model Policy is to provide state medical and osteopathic boards with an updated guideline for assessing a clinician's management of pain, so as to determine whether opioid analgesics are used in a manner that is both medically appropriate and in compliance with applicable state and federal laws and regulations. The appropriate management of pain, particularly as related to the prescribing of opioid analgesics may include the following:

- **Adequate attention to initial assessment to determine if opioids are clinically indicated and to determine risks associated with their use in a particular individual with pain:** Not unlike many drugs used in medicine today, there are significant risks associated with opioids and therefore benefits must outweigh the risks.

- **Adequate monitoring during the use of potentially abusable medications:** Opioids may be associated with substance use disorder and other dysfunctional behavioral problems, and some patients may benefit from opioid dose reductons or tapering or weaning off the opioid.

- **Adequate attention to patient education and informed consent:** The decision to begin opioid therapy for chronic pain is a shared decision of the clinician and patient after a discussion of the risks and a clear understanding that the clinical basis for the use of these medications for chronic pain is limited, that some pain may worsen with opioids, and taking opioids with other substances (such as benzodiazpines, alcohol, cannabis, or other central nervous system depressants) or certain conditions (e.g., sleep apnea, mental illness, pre-existing substance use disorder) may increase risk.

- **Justified dose escalation with adequate attention to risks or alternative treatments:** Risks associated with opioids increase with escalating doses as well as in the setting of other comorbidities (i.e. mental illness, respiratory disorders, pre-existing substance use disorder and sleep apnea) and with concurrent use with respiratory depressants such as benzodiazepines or alcohol.

- **Avoid excessive reliance on opioids, particularly high dose opioids for chronic pain management:** It is strongly recommended that prescibers be prepared for risk management with opioids in advance of prescribing, and should use opioid therapy for chronic pain that is not cancer-related, or part of palliative care or end-of-life care, only when non-opioid and non-pharmacological options have not been effective. Maintain opioid dosage as low as possible and continue only if clear and objective outcomes are being met.

- **Utilization of available tools for risk mitigations:** The state prescription drug monitoring program should be checked in advance of prescribing opioids and should be utilized for ongoing monitoring.

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TAB 4

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TAB 5

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TAB 6

OSTEOPATHIC MEDICAL BOARD - 0264
BUDGET REPORT
FY 2016-17 EXPENDITURE PROJECTION
Apr-2017

FISCAL MONTH 10

OBJECT DESCRIPTION	FY 2015-16 ACTUAL EXPENDITURES (MONTH 13)	FY 2015-16 PRIOR YEAR EXPENDITURES 4/30/2016	FY 2016-17 BUDGET STONE 2016-17	FY 2016-17 CURRENT YEAR EXPENDITURES 4/30/2017	FY 2016-17 PERCENT SPENT	FY 2016-17 PROJECTIONS TO YEAR END	FY 2016-17 UNENCUMBERED BALANCE
PERSONNEL SERVICES							
Salary & Wages (Staff)	582,326	481,318	**665,000**	509,355	77%	**645,112**	19,888
Statutory Exempt (EO)	89,728	71,686	**76,000**	74,851	98%	**87,058**	(11,058)
Temp Help Reg (Seasonals)	500	500	**0**	17,643	0%	**20,000**	(20,000)
Board Member Per Diem	600	600	**3,000**	900	30%	**1,080**	1,920
Committee Members (DEC)	800	0	**0**	0		**0**	0
Overtime	0	0	**0**	314		**0**	0
Staff Benefits	331,722	272,730	**398,000**	302,897	76%	**363,476**	34,524
TOTALS, PERSONNEL SVC	1,005,676	826,834	**1,142,000**	**905,960**	**79%**	**1,116,726**	25,274
OPERATING EXPENSE AND EQUIPMENT							
General Expense	8,652	8,342	**112,000**	7,836	7%	**9,403**	102,597
Fingerprint Reports	36,456	27,538	**25,000**	35,521	142%	**42,625**	(17,625)
Minor Equipment	1,081	1,081	**0**	(49)		**0**	0
Printing	10,125	9,007	**5,000**	8,112	162%	**9,734**	(4,734)
Communication	5,544	3,382	**16,000**	4,702	29%	**5,642**	10,358
Postage	1,110	1,104	**6,000**	7,504	125%	**9,005**	(3,005)
Insurance	0	0	**0**	11		**13**	(13)
Travel In State	12,725	6,288	**14,000**	4,921	35%	**5,905**	8,095
Travel, Out-of-State	0	0	**0**	0		**0**	0
Training	1,485	0	**5,000**	457	9%	**548**	4,452
Facilities Operations	61,344	61,438	**110,000**	61,628	56%	**61,628**	48,372
Utilities	0	0	**0**	0		**0**	0
C & P Services - Interdept.	0	0	**7,000**	0	0%	**0**	7,000
C & P Services - External	52,872	82,404	**77,000**	77,906	101%	**77,906**	(906)
DEPARTMENTAL SERVICES:							
Departmental Pro Rata	157,690	119,250	**145,000**	120,000	83%	**145,000**	0
Admin/Exec	138,854	104,250	**142,000**	113,330	80%	**142,000**	0
Interagency Services	0	0	**0**	0		**0**	0
IA w/ DOI Direct	0	0	**0**	63,852		**100,000**	(100,000)
DOI-ProRata Internal	3,933	3,000	**4,000**	3,330	83%	**4,000**	0
Public Affairs Office	9,000	6,750	**18,000**	15,000	83%	**18,000**	0
PCSD Pro Rata	0	0	**1,000**	830	83%	**1,000**	0
INTERAGENCY SERVICES:							
Consolidated Data Center	18,404	13,809	**1,000**	14,139	1414%	**16,967**	(15,967)
DP Maintenance & Supply	1,850	267	**4,000**	1,218	30%	**1,462**	2,538
Central Admin Svc-ProRata	81,892	61,419	**0**	0		**0**	0
EXAM EXPENSES:							
C/P Svcs-External Subject Matter	0	0	**0**	1,458		**1,750**	(1,750)
ENFORCEMENT:							
Attorney General	199,446	189,417	**324,000**	289,031	89%	**310,000**	14,000
Office Admin. Hearings	67,950	40,675	**52,000**	85,000	163%	**102,000**	(50,000)
Court Reporters	3,270	2,625	**0**	2,742		**3,290**	(3,290)
Evidence/Witness Fees	74,695	43,996	**8,000**	44,087	551%	**52,904**	(44,904)
Invest SVS - MBC ONL	70,848	52,899	**94,000**	21,041		**25,249**	68,751
Major Equipment	0	0	**0**	0		**0**	0
Special Items of Expense	0	0	**0**	0		**0**	0
Other (Vehicle Operations)	0	0	**0**	0		**0**	0
TOTALS, OE&E	1,019,226	838,941	**1,170,000**	983,607	84%	1,146,033	23,967
TOTAL EXPENSE	2,024,902	1,665,775	**2,312,000**	1,889,567	163%	**2,262,759**	49,241
Sched. Reimb. - External/Private							0
Sched. Reimb. - Fingerprints	(38,367)	(31,561)	**(25,000)**	(34,888)	140%	**(25,000)**	0
Sched. Reimb. - Other	(3,760)	(3,290)	**(28,000)**	(2,350)		**(28,000)**	0
Distributed - From Naturopathic			**(14,000)**			**(14,000)**	0
Unsched. Reimb. - Other	(137,965)	(105,489)	**0**	(68,474)			0
NET APPROPRIATION	1,844,810	1,525,435	**2,245,000**	1,783,855	79%	**2,195,759**	**49,241**
						SURPLUS/(DEFICIT):	**2.2%**

0264 Osteopathic Medical Board
Analysis of Fund Condition

Prepared 5.15.17

(Dollars in Thousands)

2017-18 Governor's Budget		ACTUAL 2015-16	Budget Act CY 2016-17	Governor's Budget BY 2017-18	BY +1 2018-19
BEGINNING BALANCE		$ 3,153	$ 3,057	$ 2,765	$ 2,457
Prior Year Adjustment		$ -65	$ -	$ -	$ -
Adjusted Beginning Balance		$ 3,088	$ 3,057	$ 2,765	$ 2,457
REVENUES AND TRANSFERS					
Revenues:					
125600	Other regulatory fees	$ 21	$ 24	$ 25	$ 25
125700	Other regulatory licenses and permits	$ 338	$ 367	$ 397	$ 397
125800	Renewal fees	$ 1,419	$ 1,608	$ 1,648	$ 1,648
125900	Delinquent fees	$ 15	$ 16	$ 16	$ 16
141200	Sales of documents	$ -	$ -	$ -	$ -
142500	Miscellaneous services to the public	$ -	$ -	$ -	$ -
150300	Income from surplus money investments	$ 14	$ -	$ -	$ -
150500	Interest Income From Interfund Loans	$ -	$ -	$ -	$ -
160400	Sale of fixed assets	$ -	$ -	$ -	$ -
161000	Escheat of unclaimed checks and warrants	$ -	$ -	$ -	$ -
161400	Miscellaneous revenues	$ -	$ -	$ -	$ -
Totals, Revenues		$ 1,807	$ 2,015	$ 2,086	$ 2,086
Transfers from Other Funds					
F00001	GF loan repayment per Item 1485-011-0264, BA of 2002	$ -	$ -	$ -	$ -
Totals, Revenues and Transfers		$ 1,807	$ 2,015	$ 2,086	$ 2,086
Totals, Resources		$ 4,895	$ 5,072	$ 4,851	$ 4,543
EXPENDITURES					
Disbursements:					
1110	Program Expenditures (State Operations)	$ 1,835	$ -	$ -	$ -
1111	Program Expenditures (State Operations)	$ -	$ 2,211	$ 2,271	$ 2,316
8880	Financial Information System of CA (State Operations)	$ 3	$ 3	$ 4	$ -
9900	Statewide Pro Rata	$ -	$ 93	$ 119	$ 119
Total Disbursements		$ 1,838	$ 2,307	$ 2,394	$ 2,435
FUND BALANCE					
Reserve for economic uncertainties		$ 3,057	$ 2,765	$ 2,457	$ 2,108
Months in Reserve		15.9	13.9	12.1	10.2

OMBC Enforcement Report

May 18, 2017

The following OMBC Enforcement Report covers a 12 month period starting from 2nd Quarter 2016 though 1st Quarter 2017. The OMBC Enforcement Report is divided into five sections; Intake, Investigations, Enforcement, Performance Measures, and Probation. The data is reproduced from the Breeze Enforcement Reports.

COMPLAINT INTAKE

	2Q 2016			3Q 2016			4Q 2016			1Q 2017			
COMPLAINTS	**4/16**	**5/16**	**6/16**	**7/16**	**8/16**	**9/16**	**10/16**	**11/16**	**12/16**	**1/17**	**2/17**	**3/17**	**YTD**
Received	32	71	33	43	39	35	38	52	30	32	39	28	472
Assigned	21	39	35	92	30	29	37	27	52	30	40	26	458
Aging	16	20	17	24	8	11	12	16	32	29	16	17	18
	2Q 2016			**3Q 2016**			**4Q 2016**			**1Q 2017**			
CONV/ARRESTS	**4/16**	**5/16**	**6/16**	**7/16**	**8/16**	**9/16**	**10/16**	**11/16**	**12/16**	**1/17**	**2/17**	**3/17**	**YTD**
Received	2	4	1	2	2	3	1	3	3	4	1	6	32
Assigned	3	3	2	2	2	2	2	3	2	5	1	5	32
Aging	2	2	6	11	2	2	9	3	3	7	3	4	5
	2Q 2016			**3Q 2016**			**4Q 2016**			**1Q 2017**			
TOTAL INTAKE	**4/16**	**5/16**	**6/16**	**7/16**	**8/16**	**9/16**	**10/16**	**11/16**	**12/16**	**1/17**	**2/17**	**3/17**	**YTD**
Received	34	75	34	45	41	38	39	55	33	36	40	34	504
Assigned	24	42	37	94	32	31	39	30	54	35	41	31	490
Aging	15	19	17	24	8	10	12	15	31	26	15	15	17
Pending	24	57	54	5	14	21	21	46	24	24	23	26	26

Table 1: Complaint Intake with Convictions/Arrests

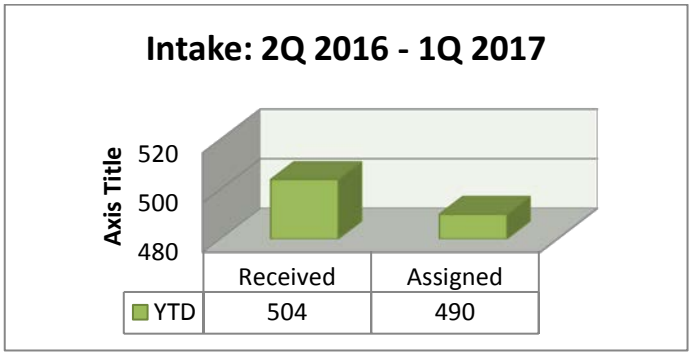


Figure 1.1: Intake Totals

In Table 1 above, under TOTAL INTAKE, OMBC received 504 complaints. 32 of these cases were convictions/arrests. During this period, 490 cases were assigned for investigations and the average number of days to assign a case was 17. In Figure 1.2 below we see the intake totals for each month. In May there was slight increase of complaints of 75 cases and this increased the pending numbers for May and June. Most of these cases were assigned in July which accounts for the increase of 94. We also a very slight increase in complaints in November which also increased the pending cases in November and Assigned cases in December.

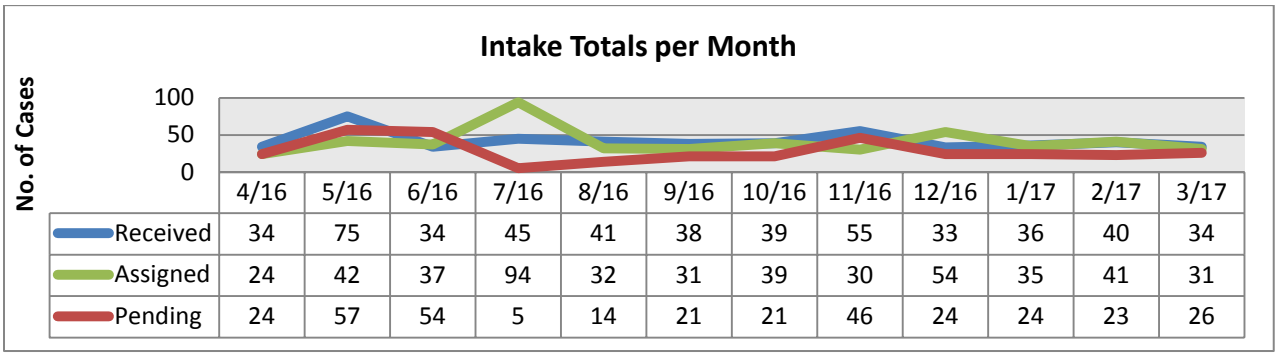


Figure 1.2: Intake Monthly Totals

In Figure 1.3 below, the bar graph illustrates the monthly average number of days to assign or close a complaint. The aging measures the period from the time the complaint is received in the office (the date stamp) to the time the complaint is assigned to investigations or closed. The performance target for intake is 30 days. The Board met the performance target for the last 12 months with one exception, the month of December which averaged 31 days. The overall average for the last 12 months was 17 days.

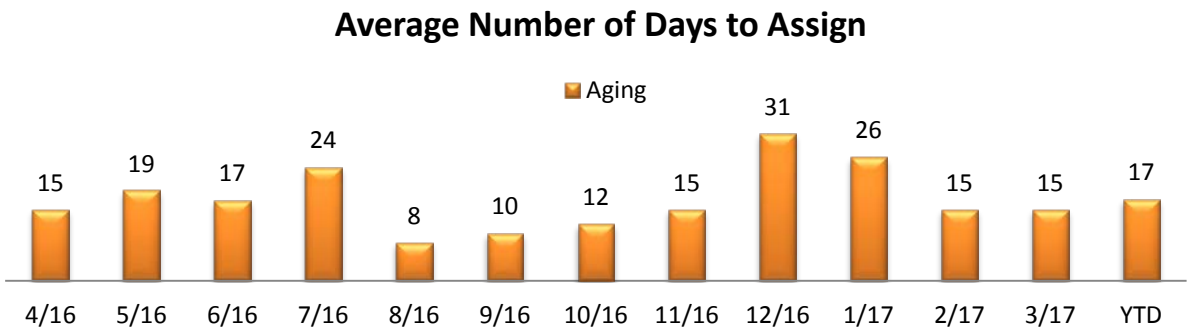


Figure 1.3: Aging

INVESTIGATIONS

Desk (internal) Investigations

	2Q 2016			3Q 2016			4Q 2016			1Q 2017			
Desk Inv.	**4/16**	**5/16**	**6/16**	**7/16**	**8/16**	**9/16**	**10/16**	**11/16**	**12/16**	**1/17**	**2/17**	**3/17**	**YTD**
Assigned	40	42	37	94	35	31	38	30	54	35	41	31	508
Completed	47	53	64	62	59	35	50	27	32	50	29	37	545
Aging	112	80	111	124	82	106	96	57	79	86	105	108	96
Pending	152	142	116	148	125	120	109	111	136	120	133	127	127

Table 2: Desk Investigations

For all desk (internal) investigations during this period, Table 2 above breaks down the monthly totals for how many complaints were assigned and completed; the monthly aging and cases pending. During this period, a totaled of 508 desk investigations were assigned, 545 were completed, and 127 cases were pending. The average number of days to complete a desk investigation was 96 days.

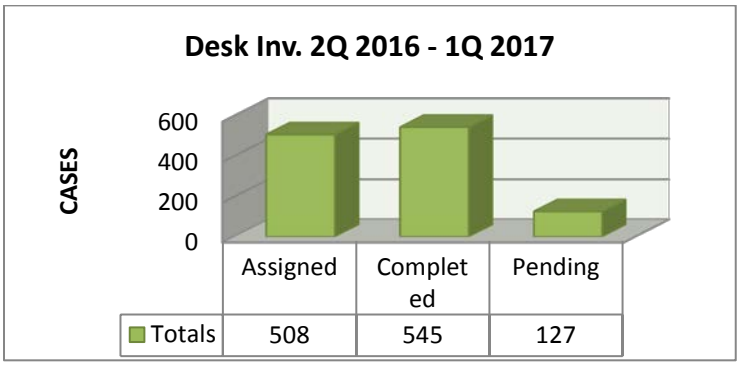


Figure 2.1: Desk Inv. Totals

In Figure 2.2 below, we can see the assigned cases (blue) sharply increased to 94 cases in the month of July. Completed desk investigations (red line) gradually increased in June and July as well. The pending cases (green) where high for the months of April and July and a slight increase in December.

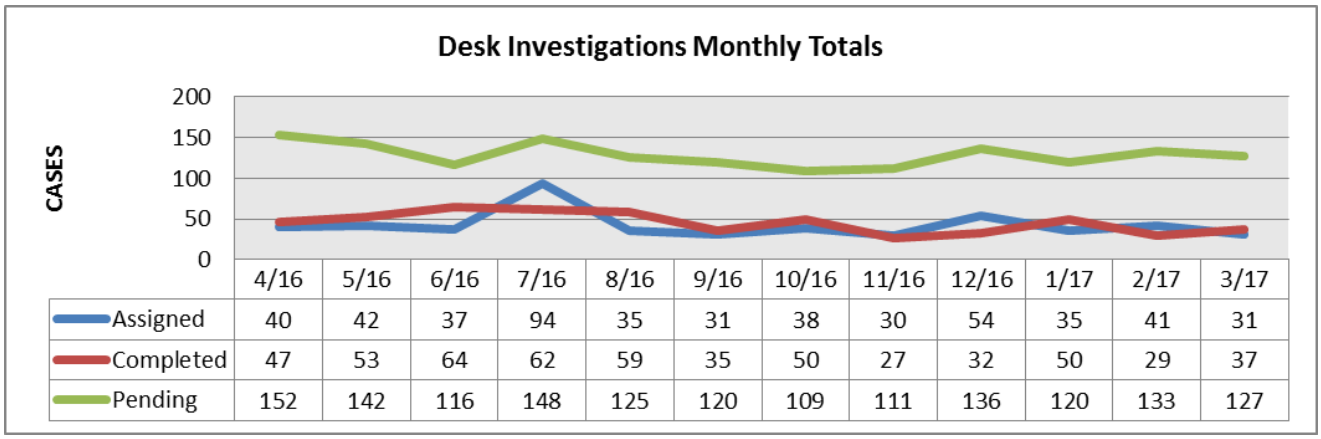


Figure 2.2: Desk Investigations

Field (Sworn) Investigations

	2Q 2016			3Q 2016			4Q 2016			1Q 2017			
Field Inv.	**4/16**	**5/16**	**6/16**	**7/16**	**8/16**	**9/16**	**10/16**	**11/16**	**12/16**	**1/17**	**2/17**	**3/17**	**YTD**
Assigned	6	1	0	2	3	1	2	7	1	1	0	0	24
Completed	2	4	6	1	2	2	2	1	3	2	1	5	31
Aging	172	221	399	155	705	405	177	3	375	353	460	454	323
Pending	43	42	36	35	38	37	37	43	41	40	40	38	38

Table 3: Field Investigations

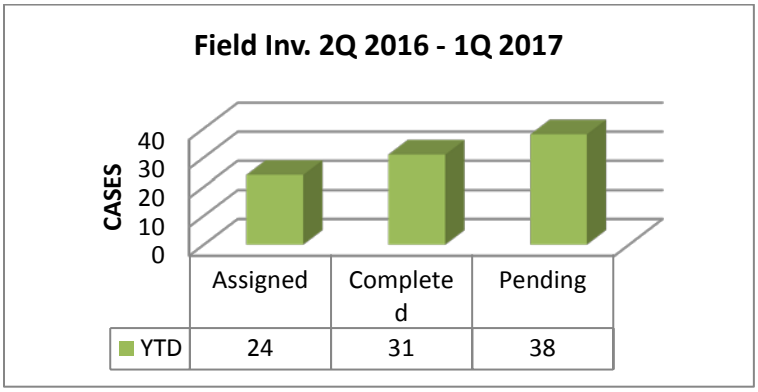


Figure 3.1

Table 3 above breaks down the monthly totals for field investigations assigned to the Division of Investigations. Completed cases are either closed with insufficient evidence or referred to the Attorney General's office for disciplinary action. During this 12 month period, 24 cases were assigned to field investigations; 31 were completed; and the average number of days to complete an investigation was 323. 38 cases were pending at the end of 2016.

Figure 3.2 below compares the aging of completed Desk and Field Investigations per month. The aging is the average number of days to complete an investigation starting from the complaint received date to the date that the investigation is completed. The YTD average to complete a desk (internal) investigation shows a very respectable 96, which is close to three months. The YTD average for Field Investigations was 323; which is 37 days below the performance target of 360. In July we see 705 days for 2 field investigation cases. Both of these cases have been submitted to the Attorney General for discipline. In November, one field investigation case was closed with an aging of 3 days. This was a result of the subject complying with a field inspector from another State Agency.

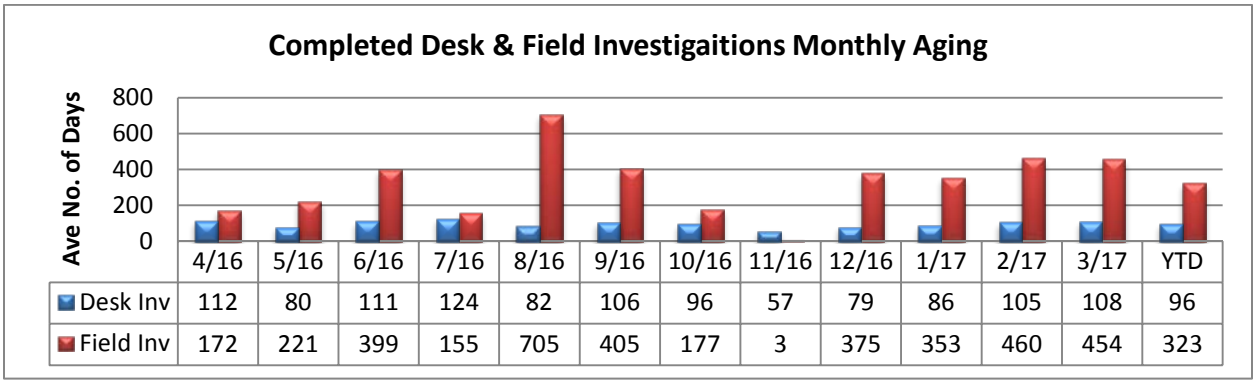


Figure 3.2: Completed Investigations Monthly Aging

Aging for Desk and Field Investigations

	2Q 2016			3Q 2016			4Q 2016			1Q 2017			
All Inv Aging	**4/16**	**5/16**	**6/16**	**7/16**	**8/16**	**9/16**	**10/16**	**11/16**	**12/16**	**1/17**	**2/17**	**3/17**	**YTD**
90 days	33	24	22	34	46	18	18	21	22	26	15	25	304
91-180 days	4	22	30	23	7	14	27	3	8	19	7	6	170
181-1 yr	5	6	12	0	3	2	2	1	1	3	5	5	45
1 yr-2 yrs	0	3	4	1	5	0	1	0	1	1	2	1	19
2 yrs-3 yrs	2	0	1	4	1	2	0	0	1	0	0	0	11
over 3 yrs	1	0	1	1	0	0	0	0	0	0	0	1	4
Totals	**45**	**55**	**70**	**63**	**62**	**36**	**48**	**25**	**33**	**49**	**29**	**38**	**553**

Table 4: All Investigations Aging

In Table 4 and Figure 4.1 we see the aging matrix for the number of investigations that were closed per month within a specific time period. 304 cases, (55%) were completed within 90 days; 170 cases (31%) were completed between 91-180 days; 45 cases (8%) were completed between 181-365 days; 19 cases (3%) were completed between 1 – 2 years; 11 cases (2%) were completed between 2-3 years; and 4 cases (1%) were completed after 3 years. The majority of the investigations (86%) were completed within 6 months; and 94% were completed within a year.

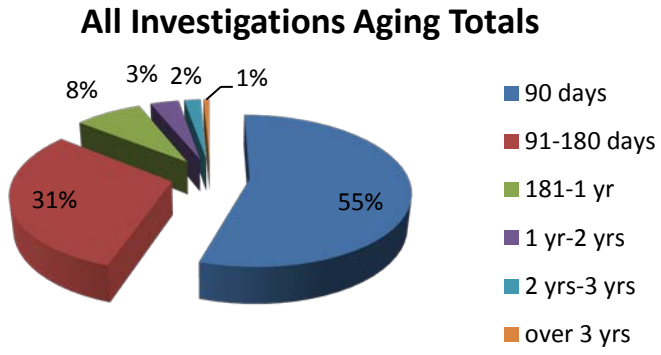


Figure 4.1 All Investigations Aging

ENFORCEMENT ACTIONS

	2Q 2016			3Q 2016			4Q 2016			1Q 2017			
	4/16	5/16	6/16	7/16	8/16	9/16	10/16	11/16	12/16	1/17	2/17	3/17	YTD
AG Cases Initiated	2	3	2	1	5	1	2	0	3	2	2	1	24
Acc/SOI Filed	1	1	0	2	1	1	2	1	1	3	2	0	15
Final Discplinary Orders	2	2	3	0	4	2	2	1	0	1	0	1	18
Acc Withdrawn	0	0	0	0	1	0	0	0	0	0	0	0	1
Closed w/out Disc Action	0	1	0	0	0	0	0	0	0	0	0	2	3
Citations	0	0	0	0	1	1	1	0	0	0	0	1	4
Suspension Orders	1	3	0	0	1	0	0	0	0	0	0	1	6
AG Cases Pending	25	25	23	23	25	24	25	24	26	26	28	25	25

Table 5: Enforcement Actions

For all enforcement actions, Table 5 above breaks down the monthly totals for each disciplinary action. During this 12 month period, 24 cases were transmitted to the Attorney General's Office for disciplinary actions; 15 Accusations and Statement of Issues were filed; 18 Final Disciplinary Orders were filed; 1 accusation was withdrawn; 3 cases were closed without disciplinary action; 4 citations were issued; and 6 Suspension Orders. At the end of 1Q 2017 there were 25 pending AG cases.

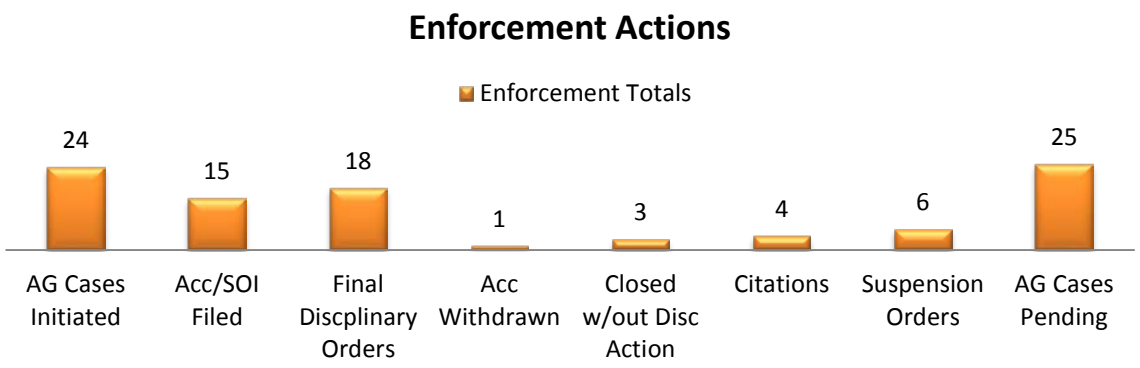


Figure 5.1: Enforcement Actions Totals

Total Final Orders Aging

	2Q 2016			3Q 2016			4Q 2016			1Q 2017			
Total Orders Aging	4/16	5/16	6/16	7/16	8/16	9/16	10/16	11/16	12/16	1/17	2/17	3/17	YTD
90 Days	0	0	0	0	0	0	0	0	0	0	0	0	0
91-180 Days	0	0	1	0	0	0	0	0	0	0	0	0	1
181 - 1 Yr	0	1	0	0	0	0	0	1	0	0	0	0	2
1 - 2 Yrs	1	0	1	0	1	2	1	0	0	0	0	0	6
2 - 3 Yrs	0	0	0	0	0	0	0	0	0	1	0	1	2
3-4 Yrs	1	0	1	0	2	0	1	0	0	0	0	0	5
4 yrs	0	1	0	0	1	0	0	0	0	0	0	0	2
Totals	2	2	3	0	4	2	2	1	0	1	0	1	18

Table 6: Total Final Orders Aging Matrix

In Table 6 (previous page) and Figure 6.1 we see the aging matrix of the 20 Final Orders that were completed from 1Q 2016 to 4Q 2016. The aging measures the period from the date the case was received in the office to the order date (filed date) of the Final Order. The pie chart shows the percentage of cases distributed within each time period. Of the 20 final orders, 1 cases (6%) were completed within 180 days; 2 cases (11%) within 181-365 days; 6 cases (33%) within 1-2 years; 2 cases (11%) within 2-3 years; 5 cases (28%) within 3-4 years, and 2 cases (11%) over 4 years. 50% of the Final Orders were completed within 2 years.

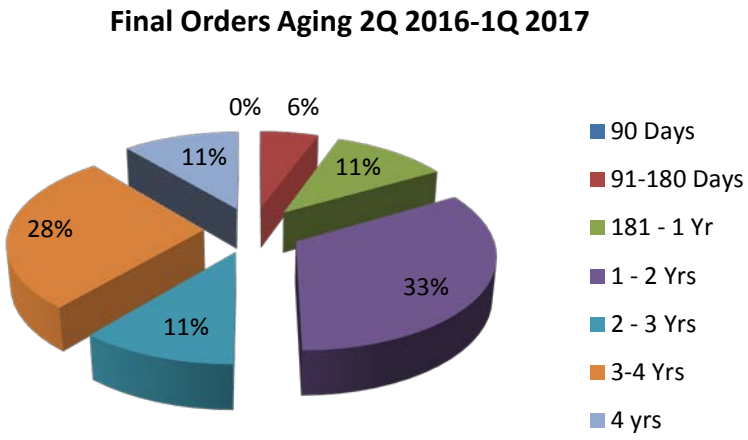
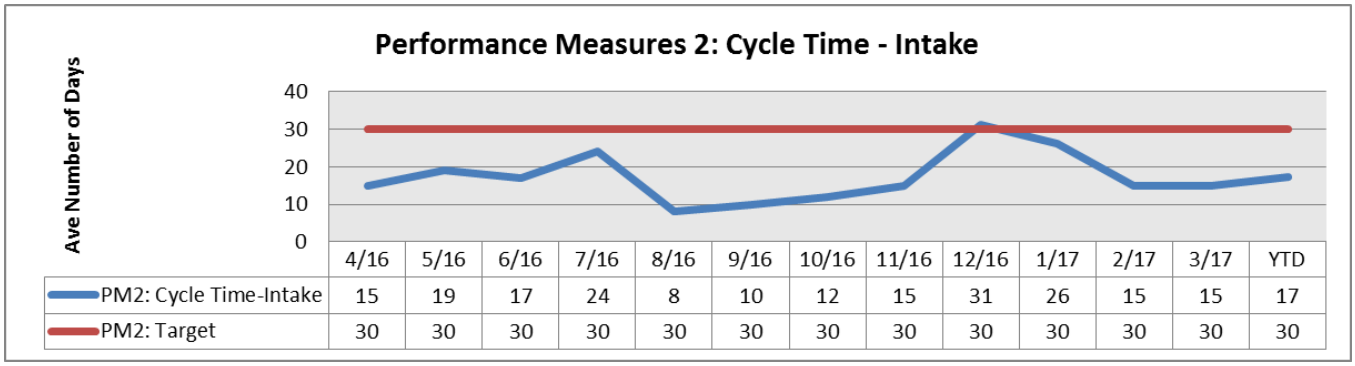


Figure 6.1: Final Orders Aging

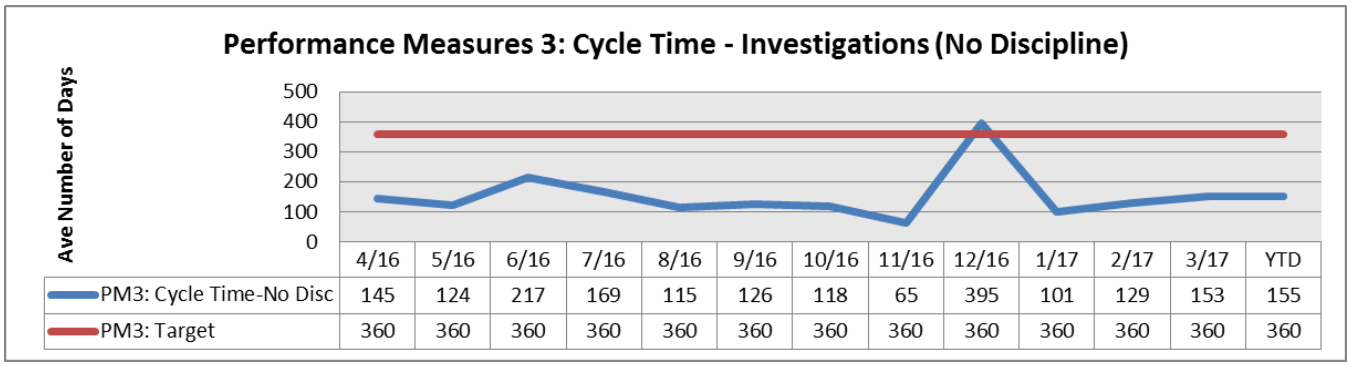
PERFORMANCE MEASURES

PM2: CYCLE TIME-INTAKE: Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



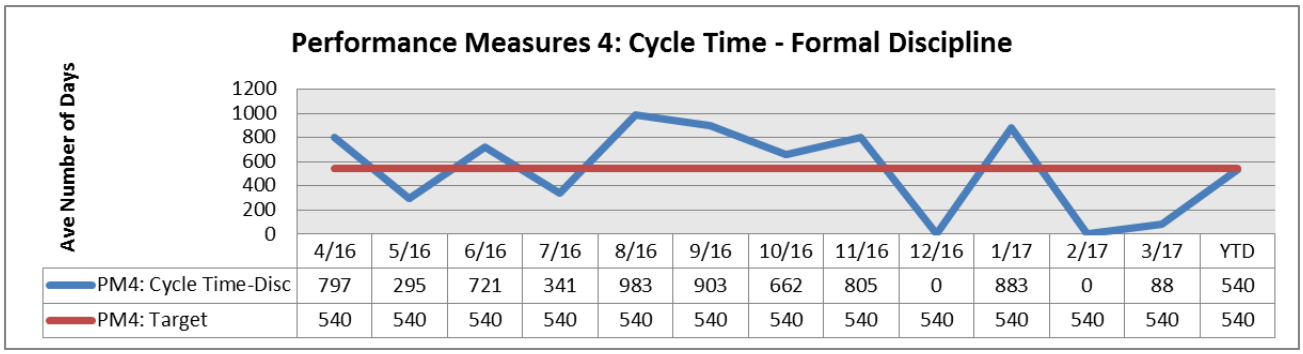
	4/16	5/16	6/16	7/16	8/16	9/16	10/16	11/16	12/16	1/17	2/17	3/17	YTD
PM2: Cycle Time-Intake	15	19	17	24	8	10	12	15	31	26	15	15	17
PM2: Target	30	30	30	30	30	30	30	30	30	30	30	30	30

PM3: CYCLE TIME – INTAKE & INVESTIGATION: Average number of days to complete the entire enforcement process for cases not transmitted to the Attorney General. (Includes Intake and Investigation)



	4/16	5/16	6/16	7/16	8/16	9/16	10/16	11/16	12/16	1/17	2/17	3/17	YTD
PM3: Cycle Time-No Disc	145	124	217	169	115	126	118	65	395	101	129	153	155
PM3: Target	360	360	360	360	360	360	360	360	360	360	360	360	360

PM4: CYCLE TIME – FORMAL DISCIPLNE: Average number of days to complete the entire enforcement process for cases transmitted to the Attorney General for formal discipline. (Includes intake, investigation, and transmittal outcome)

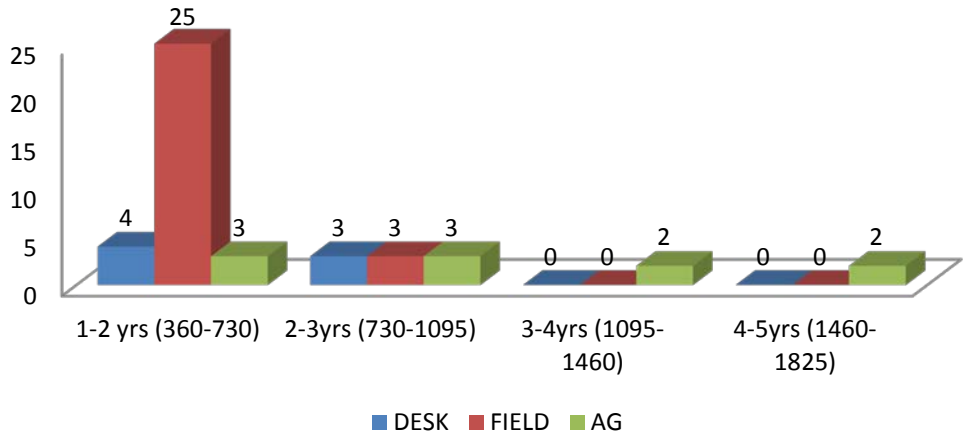


	4/16	5/16	6/16	7/16	8/16	9/16	10/16	11/16	12/16	1/17	2/17	3/17	YTD
PM4: Cycle Time-Disc	797	295	721	341	983	903	662	805	0	883	0	88	540
PM4: Target	540	540	540	540	540	540	540	540	540	540	540	540	540

PENDING CASES EXCEEDING PERFORMANCE TARGETS

For all current pending cases exceeding the Performance Targets, there are 7 desk investigations cases, 28 field investigations cases and 10 Attorney General cases.

	Case Disposition	Target	1-2 yrs (360-730)	2-3yrs (730-1095)	3-4yrs (1095-1460)	4-5yrs (1460-1825)	Totals	Highest aging value
PM3	DESK	360 days	4	3	0	0	7	1064 days
PM3	FIELD	360 days	25	3	0	0	28	1048 days
PM4	AG	540 days	3	3	2	2	10	1712 days



PROBATION

There are currently 43 probation cases, of which 34 cases have a cost recovery order. To date, the total ordered cost recovery is $300,171.72. As of January 18, 2017, $233.128.22 has been paid leaving a balance of $67,043.50

TAB 7

OMBC Bill List May 2017

Bills To Consider Taking Position					
Bill	Subject	Description	Status	Position	Comment
SB 798	OMBC Sunrise	Creates Postgraduate training license, Requires patient notification if on probation.	APPR Com	Support	Need Board decision on support of Postgraduate training license and patient notification.
AB 505	Physicians and Surgeons: Probation	This bill would prohibit the board from entering into any stipulation for disciplinary action if the stipulation places a licensee on probation and the operative accusation includes specified acts.	APPR Com: consent		Will significantly increase Enforcement costs. Intended for MBC, but impacts OMBC. CMA bill.
SB 572	Healing arts licensees: violations: grace period.	This bill would prohibit the boards from taking disciplinary action against, or otherwise penalizing, healing arts licensees who violate those provisions but correct the violations within 15-days if no irreparable harm.	B & P Com		Author refuses to exempt healing arts boards. Rewards non-compliance. Would impact citations.
SB 762	Healing Arts: Volunteer: Fee Waiver	This bill would require OMBC to create a volunteer license, waive the fee for those becoming active: Voluntary, unpaid service to a public agency, not-for-profit agency, institution, or corporation that provides medical services to indigent patients in medically underserved or critical-need population areas of the state.	APPR		Creates loophole for CMEs, Competency concerns, no defined period. Requires Board to create volunteer category. Consent—moving fast.
AB 703	License: Fee Waiver	Requires Boards to grant fee waiver to spouse of active military for initial license, if licensed elsewhere.	B & P Com		Bill not moving.
AB 845	Cannabidiol	Authorizes physician prescription of Cannabidiol for medical purpose if Federal Authority exists.	Asm Fl		Anticipates reclass at Federal Level.
INFORMATIONAL BILLS					
AB 1002	Cannabis: Research.	Expand research to allow clinical trials.	APPR Com	Watch	Informational.
AB 715	Opioid: Workgroup	Creates workgroup in CDPH to review use and abuse of opioids.	APPR Com	Watch	Informational. Bill in suspense.
SB 790	Health Care Providers: Gifts/Benefits	Prohibits gifts from manufactures to physicians—travel, CME, conference, etc.	APPR Com	Watch	Informational.
AB 40	CURES: Access	Urgency Clause, allow ER Physician interface access to CURES	APPR Com	Watch	Informational.

SB 798 Healing arts:
boards (Sunset Bill)

COMMITTEE ANALYSIS

SENATE COMMITTEE ON
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Jerry Hill, Chair
2017 - 2018 Regular

Bill No:	SB 798	**Hearing Date:**	April 24, 2017
Author:	Hill		
Version:	April 18, 2017 Amended		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Sarah Mason		

Subject: Healing arts: boards

SUMMARY: Extends the operation of the Medical Board of California (MBC) and Medical Practice Act (MBC Act) until 2022 and subjects the Osteopathic Medical Board of California (OMBC) and Osteopathic Act (OMBC Act) to review by the appropriate policy committees of the Legislature, to be performed as if the OMBC Act were scheduled to be repealed as of 2022, and makes various changes to the MBC Act and OMBC Act intended to improve oversight of physicians and surgeons and osteopathic physicians and surgeons.

Existing law:

1) Establishes the MBC Act which provides for the licensing and regulation of physicians and surgeons by the Medial Board of California (MBC) until January 1, 2018 within the Department of Consumer Affairs (DCA). MBC has jurisdiction for special program registrants/organizations and special faculty permits which allow those who are not MBC licensees but meet licensure exemption criteria outlined in the Act to perform duties in specified settings. MBC also has statutory and regulatory authority over licensed midwives (LMs), medical assistants, registered polysomnographic trainees, registered polysomnographic technicians, registered polysomnographic technologists, research psychoanalysts and student research psychoanalysts. MBC also approves accreditation agencies that accredit outpatient surgery settings and issues Fictitious Name Permits to physicians practicing under a name other than their own.

2) Establishes the OMBC which provides for the licensing and regulation of osteopathic physicians and surgeons (D.O.s.) by the Osteopathic MBC.

This bill:

1) Extends the operation of MBC until January 1, 2022 and subjects the OMBC and to review by the appropriate policy committees of the Legislature, to be performed as if the OMBC Act were scheduled to be repealed as of January 1, 2022.

2) Makes various changes to clarify that doctors of podiatric medicine (DPMs) are licensed by the Board of Podiatric Medicine (BPM).

3) Requires MBC and OMBC to provide information to an inquiring member of the public, and on any board documents like newsletters, about licensees on probation and licensees practicing under probationary licenses.

4) On and after July 1, 2018, requires MBC and OMBC licensees to provide a patient or the patient's guardian or healthcare surrogate with a disclosure prior to the patient's first visit if the licensee is on probation on or after July 1, 2018 that contains the following:

   a) The licensee's probationary status.

   b) The length of the probation and the end date.

   c) All practice restrictions placed on the licensee by MBC or OMBC.

   d) MBC or OMBC's phone number.

   e) An explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the MBC or OMBC online license information site, if the probation was imposed by MBC or OMBC.

5) Requires MBC and OMBC licensees to obtain a signed copy of the disclosure outlined above from the patient or the patient's guardian or health surrogate. Provides an exemption to the disclosure requirement if the patient is unconscious or otherwise unable to comprehend the disclosure and if a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the receipt of disclosure and if the visit occurs in an emergency room and the licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit. Specifies that the licensee shall disclose his or her status as soon as either the patient or a guardian or health care surrogate is available to comprehend and sign the disclosure.

6) Requires MBC and OMBC to provide the following information on the MBC and OMBC online license information sites for licensees on probation and practicing under probationary licenses:

   a) The causes alleged in the operative accusation for probation imposed pursuant to a stipulated settlement along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

   b) The causes for probation stated in the final probationary order for probation imposed by an adjudicated decision of MBC or OMBC.

   c) The causes by which the probationary license was imposed for a licensee granted a probationary license.

   d) The length of the probation and an end date.

   e) All practice restrictions placed on the license by MBC or OMBC.

MBC Specific Provisions

7) Authorizes MBC to seek cost recovery from physicians found in violation of the Act to recoup resources utilized for enforcement of these cases.

8) Removes MBC's authority to approve specialty boards that provide certification to physicians that are not approved by the American Board of Medical Specialties (ABMS). Prohibits a physician from advertising that he or she is "board certified" unless the individual holds a certification from a specialty board approved by the ABMS, a specialty board with an Accreditation Council for Graduate Medical Education (ACGME) accredited post graduate training program, or a specialty board approved by MBC prior to January 1, 2018.

9) Requires state agencies and hospital accrediting agencies to report peer review incidents to MBC that are found during an inspection of a health care facility or clinic, subject to BPC § 805 reporting requirements (which require alerting MBC if a licensee's application for staff privileges is denied or rejected; his or her membership, staff privileges, or employment is terminated of revoked for medical disciplinary reasons; or if restrictions are imposed, or voluntarily accepted, on staff privileges, membership or employment for a cumulative total of 30 days or more for any 12 month period, for a medical disciplinary cause or reason that are found).

10) Provides that a willful failure to file a report pursuant to BPC § 805.1 is punishable by a fine of up to $100,000 per violation. Provides that any failure by the administrator of a peer review body, by the chief executive officer or administrator of a health care facility or by any person designated to file a 805.1 report is punishable by a fine up to $50,000. Requires state agencies and hospital accrediting agencies to report peer review incidents subject to BPC § 805.1 reporting requirements that are found during an inspection of a health care facility or clinic.

11) Authorizes the MBC president to serve on a MBC panel established to carry out disciplinary actions.

12) Requires MBC adopt regulations on or before January 1, 2019 to require licensees and registrants to provide notice to clients or patients that the practitioner is licensed or registered by MBC and that the license can be checked and complaints against the licensee made through MBC's website or by contacting MBC.

13) Changes the postgraduate training requirements for licensure from one or two years of postgraduate training to three years of postgraduate training. Deletes the requirement for MBC to recognize international medical schools and instead requires individuals to have graduated from a medical school listed in the World Health Organization's directory as an approved school.

14) Authorizes MBC to issue licenses on a two-year cycle.

15) Requires accredited outpatient surgery settings to report data to the Office of Statewide Health Planning and Development (OSHPD). Updates reporting requirements for adverse events in outpatient surgery settings.

16) Replaces "promptly" with "automatically" for the MBC to revoke the license of an individual required to register as a sex offender.

17) Authorizes MBC to issue a cease practice order in cases where the licensee delays, or fails to comply with, an order issued under BPC § 820 (which authorizes MBC to order a physician to undergo a physical or mental health examination when MBC determines, through the course of an investigation, that a licensee's ability to practice may be impaired by physical or mental illness) within the specified time frame as set forth in the order.

18) Prohibits the use of expert witness testimony in matters before MBC unless a complete expert witness report is received that includes a complete statement of all opinions the expert witness will express with the basis for those, the facts or data considered by the expert in forming opinions and any exhibits that will be used to summarize or support the opinions.

19) Transfers registration of research psychoanalysts from MBC to the Board of Psychology (BOP) which already successfully administers registration programs for individuals practicing psychologists.

20) Deletes provisions that states that a vertical enforcement prosecution model for investigation of certain cases is in the best interests of the people of California and that require certain complaints referred for investigation to be simultaneously and jointly assigned to a MBC investigator and to a deputy attorney general (DAG) within the Office of the Attorney General (OAG) Health Quality Enforcement Section (HQE).

21) Authorizes MBC to once again appoint members to the board of the Health Professions and Education Foundation which administers the Steven M. Thompson Physician Corps Loan Repayment Program.

OMBC Specific Provisions

22) Authorizes OMBC to obtain criminal history information from the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI).

23) Aligns the OMBC continuing medical education (CME) cycle with the with the renewal cycle for D.O. licenses.

Provisions Related to Licensed Midwives

24) Adds LMs and midwifery societies to peer review provisions outlined in BPC § 805 (which states that a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, in order to determine whether a licentiate may practice, or continue to practice in a health care facility, clinic, or other setting providing medical services, and if so, to determine the parameters of that practice, and/or to assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.)

25) Authorizes LMs to be shareholders, officers, and directors of corporations.

FISCAL EFFECT: Unknown. This bill is keyed "fiscal" by Legislative Counsel.

COMMENTS:

1. **Purpose.** This bill is sponsored by the Author, and is one of four "sunset bills" the Author is sponsoring this year. According to the Author, this bill is necessary to make changes to the MBC Act, MBC operations, OMBC Act and OMBC operations in order to improve oversight of oversight of physicians and surgeons and osteopathic physicians and surgeons.

2. **Oversight Hearings and Sunset Review of Licensing Boards and Programs.** Beginning in 2016, the Senate Business and Professions Committee and the Assembly Business and Professions Committee (Committees) began their comprehensive sunset review oversight of 13 regulatory entities and the DCA which included: MBC, OMBC, California Council for Interior Design Certification, Board of Chiropractic Examiners, State Board of Guide Dogs for the Blind, Naturopathic Medicine Committee, California Board of Occupational Therapy, California State Board of Optometry, Physical Therapy Board of California, Board of Registered Nursing, Respiratory Care Board of California, Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board and Board of Vocational Nursing and Psychiatric Technicians

   The Committees conducted three oversight hearings in February and March. This bill and the accompanying sunset bills are intended to implement legislative changes as recommended by staff of the Committees and which are reflected in the Background Papers prepared by Committee staff for each agency and program reviewed this year.

3. **Background on MBC.** MBC's history dates back to 1876 with the passage of the first MBC Act. Through its licensing program, MBC ensures that only qualified applicants, pursuant to the requirements in the MBC Act and related regulations, receive a license or registration to practice. Via its enforcement program, allegations of wrongdoing are investigated and disciplinary or administrative action is taken as appropriate. Under the MBC Act, MBC has jurisdiction over physicians licensed by the state as well as special program registrants/organizations and special faculty permits which allow those who are not MBC licensees, but meet licensure exemption criteria outlined in the MBC Act, to perform duties in specified settings. MBC also has statutory and regulatory authority over licensed midwives, medical assistants, registered polysomnographic trainees, registered polysomnographic technicians, registered polysomnographic technologists, research psychoanalysts and student research psychoanalysts. MBC also approves accreditation agencies that accredit outpatient surgery settings and issues Fictitious Name Permits to physicians practicing under a name other than their own. MBC is comprised of 15 members: eight physicians and seven public members. MBC currently has 141,967 physician and surgeon licensees.

4. **Review of the MBC – Issues Identified and Recommended Changes.** The following are some of the major issues pertaining to MBC along with background information concerning the particular issue. Recommendations were made by Committee staff regarding the particular issue areas which needed to be addressed.

a) **Issue: Board of Podiatric Medicine (BPM).**

Background: MBC provides administrative services to other entities at the DCA under the term "shared services." MBC provides these shared services on a contract basis for the BPM and the Physician Assistant Board, smaller programs that do not have sufficient infrastructure and administrative capacity. Unfortunately, confusion has arisen as to the exact nature of MBC's role in BPM operations.

When the Podiatry Examining Committee was first created under MBC, terminology describing the relationship between the two entities, as well as the relationship itself was entirely different. In 1980, BPC § 2460 "created within the jurisdiction of the Division of Allied Health Professions of the Board of Medical Quality Assurance, a Podiatry Examining Committee." BPC 2460 today reads that there is "created within the jurisdiction of the Medical Board of California the California Board of Podiatric Medicine." However in practice, BPM is a wholly separately entity; it appears that the Act has not always been updated to reflect changes in both the relationship, as well as terminology of these two entities.

Historically, MBC issued certificates to practice podiatric medicine to qualified applicants because the Committee was under MBC's jurisdiction. The Act defines "podiatric medicine" as all medical treatment of the foot, ankle, and tendons that insert into the foot, including diagnosis, surgery, and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot. Therefore, a DPM's scope of practice is similar to that of a physician and surgeon who specializes in the foot and ankle. However, unlike a physician and surgeon, whose scope is only limited by the licensee's own area of competence, a DPM's scope is statutorily limited to the foot and ankle.

BPM determines the qualifications for licensure, reviews applications, and makes all decisions about DPM licensure, and until 2016, issued its own licenses to its own licensees. However, the actual BPM licenses included a Medical Board of California seal, despite the BPM being functionally separate. MBC staff, through a shared services agreement, offered to update the BreEZe system in order to ministerially issue a DPM license on behalf of BPM because existing law specifies that the MBC issues the podiatric medicine license.

MBC subsequently requested, and legislation was proposed last year (SB 1039, Hill), to clarify that BPM is its own board that performs its own licensing functions and that the law should accurately reflect the responsibility of each independent entity. In response to concerns raised by the BPM, California Podiatric Medical Association (CPMA), and California Medical Association, SB 1039 was amended in the Assembly to remove the provisions related to BPM because certain individuals believed that affiliation with the MBC was not only intangibly

advantageous due to physicians' greater scope and prestige, but that BPM's statutory siting within MBC's jurisdiction conferred tangible benefits.

Technical statutory changes to the Act will not impact the two boards' shared services agreement, as that is separate from statute and clarifies the contractual services MBC provides to BPM. Further, there has been no evidence that any code cleanup will impact either of the boards' roles in effectively carrying out its administrative responsibilities, nor does it appear that additional cost will arise from changes to the Act, since the administrative shared services agreement delineates the charges and services MBC provides.

Recommendation and Proposed Statutory Change: *The Act should be amended to clarify the nature of DPM licensure by BPM.*

This bill makes various changes to clarify that DPMs are licensed by the BPM.

b) **Issue: Public Notification of Disciplinary Action.**

Background: The background paper noted concerns about barriers to consumers' access to easily understandable information about MBC and OMB licensees who have been the subject of disciplinary action, placed on probation and continue practicing. When the MBC places physicians on probation, generally they continue to practice medicine and see patients under restricted conditions. Terms of probation may include certain practice limitations and requirements, but most commonly physicians on probation are not required to provide any information to their patients regarding discipline taken by MBC.

A determination of probation is a step in a lengthy disciplinary process, conducted in accordance with the Administrative Procedures Act, and offering due process for accused licensees. Once an individual is placed on probation, they have already had an accusation filed against them which is publicly available on MBC's website. The filing of an accusation alone requires significant justification that a violation of the Act has occurred. In reviewing MBC data for current physicians on probation, proven violations that result in probation include gross negligence or incompetence, substance abuse, inappropriate prescribing, sexual misconduct or conviction of a felony. According to MBC data, there are currently 635 physicians on probation, only a fraction of overall MBC licensees.

The MBC posts information regarding probation on its Web site and distributes the information to its email list. However, the groups most likely to benefit from this information are the least likely to have access to electronic communications. According to a recent Pew Research Center U.S. analysis, seniors, the most likely group to seek healthcare, are also the group most likely to say they never go online. About four in ten adults ages 65 and older (39 percent) do not use the internet, compared with only 3 percent of 18- to 29-year-olds. One-in-five African Americans, 18 percent of Hispanics and 5 percent of English-speaking Asian Americans do not use the internet, compared with 14 percent of whites.

Patients may be especially deserving of greater access to information about a physician on probation given the potential for future disciplinary action. The 2008 California Research Bureau (CRB) study reported that physicians who have received serious sanctions in the past are far more likely to receive additional sanctions in the future. According to the CRB report, "These findings strongly imply that disciplinary histories provide patients with important information about the likely qualities of different physicians." The CRB cited research that examined physician discipline data provided by Federation of State Medical Boards.

In October 2012 MBC staff proposed to the MBC that physicians be required to inform their patients when he or she is on probation and required to have a monitor. In its recommendation staff said, "This would insure the public has the ability to make informed decisions regarding their healthcare provider." MBC did not approve the staff proposal.

In 2015, a petition filed before the MBC by Consumers' Union Safe Patient Project called on MBC to amend its Manual of Model Disciplinary Orders and Disciplinary Guidelines by requiring physicians on probation to notify patients about their status as a probationer.

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

Recommendation and Proposed Statutory Change: *The Act should be amended to ensure that patients receive timely notification of their physician's probationary status, that patients are easily able to obtain understandable information about violations leading to probation, and that MBC makes changes to the disciplinary enforcement information displayed on its website to allow for easier public access and understanding of actions MBC has taken.*

This bill implements the above recommendation and requires MBC and the OMBC licensee to provide a patient or the patient's guardian or healthcare surrogate with a disclosure prior to the patient's first visit if the licensee is on probation that contains certain information as specified. Requires MBC and OMBC licensees to obtain a signed copy of the disclosure but provides an exemption to the disclosure requirement if certain circumstances exist

prior to disclosure, but specifies that the licensee shall still disclose his or her probationary status as soon as the patient or a guardian or health care surrogate is available to comprehend and sign the disclosure.

Also requires MBC and OMBC to provide specified information online for licensees on probation and practicing under probationary licenses.

c) **Issue: Board Certification.**

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

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

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

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

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

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

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

The law addresses advertising and does not in any way require physicians to be board certified or formally trained to practice in a specialty or in the specialty of which they practice. Physicians only need to possess a valid physician's license to practice in any specialty.

MBC does not appear to face significant cost pressure for its actual review of these boards, as there have been few applications in recent years. MBC has statutory authority to increase the application fee as necessary to cover its review costs.

However, MBC has incurred significant costs related to litigation over MBC board denials. The American Academy of Pain Management was denied and filed four suits against the MBC, including one in Federal Court. The American Board of Cosmetic Surgery applied for approval twice, was denied both times, and filed suit on the second denial. To date, MBC has prevailed in these cases but at considerable costs, conservatively estimated in excess of $200,000 due in large part to the very high charges for OAG attorneys to represent MBC in these matters.

The ABMS is a well-established, large organization with tremendous resources, both in revenue, infrastructure, and expertise, far beyond those of MBC. The Act basically tasks MBC with performing the same duties, with regards to the work MBC undertakes to approve non-ABMS boards, as the tasks of ABMS, the ACGME and the specialty boards and their residency review committees, yet MBC has only a fraction of their resources. Unlike the ABMS process, the MBC is not a part of developing curriculum or training programs, but is being required to consider whether or not the criteria for certification and the training provided is "equivalent" as defined by the MBC regulation.

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

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

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

This bill removes MBC's authority to approve specialty boards that provide certification to physicians that are not approved by the American Board of Medical Specialties (ABMS). Prohibits a physician from advertising that he or she is "board certified" unless the individual holds a certification from a specialty board approved by the ABMS, a specialty board with an Accreditation Council for Graduate Medical Education (ACGME) accredited post graduate training program, or a specialty board approved by MBC prior to January 1, 2018.

d) **Issue: Cost Recovery.**

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

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

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

This bill authorizes MBC to seek cost recovery from physicians found in violation of the Act to recoup resources utilized for enforcement of these cases.

e) **Issue: Enforcement Enhancements.**

Background: The background paper noted a number of changes to the MBC Act to improve MBC enforcement efforts.

BPC § 2232 requires the "prompt revocation" of a physician and surgeon's license when a licensee has been required to register as a sex offender based on a conviction for certain sexual offenses. MBC notes in its 2016 report to the Legislature that allowing physicians who are sex offenders to continue to practice medicine is contrary to its public protection mandate.

However, as currently written, obtaining a prompt revocation has proven to be difficult for MBC. Once MBC learns that a doctor has been convicted of a crime requiring that he or she register as a sex offender, the MBC requests OAG to file an accusation on its behalf. This accusation, along with several other documents, is served on the respondent physician, and he or she has 15 days to file a Notice of Defense (NOD). MBC and OAG are then required to wait to receive that NOD before requesting to set a hearing with the Office of Administrative Hearings (OAH). Once the hearing is set, pursuant to the APA, OAG is then required to send the respondent physician a Notice of Hearing no less than 10 days prior to the date of the hearing. Therefore, over a month will have passed before a hearing can even be set from the time MBC is notified that a physician has registered as a sex offender. If OAH does not quickly set the hearing after a request has been filed, a prompt revocation can actually turn into a several-month delay. In the meantime, because there are no restrictions on the license, the offending doctor may practice medicine and the public is at risk for possible further harm, unless MBC has been able to successfully take other action like obtaining an Interim Suspension Order.

MBC notes that without a definition of "prompt" in the Act and without tools for "prompt revocation", MBC is actually not able to take quick action. According to MBC, an automatic revocation of a license would make more sense for these situations. MBC notes that automatic revocations are not new to professional licensees and cites the example of teachers who have been convicted of certain sex offenses who are suspended by the Commission on Teacher Credentialing without having a hearing beforehand. Once the conviction becomes final, the teacher's license is revoked.

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

addition, if the physician requests a hearing at OAH after the revocation, their due process rights will be satisfied at the administrative level by allowing review of MBC's decision.

BPC § 2225 provides that "Notwithstanding § 2263 and any other law making a communication between a physician and surgeon…and his or her patients a privileged communication, those provision shall not apply to investigations or proceedings conducted under this chapter."

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

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

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

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

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

This bill makes a number of changes to enhance MBC's enforcement efforts.

f) **Issue: Licensed Midwives.**

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

MBC receives guidance on midwifery issues through a Midwifery Advisory Council (MAC). The MAC is made up of LMs, a physician, and two non-physician public members. MBC is working with stakeholders through the MAC and a specified task force in order to define "normal" in regulations, for purposes of clarifying births an LM can attend, as required under current law. Until MBC adopts regulations, LMs are not able to be a "comprehensive perinatal provider" for purposes of providing comprehensive perinatal services to Medi-Cal beneficiaries in the Comprehensive Perinatal Services Program (CPSP).

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

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

Current law authorizes a medical corporation to have a number of health licensees as officers, directors, and shareholders but LMs are not included.

Peer Review. Current law, BPC § 805, requires specified health-related professional societies, duly-appointed committees of a medical specialty society, duly-appointed committees of a state or local health related professional society or duly-appointed members of a committee of a professional staff of a licensed hospital that undertakes peer review, to provide reports to the MBC or other state licensing board under certain circumstances. LMs are not currently included in this requirement and should be added.

Existing law also provides that there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, these entities for acts performed within the scope of the functions of peer review.

Existing law also provides that the proceedings and actions of these entities that have responsibility for the evaluation and improvement of the quality of care

provided by the members of the professional society are not subject to discovery in civil actions. Likewise, persons in attendance at any meeting of any such committee cannot be compelled to testify regarding what transpired at the meeting. LM professional societies and LM review committees are not included and should be added. Peer review provisions should include LMs.

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

This bill adds LMs and midwifery societies to peer review provisions outlined in BPC § 805 and authorizes LMs to be shareholders, officers, and directors of corporations.

g) **Issue: Vertical Enforcement.**

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

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

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

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

sought to address disagreements by providing clarified definitions regarding the roles of each office and the expected amounts of direction and supervision HQE should provide HQIU.

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

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

There are still significant working relationship challenges between HQIU and HQE, despite completion of the protocol manual. HQE DAGs may direct investigators to seek out certain information that could prove beneficial in an administrative licensure case but that impacts the independence trained peace officer investigators need in order to effectively investigate cases. Government Code provisions related to VE specifically use the word "direction," stating that an investigator shall, "under the direction but not the supervision of the deputy attorney general," be responsible for obtaining evidence in a matter. This no doubt impacts the team approach and may result in the expertise of both the investigator and DAG not being effectively utilized. Not every case should result solely in administrative action as initiated by a DAG, as investigations may bring criminal violations to light as well. HQIU faces an almost 40 percent vacancy in investigators, numbers that are not the same for other DOI investigators whose cases are not required to be coordinated with a DAG from the outset, and who may have independence in how they put their investigative skills to use.

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

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

This bill deletes provisions that state a vertical enforcement prosecution model for investigation of certain cases is in the best interests of the people of California and that require certain complaints referred for

investigation to be simultaneously and jointly assigned to a MBC investigator and to a DAG within the OAG HQE.

5. **Background on OMBC.** The Osteopathic Initiative Act (Act) was approved by California voters in 1922, establishing a Board of Osteopathic Examiners tasked with licensing osteopathic physicians and surgeons, who had previously been regulated by the Board of Medical Examiners (the predecessor of today's MBC). OMBC is charged with the licensing and regulation of D.O.s. OMBC's statutes and regulations set forth the requirements for licensure and provide OMBC the authority to discipline a licensee. D.O.s are authorized to prescribe medication and practice in all medical and all surgical specialty areas similar to Medical Doctors (M.D.s). According to OMBC, D.O.s are trained to consider the health of the whole person and use their hands in an integrated approach to help diagnose and treat their patient. A D.O. may use the title "Doctor" or "Dr." but must clearly state that he or she is a D.O. or osteopathic physician and surgeon. OMBC states that a key difference between the two professions is that D.O.s have additional dimension in their training and practice, a component that is not taught in allopathic medical schools. Osteopathic medicine gives particular recognition to the musculoskeletal system (the muscles, bones and joints) which comprise over 60 percent of body mass. The D.O. is trained to recognize that all body systems, including the musculoskeletal system, are interdependent, and a disturbance in one can cause altered functions in other systems of the body. The D.O. is also trained in how this interrelationship of body systems is facilitated by the nervous and circulatory systems. The emphasis on the relationship between body structure and organic functioning is intended to provide a broader base for the treatment of the patient as a unit. D.O.s use structural diagnosis and manipulative therapy along with all of the other traditional forms of diagnosis and treatment to care for patients. At the end of 2016, OMBC reported that there are over 7,700 licensed D.O.s, almost 6,700 of which are practicing in California.

6. **Review of the OMBC – Issues Identified and Recommended Changes.** The following are some of the major issues pertaining to OMBC along with background information concerning the particular issue. Recommendations were made by Committee staff regarding the particular issue areas which needed to be addressed.

   a) **Issue: Arrest and Conviction Information.**

   Background: Current law authorizes specified boards to obtain fingerprints of prospective licensees for the purposes of allowing the board to ascertain if an applicant had been convicted of any crimes prior to licensure. The law allows DOJ and FBI to subsequently notify boards of arrests or convictions of an applicant and subsequent licensee. When the statute was put into place, OMBC already had regulations requiring all applicants to be fingerprinted prior to issuance of a license.

   Subsequent legislation in 2013 (SB 305, Lieu, Chapter 516, Statutes of 2013) amended BPC § 144.5 to authorize specified boards to receive certified records of all arrests and convictions, certified records regarding probation and any and all other related documentation needed to complete an applicant or licensee investigation from a local or state agency. At the time, boards reported that they

were being challenged by courts and local law enforcement agencies about eligibility to obtain this important information. These records are necessary for boards to determine when disciplinary action is warranted, however, because the new code section was based on the previous code section, OMBC is not one of the boards authorized to receive these records. Yet, OMBC has express authority to take disciplinary action based on certain criminal convictions.

When a D.O. is arrested, OMBC does receive reports from DOJ but needs to be able to determine when administrative action against a license should be taken and having certified copies of police reports and court documents assists OMBC in determining the proper course of disciplinary action. OMBC cites its lack of inclusion in BPC 144.5 as creating challenges for OMBC to take swift action against licensees who pose a risk to the public.

Recommendation and Proposed Statutory Change: *OMBC should be authorized to obtain information documents that can assist OMBC in taking swift disciplinary action when necessary. BPC § 144 should be amended to include OMBC, which in turn will ensure that the provisions of BPC § 144.5 apply to them as well.*

This bill authorizes OMBC to obtain criminal history information from the DOJ and FBI.

b) **Issue: Continuing Medical Education (CME).**

Background: In 1995, OMBC changed its CME reporting and compliance cycle from an annual cycle to a three year cycle, resulting in different cycle times to validate CME and to validate D.O. licenses. This may cause confusion for licensees renewing their license according to one cycle and adhering to a separate cycle for showing compliance with CME requirements which is required for a license to be renewed.

By amending BPC 2454.5, OMBC may be able to be more effective in issuing renewals and confirming CME completion. A two-year cycle for both licensure renewal and CME compliance will not result in changes to the number of CME hours required, as OMBC would still requires 100 hours every two years (the current 150 hour requirement is based on this three-year cycle and 50 CME hours annually).

OMBC also requires D.O.s to provide documentation showing that CME was completed at the time of renewal, but does not require any verification from CME providers (primary source documentation) that the education was completed. The new Executive Officer of the Board of Registered Nursing recently proposed an innovative solution to receipt of information from third-party sources, specifically uploading materials directly into a cloud that DCA manages. OMBC may consider whether there are more efficient ways to ensure CME completion such as proof of completion provided directly to OMBC through the DCA cloud. OMBC may wish to explore how the receipt of documents in this model could then be noted in BreEZe so that when a D.O. attempts to renew a license, this information data piece is readily available.

Recommendation and Proposed Statutory Change: *The Committees should amend the Act to align the CME and license renewal cycles. OMBC should explore innovative methods to confirm CME completion and update the Committees on steps it is taking to streamline processes.*

This bill aligns the OMBC continuing medical education (CME) cycle with the with the renewal cycle for D.O. licenses.

7. **Related Legislation This Year.** SB 796 (Hill) of 2016 adds a four year sunset date to the Naturopathic Medicine Committee and Respiratory Care Board of California and makes statutory changes to improve the effectiveness of these regulatory entities. (Status: *This bill is currently set for a hearing in this committee on April 24, 2017*.)

   SB 797 (Hill) of 2016 permits the Board of Vocational Nursing and Psychiatric Technicians to delegate its authority to adopt a decision entered by default and a stipulation for surrender of a license to the Executive Officer. (Status: *This bill is currently set for a hearing in this committee on April 24, 2017*.)

   SB 799 (Hill) of 2016 extends the sunset date on the Board of Registered Nursing (BRN) and makes other statutory changes to improve the effectiveness and efficiency of this regulatory and licensing entity. (Status: *This bill is currently set for a hearing in this committee on April 24, 2017*.)

8. **Arguments in Support.** OMBC and the Naturopathic Medicine Committee support provisions related to OMBC in this bill.

9. **Arguments in Opposition.** The Center for Public Interest Law (CPIL) opposes provisions in this bill that eliminate the VE model. According to CPIL, "the use of VE decreased MBC investigative case cycle times by 30 percent since its inception on January 1, 2006 through July 1, 2014. Yet VE is now being blamed for a recent spike in the time it takes to investigate MBC disciplinary matters. In reality, a serious, chronic, longstanding investigator vacancy rate – dating back to the mid-1980s – is more likely to blame." CPIL believes that the transfer of MBC investigators to DCA's DOI in 2014 has exacerbated the vacancy problem and caused the case cycle times to soar and notes that the amendments to this bill do nothing to address this persistent problem. CPIL instead suggests that, rather than eliminating VE, the enduring solution is to relocate the investigators to OAG's HQE which would not only address the investigator vacancy rate, but greatly facilitate implementation of the VE process to function as originally intended.

   CPIL states VE is not the problem, the problem is that VE has never been implemented in an acceptable way. According to CPIL, it is necessary to put all of the team members (prosecutors, investigators, and medical consultants) within the same agency so they can be collocated in the same buildings (or at least in the same city) and can use the same computer system.

SUPPORT AND OPPOSITION:

Support:

Naturopathic Medicine Committee
Osteopathic Medical Board of California

Opposition:

Center for Public Interest Law

-- END --

PROPOSED LEGISLATION

SB-798 Healing arts: boards. (2017-2018)

Date Published: 04/18/2017 09:00 PM

AMENDED IN SENATE APRIL 18, 2017

CALIFORNIA LEGISLATURE— 2017–2018 REGULAR SESSION

SENATE BILL No. 798

Introduced by Senator Hill

February 17, 2017

An act to amend Sections *115.6, 125.3, 144, 146, 328, 651, 656, 683, 800, 803.1, 805, 805.01, 805.1, 805.5, 805.6, 810,* 2001, *2006, 2008,* 2020, ~~and 2450 of~~ *2054, 2064, 2065, 2066.5, 2082, 2084, 2084.5, 2087, 2096, 2105, 2111, 2112, 2113, 2135, 2135.5, 2143, 2168.4, 2191, 2216.3, 2220.05, 2221, 2225, 2232, 2334, 2415, 2421, 2423, 2435, 2435.2, 2450, 2454.5, 2460, 2461, 2472, 2474, 2475, 2479, 2486, 2488, 2492, 2499, 2525.2, 4170, and 4175 of, to amend and renumber Sections 2529, 2529.1, 2529.5, and 2529.6 of, to add Sections 2026, 2064.5, 2216. 5, 2228.1, 2499.7, and 2566.2 to, to add the heading of Article 3.5 (commencing with Section 2950) to Chapter 6.6 of Division 2 of, to repeal Sections 2052.5, 2066, 2067, 2072, 2073, 2085, 2089, 2089.5, 2089.7, 2090, 2091, 2091.1, 2091.2, 2100, 2102, 2103, 2104, 2104.5, 2107, 2115, 2135.7, 2420, and 2422 of, and to repeal the heading of Chapter 5.1 (commencing with Section 2529) of Division 2 of,* the Business and Professions Code, *to amend Section 43.7 and 43.8 of the Civil Code, to amend Sections 13401 and 13401.5 of the Corporations Code, to amend Section 1157 of the Evidence Code, to amend Section 11529 of, and to repeal Section 12529.6 of, the Government Code, and to amend Sections 11362.7 and 128335 of the Health and Safety Code,* relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 798, as amended, Hill. Healing arts: boards.

~~Existing~~

(1) Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensure and regulation of physicians and surgeons. Existing law requires the Governor to appoint members to the board, as provided. Existing law authorizes the board to employ an executive director, investigators, legal counsel, medical consultants, and other assistance as specified. Existing law requires the Attorney General to act as legal counsel for the board, as specified. Existing law provides that those provisions will be repealed on January 1, 2018.

This bill would instead repeal those provisions on January 1, 2022.

(2) Existing law relating to research psychoanalysts authorizes certain students and graduates in psychoanalysis to engage in psychoanalysis under prescribed circumstances if they register with the Medical Board of California and present evidence of their student or graduate status. Existing law authorizes that board to suspend or revoke the exemption of those persons from licensure for unprofessional conduct, as specified. Existing law requires a registrant to pay into the Contingent Fund of the Medical Board of California a fee fixed by that board, as specified. Existing law, the Psychology Law, makes a violation of its provisions a crime.

This bill would transfer the administration and enforcement duties of those provisions from the Medical Board of California to the Board of Psychology. The bill would require that any moneys within the Contingent Fund of the Medical Board of California collected pursuant to those provisions be deposited in the Psychology Fund, and would require a registrant to pay into the Psychology Fund a fee fixed by the Board of Psychology. The bill would authorize the Board of Psychology to employ, subject to civil service regulations, whatever additional clerical assistance is necessary for the administration of these provisions. By placing these provisions in the Psychology Law, the bill would expand the definition of a crime, thereby imposing a state-mandated local program.

(3) Existing law establishes a peer review process for certain healing arts licensees and requires peer review bodies to review licensee conduct under specified circumstances. Existing law makes the willful failure of a peer review body to make specified reports a crime. Existing law provides that there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, certain health related professional societies or its members for act performed within the scope of the functions of peer review, as provided.

This bill would apply these provisions to licensed midwives. Because the willful failure of such a peer review body to make specified reports would be punishable as a crime, the bill would impose a state-mandated local program.

Existing law prohibits the proceedings and records of organized committees of healing arts professions or of a peer review body from being subject to discovery, except as specified.

This bill would apply these provisions to the proceedings and records of committees or peer review bodies of licensed midwives, except as specified.

The Moscone-Knox Professional Corporation Act provides for the organization of a corporation under certain existing law for the purposes of qualifying as a professional corporation under that act and rendering professional services. The act authorizes specified healing arts practitioners to be shareholders, officers, directors, or professional employees of a designated professional corporation, subject to certain limitations relating to ownership of shares.

This bill would add licensed midwives to the lists of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation, a psychological corporation, a nursing corporation, a marriage and family therapist corporation, a licensed clinical social worker corporation, a physician assistants corporation, a chiropractic corporation, an acupuncture corporation, a naturopathic doctor

corporation, a professional clinical counselor corporation, a physical therapy corporation, and a registered dental hygienist in alternative practice corporation. The bill would also add a licensed midwives corporation to the list of professional corporations, and would authorize licensed physicians and surgeons, licensed psychologists, registered nurses, licensed marriage and family therapists, licensed clinical social workers, licensed physician assistants, licensed chiropractors, licensed acupuncturists, licensed naturopathic doctors, licensed professional clinical counselors, and licensed physical therapists to be shareholders, officers, directors, or professional employees, subject to those limitations relating to ownership of shares.

(4) Existing law, the Medical Practice Act, creates, within the Department of Consumer Affairs, the Medical Board of California consisting of 15 members. The act requires the board to elect a president from its members, and authorizes the board to appoint panels from its members for the purpose of fulfilling specified obligations. The act prohibits the president of the board from being a member of any panel unless there is a vacancy in the membership of the board.

This bill would discontinue that prohibition on the president being a member of a panel.

Existing law requires the Office of Statewide Health Planning and Development to establish a nonprofit public benefit corporation known as the Health Professions Education Foundation to perform various duties with respect to implementing health professions scholarship and loan programs. Existing law requires the foundation to be governed by a board consisting of 9 members appointed by the Governor, one member appointed by the Speaker of the Assembly, and one member appointed by the Senate Committee on Rules. Existing law requires the Governor to appoint the president of the board of trustees from among those members appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules. Existing law requires the members of the board to serve without compensation but requires that they be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the board.

This bill would add to that governing board of the foundation 2 members appointed by the Medical Board of California. The bill would include these members in the list of members from which the Governor is required to appoint the president of the board. The bill would require the Medical Board of California to reimburse its 2 appointed member for any actual and necessary expenses incurred in connection with their duties as member of the board. The bill would require the Medical Board of California to reimburse its 2 appointed foundation board members for any actual and necessary expenses incurred in connection with their duties as members of the foundation board.

Existing law, the Medical Practice Act, requires the Medical Board of California to post on the Internet certain information regarding licensed physicians and surgeons.

This bill would require the board to initiate the process of adopting regulations on or before January 1, 2019, to require its licentiates and registrants to provide notice to their clients or patients that the practitioner is licensed or registered in this state by the board, that the practitioner's license can be checked, and that complaints against the practitioner can be made through the board's Internet Web site or by the contracting the board.

Existing law makes it unlawful for a healing arts practitioner to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. Existing law prohibits a physician and surgeon from including a statement that he or she is certified or eligible for certification by a private or public board or parent association, including a multidisciplinary board or association, as defined, unless that board or association is one of a specified list of boards and associations, including a board or association with equivalent requirements approved by that physician and surgeon's licensing board. Existing law requires the Medical Board of California to adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition.

This bill would discontinue the Medical Board of California approval of a board or association. The bill would continue to authorize a physician and surgeon to make a statement that he or she is certified or eligible for certification by a board or association with equivalent requirements approved by that physician and surgeon's

licensing board prior to January 1, 2018.

Existing law requires each applicant for a physician's and surgeon's certificate to show by official transcript or other official evidence that he or she has successfully completed a medical curriculum meeting specified requirements.

This bill would remove these medical curriculum requirements.

Existing law requires an applicant to show by evidence satisfactory to the board that he or she has satisfactorily completed at least one year of postgraduate training. Existing law requires the postgraduate training to be obtained in a postgraduate training program approved by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada.

This bill would instead require an applicant to show by evidence satisfactory to the board that he or she has satisfactorily completed at least 36 months of board-approved postgraduate training. The bill would authorize an applicant to obtain postgraduate training in a postgraduate training program approved by the College of Family Physicians of Canada. The bill would make eligible for licensure an applicant who has completed at least 36 months of board-approved postgraduate training, not less than 24 months of which was completed as a resident after receiving a medical degree from a combined dental and medical degree program accredited by the Commission on Dental Accreditation or approved by the board.

Existing law authorizes a graduate of an approved medical school who is enrolled in a postgraduate training program approved by the board to engage in the practice of medicine whenever and wherever required as part of the program under specified conditions.

This bill would add to these conditions a requirement that the medical school graduate obtain a postgraduate training license, as specified.

Existing law requires an applicant for a physician's and surgeon's certificate whose professional instruction was acquired in a country other than the United States or Canada to provide evidence satisfactory to the board of satisfactory completion of various requirements, including showing by evidence satisfactory to the board that he or she has satisfactorily completed at least two years of postgraduate training.

This bill would recast some of those provisions and make conforming changes to other provisions. The bill would require those applicants to show by evidence satisfactory to the board that he or she has satisfactorily completed at least 36 months of board-approved postgraduate training.

Existing law authorizes the holder of a special faculty permit to practice medicine, without a physician's and surgeon's certificate, within a medical school and certain affiliated institutions. Under existing law, a special faculty permit expires and becomes invalid at midnight on the last day of the permitholder's birth month during the 2nd year of a 2-year term, if not renewed.

The bill would instead specify that a special faculty permit expires and becomes invalid at midnight on the last day of the month in which the permit was issued during the 2nd year of a 2-year term commencing from the date of issuance, if not renewed.

The Medical Practice Act creates, within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine. Under the act, certificates to practice podiatric medicine expire on a certain date during the 2nd year of a 2-year term if not renewed. The act authorizes a doctor of podiatric medicine who is ankle certified, as specified, to perform certain services and procedures.

This bill would instead create the California Board of Podiatric Medicine in the Department of Consumer Affairs, and would make conforming and related changes. This bill would discontinue the ankle certification requirement for a doctor of podiatric medicine to perform those services and procedures.

Under the act, certificates to practice podiatric medicine and registrations of spectacle lens dispensers and contact lens dispensers, among others, expire on a certain date during the second year of a 2-year term if not renewed.

This bill would discontinue the requirement for the expiration of the registrations of spectacle lens dispensers

and contact lens dispensers.

Existing law requires the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of a peer review body, as defined, and the chief executive officer or administrator of a licensed health care facility or clinic to file reports with the applicable state licensing agency of specified health care practitioners upon the occurrence of specified events. Existing law also requires those individuals.

This bill would additionally require state agencies and hospitals to report to the Medical Board of California any peer review incidents subject to those provisions that are found during an inspection of a health care facility or clinic. The bill would impose a $100,000 fine for a willful failure to file a specified report and a $50,000 fine for all other failures to file the report.

Existing law requires an accredited outpatient setting to report an adverse event, as defined, to the Medical Board of California no later than 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.

This bill would redefine adverse event for those purposes and would require the outpatient setting to inform the patient or the party responsible for the patient of the adverse event by the time the report is made. The bill would require an accredited outpatient setting to annually file a specified report with the Office of Statewide Health Planning and Development. The bill would also require an accredited outpatient setting to file an Ambulatory Surgery Data Record, as specified, for each patient encounter during which at least one ambulatory surgery procedure is performed. The bill would subject accredited outpatient settings to specified fee for freestanding ambulatory surgery clinics.

Existing law requires the board to promptly revoke the license of any person who has been required to register as a sex offender.

This bill would instead require the board to make the revocation automatically, regardless of whether the related conviction has been appealed. The bill would require the board to notify the licensee of the license revocation and of his or her right to elect to have a hearing. The bill would authorize the holder of the physician's and surgeon's certificate to request a hearing, as specified, within 30 days of the revocation. The bill would require the revocation to cease automatically if the conviction is overturned on appeal.

Existing law makes certain privileged communication provisions not applicable to investigations or proceedings related to violations of the Medical Practices Act.

This bill would specify that provisions pertaining to the psychotherapist-patient privilege are also not applicable to those investigations or proceedings.

Existing law authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order suspending a license or imposing license restrictions, as specified. Existing law requires the order to be dissolved if an accusation is not filed and served, as specified, within 30 days of the date on which the parties to the hearing on the order have submitted the matter.

This bill would also require the order to be dissolved if a petition to revoke probation is not filed and served, as specified, within 30 days of the date on which the parties to the hearing on the order have submitted the matter.

Existing law prohibits a party's use of expert testimony in matters brought by the Medical Board of California unless specified information, including a brief narrative statement of the general substance of the testimony that the expert is expected to give, is exchanged in written form with the counsel for the other party. Existing law requires the exchange of information to be completed at least 30 days prior to the commencement date of the hearing.

This bill would instead require the exchange of information to be completed either within 90 days from the filing of an accusation or petition to revoke probation or 30 calendar days prior to the originally scheduled commencement date of the hearing, whichever occurs first, or as determined by an administrative law judge, as specified. The bill would replace the requirement that a brief narrative statement be exchanged with the

requirement that a complete expert witness report, as specified, be exchanged.

Under existing law, if a healing arts licensee may be unable to practice his or her profession safely due to mental or physical illness, his or her licensing agency may order the licentiate to be examined by specified professionals. Existing law specifies that a licentiate's failure to comply with this order constitutes grounds for the suspension or revocation of the licentiate's certificate or license.

This bill would require that a physician and surgeon's failure to comply with an order related to these examination requirements result in the issuance of notification from the board to cease the practice of medicine immediately until the ordered examinations have been completed and would provide that continued failure to comply would be grounds for suspension or revocation of his or her certificate.

Existing law establishes the Health Quality Enforcement Section within the Department of Justice to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California. Existing law requires each complaint that is referred to a district office of one of these boards for investigation to be jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section of the Department of Justice responsible for prosecuting the case if the investigation results in the filing of an accusation.

This bill would remove this requirement, and make conforming changes.

Existing law establishes the State Board of Chiropractic Examiners, the Medical Board of California, the California Board of Podiatric Medicine within the Medical Board of California, the Osteopathic Medical Board of California, the Naturopathic Medicine Committee, and the Acupuncture Board for the licensure and regulation of chiropractors, physicians and surgeons, podiatrists, osteopathic physicians and surgeons, naturopathic doctors, and acupuncturists, respectively. Existing law authorizes each of those regulatory entities to discipline its licensee by placing that licensee on probation, as specified. Existing law also requires 3 of those regulatory entities, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine, to disclose to an inquiring member of the public and to post on their Internet Web sites specified information concerning licensees including revocations, suspensions, probations, and limitations on practice.

This bill, on and after July 1, 2018, would require each of those regulatory entities to require a licensee on probation pursuant to a probationary order made on or after July 1, 2018, to provide a patient, or the patient's guardian or health care surrogate, with a separate disclosure containing specified information relating to the licensee's probationary status, with certain exceptions, and would require the licensee to obtain a signed copy of that disclosure from the patient, or the patient's guardian or health care surrogate. The bill would further require each of those regulatory entities, on and after July 1, 2018, to provide certain information regarding licensees on probation and licensees practicing under probationary licenses to an inquiring member of the public, on any of the regulatory entity's documents informing the public of individual probation orders and probationary licenses, and in plain view on the licensee's profile page on the regulatory entity's online license information site.

Existing law, in any order issued in resolution of a disciplinary proceeding before any board within the Department of Consumer Affairs or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding unless the entity is the Medical Board of California, authorizes the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, as specified. Existing law requires the Medical Board of California to ensure that any loss of revenue or increases in costs incurred pursuant to its inability to request and obtain investigation and prosecution costs for a disciplinary proceeding is offset by initial license and renewal fees.

This bill would authorize the Medical Board of California to request and obtain from a physician and surgeon the investigation and prosecution costs for a disciplinary proceeding and would make related and conforming changes.

Existing law, the Osteopathic Act, establishes the Osteopathic Medical Board of California, which issues certificates to, and regulates, osteopathic physicians and surgeons and requires that the powers and duties of

the board in that regard be subject to review by the appropriate committees of the Legislature. Existing law requires that review to be performed as if those provisions were scheduled to be repealed as of January 1, 2018.

This bill would instead require that review to be performed as if those provisions were scheduled to be repealed as of January 1, 2022.

Existing law requires the Osteopathic Medical Board of California to require each licensed osteopathic physician and surgeon to demonstrate satisfaction of continuing education requirements as a condition for the renewal of a license at intervals of not less than one year nor more than three years. Existing law requires the board to require each licensed osteopathic physician and surgeon to complete a minimum of 150 hours of American Osteopathic Association continuing education hours during each three-year cycle, of which 60 hours must be completed in American Osteopathic Association Category 1 continuing education hours as a condition for renewal of an active license.

This bill would instead require the board to require satisfaction of the continuing education requirements not less than one year nor more than two years. The bill would require each licensed osteopathic physician and surgeon to complete a minimum of 100 hours of American Osteopathic Association continuing education hours during each two-year cycle, of which 40 hours must be completed in American Osteopathic Association Category 1 continuing education hours and the remaining 60 hours shall be either American Osteopathic Association or American Medical Association accredited.

Existing law authorizes a list of specified boards to request and receive from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other documentation needed to complete an applicant or licensee investigation.

This bill would add the California Board of Podiatric Medicine and the Osteopathic Medical Board of California to that list of specified boards.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: ~~no~~*yes*

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. *Section 115.6 of the Business and Professions Code is amended to read:*

115.6. (a) A board within the department shall, after appropriate investigation, issue the following eligible temporary licenses to an applicant if he or she meets the requirements set forth in subdivision (c):

(1) Registered nurse license by the Board of Registered Nursing.

(2) Vocational nurse license issued by the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(3) Psychiatric technician license issued by the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(4) Speech-language pathologist license issued by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.

(5) Audiologist license issued by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.

(6) Veterinarian license issued by the Veterinary Medical Board.

(7) All licenses issued by the Board for Professional Engineers, Land Surveyors, and Geologists.

(8) All licenses issued by the Medical Board of California.

(9) All licenses issued by the California Board of Podiatric Medicine.

(b) The board may conduct an investigation of an applicant for purposes of denying or revoking a temporary license issued pursuant to this section. This investigation may include a criminal background check.

(c) An applicant seeking a temporary license pursuant to this section shall meet the following requirements:

(1) The applicant shall supply evidence satisfactory to the board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders.

(2) The applicant shall hold a current, active, and unrestricted license that confers upon him or her the authority to practice, in another state, district, or territory of the United States, the profession or vocation for which he or she seeks a temporary license from the board.

(3) The applicant shall submit an application to the board that shall include a signed affidavit attesting to the fact that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate, to the best of his or her knowledge. The application shall also include written verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing in that jurisdiction.

(4) The applicant shall not have committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license under this code at the time the act was committed. A violation of this paragraph may be grounds for the denial or revocation of a temporary license issued by the board.

(5) The applicant shall not have been disciplined by a licensing entity in another jurisdiction and shall not be the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction.

(6) The applicant shall, upon request by a board, furnish a full set of fingerprints for purposes of conducting a criminal background check.

(d) A board may adopt regulations necessary to administer this section.

(e) A temporary license issued pursuant to this section may be immediately terminated upon a finding that the temporary licenseholder failed to meet any of the requirements described in subdivision (c) or provided substantively inaccurate information that would affect his or her eligibility for temporary licensure. Upon termination of the temporary license, the board shall issue a notice of termination that shall require the temporary licenseholder to immediately cease the practice of the licensed profession upon receipt.

(f) An applicant seeking a temporary license as a civil engineer, geotechnical engineer, structural engineer, land surveyor, professional geologist, professional geophysicist, certified engineering geologist, or certified hydrogeologist pursuant to this section shall successfully pass the appropriate California-specific examination or examinations required for licensure in those respective professions by the Board for Professional Engineers, Land Surveyors, and Geologists.

(g) A temporary license issued pursuant to this section shall expire 12 months after issuance, upon issuance of an expedited license pursuant to Section 115.5, or upon denial of the application for expedited licensure by the board, whichever occurs first.

SEC. 2. *Section 125.3 of the Business and Professions Code is amended to read:*

125.3. (a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) The administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of the administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licentiate to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licentiate who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licentiate who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

~~(k)Notwithstanding the provisions of this section, the Medical Board of California shall not request nor obtain from a physician and surgeon, investigation and prosecution costs for a disciplinary proceeding against the licentiate. The board shall ensure that this subdivision is revenue neutral with regard to it and that any loss of revenue or increase in costs resulting from this subdivision is offset by an increase in the amount of the initial license fee and the biennial renewal fee, as provided in subdivision (e) of Section 2435.~~

SEC. 3. *Section 144 of the Business and Professions Code is amended to read:*

144. (a) Notwithstanding any other law, an agency designated in subdivision (b) shall require an applicant to furnish to the agency a full set of fingerprints for purposes of conducting criminal history record checks. Any agency designated in subdivision (b) may obtain and receive, at its discretion, criminal history information from the Department of Justice and the United States Federal Bureau of Investigation.

(b) Subdivision (a) applies to the following:

(1) California Board of Accountancy.

(2) State Athletic Commission.

(3) Board of Behavioral Sciences.

(4) Court Reporters Board of California.

(5) State Board of Guide Dogs for the Blind.

(6) California State Board of Pharmacy.

(7) Board of Registered Nursing.

(8) Veterinary Medical Board.

(9) Board of Vocational Nursing and Psychiatric Technicians.

(10) Respiratory Care Board of California.

(11) Physical Therapy Board of California.

(12) Physician Assistant Committee of the Medical Board of California.

(13) Speech-Language Pathology and Audiology and Hearing Aid Dispenser Board.

(14) Medical Board of California.

(15) State Board of Optometry.

(16) Acupuncture Board.

(17) Cemetery and Funeral Bureau.

(18) Bureau of Security and Investigative Services.

(19) Division of Investigation.

(20) Board of Psychology.

(21) California Board of Occupational Therapy.

(22) Structural Pest Control Board.

(23) Contractors' State License Board.

(24) Naturopathic Medicine Committee.

(25) Professional Fiduciaries Bureau.

(26) Board for Professional Engineers, Land Surveyors, and Geologists.

(27) Bureau of Medical Cannabis Regulation.

(28) California Board of Podiatric Medicine.

(29) Osteopathic Medical Board of California.

(c) For purposes of paragraph (26) of subdivision (b), the term "applicant" shall be limited to an initial applicant who has never been registered or licensed by the board or to an applicant for a new licensure or registration category.

SEC. 4. *Section 146 of the Business and Professions Code is amended to read:*

146. (a) Notwithstanding any other provision of law, a violation of any code section listed in subdivision (c) is an infraction subject to the procedures described in Sections 19.6 and 19.7 of the Penal Code when either of the following applies:

(1) A complaint or a written notice to appear in court pursuant to Chapter 5c (commencing with Section 853.5) of Title 3 of Part 2 of the Penal Code is filed in court charging the offense as an infraction unless the defendant, at the time he or she is arraigned, after being advised of his or her rights, elects to have the case proceed as a misdemeanor.

(2) The court, with the consent of the defendant and the prosecution, determines that the offense is an infraction in which event the case shall proceed as if the defendant has been arraigned on an infraction complaint.

(b) Subdivision (a) does not apply to a violation of the code sections listed in subdivision (c) if the defendant has had his or her license, registration, or certificate previously revoked or suspended.

(c) The following sections require registration, licensure, certification, or other authorization in order to engage in certain businesses or professions regulated by this code:

(1) Section 2474.

~~(1)~~

(2) Sections 2052 and 2054.

~~(2)~~

(3) Section 2630.

~~(3)~~

(4) Section 2903.

~~(4)~~

(5) Section 3575.

~~(5)~~

(6) Section 3660.

~~(6)~~

(7) Sections 3760 and 3761.

~~(7)~~

(8) Section 4080.

~~(8)~~

(9) Section 4825.

~~(9)~~

(10) Section 4935.

~~(10)~~

(11) Section 4980.

~~(11)~~

(12) Section 4989.50.

~~(12)~~

(13) Section 4996.

~~(13)~~

(14) Section 4999.30.

~~(14)~~

(15) Section 5536.

~~(15)~~

(16) Section 6704.

~~(16)~~

(17) Section 6980.10.

~~(17)~~

(18) Section 7317.

~~(18)~~

(19) Section 7502 or 7592.

~~(19)~~

(20) Section 7520.

~~(20)~~

(21) Section 7617 or 7641.

~~(21)~~

(22) Subdivision (a) of Section 7872.

~~(22)~~

(23) Section 8016.

~~(23)~~

(24) Section 8505.

~~(24)~~

(25) Section 8725.

~~(25)~~

(26) Section 9681.

~~(26)~~

(27) Section 9840.

~~(27)~~

(28) Subdivision (c) of Section 9891.24.

~~(28)~~

(29) Section 19049.

(d) Notwithstanding any other law, a violation of any of the sections listed in subdivision (c), which is an infraction, is punishable by a fine of not less than two hundred fifty dollars ($250) and not more than one thousand dollars ($1,000). No portion of the minimum fine may be suspended by the court unless as a condition of that suspension the defendant is required to submit proof of a current valid license, registration, or certificate for the profession or vocation that was the basis for his or her conviction.

SEC. 5. *Section 328 of the Business and Professions Code is amended to read:*

328. (a) In order to implement the Consumer Protection Enforcement Initiative of 2010, the director, through

the Division of Investigation, shall implement "Complaint Prioritization Guidelines" for boards to utilize in prioritizing their respective complaint and investigative workloads. The guidelines shall be used to determine the referral of complaints to the division and those that are retained by the health care boards for investigation.

(b) ~~The~~ *Neither the* Medical Board of California *nor the California Board of Podiatric Medicine* shall ~~not~~ be required to utilize the guidelines implemented pursuant to subdivision (a).

SEC. 6. *Section 651 of the Business and Professions Code is amended to read:*

651. (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.

(b) A false, fraudulent, misleading, or deceptive statement, claim, or image includes a statement or claim that does any of the following:

(1) Contains a misrepresentation of fact.

(2) Is likely to mislead or deceive because of a failure to disclose material facts.

(3) (A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

(B) Use of any photograph or other image of a model without clearly stating in a prominent location in easily readable type the fact that the photograph or image is of a model is a violation of subdivision (a). For purposes of this paragraph, a model is anyone other than an actual patient, who has undergone the procedure being advertised, of the licensee who is advertising for his or her services.

(C) Use of any photograph or other image of an actual patient that depicts or purports to depict the results of any procedure, or presents "before" and "after" views of a patient, without specifying in a prominent location in easily readable type size what procedures were performed on that patient is a violation of subdivision (a). Any "before" and "after" views (i) shall be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of presentation, and (ii) shall contain a statement that the same "before" and "after" results may not occur for all patients.

(4) Relates to fees, other than a standard consultation fee or a range of fees for specific types of services, without fully and specifically disclosing all variables and other material factors.

(5) Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.

(6) Makes a claim either of professional superiority or of performing services in a superior manner, unless that claim is relevant to the service being performed and can be substantiated with objective scientific evidence.

(7) Makes a scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies.

(8) Includes any statement, endorsement, or testimonial that is likely to mislead or deceive because of a failure to disclose material facts.

(c) Any price advertisement shall be exact, without the use of phrases, including, but not limited to, "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to services, or costs for services, and that uses words of comparison shall be based on verifiable data

substantiating the comparison. Any person so advertising shall be prepared to provide information sufficient to establish the accuracy of that comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(d) Any person so licensed shall not compensate or give anything of value to a representative of the press, radio, television, or other communication medium in anticipation of, or in return for, professional publicity unless the fact of compensation is made known in that publicity.

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

(f) Any person so licensed who violates this section is guilty of a misdemeanor. A bona fide mistake of fact shall be a defense to this subdivision, but only to this subdivision.

(g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action.

(h) Advertising by any person so licensed may include the following:

(1) A statement of the name of the practitioner.

(2) A statement of addresses and telephone numbers of the offices maintained by the practitioner.

(3) A statement of office hours regularly maintained by the practitioner.

(4) A statement of languages, other than English, fluently spoken by the practitioner or a person in the practitioner's office.

(5) (A) A statement that the practitioner is certified by a private or public board or agency or a statement that the practitioner limits his or her practice to specific fields.

(B) A statement of certification by a practitioner licensed under Chapter 7 (commencing with Section 3000) shall only include a statement that he or she is certified or eligible for certification by a private or public board or parent association recognized by that practitioner's licensing board.

(C) A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she limits his or her practice to specific fields, but shall not include a statement that he or she is certified or eligible for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, unless that board or association is (i) an American Board of Medical Specialties member board, (ii) a board or association with equivalent requirements approved by that physician and surgeon's licensing ~~board,~~ *board prior to January 1, 2018,* or (iii) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty. A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification, unless the physician and surgeon is also licensed under Chapter 4 (commencing with Section 1600) and the use of the term "board certified" in reference to that certification is in accordance with subparagraph (A). A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the Medical Board of California, for

certifying medical doctors and other health care professionals that is based on the applicant's education, training, and experience. *A multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2018, shall retain that approval.*

For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is an American Board of Medical Specialties member board, an organization with equivalent requirements approved by a physician and surgeon's licensing ~~board,~~ *board prior to January 1, 2018,* or an organization with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in a specialty or subspecialty.

~~The Medical Board of California shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this subparagraph. The fee shall not exceed the cost of administering this subparagraph. Notwithstanding Section 2 of Chapter 1660 of the Statutes of 1990, this subparagraph shall become operative July 1, 1993. However, an administrative agency or accrediting organization may take any action contemplated by this subparagraph relating to the establishment or approval of specialist requirements on and after January 1, 1991.~~

(D) A doctor of podiatric medicine licensed under ~~Chapter 5 (commencing with Section 2000) by the Medical Board of~~ *Article 22 (commencing with Section 2460) of Chapter 5 by the* California *Board of Podiatric Medicine* may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or association with the Council on Podiatric Medical Education approved postgraduate training programs that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under ~~Chapter 5 (commencing with Section 2000) by the Medical Board of~~ *Article 22 (commencing with Section 2460) of Chapter 5 by the* California *Board of Podiatric Medicine* who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement. A doctor of podiatric medicine licensed under ~~Chapter 5 (commencing with Section 2000) by the Medical Board of~~ *Article 22 (commencing with Section 2460) of Chapter 5 by the* California *Board of Podiatric Medicine* who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical Education approved board, an organization with equivalent requirements approved by the California Board of Podiatric Medicine, or an organization with a Council on Podiatric Medical Education approved postgraduate training program that provides training in podiatric medicine and podiatric surgery.

The California Board of Podiatric Medicine shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this subparagraph, to be deposited in the State Treasury in the Podiatry Fund, pursuant to Section 2499. The fee shall not exceed the cost of administering this subparagraph.

(6) A statement that the practitioner provides services under a specified private or public insurance plan or health care plan.

(7) A statement of names of schools and postgraduate clinical training programs from which the practitioner has graduated, together with the degrees received.

(8) A statement of publications authored by the practitioner.

(9) A statement of teaching positions currently or formerly held by the practitioner, together with pertinent dates.

(10) A statement of his or her affiliations with hospitals or clinics.

(11) A statement of the charges or fees for services or commodities offered by the practitioner.

(12) A statement that the practitioner regularly accepts installment payments of fees.

(13) Otherwise lawful images of a practitioner, his or her physical facilities, or of a commodity to be advertised.

(14) A statement of the manufacturer, designer, style, make, trade name, brand name, color, size, or type of commodities advertised.

(15) An advertisement of a registered dispensing optician may include statements in addition to those specified in paragraphs (1) to (14), inclusive, provided that any statement shall not violate subdivision (a), (b), (c), or (e) or any other section of this code.

(16) A statement, or statements, providing public health information encouraging preventative or corrective care.

(17) Any other item of factual information that is not false, fraudulent, misleading, or likely to deceive.

(i) Each of the healing arts boards and examining committees within Division 2 shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

Each of the healing arts boards and committees and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by businesses or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading. Until a definition for that service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not, by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

(j) The Attorney General shall commence legal proceedings in the appropriate forum to enjoin advertisements disseminated or about to be disseminated in violation of this section and seek other appropriate relief to enforce this section. Notwithstanding any other provision of law, the costs of enforcing this section to the respective licensing boards or committees may be awarded against any licensee found to be in violation of any provision of this section. This shall not diminish the power of district attorneys, county counsels, or city attorneys pursuant to existing law to seek appropriate relief.

(k) A physician and surgeon or doctor of podiatric medicine licensed pursuant to Chapter 5 (commencing with Section 2000) by the Medical Board of California who knowingly and intentionally violates this section may be cited and assessed an administrative fine not to exceed ten thousand dollars ($10,000) per event. Section 125.9 shall govern the issuance of this citation and fine except that the fine limitations prescribed in paragraph (3) of subdivision (b) of Section 125.9 shall not apply to a fine under this subdivision.

SEC. 7. *Section 656 of the Business and Professions Code is amended to read:*

656. Whenever any person has engaged, or is about to engage, in any acts or practices that constitute, or will constitute, a violation of this article, the superior court in and for the county wherein the acts or practices take place, or are about to take place, may issue an injunction, or other appropriate order, restraining the conduct on application of the State Board of Optometry, the Medical Board of California, *the California Board of Podiatric Medicine,* the Osteopathic Medical Board of California, the Attorney General, or the district attorney

of the county.

The proceedings under this section shall be governed by Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure.

The remedy provided for in this section shall be in addition to, and not a limitation upon, the authority provided by any other provision of this code.

SEC. 8. *Section 683 of the Business and Professions Code is amended to read:*

683. (a) A board shall report, within 10 working days, to the State Department of Health Care Services the name and license number of a person whose license has been revoked, suspended, surrendered, made inactive by the licensee, or placed in another category that prohibits the licensee from practicing his or her profession. The purpose of the reporting requirement is to prevent reimbursement by the state for Medi-Cal and Denti-Cal services provided after the cancellation of a provider's professional license.

(b) "Board," as used in this section, means the Dental Board of California, the Medical Board of California, the Board of Psychology, the State Board of Optometry, the California State Board of Pharmacy, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Behavioral Sciences, *the California Board of Podiatric Medicine,* and the California Board of Occupational Therapy.

(c) This section shall become operative on January 1, 2015.

SEC. 9. *Section 800 of the Business and Professions Code is amended to read:*

800. (a) The Medical Board of California, *the California Board of Podiatric Medicine,* the Board of Psychology, the Dental Board of California, the Dental Hygiene Committee of California, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the State Board of Optometry, the Veterinary Medical Board, the Board of Behavioral Sciences, the Physical Therapy Board of California, the California State Board of Pharmacy, the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, the California Board of Occupational Therapy, the Acupuncture Board, and the Physician Assistant Board shall each separately create and maintain a central file of the names of all persons who hold a license, certificate, or similar authority from that board. Each central file shall be created and maintained to provide an individual historical record for each licensee with respect to the following information:

(1) Any conviction of a crime in this or any other state that constitutes unprofessional conduct pursuant to the reporting requirements of Section 803.

(2) Any judgment or settlement requiring the licensee or his or her insurer to pay any amount of damages in excess of three thousand dollars ($3,000) for any claim that injury or death was proximately caused by the licensee's negligence, error or omission in practice, or by rendering unauthorized professional services, pursuant to the reporting requirements of Section 801 or 802.

(3) Any public complaints for which provision is made pursuant to subdivision (b).

(4) Disciplinary information reported pursuant to Section 805, including any additional exculpatory or explanatory statements submitted by the licentiate pursuant to subdivision (f) of Section 805. If a court finds, in a final judgment, that the peer review resulting in the 805 report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, the board shall include that finding in the central file. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(5) Information reported pursuant to Section 805.01, including any explanatory or exculpatory information submitted by the licensee pursuant to subdivision (b) of that section.

(b) (1) Each board shall prescribe and promulgate forms on which members of the public and other licensees or certificate holders may file written complaints to the board alleging any act of misconduct in, or connected with, the performance of professional services by the licensee.

(2) If a board, or division thereof, a committee, or a panel has failed to act upon a complaint or report within five years, or has found that the complaint or report is without merit, the central file shall be purged of information relating to the complaint or report.

(3) Notwithstanding this subdivision, the Board of Psychology, the Board of Behavioral Sciences, and the Respiratory Care Board of California shall maintain complaints or reports as long as each board deems necessary.

(c) (1) The contents of any central file that are not public records under any other provision of law shall be confidential except that the licensee involved, or his or her counsel or representative, shall have the right to inspect and have copies made of his or her complete file except for the provision that may disclose the identity of an information source. For the purposes of this section, a board may protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source or by providing a comprehensive summary of the substance of the material. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications. The information required to be disclosed pursuant to Section 803.1 shall not be considered among the contents of a central file for the purposes of this subdivision.

(2) The licensee may, but is not required to, submit any additional exculpatory or explanatory statement or other information that the board shall include in the central file.

(3) Each board may permit any law enforcement or regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes to inspect and have copies made of that licensee's file, unless the disclosure is otherwise prohibited by law.

(4) These disclosures shall effect no change in the confidential status of these records.

SEC. 10. *Section 803.1 of the Business and Professions Code is amended to read:*

803.1. (a) Notwithstanding any other ~~provision of~~ law, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall disclose to an inquiring member of the public information regarding any enforcement actions taken against a licensee, including a former licensee, by the board or by another state or jurisdiction, including all of the following:

(1) Temporary restraining orders issued.

(2) Interim suspension orders issued.

(3) Revocations, suspensions, probations, or limitations on practice ordered by the board, including those made part of a probationary order or stipulated agreement.

(4) Public letters of reprimand issued.

(5) Infractions, citations, or fines imposed.

(b) Notwithstanding any other ~~provision of~~ law, in addition to the information provided in subdivision (a), the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall disclose to an inquiring member of the public all of the following:

(1) Civil judgments in any amount, whether or not vacated by a settlement after entry of the judgment, that were not reversed on appeal and arbitration awards in any amount of a claim or action for damages for death or personal injury caused by the physician and surgeon's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(2) (A) All settlements in the possession, custody, or control of the board shall be disclosed for a licensee in the low-risk category if there are three or more settlements for that licensee within the last 10 years, except for settlements by a licensee regardless of the amount paid where (i) the settlement is made as a part of the

settlement of a class claim, (ii) the licensee paid in settlement of the class claim the same amount as the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case where the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action. All settlements in the possession, custody, or control of the board shall be disclosed for a licensee in the high-risk category if there are four or more settlements for that licensee within the last 10 years except for settlements by a licensee regardless of the amount paid where (i) the settlement is made as a part of the settlement of a class claim, (ii) the licensee paid in settlement of the class claim the same amount as the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case where the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action. Classification of a licensee in either a "high-risk category" or a "low-risk category" depends upon the specialty or subspecialty practiced by the licensee and the designation assigned to that specialty or subspecialty by the Medical Board of California, as described in subdivision (f). For the purposes of this paragraph, "settlement" means a settlement of an action described in paragraph (1) entered into by the licensee on or after January 1, 2003, in an amount of thirty thousand dollars ($30,000) or more.

(B) The board shall not disclose the actual dollar amount of a settlement but shall put the number and amount of the settlement in context by doing the following:

(i) Comparing the settlement amount to the experience of other licensees within the same specialty or subspecialty, indicating if it is below average, average, or above average for the most recent 10-year period.

(ii) Reporting the number of years the licensee has been in practice.

(iii) Reporting the total number of licensees in that specialty or subspecialty, the number of those who have entered into a settlement agreement, and the percentage that number represents of the total number of licensees in the specialty or subspecialty.

(3) Current American Board of Medical Specialties certification or board equivalent as certified by the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine.

(4) Approved postgraduate training.

(5) Status of the license of a licensee. By January 1, 2004, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine shall adopt regulations defining the status of a licensee. The board shall employ this definition when disclosing the status of a licensee pursuant to Section 2027.

(6) Any summaries of hospital disciplinary actions that result in the termination or revocation of a licensee's staff privileges for medical disciplinary cause or reason, unless a court finds, in a final judgment, that the peer review resulting in the disciplinary action was conducted in bad faith and the licensee notifies the board of that finding. In addition, any exculpatory or explanatory statements submitted by the licentiate electronically pursuant to subdivision (f) of that section shall be disclosed. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(c) Notwithstanding any other ~~provision of~~ law, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall disclose to an inquiring member of the public information received regarding felony convictions of a physician and surgeon or doctor of podiatric medicine.

(d) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board may formulate appropriate disclaimers or explanatory statements to be included with any information released, and may by regulation establish categories of information that need not be disclosed to an inquiring member of the public because that information is unreliable or not sufficiently related to the licensee's professional practice. The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall include the following statement when disclosing information concerning a settlement:

"Some studies have shown that there is no significant correlation between malpractice history and a doctor's

competence. At the same time, the State of California believes that consumers should have access to malpractice information. In these profiles, the State of California has given you information about both the malpractice settlement history for the doctor's specialty and the doctor's history of settlement payments only if in the last 10 years, the doctor, if in a low-risk specialty, has three or more settlements or the doctor, if in a high-risk specialty, has four or more settlements. The State of California has excluded some class action lawsuits because those cases are commonly related to systems issues such as product liability, rather than questions of individual professional competence and because they are brought on a class basis where the economic incentive for settlement is great. The State of California has placed payment amounts into three statistical categories: below average, average, and above average compared to others in the doctor's specialty. To make the best health care decisions, you should view this information in perspective. You could miss an opportunity for high-quality care by selecting a doctor based solely on malpractice history.

When considering malpractice data, please keep in mind:

Malpractice histories tend to vary by specialty. Some specialties are more likely than others to be the subject of litigation. This report compares doctors only to the members of their specialty, not to all doctors, in order to make an individual doctor's history more meaningful.

This report reflects data only for settlements made on or after January 1, 2003. Moreover, it includes information concerning those settlements for a 10-year period only. Therefore, you should know that a doctor may have made settlements in the 10 years immediately preceding January 1, 2003, that are not included in this report. After January 1, 2013, for doctors practicing less than 10 years, the data covers their total years of practice. You should take into account the effective date of settlement disclosure as well as how long the doctor has been in practice when considering malpractice averages.

The incident causing the malpractice claim may have happened years before a payment is finally made. Sometimes, it takes a long time for a malpractice lawsuit to settle. Some doctors work primarily with high-risk patients. These doctors may have malpractice settlement histories that are higher than average because they specialize in cases or patients who are at very high risk for problems.

Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the doctor. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred.

You may wish to discuss information in this report and the general issue of malpractice with your doctor."

(e) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall, by regulation, develop standard terminology that accurately describes the different types of disciplinary filings and actions to take against a licensee as described in paragraphs (1) to (5), inclusive, of subdivision (a). In providing the public with information about a licensee via the Internet pursuant to Section 2027, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall not use the terms "enforcement," "discipline," or similar language implying a sanction unless the physician and surgeon has been the subject of one of the actions described in paragraphs (1) to (5), inclusive, of subdivision (a).

(f) The Medical Board of California shall adopt regulations no later than July 1, 2003, designating each specialty and subspecialty practice area as either high risk or low risk. In promulgating these regulations, the board shall consult with commercial underwriters of medical malpractice insurance companies, health care systems that self-insure physicians and surgeons, and representatives of the California medical specialty societies. The board shall utilize the carriers' statewide data to establish the two risk categories and the averages required by subparagraph (B) of paragraph (2) of subdivision (b). Prior to issuing regulations, the board shall convene public meetings with the medical malpractice carriers, self-insurers, and specialty representatives.

(g) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, *and* the Physician Assistant Board shall provide each licensee, including a former licensee under subdivision (a), with a copy of the text of any proposed public disclosure authorized by this section prior to release of the disclosure to the public. The licensee shall have 10 working days from the date the board

provides the copy of the proposed public disclosure to propose corrections of factual inaccuracies. Nothing in this section shall prevent the board from disclosing information to the public prior to the expiration of the 10-day period.

(h) Pursuant to subparagraph (A) of paragraph (2) of subdivision (b), the specialty or subspecialty information required by this section shall group physicians by specialty board recognized pursuant to paragraph (5) of subdivision (h) of Section 651 unless a different grouping would be more valid and the board, in its statement of reasons for its regulations, explains why the validity of the grouping would be more valid.

(i) On and after July 1, 2018, the Medical Board of California and the Osteopathic Medical Board of California shall provide the information described in subdivision (d) of Section 2228.1, with respect to licensees on probation and licensees practicing under probationary licenses, to an inquiring member of the public and on any board documents, such as newsletters, informing the public of individual probation orders and probationary licenses.

SEC. 11. *Section 805 of the Business and Professions Code is amended to read:*

805. (a) As used in this section, the following terms have the following definitions:

(1) (A) "Peer review" means both of the following:

(i) A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following:

(I) Determine whether a licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, to determine the parameters of that practice.

(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.

(ii) Any other activities of a peer review body as specified in subparagraph (B).

(B) "Peer review body" includes:

(i) A medical or professional staff of any health care facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare program as an ambulatory surgical center.

(ii) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code.

(iii) Any medical, psychological, marriage and family therapy, social work, professional clinical counselor, dental, *midwifery,* or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.

(iv) A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

(2) "Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, *licensed midwife,* or physician assistant. "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113 or 2168.

(3) "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

(4) "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

(5) "Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

(6) "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

(7) "805 report" means the written report required under subdivision (b).

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body:

(1) A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

(2) A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

(3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

(c) If a licentiate takes any action listed in paragraph (1), (2), or (3) after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is denied or will be denied for a medical disciplinary cause or reason, the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within 15 days after the licentiate takes the action.

(1) Resigns or takes a leave of absence from membership, staff privileges, or employment.

(2) Withdraws or abandons his or her application for staff privileges or membership.

(3) Withdraws or abandons his or her request for renewal of staff privileges or membership.

(d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.

(e) An 805 report shall also be filed within 15 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

(f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information, electronically or otherwise, pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The notice shall also advise the licentiate that information submitted electronically will be publicly disclosed to those who request the information.

The information to be reported in an 805 report shall include the name and license number of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have

satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report.

If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension. *If the California Board of Podiatric Medicine or a licensing agency of another state revokes or suspends, without a stay, the license of a doctor of podiatric medicine, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.*

(g) The reporting required by this section shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800 and Sections 803.1 and 2027, provided that a copy of the report containing the information required by this section may be disclosed as required by Section 805.5 with respect to reports received on or after January 1, 1976.

(h) The Medical Board of California, *the California Board of Podiatric Medicine,* the Osteopathic Medical Board of California, and the Dental Board of California shall disclose reports as required by Section 805.5.

(i) An 805 report shall be maintained electronically by an agency for dissemination purposes for a period of three years after receipt.

(j) No person shall incur any civil or criminal liability as the result of making any report required by this section.

(k) A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. *If the person who is designated or otherwise required to file an 805 report is a licensed doctor of podiatric medicine, the action or proceeding shall be brought by the California Board of Podiatric Medicine.* The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, "willful" means a voluntary and intentional violation of a known legal duty.

(l) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. *If the person who is designated or otherwise required to file an 805 report is a licensed doctor of podiatric medicine, the action or proceeding shall be brought by the California Board of Podiatric Medicine.* The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also

differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

(m) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates.

(n) State agencies and hospital accrediting agencies shall report to the Medical Board of California any peer review incidents subject to 805 reporting that are found during an inspection of a health care facility or clinic.

SEC. 12. *Section 805.01 of the Business and Professions Code is amended to read:*

805.01. (a) As used in this section, the following terms have the following definitions:

(1) "Agency" has the same meaning as defined in Section 805.

(2) "Formal investigation" means an investigation performed by a peer review body based on an allegation that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) occurred.

(3) "Licentiate" has the same meaning as defined in Section 805.

(4) "Peer review body" has the same meaning as defined in Section 805.

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file a report with the relevant agency within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action, as specified in subdivision (b) of Section 805, resulting in a final proposed action to be taken against a licentiate based on the peer review body's determination, following formal investigation of the licentiate, that any of the acts listed in paragraphs (1) to (4), inclusive, may have occurred, regardless of whether a hearing is held pursuant to Section 809.2. The licentiate shall receive a notice of the proposed action as set forth in Section 809.1, which shall also include a notice advising the licentiate of the right to submit additional explanatory or exculpatory statements electronically or otherwise.

(1) Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public. This paragraph shall not be construed to affect or require the imposition of immediate suspension pursuant to Section 809.5.

(2) The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extent or in such a manner as to be dangerous or injurious to the licentiate, any other person, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain, consistent with lawful prescribing, be reported for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(c) The relevant agency shall be entitled to inspect and copy the following documents in the record of any formal investigation required to be reported pursuant to subdivision (b):

(1) Any statement of charges.

(2) Any document, medical chart, or exhibit.

(3) Any opinions, findings, or conclusions.

(4) Any certified copy of medical records, as permitted by other applicable law.

(d) The report provided pursuant to subdivision (b) and the information disclosed pursuant to subdivision (c) shall be kept confidential and shall not be subject to discovery, except that the information may be reviewed as provided in subdivision (c) of Section 800 and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

(e) The report required under this section shall be in addition to any report required under Section 805.

(f) A peer review body shall not be required to make a report pursuant to this section if that body does not make a final decision or recommendation regarding the disciplinary action to be taken against a licentiate based on the body's determination that any of the acts listed in paragraphs (1) to (4), inclusive, of subdivision (b) may have occurred.

(g) A willful failure to file a report pursuant to this section by any person who is designated or otherwise required by law to file a report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person who filed of should have filed the report. If the person who is designated or otherwise required to file a report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, "willful" means a voluntary and intentional violation of a known legal duty.

(h) Except as otherwise provided in subdivision (g), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file a report pursuant to this section, shall be punishable by a fine that under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person who filed or should have filed the report. If the person who is designated or otherwise required to file a report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including (i) whether the failure to file caused harm to a patient or created a risk to patient safety, (ii) whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file a report exercised due diligence despite the failure to file or whether they knew or should have known that a report would not be filed, and (3) whether there has been a prior failure to file a report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

(i) State agencies and hospital accrediting agencies shall report to the Medical Board of California any peer review incidents subject to 805.01 reporting that are found during an inspection of a health care facility or clinic.

***SEC. 13.** Section 805.1 of the Business and Professions Code is amended to read:*

805.1. (a) The Medical Board of California, *the California Board of Podiatric Medicine,* the Osteopathic Medical Board of California, and the Dental Board of California shall be entitled to inspect and copy the following documents in the record of any disciplinary proceeding resulting in action that is required to be reported pursuant to Section 805:

(1) Any statement of charges.

(2) Any document, medical chart, or exhibits in evidence.

(3) Any opinion, findings, or conclusions.

(4) Any certified copy of medical records, as permitted by other applicable law.

(b) The information so disclosed shall be kept confidential and not subject to discovery, in accordance with Section 800, except that it may be reviewed, as provided in subdivision (c) of Section 800, and may be disclosed in any subsequent disciplinary hearing conducted pursuant to the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

SEC. 14. *Section 805.5 of the Business and Professions Code is amended to read:*

805.5. (a) Prior to granting or renewing staff privileges for any physician and surgeon, psychologist, podiatrist, or dentist, any health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code, any health care service plan or medical care foundation, the medical staff of the institution, a facility certified to participate in the federal Medicare Program as an ambulatory surgical center, or an outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code shall request a report from the Medical Board of California, the Board of Psychology, *the California Board of Podiatric Medicine,* the Osteopathic Medical Board of California, or the Dental Board of California to determine if any report has been made pursuant to Section 805 indicating that the applying physician and surgeon, psychologist, podiatrist, or dentist has been denied staff privileges, been removed from a medical staff, or had his or her staff privileges restricted as provided in Section 805. The request shall include the name and California license number of the physician and surgeon, psychologist, podiatrist, or dentist. Furnishing of a copy of the 805 report shall not cause the 805 report to be a public record.

(b) Upon a request made by, or on behalf of, an institution described in subdivision (a) or its medical staff the board shall furnish a copy of any report made pursuant to Section 805 as well as any additional exculpatory or explanatory information submitted electronically to the board by the licensee pursuant to subdivision (f) of that section. However, the board shall not send a copy of a report (1) if the denial, removal, or restriction was imposed solely because of the failure to complete medical records, (2) if the board has found the information reported is without merit, (3) if a court finds, in a final judgment, that the peer review, as defined in Section 805, resulting in the report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, or (4) if a period of three years has elapsed since the report was submitted. This three-year period shall be tolled during any period the licentiate has obtained a judicial order precluding disclosure of the report, unless the board is finally and permanently precluded by judicial order from disclosing the report. If a request is received by the board while the board is subject to a judicial order limiting or precluding disclosure, the board shall provide a disclosure to any qualified requesting party as soon as practicable after the judicial order is no longer in force.

If the board fails to advise the institution within 30 working days following its request for a report required by this section, the institution may grant or renew staff privileges for the physician and surgeon, psychologist, podiatrist, or dentist.

(c) Any institution described in subdivision (a) or its medical staff that violates subdivision (a) is guilty of a misdemeanor and shall be punished by a fine of not less than two hundred dollars ($200) nor more than one thousand two hundred dollars ($1,200).

SEC. 15. *Section 805.6 of the Business and Professions Code is amended to read:*

805.6. (a) The Medical Board of California, *California Board of Podiatric Medicine,* the Osteopathic Medical Board, and the Dental Board of California shall establish a system of electronic notification that is either initiated by the board or can be accessed by qualified subscribers, and that is designed to achieve early notification to qualified recipients of the existence of new reports that are filed pursuant to Section 805.

(b) The State Department of Health Services shall notify the appropriate licensing agency of any reporting violations pursuant to Section 805.

(c) The Department of Managed Health Care shall notify the appropriate licensing agency of any reporting violations pursuant to Section 805.

SEC. 16. *Section 810 of the Business and Professions Code is amended to read:*

810. (a) It shall constitute unprofessional conduct and grounds for disciplinary action, including suspension or revocation of a license or certificate, for a health care professional to do any of the following in connection with his or her professional activities:

(1) Knowingly present or cause to be presented any false or fraudulent claim for the payment of a loss under a contract of insurance.

(2) Knowingly prepare, make, or subscribe any writing, with intent to present or use the same, or to allow it to be presented or used in support of any false or fraudulent claim.

(b) It shall constitute cause for revocation or suspension of a license or certificate for a health care professional to engage in any conduct prohibited under Section 1871.4 of the Insurance Code or Section 549 or 550 of the Penal Code.

(c) (1) It shall constitute cause for automatic suspension of a license or certificate issued pursuant to Chapter 4 (commencing with Section 1600), Chapter 5 (commencing with Section 2000), Chapter 6.6 (commencing with Section 2900), Chapter 7 (commencing with Section 3000), or Chapter 9 (commencing with Section 4000), or pursuant to the Chiropractic Act or the Osteopathic Act, if a licensee or certificate holder has been convicted of any felony involving fraud committed by the licensee or certificate holder in conjunction with providing benefits covered by worker's compensation insurance, or has been convicted of any felony involving Medi-Cal fraud committed by the licensee or certificate holder in conjunction with the Medi-Cal program, including the Denti-Cal element of the Medi-Cal program, pursuant to Chapter 7 (commencing with Section 14000), or Chapter 8 (commencing with Section 14200), of Part 3 of Division 9 of the Welfare and Institutions Code. The board shall convene a disciplinary hearing to determine whether or not the license or certificate shall be suspended, revoked, or some other disposition shall be considered, including, but not limited to, revocation with the opportunity to petition for reinstatement, suspension, or other limitations on the license or certificate as the board deems appropriate.

(2) It shall constitute cause for automatic suspension and for revocation of a license or certificate issued pursuant to Chapter 4 (commencing with Section 1600), Chapter 5 (commencing with Section 2000), Chapter 6.6 (commencing with Section 2900), Chapter 7 (commencing with Section 3000), or Chapter 9 (commencing with Section 4000), or pursuant to the Chiropractic Act or the Osteopathic Act, if a licensee or certificate holder has more than one conviction of any felony arising out of separate prosecutions involving fraud committed by the licensee or certificate holder in conjunction with providing benefits covered by worker's compensation insurance, or in conjunction with the Medi-Cal program, including the Denti-Cal element of the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000), or Chapter 8 (commencing with Section 14200), of Part 3 of Division 9 of the Welfare and Institutions Code. The board shall convene a disciplinary hearing to revoke the license or certificate and an order of revocation shall be issued unless the board finds mitigating circumstances to order some other disposition.

(3) It is the intent of the Legislature that paragraph (2) apply to a licensee or certificate holder who has one or more convictions prior to January 1, 2004, as provided in this subdivision.

(4) Nothing in this subdivision shall preclude a board from suspending or revoking a license or certificate pursuant to any other provision of law.

(5) "Board," as used in this subdivision, means the Dental Board of California, the Medical Board of California, *the California Board of Podiatric Medicine,* the Board of Psychology, the State Board of Optometry, the California State Board of Pharmacy, the Osteopathic Medical Board of California, and the State Board of Chiropractic Examiners.

(6) "More than one conviction," as used in this subdivision, means that the licensee or certificate holder has one or more convictions prior to January 1, 2004, and at least one conviction on or after that date, or the licensee or certificate holder has two or more convictions on or after January 1, 2004. However, a licensee or

certificate holder who has one or more convictions prior to January 1, 2004, but who has no convictions and is currently licensed or holds a certificate after that date, does not have "more than one conviction" for the purposes of this subdivision.

(d) As used in this section, health care professional means any person licensed or certified pursuant to this division, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

~~**SECTION 1.**~~***SEC. 17.*** Section 2001 of the Business and Professions Code is amended to read:

2001. (a) There is in the Department of Consumer Affairs a Medical Board of California that consists of 15 members, 7 of whom shall be public members.

(b) The Governor shall appoint 13 members to the board, subject to confirmation by the Senate, 5 of whom shall be public members. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.

(c) This section shall remain in effect only until January 1, 2022, and as of that date is repealed. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 18. *Section 2006 of the Business and Professions Code is amended to read:*

2006. (a) Any reference in this chapter to an investigation by the board shall be deemed to refer to ~~a joint investigation conducted by employees of the Department of Justice and the Health Quality Investigation Unit under the vertical enforcement and prosecution model, as specified in Section 12529.6 of the Government Code.~~ *an investigation conducted by employees of the Health Quality Investigation Unit within the Department of Consumer Affairs Division of Investigation.*

~~(b)This section shall become operative on July 1, 2014.~~

SEC. 19. *Section 2008 of the Business and Professions Code is amended to read:*

2008. The board may appoint panels from its members for the purpose of fulfilling the obligations established in subdivision (c) of Section 2004. Any panel appointed under this section shall at no time be comprised of less than four members and the number of public members assigned to the panel shall not exceed the number of licensed physician and surgeon members assigned to the panel. ~~The president of the board shall not be a member of any panel unless there is a vacancy in the membership of the board.~~ Each panel shall annually elect a chair and a vice chair.

~~**SEC. 2.**~~***SEC. 20.*** Section 2020 of the Business and Professions Code is amended to read:

2020. (a) The board, by and with the approval of the director, may employ an executive director exempt from the provisions of the Civil Service Act and may also employ investigators, legal counsel, medical consultants, and other assistance as it may deem necessary to carry this chapter into effect. The board may fix the compensation to be paid for services subject to the provisions of applicable state laws and regulations and may incur other expenses as it may deem necessary. Investigators employed by the board shall be provided special training in investigating medical practice activities.

(b) The Attorney General shall act as legal counsel for the board for any judicial and administrative proceedings and his or her services shall be a charge against it.

(c) This section shall remain in effect only until January 1, 2022, and as of that date is repealed.

SEC. 21. *Section 2026 is added to the Business and Professions Code, to read:*

2026. *The board shall initiate the process of adopting regulations on or before January 1, 2019, to require its licentiates and registrants to provide notice to their clients or patients that the practitioner is licensed or*

registered in this state by the board, that the practitioner's license can be checked, and that complaints against the practitioner can be made through the board's Internet Web site or by contacting the board.

SEC. 22. *Section 2052.5 of the Business and Professions Code is repealed.*

~~2052.5.(a)The proposed registration program developed pursuant to subdivision (b) shall provide that, for purposes of the proposed registration program:~~

~~(1)A physician and surgeon practices medicine in this state across state lines when that person is located outside of this state but, through the use of any medium, including an electronic medium, practices or attempts to practice, or advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person in this state.~~

~~(2)A doctor of podiatric medicine practices podiatric medicine in this state across state lines when that person is located outside of this state but, through the use of any medium, including an electronic medium, practices or attempts to practice podiatric medicine, as defined in Section 2472, in this state.~~

~~(3)The proposed registration program shall not apply to any consultation described in Section 2060.~~

~~(b)The board may, at its discretion, develop a proposed registration program to permit a physician and surgeon, or a doctor of podiatric medicine, located outside this state to register with the board to practice medicine or podiatric medicine in this state across state lines.~~

~~(1)The proposed registration program shall include proposed requirements for registration, including, but not limited to, licensure in the state or country where the physician and surgeon, or the doctor of podiatric medicine, resides, and education and training requirements.~~

~~(2)The proposed registration program may also include all of the following: (A) standards for confidentiality, format, and retention of medical records, (B) access to medical records by the board, (C) registration fees, renewal fees, delinquency fees, and replacement document fees in an amount not to exceed the actual cost of administering the registration program, and (D) provisions ensuring that enforcement and consumer education shall be integral parts of administering the registration program.~~

~~(3)The proposed registration program may also provide all of the following:~~

~~(A)All laws, rules, and regulations that govern the practice of medicine or podiatric medicine in this state, including, but not limited to, confidentiality and reporting requirements, shall apply to a physician and surgeon, or a doctor of podiatric medicine, who is registered by the board to practice medicine or podiatric medicine in this state across state lines.~~

~~(B)The board may deny an application for registration or may suspend, revoke, or otherwise discipline a registrant for any of the following: (i) on any ground prescribed by this chapter, (ii) failure to possess or to maintain a valid license in the state where the registrant resides, or (iii) if the applicant or registrant is not licensed by the state or country in which he or she resides, and that state or country prohibits the practice of medicine or podiatric medicine from that state or country into any other state or country without a valid registration or license issued by the state or country in which the applicant or registrant practices. Action to deny or discipline a registrant shall be taken in the manner provided for in this chapter.~~

~~(C)Any of the following shall be grounds for discipline of a registrant: (i) to allow any person to engage in the practice of medicine or podiatric medicine in this state across state lines under his or her registration, including, but not limited to, any nurse, physician assistant, medical assistant, or other person, (ii) to fail to include his or her registration number on any invoice or other type of billing statement submitted for care or treatment provided to a patient located in this state, (iii) to practice medicine or podiatric medicine in any other state or country without meeting the legal requirements to practice medicine or podiatric medicine in that state or country, or (iv) to fail to notify the board, in a manner prescribed by the board, of any restrictions placed on his or her medical license, or podiatric medical license, in any state.~~

~~(D)A registration issued pursuant to the registration program shall automatically be suspended upon receipt of~~

~~a copy, from the state that issued the license, of the surrender, revocation, suspension, or other similar type of action taken by another state or country against a medical license, or podiatric medical license, issued to a registrant. The board shall notify the registrant in writing of the suspension and of the registrant's right to a hearing.~~

~~(4)Section 2314 shall not apply to the registration program.~~

~~(c)This section shall not be construed to authorize the board to implement a registration program for physicians and surgeons or doctors of podiatric medicine located outside this state. This section is intended to authorize the board to develop a proposed registration program to be authorized for implementation by future legislation.~~

SEC. 23. *Section 2054 of the Business and Professions Code is amended to read:*

2054. (a) Any person who uses in any sign, business card, or letterhead, or, in an advertisement, the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D.," or any other terms or letters indicating or implying that he or she is a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, or that he or she is entitled to practice hereunder, or who represents or holds himself or herself out as a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as a physician and surgeon under this chapter, is guilty of a misdemeanor.

~~(b)A holder of a valid, unrevoked, and unsuspended certificate to practice podiatric medicine may use the phrases "doctor of podiatric medicine," "doctor of podiatry," and "podiatric doctor," or the initials "D.P.M.," and shall not be in violation of subdivision (a).~~

~~(c)~~

(b) Notwithstanding subdivision (a), any of the following persons may use the words "doctor" or "physician," the letters or prefix "Dr.," or the initials "M.D.":

(1) A graduate of a medical school approved or recognized by the board while enrolled in a postgraduate training program approved by the board.

(2) A graduate of a medical school who does not have a certificate as a physician and surgeon under this chapter if he or she meets all of the following requirements:

(A) If issued a license to practice medicine in any jurisdiction, has not had that license revoked or suspended by that jurisdiction.

(B) Does not otherwise hold himself or herself out as a physician and surgeon entitled to practice medicine in this state except to the extent authorized by this chapter.

(C) Does not engage in any of the acts prohibited by Section 2060.

(3) A person authorized to practice medicine under Section 2111 or 2113 subject to the limitations set forth in those sections.

SEC. 24. *Section 2064 of the Business and Professions Code is amended to read:*

2064. Nothing in this chapter shall be construed to prevent a regularly matriculated student undertaking a course of professional instruction in an approved medical school, or to prevent a foreign medical student who is enrolled in an approved medical school or clinical training program in this state, ~~or to prevent students enrolled in a program of supervised clinical training under the direction of an approved medical school pursuant to Section 2104,~~ from engaging in the practice of medicine whenever and wherever prescribed as a part of his or her course of study.

SEC. 25. *Section 2064.5 is added to the Business and Professions Code, to read:*

2064.5. *(a) Within 180 days after enrollment in a board approved postgraduate training program pursuant to*

Section 2065, medical school graduates shall obtain a physician's and surgeon's postgraduate training license. To be considered for a postgraduate training license, the applicant shall submit the application forms and primary source documents required by the board, shall successfully pass all required licensing examinations, shall pay the reduced licensing fee, and shall not have committed any act that would be grounds for denial.

(1) Each application submitted pursuant to this section shall be made upon a form provided by the board, and each application form shall contain a legal verification to be signed by the applicant verifying under penalty of perjury that the information provided by the applicant is true and correct and that any information in supporting documents provided by the applicant is true and correct.

(2) Each application shall include the following:

(A) A diploma issued by a board-approved medical school. The requirements of the school shall not have been less than those required under this chapter at the time the diploma was granted or by any preceding medical practice act at the time that the diploma was granted. In lieu of a diploma, the applicant may submit evidence satisfactory to the board of having possessed the same.

(B) An official transcript or other official evidence satisfactory to the board showing each approved medical school in which a resident course of professional instruction was pursued covering the minimum requirements for certification as a physician and surgeon, and that a diploma and degree were granted by the school.

(C) Other information concerning the professional instruction and preliminary education of the applicant as the board may require.

(D) An affidavit showing to the satisfaction of the board that the applicant is the person named in each diploma and transcript that he or she submits, that he or she is the lawful holder thereof, and that the diploma or transcript was procured in the regular course of professional instruction and examination without fraud or misrepresentation.

(E) Either fingerprint cards or a copy of a completed Live Scan form from the applicant in order to establish the identity of the applicant and in order to determine whether the applicant has a record of any criminal convictions in this state or in any other jurisdiction, including foreign countries. The information obtained as a result of the fingerprinting of the applicant shall be used in accordance with Section 11105 of the Penal Code, and to determine whether the applicant is subject to denial of licensure under the provisions of Division 1.5 (commencing with Section 475) and Section 2221.

(F) If the medical school graduate graduated from a foreign medical school approved by the board pursuant to Section 2084, an official Educational Commission for Foreign Medical Graduates (ECFMG) Certification Status Report confirming the graduate is ECFMG certified.

(b) The physician's and surgeon's postgraduate training license shall be valid until 90 days after the holder has completed 36 months of board-approved postgraduate training. The physician's and surgeon's postgraduate training licensee may engage in the practice of medicine only in connection with his or her duties as an intern or resident physician in a board approved program, including its affiliated sites, or under those conditions as are approved in writing and maintained in the postgraduate training licensee's file by the director of his or her program.

(c) The postgraduate training licensee may engage in the practice of medicine in locations authorized by subdivision (b), and as permitted by the Medical Practice Act and other applicable statutes and regulations, including, but not limited to, the following:

(1) Diagnose and treat patients.

(2) Prescribe medications without a cosigner, including prescriptions for controlled substances, if the training licensee has the appropriate Drug Enforcement Agency registration/permit and is registered with the Department of Justice CURES program.

(3) Sign birth certificates without a cosigner.

(4) Sign death certificates without a cosigner.

(d) The postgraduate training licensee may be disciplined by the board at any time for any of the grounds that would subject the holder of a physician's and surgeon's certificate to discipline.

(e) If the medical school graduate fails to obtain a postgraduate training license within 180 days after enrollment in a board approved postgraduate training program or if the board denies his or her application for a postgraduate training license, all privileges and exemptions under this section shall automatically cease.

SEC. 26. *Section 2065 of the Business and Professions Code is amended to read:*

2065. *(a)* Unless otherwise provided by law, no postgraduate trainee, intern, resident, postdoctoral fellow, or instructor may engage in the practice of medicine, or receive compensation therefor, or offer to engage in the practice of medicine unless he or she holds a valid, unrevoked, and unsuspended physician's and surgeon's certificate issued by the board. However, a graduate of an approved medical ~~school, who is registered with the board and who is enrolled in a postgraduate training program approved by the board,~~ *school* may engage in the practice of medicine whenever and wherever required as a part of ~~the~~ *a postgraduate training* program under the following conditions:

(1) The medical school graduate has taken and passed the board-approved medical licensing examinations required to qualify the applicant to participate in an approved postgraduate training program.

(2) The medical school graduate is registered with the board.

(3) If the medical school graduate graduated from a foreign medical school approved by the board pursuant to Section 2084, the Educational Commission for Foreign Medical Graduates (ECFMG) has submitted an official ECFMG Certification Status Report directly to the board confirming the graduate is ECFMG certified.

(4) The medical school graduate is enrolled in a postgraduate training program approved by the board.

(5) The board-approved postgraduate training program has submitted the required board approved form to the board documenting the medical school graduate is enrolled in an approved postgraduate training program.

(6) The medical school graduate obtains a physician's and surgeon's postgraduate training license in accordance with Section 2064.5.

~~(a)~~

(b) A *medical school* graduate enrolled in an approved first-year postgraduate training program *in accordance with this section* may ~~so~~ engage in the practice of medicine ~~for a period not to exceed one year~~ whenever and wherever required as a part of the training program, and may receive compensation for that ~~practice.~~ *practice not to exceed 12 months.*

~~(b)~~

(c) A graduate who has completed the first year of postgraduate training may, in an approved residency or fellowship, engage in the practice of medicine whenever and wherever required as part of that residency or fellowship, and may receive compensation for that ~~practice.~~ *practice not to exceed 27 months.* The resident or fellow shall qualify for, take, and pass the next succeeding written examination for ~~licensure, or shall qualify for and receive a physician's and surgeon's certificate by one of the other methods specified in this chapter.~~ *licensure.* If the resident or fellow fails to receive a license to practice medicine under this chapter within ~~one year~~ *27 months* from the commencement of the residency or fellowship or if the board denies his or her application for licensure, all privileges and exemptions under this section shall automatically cease.

(d) All approved postgraduate training the medical school graduate has participated in the United States or Canada shall count toward the 39-month license exemption.

(e) A medical school graduate from a medical school approved by the board shall have successfully completed a minimum of 36 months of approved postgraduate training with at least 24 consecutive months in the same program, to be eligible for a California physician's and surgeon's certificate.

SEC. 27. *Section 2066 of the Business and Professions Code is repealed.*

~~2066.(a)Nothing in this chapter shall be construed to prohibit a foreign medical graduate from engaging in the practice of medicine whenever and wherever required as a part of a clinical service program under the following conditions:~~

~~(1)The clinical service is in a postgraduate training program approved by the Division of Licensing.~~

~~(2)The graduate is registered with the division for the clinical service.~~

~~(b)A graduate may engage in the practice of medicine under this section until the receipt of his or her physician and surgeon's certificate. If the graduate fails to pass the examination and receive a certificate by the completion of the graduate's third year of postgraduate training or if the division denies his or her application for licensure, all privileges and exemptions under this section shall automatically cease.~~

~~(c)Nothing in this section shall preclude a foreign medical graduate from engaging in the practice of medicine under any other exemption contained in this chapter.~~

SEC. 28. *Section 2066.5 of the Business and Professions Code is amended to read:*

2066.5. (a) The pilot program authorized by this section shall be known and may be cited as the University of California at Los Angeles David Geffen School of Medicine's International Medical Graduate Pilot Program.

(b) Nothing in this chapter shall be construed to prohibit a foreign medical graduate from engaging in the practice of medicine when required as part of the pilot program authorized by this section.

(c) There is currently a preresidency training program at the University of California, Los Angeles David Geffen School of Medicine, Department of Family Medicine, hereafter referred to as UCLA, for selected international medical graduates (IMGs). Participation in the pilot program authorized by this section shall be at the option of UCLA. This section authorizes those IMGs, through the new pilot program authorized by this section, to receive, through the existing program, hands-on clinical ~~instruction in the courses specified in subdivision (c) of Section 2089.5.~~ *instruction.* The pilot program, as administered by UCLA, shall include all of the following elements:

(1) Each pilot program participant shall have done all of the following:

(A) Graduated from a medical school recognized by the Medical Board of California at the time of selection.

(B) Taken and passed the United States Medical Licensing Examination Steps 1 and 2 (Clinical Knowledge and Clinical Science).

(C) Submitted an application and materials to the Educational Commission for Foreign Medical Graduates.

(2) A pilot program participant shall receive all clinical instruction at health care facilities operated by the University of California, Los Angeles, or other approved UCLA-designated teaching sites, which shall be hospitals or clinics with either a signed formal affiliation agreement with UCLA or a signed letter of agreement.

(3) Participation of a trainee in clinical instruction offered by the pilot program shall not generally exceed 16 weeks. However, at the discretion of UCLA, an additional eight weeks of clinical instruction may be granted. In no event shall a participant receive more than 24 weeks of clinical instruction under the pilot program.

(4) The clinical instruction shall be supervised by licensed physicians on faculty at UCLA or faculty affiliated with UCLA as specified in an approved affiliation agreement between UCLA and the affiliated entity.

(5) The clinical instruction shall be provided pursuant to written affiliation agreements for clinical instruction of trainees established by UCLA.

(6) The supervising faculty shall evaluate each participant on a regular basis and shall document the completion of each aspect of the clinical instruction portion of the program for each participant.

(d) UCLA shall provide the board with the names of the participants in the pilot program on an annual basis, or more frequently if necessary to maintain accuracy. Upon a reasonable request of the board, UCLA shall provide additional information such as the courses successfully completed by program participants, the dates

of instruction, and other relevant information.

~~(e)Nothing in this section shall be construed to alter the requirements for licensure set forth in Sections 2089 and 2089.5. The board may consider participation in the clinical instruction portion of the pilot program as remediation for medical education deficiencies identified in a participant's application for licensure or authorization for postgraduate training should such a deficiency apply to that applicant.~~

~~(f)~~

(e) On or before January 1, 2018, UCLA is requested to prepare a report for the board and the Legislature. Topics to be addressed in the report shall include the number of participants in the pilot program, the number of participants in the pilot program who were issued physician's and surgeon's certificates by the board, the number of participants who practice in designated medically underserved areas, and the potential for retention or expansion of the pilot program.

~~(g)~~

(f) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

SEC. 29. *Section 2067 of the Business and Professions Code is repealed.*

~~2067.An applicant for a physician's and surgeon's certificate who is found by the Division of Licensing to be deficient in the education and clinical instruction required by Sections 2089 and 2089.5 or who is required pursuant to Section 2185 to complete additional medical instruction may engage in the practice of medicine in this state in any setting approved by the Division of Licensing for the period of time prescribed by the Division of Licensing.~~

SEC. 30. *Section 2072 of the Business and Professions Code is repealed.*

~~2072.Notwithstanding any other provision of law and subject to the provisions of the State Civil Service Act, any person who is licensed to practice medicine in any other state, who meets the requirements for application set forth in this chapter and who registers with and is approved by the Division of Licensing, may be appointed to the medical staff within a state institution and, under the supervision of a physician and surgeon licensed in this state, may engage in the practice of medicine on persons under the jurisdiction of any state institution. Qualified physicians and surgeons licensed in this state shall not be recruited pursuant to this section.~~

~~No person appointed pursuant to this section shall be employed in any state institution for a period in excess of two years from the date the person was first employed, and the appointment shall not be extended beyond the two-year period. At the end of the two-year period, the physician shall have been issued a physician's and surgeon's certificate by the board in order to continue employment. Until the physician has obtained a physician's and surgeon's certificate from the board, he or she shall not engage in the practice of medicine in this state except to the extent expressly permitted herein.~~

SEC. 31. *Section 2073 of the Business and Professions Code is repealed.*

~~2073.Notwithstanding any other provision of law, any person who is licensed to practice medicine in any other state who meets the requirements for application set forth in this chapter, and who registers with and is approved by the Division of Licensing, may be employed on the resident medical staff within a county general hospital and, under the supervision of a physician and surgeon licensed in this state, may engage in the practice of medicine on persons within the county institution. Employment pursuant to this section is authorized only when an adequate number of qualified resident physicians cannot be recruited from intern staffs in this state.~~

~~No person appointed pursuant to this section shall be employed in any county general hospital for a period in excess of two years from the date the person was first employed, and the employment shall not be extended beyond the two-year period. At the end of the two-year period, the physician shall have been issued a physician's and surgeon's certificate by the board in order to continue as a member of the resident staff. Until the physician has obtained a physician's and surgeon's certificate from the board, he or she shall not engage~~

~~in the practice of medicine in this state except to the extent expressly permitted herein.~~

SEC. 32. *Section 2082 of the Business and Professions Code is amended to read:*

2082. Each application shall include the following:

(a) A diploma issued by an approved medical school. The requirements of the school shall have been at the time of granting the diploma in no degree less than those required under this chapter or by any preceding medical practice act at the time that the diploma was granted. In lieu of a diploma, the applicant may submit evidence satisfactory to the ~~Division of Licensing~~ *board* of having possessed the same.

(b) An official transcript or other official evidence satisfactory to the ~~division~~ *board* showing each approved medical school in which a resident course of professional instruction was pursued covering the minimum requirements for certification as a physician and surgeon, and that a diploma and degree were granted by the school.

(c) Other information concerning the professional instruction and preliminary education of the applicant as the ~~division~~ *board* may require.

(d) Proof of passage of the written examinations as provided under Article 9 (commencing with Section 2170) with a score acceptable to the board.

(e) Proof of satisfactory completion of the postgraduate training required under Section 2096 on a form approved by the board.

~~(d)~~

(f) An affidavit showing to the satisfaction of the ~~division~~ *board* that the applicant is the person named in each diploma and transcript that he or she submits, that he or she is the lawful holder thereof, and that the diploma or transcript was procured in the regular course of professional instruction and examination without fraud or misrepresentation.

~~(e)~~

(g) Either fingerprint cards or a copy of a completed Live Scan form from the applicant in order to establish the identity of the applicant and in order to determine whether the applicant has a record of any criminal convictions in this state or in any other jurisdiction, including foreign countries. The information obtained as a result of the fingerprinting of the applicant shall be used in accordance with Section 11105 of the Penal Code, and to determine whether the applicant is subject to denial of licensure under the provisions of Division 1.5 (commencing with Section 475) and Section 2221.

(h) If the applicant attended a foreign medical school approved by the board pursuant to Section 2084, an official Educational Commission for Foreign Medical Graduates (ECFMG) Certification Status Report submitted by the Educational Commission for Foreign Medical Graduates confirming the graduate is ECFMG certified.

(i) If the applicant attended a foreign medical school approved by the board pursuant to Section 2084, official evidence satisfactory to the board of completion of all formal requirements of the medical school for graduation, except the applicant shall not be required to have completed an internship or social service or be admitted or licensed to practice medicine in the country in which the professional instruction was completed.

SEC. 33. *Section 2084 of the Business and Professions Code is amended to read:*

2084. ~~The Division of Licensing may approve every school which substantially complies with the requirements of this chapter for resident courses of professional instruction. Graduates of medical schools approved under this section shall be deemed to meet the requirements of Section 2089.~~ *(a)* Medical schools accredited by a national accrediting agency approved by the ~~division~~ *board* and recognized by the United States Department of Education shall be deemed approved by the ~~division under this section. Nothing in this chapter prohibits the division from considering the quality of the resident courses of professional instruction required for certification as a physician and surgeon.~~ *board.*

(b) The board shall determine a foreign medical school to be a recognized medical school if the foreign medical school meets any of the following requirements:

(1) The foreign medical school has been evaluated by the Educational Commission for Foreign Medical Graduates (ECFMG) or one of the ECFMG authorized foreign medical school accreditation agencies and deemed to meet the minimum requirements substantially equivalent to the requirements of medical schools accredited by the Liaison Committee on Medical Education, the Committee on Accreditation of Canadian Medical Schools, or the Commission on Osteopathic College Accreditation.

(2) The foreign medical school is listed on the World Federation for Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER) World Directory of Medical Schools joint directory or the World Directory of Medical Schools.

(3) The foreign medical school had been previously approved by the board. The prior approval shall only be valid for a maximum of seven years from the date of enactment of this section.

SEC. 34. *Section 2084.5 of the Business and Professions Code is amended to read:*

2084.5. Notwithstanding any other law, a medical school or medical school program accredited by the Liaison Committee on Medical Education, the Committee on Accreditation of Canadian Medical Schools, or the Commission on Osteopathic College Accreditation shall be deemed to meet the requirements of ~~Sections 2089 and 2089.5.~~ *Section 2084.*

SEC. 35. *Section 2085 of the Business and Professions Code is repealed.*

~~2085.(a)Notwithstanding Section 2084, a graduate of an approved medical school located in the United States or Canada who has graduated from a special medical school program that does not substantially meet the requirements of Section 2089 with respect to any aspect of curriculum length or content may be approved by the Division of Licensing if the division determines that the applicant has otherwise received adequate instruction in the subjects listed in subdivision (b) of Section 2089.~~

~~"Adequate instruction" means the applicant has received instruction adequate to prepare the applicant to engage in the practice of medicine in the United States. This definition applies to the sufficiency of instruction of the following courses:~~

~~(1)Anatomy, including gross anatomy, embryology, histology, and neuroanatomy.~~

~~(2)Bacteriology and immunology.~~

~~(3)Biochemistry.~~

~~(4)Pathology.~~

~~(5)Pharmacology.~~

~~(6)Physiology.~~

~~The division may require an applicant under this section to undertake additional education to bring up to standard, instruction in the subjects listed in subdivision (b) of Section 2089 as a condition of issuing a physician and surgeon's certificate. In approving an applicant under this section, the division may take into account the applicant's total relevant academic experience, including performance on standardized national examinations.~~

~~(b)(1)Notwithstanding subdivision (a) or Sections 2084 and 2089, an applicant who is a graduate of an approved medical school located in the United States or Canada who has graduated from a special medical school program that does not substantially meet the requirements of Section 2089 with respect to any aspect of curriculum length or content shall be presumed to meet the requirements of Sections 2084 and 2089 if the special medical school program has been reviewed and approved by a national accrediting agency approved by the division and recognized by the United States Department of Education.~~

~~(2)This presumption may be overcome upon a finding by the division that the medical education received by the applicant is not the educational equivalent of the medical education received by graduates of medical schools approved pursuant to subdivision (a) or Section 2084. In making its finding, the division shall consider, at a minimum, the applicant's total academic and medical training experience prior to, and following, as well as during, medical school, the applicant's performance on standardized national examinations, including the National Board Examinations, the applicant's achievements as a house staff officer, and the number of years of postgraduate medical training completed by the applicant.~~

~~(3)An applicant under this subdivision who (A) has satisfactorily completed at least two years of postgraduate clinical training approved by the Accreditation Council for Graduate Medical Education or the Coordinating Council of Medical Education of the Canadian Medical Association and whose postgraduate training has included at least one year of clinical contact with patients and (B) has achieved a passing score on the written examination required for licensure, satisfies the requirements of Sections 2084 and 2089. For purposes of this subdivision, an applicant who has satisfactorily completed at least two years of approved postgraduate clinical training on or before July 1, 1987, shall not be required to have at least one year of clinical contact with patients.~~

~~(4)Applicants under this subdivision who apply after satisfactorily completing one year of approved postgraduate training shall have their applications reviewed by the division and shall be informed by the division either that satisfactory completion of a second year of approved postgraduate training will result in their being deemed to meet the requirements of Sections 2084 and 2089, or informed of any deficiencies in their qualifications or documentation and the specific remediation, if any, required by the division to meet the requirements of Sections 2084 and 2089. Upon satisfactory completion of the specified remediation, the division shall promptly issue a license to the applicant.~~

SEC. 36. *Section 2087 of the Business and Professions Code is amended to read:*

2087. If ~~any medical school is not approved by the Division of Licensing or~~ any applicant for licensure is rejected by ~~it,~~ *the board,* then ~~the school or~~ the applicant may commence an action in the superior court as provided in Section 2019 against the ~~division~~ *board* to compel it ~~to approve the school or~~ to issue the applicant a certificate or for any other appropriate relief. If the applicant is denied a certificate on the grounds of unprofessional conduct, the provisions of Article 12 (commencing with Section 2220) shall apply. In such an action the court shall proceed under Section 1094.5 of the Code of Civil Procedure, except that the court may not exercise an independent judgment on the evidence. The action shall be speedily determined by the court and shall take precedence over all matters pending therein except criminal cases, applications for injunction, or other matters to which special precedence may be given by law.

SEC. 37. *Section 2089 of the Business and Professions Code is repealed.*

~~2089.(a)Each applicant for a physician's and surgeon's certificate shall show by official transcript or other official evidence satisfactory to the Division of Licensing that he or she has successfully completed a medical curriculum extending over a period of at least four academic years, or 32 months of actual instruction, in a medical school or schools located in the United States or Canada approved by the division, or in a medical school or schools located outside the United States or Canada which otherwise meets the requirements of this section. The total number of hours of all courses shall consist of a minimum of 4,000 hours. At least 80 percent of actual attendance shall be required. If an applicant has matriculated in more than one medical school, the applicant must have matriculated in the medical school awarding the degree of doctor of medicine or its equivalent for at least the last full academic year of medical education received prior to the granting of the degree.~~

~~(b)The curriculum for all applicants shall provide for adequate instruction in the following subjects:~~

~~Alcoholism and other chemical substance dependency, detection and treatment.~~

~~Anatomy, including embryology, histology, and neuroanatomy.~~

~~Anesthesia.~~

~~Biochemistry.~~

~~Child abuse detection and treatment.~~

~~Dermatology.~~

~~Geriatric medicine.~~

~~Human sexuality.~~

~~Medicine, including pediatrics.~~

~~Neurology.~~

~~Obstetrics and gynecology.~~

~~Ophthalmology.~~

~~Otolaryngology.~~

~~Pain management and end-of-life care.~~

~~Pathology, bacteriology, and immunology.~~

~~Pharmacology.~~

~~Physical medicine.~~

~~Physiology.~~

~~Preventive medicine, including nutrition.~~

~~Psychiatry.~~

~~Radiology, including radiation safety.~~

~~Spousal or partner abuse detection and treatment.~~

~~Surgery, including orthopedic surgery.~~

~~Therapeutics.~~

~~Tropical medicine.~~

~~Urology.~~

~~(c)The requirement that an applicant successfully complete a medical curriculum that provides instruction in pain management and end-of-life care shall only apply to a person entering medical school on or after June 1, 2000.~~

SEC. 38. *Section 2089.5 of the Business and Professions Code is repealed.*

~~2089.5.(a)Clinical instruction in the subjects listed in subdivision (b) of Section 2089 shall meet the requirements of this section and shall be considered adequate if the requirements of subdivision (a) of Section 2089 and the requirements of this section are satisfied.~~

~~(b)Instruction in the clinical courses shall total a minimum of 72 weeks in length.~~

~~(c)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 instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry.~~

~~(d)Of the instruction required by subdivision (b), including all of the instruction required by subdivision (c), 54 weeks shall be performed in a hospital that sponsors the instruction and shall meet one of the following:~~

~~(1)Is a formal part of the medical school or school of osteopathic medicine.~~

~~(2)Has a residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC), in family practice or in the clinical area of the instruction for which credit is being sought.~~

~~(3)Is formally affiliated with an approved medical school or school of osteopathic medicine located in the United States or Canada. If the affiliation is limited in nature, credit shall be given only in the subject areas covered by the affiliation agreement.~~

~~(4)Is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada.~~

~~(e)If the institution, specified in subdivision (d), is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada, it shall meet the following:~~

~~(1)The formal affiliation shall be documented by a written contract detailing the relationship between the medical school, or a school of osteopathic medicine, and hospital and the responsibilities of each.~~

~~(2)The school and hospital shall provide to the board a description of the clinical program. The description shall be in sufficient detail to enable the board to determine whether or not the program provides students an adequate medical education. The board shall approve the program if it determines that the program provides an adequate medical education. If the board does not approve the program, it shall provide its reasons for disapproval to the school and hospital in writing specifying its findings about each aspect of the program that it considers to be deficient and the changes required to obtain approval.~~

~~(3)The hospital, if located in the United States, shall be accredited by the Joint Commission on Accreditation of Hospitals, or the American Osteopathic Association's Healthcare Facilities Accreditation Program, and if located in another country, shall be accredited in accordance with the law of that country.~~

~~(4)The clinical instruction shall be supervised by a full-time director of medical education, and the head of the department for each core clinical course shall hold a full-time faculty appointment of the medical school or school of osteopathic medicine and shall be board certified or eligible, or have an equivalent credential in that specialty area appropriate to the country in which the hospital is located.~~

~~(5)The clinical instruction shall be conducted pursuant to a written program of instruction provided by the school.~~

~~(6)The school shall supervise the implementation of the program on a regular basis, documenting the level and extent of its supervision.~~

~~(7)The hospital-based faculty shall evaluate each student on a regular basis and shall document the completion of each aspect of the program for each student.~~

~~(8)The hospital shall ensure a minimum daily census adequate to meet the instructional needs of the number of students enrolled in each course area of clinical instruction, but not less than 15 patients in each course area of clinical instruction.~~

~~(9)The board, in reviewing the application of a foreign medical graduate, may require the applicant to submit a description of the clinical program, if the board has not previously approved the program, and may require the applicant to submit documentation to demonstrate that the applicant's clinical training met the requirements of this subdivision.~~

~~(10)The medical school or school of osteopathic medicine shall bear the reasonable cost of any site inspection by the board or its agents necessary to determine whether the clinical program offered is in compliance with this subdivision.~~

SEC. 39. *Section 2089.7 of the Business and Professions Code is repealed.*

~~2089.7.(a)The requirement of four weeks of clinical course instruction in family medicine shall apply only to those applicants for licensure who graduate from medical school or a school of osteopathic medicine after May 1, 1998.~~

~~(b)This section shall become operative on June 30, 1999.~~

SEC. 40. *Section 2090 of the Business and Professions Code is repealed.*

~~2090."Human sexuality" as used in Sections 2089 and 2191 means the study of a human being as a sexual being and how he or she functions with respect thereto.~~

SEC. 41. *Section 2091 of the Business and Professions Code is repealed.*

~~2091.The requirement that instruction in child abuse detection and treatment be provided shall apply only to applicants who matriculate on or after September 1, 1979.~~

SEC. 42. *Section 2091.1 of the Business and Professions Code is repealed.*

~~2091.1.The requirement that instruction in alcoholism and other chemical substance dependency be provided applies only to applicants who matriculate on or after September 1, 1985.~~

SEC. 43. *Section 2091.2 of the Business and Professions Code is repealed.*

~~2091.2.The requirements that instruction in spousal or partner abuse detection and treatment be provided shall apply only to applicants who matriculate on or after September 1, 1994. The requirement for coursework in spousal or partner abuse detection and treatment shall be satisfied by, and the board shall accept in satisfaction of the requirement, a certification from the chief academic officer of the educational institution from which the applicant graduated that the required coursework is included within the institution's required curriculum for graduation.~~

SEC. 44. *Section 2096 of the Business and Professions Code is amended to read:*

2096. (a) In addition to other requirements of this chapter, before a physician's and surgeon's license may be issued, each applicant, including an applicant applying pursuant to Article 5 (commencing with Section 2100), ~~except as provided in subdivision (b),~~ shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least ~~one year~~ *36 months* of *board-approved* postgraduate training.

~~(b)An applicant applying pursuant to Section 2102 shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least two years of postgraduate training.~~

~~(c)~~

(b) The postgraduate training required by this section shall include at least four months of general medicine and shall be obtained in a postgraduate training program approved by the Accreditation Council for Graduate Medical Education ~~(ACGME) or~~ *(ACGME),* the Royal College of Physicians and Surgeons of Canada ~~(RCPSC).~~ *(RCPSC), or the College of Family Physicians of Canada (CFPC).*

(c) An applicant who has completed at least 36 months of board-approved postgraduate training, not less than 24 months of which was completed as a resident after receiving a medical degree from a combined dental and medical degree program accredited by the Commission on Dental Accreditation (CODA) or approved by the board, shall be eligible for licensure.

~~(d)The amendments made to this section at the 1987 portion of the 1987-88 session of the Legislature shall not apply to applicants who completed their one year of postgraduate training on or before July 1, 1990.~~

SEC. 45. *Section 2100 of the Business and Professions Code is repealed.*

~~2100.The provisions of this article shall apply to all applications of graduates of medical schools located outside the United States or Canada. Such applicants shall otherwise comply with the provisions of this chapter, except where such provisions are in conflict with or inconsistent with the provisions of this article.~~

SEC. 46. *Section 2102 of the Business and Professions Code is repealed.*

~~2102.An applicant whose professional instruction was acquired in a country other than the United States or Canada shall provide evidence satisfactory to the board of compliance with the following requirements to be~~

~~issued a physician's and surgeon's certificate:~~

~~(a)Completion in a medical school or schools of a resident course of professional instruction equivalent to that required by Section 2089 and issuance to the applicant of a document acceptable to the board that shows final and successful completion of the course. However, nothing in this section shall be construed to require the board to evaluate for equivalency any coursework obtained at a medical school disapproved by the board pursuant to this section.~~

~~(b)Certification by the Educational Commission for Foreign Medical Graduates, or its equivalent, as determined by the board. This subdivision shall apply to all applicants who are subject to this section and who have not taken and passed the written examination specified in subdivision (d) prior to June 1, 1986.~~

~~(c)Satisfactory completion of the postgraduate training required under subdivision (b) of Section 2096. An applicant shall be required to have substantially completed the professional instruction required in subdivision (a) and shall be required to make application to the board and have passed steps 1 and 2 of the written examination relating to biomedical and clinical sciences prior to commencing any postgraduate training in this state. In its discretion, the board may authorize an applicant who is deficient in any education or clinical instruction required by Sections 2089 and 2089.5 to make up any deficiencies as a part of his or her postgraduate training program, but that remedial training shall be in addition to the postgraduate training required for licensure.~~

~~(d)Passage of the written examination as provided under Article 9 (commencing with Section 2170). An applicant shall be required to meet the requirements specified in subdivision (b) prior to being admitted to the written examination required by this subdivision.~~

~~(e) Nothing in this section prohibits the board from disapproving a foreign medical school or from denying an application if, in the opinion of the board, the professional instruction provided by the medical school or the instruction received by the applicant is not equivalent to that required in Article 4 (commencing with Section 2080).~~

SEC. 47. *Section 2103 of the Business and Professions Code is repealed.*

~~2103.An applicant shall be eligible for a physician's and surgeon's certificate if he or she has completed the following requirements:~~

~~(a)Submitted official evidence satisfactory to the board of completion of a resident course or professional instruction equivalent to that required in Section 2089 in a medical school located outside the United States or Canada. However, nothing in this section shall be construed to require the board to evaluate for equivalency any coursework obtained at a medical school disapproved by the board pursuant to Article 4 (commencing with Section 2080).~~

~~(b)Submitted official evidence satisfactory to the board of completion of all formal requirements of the medical school for graduation, except the applicant shall not be required to have completed an internship or social service or be admitted or licensed to practice medicine in the country in which the professional instruction was completed.~~

~~(c)Attained a score satisfactory to an approved medical school on a qualifying examination acceptable to the board.~~

~~(d)Successfully completed one academic year of supervised clinical training in a program approved by the board pursuant to Section 2104. The board shall also recognize as compliance with this subdivision the successful completion of a one-year supervised clinical medical internship operated by a medical school pursuant to Chapter 85 of the Statutes of 1972 and as amended by Chapter 888 of the Statutes of 1973 as the equivalent of the year of supervised clinical training required by this section.~~

~~(1)Training received in the academic year of supervised clinical training approved pursuant to Section 2104 shall be considered as part of the total academic curriculum for purposes of meeting the requirements of Sections 2089 and 2089.5.~~

~~(2)An applicant who has passed the basic science and English language examinations required for certification~~

~~by the Educational Commission for Foreign Medical Graduates may present evidence of those passing scores along with a certificate of completion of one academic year of supervised clinical training in a program approved by the board pursuant to Section 2104 in satisfaction of the formal certification requirements of subdivision (b) of Section 2102.~~

~~(e)Satisfactorily completed the postgraduate training required under Section 2096.~~

~~(f)Passed the written examination required for certification as a physician and surgeon under this chapter.~~

SEC. 48. *Section 2104 of the Business and Professions Code is repealed.*

~~2104.The Division of Licensing shall approve programs of supervised clinical training in hospitals for the purpose of providing basic clinical training to students who are graduates of foreign medical schools or have completed all the formal requirements for graduation except for internship or social service and who intend to apply for licensure as a physician and surgeon pursuant to Section 2103. Such programs shall be under the direction of approved medical schools.~~

SEC. 49. *Section 2104.5 of the Business and Professions Code is repealed.*

~~2104.5.The board, in consultation with various medical schools located in California, the Office of Statewide Health Planning and Development, and executive directors and medical directors of nonprofit community health centers, hospital administrators, and medical directors with experience hiring graduates of the Fifth Pathway Program or foreign medical school graduates shall study methods to reactivate the Fifth Pathway Program in medical schools located in this state. The executive directors and medical directors of nonprofit community health centers, the hospital administrators, and the medical directors should serve or work with underserved populations or in facilities located in medically underserved communities or in health professional shortage areas. The board shall submit a report to the Legislature on or before July 1, 2003, that shall include options for the Legislature to consider in order to facilitate the establishment of one or more Fifth Pathway Programs in medical schools located in California. The study shall focus on whether the Fifth Pathway Program can address the needs of areas where a shortage of providers exists, communities with a non-English speaking population in need of medical providers who speak their native language and understand their culture, and whether it can provide greater provider stability in these communities.~~

SEC. 50. *Section 2105 of the Business and Professions Code is amended to read:*

2105. No hospital licensed by this state, or operated by the state or a political subdivision thereof, or which receives state financial assistance, directly or indirectly, shall require an individual who at the time of his or her enrollment in a medical school outside the United States is a citizen of the United States, to satisfy any requirements other than those contained in ~~subdivisions (a), (b), (c), (d), and (e) of Section 2103~~ *paragraph (1) of subdivision (a) of Section 2065* prior to commencing the postgraduate training ~~required by subdivision (f)~~ which are not required for graduates of approved medical schools located in the United States or Canada.

SEC. 51. *Section 2107 of the Business and Professions Code is repealed.*

~~2107.(a)The Legislature intends that the board shall have the authority to substitute postgraduate education and training to remedy deficiencies in an applicant's medical school education and training. The Legislature further intends that applicants who substantially completed their clinical training shall be granted that substitute credit if their postgraduate education took place in an accredited program.~~

~~(b)To meet the requirements for licensure set forth in Sections 2089 and 2089.5, the board may require an applicant under this article to successfully complete additional education and training. In determining the content and duration of the required additional education and training, the board shall consider the applicant's medical education and performance on standardized national examinations, and may substitute approved postgraduate training in lieu of specified undergraduate requirements. Postgraduate training substituted for undergraduate training shall be in addition to the postgraduate training required by Sections 2102 and 2103.~~

SEC. 52. *Section 2111 of the Business and Professions Code is amended to read:*

2111. (a) Physicians who are not citizens but who meet the requirements of subdivision (b) and who seek

postgraduate study in an approved medical school may, after receipt of an appointment from the dean of the California medical school and application to and approval by the ~~Division of Licensing,~~ *board,* be permitted to participate in the professional activities of the department or division in the medical school to which they are appointed. The physician shall be under the direction of the head of the department to which he or she is appointed, supervised by the staff of the medical school's medical center, and known for these purposes as a "visiting fellow." The visiting fellow shall wear a visible name tag containing the title "visiting fellow" when he or she provides clinical services.

(b) (1) Application for approval shall be made on a form prescribed by the division and shall be accompanied by a fee fixed by the ~~division~~ *board* in an amount necessary to recover the actual application processing costs of the program. The application shall show that the person does not immediately qualify for a physician's and surgeon's certificate under this chapter and that the person has completed at least three years of postgraduate basic residency requirements. The application shall include a written statement of the recruitment procedures followed by the medical school before offering the appointment to the applicant.

(2) Approval shall be granted only for appointment to one medical school, and no physician shall be granted more than one approval for the same period of time.

(3) Approval may be granted for a maximum of three years and shall be renewed annually. The medical school shall submit a request for renewal on a form prescribed by the ~~division,~~ *board,* which shall be accompanied by a renewal fee fixed by the ~~division~~ *board* in a amount necessary to recover the actual application processing costs of the program.

(c) Except to the extent authorized by this section, the visiting fellow may not engage in the practice of medicine. Neither the visiting fellow nor the medical school may assess any charge for the medical services provided by the visiting fellow, and the visiting fellow may not receive any other compensation therefor.

(d) The time spent under appointment in a medical school pursuant to this section may not be used to meet the requirements for ~~licensure under Section 2102.~~ *license.*

(e) The ~~division~~ *board* shall notify both the visiting fellow and the dean of the appointing medical school of any complaint made about the visiting fellow.

The ~~division~~ *board* may terminate its approval of an appointment for any act that would be grounds for discipline if done by a licensee. The ~~division~~ *board* shall provide both the visiting fellow and the dean of the medical school with a written notice of termination including the basis for that termination. The visiting fellow may, within 30 days after the date of the notice of termination, file a written appeal to the ~~division.~~ *board.* The appeal shall include any documentation the visiting fellow wishes to present to the ~~division.~~ *board.*

(f) Nothing in this section shall preclude any United States citizen who has received his or her medical degree from a medical school located in a foreign country and recognized by the ~~division~~ *board* from participating in any program established pursuant to this section.

SEC. 53. *Section 2112 of the Business and Professions Code is amended to read:*

2112. (a) Physicians who are not citizens and who seek postgraduate study, may, after application to and approval by the ~~Division of Licensing,~~ *board,* be permitted to participate in a fellowship program in a specialty or subspecialty field, providing the fellowship program is given in a hospital in this state which is approved by the Joint ~~Committee on Accreditation of Hospitals~~ *Commission* and providing the service is satisfactory to the ~~division.~~ *board.* Such physicians shall at all times be under the direction and supervision of a licensed, board-certified physician and surgeon who is recognized as a clearly outstanding specialist in the field in which the foreign fellow is to be trained. The supervisor, as part of the application process, shall submit his or her curriculum vitae and a protocol of the fellowship program to be completed by the foreign fellow. Approval of the program and supervisor is for a period of one year, but may be renewed annually upon application to and approval by the ~~division.~~ *board.* The approval may not be renewed more than four times. The ~~division~~ *board* may determine a fee, based on the cost of operating this program, which shall be paid by the applicant at the time the application is filed.

(b) Except to the extent authorized by this section, no such visiting physician may engage in the practice of

medicine or receive compensation therefor. The time spent under appointment in a medical school pursuant to this section may not be used to meet the requirements for ~~licensure under Section 2101 or 2102.~~ *licensure.*

(c) Nothing in this section shall preclude any United States citizen who has received his or her medical degree from a medical school located in a foreign country from participating in any program established pursuant to this section.

SEC. 54. *Section 2113 of the Business and Professions Code is amended to read:*

2113. (a) Any person who does not immediately qualify for a physician's and surgeon's certificate under this chapter and who is offered by the dean of an approved medical school in this state a full-time faculty position may, after application to and approval by the ~~Division of Licensing,~~ *board,* be granted a certificate of registration to engage in the practice of medicine only to the extent that the practice is incident to and a necessary part of his or her duties as approved by the ~~division~~ *board* in connection with the faculty position. A certificate of registration does not authorize a registrant to admit patients to a nursing or a skilled or assisted living facility unless that facility is formally affiliated with the sponsoring medical school. A clinical fellowship shall not be submitted as a faculty service appointment.

(b) Application for a certificate of registration shall be made on a form prescribed by the ~~division~~ *board* and shall be accompanied by a registration fee fixed by the ~~division in a~~ *board in an* amount necessary to recover the actual application processing costs of the program. To qualify for the certificate, an applicant shall submit all of the following:

(1) If the applicant is a graduate of a medical school other than in the United States or Canada, documentary evidence satisfactory to the ~~division~~ *board* that he or she has been licensed to practice medicine and surgery for not less than four years in another state or country whose requirements for licensure are satisfactory to the ~~division,~~ *board,* or has been engaged in the practice of medicine in the United States for at least four years in approved facilities, or has completed a combination of that licensure and training.

(2) If the applicant is a graduate of ~~an approved~~ *a* medical school in the United States or Canada, documentary evidence that ~~he or she has completed a resident course of professional instruction as required in Section 2089.~~ *the medical school is approved by the board.*

(3) Written certification by the head of the department in which the applicant is to be appointed of all of the following:

(A) The applicant will be under his or her direction.

(B) The applicant will not be permitted to practice medicine unless incident to and a necessary part of his or her duties as approved by the ~~division~~ *board* in subdivision (a).

(C) The applicant will be accountable to the medical school's department chair or division chief for the specialty in which the applicant will practice.

(D) The applicant will be proctored in the same manner as other new faculty members, including, as appropriate, review by the medical staff of the school's medical center.

(E) The applicant will not be appointed to a supervisory position at the level of a medical school department chair or division chief.

(4) Demonstration by the dean of the medical school that the applicant has the requisite qualifications to assume the position to which he or she is to be appointed and that shall include a written statement of the recruitment procedures followed by the medical school before offering the faculty position to the applicant.

(c) A certificate of registration shall be issued only for a faculty position at one approved medical school, and no person shall be issued more than one certificate of registration for the same period of time.

(d) (1) A certificate of registration is valid for one year from its date of issuance and may be renewed twice.

A request for renewal shall be submitted on a form prescribed by the ~~division~~ *board* and shall be accompanied

by a renewal fee fixed by the ~~division~~ *board* in an amount necessary to recover the actual application processing costs of the program.

(2) The dean of the medical school may request renewal of the registration by submitting a plan at the beginning of the third year of the registrant's appointment demonstrating the registrant's continued progress toward licensure and, if the registrant is a graduate of a medical school other than in the United States or Canada, that the registrant has been issued a certificate by the Educational Commission for Foreign Medical Graduates. The ~~division~~ *board* may, in its discretion, extend the registration for a two-year period to facilitate the registrant's completion of the licensure process.

(e) If the registrant is a graduate of a medical school other than in the United States or Canada, he or she shall meet the requirements of Section ~~2102~~ *2065* or 2135, as appropriate, in order to obtain a physician's and surgeon's certificate. Notwithstanding any other provision of law, the ~~division may accept clinical practice in an appointment pursuant to this section as qualifying time to meet the postgraduate training requirements in Section 2102, and~~ *board* may, in its discretion, waive the examination and the Educational Commission for Foreign Medical Graduates certification requirements specified in ~~Section 2102~~ *paragraph (3) of subdivision (a) of Section 2065* in the event the registrant applies for a physician's and surgeon's certificate. As a condition to waiving any examination or the Educational Commission for Foreign Medical Graduates certification requirement, the ~~division~~ *board* in its discretion, may require an applicant to pass ~~the~~ *a* clinical competency examination ~~referred to in subdivision (d) of Section 2135. The division~~ *approved by the board. The board* shall not waive any examination for an applicant who has not completed at least one year in the faculty position.

(f) Except to the extent authorized by this section, the registrant shall not engage in the practice of medicine, bill individually for medical services provided by the registrant, or receive compensation therefor, unless he or she is issued a physician's and surgeon's certificate.

(g) When providing clinical services, the registrant shall wear a visible name tag containing the title "visiting professor" or "visiting faculty member," as appropriate, and the institution at which the services are provided shall obtain a signed statement from each patient to whom the registrant provides services acknowledging that the patient understands that the services are provided by a person who does not hold a physician's and surgeon's certificate but who is qualified to participate in a special program as a visiting professor or faculty member.

(h) The ~~division~~ *board* shall notify both the registrant and the dean of the medical school of a complaint made about the registrant. The ~~division~~ *board* may terminate a registration for any act that would be grounds for discipline if done by a licensee. The ~~division~~ *board* shall provide both the registrant and the dean of the medical school with written notice of the termination and the basis for that termination. The registrant may, within 30 days after the date of the notice of termination, file a written appeal to the ~~division.~~ *board.* The appeal shall include any documentation the registrant wishes to present to the ~~division.~~ *board.*

SEC. 55. *Section 2115 of the Business and Professions Code is repealed.*

~~2115.(a)Physicians who are not citizens and who seek postgraduate study may, after application to and approval by the Division of Licensing, be permitted to participate in a fellowship program in a specialty or subspecialty field, providing the fellowship program is given in a clinic or hospital in a medically underserved area of this state that is licensed by the State Department of Health Services or is exempt from licensure pursuant to subdivision (b) or (c) of Section 1206 of the Health and Safety Code, and providing service is satisfactory to the division. These physicians shall at all times be under the direction and supervision of a licensed, board certified physician and surgeon who has an appointment with a medical school in California and is a specialist in the field in which the fellow is to be trained. The supervisor, as part of the application process, shall submit his or her curriculum vitae and a protocol of the fellowship program to be completed by the foreign fellow. Approval of the program and supervisor is for a period of one year, but may be renewed annually upon application to and approval by the division. The approval may not be renewed more than four times. The division may determine a fee, based on the cost of operating this program, which shall be paid by the applicant at the time the application is filed.~~

~~(b)Except to the extent authorized by this section, no visiting physician may engage in the practice of~~

~~medicine or receive compensation therefor. The time spent under appointment in a clinic pursuant to this section may not be used to meet the requirements for licensure under Section 2102.~~

~~(c)Nothing in this section shall preclude any United States citizen who has received his or her medical degree from a medical school located in a foreign country from participating in any program established pursuant to this section.~~

~~(d)For purposes of this section, a medically underserved area means a federally designated Medically Underserved Area, a federally designated Health Professional Shortage Area, and any other clinic or hospital determined by the board to be medically underserved. Clinics or hospitals determined by the board pursuant to this subdivision shall be reported to the Office of Statewide Health Planning and Development.~~

SEC. 56. *Section 2135 of the Business and Professions Code is amended to read:*

2135. The board shall issue a physician and surgeon's certificate to an applicant who meets all of the following requirements:

(a) The applicant holds an unlimited license as a physician and surgeon in another state or states, or in a Canadian province or Canadian provinces, which was issued upon:

(1) Successful completion of a resident course of professional instruction leading to a degree of medical doctor ~~equivalent to that specified in Section 2089. However, nothing in this section shall be construed to require the board to evaluate for equivalency any coursework obtained at a medical school disapproved by the board pursuant to Article 4 (commencing with Section 2080).~~ *from a board-approved medical school pursuant to Section 2084.*

(2) Taking and passing a written examination that is recognized by the board to be equivalent in content to that administered in California.

(b) The applicant has held an unrestricted license to practice medicine, in a state or states, in a Canadian province or Canadian provinces, or as a member of the active military, United States Public Health Services, or other federal program, for a period of at least four years. Any time spent by the applicant in an approved postgraduate training program or clinical fellowship acceptable to the board shall not be included in the calculation of this four-year period.

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

(d) The applicant ~~(1)~~ has satisfactorily completed at least one year of approved postgraduate training and is certified by a specialty board approved by the American Board of Medical Specialties or approved by the board pursuant to subdivision (h) of Section ~~651; (2) has satisfactorily completed at least two years of approved postgraduate training; or (3) has satisfactorily completed at least one year of approved postgraduate training and takes and passes the clinical competency written examination.~~ *651.*

(e) The applicant has not committed any acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475) or Article 12 (commencing with Section 2220).

(f) Any application received from an applicant who has held an unrestricted license to practice medicine, in a state or states, or Canadian province or Canadian provinces, or as a member of the active military, United States Public Health Services, or other federal program for four or more years shall be reviewed and processed pursuant to this section. Any time spent by the applicant in an approved postgraduate training program or clinical fellowship acceptable to the board shall not be included in the calculation of this four-year period. This subdivision does not apply to applications that may be reviewed and processed pursuant to Section 2151.

SEC. 57. *Section 2135.5 of the Business and Professions Code is amended to read:*

2135.5. Upon review and recommendation, the ~~Division of Licensing~~ *board* may determine that an applicant for a physician's and surgeon's certificate has satisfied the medical ~~curriculum~~ *education* requirements of Section ~~2089, the clinical instruction requirements of Sections 2089.5 and 2089.7,~~ *2135,* and the examination requirements of Section 2170 if the applicant meets all of the following criteria:

(a) He or she holds an unlimited and unrestricted license as a physician and surgeon in another state and has held that license continuously for a minimum of four years prior to the date of application.

(b) He or she is certified by a specialty board that is a member board of the American Board of Medical Specialties.

(c) He or she is not subject to denial of licensure under Division 1.5 (commencing with Section 475) or Article 12 (commencing with Section 2220).

~~(d)He or she has not graduated from a medical school that has been disapproved by the division or that does not provide a resident course of instruction.~~

~~(e)He or she has graduated from a medical school recognized by the division. If the applicant graduated from a medical school that the division recognized after the date of the applicant's graduation, the division may evaluate the applicant under its regulations.~~

~~(f)~~

(d) He or she has not been the subject of a disciplinary action by a medical licensing authority or of an adverse judgment or settlement resulting from the practice of medicine that, as determined by the ~~division,~~ *board,* constitutes a pattern of negligence or incompetence.

SEC. 58. *Section 2135.7 of the Business and Professions Code is repealed.*

~~2135.7.(a)Upon review and recommendation, the board may determine that an applicant for a physician and surgeon's certificate who acquired his or her medical education or a portion thereof at a foreign medical school that is not recognized or has been previously disapproved by the board is eligible for a physician and surgeon's certificate if the applicant meets all of the following criteria:~~

~~(1)Has successfully completed a resident course of medical education leading to a degree of medical doctor equivalent to that specified in Sections 2089 to 2091.2, inclusive.~~

~~(2)(A)(i)For an applicant who acquired any part of his or her medical education from an unrecognized foreign medical school, he or she holds an unlimited and unrestricted license as a physician and surgeon in another state, a federal territory, or a Canadian province and has held that license and continuously practiced for a minimum of 10 years prior to the date of application.~~

~~(ii)For an applicant who acquired any part of his or her professional instruction from a foreign medical school that was disapproved by the board at the time he or she attended the school, he or she holds an unlimited and unrestricted license as a physician and surgeon in another state, a federal territory, or a Canadian province and has held that license and continuously practiced for a minimum of 12 years prior to the date of application.~~

~~(B)For the purposes of clauses (i) and (ii) of subparagraph (A), the board may combine the period of time that the applicant has held an unlimited and unrestricted license in other states, federal territories, or Canadian provinces and continuously practiced therein, but each applicant under this section shall have a minimum of two years continuous licensure and practice in a single state, federal territory, or Canadian province. For purposes of this paragraph, continuous licensure and practice includes any postgraduate training after 24 months in a postgraduate training program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) or postgraduate training completed in Canada that is accredited by the Royal College of Physicians and Surgeons of Canada (RCPSC).~~

~~(3)Is certified by a specialty board that is a member board of the American Board of Medical Specialties.~~

~~(4)Has successfully taken and passed the examinations described in Article 9 (commencing with Section~~

~~2170).~~

~~(5)Has not been the subject of a disciplinary action by a medical licensing authority or of adverse judgments or settlements resulting from the practice of medicine that the board determines constitutes a pattern of negligence or incompetence.~~

~~(6)Has successfully completed three years of approved postgraduate training. The postgraduate training required by this paragraph shall have been obtained in a postgraduate training program accredited by the ACGME or postgraduate training completed in Canada that is accredited by the RCPSC.~~

~~(7)Is not subject to denial of licensure under Division 1.5 (commencing with Section 475) or Article 12 (commencing with Section 2220).~~

~~(8)Has not held a healing arts license and been the subject of disciplinary action by a healing arts board of this state or by another state, federal territory, or Canadian province.~~

~~(b)The board may adopt regulations to establish procedures for accepting transcripts, diplomas, and other supporting information and records when the originals are not available due to circumstances outside the applicant's control. The board may also adopt regulations authorizing the substitution of additional specialty board certifications for years of practice or licensure when considering the certification for a physician and surgeon pursuant to this section.~~

~~(c)This section shall not apply to a person seeking to participate in a program described in Section 2072, 2073, 2111, 2112, 2113, 2115, or 2168, or seeking to engage in postgraduate training in this state.~~

SEC. 59. *Section 2143 of the Business and Professions Code is amended to read:*

2143. An applicant for a reciprocity certificate need not have completed the ~~first year of~~ postgraduate training required in Section 2096 prior to the issuance of a license in another state, if the applicant complies with the requirements of Section 2096 before application is made to the ~~Division of Licensing~~ *board* for a reciprocity certificate.

SEC. 60. *Section 2168.4 of the Business and Professions Code is amended to read:*

2168.4. (a) A special faculty permit expires and becomes invalid at midnight on the last day of the ~~permitholder's birth month during the second year of a two-year term,~~ *month in which the permit was issued during the second year of a two-year term commencing from the date of issuance,* if not renewed.

(b) A person who holds a special faculty permit shall show at the time of license renewal that he or she continues to meet the eligibility criteria set forth in Section 2168.1. After the first renewal of a special faculty permit, the permitholder shall not be required to hold a full-time faculty position, and may instead be employed part-time in a position that otherwise meets the requirements set forth in paragraph (1) of subdivision (a) of Section 2168.1.

(c) A person who holds a special faculty permit shall show at the time of license renewal that he or she meets the continuing medical education requirements of Article 10 (commencing with Section 2190).

(d) In addition to the requirements set forth above, a special faculty permit shall be renewed in accordance with Article 19 (commencing with Section 2420) in the same manner as a physician's and surgeon's certificate.

(e) Those fees applicable to a physician's and surgeon's certificate shall also apply to a special faculty permit and shall be paid into the State Treasury and credited to the Contingent Fund of the Medical Board of California.

SEC. 61. *Section 2191 of the Business and Professions Code is amended to read:*

2191. (a) In determining its continuing education requirements, the board shall consider including a course in human ~~sexuality as defined in Section 2090~~ *sexuality, defined as the study of a human being as a sexual*

being and how he or she functions with respect thereto, and nutrition to be taken by those licensees whose practices may require knowledge in those areas.

(b) The board shall consider including a course in child abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected children.

(c) The board shall consider including a course in acupuncture to be taken by those licensees whose practices may require knowledge in the area of acupuncture and whose education has not included instruction in acupuncture.

(d) The board shall encourage every physician and surgeon to take nutrition as part of his or her continuing education, particularly a physician and surgeon involved in primary care.

(e) The board shall consider including a course in elder abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected persons 65 years of age and older.

(f) In determining its continuing education requirements, the board shall consider including a course in the early detection and treatment of substance abusing pregnant women to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these women.

(g) In determining its continuing education requirements, the board shall consider including a course in the special care needs of drug addicted infants to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these infants.

(h) In determining its continuing education requirements, the board shall consider including a course providing training and guidelines on how to routinely screen for signs exhibited by abused women, particularly for physicians and surgeons in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. In the event the board establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(i) In determining its continuing education requirements, the board shall consider including a course in the special care needs of individuals and their families facing end-of-life issues, including, but not limited to, all of the following:

(1) Pain and symptom management.

(2) The psycho-social dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(j) In determining its continuing education requirements, the board shall give its highest priority to considering a course on pain management.

(k) In determining its continuing education requirements, the board shall consider including a course in geriatric care for emergency room physicians and surgeons.

SEC. 62. *Section 2216.3 of the Business and Professions Code is amended to read:*

2216.3. (a) An outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code shall report an adverse event to the board no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law.

(b) For the purposes of this section, "adverse event" ~~has the same meaning as in subdivision (b) of Section 1279.1 of the Health and Safety Code.~~ *includes any of the following:*

(1) Surgical or other invasive procedures, including the following:

(A) Surgical or other invasive procedure performed on a wrong body part that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery or a situation that is so urgent as to preclude obtaining informed consent.

(B) Surgical or other invasive procedure performed on the wrong patient.

(C) The wrong surgical or other invasive procedure performed on a patient, which is a procedure performed on a patient that is inconsistent with the documented informed consent for that patient. A reportable event under this subparagraph does not include a situation requiring prompt action that occurs in the course of surgery, or a situation that is so urgent as to preclude the obtaining of informed consent.

(D) Retention of a foreign object in a patient after surgery or other procedure, excluding objects intentionally implanted as part of a planned intervention and objects present prior to surgery that are intentionally retained.

(E) Death of a patient during or up to 24 hours after admittance of a patient to an outpatient setting.

(F) Transfer of a patient to a hospital or emergency center for medical treatment for a period exceeding 24 hours.

(2) Product or device events, including the following:

(A) Patient death or serious disability associated with the use of a contaminated drug, device, or biologic provided by the outpatient setting when the contamination is the result of generally detectable contaminants in the drug, device, or biologic, regardless of the source of the contamination or the product.

(B) Patient death or serious disability associated with the use or function of a device in patient care in which the device is used or functions other than as intended. For purposes of this subparagraph, "device" includes, but is not limited to, a catheter, drain, or other specialized tube, infusion pump, or ventilator.

(C) Patient death or serious disability associated with intravascular air embolism that occurs while being cared for in an outpatient setting, excluding deaths associated with neurosurgical procedures known to present a high risk of intravascular air embolism.

(3) Patient protection events, including the following:

(A) A minor discharged to the wrong person.

(B) A patient suicide or attempted suicide resulting in serious disability while being cared for in an outpatient setting due to patient actions after admission to the outpatient setting.

(4) Care management events, including the following:

(A) A patient death or serious disability associated with a medication error, including, but not limited to, an error involving the wrong drug, the wrong dose, the wrong patient, the wrong time, the wrong rate, the wrong preparation, or the wrong route of administration, excluding reasonable differences in clinical judgment on drug selection and dose.

(B) A patient death or serious disability associated with a hemolytic reaction due to the administration of ABO-incompatible blood or blood products.

(C) Patient death or serious disability directly related to hypoglycemia, the onset of which occurs while the patient is being cared for in an outpatient setting.

(D) Death or serious disability, including kernicterus, associated with failure to identify and treat hyperbilirubinemia in neonates during the first 28 days of life. For purposes of this subparagraph, "hyperbilirubinemia" means bilirubin levels greater than 30 milligrams per deciliter.

(E) A patient death or serious disability due to spinal manipulative therapy performed at the outpatient

setting.

(5) Environmental events, including the following:

(A) A patient death or serious disability associated with an electric shock while being cared for in an outpatient setting, excluding events involving planned treatments, such as electric countershock.

(B) Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by a toxic substance.

(C) A patient death or serious disability associated with a burn incurred from any source while being cared for in an outpatient setting.

(D) A patient death associated with a fall while being cared for in an outpatient setting.

(E) A patient death or serious disability associated with the use of restraints or bed rails while being cared for in an outpatient setting.

(6) Criminal events, including the following:

(A) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider.

(B) The abduction of a patient of any age.

(C) The sexual assault on a patient within or on the grounds of an outpatient setting.

(D) The death or significant injury of a patient or staff member resulting from a physical assault that occurs within or on the grounds of an outpatient setting.

(7) An adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor.

(c) The outpatient setting shall inform the patient or the party responsible for the patient of the adverse event by the time the report is made.

(d) "Serious disability" means a physical or mental impairment that substantially limits one or more of the major life activities of an individual, or the loss of bodily function, if the impairment or loss lasts more than seven days or is still present at the time of discharge from an inpatient health care facility, or the loss of a body part.

(e) "Surgical or other invasive procedures" are defined for the purposes of this section as operative procedures in which skin or mucous membranes and connective tissue are incised or an instrument is introduced through a natural body orifice. They include all procedures described by the codes in the surgery section of the 2017 Current Procedural Terminology.

SEC. 63. *Section 2216.5 is added to the Business and Professions Code, to read:*

2216.5. *(a) An outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code shall, on or before February 15 of each year, file with the Office of Statewide Health Planning and Development upon forms to be furnished by the office, a verified report showing the following information relating to the previous calendar year:*

(1) Number of patients served and descriptive information, including age, gender, race, and ethnic background of patients.

(2) Number of patient visits by type of service.

(3) Number of hospital transfers and admissions.

(4) Number of postoperative wound infections.

(5) Number of patient falls.

(6) Number of patient burns.

(7) Number of medication errors.

(8) Number of emergency room visits within 48 hours of discharge.

(9) Number of procedures performed on the wrong patient.

(10) Number of wrong procedures performed.

(11) Number of wrong site surgeries.

(12) Number of patients returned to surgery for reasons other than bleeding.

(13) Number of patients who had excessive bleeding that required the patient to return to the operating room or transfer.

(14) Number of patients who had cardiac or respiratory arrest.

(15) Number of medical device errors.

(16) Number of procedures that resulted in a retained foreign body in the patient.

(17) Number of patient deaths.

(b) An outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code shall file with the Office of Statewide Health Planning and Development an Ambulatory Surgery Data Record for each patient encounter during which at least one ambulatory surgery procedure is performed. The Ambulatory Surgery Data Record shall include all of the following:

(1) Date of birth.

(2) Sex.

(3) Race.

(4) Ethnicity.

(5) Principal language spoken.

(6) ZIP Code.

(7) Patient social security number, if it is contained in the patient's medical record.

(8) Service date.

(9) Principal diagnosis.

(10) Other diagnoses.

(11) Principal procedure.

(12) Other procedures.

(13) Principal external cause of injury, if known.

(14) Other external cause of injury, if known.

(15) Disposition of patient.

(c) Outpatient settings accredited pursuant to Section 1248.1 of the Health and Safety Code shall be subject to the fees required in subdivision (f) of Section 127280 of the Health and Safety Code. Any fees collected pursuant to subdivision (f) of Section 127280 of the Health and Safety Code shall not exceed the reasonable costs incurred by the Office of Statewide Health Planning and Development.

(d) It is the expressed intent of the Legislature that the patient's rights of confidentiality shall not be violated in any manner. Patient social security numbers and any other data elements that the office believes could be used to determine the identity of an individual patient shall be exempt from the disclosure requirements of the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(e) No person reporting data pursuant to this section shall be liable for damages in any action based on the use or misuse of patient-identifiable data that has been mailed or otherwise transmitted to the office pursuant to the requirements of this section.

SEC. 64. *Section 2220.05 of the Business and Professions Code is amended to read:*

2220.05. (a) In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California *and the California Board of Podiatric Medicine* shall prioritize ~~its~~ *their* investigative and prosecutorial resources to ensure that physicians and surgeons *and doctors of podiatric medicine* representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon *or the doctor of podiatric medicine* represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon *or a doctor of podiatric medicine* involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing, including, but not limited to, Sections 725, 2241.5, and 2241.6 of this code and Sections 11159.2 and 124961 of the Health and Safety Code, be prosecuted for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation.

(5) Sexual misconduct with one or more patients during a course of treatment or an examination.

(6) Practicing medicine while under the influence of drugs or alcohol.

(7) Repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor.

(b) The board may by regulation prioritize cases involving an allegation of conduct that is not described in subdivision (a). Those cases prioritized by regulation shall not be assigned a priority equal to or higher than the priorities established in subdivision (a).

(c) The Medical Board of California shall indicate in its annual report mandated by Section 2312 the number of temporary restraining orders, interim suspension orders, and disciplinary actions that are taken in each priority category specified in subdivisions (a) and (b).

SEC. 65. *Section 2221 of the Business and Professions Code is amended to read:*

2221. (a) The board may deny a physician's and surgeon's certificate or postgraduate training authorization letter to an applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license. The board in its sole discretion, may issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions, including, but not limited

to, any of the following conditions of probation:

(1) Practice limited to a supervised, structured environment where the licensee's activities shall be supervised by another physician and surgeon.

(2) Total or partial restrictions on drug prescribing privileges for controlled substances.

(3) Continuing medical or psychiatric treatment.

(4) Ongoing participation in a specified rehabilitation program.

(5) Enrollment and successful completion of a clinical training program.

(6) Abstention from the use of alcohol or drugs.

(7) Restrictions against engaging in certain types of medical practice.

(8) Compliance with all provisions of this chapter.

(9) Payment of the cost of probation monitoring.

(b) The board may modify or terminate the terms and conditions imposed on the probationary certificate upon receipt of a petition from the *licensee; however, the requirements of Section 2228.1 are mandatory with any probationary* licensee. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board.

(c) The board shall deny a physician's and surgeon's certificate to an applicant who is required to register pursuant to Section 290 of the Penal Code. This subdivision does not apply to an applicant who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(d) An applicant shall not be eligible to reapply for a physician's and surgeon's certificate for a minimum of three years from the effective date of the denial of his or her application, except that the board may, in its discretion and for good cause demonstrated, permit reapplication after not less than one year has elapsed from the effective date of the denial.

SEC. 66. *Section 2225 of the Business and Professions Code is amended to read:*

2225. (a) Notwithstanding Section 2263 and any other ~~law~~ *law, including laws pertaining to the psychotherapist-patient privilege,* making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and shall not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient

consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied if relevant to an investigation of a licensee.

(c) (1) Notwithstanding subdivision (b) or any other law, in any investigation that involves the death of a patient, the board may inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely for the purpose of determining the extent to which the death was the result of the physician and surgeon's conduct in violation of the Medical Practice Act, if the board provides a written request to either the physician and surgeon or the facility where the medical records are located or the care to the deceased patient was provided, that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts. Nothing in this subdivision shall be construed to allow the board to inspect and copy the medical records of a deceased patient without a court order when the beneficiary or personal representative of the deceased patient has been located and contacted but has refused to consent to the board inspecting and copying the medical records of the deceased patient.

(2) The Legislature finds and declares that the authority created in the board pursuant to this section, and a physician and surgeon's compliance with this section, are consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA).

(d) In all cases in which documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

SEC. 67. *Section 2228.1 is added to the Business and Professions Code, to read:*

2228.1. *(a) On and after July 1, 2018, except as otherwise provided in subdivision (c), the board shall require a licensee on probation pursuant to a probationary order made on or after July 1, 2018, before a patient's first visit following the probationary order, to provide the patient, or the patient's guardian or health care surrogate, with a separate disclosure containing all of the following information:*

(1) The licensee's probationary status.

(2) The length of the probation and the end date.

(3) All practice restrictions placed on the licensee by the board.

(4) The board's telephone number, if the probation was imposed by the board.

(5) An explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the board's online license information site, if the probation was imposed by the board.

(b) A licensee required to provide a disclosure pursuant to subdivision (a) shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of that disclosure.

(c) A licensee shall not be required to provide a disclosure pursuant to subdivision (a) if any of the following

applies:

(1) The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure pursuant to subdivision (b) and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the copy. In that instance, the licensee shall disclose her or his status as soon as either the patient can comprehend the disclosure and sign the copy or a guardian or health care surrogate is available to comprehend the disclosure and sign the copy.

(2) The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled.

(3) The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

(d) On and after July 1, 2018, the board shall provide the following information, with respect to licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the board's online license information site.

(1) For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.

(2) For probation imposed by an adjudicated decision of the board, the causes for probation stated in the final probationary order.

(3) For a licensee granted a probationary license, the causes by which the probationary license was imposed.

(4) The length of the probation and end date.

(5) All practice restrictions placed on the license by the board.

(e) Section 2314 shall not apply to this section.

SEC. 68. *Section 2232 of the Business and Professions Code is amended to read:*

2232. (a) Except as provided in subdivisions ~~(b), (c), and~~ *(c),* (d), *and (e),* the board shall ~~promptly~~ *automatically* revoke the license of any person who, at any time after January 1, 1947, has been required to register as a sex offender pursuant to the provisions of Section 290 of the Penal ~~Code.~~ *Code, regardless of whether the related conviction has been appealed. The board shall notify the licensee of the license revocation and of his or her right to elect to have a hearing as provided in subdivision (b).*

(b) Upon revocation of the physician's and surgeon's certificate, the holder of the certificate may request a hearing within 30 days of the revocation. The proceeding shall be conducted in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code).

~~(b)~~

(c) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

~~(c)~~

(d) (1) Five years after the effective date of the revocation and three years after successful discharge from parole, probation, or both parole and probation if under simultaneous supervision, an individual who after January 1, 1947, and prior to January 1, 2005, was subject to subdivision (a), may petition the superior court, in the county in which the individual has resided for, at minimum, five years prior to filing the petition, to hold a hearing within one year of the date of the petition, in order for the court to determine whether the individual no longer poses a possible risk to patients. The individual shall provide notice of the petition to the Attorney General and to the board at the time of its filing. The Attorney General and the board may present written and oral argument to the court on the merits of the petition.

(2) If the court finds that the individual no longer poses a possible risk to patients, and there are no other underlying reasons for which the board pursued disciplinary action, the court shall order, in writing, the board to reinstate the individual's license within 180 days of the date of the order. The board may issue a probationary license to a person subject to this paragraph subject to terms and conditions, including, but not limited to, any of the conditions of probation specified in Section 2221.

(3) If the court finds that the individual continues to pose a possible risk to patients, the court shall deny relief. The court's decision shall be binding on the individual and the board, and the individual shall be prohibited from filing a subsequent petition under this section based on the same conviction.

~~(d)~~

(e) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(f) If the related conviction of the certificate holder is overturned on appeal, the revocation ordered pursuant to this section shall automatically cease. Nothing in this subdivision shall prohibit the board from pursuing disciplinary action based on any cause other than the overturned conviction.

(g) The other provisions of this article setting forth a procedure for the revocation of a physician's and surgeon's certificate shall not apply to proceedings conducted pursuant to this section.

SEC. 69. *Section 2291.5 is added to the Business and Professions Code, to read:*

2291.5. *A physician and surgeon's failure to comply with an order issued under Section 820 shall result in the issuance of notification from the board to cease the practice of medicine within three calendar days after being so notified. The physician and surgeon shall cease the practice of medicine until the ordered examinations have been completed. A physician and surgeon's continued failure to comply with an order issued under Section 820 shall constitute grounds for the suspension or revocation of his or her certificate.*

SEC. 70. *Section 2334 of the Business and Professions Code is amended to read:*

2334. (a) Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party, as ordered by the Office of Administrative Hearings:

(1) A curriculum vitae setting forth the qualifications of the expert.

(2) A ~~brief narrative statement of the general substance of the testimony that the expert is expected to give, including any opinion testimony and its basis.~~ *complete expert witness report, which must include the following:*

(A) A complete statement of all opinions the expert will express and the bases and reasons for each opinion.

(B) The facts or data considered by the expert in forming the opinions.

(C) Any exhibits that will be used to summarize or support the opinions.

(3) A representation that the expert has agreed to testify at the hearing.

(4) A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party who retained his or her services.

(b) The exchange of the information described in subdivision (a) shall be completed ~~at least~~ *no later than 90 days from the filing of an accusation or petition to revoke probation or* 30 calendar days prior to the commencement date of the ~~hearing.~~ *hearing, whichever occurs first, or as determined by an administrative law judge when Section 11529 of the Government Code applies.*

(c) The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section.

SEC. 71. *Section 2415 of the Business and Professions Code is amended to read:*

2415. (a) Any physician and surgeon or any doctor of podiatric medicine, as the case may be, who as a sole proprietor, or in a partnership, group, or professional corporation, desires to practice under any name that would otherwise be a violation of Section 2285 may practice under that name if the proprietor, partnership, group, or corporation obtains and maintains in current status a fictitious-name permit issued by the Division of Licensing, or, in the case of doctors of podiatric medicine, the California Board of Podiatric Medicine, under the provisions of this section.

(b) The division or the board shall issue a fictitious-name permit authorizing the holder thereof to use the name specified in the permit in connection with his, her, or its practice if the division or the board finds to its satisfaction that:

(1) The applicant or applicants or shareholders of the professional corporation hold valid and current licenses as physicians and surgeons or doctors of podiatric medicine, as the case may be.

(2) The professional practice of the applicant or applicants is wholly owned and entirely controlled by the applicant or applicants.

(3) The name under which the applicant or applicants propose to practice is not deceptive, misleading, or confusing.

(c) Each permit shall be accompanied by a notice that shall be displayed in a location readily visible to patients and staff. The notice shall be displayed at each place of business identified in the permit.

(d) This section shall not apply to licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with that medical school.

(e) Fictitious-name permits issued under this section shall be subject to Article 19 (commencing with Section ~~2420)~~ *2421)* pertaining to renewal of ~~licenses, except the division shall establish procedures for the renewal of fictitious-name permits every two years on an anniversary basis. For the purpose of the conversion of existing permits to this schedule the division may fix prorated renewal fees.~~ *licenses.*

(f) The division or the board may revoke or suspend any permit issued if it finds that the holder or holders of the permit are not in compliance with the provisions of this section or any regulations adopted pursuant to this section. A proceeding to revoke or suspend a fictitious-name permit shall be conducted in accordance with Section 2230.

(g) A fictitious-name permit issued to any licensee in a sole practice is automatically revoked in the event the licensee's certificate to practice medicine or podiatric medicine is revoked.

(h) The division or the board may delegate to the executive director, or to another official of the board, its authority to review and approve applications for fictitious-name permits and to issue those permits.

(i) The California Board of Podiatric Medicine shall administer and enforce this section as to doctors of podiatric medicine and shall adopt and administer regulations specifying appropriate podiatric medical name designations.

SEC. 72. *Section 2420 of the Business and Professions Code is repealed.*

~~2420.The provisions of this article apply to, determine the expiration of, and govern the renewal of, each of the following certificates, licenses, registrations, and permits issued by or under the Medical Board of California: physician's and surgeon's certificates, certificates to practice podiatric medicine, physical therapy licenses and approvals, registrations of research psychoanalysts, registrations of dispensing opticians, registrations of nonresident contact lens sellers, registrations of spectacle lens dispensers, registrations of~~

~~contact lens dispensers, certificates to practice midwifery, and fictitious name permits.~~

SEC. 73. *Section 2421 of the Business and Professions Code is amended to read:*

2421. As used in this article, the terms:

(a) "License" includes "certificate," "permit," and "registration."

(b) "Licensee" includes the holder of a license.

(c) "Licensing authority" means the ~~appropriate division or examining committee, under the~~ board, which has jurisdiction over a particular licensee.

SEC. 74. *Section 2423 of the Business and Professions Code is amended to read:*

2423. (a) Notwithstanding Section 2422:

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

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

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

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

SEC. 75. *Section 2435 of the Business and Professions Code is amended to read:*

2435. The following fees apply to the licensure of physicians and surgeons:

(a) Each applicant for a certificate based upon a national board diplomate certificate, each applicant for a certificate based on reciprocity, and each applicant for a certificate based upon written examination, shall pay a nonrefundable application and processing fee, as set forth in subdivision (b), at the time the application is filed.

(b) The application and processing fee shall be fixed by the board by May 1 of each year, to become effective on July 1 of that year. The fee shall be fixed at an amount necessary to recover the actual costs of the licensing program as projected for the fiscal year commencing on the date the fees become effective.

(c) Each applicant who qualifies for a certificate, as a condition precedent to its issuance, in addition to other fees required herein, shall pay an initial license fee, if any, in an amount fixed by the board consistent with this section. The initial license fee shall not exceed seven hundred ninety dollars ($790). An applicant enrolled in an approved postgraduate training program shall be required to pay only 50 percent of the initial license fee.

(d) The biennial renewal fee shall be fixed by the board consistent with this section and shall not exceed seven hundred ninety dollars ($790).

~~(e)Notwithstanding subdivisions (c) and (d), and to ensure that subdivision (k) of Section 125.3 is revenue neutral with regard to the board, the board may, by regulation, increase the amount of the initial license fee and the biennial renewal fee by an amount required to recover both of the following:~~

~~(1)The average amount received by the board during the three fiscal years immediately preceding July 1,~~

~~2006, as reimbursement for the reasonable costs of investigation and enforcement proceedings pursuant to Section 125.3.~~

~~(2)Any increase in the amount of investigation and enforcement costs incurred by the board after January 1, 2006, that exceeds the average costs expended for investigation and enforcement costs during the three fiscal years immediately preceding July 1, 2006. When calculating the amount of costs for services for which the board paid an hourly rate, the board shall use the average number of hours for which the board paid for those costs over these prior three fiscal years, multiplied by the hourly rate paid by the board for those costs as of July 1, 2005. Beginning January 1, 2009, the board shall instead use the average number of hours for which it paid for those costs over the three-year period of fiscal years 2005–06, 2006–07, and 2007–08, multiplied by the hourly rate paid by the board for those costs as of July 1, 2005. In calculating the increase in the amount of investigation and enforcement costs, the board shall include only those costs for which it was eligible to obtain reimbursement under Section 125.3 and shall not include probation monitoring costs and disciplinary costs, including those associated with the citation and fine process and those required to implement subdivision (b) of Section 12529 of the Government Code.~~

~~(f)~~

(e) Notwithstanding Section 163.5, the delinquency fee shall be 10 percent of the biennial renewal fee.

~~(g)~~

(f) The duplicate certificate and endorsement fees shall each be fifty dollars ($50), and the certification and letter of good standing fees shall each be ten dollars ($10).

~~(h)~~

(g) It is the intent of the Legislature that, in setting fees pursuant to this section, the board shall seek to maintain a reserve in the Contingent Fund of the Medical Board of California in an amount not less than two nor more than four months' operating expenditures.

~~(i)~~

(h) Not later than January 1, 2012, the Office of State Audits and Evaluations within the Department of Finance shall commence a preliminary review of the board's financial status, including, but not limited to, its projections related to expenses, revenues, and reserves, and the impact of the loan from the Contingent Fund of the Medical Board of California to the General Fund made pursuant to the Budget Act of 2008. The office shall make the results of this review available upon request by June 1, 2012. This review shall be funded from the existing resources of the office during the 2011–12 fiscal year.

SEC. 76. *Section 2435.2 of the Business and Professions Code is amended to read:*

2435.2. (a) Notwithstanding any other provision of law, if Article 14 (commencing with Section 2340) becomes inoperative or the diversion program described in that article is discontinued, the board shall reduce the amount of the following fees:

(1) The initial license fee, as described in subdivision (c) of Section 2435.

(2) The biennial renewal fee, as described in subdivision (d) of Section 2435.

~~(3)An increase in the fees established pursuant to subdivision (e) of Section 2435.~~

(b) The amount of the reductions made pursuant to subdivision (a) shall equal the board's cost of operating the diversion program.

(c) The board shall not make the reductions described in subdivision (a) if a diversion program is established by statute and requires the board to fund it in whole or in part from licensure fees.

~~**SEC. 3.**~~***SEC. 77.*** Section 2450 of the Business and Professions Code is amended to read:

2450. There is a Board of Osteopathic Examiners of the State of California, established by the Osteopathic Act, which shall be known as the Osteopathic Medical Board of California which enforces this chapter relating to persons holding or applying for physician's and surgeon's certificates issued by the Osteopathic Medical Board of California under the Osteopathic Act.

Persons who elect to practice using the term of suffix "M.D.," as provided in Section 2275, shall not be subject to this article, and the Medical Board of California shall enforce the provisions of this chapter relating to persons who made the election.

Notwithstanding any other law, the powers and duties of the Osteopathic Medical Board of California, as set forth in this article and under the Osteopathic Act, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2022.

SEC. 78. *Section 2454.5 of the Business and Professions Code is amended to read:*

2454.5. In order to ensure the continuing competence of licensed osteopathic physicians and surgeons, the board shall adopt and administer standards for the continuing education of those licensees. The board shall require each licensed osteopathic physician and surgeon to demonstrate satisfaction of the continuing education requirements as a condition for the renewal of a license at intervals of not less than one year nor more than ~~three~~ *two* years. Commencing January 1, ~~1995,~~ *2018,* the board shall require each licensed osteopathic physician and surgeon to complete a minimum of ~~150~~ *100* hours of American Osteopathic Association continuing education hours during each ~~three-year~~ *two-year* cycle, of which ~~60~~ *40* hours ~~must~~ *shall* be completed in American Osteopathic Association Category 1 continuing education hours *and the remaining 60 hours shall be either American Osteopathic Association or American Medical Association accredited* as a condition for renewal of an active license.

For purposes of this section, "American Osteopathic Association Category 1" means continuing education activities and programs approved for Category 1 credit by the Committee on Continuing Medical Education of the American Osteopathic Association.

SEC. 79. *Section 2460 of the Business and Professions Code is amended to read:*

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

(b) This section shall remain in effect only until January 1, 2021, and as of that date is repealed. Notwithstanding any other law, the repeal of this section renders the California Board of Podiatric Medicine subject to review by the appropriate policy committees of the Legislature.

SEC. 80. *Section 2461 of the Business and Professions Code is amended to read:*

2461. As used in this article:

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

~~(b)~~

(a) "Board" means the California Board of Podiatric Medicine.

~~(c)~~

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

SEC. 81. *Section 2472 of the Business and Professions Code is amended to read:*

2472. (a) The certificate to practice podiatric medicine authorizes the holder to practice podiatric medicine.

(b) As used in this chapter, "podiatric medicine" means the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.

(c) A doctor of podiatric medicine may not administer an anesthetic other than local. If an anesthetic other than local is required for any procedure, the anesthetic shall be administered by another licensed health care practitioner who is authorized to administer the required anesthetic within the scope of his or her practice.

(d) (1) A doctor of podiatric medicine ~~who is ankle certified by the board on and after January 1, 1984,~~ may do the following:

(A) Perform surgical treatment of the ankle and tendons at the level of the ankle pursuant to subdivision (e).

(B) Perform services under the direct supervision of a physician and surgeon, as an assistant at surgery, in surgical procedures that are otherwise beyond the scope of practice of a doctor of podiatric medicine.

(C) Perform a partial amputation of the foot no further proximal than the Chopart's joint.

(2) Nothing in this subdivision shall be construed to permit a doctor of podiatric medicine to function as a primary surgeon for any procedure beyond his or her scope of practice.

(e) A doctor of podiatric medicine may perform surgical treatment of the ankle and tendons at the level of the ankle only in the following locations:

(1) A licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code.

(2) A licensed surgical clinic, as defined in Section 1204 of the Health and Safety Code, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1) and meets all the protocols of the surgical clinic.

(3) An ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1) and meets all the protocols of the surgical center.

(4) A freestanding physical plant housing outpatient services of a licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1). For purposes of this section, a "freestanding physical plant" means any building that is not physically attached to a building where inpatient services are provided.

(5) An outpatient setting accredited pursuant to subdivision (g) of Section 1248.1 of the Health and Safety Code.

SEC. 82. *Section 2474 of the Business and Professions Code is amended to read:*

2474. *(a)* Any person who uses in any sign or in any advertisement or otherwise, the word or words *"podiatric physician," "podiatric surgeon," "podiatric physician and surgeon," "foot and ankle physician and surgeon," "foot and ankle doctor,"* "doctor of podiatric medicine," "doctor of podiatry," "podiatric doctor," "D.P.M.," "podiatrist," "foot specialist," or any other term or terms or any letters indicating or implying that he or she is a doctor of podiatric medicine, or that he or she practices podiatric medicine, or holds himself out as practicing podiatric medicine or foot correction as defined in Section 2472, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as provided for in this chapter, is guilty of a misdemeanor.

(b) A holder of a valid, unrevoked, and unsuspended certificate to practice podiatric medicine may use the phrases "doctor of podiatric medicine," "podiatric physician and surgeon," "doctor of podiatry," and "podiatric doctor, or the initials "D.P.M.," and shall not be in violation of subdivision (a) of Section 2054

SEC. 83. *Section 2475 of the Business and Professions Code is amended to read:*

2475. Unless otherwise provided by law, no postgraduate trainee, intern, resident postdoctoral fellow, or instructor may engage in the practice of podiatric medicine, or receive compensation therefor, or offer to engage in the practice of podiatric medicine unless he or she holds a valid, unrevoked, and unsuspended certificate to practice podiatric medicine issued by the ~~division.~~ *board.* However, a graduate of an approved college or school of podiatric medicine upon whom the degree doctor of podiatric medicine has been conferred, who is issued a resident's license, which may be renewed annually for up to eight years for this purpose by the ~~division upon recommendation of the~~ board, and who is enrolled in a postgraduate training program approved by the board, may engage in the practice of podiatric medicine whenever and wherever required as a part of that program and may receive compensation for that practice under the following conditions:

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

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

SEC. 84. *Section 2479 of the Business and Professions Code is amended to read:*

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

SEC. 85. *Section 2486 of the Business and Professions Code is amended to read:*

2486. The ~~Medical Board of California shall issue, upon the recommendation of the board,~~ *board shall issue* a certificate to practice podiatric medicine if the applicant has submitted directly to the board from the credentialing organizations verification that he or she meets all of the following requirements:

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

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

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

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

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

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

negligence or incompetence.

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

SEC. 86. *Section 2488 of the Business and Professions Code is amended to read:*

2488. ~~Notwithstanding any other provision of law, the Medical Board of California shall issue, upon the recommendation of the board,~~ *The board shall issue* a certificate to practice podiatric medicine by credentialing if the applicant has submitted directly to the board from the credentialing organizations verification that he or she is licensed as a doctor of podiatric medicine in any other state and meets all of the following requirements:

(a) The applicant has graduated from an approved school or college of podiatric medicine.

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

(c) The applicant has satisfactorily completed a postgraduate training program approved by the Council on Podiatric Medical Education.

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

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

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

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

SEC. 87. *Section 2492 of the Business and Professions Code is amended to read:*

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

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

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

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

SEC. 88. *Section 2499 of the Business and Professions Code is amended to read:*

2499. There is in the State Treasury the Board of Podiatric Medicine Fund. Notwithstanding Section 2445, the ~~division~~ *board* shall report to the Controller at the beginning of each calendar month for the month preceding

the amount and source of all revenue received by it on behalf of the board, pursuant to this chapter, and shall pay the entire amount thereof to the Treasurer for deposit into the fund. All revenue received by the board and the division from fees authorized to be charged relating to the practice of podiatric medicine shall be deposited in the fund as provided in this section, and shall be available, upon appropriation of the Legislature, to carry out the provisions of this chapter relating to the regulation of the practice of podiatric medicine.

SEC. 89. *Section 2499.7 is added to the Business and Professions Code, to read:*

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

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

SEC. 90. *Section 2525.2 of the Business and Professions Code is amended to read:*

2525.2. An individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of ~~California~~ *California, the California Board of Podiatric Medicine,* or the Osteopathic Medical Board of California shall not recommend medical cannabis to a patient, unless that person is the patient's attending physician, as defined by subdivision (a) of Section 11362.7 of the Health and Safety Code.

SEC. 91. *The heading of Chapter 5.1 (commencing with Section 2529) of Division 2 of the Business and Professions Code is repealed.*

~~5.1.Research Psychoanalysts~~

SEC. 92. *Section 2529 of the Business and Professions Code is amended and renumbered to read:*

~~**2529.**~~***2950.*** (a) Graduates of the Southern California Psychoanalytic Institute, the Los Angeles Psychoanalytic Society and Institute, the San Francisco Psychoanalytic Institute, the San Diego Psychoanalytic Center, or institutes deemed equivalent by the ~~Medical Board of California~~ *board* who have completed clinical training in psychoanalysis may engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts, and students in those institutes may engage in psychoanalysis under supervision, if the students and graduates do not hold themselves out to the public by any title or description of services incorporating the words "psychological," "psychologist," "psychology," "psychometrists," "psychometrics," or "psychometry," or that they do not state or imply that they are licensed to practice psychology.

(b) Those students and graduates seeking to engage in psychoanalysis under this ~~chapter~~ *article* shall register with the ~~Medical Board of California,~~ *board,* presenting evidence of their student or graduate status. The board may suspend or revoke the exemption of those persons for unprofessional conduct as defined in Sections 726, ~~2234, 2235, and 2529.1~~ *2960, 2960.6, 2969, and 2996.*

SEC. 93. *Section 2529.1 of the Business and Professions Code is amended and renumbered to read:*

~~**2529.1.**~~***2951.*** (a) The use of any controlled substance or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the registrant, or to any other person or to the public, or to the extent that this use impairs the ability of the registrant to practice safely or more than one misdemeanor or any felony conviction involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of this unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The board may order discipline of the registrant in accordance with ~~Section 2227~~ *Article 4 (commencing with Section 2960)* or may order the denial of the registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting

probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing this person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

SEC. 94. *Section 2529.5 of the Business and Professions Code is amended and renumbered to read:*

~~**2529.5.**~~***2952.*** *(a)* Each person to whom registration is granted under the provisions of this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the ~~Medical Board of California~~ *board* at a sum not in excess of one hundred dollars ($100).

~~The~~

(b) The registration shall expire after two years. The registration may be renewed biennially at a fee to be fixed by the board at a sum not in excess of fifty dollars ($50). Students seeking to renew their registration shall present to the board evidence of their continuing student status.

~~The~~

(c) The money in the Contingent Fund of the Medical Board of California shall be used for the administration of this chapter. *Any moneys within the Contingent Fund of the Medial Board of California collected pursuant to Chapter 5.1 (commencing with Section 2529) as it read before the enactment of the statute that amended and renumbered this section, shall be deposited in the Psychology Fund.*

(d) The board may employ, subject to civil service regulations, whatever additional clerical assistance is necessary for the administration of this article.

SEC. 95. *Section 2529.6 of the Business and Professions Code is amended and renumbered to read:*

~~**2529.6.**~~***2953.*** (a) Except as provided in subdivisions (b) and (c), the board shall revoke the registration of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal Code for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 96. *The heading of Article 3.5 (commencing with Section 2950) is added to Chapter 6.6 of Division 2 of the Business and Professions Code, to read:*

Article 3.5. Research Psychoanalysts

SEC. 97. *Section 2566.2 is added to the Business and Professions Code, to read:*

2566.2. *Every registration issued to a dispensing optician, contact lens dispenser, and spectacle lens dispenser shall expire 24 months after the initial date of issuance. To renew an unexpired registration, the registrant shall, before the time at which the license would otherwise expire, apply for renewal on a form prescribed by the board, and pay the renewal fee prescribed by this chapter.*

SEC. 98. *Section 43.7 of the Civil Code is amended to read:*

43.7. (a) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any member of a duly appointed mental health professional quality assurance committee that is established in compliance with Section 14725 of the Welfare and Institutions Code, for any act or proceeding

undertaken or performed within the scope of the functions of the committee which is formed to review and evaluate the adequacy, appropriateness, or effectiveness of the care and treatment planned for, or provided to, mental health patients in order to improve quality of care by mental health professionals if the committee member acts without malice, has made a reasonable effort to obtain the facts of the matter as to which he or she acts, and acts in reasonable belief that the action taken by him or her is warranted by the facts known to him or her after the reasonable effort to obtain facts.

(b) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any professional society, any member of a duly appointed committee of a medical specialty society, or any member of a duly appointed committee of a state or local professional society, or duly appointed member of a committee of a professional staff of a licensed hospital (provided the professional staff operates pursuant to written bylaws that have been approved by the governing board of the hospital), for any act or proceeding undertaken or performed within the scope of the functions of the committee which is formed to maintain the professional standards of the society established by its bylaws, or any member of any peer review committee whose purpose is to review the quality of medical, dental, dietetic, chiropractic, optometric, acupuncture, psychotherapy, *midwifery,* or veterinary services rendered by physicians and surgeons, dentists, dental hygienists, podiatrists, registered dietitians, chiropractors, optometrists, acupuncturists, veterinarians, marriage and family therapists, professional clinical counselors, *licensed midwives,* or psychologists, which committee is composed chiefly of physicians and surgeons, dentists, dental hygienists, podiatrists, registered dietitians, chiropractors, optometrists, acupuncturists, veterinarians, marriage and family therapists, professional clinical counselors, *licensed midwives* or psychologists for any act or proceeding undertaken or performed in reviewing the quality of medical, dental, dietetic, chiropractic, optometric, acupuncture, psychotherapy, *midwifery,* or veterinary services rendered by physicians and surgeons, dentists, dental hygienists, podiatrists, registered dietitians, chiropractors, optometrists, acupuncturists, veterinarians, marriage and family therapists, professional clinical counselors, *midwifery,* or psychologists or any member of the governing board of a hospital in reviewing the quality of medical services rendered by members of the staff if the professional society, committee, or board member acts without malice, has made a reasonable effort to obtain the facts of the matter as to which he, she, or it acts, and acts in reasonable belief that the action taken by him, her, or it is warranted by the facts known to him, her, or it after the reasonable effort to obtain facts. "Professional society" includes legal, medical, psychological, dental, dental hygiene, dietetic, accounting, optometric, acupuncture, podiatric, pharmaceutic, chiropractic, physical therapist, veterinary, licensed marriage and family therapy, licensed clinical social work, licensed professional clinical counselor, and engineering organizations having as members at least 25 percent of the eligible persons or licentiates in the geographic area served by the particular society. However, if the society has fewer than 100 members, it shall have as members at least a majority of the eligible persons or licentiates in the geographic area served by the particular society.

"Medical specialty society" means an organization having as members at least 25 percent of the eligible physicians and surgeons within a given professionally recognized medical specialty in the geographic area served by the particular society.

(c) This section does not affect the official immunity of an officer or employee of a public corporation.

(d) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any physician and surgeon, podiatrist, or chiropractor who is a member of an underwriting committee of an interindemnity or reciprocal or interinsurance exchange or mutual company for any act or proceeding undertaken or performed in evaluating physicians and surgeons, podiatrists, or chiropractors for the writing of professional liability insurance, or any act or proceeding undertaken or performed in evaluating physicians and surgeons for the writing of an interindemnity, reciprocal, or interinsurance contract as specified in Section 1280.7 of the Insurance Code, if the evaluating physician and surgeon, podiatrist, or chiropractor acts without malice, has made a reasonable effort to obtain the facts of the matter as to which he or she acts, and acts in reasonable belief that the action taken by him or her is warranted by the facts known to him or her after the reasonable effort to obtain the facts.

(e) This section shall not be construed to confer immunity from liability on any quality assurance committee established in compliance with Section 14725 of the Welfare and Institutions Code or hospital. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against

a quality assurance committee established in compliance with Section 14725 of the Welfare and Institutions Code or hospital, the cause of action shall exist as if the preceding provisions of this section had not been enacted.

SEC. 99. *Section 43.8 of the Civil Code is amended to read:*

43.8. (a) In addition to the privilege afforded by Section 47, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person on account of the communication of information in the possession of that person to any hospital, hospital medical staff, veterinary hospital staff, professional society, medical, dental, podiatric, psychology, marriage and family therapy, professional clinical counselor, *midwifery,* or veterinary school, professional licensing board or division, committee or panel of a licensing board, the Senior Assistant Attorney General of the Health Quality Enforcement Section appointed under Section 12529 of the Government Code, peer review committee, quality assurance committees established in compliance with Sections 4070 and 5624 of the Welfare and Institutions Code, or underwriting committee described in Section 43.7 when the communication is intended to aid in the evaluation of the qualifications, fitness, character, or insurability of a practitioner of the healing or veterinary arts.

(b) The immunities afforded by this section and by Section 43.7 shall not affect the availability of any absolute privilege that may be afforded by Section 47.

(c) Nothing in this section is intended in any way to affect the California Supreme Court's decision in Hassan v. Mercy American River Hospital (2003) 31 Cal.4th 709, holding that subdivision (a) provides a qualified privilege.

SEC. 100. *Section 13401 of the Corporations Code is amended to read:*

13401. As used in this part:

(a) "Professional services" means any type of professional services that may be lawfully rendered only pursuant to a license, certification, or registration authorized by the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act.

(b) "Professional corporation" means a corporation organized under the General Corporation Law or pursuant to subdivision (b) of Section 13406 that is engaged in rendering professional services in a single profession, except as otherwise authorized in Section 13401.5, pursuant to a certificate of registration issued by the governmental agency regulating the profession as herein provided and that in its practice or business designates itself as a professional or other corporation as may be required by statute. However, any professional corporation or foreign professional corporation rendering professional services by persons duly licensed by the Medical Board of California or any examining committee under the jurisdiction of the board, *the California Board of Podiatric Medicine,* the Osteopathic Medical Board of California, the Dental Board of California, the Dental Hygiene Committee of California, the California State Board of Pharmacy, the Veterinary Medical Board, the California Architects Board, the Court Reporters Board of California, the Board of Behavioral Sciences, the Speech-Language Pathology and Audiology Board, the Board of Registered Nursing, or the State Board of Optometry shall not be required to obtain a certificate of registration in order to render those professional services.

(c) "Foreign professional corporation" means a corporation organized under the laws of a state of the United States other than this state that is engaged in a profession of a type for which there is authorization in the Business and Professions Code for the performance of professional services by a foreign professional corporation.

(d) "Licensed person" means any natural person who is duly licensed under the provisions of the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to render the same professional services as are or will be rendered by the professional corporation or foreign professional corporation of which he or she is, or intends to become, an officer, director, shareholder, or employee.

(e) "Disqualified person" means a licensed person who for any reason becomes legally disqualified (temporarily or permanently) to render the professional services that the particular professional corporation or

foreign professional corporation of which he or she is an officer, director, shareholder, or employee is or was rendering.

SEC. 101. *Section 13401.5 of the Corporations Code is amended to read:*

13401.5. Notwithstanding subdivision (d) of Section 13401 and any other provision of law, the following licensed persons may be shareholders, officers, directors, or professional employees of the professional corporations designated in this section so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the professional corporation so designated herein, and so long as the number of those licensed persons owning shares in the professional corporation so designated herein does not exceed the number of persons licensed by the governmental agency regulating the designated professional corporation. This section does not limit employment by a professional corporation designated in this section to only those licensed professionals listed under each subdivision. Any person duly licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act may be employed to render professional services by a professional corporation designated in this section.

(a) Medical corporation.

(1) Licensed doctors of podiatric medicine.

(2) Licensed psychologists.

(3) Registered nurses.

(4) Licensed optometrists.

(5) Licensed marriage and family therapists.

(6) Licensed clinical social workers.

(7) Licensed physician assistants.

(8) Licensed chiropractors.

(9) Licensed acupuncturists.

(10) Naturopathic doctors.

(11) Licensed professional clinical counselors.

(12) Licensed physical therapists.

(13) Licensed pharmacists.

(14) Licensed midwives.

(b) Podiatric medical corporation.

(1) Licensed physicians and surgeons.

(2) Licensed psychologists.

(3) Registered nurses.

(4) Licensed optometrists.

(5) Licensed chiropractors.

(6) Licensed acupuncturists.

(7) Naturopathic doctors.

(8) Licensed physical therapists.

(c) Psychological corporation.

(1) Licensed physicians and surgeons.

(2) Licensed doctors of podiatric medicine.

(3) Registered nurses.

(4) Licensed optometrists.

(5) Licensed marriage and family therapists.

(6) Licensed clinical social workers.

(7) Licensed chiropractors.

(8) Licensed acupuncturists.

(9) Naturopathic doctors.

(10) Licensed professional clinical counselors.

(11) Licensed midwives.

(d) Speech-language pathology corporation.

(1) Licensed audiologists.

(e) Audiology corporation.

(1) Licensed speech-language pathologists.

(f) Nursing corporation.

(1) Licensed physicians and surgeons.

(2) Licensed doctors of podiatric medicine.

(3) Licensed psychologists.

(4) Licensed optometrists.

(5) Licensed marriage and family therapists.

(6) Licensed clinical social workers.

(7) Licensed physician assistants.

(8) Licensed chiropractors.

(9) Licensed acupuncturists.

(10) Naturopathic doctors.

(11) Licensed professional clinical counselors.

(12) Licensed midwives.

(g) Marriage and family therapist corporation.

(1) Licensed physicians and surgeons.

(2) Licensed psychologists.

(3) Licensed clinical social workers.

(4) Registered nurses.

(5) Licensed chiropractors.

(6) Licensed acupuncturists.

(7) Naturopathic doctors.

(8) Licensed professional clinical counselors.

(9) Licensed midwives.

(h) Licensed clinical social worker corporation.

(1) Licensed physicians and surgeons.

(2) Licensed psychologists.

(3) Licensed marriage and family therapists.

(4) Registered nurses.

(5) Licensed chiropractors.

(6) Licensed acupuncturists.

(7) Naturopathic doctors.

(8) Licensed professional clinical counselors.

(i) Physician assistants corporation.

(1) Licensed physicians and surgeons.

(2) Registered nurses.

(3) Licensed acupuncturists.

(4) Naturopathic doctors.

(5) Licensed midwives.

(j) Optometric corporation.

(1) Licensed physicians and surgeons.

(2) Licensed doctors of podiatric medicine.

(3) Licensed psychologists.

(4) Registered nurses.

(5) Licensed chiropractors.

(6) Licensed acupuncturists.

(7) Naturopathic doctors.

(k) Chiropractic corporation.

(1) Licensed physicians and surgeons.

(2) Licensed doctors of podiatric medicine.

(3) Licensed psychologists.

(4) Registered nurses.

(5) Licensed optometrists.

(6) Licensed marriage and family therapists.

(7) Licensed clinical social workers.

(8) Licensed acupuncturists.

(9) Naturopathic doctors.

(10) Licensed professional clinical counselors.

(11) Licensed midwives.

(l) Acupuncture corporation.

(1) Licensed physicians and surgeons.

(2) Licensed doctors of podiatric medicine.

(3) Licensed psychologists.

(4) Registered nurses.

(5) Licensed optometrists.

(6) Licensed marriage and family therapists.

(7) Licensed clinical social workers.

(8) Licensed physician assistants.

(9) Licensed chiropractors.

(10) Naturopathic doctors.

(11) Licensed professional clinical counselors.

(12) Licensed midwives.

(m) Naturopathic doctor corporation.

(1) Licensed physicians and surgeons.

(2) Licensed psychologists.

(3) Registered nurses.

(4) Licensed physician assistants.

(5) Licensed chiropractors.

(6) Licensed acupuncturists.

(7) Licensed physical therapists.

(8) Licensed doctors of podiatric medicine.

(9) Licensed marriage and family therapists.

(10) Licensed clinical social workers.

(11) Licensed optometrists.

(12) Licensed professional clinical counselors.

(13) Licensed midwives.

(n) Dental corporation.

(1) Licensed physicians and surgeons.

(2) Dental assistants.

(3) Registered dental assistants.

(4) Registered dental assistants in extended functions.

(5) Registered dental hygienists.

(6) Registered dental hygienists in extended functions.

(7) Registered dental hygienists in alternative practice.

(o) Professional clinical counselor corporation.

(1) Licensed physicians and surgeons.

(2) Licensed psychologists.

(3) Licensed clinical social workers.

(4) Licensed marriage and family therapists.

(5) Registered nurses.

(6) Licensed chiropractors.

(7) Licensed acupuncturists.

(8) Naturopathic doctors.

(9) Licensed midwives.

(p) Physical therapy corporation.

(1) Licensed physicians and surgeons.

(2) Licensed doctors of podiatric medicine.

(3) Licensed acupuncturists.

(4) Naturopathic doctors.

(5) Licensed occupational therapists.

(6) Licensed speech-language therapists.

(7) Licensed audiologists.

(8) Registered nurses.

(9) Licensed psychologists.

(10) Licensed physician assistants.

(11) Licensed midwives.

(q) Registered dental hygienist in alternative practice corporation.

(1) Registered dental assistants.

(2) Licensed dentists.

(3) Registered dental hygienists.

(4) Registered dental hygienists in extended functions.

(r) Licensed midwifery corporation.

(1) Licensed physicians and surgeons.

(2) Licensed psychologists.

(3) Registered nurses.

(4) Licensed marriage and family therapists.

(5) Licensed clinical social workers.

(6) Licensed physician assistants.

(7) Licensed chiropractors.

(8) Licensed acupuncturists.

(9) Licensed naturopathic doctors.

(10) Licensed professional clinical counselors.

(11) Licensed physical therapists.

SEC. 102. *Section 1157 of the Evidence Code is amended to read:*

1157. (a) Neither the proceedings nor the records of organized committees of medical, medical-dental, podiatric, registered dietitian, psychological, marriage and family therapist, licensed clinical social worker, professional clinical counselor, pharmacist, or veterinary staffs in hospitals, or of a peer review body, as defined in Section 805 of the Business and Professions Code, having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, or for that peer review body, or medical or dental review or dental hygienist review or chiropractic review or podiatric review or registered dietitian review or pharmacist review or veterinary review or acupuncturist review *or licensed midwife review* committees of local medical, dental, dental hygienist, podiatric, dietetic, pharmacist, veterinary, acupuncture, or chiropractic societies, marriage and family therapist, licensed clinical social worker, professional clinical counselor, or psychological review committees of state or local marriage and family therapist, state or local licensed clinical social worker, state or local licensed professional clinical counselor, or state or local psychological associations or societies *or licensed midwife associations or societies* having the responsibility of evaluation and improvement of the quality of care, shall be subject to discovery.

(b) Except as hereinafter provided, a person in attendance at a meeting of any of the committees described in subdivision (a) shall not be required to testify as to what transpired at that meeting.

(c) The prohibition relating to discovery or testimony does not apply to the statements made by a person in attendance at a meeting of any of the committees described in subdivision (a) if that person is a party to an action or proceeding the subject matter of which was reviewed at that meeting, to a person requesting hospital staff privileges, or in an action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits.

(d) The prohibitions in this section do not apply to medical, dental, dental hygienist, podiatric, dietetic, psychological, marriage and family therapist, licensed clinical social worker, professional clinical counselor, pharmacist, veterinary, acupuncture, *midwifery,* or chiropractic society committees that exceed 10 percent of the membership of the society, nor to any of those committees if a person serves upon the committee when his or her own conduct or practice is being reviewed.

(e) The amendments made to this section by Chapter 1081 of the Statutes of 1983, or at the 1985 portion of the 1985–86 Regular Session of the Legislature, at the 1990 portion of the 1989–90 Regular Session of the Legislature, at the 2000 portion of the 1999–2000 Regular Session of the Legislature, at the 2011 portion of the 2011–12 Regular Session of the Legislature, or at the 2015 portion of the 2015–16 Regular Session of the Legislature, do not exclude the discovery or use of relevant evidence in a criminal action.

SEC. 103. *Section 11529 of the Government Code is amended to read:*

11529. (a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, imposing drug testing, continuing education, supervision of procedures, limitations on the authority to prescribe, furnish, administer, or dispense controlled substances, 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. The failure to comply with an order issued pursuant to Section 820 of the Business and Professions Code may constitute grounds to issue an interim suspension order under this section.

(b) All orders authorized by this section shall be issued only after a hearing conducted pursuant to subdivision (d), unless it appears from the facts shown by affidavit that serious injury would result to the public before the matter can be heard on notice. Except as provided in subdivision (c), the licensee shall receive at least 15 days' prior notice of the hearing, which notice shall include affidavits and all other information in support of the order.

(c) If an interim order is issued without notice, the administrative law judge who issued the order without notice shall cause the licensee to be notified of the order, including affidavits and all other information in support of the order by a 24-hour delivery service. That notice shall also include the date of the hearing on the order, which shall be conducted in accordance with the requirement of subdivision (d), not later than 20 days from the date of issuance. The order shall be dissolved unless the requirements of subdivision (a) are satisfied.

(d) For the purposes of the hearing conducted pursuant to this section, the licentiate shall, at a minimum, have the following rights:

(1) To be represented by counsel.

(2) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the record.

(3) To present written evidence in the form of relevant declarations, affidavits, and documents.

The discretion of the administrative law judge to permit testimony at the hearing conducted pursuant to this section shall be identical to the discretion of a superior court judge to permit testimony at a hearing conducted pursuant to Section 527 of the Code of Civil Procedure.

(4) To present oral argument.

(e) Consistent with the burden and standards of proof applicable to a preliminary injunction entered under Section 527 of the Code of Civil Procedure, the administrative law judge shall grant the interim order if, in the exercise of discretion, the administrative law judge concludes that:

(1) There is a reasonable probability that the petitioner will prevail in the underlying action.

(2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order.

(f) In all cases in which an interim order is issued, and an accusation *or petition to revoke probation* is not filed and served pursuant to Sections 11503 and 11505 within 30 days of the date on which the parties to the hearing on the interim order have submitted the matter, the order shall be dissolved.

Upon service of the accusation *or petition to revoke probation* the licensee shall have, in addition to the rights granted by this section, all of the rights and privileges available as specified in this chapter. If the licensee requests a hearing on the accusation, the board shall provide the licensee with a hearing within 30 days of the request, unless the licensee stipulates to a later hearing, and a decision within 15 days of the date the decision is received from the administrative law judge, or the board shall nullify the interim order previously

issued, unless good cause can be shown by the Division of Medical Quality for a delay.

(g) If an interim order is issued, a written decision shall be prepared within 15 days of the hearing, by the administrative law judge, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

(h) Notwithstanding the fact that interim orders issued pursuant to this section are not issued after a hearing as otherwise required by this chapter, interim orders so issued shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure. The relief that may be ordered shall be limited to a stay of the interim order. Interim orders issued pursuant to this section are final interim orders and, if not dissolved pursuant to subdivision (c) or (f), may only be challenged administratively at the hearing on the accusation.

(i) The interim order provided for by this section shall be:

(1) In addition to, and not a limitation on, the authority to seek injunctive relief provided for in the Business and Professions Code.

(2) A limitation on the emergency decision procedure provided in Article 13 (commencing with Section 11460.10) of Chapter 4.5.

SEC. 104. *Section 12529.6 of the Government Code is repealed.*

~~12529.6.(a)The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical enforcement and prosecution model for those investigations is in the best interests of the people of California.~~

~~(b)Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction but not the supervision of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.~~

~~(c)The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section.~~

~~(d)This section does not affect the requirements of Section 12529.5 as applied to the Medical Board of California where complaints that have not been assigned to a field office for investigation are concerned.~~

~~(e)It is the intent of the Legislature to enhance the vertical enforcement and prosecution model as set forth in subdivision (a). The Medical Board of California shall do all of the following:~~

~~(1)Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.~~

~~(2)Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model.~~

~~(3)Establish and implement a plan to assist in team building between its enforcement staff and the staff of the Health Quality Enforcement Section in order to ensure a common and consistent knowledge base.~~

SEC. 105. *Section 11362.7 of the Health and Safety Code is amended to read:*

11362.7. For purposes of this article, the following definitions shall apply:

(a) "Attending physician" means an individual who possesses a license in good standing to practice ~~medicine~~ *medicine, podiatry,* or osteopathy issued by the Medical Board of ~~California~~ *California, the California Board of Podiatric Medicine,* or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient and who has conducted a medical examination of that patient before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the medical use of marijuana is appropriate.

(b) "Department" means the State Department of Health Services.

(c) "Person with an identification card" means an individual who is a qualified patient who has applied for and received a valid identification card pursuant to this article.

(d) "Primary caregiver" means the individual, designated by a qualified patient or by a person with an identification card, who has consistently assumed responsibility for the housing, health, or safety of that patient or person, and may include any of the following:

(1) In any case in which a qualified patient or person with an identification card receives medical care or supportive services, or both, from a clinic licensed pursuant to Chapter 1 (commencing with Section 1200) of Division 2, a health care facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 (commencing with Section 1568.01) of Division 2, a residential care facility for the elderly licensed pursuant to Chapter 3.2 (commencing with Section 1569) of Division 2, a hospice, or a home health agency licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2, the owner or operator, or no more than three employees who are designated by the owner or operator, of the clinic, facility, hospice, or home health agency, if designated as a primary caregiver by that qualified patient or person with an identification card.

(2) An individual who has been designated as a primary caregiver by more than one qualified patient or person with an identification card, if every qualified patient or person with an identification card who has designated that individual as a primary caregiver resides in the same city or county as the primary caregiver.

(3) An individual who has been designated as a primary caregiver by a qualified patient or person with an identification card who resides in a city or county other than that of the primary caregiver, if the individual has not been designated as a primary caregiver by any other qualified patient or person with an identification card.

(e) A primary caregiver shall be at least 18 years of age, unless the primary caregiver is the parent of a minor child who is a qualified patient or a person with an identification card or the primary caregiver is a person otherwise entitled to make medical decisions under state law pursuant to Sections 6922, 7002, 7050, or 7120 of the Family Code.

(f) "Qualified patient" means a person who is entitled to the protections of Section 11362.5, but who does not have an identification card issued pursuant to this article.

(g) "Identification card" means a document issued by the State Department of Health Services that document identifies a person authorized to engage in the medical use of marijuana and the person's designated primary caregiver, if any.

(h) "Serious medical condition" means all of the following medical conditions:

(1) Acquired immune deficiency syndrome (AIDS).

(2) Anorexia.

(3) Arthritis.

(4) Cachexia.

(5) Cancer.

(6) Chronic pain.

(7) Glaucoma.

(8) Migraine.

(9) Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis.

(10) Seizures, including, but not limited to, seizures associated with epilepsy.

(11) Severe nausea.

(12) Any other chronic or persistent medical symptom that either:

(A) Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336).

(B) If not alleviated, may cause serious harm to the patient's safety or physical or mental health.

(i) "Written documentation" means accurate reproductions of those portions of a patient's medical records that have been created by the attending physician, that contain the information required by paragraph (2) of subdivision (a) of Section 11362.715, and that the patient may submit to a county health department or the county's designee as part of an application for an identification card.

SEC. 106. *Section 128335 of the Health and Safety Code is amended to read:*

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

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

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

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

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

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

SEC. 107. *No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California*

Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

SB 572 Healing arts licensees: violations: grace period

PROPOSED LEGISLATION

AMENDED IN SENATE MARCH 27, 2017

SENATE BILL No. 572

Introduced by Senator Stone

February 17, 2017

An act to add Article 16 (commencing with Section 870) to Chapter 1 of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 572, as amended, Stone. Healing arts licensees: violations: grace period.

Existing law provides for the licensure and regulation of various healing arts professions by various boards, as defined, within the Department of Consumer Affairs. Existing law imposes certain fines and other penalties for, and authorizes these boards to take disciplinary action against licensees for, violations of the provisions governing those professions.

This bill would prohibit the boards from taking disciplinary action against, or otherwise penalizing, healing arts licensees who violate those provisions but correct the violations within 15 ~~days,~~ *days and who are not currently on probation at the time of the violations,* if the violations did not cause irreparable harm and will not result in irreparable harm if left uncorrected for 15 days.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Article 16 (commencing with Section 870) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:

Article 16. Grace Period for Violations

870. Notwithstanding any other law, a person with a license issued pursuant to this division shall not be subject to disciplinary action by, or otherwise penalized by, the board that issued the license for a violation of a provision applicable to the license if ~~both~~ *all* of the following apply:

(a) The violation did not cause any irreparable harm and will not result in irreparable harm if left uncorrected for 15 days.

(b) The ~~person~~ *licensee* corrects the violation within 15 days.

(c) The licensee is not currently on probation at the time of the violation.

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SB 715 Department of Consumer Affairs: regulatory boards: removal of board members

COMMITTEE ANALYSIS

SENATE COMMITTEE ON
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Jerry Hill, Chair
2017 - 2018 Regular

Bill No:	SB 715	**Hearing Date:**	May 1, 2017
Author:	Newman		
Version:	April 25, 2017		
Urgency:	No	**Fiscal:**	No
Consultant:	Sarah Mason		

Subject: Department of Consumer Affairs: regulatory boards: removal of board members

SUMMARY: Adds failure to attend board meetings to the reasons the Governor may remove one of his or her appointed board members from office.

Existing law:

1) Authorizes the Governor to remove any member of any board that he or she has appointed for continued neglect of duties required by law or for incompetence or unprofessional or dishonorable conduct. Specifies that this authority shall not be construed as a limitation or restriction on the power of the Governor to remove any member of any board. (Business and Professions Code (BPC) § 106)

2) Authorizes the Governor to remove a member of a board or other licensing entity under the Department of Consumer Affairs (DCA) if it is shown that the member has knowledge of the specific questions to be asked on the licensing entity's next examination and directly or indirectly discloses any such question or questions in advance of or during the examination to any applicant. (BPC § 106.5)

3) Requires every newly appointed board member complete a training and orientation program offered by the DCA within one year regarding, among other things, his or her functions, responsibilities, and obligations as a member of a board. (BPC § 453)

4) Defines "meeting", for purposes of the Bagley-Keene Open Meeting Act which sets forth requirements for public meetings of all state boards and commissions, as any congregation of a majority of the members of a state body at the same time and place to hear, discuss, or deliberate upon any item that is within the subject matter jurisdiction of the state body to which it pertains. (Government Code section 11122.5.)

This bill: Adds the failure to attend board meetings to the reasons the Governor may remove one of his or her appointed board members from office.

FISCAL EFFECT: This bill is not keyed fiscal by Legislative Counsel.

COMMENTS:

1. **Purpose.** The Author is the Sponsor of this measure. According to the Author, "discretion for the removal of board members for instances of absences is a good government approach to ensuring the effectiveness and efficiency of the important regulatory boards within the DCA. Member absences can impact the professions and public alike, as key decisions are made and votes taken at board meetings directly related to oversight of licensees. The Governor should have authority to remove board members from their position when their absences impact their ability to successfully serve."

2. **Background.** Within the DCA there are 40 entities, including 26 boards, ten bureaus, two committees, one program, and one commission (hereafter "boards" unless otherwise noted). Collectively, these boards regulate more than 100 types of businesses and 200 different industries and professions. As regulators, these boards perform two primary functions:

   - Licensing—which entails ensuring only those who meet minimum standards are issued a license to practice, and

   - Enforcement—which entails investigation of alleged violations of laws and/or regulations and taking disciplinary action, when appropriate.

   The regulatory power granted by the professional practice acts is vested in each DCA board. Although given a modest per diem and reimbursed for necessary travel expenses, DCA board members are volunteers, and the majority have full-time jobs in addition to their oversight responsibilities. DCA boards are only required to meet two times in a given year, though most meet at least quarterly. In order to effectively manage California's substantial regulatory programs, boards are provided the authority in statute to hire an executive officer (EO), who then effectuates the board's requests or decisions through day-to-day management.

   DCA boards are subject to the Bagley-Keene Open Meetings Act which requires a quorum for boards to meet and conduct official business or take official action such as voting on agenda items. While attendance at board meetings by board members is an inherent part of their duties, failure to attend meetings and participate in proceedings can significantly impact a board's work, as well as impact a board member's ability to successfully serve.

3. **Related Legislation.** SB 496 (De Leon) was identical to this measure when this Committee heard that bill on March 27, 2017. SB 496 was amended to deal with a different subject entirely.

SUPPORT AND OPPOSITION:

Support: None on file as of April 26, 2017.

Opposition: None on file as of April 26, 2017.

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PROPOSED LEGISLATION

AMENDED IN SENATE APRIL 25, 2017

SENATE BILL No. 715

Introduced by Senator Newman

February 17, 2017

~~An act to amend Section 5503 of the Public Resources Code, relating to park districts.~~ *An act to amend Section 106 of the Business and Professions Code, relating to consumer affairs.*

LEGISLATIVE COUNSEL'S DIGEST

SB 715, as amended, Newman. ~~Park and open-space districts.~~ *Department of Consumer Affairs: regulatory boards: removal of board members.*

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes the Governor to remove from office any member of any board within the department appointed by him or her, on specific grounds, including continued neglect of duties required by law.

This bill would specifically include the failure to attend meetings of the board as one example of continued neglect of duties required by law that the Governor can use as a reason to remove a member from a board.

~~Existing law provides a procedure for the formation of a regional park district, regional park and open-space district, or a regional open-space district.~~

~~This bill would make nonsubstantive changes to one of those provisions.~~

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 106 of the Business and Professions Code is amended to read:

106. The Governor has power to remove from office at any time, any member of any board appointed by him *or her* for continued neglect of duties required by law, *which may include the failure to attend board meetings,* or for incompetence, or unprofessional or dishonorable conduct. Nothing in this section shall be construed as a limitation or restriction on the power of the Governor, conferred on him *or her* by any other ~~provision of~~ law, to remove any member of any board.

~~SECTION 1. Section 5503 of the Public Resources Code is amended to read:~~

~~5503. Whenever it is desired to form a district under this article, a petition requesting the creation and maintenance of a district, and describing the exterior boundaries of the proposed district shall be signed by at least 5,000 electors residing within the territory proposed to be included in the district. The petition shall be presented to the board of supervisors of the county containing the largest area within the proposed district.~~

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SB 762 Healing arts licensees: activation fee: waiver

COMMITTEE ANALYSIS

SENATE COMMITTEE ON
BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Jerry Hill, Chair
2017 - 2018 Regular

Bill No:	SB 762	**Hearing Date:**	April 24, 2017
Author:	Hernandez		
Version:	April 17, 2017		
Urgency:	No	**Fiscal:**	Yes
Consultant:	Mark Mendoza		

Subject: Healing arts licensee: license activation fee: waiver

SUMMARY: Waives the renewal license fee for inactive licensees under all allied health boards and bureaus for the sole purpose of providing voluntary, unpaid service to a public agency, not-for-profit agency, institution, or corporation that provides medical services to indigent patients in medically underserved or critical-need population areas of the state.

Existing law:

1) Provides for the licensing and regulation of various professions and businesses by some 26 boards, 3 committees (20 of which are designated as healing arts boards or committees), 8 bureaus and 1 commission within the Department of Consumer Affairs (DCA) under various licensing acts within the Business and Professions Code (BPC). (For future reference, "board(s)" means all of the above.)

2) Provides it is the intent of the Legislature to establish an inactive category of health professionals' licensure. Such inactive licenses or certificates are intended to allow a person who has a license or certificate in one of the healing arts, but who is not actively engaged in the practice of his or her profession, to maintain licensure or certification in a nonpracticing status. (BPC § 700)

3) Requires that each healing arts board issue, upon application and payment of the normal renewal fee, an inactive license or certificate to a current holder of an active license or certificate whose license or certificate is not suspended, revoked, or otherwise punitively restricted by that board. Provides that "board" refers to any healing arts board, division, or examining committee which licenses or certifies health professionals. (BPC § 701)

4) Requires that the holder of an inactive healing arts license or certificate issued not engage in any activity for which an active license or certificate is required. (BPC § 702)

5) Requires that an inactive healing arts license or certificate issued be renewed during the same time period at which an active license or certificate is renewed. In order to renew a license or certificate, the holder thereof need not comply with any continuing education requirement for renewal of an active license or certificate. Requires that the renewal fee for a license or certificate in an active status apply also for renewal of a license or certificate in an inactive status. (BPC § 703)

6) Provides that in order for the holder of an inactive license or certificate issued to restore his or her license or certificate to an active status, the holder of an inactive license or certificate shall comply with all the following: (BPC § 704)

   a) Pay the renewal fee; provided, that the renewal fee shall be waived for a physician and surgeon who certifies to the Medical Board of California that license restoration is for the sole purpose of providing voluntary, unpaid service to a public agency, not-for-profit agency, institution, or corporation which provides medical services to indigent patients in medically underserved or critical-need population areas of the state.

   b) If the board requires completion of continuing education for renewers of an active license or certificate, complete continuing education equivalent to that required for a single license renewal period.

7) Authorizes certain healthcare boards to allow healthcare practitioners licensed in another state to provide healthcare services in limited circumstances, for a nonprofit organization which sponsors an event through which health care is provided to the public without compensation to the health care practitioner. (BPC § 901)

8) Makes findings and declarations stating that: (BPC § 921)

   a) In times of national or state disasters, a shortage of qualified health care practitioners may exist in areas throughout the state where they are desperately required to respond to public health emergencies.

   b) Health care practitioners with lapsed or inactive licenses could potentially serve in those areas where a shortage of qualified health care practitioners exists, if licensing requirements were streamlined and fees curtailed.

This bill: Waives the renewal license fee for inactive licensees under all allied health boards and bureaus for the sole purpose of providing voluntary, unpaid service to a public agency, not-for-profit agency, institution, or corporation that provides medical services to indigent patients in medically underserved or critical-need population areas of the state.

FISCAL EFFECT: Unknown. This bill is keyed "fiscal" by Legislative Counsel.

COMMENTS:

1. **Purpose.** The Author is the sponsor of this bill. According to the Author, "The coverage expansions under the Affordable Care Act (ACA) led to 20 million newly insured individuals in this country, including over 5 million Californians. While a monumental step towards ensuring access, these expansions came with increased demand for services on an already strained system, particularly in medically underserved areas. Furthermore, fundamental to health care reform is the evolution in how care is delivered. The ACA included incentives for expanded and improved primary care and to create team-based models of service delivery, both of which

may affect demand for services from certain health care professionals. Given the shortage of primary care physicians in certain regions and the continued advancements in training of other health care professionals, SB 762 will help ease the strain on the system by providing the opportunity for all health care professionals to deliver volunteer services under their licenses."

2. **Background.** SB 450 (Speier, Chapter 631, Statutes of 1999) originally waived renewal fees for inactive physician licensees for the sole purpose of providing voluntary, unpaid service to a public agency, not-for-profit agency, institution, or corporation that provides medical services to indigent patients in medically underserved or critical-need population areas of the state. The Senate floor analysis, dated September 2, 1999, states:

   "Finally, in regard to waiving the physician's fee for volunteer work, the author provided information about a program that started in South Carolina called the Volunteers in Medicine Institute that used retired physicians to provide care to the needy, and the author suggests that this provision will assist organizations such as this one to operate in California."

SUPPORT AND OPPOSITION:

Support:

None on file as of April 19, 2017.

Opposition:

None on file as of April 19, 2017.

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PROPOSED LEGISLATION

AMENDED IN SENATE APRIL 17, 2017

SENATE BILL No. 762

Introduced by Senator Hernandez

February 17, 2017

An act *to amend Section 704 of the Business and Professions Code,* relating to ~~workforce development.~~ *healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

SB 762, as amended, Hernandez. ~~Health care workforce development.~~ *Healing arts licensee: license activation fee: waiver.*

Existing law requires a healing arts board, as defined, to issue, upon application and payment of the normal renewal fee, an inactive license or certificate to a current holder of an active license or certificate whose license or certificate is not suspended, revoked, or otherwise punitively restricted by the board. Existing law requires the holder of an inactive license or certificate to, among other things, pay the renewal fee in order to restore his or her license or certificate to an active status. Existing law requires the renewal fee to be waived for a physician and surgeon who certifies to the Medical Board of California that license restoration is for the sole purpose of providing voluntary, unpaid service to a public agency, not-for-profit agency, institution, or corporation that provides medical services to indigent patients in medically underserved or critical-need population areas of the state.

This bill would require the renewal fee to be waived for any healing arts licensee who certifies to his or her respective board that license restoration is for the sole purpose of providing voluntary, unpaid service to a public agency, not-for-profit agency, institution, or corporation that provides medical services to indigent patients in medically underserved or critical-need population areas of the state.

~~The federal Workforce Innovation and Opportunity Act of 2014 provides for workforce investment activities, including activities in which states may participate. Existing law contains various programs for job training and employment investment, including work incentive programs, as specified, and establishes local workforce investment boards to perform duties related to the implementation and coordination of local workforce investment activities. Existing law requires local workforce investment boards to spend a minimum percentage of specified funds for adults and dislocated workers on federally identified workforce training programs and allows the boards to leverage specified funds to meet the funding requirements, as specified.~~

~~This bill would state the intent of the Legislature to enact legislation relating to health care workforce development.~~

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 704 of the Business and Professions Code is amended to read:

704. In order for the holder of an inactive license or certificate issued pursuant to this article to restore his or her license or certificate to an active status, the holder of an inactive license or certificate shall comply with ~~all~~ *both* the following:

(a) Pay the renewal fee; provided, that the renewal fee shall be waived for a ~~physician and surgeon~~ *healing arts licensee* who certifies to the ~~Medical Board of California~~ *board* that license restoration is for the sole purpose of providing voluntary, unpaid service to a public agency, not-for-profit agency, institution, or corporation ~~which~~ *that* provides medical services to indigent patients in medically underserved or critical-need population areas of the state.

(b) If the board requires completion of continuing education for renewers of an active license or certificate, complete continuing education equivalent to that required for a single license renewal period.

~~SECTION 1. It is the intent of the Legislature to enact legislation relating to health care workforce development.~~

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SB 790 Health care providers:
gifts and benefits

COMMITTEE ANALYSIS

SENATE COMMITTEE ON HEALTH
Senator Ed Hernandez, O.D., Chair

BILL NO: SB 790
AUTHOR: McGuire
VERSION: April 17, 2017
HEARING DATE: April 26, 2017
CONSULTANT: Melanie Moreno

SUBJECT: Health care providers: gifts and benefits

SUMMARY: Prohibits a drug manufacturer or a wholesale distributor of medical devices from offering or giving a gift to a health care provider. Prohibits a manufacturer or an entity on behalf of a manufacturer from providing a fee, payment, subsidy, or other economic benefit to a health care provider in connection with the provider's participation in research, except for the annual direct salary support for principal investigators and other health care professionals for the purposes of a bona fide clinical trial.

Existing federal law:

1) Under federal law, requires drug manufacturers to obtain approval of new drugs from the federal Food and Drug Administration (FDA).

2) Under the Physician Payments Sunshine Act (Sunshine Act), requires manufacturers of specified drugs, devices, biologicals, or medical supplies to disclose to the federal Centers for Medicare and Medicaid Services (CMS) payments or other transfers of value made to physicians or teaching hospitals.

Existing state law:

1) Establishes the Sherman Law, administered by Department of Public Health (DPH), which, among other things, regulates the packaging, labeling, and advertising of drugs and medical devices in California.

2) Prohibits, in the Sherman Law, the sale, delivery, or giving away of any new drug or new device unless it is either:

    a) A new drug, and a new drug application has been approved for it by the FDA, pursuant to federal law, or it is a new device for which a premarket approval application has been approved, and that approval has not been withdrawn, terminated, or suspended under the FDA; or
    b) A new drug or new device for which DPH has approved a new drug or device application, and has not withdrawn, terminated, or suspended that approval.

3) Requires DPH to adopt regulations to establish the application form and set the fee for licensure and renewal of a drug or device license.

4) Requires drug companies to adopt a Comprehensive Compliance Program (CCP), as specified, and include limits on gifts or incentives provided to medical or health professionals. Requires drug companies to establish explicitly in its CCP a specific annual dollar limit on gifts, promotional materials, or items.

5) Requires drug companies to make CCPs and annual written declarations of compliance with the program available to the public on the company's Web site and to provide a toll-free telephone number where copies may be obtained.

This bill:

1) Prohibits a manufacturer of a prescribed product or a wholesale distributor of medical devices, or an agent thereof, from offering or giving a gift to a health care provider. Defines "prescribed product" as a prescription drug or device, a compounded drug or drugs, a biological product for human use, or a combination product, as specified. Excludes prescription eyeglasses, prescription sunglasses, or other prescription eyewear from this definition.

2) Defines "gift" as either anything of value provided for free to a health care provider or a payment, food, entertainment, travel, subscription, advance, service, or anything else of value provided to a health care provider, unless it is an allowable expenditure or the health care provider reimburses the cost at fair market value. Defines "allowable expenditure" as:

    a) Payment by a manufacturer of a prescribed product or a wholesale distributor of medical devices to the sponsor of a significant educational, medical, scientific, or policymaking conference or seminar, provided that all of the following conditions are satisfied:

        i. The payment is not made directly to a health care professional or pharmacist;
        ii. Funding is used solely for bona fide educational purposes, except that the sponsor may, in the sponsor's discretion, apply some or all of the funding to provide meals and other food for all conference participants; and,
        iii. All program content is objective, free from industry control, and does not promote specific products.

    b) Honoraria and payment of the expenses of a health care professional who serves on the faculty at a bona fide educational, medical, scientific, or policymaking conference or seminar, provided that all of the following conditions are satisfied:
        i. The honoraria or payment is governed by an explicit contract with specific deliverables which are restricted to medical issues, not marketing activities; and,
        ii. Consistent with federal law, the content of the presentation, including slides and written materials, is determined by the health care professional.

    c) For a bona fide clinical trial, the annual direct salary support for principal investigators and other health care professionals;
    d) For a research project that constitutes a systematic investigation, is designed to develop or contribute to general knowledge, and reasonably can be considered to be of significant interest or value to scientists or health care professionals working in the particular field of inquiry, gross compensation, direct salary support per health care professional, and expenses paid on behalf of each health care professional;
    e) Payment or reimbursement for reasonable expenses, including travel and lodging-related expenses, necessary for technical training of individual health care professionals on the use of a medical device, if the commitment to provide those

expenses and the amounts or categories of reasonable expenses to be paid are described in a written agreement between the health care provider and the manufacturer;

f) Royalties and licensing fees paid to health care providers in return for contractual rights to use or purchase a patented or otherwise legally recognized discovery for which the health care provider holds an ownership right;
g) The payment of reasonable expenses of an individual related to the interview of the individual by a manufacturer of prescribed products in connection with a bona fide employment opportunity or for health care services on behalf of an employee of the manufacturer; and,
h) Provision of meals for a health care provider that do not exceed $250 per person, per year in value.

3) Prohibits a manufacturer or an entity on behalf of a manufacturer from providing a fee, payment, subsidy, or other economic benefit to a health care provider in connection with the provider's participation in research. Exempts the annual direct salary support for principal investigators and other health care professionals for the purposes of a bona fide clinical trial from this provision.

4) Exempts the following from the gift bans contained in 1) and 3) above:

a) Samples of a prescribed product or reasonable quantities of an over-the-counter drug, a nonprescription medical device, an item of nonprescription durable medical equipment, or an item of medical food or infant formula that are provided to a health care provider for free distribution to patients. Defines "sample" as a unit of a prescription drug, biological product, or medical device that is not intended to be sold and is intended to promote the sale of the drug, product, or device, and includes starter packs and coupons or other vouchers that enable an individual to receive a prescribed product free of charge or at a discounted price. Specifies that "sample" does not include prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded patient assistance program;
b) The loan of a medical device for a short-term trial period, not to exceed 120 days, to permit evaluation of the device by a health care provider or patient;
c) The provision of reasonable quantities of medical device demonstration or evaluation units to a health care provider to assess the appropriate use and function of the product and determine whether and when to use or recommend the product in the future;
d) The provision, distribution, dissemination, or receipt of peer-reviewed academic, scientific, or clinical articles or journals and other items that serve a genuine educational function provided to a health care provider for the benefit of patients;
e) Scholarship or other support for medical students, residents, and fellows to attend a significant educational, scientific, or policymaking conference or seminar of a national, regional, or specialty medical or other professional association if the recipient of the scholarship or other support is selected by the association;
f) Rebates and discounts for prescribed products provided in the normal course of business;
g) Labels approved by the federal Food and Drug Administration (FDA) for prescribed products;

h) The provision to a free clinic of financial donations or of free prescription drugs, over-the-counter drugs, medical devices, biological products, combination products, medical food, infant formula, medical equipment, or medical supplies;
i) Prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufactured-funded patient assistance program; and,
j) Fellowship salary support provided to fellows through grants for manufacturers of prescribed products, provided that all of the following conditions are satisfied:

i. The grants are applied for by an academic institution or hospital.
ii. The institution or hospital selects the recipient fellows.
iii. The manufacturer imposes no further demands or limits on the institution's, hospital's, or fellow's use of the funds.
iv. Fellowships are not named for a manufacturer and no individual recipient's fellowship is attributed to a particular manufacturer of prescribed products.

5) Defines numerous other terms associated with these provisions, including:
a) "Health care professional" means any of the following:

i. A person who is authorized by law to prescribe or to recommend prescribed products, who regularly practices in the state, and who is either licensed by the state to provide or is otherwise lawfully providing health care in the state, or a partnership or corporation made up of these persons; or,
ii. An officer, employee, agent, or contractor of a person who is acting in the course and scope of employment, of an agency, or of a contract related to or supportive of the provision of health care to individuals.

b) "Health care provider" means a health care professional, hospital, nursing home, pharmacist, health benefit plan administrator, or any other person authorized to dispense or purchase for distribution prescribed products in the state. "Health care provider" does not include a hospital foundation that is organized as a nonprofit entity separate from a hospital.

6) Permits the Attorney General (AG) to bring an action seeking injunctive relief, costs, attorney's fees, and imposition of a civil penalty of up to $10,000 for each violation of 1) or 3) above. Specifies that each unlawful gift offered or given, or each fee, subsidy, payment or other economic benefit given constitutes a separate violation.

7) Requires the AG in connection with an action brought pursuant to this bill, in addition to the powers granted to him or her by law, to have the same powers to investigate and obtain remedies as are granted to the Director of Consumer Affairs (DCA).

8) States legislative intent that the requirements and prohibitions of this bill complement and operate in conjunction with the Sunshine Act, and that if that law is repealed or becomes inoperative, it is the intent of the Legislature to enact similar legislation requiring manufacturers to disclose payments or other transfers of value made to health care providers.

FISCAL EFFECT: This bill has not been analyzed by a fiscal committee.

COMMENTS:

1) *Author's statement.* According to the author, extensive research and exhaustive studies from some of the world's most renowned universities have shown there is a direct correlation between pharmaceutical industry payments to medical professionals and the price of prescription drugs. These studies have shown that doctors who receive industry payments such as meals, travel, speaking fees and royalties were two to three times more likely to prescribe brand-name drugs at exceptionally high rates than others in their specialty. Each year in the U.S. $73 billion is spent on brand name drugs for which an equivalent generic available at a significant lower cost, resulting in patients overpaying approximately $24 billion of that amount themselves. Studies have shown that interaction with the pharmaceutical industry is associated with substantially negative consequences that include risks to patient safety associated with unnecessary drug prescriptions, drug cost increases borne by the patient, less availability of generic drugs, and less attention paid to evidence-based prescribing. California's largest hospitals such as Kaiser, the University of California Medical Centers, and Stanford have implemented policies restricting pharma gifts to doctors. Eight other states and the District of Columbia have also adopted gift bans and restrictions. By restricting pharmaceutical gifts to control drug costs and protect patient safety, this bill gives California an opportunity to put patient care and drug affordability before corporate profits.

2) *Drug costs.* According to CMS, although the rate of growth for retail prescription drug spending slowed in 2015, it still increased by 9% to $324.6 billion. Spending on prescription drugs outpaced all other services in 2015. The growth in spending for prescription drugs is attributed to increased spending on new medicines, price growth for existing brand name drugs, increased spending on generics, and fewer expensive blockbuster drugs going off-patent.

   According to a Health Affairs Blog post from May 2016, one of the primary drivers of high drug costs is specialty drugs. Because of their extremely high costs, specialty drugs account for a disproportionate share of overall drug spending and have a corresponding effect on spending growth. In fact, spending on specialty medicines was responsible for 73% of overall medicine spending growth over the past five years. The prices of specialty drugs are also growing dramatically. For example, the Memorial Sloan Kettering Cancer Center reported that the median launch price of new cancer agents doubled in the last decade, from $4,500 per month to more than $10,000 per month. Similarly, the launch prices of new multiple sclerosis drugs increased from $8,000 to $12,000 per year in the 1990s to $50,000 to $65,000 per year today. Specialty drugs also often experience substantial price growth every year they are on the market. For example, the AARP Public Policy Institute's December 2016 Rx Price Watch report found that the retail prices of specialty drugs widely used by older Americans increased by almost 11% in 2013. Hefty increases are not limited to specialty drugs; prices for drugs that have been on the market for decades have also seen inexplicable increases. For example, over the past 20 years, the price of human insulin produced by two major manufacturers – Eli Lilly and Novo Nordisk – rose 450% after accounting for inflation, according to a 2016 Washington Post analysis of data from Truven Health Analytics. A single 10-milliliter vial of Eli Lilly's Humalog insulin, which is less than a month's supply for many adults, was listed at $254.80 last year, compared with $20.82 in 1996.

3) *Physician relationships with drug companies.* According to a 2014 Health Affairs Policy Brief, financial relationships between physicians and medical product manufacturers are

common and can include everything from free meals to consulting or speaker fees to direct research funding. These relationships can have many positive outcomes and, particularly in the context of consulting and research funding, are often a key component in the development of new drugs and devices. However, they can also create conflicts of interest and in some cases can blur the line between promotional activities and the conduct of medical research, training, and practice. According to an author of a 2016 study on industry gifts and physician prescribing published in the medical journal (JAMA), doctors are taught how and what to prescribe during medical school, but after becoming a practicing physician, sometimes that kind of knowledge is derived from pharmaceutical salespeople.

4) *Gifts are associated with prescribing patterns.* A ProPublica study that was widely reported on in 2016 found that that the more money physicians receive from the pharmaceutical industry, the more likely they are to prescribe brand-name drugs. The authors were careful to state that there was an "association" rather than a cause-effect relationship found in the data. Two studies were also recently published on this subject in JAMA. In June 2016, a study of prescribing patterns for statins paid for under the Medicare drug benefit in 2011 showed that doctors who receive payments or gifts from drug companies are more likely to prescribe brand name medications. The rate at which doctors prescribed brand name drugs increased with the amount of money or gifts (such as dinners) they received from drug companies. For physicians who took industry payments, the rate of prescribing brand name drugs was 22.8%, compared to a rate of 17.8% for physicians with no industry payments listed. For every $1,000 in total payments received, the brand-name statin prescribing rate increased by 0.1%. Payments for educational training were associated with a 4.8% increase in the rate of brand-name prescribing; other forms of payments were not. The authors concluded that industry payments to physicians are associated with higher rates of prescribing brand-name statins, and stated that as the U.S. seeks to rein in the costs of prescription drugs and make them less expensive for patients, the findings are concerning. Another study published in JAMA in August 2016 found that receipt of additional meals and receipt of meals costing more than $20 were associated with higher relative prescribing rates.

5) *The Sunshine Act*. The studies described above were made possible due to data gleaned from the Sunshine Act, which was enacted under the ACA. The Sunshine Act requires manufacturers of drugs, devices, biologicals, or medical supplies covered under Medicare, Medicaid, or CHIP to report annually to the federal Health and Human Services Secretary certain payments or other transfers of value to physicians and teaching hospitals. The Act also requires applicable manufacturers and applicable group purchasing organizations (GPOs) to report certain information regarding the ownership or investment interests held by physicians or the immediate family members of physicians in such entities. Manufacturers and GPOs are subject to civil monetary penalties for failing to comply with the reporting requirements. The Secretary is required to publish the reported data on a public website, and must be downloadable, easily searchable, and aggregated. States are generally preempted from enacting laws that require disclosure of the same type of information by manufacturers, but the Act explicitly permit states to require the reporting of additional data by drug companies. The passage of the Sunshine Act was intended to increase transparency around the financial relationships between physicians, teaching hospitals and manufacturers of drugs, medical devices and biologics. CMS fulfills the law's mandate via the Open Payments Program. In June 2016, CMS published the 2015 Open Payments data of financial transactions between drug and medical device makers and health care providers. The data includes information about 11.9 million financial transactions attributed to over 600,000 physicians and more than 1,100 teaching hospitals nationwide, totaling $7.52 billion.

6) *Vermont's gift ban.* According to the author, this bill is modeled after a 2009 Vermont law. In Vermont, it is unlawful for any manufacturer of a prescribed product or any wholesale distributor of medical devices to offer or give any gift (including food, entertainment, and travel) to a health care provider. Vermont is the only state that prohibits all payments in the form of meals in any setting, even if the meal is associated with an educational purpose. Exemptions to this statute included free samples, payments for clinical trials, scholarships, and payments valued less than $25.00. Public disclosures could also be exempted if they were considered a "trade secret". According to information provided by the author, Vermont's AG analysis of the data found that payments decreased by 84% from 2009 to 2010 (14,636 to 2,322). In 2008, 78 pharmaceutical companies reported spending approximately $2.9 million on 2280 recipient health care professionals. Nearly $1.77 million was expended on the top 100 individual recipients. While food expenses totaled only 29% ($862,000) of the total amount spent, these payments accounted for 83.7% of the individual payment transactions, meaning that the majority of interactions with pharmaceutical representatives involved a meal. Approximately 40% of all meal recipients had less than $100 worth of meals expended on them throughout the year, while approximately 20% of meal recipients had over $500 worth in meals expended on them.

7) *Self-imposed gift bans.* While not commonplace, there are some self-imposed gift bans or limits in California today. For example, in 2008 the UC instituted a system-wide gift ban. According to the UC policy, in circumstances where health care vendors wish to provide a gift in support of the mission of UC (e.g., food for conferences or payment for educational travel), appropriate alternatives may be available. However, free samples, vouchers, supplies, or equipment designated for an individual health care provider are considered gifts and are prohibited. Vendors may donate their product to a UC department or division under very limited circumstances. Kaiser Permanente Medical Group has adopted strict conflict of interest rules for their 5,500 participating northern California physicians. The rule bans gifts, such as tickets to entertainment events and meals for physicians and their families from vendors and manufacturers. Additionally, physicians can no longer accept honoraria from vendors for teaching or giving presentations, including payment for time, travel expenses, meals or social activities. All education funding on behalf of companies is directed to the group's continuing medical education programs. Kaiser's southern California doctors who accept over $500 in industry gifts receive special scrutiny from the medical group leadership and may be disciplined. Southern California Permanente Medical Group's conflict of interest/principles of responsibility policy sets up a clear ban for physicians who have direct decision making authority over the pharmaceuticals that Kaiser Permanente buys and are not allowed to accept anything of value from any pharmaceutical manufacturer or distributor.

8) *California's Comprehensive Compliance Program*. SB 1765 (Sher, Chapter 927, Statutes of 2004) requires pharmaceutical companies to adopt and update a CCP for interactions with health care professionals and to establish explicitly in their CCPs an annual dollar limit on gifts, promotional materials or other items or activities, with certain exceptions, in accordance with the PhRMA Code and with specified federal guidance. The sponsor of that bill, CALPIRG, analyzed compliance of drug companies with SB 1765 (using 2005 reports) and released a report in a March 2008 report entitled "Playing by Their Own Rules: An Analysis of Drug Company Gifts to Doctors." Among the report's findings were: a) The range of gift limits for reporting companies was $1,000 to $3,500; b) a number of companies exclude gifts of less than $25 in their cumulative gift limit and others report they occasionally exceed their stated gift limit based on various justifications; c) the definition of

a modest dinner (which is permitted under the law) by at least one company was one that does not exceed $125 per individual; and, d) a number of companies failed to include their required gift limits or failed to report at all.

9) *Related legislation.* SB 17 (Hernandez) Requires health plans and insurers that report rate information through the existing large and small group rate review process to also report specified information related to prescription drug pricing to Department of Managed Health Care (DMHC) and California Department of Insurance (CDI). Requires DMHC and CDI to compile specified reported information into a consumer-friendly report that demonstrates the overall impact of drug costs on health care premiums. Requires drug manufacturers to notify specified state purchasers, health plans, and health insurers, in writing at least 90 days prior to the planned effective date, if it is increasing the wholesale acquisition cost (WAC) of a prescription drug by specified amounts. Requires drug manufacturers to notify OSHPD within three days of commercial availability if it is introducing a new prescription drug to market at a WAC that exceeds the Medicare Part D specialty drug threshold. Requires drug manufacturers to provide specified information to the Office of Statewide Health Planning and Development related to the drug's price. *SB 17 passed by a vote of 7-2 when it was heard in the Senate Health Committee on April 19, 2017.*

   AB 265 (Wood) would prohibit, with some exceptions, prescription drug manufacturers from offering any discount,–repayment, product voucher, or other reduction in an individual's out-of-pocket- expenses associated with his or her insurance coverage, including, but not limited to, a copayment or deductible, for any prescription drug if a lower cost brand name or non-brand name prescription drug is available that is designated– as therapeutically equivalent to, or interchangeable with, the prescription drug. *AB 265 passed by a vote of 9-2 when it was heard in the Assembly Health Committee on April 18, 2017.*

10) *Prior legislation.* SB 1010 (Hernandez of 2016) was substantially similar to SB 17 described in related legislation above. *SB 1010 was placed on the inactive file on the Assembly Floor.*

   AB 2436 (Roger Hernández of 2016) would have required carriers to provide at the time that a prescription drug is delivered or within 30 days of purchase, specified information related to the cost of the prescription drug. *AB 2436 failed passage on the Assembly Floor.*

   AB 2711 (Chiu of 2016) would have reinstated a previously repealed requirement for the Department of General Services to report to the Legislature on its prescription drug bulk purchasing program. *AB 2711 was held on the Assembly Appropriations Committee suspense file.*

   AB 463 (Chiu of 2015) would have required pharmaceutical companies to file an annual report with OSHPD containing specified information regarding the development and pricing of prescription drugs. *AB 463 was not heard in the Assembly Health Committee.*

   AB 2112 (Monning of 2010) would have prohibited a person or entity from selling or releasing to a third party any physician prescribing data for marketing purposes, as defined, included specified exceptions, and would have required a person or entity that knowingly fails to comply with these provisions be subject to a specified administrative fine. *AB 2112 was not heard in the Assembly Health Committee.*

AB 2821 (Feuer of 2008) would have established a gift limit of $250 per physician per year for each pharmaceutical company and required both the public disclosure of gifts of $50 or more and the payment of a disclosure fee to the Department of Health Care Services. *AB 2821 failed passage in the Assembly Health Committee.*

SB 1765 (Sher, Chapter 927, Statutes of 2004) requires pharmaceutical companies to adopt and update CCPs for interactions with health care professionals. Requires pharmaceutical companies to establish explicitly in its CCP an annual dollar limit on gifts, promotional materials or other items or activities, with exceptions, in accordance with existing guidelines, as specified. Requires such companies to annually declare in writing that they are in compliance with their CCPs and with the limits on gifts established by the bill.

AB 262 (Chan, of 2004) would have prohibited pharmacists and other entities that have access to physician prescribing data from selling such data except to a data vendor, required the Medical Board of California to create and administer a "Do Not Use" list for physicians who do not wish their prescribing data to be shared with data vendors, and prohibited data vendors from releasing or selling any prescribing data for physicians included on the list.

AB 1437 (Koretz, of 2004) would have prohibited inappropriate marketing by pharmaceutical companies by codifying the PhRMA Code on Interactions with Healthcare Professionals. *AB 1437 failed passage in the Assembly Health Committee.*

AB 103 (Reyes of 2003) would have required pharmaceutical manufacturers to disclose to the Department of Health Services (now DHCS) information about gifts made to any person authorized to prescribe, dispense, or purchase prescription drugs. *AB 103 failed passage on the Assembly Floor.*

11) *Support*. Health Access California (HAC) writes that while no one who receives a gift thinks it influences their judgment, numerous academic studies have demonstrated that it does—as does the willingness of pharmaceutical manufacturers to fund such gifts and other payments. HAC states that such marketing works: otherwise companies would not pay for it and because of this, federal law and efforts by some health systems have limited these gifts and payments, or required public disclosure of such marketing by pharmaceutical manufacturers to physicians and other prescribers. CALPIRG writes that upon review of drug companies' CCPs, they determined that drug companies cannot be trusted to actually protect consumers through voluntary restrictions on their direct-to-doctor marketing, and by playing by their own rules, the manufactures have created limits that in many cases fail to constrain actions at all. School Employers Association of California and the Small School Districts Association write that by restricting pharmaceutical gifts to control drug costs and protect patient safety, this bill give California an opportunity to put patient care and drug affordability before corporate profits. Several supporters write to say that studies have shown that there is a direct correlation between pharmaceutical industry payments to medical professionals and the price of prescription drugs, and doctors who receive industry payments such as meals, travel, speaking fees and royalties were two to three times more likely to prescribe brand-name drugs at exceptionally high rates than others in their specialty. Supporters state that data from 2014 shows that California physicians received the highest number of payments from pharmaceutical companies than any state ($1.44B – representing payments received between August 2013 to December 2015) compared to the second and third ranking states, New York ($517M) and Texas ($435M), with Alaska at the bottom, receiving the lowest amount ($1.8M). Supporters further write that each year in

the U.S., $73 billion is spent on brand name drugs for which an equivalent generic available at a significant lower cost, resulting in patients overpaying approximately $24 billion of that amount themselves. Supporters contend that interaction with the pharmaceutical industry is associated with substantially negative consequences that include risks to patient safety associated with unnecessary drug prescriptions, drug cost increases borne by the patient, less availability of generic drugs, and less attention paid to evidence-based prescribing.

12) *Opposition*. The California Medical Association (CMA) writes that physicians are often reluctant to prescribe a new drug until they have the proper scientific basis they feel is necessary to safely put a patient on that regimen, and it is logical that a physician will be more likely to prescribe a certain drug after they have been educated on the risks and benefits that drug or treatment presents to their patients. CMA further states that physicians do not want to devote practice time to these meetings, so it is often done during lunch or dinner and the presentations are made to the entire health care staff, not just the physicians. The California Life Sciences Association states that this bill completely disregards the extensive existing law at the state and federal level already regulating interactions between drug manufacturers and health care providers. The Biotechnology Innovation Organization (BIO) states that their member companies know the importance of basing relationships with health care practitioners on high standards of ethics and professional conduct, which is why they strictly adhere to federal statutes, regulations, and internal policies already in place. BIO is concerned that this bill could encumber important interactions between biopharmaceutical manufacturers and health care practitioners. The Pharmaceutical Research and Manufacturers of America writes that this bill is unnecessary because current law already addresses interactions between health care practitioners and drug manufacturers, public disclosures are already required, and they know of no problem that has surfaced recently which would give rise to more legislation in this area. ResMed states that the current federal and California framework are substantial and sufficient to ensure that the necessary interactions are ethical, and this bill will hinder the spark of innovation for new medical devices.

13) *Amendments*. The author requests that the Committee approve amendments to delete medical devices from this bill as follows:

a) Section 150300(a)(1) delete "or a wholesale distributor of medical devices"
b) Delete 150300(a)(5).
c) Section 150300(i) delete "or medical device manufacturer".
d) Section 150300(l) after "include" add, "products where a medical device is part of the combination", and delete "prescription eyeglasses, prescription sunglasses, or other prescription eyewear"
e) Section 150300(m) delete "or medical device", and "or device"
f) Section 150302 delete "or a wholesale distributor of medical devices"
g) Section 150306(a) delete "nonprescription medical device, an item of nonprescription durable medical equipment"
h) Delete Section 150306(b) and (c)
i) Section 150306(h) delete "medical devices" and "medical equipment, or medical supplies"

SUPPORT AND OPPOSITION:

Support: California Alliance for Retired Americans
CALPIRG
Courage Campaign
Consumers Union
Families USA
Health Access California
National Center for Youth Law
School Employers Association of California
Small School Districts' Association
Two individuals

Oppose: Biotechnology Innovation Organization
California Life Sciences Association
California Medical Association
Pharmaceutical Research and Manufacturers of America
ResMed

-- END --

PROPOSED LEGISLATION

AMENDED IN SENATE APRIL 17, 2017

AMENDED IN SENATE MARCH 29, 2017

SENATE BILL No. 790

Introduced by Senator McGuire

February 17, 2017

An act to ~~add Article 16 (commencing with Section 870) to Chapter 1 of Division 2 of the Business and Professions Code, and to~~ add Division 117 (commencing with Section 150300) to the Health and Safety Code, relating to health care providers.

LEGISLATIVE COUNSEL'S DIGEST

SB 790, as amended, McGuire. Health care providers: gifts and benefits.

The Sherman Food, Drug, and Cosmetic Law, administered by the *State* Department of Public Health, regulates the packaging, labeling, and advertising of drugs and devices, and requires a manufacturer of any drug or device in the state to be licensed by the department. Existing law imposes various requirements on persons engaged in the provision of health care services in the state.

This bill would prohibit a manufacturer of a prescribed product or a wholesale distributor of medical devices, as defined, from offering or giving a gift to a health care provider. The bill would define a gift as anything of value provided for free to a health care provider, or a payment, food, entertainment, travel, subscription, advance, service, or anything else of value provided to a health care provider, unless it is a specified allowable expenditure or the health care provider reimburses the cost at fair market value. The bill would prohibit a manufacturer of a prescribed product or an entity on behalf of a manufacturer of a prescribed product from providing a fee, payment, subsidy, or other

economic benefit to a health care provider in connection with the provider's participation in research. The bill would specify circumstances to which these prohibitions do not apply. The bill would authorize the Attorney General to bring an action to enforce a violation of these prohibitions and to seek injunctive relief and imposition of a civil penalty for each violation, as specified. ~~The bill would require a health care professional, as defined, who is a member of a committee that sets formularies or develops clinical guidelines and who also serves as a speaker or commercial consultant for a manufacturer of prescribed products to disclose to the committee his or her relationship with the manufacturer, as specified.~~

Existing federal law, the Physician Payments Sunshine Act (Sunshine Act), requires manufacturers of specified drugs, devices, biologicals, or medical supplies to disclose to the federal Centers for Medicare and Medicaid Services payments or other transfers of value made to physicians or teaching hospitals.

This bill would state the intent of the Legislature that the prohibitions and requirements described above complement and operate in conjunction with the Sunshine Act. The bill would state the intent of the Legislature to enact legislation similar to the Sunshine Act if the Sunshine Act is repealed or becomes inoperative.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

~~SECTION 1. Article 16 (commencing with Section 870) is added to Chapter 1 of Division 2 of the Business and Professions Code, to read:~~

~~Article 16. Disclosure of Relationship with Manufacturer of Prescribed Products~~

~~870. (a) A health care professional, as defined in subdivision (g) of Section 150300 of the Health and Safety Code, who is a member of a committee that sets formularies or develops clinical guidelines and who also serves as a speaker or commercial consultant for a manufacturer, as defined in subdivision (i) of Section 150300, shall disclose to the committee his or her relationship with the manufacturer.~~

~~(b) A health care professional shall make the disclosure required by subdivision (a) during and for a period of two years after the termination of his or her relationship with a manufacturer.~~

~~SEC. 2.~~

SECTION 1. Division 117 (commencing with Section 150300) is added to the Health and Safety Code, to read:

DIVISION 117. EXPENDITURES BY MANUFACTURERS OF PRESCRIBED PRODUCTS

150300. For the purposes of this division, the following definitions shall apply:

(a) "Allowable expenditure" means any of the following:

(1) Payment by a manufacturer of a prescribed product or a wholesale distributor of medical devices to the sponsor of a significant educational, medical, scientific, or policymaking conference or seminar, provided that all of the following conditions are satisfied:

(A) The payment is not made directly to a health care professional or pharmacist.

(B) Funding is used solely for bona fide educational purposes, except that the sponsor may, in the sponsor's discretion, apply some or all of the funding to provide meals and other food for all conference participants.

(C) All program content is objective, free from industry control, and does not promote specific products.

(2) Honoraria and payment of the expenses of a health care professional who serves on the faculty at a bona fide educational, medical, scientific, or policymaking conference or seminar, provided that all of the following conditions are satisfied:

(A) The honoraria or payment is governed by an explicit contract with specific deliverables which are restricted to medical issues, not marketing activities.

(B) Consistent with federal law, the content of the presentation, including slides and written materials, is determined by the health care professional.

(3) For a bona fide clinical trial, the annual direct salary support for principal investigators and other health care professionals.

(4) For a research project that constitutes a systematic investigation, is designed to develop or contribute to general

knowledge, and reasonably can be considered to be of significant interest or value to scientists or health care professionals working in the particular field of inquiry, all of the following:

(A) Gross compensation.

(B) Direct salary support per health care professional.

(C) Expenses paid on behalf of each health care professional.

(5) Payment or reimbursement for reasonable expenses, including travel and lodging-related expenses, necessary for technical training of individual health care professionals on the use of a medical device, if the commitment to provide those expenses and the amounts or categories of reasonable expenses to be paid are described in a written agreement between the health care provider and the manufacturer.

(6) Royalties and licensing fees paid to health care providers in return for contractual rights to use or purchase a patented or otherwise legally recognized discovery for which the health care provider holds an ownership right.

(7) The payment of reasonable expenses of an individual related to the interview of the individual by a manufacturer of prescribed products in connection with a bona fide employment opportunity or for health care services on behalf of an employee of the manufacturer.

(8) Provision of meals for a health care provider that do not exceed two hundred fifty dollars ($250) per person, per year in value.

(b) “Bona fide clinical trial” means an FDA-reviewed clinical trial that constitutes research as defined in Section 46.102 of Title 45 of the Code of Federal Regulations that can be reasonably considered to be of interest to scientists or health care professionals working in the particular field of inquiry.

(c) “Clinical trial” means a study that does either of the following:

(1) Assesses the safety or efficacy of prescribed products administered alone or in combination with other prescribed products or other therapies.

(2) Assesses the relative safety or efficacy of prescribed products in comparison with other prescribed products or therapies.

(d) “Free clinic” means a health care facility operated by a nonprofit private entity that satisfies all of the following conditions:

(1) In providing health care, the health care facility does not accept reimbursement from any third-party payer, including reimbursement from any insurance policy, health plan, or federal or state health benefits program that is individually determined.

(2) In providing health care, the health care facility either does not impose charges on patients to whom service is provided, or imposes charges on patients according to their ability to pay.

(3) The health care facility may accept voluntary donations from patients for the provision of health care services.

(4) The health care facility is licensed or certified to provide health services under applicable law.

(e) "Gift" means either of the following:

(1) Anything of value provided for free to a health care provider.

(2) A payment, food, entertainment, travel, subscription, advance, service, or anything else of value provided to a health care provider, unless it is an allowable expenditure as defined in subdivision (a) or the health care provider reimburses the cost at fair market value.

(f) "Health benefit plan administrator" means the person or entity who sets formularies on behalf of an employer or health insurer.

(g) "Health care professional" means any of the following:

(1) A person who is authorized by law to prescribe or to recommend prescribed products, who regularly practices in the state, and who is either licensed by the state to provide or is otherwise lawfully providing health care in the state.

(2) A partnership or corporation made up of the persons described in paragraph (1).

(3) An officer, employee, agent, or contractor of a person described in paragraph (1) who is acting in the course and scope of employment, of an agency, or of a contract related to or supportive of the provision of health care to individuals.

(h) "Health care provider" means a health care professional, hospital, nursing home, pharmacist, health benefit plan administrator, or any other person authorized to dispense or purchase for distribution prescribed products in the state. "Health care provider" does not include a hospital foundation that is organized as a nonprofit entity separate from a hospital.

(i) "Manufacturer" means a pharmaceutical manufacturer, biological product manufacturer, or medical device manufacturer

or any other person who is engaged in the production, preparation, propagation, compounding, processing, marketing, packaging, repacking, distributing, or labeling of prescribed products. "Manufacturer" does not include a wholesale distributor of biological products, a retailer, or a pharmacist.

(j) "Marketing" means promoting, detailing, or any activity that is intended to be used or is used to influence sales or market share or to evaluate the effectiveness of a professional sales force.

(k) "Pharmaceutical manufacturer" means either of the following:

(1) An entity that is engaged in the production, preparation, propagation, compounding, conversion, or processing of prescription drugs, whether directly or indirectly by extraction from substances of natural origin, independently by means of chemical synthesis, or by a combination of extraction and chemical synthesis.

(2) An entity engaged in the packaging, repackaging, labeling, relabeling, or distribution of prescription drugs.

(*l*) "Prescribed product" means a drug or device as defined in Section 321 of Title 21 of the United States Code, a compounded drug or drugs, a biological product as defined in Section 262 of Title 42 of the United States Code for human use, or a combination product as defined in subdivision (e) of Section 3.2 of Title 21 of the Code of Federal Regulations, but shall not include prescription eyeglasses, prescription sunglasses, or other prescription eyewear.

(m) "Sample" means a unit of a prescription drug, biological product, or medical device that is not intended to be sold and is intended to promote the sale of the drug, product, or device, and includes starter packs and coupons or other vouchers that enable an individual to receive a prescribed product free of charge or at a discounted price. "Sample" does not include prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded patient assistance program.

(n) "Significant educational, scientific, or policymaking conference or seminar" means an educational, scientific, or policymaking conference or seminar that satisfies both of the following:

(1) The conference or seminar is accredited by the Accreditation Council for Continuing Medical Education or a comparable

organization or is presented by an approved sponsor of continuing education, provided that the sponsor is not a manufacturer of prescribed products.

(2) The conference or seminar offers continuing education credit, features multiple presenters on scientific research, or is authorized by the sponsor to recommend or make policy.

150302. A manufacturer of a prescribed product or a wholesale distributor of medical devices, or an agent thereof, shall not offer or give a gift to a health care provider.

150304. Except as described in paragraph (3) of subdivision (a) of Section 150300, a manufacturer or an entity on behalf of a manufacturer shall not provide a fee, payment, subsidy, or other economic benefit to a health care provider in connection with the provider's participation in research.

150306. Sections 150302 and 150304 shall not apply to the following:

(a) Samples of a prescribed product or reasonable quantities of an over-the-counter drug, a nonprescription medical device, an item of nonprescription durable medical equipment, an item of medical food as defined in Section 360ee of Title 21 of the United States Code, or infant formula as defined in Section 321 of Title 21 of the United States Code, that are provided to a health care provider for free distribution to patients.

(b) The loan of a medical device for a short-term trial period, not to exceed 120 days, to permit evaluation of the device by a health care provider or patient.

(c) The provision of reasonable quantities of medical device demonstration or evaluation units to a health care provider to assess the appropriate use and function of the product and determine whether and when to use or recommend the product in the future.

(d) The provision, distribution, dissemination, or receipt of peer-reviewed academic, scientific, or clinical articles or journals and other items that serve a genuine educational function provided to a health care provider for the benefit of patients.

(e) Scholarship or other support for medical students, residents, and fellows to attend a significant educational, scientific, or policymaking conference or seminar of a national, regional, or specialty medical or other professional association if the recipient of the scholarship or other support is selected by the association.

(f) Rebates and discounts for prescribed products provided in the normal course of business.

(g) Labels approved by the federal Food and Drug Administration for prescribed products.

(h) The provision to a free clinic of financial donations or of free prescription drugs, over-the-counter drugs, medical devices, biological products, combination products, medical food, infant formula, medical equipment, or medical supplies.

(i) Prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufactured-funded patient assistance program.

(j) Fellowship salary support provided to fellows through grants for manufacturers of prescribed products, provided that all of the following conditions are satisfied:

(1) The grants are applied for by an academic institution or hospital.

(2) The institution or hospital selects the recipient fellows.

(3) The manufacturer imposes no further demands or limits on the institution's, hospital's, or fellow's use of the funds.

(4) Fellowships are not named for a manufacturer and no individual recipient's fellowship is attributed to a particular manufacturer of prescribed products.

150308. (a) The Attorney General may bring an action seeking injunctive relief, costs, attorney's fees, and imposition of a civil penalty of up to ten thousand dollars ($10,000) for each violation of Section 150302 or 150304.

(b) For purposes of this section, each unlawful gift offered or given in violation of Section 150302, or each fee, subsidy, payment or other economic benefit given in violation of Section 150304 shall constitute a separate violation.

(c) In connection with an action brought pursuant to this section, the Attorney General shall, in addition to the powers granted to him or her by law, have the same powers to investigate and obtain remedies as are granted to the Director of Consumer Affairs pursuant to Chapter 4 (commencing with Section 300) of Division 1 of the Business and Professions Code.

150310. It is the intent of the Legislature that the requirements and prohibitions of this division complement and operate in conjunction with the federal Physician Payments Sunshine Act (42 U.S.C. Sec. 1320a-7h). If the Physician Payments Sunshine Act is

repealed or becomes inoperative, it is the intent of the Legislature to enact similar legislation requiring manufacturers to disclose payments or other transfers of value made to health care providers in the state.

O

AB 40 CURES database:
health information technology system

CALIFORNIA ACEP
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

AB 40 (Santiago) – CURES Integration

Emergency departments (ED) across California use health information technology, such as health information exchanges and electronic medical records; software that draws upon patient information from multiple healthcare providers. This type of information is particularly helpful when patients come into the ED.

At many EDs, the emergency physician will receive a report on a patient's known information, including current care plans and recent imaging and tests, prior to seeing that patient. This information provides emergency physicians with a more complete picture of the patient's health history. What is currently lacking from this patient information that emergency physicians receive is the patient's prescription history from the Controlled Substances Utilization Review and Evaluation System (CURES).

AB 40 (Santiago) would allow health information technologies to integrate with and automatically query CURES on behalf of a registered provider. This means a summary of a patient's opioid prescription history would be given directly to the emergency physician without them needing to take time away from patient care to manually check CURES.

Currently, only after the emergency physician sees the patient and considers whether opioids may be warranted will the emergency physician manually query the CURES database. Providing physicians with access to CURES information early on will not only reduce the time needed to manually obtain the information, but also better informs the emergency physician as they decide the best course of treatment for the patient.

Allowing CURES to integrate with health information technologies will allow prescription information to be included in the same patient information that physicians already receive. This will help reduce stress on California's overcrowded EDs by allowing emergency physicians to more efficiently treat patients, ensuring all patients receive timely care.

Sponsor:

- California Chapter, American College of Emergency Physicians

California Chapter, American College of Emergency Physicians
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COMMITTEE ANALYSIS

Date of Hearing: April 25, 2017
Consultant: Adam Smith

ASSEMBLY COMMITTEE ON PUBLIC SAFETY
Reginald Byron Jones-Sawyer, Sr., Chair

AB 40 (Santiago) – As Amended April 19, 2017

SUMMARY: Requires the Department of Justice (DOJ) to make the electronic history of controlled substances prescribed to an individual by a health care practitioner available to the practitioner based on data from the Controlled Substance Utilization Review and Evaluation System (CURES). Specifically, **this bill**:

1) Specifies that the electronic history of controlled substances based on data from CURES Prescription Drug Monitoring Program (PDMP) be made available to the practitioner through either an Internet Web portal or an authorized health information technology system.

2) States that a health information technology system may establish an integration and submit queries to the CURES database on either a user-initiated basis or an automated basis if the system can certify the following:

    a) The system can establish it has been authorized to query the CURES database, as specified;

    b) The system will not use or disclose data received from the CURES database for any purpose other than delivering the data to an authorized health care practitioner or performing data processing activities needed to deliver data;

    c) The system authenticates the identity of any authorized health care practitioner initiating queries to the CURES database and, at the time of the query, submits data regarding the query to CURES, as specified; and

    d) The system meets applicable patient privacy and information security requirements of state and federal law.

3) Provides that the DOJ may, in its discretion, determine whether to establish direct system integration between one or more health information technology systems and the CURES database, or whether to develop a gateway system to which multiple health information technology systems can establish integration for purposes of accessing the CURES database.

4) Provides that the DOJ may require an entity that operates a health information technology system to enter into a memorandum of understanding or other agreement that sets forth terms and conditions with which the entity shall comply, including, but not limited to the following:

a) Paying a reasonable fee to cover the cost of establishing and maintaining integration with the CURES database;

b) Enforcement mechanisms for failure to comply with oversight or audit activities by the DOJ, up to and including termination of access to the CURES database; and

c) Any other term of condition that the DOJ may determine in its reasonable discretion is necessary.

5) States that an authorized health care practitioner, in order to prevent the inappropriate or illegal use of certain controlled substances, may use a health information technology system to initiate the referral of the history of controlled substances dispensed to an individual to other licensed health care practitioners, pharmacists, or both.

6) Defines "automated basis" as "using predefined criteria established or approved by a health care practitioner to trigger an automated query to the CURES database, which can be attributed to a specific health care practitioner by an audit trial in the health information technology system."

7) Defines "Department" as "the Department of Justice."

8) Defines "User-initiated basis" as "an authorized health care practitioner had taken an action to initiate the query to the CURES database, such as clicking a button, issuing a voice command, or taking some other action that can be attributed to a specific health care practitioner by an audit trail in the health information technology system."

9) Contains an urgency clause stating that immediate implementation is necessary in order for prescribing physicians to access the CURES database and prevent the abuse of prescription drugs.

EXISTING LAW:

1) Establishes the California Uniform Controlled Substances Act which regulates controlled substances. (Health & Saf. Code, § 11000 et seq.)

2) Defines controlled substances as any drug, precursor, or substance categorized in any of the five schedules based on their danger and potential for abuse. (Health & Saf. Code, §§ 11007; 11054-11058.)

3) Defines "practitioner" as "a physician, dentist, veterinarian, podiatrist, or pharmacist, registered nurse or physician assistant acting within the scope of an experimental health workforce projects authorized by the Office of Statewide Health Planning and Development, a certified nurse-midwife, a nurse practitioner, a physician assistant, or an optometrist licensed under the Optometry Practice Act." Includes in the definition of "practitioner" as "a pharmacy, hospital, or other institution licensed, registered, or otherwise permitted to distribute, dispense, conduct research with respect to, or to administer, a controlled substance in the course of professional practice or research in this state." Also includes in the definition of "practitioner" a "scientific investigator, or other person licensed, registered, or otherwise permitted, to distribute, dispense, conduct research with respect to, or administer, a

controlled substance in the course of professional practice or research in this state." (Health & Saf. Code, § 11026.)

4) Defines "prescription" as "an oral order or electronic transmission prescription for a controlled substance given individually for the person(s) for whom prescribed, directly from the prescriber to the furnisher or indirectly by means of a written order of the prescriber." (Health & Saf. Code, §11027.)

5) Prohibits any person other than a physician, dentist, podiatrist, veterinarian, naturopathic doctor, pharmacist, certified nurse-midwife, nurse practitioner; a pharmacist or registered nurse or physician assistant acting within the scope of an experimental health workforce project authorized by the Office of Statewide Health Planning and Development (Health & Saf. Code, § 128125 et seq.); an optometrist licensed under the Optometry Practice Act, or an out-of-state prescriber acting in an emergency situation from writing or issuing a prescription for a controlled substance. (Health & Saf. Code, § 11150.)

6) Specifies that a prescription for a controlled substance shall only be issued for a legitimate medical purpose and establishes responsibility for proper prescribing on the prescribing practitioner. States that a violation shall result in imprisonment for up to one year or a fine of up to $20,000, or both. (Health & Saf. Code, § 11153.)

7) Requires special prescription forms for controlled substances to be obtained from security printers approved by DOJ, establishes certain criteria for features on the forms and requires controlled substance prescriptions to be made on the specified form. (Health & Saf. Code, §§ 11161.5, 11162.1, 11164.)

8) Establishes the CURES for electronic monitoring of Schedule II, III and IV controlled substance prescriptions. The CURES provides for the electronic transmission of Schedule II, III and IV controlled substance prescription information to the DOJ at the time prescriptions are dispensed. (Health & Saf. Code, § 11165.)

9) States that the purpose of CURES is to assist law enforcement and regulatory agencies in controlling diversion and abuse of Schedule II, III and IV controlled substances and for statistical analysis, education and research. (Health & Saf. Code, § 11165, subd. (a).)

10) Establishes privacy protections for patient data and specifies that CURES data can only be accessed by appropriate state, local and federal persons or public agencies for disciplinary, civil or criminal actions. Specifies that CURES data shall also only be provided, as determined by DOJ, to other agencies or entities for educating practitioners and others, in lieu of disciplinary, civil or criminal actions. Authorizes non-identifying CURES data to be provided to public and private entities for education, research, peer review and statistical analysis. (Health & Saf. Code, § 11165, subd. (c).)

11) Provides that pharmacies or clinics, in filling a prescription for a federally Scheduled II, III or IV drug, shall provide weekly information to DOJ including the patient's name, date of birth, the name, form, strength and quantity of the drug, and the pharmacy name, pharmacy number and the prescribing physician information. (Health & Saf. Code, § 11165, subd. (d).)

12) Provides that a licensed health care practitioner eligible to prescribe Schedule II, III or IV controlled substances, or a pharmacist, shall apply to participate in the CURES PDMP by

January 1, 2016. Authorizes DOJ to deny an application or suspend a subscriber for certain violations and falsifying information. Provides that the history of controlled substances dispensed to a patient based on CURES data that is received by a practitioner or pharmacist shall be considered medical information, subject to provisions of the Confidentiality of Medical Information Act. (Health & Saf. Code, § 11165.1.)

13) Authorizes the DOJ to conduct audits of the CURES PDMP system and its users and create a system for issuing citations for violations. (Health & Saf. Code, 1165.2, subd. (a) & (b).)

14) Requires a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance to consult the CURES database to review a patient's controlled substance history, as specified.

15) Requires health practitioners who prescribe or administer a controlled substance classified in Schedule II to make a record containing the name and address of the patient, date, and the character, name, strength, and quantity of the controlled substance prescribed, as well as the pathology and purpose for which the controlled substance was administered or prescribed. (Health & Saf. Code, § 11190, subd. (a) and (b).)

16) Requires prescribers who are authorized to dispense Schedule II, III or IV controlled substance in their office or place of practice to record and maintain information for three years for each such prescription that includes the patient's name, address, gender, and date of birth, prescriber's license and license number, federal controlled substance registration number, state medical license number, National Drug Code number of the controlled substance dispensed, quantity dispensed, diagnosis code, if available, and original date of dispensing. Requires that this information be provided to DOJ on a monthly basis. (Health & Saf. Code, § 11190, subd. (c).)

FISCAL EFFECT: Unknown

COMMENTS:

1) **Author's Statement**: According to the author, "Emergency departments (ED) and other health care settings across California use health information technology, such as health information exchanges and electronic medical records; software that draws upon patient information from multiple healthcare providers. This type of information is particularly helpful when patients come into the ED.

   "At many EDs, the emergency physician will receive a report on a patient's known information, including current care plans and recent imaging and tests, prior to seeing that patient. This information provides emergency physicians with a more complete picture of the patient's health history. What is currently lacking from this patient information that emergency physicians receive is the patient's prescription history from the Controlled Substances Utilization Review and Evaluation System (CURES).

   "AB 40 would allow health information technologies to integrate with and automatically query CURES on behalf of a registered provider. For emergency physicians, this means a summary of a patient's opioid prescription history would be given directly to them without needing to take time away from patient care to manually check CURES. AB 40 would also

benefit office based physicians by providing the same summary from CURES for patients scheduled to be seen in advance of their appointment.

"Allowing CURES to integrate with health information technologies will allow prescription information to be included in the same patient information that physicians already receive. This is an important step towards providing better care while combatting prescription opioid abuse."

2) **CURES Integration and Opioid Abuse**: According to recent reports regarding America's opioid epidemic, almost 2 million Americans abused or were dependent on prescription opioids in 2014. In 2015, more than 15,000 people died from overdoses involving prescription opioids. Today, nearly half of all U.S. opioid overdose deaths involve a prescription opioid and, due to the large population that abuses prescription opioids, over 1,000 people are treated in emergency departments for misusing prescription opioids every day. <https://www.cdc.gov/drugoverdose/opioids/prescribed.html> (as of April 14, 2017.)

   In order to address the prevalence of prescribed opioid abuses, the DOJ implemented and maintains the CURES PDMP searchable database so that practitioners have increased access to information regarding a patient's prescription history. However, because current law does not provide authority for the CURES PDMP to integrate with health information technology systems, health care practitioners face several additional burdens including, but not limited to, a delay in access to potentially vital information for rapid treatment, increased opportunities for patients to abuse practitioner services, and decreased peer-to-peer benefits between health information technology providers. During the process of decommissioning the original CURES database and transitioning to CURES 2.0, the current operating system, the DOJ expressed the need to address these concerns through integration. <https://www.cdph.ca.gov/programs/cclho/Documents/SMALL%2020140203%20PDMP%20A%20Powerful%20Tool.pdf> (as of April 14, 2017.)

   AB 40 will authorize the CURES PDMP database to integrate with health information technology services and authorize the DOJ to allow peer-to-peer direct integration between health information technologies. By doing so, AB 40 will provide practitioners with more immediate access to records that are instrumental to addressing the opioid abuse epidemic. Furthermore, AB 40 would ensure that health care information technology providers are submitting certain information regarding PDMP queries, which would deter abuse and inappropriate access to information in the CURES database.

3) **Argument in Support**: According to *The California American College of Emergency Physicians*, "AB 40 would allow health information technologies to integrate with and automatically query CURES on behalf of a registered provider. This means a summary of a patient's opioid prescription history would be given directly to the emergency physician without them needing to take time away from patient care to manually check the Controlled Substances Utilization Review and Evaluation System (CURES).

   "Emergency departments (ED) across California use health information technology, such as health information exchanges and electronic medical records; software that draws upon patient information from multiple healthcare providers. This type of information is particularly helpful when patients come into the ED.

"At many EDs, the emergency physician will receive a report on a patient's known information, including current care plans and recent imaging and tests, prior to seeing that patient. This information provides emergency physicians with a more complete picture of the patient's health history. What is currently lacking from this patient information is the patient's prescription history from CURES.

"Currently, only after the emergency physician sees the patient and considers whether opioids may be warranted will the emergency physician manually query the CURES database. Providing physicians with access to CURES information early on will not only reduce the time needed to manually obtain the information, but also better informs the emergency physician as they decide the best course of treatment for the patient.

"Allowing CURES to integrate with health information technologies will allow prescription information to be included in the same patient information that physicians already receive. This will help reduce stress on California's overcrowded EDs by allowing emergency physicians to more efficiently treat patients, ensuring all patients receive timely care."

4) **Related Legislation**: SB 641 (Lara), would prohibit the release of data obtained from CURES to a law enforcement agency except pursuant to a valid court order, as specified. SB 641 is set for hearing in Senate Public Safety on April 18th.

5) **Prior Legislation**:

   a) SB 482 (Lara), Chapter 708, Statutes of 2016, required prescribers to consult the Controlled Substances Utilization Review and Evaluation System (CURES) prior to prescribing a Schedule II or III drug to a patient for the first time and required a dispenser to consult the CURES system prior to dispensing a Schedule II or III drug to a patient for the first time.

   b) AB 679 (Allen), Chapter 778, Statutes of 2015, extended the date by which specified health care practitioners and pharmacists must register with the CURES PDMP by six months, from January 1, 2016 to July 1, 2016.

   c) SB 809 (DeSaulnier), Chapter 400, Statutes of 2013, made various changes to the funding and operations of the CURES PDMP, including the requirement that practitioners who prescribe Schedule II, III and IV controlled substances and pharmacists also enroll in and consult the CURES PDMP.

   d) SB 360 (DeSaulnier), Chapter 418, Statutes of 2011, updated CURES to reflect the new PDMP and authorizes DOJ to initiate administrative enforcement actions to prevent the misuse of confidential information collected through CURES.

REGISTERED SUPPORT / OPPOSITION:

Support

California American College of Emergency Physicians (Sponsor)
California Access Coalition

County Health Executives Association of California
Medical Board of California
Tenet Healthcare

Opposition

None

Analysis Prepared by: Adam Smith / PUB. S. /

COMMITTEE ANALYSIS

Date of Hearing: April 4, 2017

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Rudy Salas, Chair
AB 40 (Santiago) – As Introduced December 5, 2016

NOTE: *This bill adds an urgency clause.*

SUBJECT: CURES database: health information technology system.

SUMMARY: Requires the California Department of Justice (DOJ) to make the Controlled Substance Utilization Review and Evaluation System (CURES) more readily available to prescribing health care practitioners, through a web site or software system. Authorizes the DOJ to require entities utilizing the system to enter into a memorandum of understanding setting forth terms and conditions for use of CURES and to conduct audits of any authorized technology system integrated with CURES.

EXISTING LAW:

1) Directs the DOJ to maintain CURES for the purpose of tracking and ensuring the appropriate dispensing and prescribing of Schedule II, Schedule III, and Schedule IV controlled substances. (Health and Safety Code (HSC) Section 11165)

2) Directs health care practitioners and pharmacists to apply for access to CURES, sets standards for application denial, and clarifies actions that may be taken by DOJ and subscribers. (HSC Section 11165.1)

3) Establishes the penalties and structure for issuing a citation if a subscriber is in violation with any provision of the chapter. (HSC Section 11165.2)

THIS BILL:

1) Requires the DOJ to make CURES information available to physicians, pharmacist, and other health care practitioners through an online web portal or by permitting interfacing software.

2) Stipulates conditions for the approval and use of interfacing technology systems, including, security, use of information, and privacy. Requires health systems utilizing a health information system that would interface with CURES to enter into a memorandum of understanding or other agreement setting terms and conditions for usage.

3) Authorizes the DOJ to conduct audits of any interfacing technology systems.

FISCAL EFFECT: Unknown. This bill is keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the California Chapter of the American College of Emergency Physicians. According to the author, "The overuse of prescription opioids is a significant national public health problem and California communities face rising rates of opioid

related deaths. California's prescription drug monitoring program, CURES, is a critical tool that helps combat prescription drug abuse. AB 40 integrates CURES with emergency room health information technology systems. This will allow prescription information to be included in the same patient information that emergency physicians already receive. AB 40 will help reduce stress on California's overcrowded emergency departments by allowing emergency physicians to more efficiently receive information and helps fight prescription drug abuse."

Background. This bill would require the DOJ to establish a system for evaluating and utilizing outside health management software to allow health care practitioners to more effectively manage care for patients who may be using or need to be prescribed opioids. Utilizing an interfacing technology system, with the potential for automation, would increase ease of use of CURES information and potentially increase positive outcomes for patients. Existing law does not allow the DOJ to authorize health information systems to access CURES. The bill also allows the DOJ to audit any approved technology systems that interface with CURES.

CURES was established in 1997 by AB 3042 (Takasugi), Chapter 738, Statutes of 1996, in response to recommendations of the Controlled Substance Prescription Advisory Council. (SCR 74, 1992.) The program initially was intended to electronically monitor the prescribing and dispensing of Schedule II controlled substances, such as oxycodone. The CURES provides for real-time electronic transmission of specified prescription data to DOJ. Essentially, the data is analyzed for indications that controlled substances are being improperly prescribed, or that drug abusers are obtaining prescriptions from many doctors (doctor shopping). Currently, physicians and pharmacists have access to CURES data through patient activity reports. Currently, physicians must manually query the CURES database, something which, according to the sponsor, does not usually occur unless the physician is planning to prescribe controlled substances.

To support health care practitioners in more efficiently and effectively serving patients, and preventing a variety of health care complications from not being aware of a patient's potential opioid usage, the bill would allow health care technology systems that are approved by DOJ to automatically query the system to pull relevant prescribing information. This is especially relevant in emergency departments where many patients are seeking immediate pain relief and may be prescribed controlled substance medications as a result.

Current Related Legislation. SB 641 (Lara) revises the privacy provisions of CURES. The bill specifies that, except as specified, information within CURES is confidential, not subject to discovery or admissible in any civil or administrative action, and exempt from public inspection, copying, and disclosure pursuant to the California Public Records Act. The bill specifies to whom the information within CURES may be disclosed or released, including, among others, to a health care practitioner providing care to a current patient, to a pharmacist dispensing a controlled substance to a current patient, and, upon a written request, to certain regulatory boards. The bill requires a pharmacy to provide a specific notification about CURES to each patient who is dispensed a Schedule II, Schedule III, or Schedule IV controlled substance.

Prior Related Legislation.

AB 2968 (Mullin), Chapter 286, Statutes of 2006, added more information to the requirements for a physician to prescribe a controlled substance, and required electronic monitoring of Schedule IV drugs.

SB 151 (Burton), Chapter 406, Statutes of 2004, made the CURES reporting system permanent.

AB 3042 (Takasugi), Chapter 738, Statutes of 1996, established CURES as a three-year pilot program.

ARGUMENTS IN SUPPORT:

California American College of Emergency Physicians – "Allowing CURES to integrate with health information technologies will allow prescription information to beincluded in the same patient information that physicians already receive. This will help reduce stress on California's overcrowded EDs by allowing emergency physicians to more efficiently treat patients, ensuring all patients receive timely care."

California Access Coalition – "This bill properly balances the needs for shared information and patient privacy in addressing at least one aspect of the opioid epidemic and we appreciate your efforts on this issue."

California Medical Board – "The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent doctor shopping. The Board supports the concept of integrating existing health information technology systems with the CURES database."

ARGUMENTS IN OPPOSITION:

None on file

IMPLEMENTATION ISSUES:

While supporting the interoperability of CURES and established medical information systems may assist health care practitioners and allow them to provide more effective care, attention must be paid to ensure data security and patient privacy. The DOJ and practitioners must ensure that integrated technology systems do not sacrifice privacy for the sake of convenience. The author should consider amending the bill to strengthen data security and privacy protections.

REGISTERED SUPPORT:

California American College of Emergency Physicians
California Access Coalition
California Medical Board

REGISTERED OPPOSITION:

None on file

PROPOSED LEGISLATION

ASSEMBLY BILL No. 40

Introduced by Assembly Member Santiago

December 5, 2016

An act to amend Sections 11165.1 and 11165.2 of the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 40, as introduced, Santiago. CURES database: health information technology system.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a Schedule II, Schedule III, or Schedule IV controlled substance.

This bill would require the Department of Justice to make the electronic history of controlled substances dispensed to an individual under a health care practitioner's care, based on data contained in the CURES database, available to the practitioner through either an online Internet Web portal or an authorized health information technology system, as defined. The bill would authorize a health information technology system to establish an integration with and submit queries to the CURES database if the system can certify, among other requirements, that the data received from the CURES database will not be used for any purpose other than delivering the data to an authorized

health care practitioner or performing data processing activities necessary to enable delivery, and that the system meets applicable patient privacy and information security requirements of state and federal law. The bill would also authorize the Department of Justice to require an entity operating a health information technology system to enter into a memorandum of understanding or other agreement setting forth terms and conditions with which the entity must comply.

Existing law authorizes the Department of Justice to conduct audits of the CURES database and its users.

This bill would authorize the Department of Justice to conduct audits of any authorized health information technology system integrated with the CURES database.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 11165.1 of the Health and Safety Code, as amended by Section 2 of Chapter 708 of the Statutes of 2016, is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the ~~Department of Justice~~ *department* to obtain approval to access information ~~online~~ regarding the controlled substance history of a patient *through an online Internet Web portal* that is ~~stored on the Internet and~~ maintained ~~within the Department of Justice~~, *by the department, or through an authorized health information technology system,* and, upon approval, the department shall release to that ~~practitioner~~ *practitioner, through an online Internet Web portal or an authorized health information technology system,* the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the ~~Department of Justice~~ *department* to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the ~~Department of Justice,~~ *department*, and, upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application for a subscriber.

(ii) Failure to maintain effective controls for access to the patient activity report.

(iii) Suspended or revoked federal DEA registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Any subscriber accessing information for any other reason than caring for his or her patients.

(C) Any authorized subscriber shall notify the ~~Department of Justice~~ *department* within 30 days of any changes to the subscriber account.

(D) A health information technology system may establish an integration with and submit queries to the CURES database on either a user-initiated basis or an automated basis if the system can certify all of the following:

(i) The health information technology system can establish it has been authorized to query the CURES database on behalf of an authorized health care practitioner on either a user-initiated basis, an automated basis, or both, for purposes of delivering patient data from the CURES database to assist an authorized health care practitioner with evaluating the need for medical or pharmaceutical treatment or providing medical or pharmaceutical treatment to a patient for whom a health care practitioner is providing or has provided care.

(ii) The health information technology system will not use or disclose data received from the CURES database for any purpose

other than delivering the data to an authorized health care practitioner or performing data processing activities that may be necessary to enable this delivery.

(iii) The health information technology system authenticates the identity of any authorized health care practitioner initiating queries to the CURES database on either a user-initiated basis or an automated basis and maintains an audit trail documenting this authentication.

(iv) The health information technology system meets applicable patient privacy and information security requirements of state and federal law.

(E) The department may, in its discretion, determine whether to establish a direct system integration between one or more health information technology systems and the CURES database, or whether to develop a gateway system to which multiple health information technology systems can establish an integration for purposes of accessing the CURES database.

(F) The department may require an entity that operates a health information technology system to enter into a memorandum of understanding or other agreement that sets forth terms and conditions with which the entity shall comply, including, but not limited to, all of the following:

(i) Paying a reasonable fee to cover the cost of establishing and maintaining integration with the CURES database.

(ii) Enforcement mechanisms for failure to comply with oversight or audit activities by the department, up to and including termination of access to the CURES database.

(iii) Any other term or condition that the department may determine in its reasonable discretion is necessary to carry out the intent of this section.

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the ~~Department of Justice.~~ *department.*

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the ~~Department of Justice~~ *department* may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual. *An authorized health care practitioner may use a health information technology system, either on a user-initiated basis or an automated basis, to initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to other licensed health care practitioners, pharmacists, or both.*

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the ~~Department of Justice~~ *department* pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

(f) A health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

(g) For purposes of this section, the following terms have the following meanings:

(1) "Automated basis" means using predefined criteria established or approved by a health care practitioner to trigger an automated query to the CURES database, which can be

attributed to a specific health care practitioner by an audit trail in the health information technology system.

(2) "Department" means the Department of Justice.

(3) "Health information technology system" means an information processing application using hardware and software for the storage, retrieval, sharing of or use of patient data for communication, decisionmaking, coordination of care, or the quality, safety, or efficiency of the practice of medicine or delivery of health care services, including, but not limited to, electronic medical record applications, health information exchange systems, or other interoperable clinical or health care information system.

(4) "User-initiated basis" means an authorized health care practitioner has taken an action to initiate the query to the CURES database, such as clicking a button, issuing a voice command, or taking some other action that can be attributed to a specific health care practitioner by an audit trail in the health information technology system.

SEC. 2. Section 11165.2 of the Health and Safety Code is amended to read:

11165.2. (a) The Department of Justice may conduct audits of the CURES Prescription Drug Monitoring Program system and its ~~users.~~ *users, including any authorized health information technology system, as defined in subdivision (g) of Section 11165.1, integrated with the CURES database.*

(b) The Department of Justice may establish, by regulation, a system for the issuance to a CURES Prescription Drug Monitoring Program subscriber of a citation which may contain an order of abatement, or an order to pay an administrative fine assessed by the Department of Justice if the subscriber is in violation of any provision of this chapter or any regulation adopted by the Department of Justice pursuant to this chapter.

(c) The system shall contain the following provisions:

(1) Citations shall be in writing and shall describe with particularity the nature of the violation, including specific reference to the provision of law or regulation of the department determined to have been violated.

(2) Whenever appropriate, the citation shall contain an order of abatement establishing a reasonable time for abatement of the violation.

(3) In no event shall the administrative fine assessed by the department exceed two thousand five hundred dollars ($2,500) for each violation. In assessing a fine, due consideration shall be given to the appropriateness of the amount of the fine with respect to such factors as the gravity of the violation, the good faith of the subscribers, and the history of previous violations.

(4) An order of abatement or a fine assessment issued pursuant to a citation shall inform the subscriber that if the subscriber desires a hearing to contest the finding of a violation, a hearing shall be requested by written notice to the CURES Prescription Drug Monitoring Program within 30 days of the date of issuance of the citation or assessment. Hearings shall be held pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(5) In addition to requesting a hearing, the subscriber may, within 10 days after service of the citation, request in writing an opportunity for an informal conference with the department regarding the citation. At the conclusion of the informal conference, the department may affirm, modify, or dismiss the citation, including any fine levied or order of abatement issued. The decision shall be deemed to be a final order with regard to the citation issued, including the fine levied or the order of abatement which could include permanent suspension to the system, a monetary fine, or both, depending on the gravity of the violation. However, the subscriber does not waive its right to request a hearing to contest a citation by requesting an informal conference. If the citation is affirmed, a formal hearing may be requested within 30 days of the date the citation was affirmed. If the citation is dismissed after the informal conference, the request for a hearing on the matter of the citation shall be deemed to be withdrawn. If the citation, including any fine levied or order of abatement, is modified, the citation originally issued shall be considered withdrawn and a new citation issued. If a hearing is requested for a subsequent citation, it shall be requested within 30 days of service of that subsequent citation.

(6) Failure of a subscriber to pay a fine within 30 days of the date of assessment or comply with an order of abatement within the fixed time, unless the citation is being appealed, may result in disciplinary action taken by the department. If a citation is not

contested and a fine is not paid, the subscriber account will be terminated:

(A) A citation may be issued without the assessment of an administrative fine.

(B) Assessment of administrative fines may be limited to only particular violations of law or department regulations.

(d) Notwithstanding any other provision of law, if a fine is paid to satisfy an assessment based on the finding of a violation, payment of the fine shall be represented as a satisfactory resolution of the matter for purposes of public disclosure.

(e) Administrative fines collected pursuant to this section shall be deposited in the CURES Program Special Fund, available upon appropriation by the Legislature. These special funds shall provide support for costs associated with informal and formal hearings, maintenance, and updates to the CURES Prescription Drug Monitoring Program.

(f) The sanctions authorized under this section shall be separate from, and in addition to, any other administrative, civil, or criminal remedies; however, a criminal action may not be initiated for a specific offense if a citation has been issued pursuant to this section for that offense, and a citation may not be issued pursuant to this section for a specific offense if a criminal action for that offense has been filed.

(g) Nothing in this section shall be deemed to prevent the department from serving and prosecuting an accusation to suspend or revoke a subscriber if grounds for that suspension or revocation exist.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure that information in the CURES database is available to prescribing physicians so they may prevent the dangerous abuse of prescription drugs and to safeguard the health and safety of the people of this state, it is necessary that this act take effect immediately.

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Analysis Prepared by: Jimmy Fremgen / B. & P. / 916.319.3301

AB 505 Physicians and surgeons: probation

COMMITTEE ANALYSIS

Date of Hearing: May 3, 2017

ASSEMBLY COMMITTEE ON APPROPRIATIONS
Lorena Gonzalez Fletcher, Chair
AB 505 (Caballero) – As Amended March 27, 2017

Policy Committee: Business and Professions Vote: 15 - 0

Urgency: No State Mandated Local Program: No Reimbursable: No

SUMMARY:

This bill prohibits the Medical Board of California (MBC) from entering into a stipulation for disciplinary action if the stipulation places a licensee on probation and the operative accusation includes any of the following:

a) Felony conviction involving harm to patient safety or health.

b) Drug or alcohol abuse directly resulting in harm to patient safety or health.

c) Sexual act or sexual exploitation, as defined.

FISCAL EFFECT:

By reducing the number of cases that can enter into a stipulated judgment, this bill has the potential to significantly increase enforcement costs. The MBC projects costs to refer more cases to the Attorney General (AG) would be in the range of $3.5 to $4.4 million, and related costs to the Office of Administrative Hearings by $500,000 to $600,000 per year (reimbursed from the Contingent Fund of the Medical Board of California).

COMMENTS:

1) **Purpose**. This bill, sponsored by the California Medical Association, will effectively prohibit probation from being offered as a means to settle the enumerated accusations unless an investigation has been completed and reviewed by a judge.

2) **Background**. Stipulations are legal documents that typically contain admissions by the licensee to one or more violations of law and set forth a proposal for appropriate discipline. Appropriate discipline is based on the MBC's disciplinary guidelines, and for serious matters may include probation with terms and conditions, suspension, surrender of license, or even revocation. Stipulations are negotiated between the licensee or his/her attorney and the MBC's legal representative from the Office of the AG. Once a stipulation is agreed upon and signed by the licensee and the MBC's legal representative, the document is voted upon by the MBC. The MBC votes to either adopt the stipulation, reject it, or offer a counterproposal. If the licensee does not agree with the counterproposal, s/he has the right to request a formal hearing before an administrative law judge. This bill would reduce the number of cases for which stipulation is an option.

Analysis Prepared by: Lisa Murawski / APPR. / (916) 319-2081

Date of Hearing: April 25, 2017

ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS
Evan Low, Chair
AB 505 (Caballero) – As Amended March 27, 2017

SUBJECT: Physicians and surgeons: probation.

SUMMARY: Prohibits the Medical Board of California (MBC) from entering into a stipulated settlement for a disciplinary action with a physician if the underlying accusations of the complaint allege a felony conviction resulting in harm to patient safety; drug or alcohol abuse directly resulting in harm to patient safety; or, sexual acts or sexual exploitation.

EXISTING LAW:

1) Provides for the licensure and regulation of physicians and surgeons by MBC pursuant to the Medical Practice Act (Act). (BPC § 2000 *et. seq.*)

2) Requires the MBC to disclose on the Internet specified information in its possession, custody, or control regarding licensed physicians and surgeons, including: any felony convictions reported to the MBC after January 3, 1991; or, any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed. (BPC § 2027)

3) Requires MBC to investigate complaints from the public, other licensees, health care facilities or from others as specified. (BPC § 2220)

4) Requires MBC to prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. (BPC § 2220.05)

5) Sets forth what the MBC may do in disciplining a physician (e.g., revoke or suspend a license, place a physician on probation, etc); further states that a licensee can "Have any other action taken in relation to discipline as part of an order as the board or administrative law judge may deem proper." (BPC § 2227)

6) Requires the automatic suspension of a physician and surgeon's certificate during any time that the holder of the certificate is incarcerated after conviction of a felony, regardless of whether the conviction has been appealed. Requires the MBC, immediately upon receipt of the certified copy of the record of conviction, to determine whether the certificate of the physician and surgeon has been automatically suspended by virtue of his or her incarceration, and if so, the duration of that suspension. Requires the MBC to notify the physician and surgeon of the license suspension and of his or her right to elect to have the issue of penalty heard, as provided. (BPC § 2236.1)

THIS BILL:

1) Specifies that the MBC may not enter into any stipulation for disciplinary action, if the stipulation places a licensee on probation, and the operative accusation includes any of the following:

   a) Felony conviction involving harm to patient safety or health;

   b) Drug or alcohol abuse directly resulting in harm to patient safety or health; or,

   c) Sexual act or sexual exploitation.

FISCAL EFFECT: Unknown. This bill has been keyed fiscal by the Legislative Counsel.

COMMENTS:

Purpose. This bill is sponsored by the **California Medical Association**. According to the author, "AB 505 prohibits the Medical Board from entering into a stipulated settlement with a physician accused of certain enumerated violations unless there is a finding of fact by an administrative law judge after a full investigation by the board. These accusations include 1) felony convictions resulting in direct patient harm; 2) alcohol or drug abuse resulting in direct patient harm and 3) Sexual acts or sexual exploitation. This bill would effectively prohibit probation from being offered as a means to settle the enumerated accusations unless an investigation has been completed and reviewed by a judge."

Background. *MBC Enforcement Data*. According to information obtained from the MBC, in fiscal year 2015-2016, the Enforcement Program received 8,679 complaints against physicians and surgeons and unlicensed individuals alleged to be practicing medicine without a license. This was an increase of 412 complaints from the prior fiscal year. Since fiscal year 2012-2013, the MBC has seen a significant increase in complaints received. These complaints include allegations including excessive prescribing, gross negligence/incompetence, licensee self-abuse of drugs or alcohol, convictions of a crime and general unprofessional conduct.

Stipulated Settlements. According to information obtained from the Department of Consumer Affairs (DCA), stipulations are legal documents that typically contain admissions by the licensee to one or more violations of law and set forth a proposal for appropriate discipline. Appropriate discipline is based on the MBC's disciplinary guidelines which outline both minimum and maximum penalties for every violation of the Medical Practice Act.

Discipline comes in many forms and, depending on the admission(s) of misconduct, may include probation with terms and conditions, suspension, surrender of license, or even revocation. Minor violations are settled less stringently by way of reprimands, educational coursework or conferences, or perhaps an oral examination. Stipulations are negotiated between the licensee or his/her attorney and the MBC's legal representative from the Office of the Attorney General. Once a stipulation is agreed upon and signed by the licensee and the MBC's legal representative, the document is voted upon by the MBC. The MBC votes to either adopt the stipulation, reject it, or offer a counterproposal. If the licensee does not agree with the counterproposal, s/he has the right to request a formal hearing before an Administrative Law Judge.

Licensees who choose stipulated agreements over formal hearings waive their rights to further due process procedures and appeals and are legally bound by the terms of the penalty order, but in so doing, save time and money and often end up with the same penalty order that would result after a full administrative hearing. This bill would prohibit the option to enter into a stipulated settlement if the stipulation places a licensee on probation if the accusation includes felony conviction resulting in harm to patient safety; drug or alcohol abuse directly resulting in harm to patient safety; or, sexual acts or sexual exploitation.

ARGUMENTS IN SUPPORT:

The **California Medical Association** (sponsor) writes in support, "CMA believe AB 505 enhances the integrity of the profession by ensuring that serious allegations are fully investigated by an administrative law judge and probation can be offered only after a finding of fact. When serious allegations are leveled, it is important that they be treated in a manner that ensures public trust in the disciplinary process while maintain due process for physicians at the same time."

ARGUMENTS IN OPPOSITION:

None on file.

REGISTERED SUPPORT:

California Medical Association (sponsor)

REGISTERED OPPOSITION:

None on file.

Analysis Prepared by: Le Ondra Clark Harvey Ph.D. / B. & P. / 916-319-3301

PROPOSED LEGISLATION

AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 505

Introduced by Assembly Member Caballero

February 13, 2017

An act to add Section 2227.1 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 505, as amended, Caballero. Physicians and surgeons: probation.

Under existing law, a physician and surgeon whose matter has been heard by an administrative law judge, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the Medical Board of California, is authorized to be subject to, among other things, license revocation, suspension, or probation, as specified. Existing law authorizes the board to discipline a licensee by placing him or her on probation subject to specified conditions.

This bill would prohibit the board from entering into any stipulation for disciplinary ~~action, including placing~~ *action if the stipulation places* a licensee on ~~probation, if~~ *probation and* the operative accusation includes specified acts.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 2227.1 is added to the Business and Professions Code, to read:

2227.1. Notwithstanding Sections 2227 and 2228, the board may not enter into any stipulation for disciplinary ~~action, which includes placing~~ *action if the stipulation places* a licensee on ~~probation, if~~ *probation and* the operative accusation includes any of the following:

(a) Felony conviction involving harm to patient safety or health.

(b) Drug or alcohol abuse directly resulting in harm to patient safety or health.

(c) Sexual act or sexual exploitation as defined in Section 726 and subdivision (a) of Section 729.

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AB 703 Professions and vocations: licenses: fee waivers

PROPOSED LEGISLATION

ASSEMBLY BILL No. 703

Introduced by Assembly Member Flora

February 15, 2017

An act to add Section 115.7 to the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 703, as introduced, Flora. Professions and vocations: licenses: fee waivers.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law requires a board within the department to expedite the licensure process for an applicant who is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state if the applicant holds a current license in the same profession or vocation in another state, district, or territory. Existing law also requires a board to issue temporary licenses in specified professions to applicants as described above if certain requirements are met.

This bill would require every board within the Department of Consumer Affairs to grant a fee waiver for application and issuance of an initial license for an applicant who is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States if the applicant holds a current license in the same profession or vocation in another state, district, or territory. The bill would require that an applicant be granted fee waivers for both the application for and issuance of a license if the board charges fees for both. The bill would prohibit fee waivers from being issued for

renewal of a license, for an additional license, a certificate, a registration, or a permit associated with the initial license, or for the application for an examination.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 115.7 is added to the Business and Professions Code, to read:

115.7. (a) Notwithstanding any other law, every board within the department of Consumer Affairs shall grant a fee waiver for the application for and issuance of an initial license to an applicant who does both of the following:

(1) Supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with an active duty member of the Armed Forces of the United States.

(2) Holds a current, active, and unrestricted license that confers upon him or her the authority to practice, in another state, district, or territory of the United States, the profession or vocation for which he or she seeks a license from the board.

(b) If a board charges a fee for the application for a license and another fee for the issuance of a license, the applicant shall be granted fee waivers for both the application for and issuance of a license.

(c) A fee waiver shall not be issued for any of the following:

(1) Renewal of an existing California license.

(2) The application for and issuance of an additional license, a certificate, a registration, or a permit associated with the initial license.

(3) The application for an examination.

O

AB 715 Workgroup review of opioid pain reliever use and abuse

PROPOSED LEGISLATION

ASSEMBLY BILL No. 715

Introduced by Assembly Member Wood

February 15, 2017

An act to add and repeal Part 6.3 (commencing with Section 1179.90) of Division 1 of the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 715, as introduced, Wood. Workgroup review of opioid pain reliever use and abuse.

Existing law creates the State Department of Public Health and vests it with duties, powers, functions, jurisdiction, and responsibilities with regard to the advancement of public health.

This bill would require the department to convene a workgroup, comprised of members selected by the department, to review existing prescription guidelines and develop a recommended statewide guideline addressing best practices for prescribing opioid pain relievers. The bill would require the department, on or before March 1, 2019, to report the workgroup's conclusions and recommendations to the Legislature. The bill would repeal its provisions on January 1, 2020.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Opioid abuse is a serious problem that affects the health, social, and economic welfare of the state.

(b) After alcohol, prescription drugs are the most commonly abused substances by Americans over 12 years of age.

(c) Almost 2 million people in the United States suffer from substance use disorders related to prescription opioid pain relievers.

(d) Deaths involving prescription opioid pain relievers represent the largest portion of drug overdose deaths involving heroin or cocaine.

(e) The number of unintentional overdose deaths involving prescription opioid pain relievers has more than quadrupled since 1999.

SEC. 2. Part 6.3 (commencing with Section 1179.90) is added to Division 1 of the Health and Safety Code, to read:

PART 6.3 WORKGROUP REVIEW OF OPIOID PAIN RELIEVER USE AND ABUSE

1179.90. (a) The State Department of Public Health shall convene a workgroup to do all of the following:

(1) Review existing prescription guidelines, including, but not limited to, guidelines developed by the federal Centers for Disease Control and Prevention and the Medical Board of California.

(2) Develop a recommended statewide guideline addressing best practices for prescribing opioid pain relievers. In developing the statewide guideline, the workgroup may consider, among other things, evidence-based, peer-reviewed research, lessons learned from demonstration pilot projects, or other policies that have been successful in reducing opioid use and abuse.

(b) The State Department of Public Health shall determine the membership of the workgroup. Members of the workgroup may include multidisciplinary experts from the fields of pain management and substance abuse prevention and treatment.

1179.91. On or before March 1, 2019, the State Department of Public Health shall submit to the Legislature a report of the workgroup's conclusions and recommendations pursuant to paragraphs (1) and (2) of subdivision (a) of Section 1179.90 and any other recommendations made by the workgroup. The report shall be submitted in compliance with Section 9795 of the Government Code.

1179.92. This part shall remain in effect only until January 1, 2020, and as of that date is repealed.

O

AB 845 Cannabidiol

COMMITTEE ANALYSIS

Date of Hearing: April 18, 2017

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 845 (Wood) – As Amended March 28, 2017

SUBJECT: Cannabidiol.

SUMMARY: Authorizes a physician to prescribe and a pharmacist to dispense a product containing cannabidiol (CBD), if permitted under federal law. Contains an urgency clause to ensure that the provisions of this bill go into effect immediately upon enactment. Specifically, **this bill**:

1) Provides that if CBD is removed from Schedule I of the federal Controlled Substances Act (the Act) and placed on a schedule of the act other than Schedule I, or if a product composed of CBD is approved by the federal Food and Drug Administration (FDA) and either placed on a schedule of the act other than Schedule I, or exempted from one or more provisions of the act, so as to permit a physician to prescribe and a pharmacist to dispense that product, a physician who prescribes, and a pharmacist who dispenses, that product in accordance with federal law shall be deemed to be in compliance with state law governing those acts.

2) Indicates that upon the effective dates of the changes specified in 1) above, the prescription, furnishing, dispensing, transfer, possession, or use of a product composed of CBD in accordance with federal law is for a legitimate medical purpose and is authorized pursuant to state law.

3) Finds and declares that both children and adults with epilepsy are in desperate need of new treatment options and that CBD is showing potential as one of these treatments.

EXISTING LAW:

1) Establishes the federal Controlled Substances Act which regulates the manufacture, importation, possession, use and distribution of controlled substances such as hallucinogens, narcotics, depressants, and stimulants. Categorizes drugs into five schedules or classifications based on their potential for abuse, status in international treaties, and any medical benefits they may provide. Specifies that Schedule I drugs are considered the most harmful with no medical benefits, and includes marijuana in this schedule. Indicates that Schedule 5 substances are the least restricted.

2) Establishes the California Uniform Controlled Substances Act (UCSA), which among other provisions, classifies controlled substances into five designated schedules.

3) Requires, under UCSA, a prescription for a controlled substance to only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. Indicates that the responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility rests with the pharmacist who fills the prescription. Indicates that any person who knowingly violates this provision shall be punished by imprisonment not exceeding one year, or by a fine not exceeding twenty thousand dollars ($20,000), or by both fine and imprisonment.

4) Establishes Proposition 215, also known as the Compassionate Use Act of 1996, which exempts certain patients and their primary caregivers from criminal liability under state law for the possession and cultivation of marijuana.

5) Establishes the Medical Cannabis Regulation and Safety Act (MCRSA) to regulate medical cannabis in California, including its cultivation, transportation, storage, distribution, and sale, as specified in AB 243 (Wood), Chapter 688, Statutes of 2015; AB 266 (Bonta), Chapter 689, Statutes of 2015; and, SB 643 (McGuire), Chapter 719, Statutes of 2015.

6) Establishes within the Department of Consumer Affairs the Bureau of Medical Cannabis Regulation (Bureau) for the licensure and regulation of medical cannabis.

7) Establishes, through the voter initiative process, Proposition 64 or the Adult Use of Marijuana Act (AUMA) which permits adults 21 years of age or older to legally grow, possess, and use cannabis for non-medical purposes, as specified. Authorizes, beginning January 1, 2018, the selling and distributing of cannabis through a regulated business.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately one in 26 Americans will develop epilepsy at some point in their lifetime. There is no "one size fits all" treatment option and about one million people live with uncontrolled or intractable seizures. Uncontrolled seizures can lead to disability, injury, and even death, and many individuals living with uncontrolled seizures suffer from rare epilepsies characterized by seizures that are difficult to treat with existing treatment options. Access to new treatments is particularly important for these individuals, who live with the continual risk of serious injuries and loss of life.

The FDA is currently reviewing at least one CBD derived therapy that shows promise for the treatment of rare epilepsy conditions. This potential treatment option has both "Orphan Drug Designation" and Fast Track Designation from the FDA. Given the Fast Track Designation, this potential treatment option could be available as soon as early 2018.

Currently, any product that contains any material, compound, mixture, or preparation, which contains any quantity of marijuana is considered a Schedule I Controlled Substance unless specifically exempted. Under current law, should a product derived from CBD, like Epidiolex, be approved and rescheduled, it would still be considered a Schedule I substance under California statute and therefore could not be prescribed by a physician unless specifically exempted. Individuals suffering from these rare forms of epilepsy and those living with uncontrolled seizures would not be able to access the medication. This bill will ensure Californians with uncontrolled seizures have continued access to FDA approved epilepsy treatments derived from CBD.

2) BACKGROUND.

a) Cannabidiol. According to the National Cancer Institute at the National Institutes of Health, cannabis, also known as marijuana, produces resin containing compounds called

cannabinoids. Cannabinoids are active chemicals in cannabis that cause drug-like effects throughout the body, including the central nervous system and the immune system. The main active cannabinoid in Cannabis is delta-9-THC. Another active cannabinoid is CBD which may relieve pain, lower inflammation, and decrease anxiety without causing the "high" of delta-9-THC. Cannabinoids can be taken by mouth, inhaled, or sprayed under the tongue. Cannabis and CBD may have benefits in treating the symptoms of cancer of the side effects of cancer therapies. Two cannabinoids (dronabinol and nabilone) are drugs approved by the FDA for the prevention or treatment of chemotherapy-related nausea and vomiting The FDA has not approved Cannabis as a treatment for cancer or any other medical condition.

b) Epidiolex. As the author indicated, the FDA has granted orphan drug designation for a cannabis-based drug developed by GW Pharmaceutical to treat childhood-onset epilepsy. Although it does not have FDA approval (the manufacturer must demonstrate the efficacy of the drug in clinical trials), the orphan drug designation represents a tremendous step forward for cannabis-based medicine. The FDA grants the orphan drug designation to drugs intended to treat rare disorders. It qualifies the maker of the drug for certain tax incentives related to clinical testing as well as an exclusive marketing period for the drug.

Epidiolex contains a highly purified, plant-derived form of CBD, a non-psychoactive compound found in cannabis that doesn't produce the "high" sensation associated with THC, the plant's main psychoactive ingredient. CBD has long been used as a treatment for Dravet syndrome, a rare and severe form of epilepsy in children, and GW Pharmaceuticals sees Epidiolex as useful in treating both Dravet and Lennox-Gastaut syndrome (LGS), another rare form of childhood epilepsy.

c) 2016 Federal Rule. In December 2016, the Drug Enforcement Administration (DEA) finalized a federal rule entitled "Establishment of a New Drug Code for Marihuana Extract" and the DEA revealed a new identification number for marijuana extract, which is defined as "an extract containing one or more cannabinoids that has been derived from any plant of the genus Cannabis, other than the separated resin (whether crude or purified) obtained from the plant." The final rule states that the new identification number will help the DEA better track scientific studies on marijuana separately from CBD and other extracts. By making this distinction, DEA states it hopes to comply with international drug control treaties.

b) Governor's Budget Trailer Proposal. With the passage of AUMA, many inconsistencies were created between implementation of MCRSA and implementation of AUMA. The Governor, through a proposed budget trailer bill, is recommending several proposals to address the differences between MCRSA and AUMA. Among other provisions, the proposed trailer bill provides for: i) maintenance of local autonomy of zoning and planning decisions while providing state regulators with local compliance information; ii) adoption of AUMA's vertical integrated licensing structure for both adult use and medicinal cannabis licensees; iii) maintenance of AUMA's open distribution model allowing for a business to hold multiple licenses; iv) limitations on the number of Type 3 (medium size) cultivation licenses consistent with MCRSA; v) amendment of AUMA to include the same environmental protection requirements as MCRSA; and, vii) moving licensure of testing laboratories from the Department of Public Health to the Bureau.

3) **SUPPORT.** The Epilepsy Foundation of Greater Los Angeles, sponsor of this bill, states that passage of this bill would allow therapies derived from cannabidiol (CBD) and approved by the FDA to become available to patients. The FDA is currently reviewing at least one CBD derived therapy that show promise for the treatment of Dravet and Lennox Gastaut syndromes, tuberous sclerosis complex and potentially other rare epilepsies. The passing of this will would ensure Californians with uncontrolled seizures have continued access to FDA approved epilepsy treatment derived from CBD.

   The California Life Sciences Association states that as clinical evaluations of CBD continue, evidence grows of CBD's anti-seizure effects, though studies have also suggested potential anti-inflammatory, anti-anxiety, anti-psychotic, and analgesic benefits to the compound. One of the most promising applications for CBD is for the prevention and treatment of seizures in children with forms of drug-resistant epilepsy.

4) **RELATED LEGISLATION.** SJR 5 (Stone), which is pending in the Assembly, requests the United States Congress to pass a law to reschedule cannabis, marijuana, and its derivatives from a Schedule I drug, and for the President of the United States to sign such legislation.

REGISTERED SUPPORT / OPPOSITION:

Support

Epilepsy Foundation of Greater Los Angeles (sponsor)
California Life Sciences Association
Dravert Syndrome
Epilepsy Foundation of Northern California
LGS Foundation
Tuberous Sclerosis Alliance

Opposition

None on file.

Analysis Prepared by: Rosielyn Pulmano / HEALTH / (916) 319-2097

PROPOSED LEGISLATION

AMENDED IN ASSEMBLY MARCH 28, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

ASSEMBLY BILL No. 845

Introduced by Assembly Member Wood

February 16, 2017

An act to add Section 11150.2 to the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 845, as amended, Wood. Cannabidiol.

Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I, and the least restrictive limitations generally placed on controlled substances classified in Schedule V. Existing law places marijuana in Schedule I. Cannabidiol is a compound found in marijuana.

Existing law restricts the prescription, furnishing, possession, sale, and use of controlled substances, including marijuana and synthetic cannabinoid compounds, and makes a violation of those laws a crime, except as specified.

~~This bill would authorize, if federal law authorizes the prescription of a controlled substance containing cannabidiol, a physician to prescribe that substance in accordance with federal law. The bill would also provide that upon the enactment of federal law authorizing the prescription or the furnishing, transferring, possession, or use of a prescription for a controlled substance containing cannabidiol, notwithstanding any other state law, the prescription, furnishing,~~

~~transferring, possession, or use of that controlled substance in accordance with federal law is for a legitimate medical purpose and is authorized pursuant to state law.~~

This bill, if one of specified changes in federal law regarding the controlled substance cannabidiol occurs, would provide that a physician who prescribes and a pharmacist who dispenses a product composed of cannabidiol, in accordance with federal law, is in compliance with state law governing those acts. The bill would also provide that upon the effective date of one of those changes in federal law regarding cannabidiol, the prescription, furnishing, dispensing, transfer, possession, or use of that product in accordance with federal law is for a legitimate medical purpose and is authorized pursuant to state law.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares that both children and adults with epilepsy are in desperate need of new treatment options and that cannabidiol is showing potential as one of these treatments. If federal laws prohibiting the prescription of medications ~~containing~~ *composed of* cannabidiol are repealed or if an exception from the general prohibition is enacted permitting the prescription of drugs ~~containing~~ *composed of* cannabidiol, patients should have rapid access to this treatment option. The availability of this new prescription medication is intended to augment, not to restrict or otherwise amend, other cannabinoid treatment modalities currently available under state law.

~~SEC. 2. Section 11150.2 is added to the Health and Safety Code, to read:~~

~~11150.2. Notwithstanding any other law, if federal law authorizes the prescription of a controlled substance containing cannabidiol, a physician may prescribe that substance in accordance with federal law. For purposes of this chapter, including, but not limited to, Sections 11153 and 11153.5, upon the enactment of federal law authorizing the prescription or the furnishing, transferring possession, or use of a prescription for a controlled substance containing cannabidiol, notwithstanding any other state~~

~~law, the prescription, furnishing, transferring, possession, or use of that controlled substance in accordance with federal law is for a legitimate medical purpose and is authorized pursuant to state law.~~

SEC. 2. Section 11150.2 is added to the Health and Safety Code, to read:

11150.2. (a) Notwithstanding any other law, if cannabidiol is removed from Schedule I of the federal Controlled Substances Act and placed on a schedule of the act other than Schedule I, or if a product composed of cannabidiol is approved by the federal Food and Drug Administration and either placed on a schedule of the act other than Schedule I, or exempted from one or more provisions of the act, so as to permit a physician to prescribe and a pharmacist to dispense that product, a physician who prescribes, and a pharmacist who dispenses, that product in accordance with federal law shall be deemed to be in compliance with state law governing those acts.

(b) For purposes of this chapter, including, but not limited to, Sections 11153 and 11153.5, upon the effective date of one of the changes in federal law described in subdivision (a), notwithstanding any other state law, the prescription, furnishing, dispensing, transfer, possession, or use of a product composed of cannabidiol in accordance with federal law is for a legitimate medical purpose and is authorized pursuant to state law.

SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure that patients are able to obtain access to a new treatment modality as soon as federal law makes it available, it is necessary that this act take effect immediately.

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AB 1002 Center for Cannabis Research

PROPOSED LEGISLATION

ASSEMBLY BILL No. 1002

Introduced by Assembly Member Cooley
(Principal coauthor: Assembly Member Lackey)

February 16, 2017

An act to amend Sections 2525.1 and 19354 of the Business and Professions Code, and to amend Section 11362.9 of the Health and Safety Code, relating to medical cannabis.

LEGISLATIVE COUNSEL'S DIGEST

AB 1002, as introduced, Cooley. Center for Cannabis Research.

Existing law authorizes the creation by the University of California of the California Marijuana Research Program, the purpose of which is to develop and conduct studies intended to ascertain the general medical safety and efficacy of administering marijuana as part of a medical program and, if found valuable, to develop medical guidelines for the appropriate administration and use of marijuana. Existing law authorizes the program to conduct focused controlled clinical trials on the usefulness of marijuana on specified conditions, including cancer and glaucoma.

This bill would rename the program the Center for Cannabis Research and would expand the purview of the program to include the study of naturally occurring constituents of cannabis and synthetic compounds that have effects similar to naturally occurring cannabinoids. The bill would authorize the program to cultivate cannabis to be used exclusively for research purposes and to contract with a private entity to provide expertise in cultivating medical cannabis. The bill would also authorize the controlled clinical trials to focus on examining testing methods for

detecting harmful contaminants in marijuana, including mold and bacteria.

Existing law requires the President of the University of California, if the program is implemented, to appoint a multidisciplinary Scientific Advisory Council, not to exceed 15 members, to provide policy guidance in the creation and implementation of the program.

This bill would require the president to appoint the advisory council on the advice of the director of the program.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 2525.1 of the Business and Professions Code is amended to read:

2525.1. The Medical Board of California shall consult with the ~~California Marijuana Research Program, known as the~~ Center for ~~Medicinal~~ Cannabis Research, authorized pursuant to Section 11362.9 of the Health and Safety Code, on developing and adopting medical guidelines for the appropriate administration and use of medical cannabis.

SEC. 2. Section 19354 of the Business and Professions Code is amended to read:

19354. The bureau shall contract with the ~~California Marijuana Research Program, known as the~~ Center for ~~Medicinal~~ Cannabis Research, authorized pursuant to Section 11362.9 of the Health and Safety Code, to develop a study that identifies the impact that cannabis has on motor skills.

SEC. 3. Section 11362.9 of the Health and Safety Code is amended to read:

11362.9. (a) (1) It is the intent of the Legislature that the state commission objective scientific research by the premier research institute of the world, the University of California, regarding the efficacy and safety of administering ~~marijuana~~ *marijuana, its naturally occurring constituents, and synthetic compounds that have effects similar to naturally occurring cannabinoids,* as part of medical treatment. If the Regents of the University of California, by appropriate resolution, accept this responsibility, the University of California shall create a program, to be known as the ~~California Marijuana Research Program.~~ *Center for Cannabis Research.*

(2) The program shall develop and conduct studies intended to ascertain the general medical safety and efficacy of marijuana and, if found valuable, shall develop medical guidelines for the appropriate administration and use of marijuana. The studies may include studies to ascertain the effect of marijuana on motor ~~skills.~~ *skills and other behavioral and health outcomes*.

(b) The program may immediately solicit proposals for research projects to be included in the marijuana studies. Program requirements to be used when evaluating responses to its solicitation for proposals, shall include, but not be limited to, all of the following:

(1) Proposals shall demonstrate the use of key personnel, including clinicians or scientists and support personnel, who are prepared to develop a program of research regarding marijuana's general medical efficacy and safety.

(2) Proposals shall contain procedures for outreach to patients with various medical conditions who may be suitable participants in research on marijuana.

(3) Proposals shall contain provisions for a patient registry.

(4) Proposals shall contain provisions for an information system that is designed to record information about possible study participants, investigators, and clinicians, and deposit and analyze data that accrues as part of clinical trials.

(5) Proposals shall contain protocols suitable for research on marijuana, addressing patients diagnosed with acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV), cancer, glaucoma, or seizures or muscle spasms associated with a chronic, debilitating condition. The proposal may also include research on other serious illnesses, provided that resources are available and medical information justifies the research.

(6) Proposals shall demonstrate the use of a specimen laboratory capable of housing plasma, urine, and other specimens necessary to study the concentration of cannabinoids in various tissues, as well as housing specimens for studies of toxic effects of marijuana.

(7) Proposals shall demonstrate the use of a laboratory capable of analyzing marijuana, provided to the program under this section, for purity and cannabinoid content and the capacity to detect contaminants.

(c) In order to ensure objectivity in evaluating proposals, the program shall use a peer review process that is modeled on the process used by the National Institutes of Health, and that guards against funding research that is biased in favor of or against particular outcomes. Peer reviewers shall be selected for their expertise in the scientific substance and methods of the proposed research, and their lack of bias or conflict of interest regarding the applicants or the topic of an approach taken in the proposed research. Peer reviewers shall judge research proposals on several criteria, foremost among which shall be both of the following:

(1) The scientific merit of the research plan, including whether the research design and experimental procedures are potentially biased for or against a particular outcome.

(2) Researchers' expertise in the scientific substance and methods of the proposed research, and their lack of bias or conflict of interest regarding the topic of, and the approach taken in, the proposed research.

(d) If the program is administered by the Regents of the University of California, any grant research proposals approved by the program shall also require review and approval by the research advisory panel.

(e) It is the intent of the Legislature that the program be established as follows:

(1) The program shall be located at one or more University of California campuses that have a core of faculty experienced in organizing multidisciplinary scientific endeavors and, in particular, strong experience in clinical trials involving psychopharmacologic agents. The campuses at which research under the auspices of the program is to take place shall accommodate the administrative offices, including the director of the program, as well as a data management unit, and *laboratory* facilities for *detection and analysis of various naturally occurring and synthetic cannabinoids, as well as* storage of specimens.

(2) When awarding grants under this section, the program shall utilize principles and parameters of the other well-tested statewide research programs administered by the University of California, modeled after programs administered by the National Institutes of Health, including peer review evaluation of the scientific merit of applications.

(3) The scientific and clinical operations of the program shall occur, partly at University of California campuses, and partly at other postsecondary institutions, that have clinicians or scientists with expertise to conduct the required studies. Criteria for selection of research locations shall include the elements listed in subdivision (b) and, additionally, shall give particular weight to the organizational plan, leadership qualities of the program director, and plans to involve investigators and patient populations from multiple sites.

(4) The funds received by the program shall be allocated to various research studies in accordance with a scientific plan developed by the Scientific Advisory Council. As the first wave of studies is completed, it is anticipated that the program will receive requests for funding of additional studies. These requests shall be reviewed by the Scientific Advisory Council.

(5) The size, scope, and number of studies funded shall be commensurate with the amount of appropriated and available program funding.

(f) All personnel involved in implementing approved proposals shall be authorized as required by Section 11604.

(g) Studies conducted pursuant to this section shall include the greatest amount of new scientific research possible on the medical uses of, and medical hazards associated with, marijuana. The program shall consult with the Research Advisory Panel analogous agencies in other states, and appropriate federal agencies in an attempt to avoid duplicative research and the wasting of research dollars.

(h) The program shall make every effort to recruit qualified patients and qualified physicians from throughout the state.

(i) The marijuana studies shall employ state-of-the-art research methodologies.

(j) The program shall ensure that all marijuana used in the studies is of the appropriate medical quality and shall be obtained from the National Institute on Drug Abuse or any other federal agency designated to supply marijuana for authorized research. If these federal agencies fail to provide a supply of adequate quality and quantity within six months of the effective date of this section, the Attorney General shall provide an adequate supply pursuant to Section 11478.

(k) The program may review, approve, or incorporate studies and research by independent groups presenting scientifically valid protocols for medical research, regardless of whether the areas of study are being researched by the committee.

(*l*) (1) To enhance understanding of the efficacy and adverse effects of marijuana as a pharmacological agent, the program shall conduct focused controlled clinical trials on the usefulness of marijuana in patients diagnosed with AIDS or HIV, cancer, glaucoma, or seizures or muscle spasms associated with a chronic, debilitating condition. The program may add research on other serious illnesses, provided that resources are available and medical information justifies the research. The studies shall focus on comparisons of both the efficacy and safety of methods of administering the drug to patients, including inhalational, tinctural, and oral, evaluate possible uses of marijuana as a primary or adjunctive treatment, and develop further information on optimal dosage, timing, mode of administration, and variations in the effects of different cannabinoids and varieties of ~~marijuana.~~ *marijuana, or synthetic compounds that simulate the effects of naturally occurring cannabinoids. The studies may also focus on examining testing methods for detecting harmful contaminants in marijuana, including, but not limited to, mold, bacteria, and mycotoxins that could cause harm to patients.*

(2) The program shall examine the safety of marijuana in patients with various medical disorders, including marijuana's interaction with other drugs, relative safety of inhalation versus oral forms, and the effects on mental function in medically ill persons.

(3) The program shall be limited to providing for objective scientific research to ascertain the efficacy and safety of marijuana as part of medical treatment, and should not be construed as encouraging or sanctioning the social or recreational use of marijuana.

(m) (1) Subject to paragraph (2), the program shall, prior to any approving proposals, seek to obtain research protocol guidelines from the National Institutes of Health and shall, if the National Institutes of Health issues research protocol guidelines, comply with those guidelines.

(2) If, after a reasonable period of time of not less than six months and not more than a year has elapsed from the date the

program seeks to obtain guidelines pursuant to paragraph (1), no guidelines have been approved, the program may proceed using the research protocol guidelines it develops.

(n) In order to maximize the scope and size of the marijuana studies, the program may do any of the following:

(1) Solicit, apply for, and accept funds from foundations, private individuals, and all other funding sources that can be used to expand the scope or timeframe of the marijuana studies that are authorized under this section. The program shall not expend more than 5 percent of its General Fund allocation in efforts to obtain money from outside sources.

(2) Include within the scope of the marijuana studies other marijuana research projects that are independently funded and that meet the requirements set forth in subdivisions (a) to (c), inclusive. In no case shall the program accept any funds that are offered with any conditions other than that the funds be used to study the efficacy and safety of marijuana as part of medical treatment. Any donor shall be advised that funds given for purposes of this section will be used to study both the possible benefits and detriments of marijuana and that he or she will have no control over the use of these funds.

(o) The program may cultivate cannabis to be used exclusively for research purposes and may contract with a private entity to provide expertise in cultivating medical cannabis. Any program associated with the Center for Cannabis Research in cannabis cultivation shall be compliant with federal regulations governing cannabis manufacture.

~~(o)~~

(p) (1) ~~Within six months of the effective date of this section,~~ *By July 1,2017,* the program shall report to the Legislature, the Governor, and the Attorney General on the progress of the marijuana studies.

(2) Thereafter, the program shall issue a report to the Legislature every ~~six months~~ *year* detailing the progress of the studies. The interim reports required under this paragraph shall include, but not be limited to, data on all of the following:

(A) The names and number of diseases or conditions under study.

(B) The number of patients enrolled in each study by disease.

(C) Any scientifically valid preliminary findings.

~~(p)~~

(q) If the Regents of the University of California implement this section, the President of the University of ~~California~~ *California, on advice of the director of the program,* shall appoint a multidisciplinary Scientific Advisory Council, not to exceed 15 members, to provide policy guidance in the creation and implementation of the program. Members shall be chosen on the basis of scientific expertise. Members of the council shall serve on a voluntary basis, with reimbursement for expenses incurred in the course of their participation. The members shall be reimbursed for travel and other necessary expenses incurred in their performance of the duties of the council.

~~(q)~~

(r) No more than 10 percent of the total funds appropriated may be used for all aspects of the administration of this section.

~~(r)~~

(s) This section shall be implemented only to the extent that funding for its purposes is appropriated by the ~~Legislature in the annual Budget Act.~~ *Legislature.*

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TAB 8

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991
P (916) 928-8390 F (916) 928-8392 / www.ombc.ca.gov

MEMORANDUM

DATE	May 18, 2017
TO	Board Members
FROM	Angie Burton, Executive Director
SUBJECT	Proposed Changes to Continuing Medical Education Renewals to Allow Self-Certification subject to Board audit

Policy Issue: ***Changing the Renewal Requirement of Submission of CME to Allow Self-Certification Subject to Audit by the Board.***

Board approval of regulatory language to implement policy change of allowing self-certification of continuing medical education (CME) compliance subject to Board audit.

Background

Since 1995 the Osteopathic Medical Board of California (Board) has required all California licensed Doctors of Osteopathic Medicine (D.O.s) to demonstrate compliance with the Board's CME requirements by submitting documentation of completion. Completion of CME is a condition of renewal; until the Board can verify completion, the D.O.'s license cannot be renewed. The CME requirement is 150 hours over a three-year period. The review of the 150 hours for each renewal is time consuming and causes delays in renewal if submitted within 15 days of the license expiration date. Over the past several years, the Board has experienced a significant increase in the number of newly licensed D.O.s, which in turn has caused a significant increase in the Board's workload of CME review and renewals.

At the January 2017 Board meeting the Board approved changing the CME cycle from 3 year to 2 years. The CME requirement remains unchanged, but now only 100 CME are due every two years. The Board authorized the Executive Director to request the statutory change through the sunset review process. The Business and Professions Committee approved the request and the change has been placed in SB 798, the Board's sunrise bill. The Board also approved the concept of moving toward a self-certification of CMEs subject to Board audit, but postponed discussion of specific regulatory language.

Discussion

The change to self-certification would streamline the renewal process for both licensees and staff. This streamline proposal would eliminate delays in renewals and significantly reduce processing time. Reducing the processing time would also eliminate the gaps for licensees who become delinquent and are required to cease practice. Auditing CMEs would reduce workload and continue to protect public safety. While auditing CME would require the same review as occurs now, the key difference is that it would not be on a deadline of an expiration date. The constant deadline of processing CME review prior to renewal deadlines is causing stress and delays for both staff and licensees.

The Board has felt that requiring submission of all CMEs would ensure that all licensees in fact complete and comply with this requirement. The CME requirement is intended to function as a mechanism for both continued learning and competence. Requiring CMEs are intended to protect public safety and the Board's requirement to make completion a condition of renewal was designed to ensure accountability. This high standard of requiring submission of 100% of CMEs does protect public safety. However, requiring self-certification subject to Board audit also protects public safety. If a licensee is found in an audit to have failed to complete the 100 required hours of CME, the Board will issue a citation and fine of $1000 or more and they will be required to complete the deficient hours as a condition of their next renewal. The fine and required make-up of the deficient hour would protect public safety. The Board already has citation and fine authority for failure to complete required CMEs.

This streamline change would not change the CME requirements themselves, just how compliance is reported to the Board. The self-certification would reduce processing time, while the audit would identify non-compliance and impose penalties and required compliance as a condition of renewal. This streamline system would continue to protect public safety.

Recommendation:

Approval of change in renewal requirements to only require self-certification of completion of CMEs subject to random audits by the Board. Approval of the proposed regulatory language and self-certification form.

Proposed Language

California Code of Regulations Section(s)

1635: Required Continuing Medical Education
1636: Continuing Medical Education Progress Report
1641: Sanctions for Noncompliance

OMBC Revisions to CME Renewal Requirements to Add Audit and Self- Certification Provisions

PROPOSED REGULATORY LANGUAGE

The amendment format is as follows: Existing language remains unchanged; new wording is underlined; wording proposed for deletion is identified with strikeout lines through the wording to be deleted.

Amendment 1: CCR Section 1635 Required Continuing Medical Education (CME)

(a) Each physician and surgeon submitting the tax and registration fee shall submit satisfactory proof to the Board of ongoing compliance with the provisions of this article at the times specified herein.

(b) Commencing January 1, ~~1989~~2019, each physician and surgeon shall complete ~~150~~ 100 hours during each ~~three-year~~ two-year period immediately preceding the expiration date of his or her license in order ~~prior to renewal~~ to satisfy the CME requirement; this ~~three~~ two-year period is defined as the "CME requirement period."

(c) The requirement of ~~150~~100 hours during the ~~three~~ two-year CME requirement period shall include a minimum of ~~60~~40 hours of CME in American Osteopathic Association (AOA)Category 1-A or 1B defined by the American Osteopathic Association (AOA). The balance of the CME requirement of ~~90~~60 hours may consist of CME as defined by either the American Osteopathic Association (AOA) or the American Medical Association (AMA) and ~~may~~ shall be completed within the entire ~~three~~ two-year CME requirement period.

(d) Effective January 1, ~~1989~~2018, the ~~three~~ two-year CME period shall commence for those licensed on or before January 1, ~~1989~~2018. Those licensed subsequent to January 1, ~~1989~~2018 shall commence their ~~three~~ two-year CME requirement period on ~~a prorate basis commencing~~ the first full calendar year subsequent to initial licensure. Subsequent ~~three~~ two-year periods shall not include CME earned during a preceding ~~three~~ two-year requirement period.

(e) AOA Category 1-A, or other CME is defined by the American Osteopathic Association (AOA), set forth in the American Osteopathic Association's "Continuing Medical Education Guide," and is hereby incorporated by reference and can be obtained from the AOA at 142 E Ontario Street, Chicago, IL 60611; it is published once every three years by the AOA most recently in ~~1992~~ 2016. American Medical Association (AMA) CME~~Category 1~~ defined by the American Medical Association is set forth in "Physicians Recognition Award Information Booklet," and is hereby incorporated by reference and can be obtained from the American Medical

Association, ~~515 North State Street, Chicago, IL 60610~~ AMA Plaza, 330 N. Wabash Ave., Suite 39300, Chicago, IL 60611-5885; it is published on an occasional basis most recently in ~~January, 1986~~ 2010.

(f) All physicians and surgeons shall complete a one-time mandatory 12 credit hours of continuing medical education in the subjects of pain management and the treatment of terminally ill and dying patients as a condition of renewal. Each physician and surgeon shall self-certify compliance with this one-time requirement subject to audit on the renewal form. Physicians and surgeons shall complete this requirement within four years of their initial license or by their second renewal date, whichever occurs first.

Amendment 2: CCR Section 1636 Continuing Medical Education Progress Report

Each physician and surgeon shall report the total number of continuing medical education (CME) hours to the Board with the renewal application. This may be accomplished by:

(a) Effective January 1, 2018 each physician and surgeon shall self-certify completion of the required Continuing Medical Education (CME) hours by submitting to the Board a completed Continuing Medical Education Self-Certification Renewal Form (OMB-21, Effective 1/2018), which is hereby incorporated by reference. Incomplete forms shall not be deemed ineligible for renewal.

(b) CME categories are defined by Section 1635.

(c) Effective January 1, 2018 Physicians and surgeons shall be subject to audit of their CME hours. Each physician and surgeon shall retain all documents that demonstrate compliance with the CME requirement. Documents demonstrating compliance include:

(1) A copy of their computer printout of CME activity as compiled from documents submitted to the AOA Division of Continuing Medical Education by both sponsors and the physician (Individual Activity Report) which will list the amount of CME credit hours, or

(2) Copies of any certificates given for the CME credit hours of attendance at any program approved by the Board, or

(3) Reports from any program approved by the Board, to be furnished by the physician and surgeon, showing his or her CME credit hours of attendance as verified by the program organizers.

~~(a) The physician sending the Board a copy of their computer printout of CME activity as compiled from documents submitted to the AOA Division of Continuing Medical Education by both sponsors and the physician (Individual Activity Report) which will list the amount of CME credit hours, or~~

~~(b) Sending the Board copies of any certificates given for the CME credit hours of attendance at any program approved by the Board, or~~

~~(c) Reports from any program approved by the Board, to be furnished by the physician, showing his CME credit hours of attendance hour as verified by the program organizers.~~

~~CME categories are defined by Section 1635 (f).~~

Amendment 3: CCR Section 1641 Sanctions for Non-Compliance

(a) Any physician and surgeon who has not completed ~~150~~ 100 hours of approved CME ~~or the prorated share pursuant to Section 1635 (d)~~ during the ~~three~~ two-year CME requirement period will be required to make up any deficiency unless a waiver is obtained pursuant to Section 1637. Any physician who fails to complete the deficient hours shall be ineligible for renewal of his or her license to practice medicine until such time as the CME are documented to the Board.

(b) It shall constitute unprofessional conduct and grounds for disciplinary action including the filing of an accusation or citation and fine, for any physician to misrepresent his or her compliance with the provisions of this article or who fails to comply with the provisions of this article.

(c) The Board shall randomly audit physicians and surgeons who have reported compliance with the CME requirement. Those physicians and surgeons selected for audit shall be required to document their compliance with the CME requirements as specified by this article. Each physician and surgeon shall retain records for a minimum of ~~four~~ six years of all CME programs attended which indicate the title of the course or program attended, dates of attendance, the length of the course or program, the sponsoring organization and the accrediting organization, if any.

Section 1661.2:
Diversion Evaluation Committee
Duties and Responsibilities

Iu98oOSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Proposed Language

Changes to the originally proposed language are shown by underlining for new text and strikethrough for deleted text.

1. Amend Section 1661.2 of Division 16 of Title 16 of the California Code of Regulations to read as follows:

§ 1661.2 Diversion Evaluation Committee Duties and Responsibilities.

A diversion evaluation committee shall have the following duties and responsibilities in addition to those set forth in Section 2366 of the Code:

(a) To consider recommendations of the program manager and any consultants to the committee;

(b) To set forth in writing for each physician in a program a treatment and rehabilitation plan established for that physician with the requirement for supervision and surveillance.

(c) To use the uniform standards for substance-abusing licensees contained in Title 16, California Code of Regulations, Section 1663 Disciplinary Guidelines (08/1/17).

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p.xciii), Section 1; and Section 3600-1, Business and Professions Code. Reference: Section 2366, Business and Professions Code.

2. Amend Section 1663 of Division 16 of Title 16 of the California Code of Regulations to read as follows:

§ 1663. Disciplinary Guidelines.

(a)In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Osteopathic Medical Board of California shall consider the disciplinary guidelines entitled "Osteopathic Medical Board of California Disciplinary Guidelines of ~~1996~~ 2017"(Rev 05/17) ("Guidelines"), which are hereby incorporated by reference. Subject to the limitations of subsection (c), deviation from ~~these g~~Guidelines and orders, including the standard terms of probation, is appropriate where the Osteopathic Medical Board of California in its sole discretion determines that the facts of the particular case warrant such a deviation – for example: the presence of mitigating factors; the age of the case; evidentiary problems.

(b)(1) Notwithstanding the Guidelines, any proposed decision issued in accordance with the procedures set forth in Chapter 5 (commencing with Section

11500) of Part 1 of Division 3 of Title 2 of the Government Code that contains any finding of fact that the licensee engaged in any act of sexual contact, as defined in subdivision (c) of Section 729 of the Code, with a patient, or any finding that the licensee has committed a sex offense or been convicted of a sex offense, shall contain an order revoking the license. The propose decision shall not contain an order staying the revocation of the license.

(2) As used in this section, the term "sex offense" shall mean any of the following:

(a) Any offense for which registration is required by Section 290 of the Penal Code or a finding that a person committed such an offense.

(b) Any offense defined in Section 261.5, 313.1, 647b, or 647 subdivision (a) or (d) of the Penal Code or a finding that a person committed such an offense.

(c) Any attempt to commit any of the offenses specified in this section.

(d) Any offense committed or attempted in any other state or against the laws of the United State which, if committed or attempted in this state, would be punishable as one or more of the offenses specified in this section.

(c)If the conduct found to be a violation involves use of drugs, alcohol, or both, and the individual is permitted to practice under conditions of probation, a clinical diagnostic evaluation shall be ordered as a condition of probation in every case to determine whether licensee is a substance abusing licensee. The clinical diagnostic evaluator's report shall be submitted in its entirety to the board.

(1)The "Uniform Guidelines for Substance Abusing Licensees" as forth in the "Disciplinary Guidelines", shall be used in applying the probationary terms and conditions imposed pursuant to this subsection, but may be imposed contingent upon the outcome of the clinical diagnostic evaluation.

(2)The Board defines a substance abusing licensee as a license who undergoes a clinical diagnostic evaluation and the findings of the clinical diagnostic evaluator determine that the licensee is a substance abusing licensee.

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p.xciii), Sections 1, 2018, 2451, and 3600-1, Business and Professions Code~~; and Section 11400.21, Government Code~~. Reference: Sections 315, 726 and 729, 2246 Business and Professions Code; Section~~s 11400.21 and~~ 11425.50(e), Government Code; Sections 261.5, 290, 313.1, 647b, and 647 subdivision (a) or (d), Penal Code.

Section 1663:
Disciplinary Guidelines (Senate Bill 1441 Uniform Standards)

OSTEOPATHIC MEDICAL BOARD

OF CALIFORNIA

DISCIPLINARY GUIDELINES OF 2017

Osteopathic Medical Board of California
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OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA DISCIPLINARY GUIDELINES OF 2017

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PART I. OVERVIEW

INTRODUCTION

The Osteopathic Medical Board of California (Board) is a consumer protection agency with the primary mission of protecting consumers of osteopathic physician and surgeon services within the State of California. In keeping with its mission and obligation to ensure the safe and qualified practice of Osteopathic Medicine, the Board has adopted the following recommended guidelines for disciplinary orders and model terms and conditions of probation for violations of the Osteopathic and Medical Acts.

The Disciplinary Guidelines are designed for use in the disciplinary process including for hearings and settlement of cases by attorneys, administrative law judges (ALJ) and the Board. The Board may revise these guidelines from time to time as necessary.

These guidelines include general factors to be considered, Uniform, Standards for Substance Abusing Licensees, probationary terms and conditions, and penalty guidelines for specific offense(s). The guidelines for specific offense(s) reference the applicable statutory and regulatory provision(s).

The terms and conditions of probation are divided into three general categories:

(1) Standard Terms and Conditions are those terms and conditions, which should be used in all cases;

(2) Optional Terms and Conditions are those terms and conditions, which may be used to address the sustained violations and any significant mitigating or aggravating circumstances of a particular case;

(3) Uniform Standards for Substance-Abusing Licensee Terms and Conditions are those terms and conditions of probation that are required to be used in cases involving the licensee's use of drugs and/or alcohol.

ORGANIZATION OF DISCIPLINARY GUIDELINES

These Disciplinary Guidelines are divided into four parts.

Part I begins with an introductory overview of the purpose and organization of these guidelines. The General Considerations section lays out general considerations that ALJs and other users of this document should consider when a matter is being resolved. There is a section that defines each type of discipline.

Part II incorporates the Uniform Standards for Substance Abusing Licensees into the Disciplinary Guidelines in its entirety. These standards are strictly applicable to violations involving the licensee use of alcohol and/ or drugs and require the Board and ALJs to follow them when determining final disciplinary orders and outcomes for such violations. These standards include disciplinary terms and conditions for cases involving substance abusing licensees. The standards also include administrative standards and requirements related to vendors, disclosure, data gathering and reporting.

Part III, Model Language for Probationary Orders contains recommended Terms and Conditions for probationary orders. It is divided into two categories: Standard Terms and Conditions; Optional Terms and Conditions Specific to the Violation. Section A lists the Standard Terms and Conditions of Probation. Section B lists the Optional Terms and Conditions for non-substance abuse violations. The Standard Terms and Conditions in Section A must be included in all disciplinary orders; whereas, the Terms and Conditions listed in Sections B are considered optional because they are not required to be in every disciplinary order and thus are optional based on the nature of the violation(s). The terms and conditions contained in Section C only apply to cases involving licensee use of alcohol and/ or drugs.

Part IV contains recommended discipline for each violation. This section is organized by violation. Each violation lists the statutory cause of action and what the recommended minimum discipline and terms and conditions that apply.

GENERAL CONSIDERATIONS

Each disciplinary matter must be considered on a case-by-case basis. The Board carefully considers the totality of the facts and circumstances of each case, with the safety of the consuming public for medical services being paramount. Consequently, in reaching a resolution via a stipulated settlement and disciplinary order, or a proposed decision following an administrative hearing, the Board requests that the factual basis for each resolution be clearly delineated.

The Board requests that proposed decisions following administrative hearings include the following:

1. Specific code sections violated with their definitions.
2. Clear description of the violation.
3. Respondent's explanation of the violation if he/she is present at the hearing.
4. Findings regarding aggravation, mitigation, and rehabilitation where appropriate.
5. When suspension or probation is ordered, the Board requests that the disciplinary order include terms within the recommended guidelines for that offense unless the reason for departure from the recommended terms is clearly set forth in the findings and supported by evidence.

In determining whether revocation, suspension or probation is to be imposed in a given case, the following factors should be considered:

1. Nature and severity of the act(s), offense(s), or crimes(s) under consideration.
2. Actual or potential harm to any consumer, client or the general public,
3. Prior disciplinary record.
4. Number and/or variety of current violations.
5. Mitigation evidence.
6. Rehabilitation evidence.
7. In the case of a criminal conviction, compliance with terms of sentence and/or court-ordered probation.
8. Overall criminal record.

9. Time passed since the acts(s) or offense(s) occurred.
10. Whether or not the respondent cooperated with the Board's investigation, other law enforcement or regulatory agencies, and/or the injured parties.
11. Recognition by respondent of his or her wrongdoing and demonstration of corrective action to prevent recurrence.

DEFINITIONS: TYPES OF DISCIPLINE

Revocation: Permanent loss of a license. Once the license is revoked, respondent may take affirmative action to petition the Board for reinstatement of his/her license and demonstrate to the Board's satisfaction that he/she is rehabilitated.

Suspension: Invalidation of a license for a temporary, fixed period. The licensee must cease practice immediately and may not practice during any period of suspension.

Stayed Revocation: Revocation of a license, held in abeyance pending respondent's compliance with the terms of his/her probation. This stay of probation is conditioned on full compliance with the terms and conditions of probation.

Stayed Suspension: Suspension of a license, held in abeyance pending respondent's compliance with the legal terms of his/her probation. The stay of a suspension order is conditioned on full compliance with the terms and conditions of probation.

Probation: A period during which a respondent's discipline is stayed in exchange for respondent's compliance with specified conditions relating to the violation(s).

Uniform Standards for Substance Abusing Licensees. The standards adopted pursuant to Business and Professions Code Section 315 by the Substance Abuse Coordination Committee in April, 2011, relating to substance abusing licensees. These are specific standards applying to cases involving substance abusing licensees.

PART II UNIFORM STANDARDS FOR SUBSTANCE ABUSING LICENSEES

Pursuant to Section 315 of the Business and Professions Code and its regulations, the Board uses the standards developed by the Substance Abuse Coordination Committee (SACC) for substance abusing licensees. On April 11, 2011, the SACC's Uniform Standards for Substance Abusing Licensees (Uniform Standards) were issued. Administrative law judges, parties and staff are therefore required to use the language below when the violation involved the licensee's use of drugs, alcohol, or both.

To that end, unless the condition is permissive in the Uniform Standards and noted below, each of the following probationary terms and conditions must be used in every case where theviolation involved the use of drugs, alcohol, or both. Despite this requirement, appropriate additional optional conditions should still be used in formulating the penalty and in considering additional optional terms or conditions of probation appropriate for greater publicprotection.

If the conduct is found to be a violation involves use of drugs, alcohol, or both, a clinical diagnostic evaluation shall be ordered by the Board as a condition of probation. This clinical diagnostic evaluation determines and defines whether the licensee is in fact a substance abusing licensee and therefore subject to compliance with the Uniform Standards for Substance Abusing Licensees. In cases, in which, the clinical diagnostic evaluator's report finding is that the individual is not a substance-abusing licensee, then the remaining provisions of the Uniform Standards may be waived. If the violation did not involve the use of drugs or alcohol, but the facts of the case suggest that the terms are warranted, the conditions may be applied to ensure the public is protected.

Diversion Program

There are two pathways into the Board's drug and alcohol recovery monitoring program: 1) Participants with drug and/or alcohol addiction issues who have self-referred to the program and are not under a disciplinary order; and, 2) Participants who have been ordered into the Board's Diversion program as a result of violations related to drug and/or alcohol use.

Self-Referrals

A licensee can at any time enroll in the Board's Diversion program. In these self-referral cases, the Board may not have any conviction or evidence of alcohol or substance abuse to warrant disciplinary action. When a licensee enrolls in the Board's Diversion program as a self-referral, the participation is confidential. Each licensee who requests participation in the Diversion program shall agree to cooperate with the Board's Diversion program designed for him or her. Any failure to comply with the program may result in termination of participation in the program.

If a self-referred participant is determined to be too great a risk to the public health, safety, and welfare to continue the practice, the facts shall be reported to the Executive Director of the Board and all documents and information pertaining to and supporting that conclusion shall be provided to the Executive Director. The matter may be referred for investigation and disciplinary action by the Board.

Probationary Participants

Probationary participants are required to comply with terms of probation or risk losing their license. A clinical diagnostic evaluation will be ordered as a term of probation and the conditions applying the Uniform Standards will be included.

Uniform Standards Regarding Substance-Abusing Healing Arts Licensees

Senate Bill 1441 (Ridley-Thomas)

Implemented
by
Department of Consumer Affairs,
Substance Abuse Coordination Committee

Brian J. Stiger, Director
April 2011

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#1 SENATE BILL 1441 REQUIREMENT

Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

#1 Uniform Standard

If a healing arts Board orders a licensee who is either in a diversion program or whose license is on probation due to a substance abuse problem to undergo a clinical diagnosis evaluation, the following applies:

1. The clinical diagnostic evaluation shall be conducted by a licensed practitioner who:

    - holds a valid, unrestricted license, which includes scope of practice to conduct a clinical diagnostic evaluation;

    - has three (3) years experience in providing evaluations of health professionals with substance abuse disorders; and,

    - is approved by the Board.

2. The clinical diagnostic evaluation shall be conducted in accordance with acceptable professional standards for conducting substance abuse clinical diagnostic evaluations.

3. The clinical diagnostic evaluation report shall:

    - set forth, in the evaluator's opinion, whether the licensee has a substance abuse problem;

    - set forth, in the evaluator's opinion, whether the licensee is a threat to himself/herself or others; and,

    - set forth, in the evaluator's opinion, recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee's rehabilitation and safe practice.

The evaluator shall not have a financial relationship, personal relationship, or business relationship with the licensee within the last five years. The evaluator shall provide an objective, unbiased, and independent evaluation.

If the evaluator determines during the evaluation process that a licensee is a threat to himself/herself or others, the evaluator shall notify the Board within 24 hours of such a determination.

For all evaluations, a final written report shall be provided to the Board no later than ten (10) days from the date the evaluator is assigned the matter unless the evaluator requests additional information to complete the evaluation, not to exceed 30 days.

#2 SENATE BILL 1441 REQUIREMENT

Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation described in subdivision (a) and any treatment recommended by the evaluator described in subdivision (a) and approved by the Board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

#2 Uniform Standard

The following practice restrictions apply to each licensee who undergoes a clinical diagnostic evaluation:

1. The Board shall order the licensee to cease practice during the clinical diagnostic evaluation pending the results of the clinical diagnostic evaluation and review by the diversion program/Board staff.

2. While awaiting the results of the clinical diagnostic evaluation required in Uniform Standard #1, the licensee shall be randomly drug tested at least two (2) times per week.

After reviewing the results of the clinical diagnostic evaluation, and the criteria below, a diversion or probation manager shall determine, whether or not the licensee is safe to return to either part-time or fulltime practice. However, no licensee shall be returned to practice until he or she has at least 30 days of negative drug tests.

- the license type;
- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use
- the scope and pattern of use;
- the treatment history;
- the licensee's medical history and current medical condition;
- the nature, duration and severity of substance abuse, and
- whether the licensee is a threat to himself/herself or the public.

#3 SENATE BILL 1441 REQUIREMENT

Specific requirements that govern the ability of the licensing Board to communicate with the licensee's employer about the licensee's status or condition.

#3 Uniform Standard

If the licensee who is either in a Board diversion program or whose license is on probation has an employer, the licensee shall provide to the Board the names, physical addresses, mailing addresses, and telephone numbers of all employers and supervisors and shall give specific, written consent that the licensee authorizes the Board and the employers and supervisors to communicate regarding the licensee's work status, performance, and monitoring.

#4 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomnicity, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

#4 Uniform Standard

The following standards shall govern all aspects of testing required to determine abstention from alcohol and drugs for any person whose license is placed on probation or in a diversion program due to substance use:

TESTING FREQUENCY SCHEDULE

A Board may order a licensee to drug test at any time. Additionally, each licensee shall be tested RANDOMLY in accordance with the schedule below:

Level	**Segments of Probation/Diversion**	Minimum Range of Number of Random Tests
I	Year 1	52-104 per year
II*	Year 2+	36-104 per year

*The minimum range of 36-104 tests identified in level II, is for the second year of probation or diversion, and each year thereafter, up to five (5) years. Thereafter, administration of one (1) time per month if there have been no positive drug tests in the previous five (5) consecutive years of probation or diversion.

Nothing precludes a Board from increasing the number of random tests for any reason. Any Board who finds or has suspicion that a licensee has committed a violation of a Board's testing program or who has committed a Major Violation, as identified in Uniform Standard 10, may reestablish the testing cycle by placing that licensee at the beginning of level I, in addition to any other disciplinary action that may be pursued.

EXCEPTIONS TO TESTING FREQUENCY SCHEDULE

I. PREVIOUS TESTING/SOBRIETY
In cases where a Board has evidence that a licensee has participated in a treatment or monitoring program requiring random testing, prior to being subject to testing by the Board, the Board may give

consideration to that testing in altering the testing frequency schedule so that it is equivalent to this standard.

II. VIOLATION(S) OUTSIDE OF EMPLOYMENT

An individual whose license is placed on probation for a single conviction or incident or two convictions or incidents, spanning greater than seven years from each other, where those violations did not occur at work or while on the licensee's way to work, where alcohol or drugs were a contributing factor, may bypass level I and participate in level II of the testing frequency schedule.

III. NOT EMPLOYED IN HEALTH CARE FIELD

A Board may reduce testing frequency to a minimum of 12 times per year for any person who is not practicing OR working in any health care field. If a reduced testing frequency schedule is established for this reason, and if a licensee wants to return to practice or work in a health care field, the licensee shall notify and secure the approval of the licensee's Board. Prior to returning to any health care employment, the licensee shall be subject to level I testing frequency for at least 60 days. At such time the person returns to employment (in a health care field), if the licensee has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

IV. TOLLING

A Board may postpone all testing for any person whose probation or diversion is placed in a tolling status if the overall length of the probationary or diversion period is also tolled. A licensee shall notify the Board upon the licensee's return to California and shall be subject to testing as provided in this standard. If the licensee returns to employment in a health care field, and has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

V. SUBSTANCE USE DISORDER NOT DIAGNOSED

In cases where no current substance use disorder diagnosis is made, a lesser period of monitoring and toxicology screening may be adopted by the Board, but not to be less than 24 times per year.

OTHER DRUG STANDARDS

Drug testing may be required on any day, including weekends and holidays.

The scheduling of drug tests shall be done on a random basis, preferably by a computer program, so that a licensee can make no reasonable assumption of when he/she will be tested again. Boards should be prepared to report data to support back-to-back testing as well as, numerous different intervals of testing.

Licensees shall be required to make daily contact to determine if drug testing is required.

Licensees shall be drug tested on the date of notification as directed by the Board.

Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S. Department of Transportation.

Specimen collectors shall adhere to the current U.S. Department of Transportation Specimen Collection Guidelines.

Testing locations shall comply with the Urine Specimen Collection Guidelines published by the U.S. Department of Transportation, regardless of the type of test administered.

Collection of specimens shall be observed.

Prior to vacation or absence, alternative drug testing location(s) must be approved by the Board.

Laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.

A collection site must submit a specimen to the laboratory within one (1) business day of receipt. A chain of custody shall be used on all specimens. The laboratory shall process results and provide legally defensible test results within seven (7) days of receipt of the specimen. The appropriate Board will be notified of non-negative test results within one (1) business day and will be notified of negative test results within seven (7) business days.

A Board may use other testing methods in place of, or to supplement biological fluid testing, if the alternate testing method is appropriate.

PETITIONS FOR REINSTATEMENT

Nothing herein shall limit a Board's authority to reduce or eliminate the standards specified herein pursuant to a petition for reinstatement or reduction of penalty filed pursuant to Government Code section 11522 or statutes applicable to the Board that contains different provisions for reinstatement or reduction of penalty.

OUTCOMES AND AMENDMENTS

For purposes of measuring outcomes and effectiveness, each Board shall collect and report historical and post implementation data as follows:

Historical Data - Two Years Prior to Implementation of Standard

Each Board should collect the following historical data (as available), for a period of two years, prior to implementation of this standard, for each person subject to testing for banned substances, who has 1) tested positive for a banned substance, 2) failed to appear or call in, for testing on more than three occasions, 3) failed to pay testing costs, or 4) a person who has given a dilute or invalid specimen.

Post Implementation Data- Three Years

Each Board should collect the following data annually, for a period of three years, for every probationer and diversion participant subject to testing for banned substances, following the implementation of this standard.

Data Collection

The data to be collected shall be reported to the Department of Consumer Affairs and the Legislature, upon request, and shall include, but may not be limited to:

Probationer/Diversion Participant Unique Identifier
License Type
Probation/Diversion Effective Date
General Range of Testing Frequency by/for Each Probationer/Diversion Participant Dates Testing Requested
Dates Tested
Identify the Entity that Performed Each Test
Dates Tested Positive
Dates Contractor (if applicable) was informed of Positive Test Dates
Board was informed of Positive Test
Dates of Questionable Tests (e.g. dilute, high levels) Date
Contractor Notified Board of Questionable Test Identify
Substances Detected or Questionably Detected Dates Failed to Appear
Date Contractor Notified Board of Failed to Appear
Dates Failed to Call In for Testing
Date Contractor Notified Board of Failed to Call In for Testing Dates Failed to Pay for Testing
Date(s) Removed/Suspended from Practice (identify which) Final Outcome and Effective Date (if applicable)

#5 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

#5 Uniform Standard

If a Board requires a licensee to participate in group support meetings, the following shall apply:

When determining the frequency of required group meeting attendance, the Board shall give consideration to the following:

- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use;
- the recommendation of the clinical evaluator;
- the scope and pattern of use;
- the licensee's treatment history; and,
- the nature, duration, and severity of substance abuse.

Group Meeting Facilitator Qualifications and Requirements:

1. The meeting facilitator must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or other nationally certified organizations.
2. The meeting facilitator must not have a financial relationship, personal relationship, or business relationship with the licensee within the last year.
3. The group meeting facilitator shall provide to the Board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.
4. The facilitator shall report any unexcused absence within 24 hours.

#6 SENATE BILL 1441 REQUIREMENT

Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

#6 Uniform Standard

In determining whether inpatient, outpatient, or other type of treatment is necessary, the Board shall consider the following criteria:

- recommendation of the clinical diagnostic evaluation pursuant to Uniform Standard #1;
- license type;
- licensee's history;
- documented length of sobriety/time that has elapsed since substance abuse;
- scope and pattern of substance use;
- licensee's treatment history;
- licensee's medical history and current medical condition;
- nature, duration, and severity of substance abuse, and
- threat to himself/herself or the public.

#7 SENATE BILL 1441 REQUIREMENT

Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

#7 Uniform Standard

A Board may require the use of worksite monitors. If a Board determines that a worksite monitor is necessary for a particular licensee, the worksite monitor shall meet the following requirements to be considered for approval by the Board.

1. The worksite monitor shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the Board; however, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.

2. The worksite monitor's license scope of practice shall include the scope of practice of the licensee that is being monitored, be another health care professional if no monitor with like practice is available, or, as approved by the Board, be a person in a position of authority who is capable of monitoring the licensee at work.

3. If the worksite monitor is a licensed healthcare professional he or she shall have an active unrestricted license, with no disciplinary action within the last five (5) years.

4. The worksite monitor shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and/or contract and agrees to monitor the licensee as set forth by the Board.

5. The worksite monitor must adhere to the following required methods of monitoring the licensee:

    a) Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the Board, at least once per week.

    b) Interview other staff in the office regarding the licensee's behavior, if applicable.

    c) Review the licensee's work attendance.

Reporting by the worksite monitor to the Board shall be as follows:

1. Any suspected substance abuse must be verbally reported to the Board and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the Board's normal business hours the verbal report must be within one (1) hour of the next business day.A written report shall be submitted to the Board within 48 hours of

occurrence.

2. The worksite monitor shall complete and submit a written report monthly or as directed by the Board. The report shall include:

   - the licensee's name;
   - license number;
   - worksite monitor's name and signature;
   - worksite monitor's license number;
   - worksite location(s);
   - dates licensee had face-to-face contact with monitor;
   - staff interviewed, if applicable;
   - attendance report;
   - any change in behavior and/or personal habits;
   - any indicators that can lead to suspected substance abuse.

The licensee shall complete the required consent forms and sign an agreement with the worksite monitor and the Board to allow the Board to communicate with the worksite monitor.

#8 SENATE BILL 1441 REQUIREMENT

Procedures to be followed when a licensee tests positive for a banned substance.

#8 Uniform Standard

When a licensee tests positive for a banned substance:

1. The Board shall order the licensee to cease practice;

2. The Board shall contact the licensee and instruct the licensee to leave work; and

3. The Board shall notify the licensee's employer, if any, and worksite monitor, if any,that the licensee may not work.

Thereafter, the Board should determine whether the positive drug test is in fact evidence of prohibited use. If so, proceed to Standard #9. If not, the Board shall immediately lift the cease practice order.

In determining whether the positive test is evidence of prohibited use, the Board should, as applicable:

1. Consult the specimen collector and the laboratory;

2. Communicate with the licensee and/or any physician who is treating the licensee; and

3. Communicate with any treatment provider, including group facilitator/s.

#9 SENATE BILL 1441 REQUIREMENT

Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

#9 Uniform Standard

When a Board confirms that a positive drug test is evidence of use of a prohibited substance, the licensee has committed a major violation, as defined in Uniform Standard #10 and the Board shall impose the consequences set forth in Uniform Standard #10.

#10 SENATE BILL 1441 REQUIREMENT

Specific consequences for major and minor violations. In particular, the committee shall consider the use of a "deferred prosecution" stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency until or unless licensee commits a major violation, in which case it is revived and license is surrendered.

#10 Uniform Standard

Major Violations include, but are not limited to:

1. Failure to complete a Board-ordered program;

2. Failure to undergo a required clinical diagnosticevaluation;

3. Multiple minor violations;

4. Treating patients while under the influence of drugs/alcohol;

5. Any drug/alcohol related act which would constitute a violation of the practice act or state/federal laws;

6. Failure to obtain biological testing for substanceabuse;

7. Testing positive and confirmation for substance abuse pursuant to Uniform Standard #9;

8. Knowingly using, making, altering or possessing any object or product in such a way as to defraud a drug test designed to detect the presence of alcohol or a controlled substance.

Consequences for a major violation include, but are not limited to:

1. Licensee will be ordered to cease practice.

    a) the licensee must undergo a new clinical diagnostic evaluation, and

    b) the licensee must test negative for at least a month of continuous drug testing before being allowed to go back to work.

2. Termination of a contract/agreement.

3. Referral for disciplinary action, such as suspension, revocation, or other action as determined by the Board.

Minor Violations include, but are not limited to:

1. Untimely receipt of required documentation;
2. Unexcused non-attendance at group meetings;
3. Failure to contact a monitor when required;
4. Any other violations that do not present an immediate threat to the violator or to the public.

Consequences for minor violations include, but are not limited to**:**

1. Removal from practice;
2. Practice limitations;
3. Required supervision;
4. Increased documentation;
5. Issuance of citation and fine or a warning notice;
6. Required re-evaluation/testing;
7. Other action as determined by the Board.

#11 SENATE BILL 1441 REQUIREMENT

Criteria that a licensee must meet in order to petition for return to practice on a full time basis.

#11 Uniform Standard

"Petition" as used in this standard is an informal request as opposed to a "Petition for Modification" under the Administrative Procedure Act.

The licensee shall meet the following criteria before submitting a request (petition) to return to full time practice:

1. Demonstrated sustained compliance with current recovery program.

2. Demonstrated the ability to practice safely as evidenced by current work site reports, evaluations, and any other information relating to the licensee's substance abuse.

3. Negative drug screening reports for at least six (6) months, two (2) positive worksite monitor reports, and complete compliance with other terms and conditions of the program.

#12 SENATE BILL 1441 REQUIREMENT

Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

#12 Uniform Standard

"Petition for Reinstatement" as used in this standard is an informal request (petition) as opposed to a "Petition for Reinstatement" under the Administrative Procedure Act.

The licensee must meet the following criteria to request (petition) for a full and unrestricted license.

1. Demonstrated sustained compliance with the terms of the disciplinary order, if applicable.

2. Demonstrated successful completion of recovery program, if required.

3. Demonstrated a consistent and sustained participation in activities that promote and support their recovery including, but not limited to, ongoing support meetings, therapy, counseling, relapse prevention plan, and community activities.

4. Demonstrated that he or she is able to practice safely.

5. Continuous sobriety for three (3) to five (5) years.

#13 SENATE BILL 1441 REQUIREMENT

If a Board uses a private-sector vendor that provides diversion services, (1) standards for immediate reporting by the vendor to the Board of any and all noncompliance with process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors; (3) standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and (4) standards for a licensee's termination from the program and referral to enforcement.

#13 Uniform Standard

1. A vendor must report to the Board any major violation, as defined in Uniform Standard #10, within one (1) business day. A vendor must report to the Board any minor violation, as defined in Uniform Standard #10, within five (5) business days.

2. A vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors is as follows:

   (a) Specimen Collectors:

   (1) The provider or subcontractor shall possess all the materials, equipment, and technical expertise necessary in order to test every licensee for which he or she is responsible on any day of the week.

   (2) The provider or subcontractor shall be able to scientifically test for urine, blood, and hair specimens for the detection of alcohol, illegal, and controlled substances.

   (3) The provider or subcontractor must provide collection sites that are located in areas throughout California.

   (4) The provider or subcontractor must have an automated 24-hour toll-free telephone system and/or a secure on-line computer database that allows the participant to check in daily for drug testing.

   (5) The provider or subcontractor must have or be subcontracted with operating collection sites that are engaged in the business of collecting urine, blood, and hair follicle specimens for the testing of drugs and alcohol within the State of California.

   (6) The provider or subcontractor must have a secure, HIPAA compliant, website or computer system to allow staff access to drug test results and compliance reporting information that is available 24 hours a day.

   (1) The provider or subcontractor shall employ or contract with toxicologists that are

licensed physicians and have knowledge of substance abuse disorders and the appropriate medical training to interpret and evaluate laboratory drug test results, medical histories, and any other information relevant to biomedical information.

(2) A toxicology screen will not be considered negative if a positive result is obtained while practicing, even if the practitioner holds a valid prescription for the substance.

(3) Must undergo training as specified in Uniform Standard #4.

(b) Group Meeting Facilitators:

A group meeting facilitator for any support group meeting:

(1) must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse;

(2) must be licensed or certified by the state or other nationally certified organization;

(3) must not have a financial relationship, personal relationship, or business relationship with the licensee within the last year;

(4) shall report any unexcused absence within 24 hours to the Board, and,

(5) shall provide to the Board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.

(c) Work Site Monitors:

The worksite monitor must meet the following qualifications:

(1) Shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the Board; however, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.

(2) The monitor's licensure scope of practice shall include the scope of practice of the licensee that is being monitored, be another health care professional if no

monitor with like practice is available, or, as approved by the Board, be a person in a position of authority who is capable of monitoring the licensee at work.

(3) Shall have an active unrestricted license, with no disciplinary action within the last five (5) years.

(4) Shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and/or contract and agrees to monitor the licensee as set forth by the Board.

2. The worksite monitor must adhere to the following required methods of monitoring the licensee:

   a) Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the Board, at least once per week.
   b) Interview other staff in the office regarding the licensee's behavior, if applicable.
   c) Review the licensee's work attendance.

3. Any suspected substance abuse must be verbally reported to the contractor, the Board, and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the Board's normal business hours the verbal report must be within one (1) hour of the next business day. A written report shall be submitted to the Board within 48 hours of occurrence.

4. The worksite monitor shall complete and submit a written report monthly or as directed by the Board. The report shall include:

   - the licensee's name;
   - license number;
   - worksite monitor's name and signature;
   - worksite monitor's license number;
   - worksite location(s);
   - dates licensee had face-to-face contact with monitor;
   - staff interviewed, if applicable;
   - attendance report;
   - any change in behavior and/or personal habits;
   - any indicators that can lead to suspected substance abuse.

(d) <u>Treatment Providers</u>

Treatment facility staff and services must have:

(1) Licensure and/or accreditation by appropriate regulatory agencies;

(2) Sufficient resources available to adequately evaluate the physical and mental needs of the client, provide for safe detoxification, and manage any medical emergency;

(3) Professional staff who are competent and experienced members of the clinical staff;

(4) Treatment planning involving a multidisciplinary approach and specific aftercare plans;

(5) Means to provide treatment/progress documentation to the provider.

(e) General Vendor Requirements

The vendor shall disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services as follows:

(1) The vendor is fully responsible for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by any of them. No subcontract shall relieve the vendor of its responsibilities and obligations. All state policies, guidelines, and requirements apply to all subcontractors.

(2) If a subcontractor fails to provide effective or timely services as listed above, but not limited to any other subcontracted services, the vendor will terminate services of said contractor within 30 business days of notification of failure to provide adequate services.

(3) The vendor shall notify the appropriate Board within five (5) business days of termination of said subcontractor.

#14 SENATE BILL 1441 REQUIREMENT

If a Board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

#14 Uniform Standard

The Board shall disclose the following information to the public for licensees who are participating in a Board monitoring/diversion program regardless of whether the licensee is a self-referral or a Board referral. However, the disclosure shall not contain information that the restrictions are a result of the licensee's participation in a diversion program.

- Licensee's name;
- Whether the licensee's practice is restricted, or the license is on inactive status;
- A detailed description of any restriction imposed.

#15 SENATE BILL 1441 REQUIREMENT

If a Board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor's performance in adhering to the standards adopted by the committee.

#15 Uniform Standard

1. If a Board uses a private-sector vendor to provide monitoring services for its licensees, an external independent audit must be conducted at least once every three (3) years by a qualified, independent reviewer or review team from outside the department with no real or apparent conflict of interest with the vendor providing the monitoring services. In addition, the reviewer shall not be a part of or under the control of the Board. The independent reviewer or review team must consist of individuals who are competent in the professional practice of internal auditing and assessment processes and qualified to perform audits of monitoring programs.

2. The audit must assess the vendor's performance in adhering to the uniform standards established by the Board. The reviewer must provide a report of their findings to the Board by June 30 of each three (3) year cycle. The report shall identify any material inadequacies, deficiencies, irregularities, or other non- compliance with the terms of the vendor's monitoring services that would interfere with the Board's mandate of public protection.

3. The Board and the department shall respond to the findings in the audit report.

#16 SENATE BILL 1441 Requirement

Measurable criteria and standards to determine whether each Board's method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

#16 Uniform Standard

Each Board shall report the following information on a yearly basis to the Department of Consumer Affairs and the Legislature as it relates to licensees with substance abuse problems who are either in a Board probation and/or diversion program.

- Number of intakes into a diversion program
- Number of probationers whose conduct was related to a substance abuse problem
- Number of referrals for treatment programs
- Number of relapses (break in sobriety)
- Number of cease practice orders/license in-activations
- Number of suspensions
- Number terminated from program for noncompliance
- Number of successful completions based on uniform standards
- Number of major violations; nature of violation and action taken
- Number of licensees who successfully returned to practice
- Number of patients harmed while in diversion

The above information shall be further broken down for each licensing category, specific substance abuse problem (i.e. cocaine, alcohol, Demerol etc.), whether the licensee is in a diversion program and/or probation program.

If the data indicates that licensees in specific licensing categories or with specific substance abuse problems have either a higher or lower probability of success, that information shall be taken into account when determining the success of a program. It may also be used to determine the risk factor when a Board is determining whether a license should be revoked or placed on probation.

The Board shall use the following criteria to determine if its program protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

- At least 100 percent of licensees who either entered a diversion program or whose license

was placed on probation as a result of a substance abuse problem successfully completed either the program or the probation, or had their license to practice revoked or surrendered on a timely basis based on noncompliance of those programs.

- At least 75 percent of licensees who successfully completed a diversion program or probation did not have any substantiated complaints related to substance abuse for at least five (5) years after completion.

PART III Model Language For Probationary Orders

MODEL PROBATIONARY TERMS AND CONDITIONS

Unless otherwise specified, the use of the "Board" in these conditions includes the Board itself or its designee. The model probationary conditions are divided into three general categories

(A) Standard Terms and Conditions of Probation. Those conditions of probation that will generally appear in all cases involving probation as a standard term and condition;

(B) Optional Terms and Conditions of Probation. Those conditions that address the specific circumstances of the case and require discretion to be exercised depending on the nature and circumstances of the particular case: and

(C) Terms and Conditions of the Uniform Standards for Substance Abusing Licensees. Those conditions must be used in cases where the violation involved the use of drugs or alcohol.

A summary list of the model conditions appears below, followed by the model text for each condition.

A. STANDARD TERMS AND CONDITIONS FOR PROBATIONARY ORDERS MODEL LANGUAGE

A. STANDARD TERMS AND CONDITIONS FOR PROBATIONARY ORDERS (MODEL LANGUAGE)

(1) Obey all Laws
(2) Quarterly Reports
(3) Probation Surveillance Program
(4) Interviews with Medical Consultants
(5) Cost Recovery
(6) License Surrender
(7) Extension of Probation
(8) Probation Violation/Completion of Probation
(9) Notification to Board of Employers; Notification to Employers of Discipline
(10) Supervision of Physician Assistants and Advanced Practice Nurses

B. OPTIONAL TERMS AND CONDITIONS FOR PROBATIONARY ORDERS (MODEL LANGUAGE)

(11) Suspension
(12) Controlled Drugs – Total Restriction
(13) Controlled Drugs – Surrender of DEA Permit
(14) Controlled Drugs – Partial Restriction
(15) Controlled Drugs – Maintain Record
(16) Pharmacology Course
(17) Education Course

(18) Medical Ethic Course
(19) Clinical Assessment and Training Program
(20) Written Examination
(21) Third Party Presence
(22) Prohibited Practice
(23) Psychiatric Evaluation
(24) Psychotherapy
(25) Medical Evaluation
(26) Medical Treatment
(27) Community Service
(28) Restitution
(29) Monitoring – Billing/Practice
(30) Solo Practice Prohibition/Supervised Structure

C.TERMS AND CONDITIONS OF THE UNIFORM STANDARDS FOR SUBSTANCE ABUSING LICENSEES (MODEL LANGUAGE)

(31) Clinical Diagnostic Evaluation
(32) Diversion Program – Alcohol and Drugs
(33) Drugs – abstain from Use
(34) Alcohol – Abstain from Use
(35) Notification to Employer
(36) Biological Fluid Testing
(37) Group Support Meetings
(38) Worksite Monitor
(39) Results of Biological Fluid Tests
(40) Major and Minor Violations
(41) Request by a Substance Abusing Licensee to Return to Practice
(42) Request by a Substance Abusing Licensee for Reinstatement of a Full and Unrestricted License--Petition for Reinstatement

A. STANDARD TERMS AND CONDITIONS FOR PROBATIONARY ORDERS (MODEL LANGUAGE)

1. **Obey all Laws**

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

2. **Quarterly reports**

Respondent shall submit quarterly reports to the Board using the Quarterly Report of Compliance Form, OMB 10 ~~(5/97)~~ (8/17), which is hereby incorporated by reference, declaring under penalty of perjury whether there has been compliance with all the conditions of probation.

3. **Probation Surveillance Program**

Respondent shall comply with the Board's probation surveillance program. Respondent shall, at all times, keep the Board informed of his or her addresses of Business and residence, which shall both serve as addresses of record for purposes of service process. Changes of such addresses shall be immediately communicated in writing to the Board. A post office box shall not be permitted to serve as an address of record.

Respondent shall also immediately inform the Board, in writing, of any travel to any areas outside the jurisdiction of California, which lasts, or is contemplated to last, more than thirty (30) days.

4**. Interviews with Medical Consultants**

Respondent shall appear in person for interviews with the Board's medical consultants upon request at various intervals and with reasonable notice.

5**. Cost recovery**

Respondent shall reimburse the Board the amount $ _____ within 90 days from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Board's cost of its investigation and prosecution shall constitute a violation of the probation order, unless the Board agrees in writing to payment by an installment plan because of financial hardship.

6. **License surrender**

Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his/her certificate to the Board. The Board reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

7. Tolling for out of State Practice or In-State Non- Practice (inactive)

In the event respondent shall leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Board or its designee in writing within ten days of the dates of departure and return or the dates of non-practice within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Section 2051 and /or 2052 of the Business and

Professions Code. All time spent in an intensive training program approved by the Board or its designee in or out of the state shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition will extend the probationary period by the period of out-of-state residence or non-practice. Respondent's period of non-practice while on probation shall not exceed two (2) years.

8**. Probation Violation/Completion of Probation**

If respondent violates probation in any respect, the Board may revoke probation and carry out the disciplinary order that was stayed after giving respondent notice and opportunity to be heard. If an Accusation and/or Petition to revoke is filed against respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be automatically extended until the matter is final. Respondent shall comply with all financial obligations (e.g., cost recovery) no later than 60 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's license will be fully restored.

9. Notification to Board of Employers; Notification to Employers of Discipline

Respondent shall provide to the Board the names, physical addresses, mailing addresses, and telephone numbers of all employers, and supervisors and shall give specific written consent that the licensee authorizes the Board and the employers and supervisors to communicate regarding the licensee's work status, performance, and monitoring.

Respondent shall notify any employer of the terms of this probation by providing a copy of this decision to each and every employer within 30 days of this effective date of the decision, asking each employer to acknowledge receipt in writing, and submitting such acknowledgement to the Board.

10. Supervision of Physician Assistants and Advanced Practice Nurses.

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

B. OPTIONAL TERMS AND CONDITIONS FOR PROBATIONARY ORDERS (MODEL LANGUAGE)

11. Suspension

Respondent shall be suspended from the practice of medicine for beginning the effective date of this decision.

[Optional: Respondent shall be suspended from the practice of medicine until terms are completed and evidence of the completion is received and acknowledged by the Board.]

12. Controlled Drugs: Total Restriction

Respondent shall not prescribe, administer, dispense, order or possess any controlled substances as defined in the California Uniform Controlled Substance Act (ACT) except for ordering or possessing medications lawfully prescribed to respondent for a bona fide illness or condition by another practitioner.

13. Controlled Drugs: Surrender of DEA Permit

Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any triplicate prescription forms and federal order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the Board.

14. Controlled Drugs: Partial Restriction

Respondent shall not prescribe, administer, dispense, order, or possess any controlled substances as defined in the California Uniform Controlled Substance Act, except for those drugs listed in Schedule(s) _____ of the Act and prescribed to respondent for a bona fide illness or condition by another practitioner.

(OR)

Respondent is permitted to prescribe, administer, dispense or order controlled substances list in Schedule(s) _____ of the California Uniform Controlled Substances Act for in-patients in a hospital setting, and not otherwise.

NOTE: Use the following additional paragraph only if there is an actual elimination of the authority to prescribe a Scheduled Controlled Substance.

[OPTION]

Respondent shall immediately surrender his/her current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order.

15. Controlled Drugs: Maintain Record

Respondent shall maintain a record of all controlled substances prescribed, dispensed or administered by respondent during probation, showing all the following: (1) the name and address of the patient; (2) the date; (3) the character and quantity of the controlled substances involved; and (4) the pathology and purpose for which the controlled substance was furnished. Respondent shall keep these records in

a separate file or ledger, in chronological order, and shall make them available for inspection and copying by the Board or its designee, upon request.

16. Pharmacology Course

Within 60 calendar days of the effective date of this decision, Respondent shall enroll in a course in Pharmacology/prescribing practices course equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine ("Program"), approved in advance by the Board or its designee. Respondent shall provide the Program with any information and documents that the program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course no later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices/pharmacology course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirement for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the decision, may, in the sole discretion of the Board, or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board.

Respondent shall submit written evidence of successful completion of the course to the Board within fifteen (15) calendar days after successful completion.

17. Education Course

Within 90 calendar days of the effective date of this decision, respondent shall enroll in an educational course (i.e. medical records keeping, professional boundaries, professionalism, etc.) related to the violations charged in the Accusation that would be equivalent to similar courses offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine ("Program"), approved in advance by the Board or its designee. Respondent shall provide the Program with any information and documents that the program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course no later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of probation enrollment. All courses shall be at the respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the decision, may, in the sole discretion of the Board, or its designee, be

accepted towards the fulfillment of the condition if the course would have been approved by the Board.

Respondent shall submit written evidence of successful completion of the course to the Board with fifteen (15) days after successful completion.

18. Medical Ethics Course

Within 60 calendar days of the effective date of this decision, respondent shall submit to the Board for its prior approval a course in medical ethics which respondent shall successfully complete during the first year of probation.

19. Clinical Assessment and Training Program

Within 90 calendar days of the effective date of this decision, respondent shall submit to the Board for its prior approval, an intensive clinical assessment and training program equivalent to the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine. The exact number of hours and the specific content of the program shall be determined by the Board or its designee and shall be related to the violations charged in the Accusation. Respondent shall successfully complete the program within six (6) months from the date of enrollment and may be required to pass an examination administered by the Board or its designee related to the program's contents.

The program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health, basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to the area of practice to which the violation(s) related and, at a minimum, a 40 hour program of clinical education in the area of practice to which the violations related and that takes into account the assessment, decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the program.

Based upon respondent's performance and test results in the assessment and clinical education, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional education or training, treatment needed for any medical or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the recommendations of the program.

The Board may immediately order respondent to cease the practice of medicine without a hearing if the respondent should fail to enroll, participate in, or successfully complete the program within the time specified. The respondent may not resume the practice of medicine until enrollment or participation in the program is complete.

Respondent shall submit written evidence of successful completion of the program to the Board within fifteen (15) calendar days after successful completion.

OPTION # 1: Condition Precedent

Respondent shall not practice medicine until respondent has successfully enrolled, participated in, and completed the program; submitted written evidence of successful completion to the Board and the Board has confirmed receipt of such evidence of completion.

NOTE: The condition precedent option is preferred in all cases involving findings of gross negligence or incompetence or repeated acts of negligence or incompetence or repeated acts of negligence where the physician's fitness to practice should be evaluated before he or she may practice to ensure the public is protected.

OPTION #2: Additional Professional Enhancement Program

Within 60 calendar days after respondent has successfully completed the clinical assessment and training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in such professional enhancement program at the respondent's own expense during the term of probation, or until the Board, or its designee, determines that further participation is no longer necessary.

20. Written Examination

Within 60 calendar days of the effective date of this decision, (or upon completion of the required education course) (or upon completion of the required clinical training program) respondent shall take and pass a written examination administered by the Board or its designee. The written exam will be the COMVEX. If respondent fails this examination, respondent must wait three months between re-examinations, except that after three failures respondent must wait one year to take each necessary re-examination thereafter. The respondent shall pay the costs of all examinations.

(Use either of the following two options with the above paragraph.)

OPTION # 1: Condition Precedent

Respondent shall not practice medicine until respondent has passed this examination and has been so notified by the Board in writing.

Note: The condition precedent option is preferred in all cases involving findings of gross negligence or incompetence or repeated acts of negligence where the physician's fitness to practice should be

evaluated before he/she may practice, or any other case where public protections requires confirmation of respondent's skills prior to a return to practice medicine.

OPTION #2: Condition Subsequent

If respondent fails to take and pass this examination by the end of the first six (6) months of probation, respondent shall cease the practice of medicine until this examination has been successfully passed and respondent has been so notified by the Board in writing.

21. Third Party Presence

During probation, respondent shall have a third party present while examining or treating patients. Respondent shall, within 30 calendar days of the effective date of the decision, submit to the Board or its designee for its approval name(s) of persons who will act as the required third party present. The respondent shall execute a release authorizing the third party(s) present to divulge any information that the Board may request during interviews by the probation monitor on a periodic basis.

The respondent shall provide written notice to respondent's patients that the respondent is on probation and as a condition of probation the respondent must have a third party monitor that shall be present during all consultations, examinations, or treatment with [insert: male, female or minor] patients. The patient must sign the notice acknowledging receipt of the notice and the respondent shall maintain a copy of the original notification in the patient's file; and shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain notification for the entire term of probation. The practice monitor shall inspect all patient files and confirm in a report to the Board the status of compliance with such notice and maintenance of signed acknowledgement in patient's file.

NOTE: Sexual contact, as defined in Business and Professions Code (BPC) Section 729, and BPC Section 2246 requires revocation without stay of probation. Additionally,Title 16, California Code of Regulations, Section 1663(b), subsection (b) herein, requires revocation without stay of probation. This term should be used where public protection requires monitoring of a licensee's contact with specific patient populations.

22. Prohibited Practice

During probation, respondent is prohibited from practicing .

23. Psychiatric Evaluation

Within 30 days of the effective date of this decision, and on a periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo a psychiatric evaluation by a Board appointed psychiatrist who shall furnish a psychiatric report to the Board or its designee. The respondent shall pay the cost of the psychiatrist evaluation.

In the event further treatment is recommended by the evaluating psychiatrist to ensure public protection, respondent may be required by the Board or its designee to undergo psychiatric treatment. Respondent shall within 30 days of notice by the Board, submit to the Board for its prior approval the name and qualification of a psychiatrist of respondent's choice to provide the further treatment. Upon approval of the treating psychiatrist, respondent shall undergo and continue psychiatric treatment until further notice from the Board. Respondent shall have the treating psychiatrist submit quarterly status reports to the Board indicating whether or not the respondent is capable of practicing medicine safely.

(OPTIONAL)

Respondent shall not engage in the practice of medicine until further notified by the Board of its determination that respondent is mentally fit to practice safely.

24. Psychotherapy

Within 60 calendar days of the effective date of this decision, respondent shall submit to the Board for its prior approval the name and qualifications of psychotherapist of respondent's choice. Upon approval, respondent shall undergo and continue treatment until the Board deems that no further psychotherapy is necessary. Respondent shall have the treating psychotherapist submit quarterly status reports to the Board. The Board may require respondent to undergo psychiatric evaluation by a Board appointed psychiatrist. Respondent shall pay all costs of the psychiatric evaluation.

NOTE: This condition is for those cases where the evidence suggests that the respondent has had impairment (for example, impairment by mental illness, alcohol abuse and drug abuse) that related to the violations.

25. Medical Evaluation

Within 30 calendar days of the effective date of this decision, and on a periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo a medical evaluation by a Board appointed physician who shall furnish a medical report to the Board or its designee. Respondent shall pay all costs of the medical evaluation.

In the event further treatment is recommended by the evaluating physician to ensure public protections, respondent may be required by the Board or its designee to undergo such further treatment. Respondent shall, within 30 calendar days of the written notice by the Board, submit to the

Board for its prior approval the name and qualifications of a physician of respondent's choice. Upon approval of the treating physician, respondent shall undergo and continue medical treatment until further notice from the Board. Respondent shall pay the cost of such medical treatments.

(OPTIONAL)

Respondent shall not engage in the practice of medicine until notified by the Board of its determination that respondent is medically fit to practice safely.

26. Medical Treatment

Within 60 calendar days of this decision, respondent shall submit to the Board for its prior approval the name and qualifications of physician of respondent's choice. Upon approval, respondent shall undergo and continue until the Board deems that no further medical treatment is necessary. Respondent shall have the treating physician submit quarterly status reports of the periodic medical evaluations. Respondent shall pay the costs of such medical treatments. Respondent shall comply with any treatment recommended by the physician that the physician determines is required to ensure that respondent may continue to practice safely.

27. Community Services

Within 60 calendar days of the effective date of this decision, respondent shall submit to the Board for its prior approval a community service program, in which respondent provides free medical services on a regular basis to a community or charitable facility or agency for at least hours a month for the first months of probation.

NOTE: Not for quality of care issues.

28. Restitution

Respondent shall provide restitution to in the amount of prior to the completion of the first year of probation.

NOTE: Restitution should be issued to patients only.

29. Monitoring: Practice/Billing

Within 30 calendar days of the effective date of this decision, respondent shall submit to the Board or its designee for prior approval a [insert: practice, billing or practice and billing monitor(s)], the names and qualifications of one or more licensed physicians (D.O. or M.D.)

whose licenses are valid and in good standing. A monitor shall have no prior business relationship with respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to be neutral and objectively monitor the respondent. Respondent shall pay for all monitoring costs. The monitor shall be provided with copies of all decision(s), accusation(s) and other information deemed relevant by the Board or its designee. Failure to comply with this term and condition may result in an automatic order from the Board for the respondent to cease the practice of medicine until such a monitor has been approved by the Board.

30. Solo Practice Prohibition/Supervised Structure

Respondent shall not engage in the solo practice of medicine, and shall be employed as a physician, in which there is a supervised structure and environment, and wherein respondent reports to another licensed physician (D.O. or M.D.). Notice of changes to the respondent's employment or nature of practice mush be provided to the Board or its designee within five (5) days of such change. Respondent shall cease the practice of medicine of respondent is no longer in a supervised environment.

C. TERMS AND CONDITIONS APPLYING THE UNIFORM STANDARDS FOR SUBSTANCE ABUSING LICENSEES (MODEL LANGUAGE)

(NOTE: These terms and conditions must be included in any probationary order where the violation involves the use of drugs and/or alcohol.)

31. Clinical Diagnostic Evaluation (Uniform Standards for Substance Abusing Licensees #1, #2 and #6)

Upon order of the Board, respondent shall undergo a clinical diagnostic evaluation. The Board or its designee shall select or approve the evaluator(s). The evaluator must hold a valid, unrestricted license to practice, with a scope of practice that includes the conduct of clinical diagnostic evaluations and at least three (3) years experience in providing evaluations of health professionals with substance abuse disorders. The evaluator shall not have any financial relationship, personal relationship, or business relationship with the licensee within the last five (5) years. The evaluator shall provide an objective, unbiased, and independent evaluation. Respondent shall provide the evaluator with a copy of the Board's decision prior to the clinical diagnostic evaluation being performed.

The clinical diagnostic evaluation shall be conducted in accordance with acceptable professional standards for conducting substance abuse clinical diagnostic evaluations.

The clinical diagnostic evaluation report shall set forth, in the evaluator's opinion: whether the licensee has a substance abuse problem; whether the licensee is a threat to himself/herself or others; and recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee's rehabilitation and safe practice. If the evaluator determines during the evaluation process that a licensee is a threat to himself/herself or others, the evaluator shall notify the Board within 24 hours of such determination. For all evaluations, respondent shall cause the evaluator to submit to the Board a final written report no later than ten (10) calendar days from the date the evaluator is assigned the matter unless the evaluator requests additional information to complete the evaluation, not to exceed thirty calendar days. The cost of such evaluation shall be borne by the licensee.

Respondent shall cease practice during the clinical diagnostic evaluation and review by the Board. While the results of the clinical diagnostics evaluation are pending, the licensee shall be randomly drug tested at least two (2) times per week.

The Board will review the results of the clinical diagnostic evaluation to determine whether or not respondent is safe to return to either part time or full time practice and what restrictions or recommendations should be imposed on respondent after considering the following criteria: license type; licensee history; documented length of sobriety; time that has elapsed since substance use; scope and pattern of use; treatment history, licensee's medical history and current medical condition; nature, duration, and severity of the substance abuse; and whether the licensee is a threat to himself/ herself or others.

Respondent's license shall remain suspended until the Board determines that he or she is able to safely practice either full time or part time, and has had at least 30 days of negative drug test results.

32. Diversion Program: Alcohol and Drugs (Uniform Standards for Substance Abusing Licensees #13, #14, #15)

Within thirty (30) calendar days of this decision, respondent shall enroll and participate in the Board's Diversion Program until the Board determines that further treatment and rehabilitation is no longer necessary. Failure to comply with requirements of the Diversion program, quitting the Diversion Program without permission or being expelled for cause shall constitute a violation of probation by respondent. Probation shall be automatically extended until respondent successfully completes the program. Such Diversion program shall utilize the Uniform Standards for Substance Abusing Licensee, as set forth in Part II of the Disciplinary Guidelines.

Respondent shall comply with all components of the Board's Diversion program. Respondent shall sign a release authorizing the Board's Diversion program to report all aspects of participation of the Diversion program as requested by the Board or its designee.

The Diversion program shall comply with the following Uniform Standard for Substance Abusing Licensees:

A vendor that provides Diversion services must report to the Board any major violations, as defined in Uniform standard # 10 within (1) business day. A vendor must report to the Board any minor violation, as defined in Uniform Standard #10 within (5) business days.

Specimen Collectors

- The provider or subcontractor shall possess all the materials, equipment, and technical expertise necessary in order to test every licensee for which he or she is responsible on any day of the week.
- The provider or subcontractor shall be able to scientifically test for urine, blood, and hair specimens for the detection of alcohol, illegal, and controlled substances.
- The provider or subcontractor must provide collection sites that are located inareas throughout California.
- The provider or subcontractor must have an automated 24-hour toll-free telephone system and/or a secure on-line computer database that allows the participant to check in daily for drug testing.
- The provider or subcontractor must have or be subcontracted with operating collection sites that are engaged in the business of collecting urine, blood, and hair follicle specimens for the testing of drugs and alcohol within the State of California.
- The provider or subcontractor must have a secure, HIPAA compliant, website or computer system to allow staff access to drug test results and compliance reporting information that is available 24 hours a day.
- The provider or subcontractor shall employ or contract with toxicologists that are licensed physicians and have knowledge of substance abuse disorders and the appropriate medical training to interpret and evaluate laboratory drug test results, medical histories, and any other information relevant to biomedical information.
- A toxicology screen will not be considered negative if a positive result is obtained while practicing, even if the practitioner holds a valid prescription for the substance.
- Must undergo training as specified in Uniform Standard #4.

Group Meeting Facilitators:

A group meeting facilitator for any support group meeting:

- must have a minimum of three (3) years' experience in the treatment and rehabilitation of substance abuse;
- must be licensed or certified by the state or other nationally certified organization;
- must not have a financial relationship, personal relationship, or business relationship with the licensee within the last year;
- shall report any unexcused absence within 24 hours to the Board, and,
- Shall provide to the Board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.

Work Site Monitors:

The worksite monitor must meet the following qualifications:

1. Shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the Board; however, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.
2. The monitor's licensure scope of practice shall include the scope of practice of the licensee that is being monitored, be another health care professional if no monitor with like practice is available, or, as approved by the Board, be a person in a position of authority who is capable of monitoring the licensee at work.
3. Shall have an active unrestricted license, with no disciplinary action within the last five (5) years.
4. Shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and/or contract and agrees to monitor the licensee as set forth by the Board.
5. The worksite monitor must adhere to the following required methods of monitoring the licensee:

    - Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the Board, at least once per week.
    - Interview other staff in the office regarding the licensee's behavior, if applicable.
    - Review the licensee's work attendance.

Any suspected substance abuse must be verbally reported to the contractor, the Board, and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the Board's normal business hours the verbal report must be within one (1) hour of the next business day. A written report shall be submitted to the Board within 48 hours of occurrence.

The worksite monitor shall complete and submit a written report monthly or as directed by the Board. The report shall include:

- the licensee's name;
- license number;
- worksite monitor's name and signature;

- worksite monitor's license number;
- worksite location(s);
- dates licensee had face-to-face contact with monitor;
- staff interviewed, if applicable;
- attendance report;
- any change in behavior and/or personal habits;
- Any indicators that can lead to suspected substance abuse.

Treatment Providers

Treatment facility staff and services must have:

- Licensure and/or accreditation by appropriate regulatory agencies;
- Sufficient resources available to adequately evaluate the physical and mental needs of the client, provide for safe detoxification, and manage any medical emergency;
- Professional staff who are competent and experienced members of the clinical staff;
- Treatment planning involving a multidisciplinary approach and specific aftercare plans;
- Means to provide treatment/progress documentation to the provider.

General Vendor Requirements

The vendor shall disapprove and discontinue the use of providers or contractors that fail to provide effective or timely Diversion services as follows:

- The vendor is fully responsible for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by any of them. No subcontract shall relieve the vendor of its responsibilities and obligations. All state policies, guidelines, and requirements apply to all subcontractors.

- If a subcontractor fails to provide effective or timely services as listed above, but not limited to any other subcontracted services, the vendor will terminate services; of said contractor within 30 business days of notification of failure to provide adequate services.

- The vendor shall notify the appropriate Board within five (5) business days of termination of said subcontractor.

External Independent Audits

If the Board uses a private-sector vendor to provide monitoring services for its licensees, an external independent audit must be conducted at least once every three (3) years by a qualified, independent review team from outside the department with no real or apparent conflict of interest with the vendor providing the Diversion/monitoring services. In addition, the reviewer shall not be a part of or under the control of the Board. The independent review or review team must consist of individuals who are competent in the professional practice of internal auditing and assessment processes and qualified to perform audits of monitoring programs. The audit must assess the vendor's performance in adhering to the uniform standard, established by the Board. The reviewer must provide a report of their findings

to the Board by June 30 of each three (3) year cycle. The report shall identify any material inadequacies, irregularities, or other non-compliance with the terms of the vendor's Diversion/monitoring services that would interfere with the Board's mandate of public protection. The Board and the department shall respond to the findings in the audit report.

Disclosure

In the interest of balancing privacy and consumer protection, the Board shall only disclose the following information to the public for licensees who are participating in a Board Diversion/monitoring program regardless of whether the licensee is a self-referral or a Board referral:

- The licensee's name
- Whether the licensee's practice is restricted, or the license is on inactive status;
- A detailed description of any restriction(s) imposed.

This disclosure shall not contain information that the restrictions are the result of the licensee's participation in a Diversion program.

33. Drugs: Abstain from Use

Respondent shall abstain completely from the personal use or possession, injection, consumption by any route, including inhalation of all controlled substances as defined in the California Uniform Controlled Substances Act, and dangerous drugs as defined in the California Business and Professions Code, or any drugs requiring a prescription except for ordering or possessing medications lawfully prescribed to respondent by another practitioner, for a bona fide illness or condition.

[Optional language: This condition may be waived or modified by the Board upon a written finding by the Clinical Diagnostic Evaluation that respondent is not a substance abusing licensee.]

34. Alcohol: Abstain from Use

Respondent shall abstain completely from the use of alcoholic beverages.

[Optional language: This condition may be waived by the Board upon a written finding by the Clinical Diagnostic Exam that respondent is not a substance abusing licensee.]

35. Notification to Employer

If a licensee whose license is on probation has an employer, the licensee shall provide the Board the names, physical addresses, mailing addresses, and telephone numbers of all employers and supervisors and shall give specific, written consent that the licensee authorizes the Board, the worksite monitor, and the employers and supervisors to communicate regarding the licensee's work status, performance, and monitoring.

36. Biological Fluid Testing (Uniform Standards for Substance Abusing Licensees #4)

Respondent shall submit to and pay for all random and directed biological fluid or hair sample, breath alcohol, or any other mode of testing required by the Board. Biological fluid testing may be required on any day, including weekends and holidays. The scheduling of biological fluid testing shall be done on a random basis, preferably by a computer program, so that respondent can make no reasonable assumption of when he/she will be tested. Respondent shall be required to make daily contact to determine if the drug testing is required.

The following standards shall govern all aspects of testing required to determine abstention from alcohol and drugs for any person whose license is placed on probation or in a diversion program due to substance abuse

TESTING FREQUENCY SCHEDULE

The Board may order a licensee to drug test at any time. Additionally, each licensee shall be tested randomly in accordance with the following schedule:

Level	Segments of Probation/Diversion	Minimum Range of Number of Random Tests
LEVEL I	Year 1	52-104 per year
LEVEL II*	Year 2+	36-104 per year

* The minimum range of 36-104 identified in level II, is for the second year of probation or Diversion, and each year thereafter, up to five (5) years. Thereafter, administration of one (1) time per month if there have been no positive drug tests in the previous five (5) consecutive years of probation or diversion.

Nothing precludes the Board from increasing the number of random tests for any reason. If the Board finds or suspects that a licensee has committed a violation of the Board's testing program or has committed a "major violation", as defined in Uniform Standard #10, may re-establish the testing cycle by placing that licensee at the beginning of level I, in addition to any other disciplinary action that may be pursued.

Any detection through testing of alcohol, or of a controlled substance, or dangerous drug absent documentation that the detected substance was taken pursuant to a legitimate prescription and a necessary treatment, may cause the Board or its designee to increase the frequency of testing, in addition to any other action including but not limited to further disciplinary action.

Respondent shall have the test performed by a Board-approved laboratory certified and accredited by the U.S. Department of Health and Human Services on the same day that he or she is notified that a test is required. This shall ensure that the test results are sent immediately to the Board. Failure to comply within the time specified shall be considered an admission of a positive drug screen and constitutes a violation of probation.

If a test results in a determination that the urine admission was too diluted for testing, the result shall be considered an admission of a positive urine screen and constitutes a violation

of probation. If an "out of range result" is obtained, the Board may require respondent to immediately undergo a physical examination and to complete laboratory or diagnostic testing to determine if any underlying physical condition has contributed to the diluted results and to cease practice. Any such examination or laboratory and testing costs shall be paid by respondent. An "out of range result" is one in which, based on scientific principles, indicates the respondent attempted to alter the test results in order to either render the test invalid or obtain a negative results when a positive results should have been the outcome. If it is determined that respondent altered the test results, the results shall be considered an admission of a positive urine screen and constitutes a violation of probation and respondent must cease practicing. Respondent shall not resume practice until notified by the Board. If respondent tests positive for a banned substance, respondent shall be ordered by the Board to cease any practice, and may not practice unless and until notified by the Board.

The Board or its designee may require less frequent testing if any of the following apply.

EXCEPTIONS TO TESTING FREQUENCY SCHEDULE:

- **Previous Testing Sobriety**. In cases where the Board has evidence that a licensee has participated in a treatment or monitoring program requiring random testing prior to being subject to testing by the Board, the Board may give consideration to that testing frequency schedule so that it is equivalent to this standard.
- **Violation(s) Outside of Employment**. Where the basis for probation or discipline is a simple incident or conviction involving alcohol or drugs, or two incidents or convictions involving alcohol or drugs that were at least seven (7) years from each other, where those violations did not occur at work or while on the licensee's way to work, where alcohol or drugs were a contributing factor, may bypass level I and participate in level II of the testing frequency schedule.
- **Not Employed in Health Care Field.** The Board may reduce testing frequency to a minimum of 12 times per year for any person who is not practicing OR working in any health care field. If a reduced testing frequency schedule is established for this reason, and if a licensee wants to return to practice work in a health care field, the licensee shall notify and secure the approval of the Board. Prior to returning to any health care employment, the licensee shall be subject to level I testing frequency for at least 60 calendar days. At such time the licensee returns to employment (in a health care field), if the licensee has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.
- **Tolling.** The Board may postpone all testing for any person whose probation or Diversion is placed in a tolling status if the overall length of the probationary or Diversion period is also tolled. The licensee shall notify the Board upon the licensee's return to California and shall be subject to testing as provided in this standard. If the licensee returns to employment in a health care field, and has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II shall be in effect.

- **Substance Use Disorder No Diagnosed**. In cases where no current substance use disorder diagnosis is made, a lessor period of monitoring and toxicology screening may be adopted by the Board, but not to be less than 24 times per year.

OTHER DRUG STANDARDS

- Biological fluid testing may be required on any day, including weekends and holidays. The scheduling of the biological fluid testing shall be done on a random basis, preferably by a computer program, so that respondents can make no reasonable assumption of when he/she will be tested. Respondent shall be required to make daily contact to determine if drug testing is required. The Board should be prepared to report data to support back-to-back testing as well as, number different intervals of testing.
- Licensees shall be drug tested on the date of notification as directed by the Board.
- Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S. Department of Transportation.
- Specimen collectors shall adhere to the current U.S. Department of Transportation Specimen Collection Guidelines.
- Testing locations shall comply with the Urine Specimen Collection Guidelines published by the U.S. Department of Transportation, regardless of the type of test administered.
- Collection of specimens shall be observed.
- Prior to vacation or absence, alternative drug testing location(s) must be approved by the Board
- Laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.
- A collection site must submit a specimen to the laboratory within one (1) business day of receipt. A chain of custody shall be used on all specimens. The laboratory shall process results and provide legally defensible test results within seven (7) business days of receipt of the specimen. The Board should be notified of a non-negative test result within one (1) business day and will be notified of negative test results within seven (7) business days.
- The Board may use other testing methods in place of, or to supplement biological fluid testing, if the alternative testing method is appropriate.

[Optional: This condition may be waived or modified by the Board or its designee upon a written finding by the Clinical Diagnostic Evaluator that respondent is not a substance abusing licensee.]

PETITIONS FOR REINSTATEMENT

Nothing herein shall limit the Board's authority to reduce or eliminate the penalties herein pursuant to a petition for reinstatement or reduction of penalty filed pursuant to Government Code 11522 or statutes applicable to the Board that contains different provisions for reinstatement or reduction of penalty.

OUTCOMES AND AMENDMENTS

For purposes of measuring outcomes and effectiveness, the Board shall collect and report historical data and post implementation data as follows:

Historical Data: Two Years Prior to Implementation of Standard

The Board shall collect the following historical data (as available), for a period of two years, prior to implementation of this standard, for each person subject to testing for banned substances, who has:

1) tested positive for a banned substance,
2) failed to appear or call in, for testing on more than three occasions,
3) failed to pay testing costs, or
4) a licensee who has given a diluted or invalid specimen.

Post Implementation Data: Three Years

The Board shall collect the following data annually, for a period of three years, for every probationer and Diversion participant subject to testing for banned substances, following the implementation of this standard.

Data Collection

The data collected shall be reported to the Department of Consumer Affairs and the Legislature, upon request, and shall include, but may not be limited to:

1) Probationer/Diversion Participant Unique Identifier
2) License Type
3) Probation/Diversion Effective Date
4) General Range of Testing Frequency by/for Each Probationer/Diversion Participant
5) Dates Testing Requested
6) Identify the Entity that Performed Each Test
7) Dates Tested Positive
8) Dates Contractor (if applicable) was informed of Positive Test
9) Dates Board was informed of Positive Test
10) Dates of Questionable Tests (e.g. dilute, high levels)
11) Date Contractor Notified the Board of Questionable Test
12) Identify Substances Detected or Questionably Detected
13) Dates Failed to Appear
14) Dates Contractor Notified Board of Failure to Appear
15) Dates Failed to Call in for Testing
16) Date Contractor Notified Board of Failure to Call in for Testing
17) Dates Failed to Pay for Testing
18) Date(s) Removed/Suspended from Practice (identify which)
19) Final Outcome and Effective Date (if applicable)

37. Group Support Meetings (Uniform Standards for Substance Abusing Licensees #5, #13)

[OPTIONAL: If the Board requires respondent to participate in group support meetings then the following applies:]

Respondent shall participate in group support meetings. Verified documentation of attendance shall be submitted by respondent with each quarterly report. Any costs associated with attending and reporting on group support meetings shall be paid by respondent.

When determining the frequency of group support meeting to be attended, the Board shall give consideration to the following:

- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use;
- the recommendation of the clinical evaluator;
- the scope and pattern of use;
- the licensee's treatment history; and
- the nature, duration, and severity of substance abuse.

Group Meeting Facilitator Qualifications:

A group meeting facilitator for any support group meeting:

- must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse;
- must be licensed or certified by the state or other nationally certified organization;
- must not have a financial relationship, personal relationship, or business relationship with the licensee within the last year;
- shall report any unexcused absence within 24 hours to the Board, and,
- shall provide to the Board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.

[Optional: This condition may be waived or modified by the Board or its designee upon a written finding by the Clinical Diagnostic Evaluator that respondent is not a substance abusing licensee.]

38. Worksite Monitor (Uniform Standards for Substance Abusing Licensees #7, #13)

OPTIONAL: If the Board requires respondent to use a worksite monitor then the following applies:

Respondent shall obtain a worksite monitor. Respondent shall submit the name of the proposed worksite monitor within twenty (20) calendar days of the effective date of the decision. Respondent shall complete any required consent forms and sign an agreement with the worksite monitor and the Board regarding respondent and the worksite monitor's requirements and reporting responsibilities. If the worksite monitor terminates the agreement with the Board and respondent, respondent shall not resume practice until another worksite monitor is obtained by respondent and approved by the Board.

The Worksite Monitor Must Meet the Following Qualifications:

1. The worksite monitor shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the Board; however, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.
2. The worksite monitor's licensure scope of practice shall include the scope of practice of the licensee that is being monitored, be another health care professional. If no monitor with like practice is available, or, as approved by the Board, be a person in a position of authority who is capable of monitoring the licensee at work.
3. If the worksite monitor is a licensed health professional , he or she shall have an active unrestricted license, with no disciplinary action within the last five (5) years.
4. The worksite monitor shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and/or contract and agrees to monitor the licensee as set forth by the Board.

The worksite monitor must adhere to the following required methods of monitoring the licensee:

- Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the Board, at least once per week.
- Interview other staff in the office regarding the licensee's behavior, if applicable.
- Review the licensee's work attendance.

Reporting by the worksite monitor to the Board shall comply with the following:

1. Any suspected substance abuse must be verbally reported to the contractor, the Board, and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the Board's normal business hours the verbal report must be within one (1) hour of the next business day. A written report shall be submitted to the Board within 48 hours of occurrence.
2. The worksite monitor shall complete and submit a written report monthly or as directed by the Board. The report shall include:

    - the licensee's name;
    - license number;
    - worksite monitor's name and signature;
    - worksite monitor's license number;
    - worksite location(s);
    - dates licensee had face-to-face contact with monitor;
    - staff interviewed, if applicable;
    - attendance report;
    - any change in behavior and/or personal habits;
    - any indicators that can lead to suspected substance abuse.

[Optional: This condition may be waived or modified by the Board or its designee upon a written finding by the Clinical Diagnostic Evaluator that respondent is not a substance abusing licensee.]

39. Results of Biological Fluid Tests (Uniform Standards for Substance Abusing Licensees #8 and #9)

If the results of a biological fluid test indicate that a licensee has used, consumed, ingested or administered to himself or herself a prohibited substance, the Board shall order the licensee to cease practice and contact the licensee and instruct him or her to leave work immediately. The Board shall also immediately notify the licensee's employer that the licensee may not work.

Thereafter, the Board should determine whether the positive test result is in fact evidence of prohibited use by consulting the specimen collector and laboratory, communicating with the licensee and/or any physician who is treating the licensee, and communicating with any treatment provider, including group facilitator(s). If the Board confirms that a positive test result is evidence of use of a prohibited substance, the license has committed a major violation (Uniform Standards #8, #9), and the Board shall impose any or all of the consequences of committing a major violations (Uniform Standard #10), in addition to any other terms and conditions the Board determines are necessary for public protections or to enhance the rehabilitation of the licensee.

If no prohibited use exists, the Board shall immediately lift the cease practice order. If the Board confirms that a positive drug test is evidence of use of prohibited substance, the licensee has committed a major violation.

40. Major and Minor Violations (Uniform Standards for Substance Abusing Licensees #10)

Major Violations include, but are not limited to:

1. Failure to complete a Board-ordered program;
2. Failure to undergo a required clinical diagnostic evaluation;
3. Committing multiple minor violations of probation conditions and terms;
4. Treating patients while under the influence of drugs/alcohol;
5. Committing any drug/alcohol offense that would constitute a violation of the California Business and Professions Code, or other state/federal laws;
6. Failure to obtain biological testing for substance abuse when ordered;
7. Testing positive and confirmation for substance abuse pursuant to Uniform Standard for Substance Abusing Licensee # 9;
8. Knowingly using, making, altering or possessing any object or product in such a way as to defraud a drug test designed to detect the presence of alcohol or a controlled substance.

Consequences for a major violation include, but are not limited to:

1. A Board order to cease practice. The Board may also order the licensee to undergo a new clinical diagnostic evaluation. The Board's order may state that the licensee must test negative for at least a month of continuous drug testing before being allowed to go back to work.
2. Termination of a contract/agreement.

3. Referral for disciplinary action, such as suspension, revocation, or other actions as determined by the Board.

Minor Violations included, but are not limited to:

1. Untimely receipt of required documentation;
2. Unexcused non-attendance at group meetings;
3. Failure to contact a monitor when required;
4. Any other violations that do not present an immediate threat to the violator or the public.

Consequences for minor violations include, but are not limited to:

1. Removal from practice;
2. Practice limitations;
3. Required supervision;
4. Increased documentation;
5. Issuance of citation and fine or a warning notice;
6. Required re-evaluation/testing;
7. Other action as determined by the Board.

41. Request by a Substance – Abusing Licensee to Return to Practice (Uniform Standards for Substance Abusing Licensees # 11)

"Petition" as used in this standard is an information request as opposed to a "Petition for Modification" under the Administrative Procedure Act

The licensee shall meet the following criteria before submitting a request (petition) to return to full time practice:

1. Demonstrated sustained compliance with current recovery program.
2. Demonstrated the ability to practice safely as evidenced by current work site reports, evaluations, and any other information related to the licensee's substance abuse.
3. Negative drug screening reports for at least six (6) months, two (2) positive worksite monitor reports, and complete compliance with other terms and conditions of the program.

42. Request by a Substance Abusing Licensee for Reinstatement of a full and unrestricted license Petition for Reinstatement (Uniform Standards for Substance Abusing Licensees #12)

"Petition for Reinstatement" as used in this standard is an informal request (petition) as opposed to a "Petition for Reinstatement" under the Administrative e Procedure Act.

The licensee must meet the following criteria to request (petition) for a full and unrestricted license:

1. Demonstrate sustained compliance with the terms of the disciplinary order, if applicable.
2. Demonstrated successful completion of recovery/Diversion Program, if required.

3. Demonstrated a consistent and sustained participation in activities that promote and support their recovery including, but not limited to, ongoing support meetings, therapy, counseling, relapse prevention plan, and community activities.
4. Demonstrated that he or she is able to practice safely.
5. Continuous sobriety for three (3) to five (5) years.

PART IV Recommended Discipline By Violation

The following discipline, including terms and conditions of probation, generally listed by statue order as set forth in the Business and Professions Code, is recommended by the Board for proven or stipulated violations. In all circumstances, the maximum penalty for any violation of the Business and Professions Code will be revocation.

The following disciplinary penalties for selected Business and Professions Code violations are guidelines for use by administrative law judges at hearings as well as for use in settlement of cases. Individual penalties may vary depending upon the particular circumstances of the case resulting in aggravation or mitigation of the offenses alleged. If probation is imposed as part of a penalty, the probation should include: (1) standard terms and conditions, which will appear in all cases; (2) the terms and conditions specific to violation, which will be tailored according to the nature of the offense; and (3) if the violation involved the use of drugs or alcohol, terms and conditions of the Uniform Standards for Substance Abusing Licensees contained in Part II of the Disciplinary Guidelines shall be included.

B & P 725 EXCESSIVE PRESCRIBING OR TREATMENTS

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms and conditions and

1.Drugs: Total DEA restriction
Surrender DEA permit
(0R) Partial DEA Restriction
2. Pharmacology Course
3. Education Course
4. Worksite Monitor
5. Written Examination
6. Clinical Assessment and Training Program
7. Monitor for Practice
8. If warranted, suspension: 30 days or more

B & P 726 SEXUAL MISCONDUCT

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 10 years probation, standard terms and conditions, and

1. Suspension: 90 business days or more
2. Education Course
3.Clinical Assessment and Training Program
4. Psychiatric Evaluation/Psychotherapy
5. Third Party Presence

Note: If violation constitutes sexual contact, revocation must be ordered and not stayed. Sexual contact as defined in Business and Professions Code (BPC) Section 729, and BPC Section 2246 requires

revocation without stay of probation. Additionally, Title 16, California Code of Regulations, Section 1663(b), subsection (b) herein, requires revocation without stay of probation.

B & P 729 SEXUAL EXPLOITATION

Maximum Discipline: Revocation

Minimum Discipline: Revocation

Pursuant to Business and Professions Code Sections 2246, this cause of actions is grounds for revocation. Revocation may not be stayed by the Administrative Law Judge or Board.

B & P 810 INSURANCE FRAUD

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Suspension: 30 calendar days or more
2. Education Course
3. Clinical Assessment and Training Program
4. Monitor: Practice/Billing
5. Solo Practice Prohibition/Supervised Structure
6. Ethics Course
7. Restitution

Note: Suspension or revocation may be mandated by law's provision. See Business and Professions Code Section 810 subdivision (c).

B & P 820 MENTAL OR PHYSICAL ILLNESS

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Psychiatric Evaluation/Psychotherapy
2. Written or Oral Examination
3. Solo Practice Prohibition/Supervised Environment
4. Prohibited Practice
5. Monitoring: Practice/Billing
6. Clinical Assessment and Training Program

B & P 2234(b) GROSS NEGLIGENCE

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Suspension: 30 calendar days or more
2. Education Course
3. Pharmacology Course [if warranted]
4. Written Examination
5. Clinical Assessment and Training Program
6. Monitor: Practice/ Billing
7. Solo Practice Prohibition/ Supervised Structure
8. Prohibited Practice
9. Ethics Course

B & P 2234 (c) REPEATED NEGLIGENT ACTS

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Suspension: 30 calendar days or more
2. Education Course
3. Pharmacology Course [if warranted]
4. Written Examination
5. Clinical Assessment and Training Program
6. Monitor: Practice/ Billing
7. Solo Practice Prohibition/ Supervised Structure
8. Prohibited Practice
9. Ethics Course

B & P 2234 (d) INCOMPETENCE

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Suspension: 30 calendar days or more
2. Education Course
3. Pharmacology Course [if warranted]
4. Written Examination
5. Clinical Assessment and Training Program
6. Monitor: Practice/ Billing
7. Solo Practice Prohibition/ Supervised Structure
8. Prohibited Practice
9. Ethics Course

B & P 2234 (e) DISHONESTY

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 year probation, standard terms, and

1. Suspension: 30 calendar days or more
2. Education Course
3. Clinical Assessment and Training Program
4. Monitor: Practice/ Billing
5. Solo Practice Prohibition/Supervised Structure
6. Ethics Course
7. Community Service
8. Restitution

B & P 2236 CRIMINAL CONVICTION: FELONIES/MULTIPLE DISDEMEANORS

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Suspension: 30 calendar days or more
2. Psychiatric Evaluation/Psychotherapy
3. Education Course
4. Clinical Assessment and Training Program
5. Monitor: Practice/ Billing
6. Ethics Course
7. Community Service
8. Restitution

B & P 2236 CRIMINAL CONVICTION; SINGLE MISDEMEANOR

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Education Course
2. Psychiatric Evaluation/Psychotherapy
3. Monitor: Practice/ Billing
4. Ethics Course
5. Community Service
6. Restitution

B & P 2237 DRUG RELATED CONVICTION

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

If warranted,
1. Suspension: 10 calendar days or more
2. Psychiatric Evaluation/ Psychotherapy
3. Clinical Diagnostic Evaluation
4. Worksite Monitor
5. Monitor: Practice
6. Ethics Course
7. Conditions Applying the Uniform Standards (31-41), including:
    a. Substance Abuse and Addiction Evaluation
    b. Drugs: Abstain from Use
    c. Alcohol: abstain from Use
    d. Random Bodily Fluid Testing
    e. Diversion Program

B & P 2238 VIOLATION OF DRUG STATUTE

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

If warranted,
1. Suspension: 90 calendar days or more
2. Pharmacology Course
3. Clinical Assessment and Training Program
4. Ethics Course
5. Controlled Drugs: Total Restriction
6. DEA: Surrender of DEA Permit
7. Controlled Drugs: Partial Restriction
8. Controlled Drugs: Maintain Record
9. Psychiatric Evaluation/Psychotherapy
10. Worksite Monitor
11. Monitor: Practice
12. Conditions Applying the Uniform Standards (31-42), including:
    a. Substance Abuse and Addiction Evaluation
    b. Drugs: Abstain from Use
    c. Alcohol: Abstain from Use
    d. Random Bodily Fluid Testing
    e. Diversion Program

B & P 2239 SELF ABUSE OF DRUGS OR ALCOHOL

Note: Because this cause of action involves licensee use of alcohol or substance abuse, the probation must include an order by the Board for a clinical evaluation and entry into the Board's Diversion Program and the remaining provisions of the Uniform Standards for Substance Abusing Licensees may

apply contingent upon the finding of the clinical diagnostic evaluation that the licensee is a substance abusing licensee.

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, Uniform Standards for Substance Abusing Licensees (31-42) and

1. Suspension: 10 calendar days or more
2. Controlled Drugs: Total Restriction
3. DEA: Surrender of DEA Permit
4. Controlled Drugs: Partial Restriction
5. Controlled Drugs: Maintain Record
6. Psychiatric Evaluation/Psychotherapy
7. Worksite Monitor
8. Monitor: Practice
9. Ethics Course
10. Conditions Applying the Uniform Standards (31-42), including:
    a. Substance Abuse and Addiction Evaluation
    b. Drugs: Abstain from Use
    c. Alcohol: Abstain from Use
    d. Random Bodily Fluid Testing
    e. Diversion Program

B & P 2241 FURNISHING DRUGS TO AN ADDICT

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

If warranted,

1. Suspension: 10 calendar days or more
2. Pharmacology Course
3. Education Course
4. Clinical Assessment and Training Program
5. Ethics Course
6. Controlled Drugs: Total Restriction
7. DEA: Surrender of DEA Permit
8. Controlled Drugs: Partial Restriction
9. Controlled Drugs: Maintain Record
10. Psychiatric Evaluation/Psychotherapy
11. Worksite Monitor
12. Monitor: Practice
13. Conditions Applying the Uniform Standards (31-42), including:
    a. Substance Abuse and Addiction Evaluation
    b. Drugs: Abstain from Use
    c. Alcohol: Abstain from Use

d. Random Bodily Fluids Testing
e. Diversion Program

B & P 2242 PRESCRIBING DRUGS WITHOUT PRIOR EXAMINATION

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

If warranted,

1. Suspension: 10 calendar days or more
2. Pharmacology Course
3. Education Program
4. Clinical Assessment and Training Program
5. Ethics Course
6. Controlled Drugs: Total Restriction
7. DEA: Surrender of DEA Permit
8. Controlled Drugs: Partial Restriction
9. Controlled Drugs: Maintain Record
10. Psychiatric Evaluation/Psychotherapy
11. Worksite Monitor
12. Monitor: Practice

B & P 2250 FAILURE TO COMPLY WITH STERILIZATION CONSENT PROVISIONS

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, [x] years probation, standard terms, and

1. Education Course
2. Pharmacology Course [if warranted]
3. Written Examination
4. Clinical Assessment and Training Program
5. Monitor: Practice/ Billing
6. Solo Practice Prohibiting/Supervised Structure
7. Prohibited Practice
8. Ethics Course

B & P 2251 USE OF SILICONE

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Suspension: 30 calendar days or more
2. Pharmacology Course
3. Education Program
4. Clinical Assessment and Training Program
5. Ethics Course

6. Prohibited Practice [if warranted]

B & P 2252 ILLEGAL CANCER TREATMENT

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Suspension: 30 calendar days or more
2. Pharmacology Course
3. Education Program
4. Clinical Assessment and Training Program
5. Ethics Course
6. Monitor: Practice/ Billing
7. Prohibited Practice
8. Solo Practice Prohibition/ Supervised Structure

B & P 2261 MAKING OR SIGNING FALSE DOCUMENT

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Suspension: 30 calendar days or more
2. Education Course
3. Ethics Course
4. Monitoring: Practice/ Billing
5. Prohibited Practice
6. Solo Practice Prohibition/ Supervised Structure

B & P 2262 ALTERATION OF MEDICAL RECORDS/ FALSE MEDICAL RECORDS

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Suspension: 30 calendar days or more
2. Education Course
3. Pharmacology Course
4. Ethics Course
5. Monitoring: Billing/ Practice
6. Prohibited Practice
7. Solo Practice Prohibition/Supervised Structure

B & P 2263 VIOLATION OF PROFESSIONAL CONFIDENCE

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms , and

1. Suspension: 30 calendar days or more
2. Education Course
3. Ethics Course
4. Monitoring: Billing/ Practice
5. Prohibited Practice
6. Solo Practice Prohibition/Supervised Structure

B & P 2264 AIDING AND ABETTING UNLICENSED PRACTICE

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, and

1. Suspension: 90 calendar days or more
2. Education Course
3. Monitor: Billing / Practice
4. Prohibited Practice
5. Solo Practice Prohibition/Supervised Structure

B & P 2271, 651 DECEPTIVE ADVERTISING

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 1 year probation and

1. Medical Ethics Course
2. Education Course
3. Community Service

B & P 2272 ANONYMOUS ADVERTISING

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 1 year probation and

1. Medical Ethics Course
2. Education Course
3. Community Service

B & P 2273 EMPLOYMENT OF RUNNERS, CAPPERS AND STEERERS

Maximum Discipline: Revocation.

Minimum Discipline: stayed revocation, 3 years probation, standard terms, and

1. Suspension: 90 calendar days or more
2. Education Course
3. Ethics Course
4. Monitor: Billing/ Practice
5. Prohibited Practice
6. Solo Practice Prohibition/Supervised Structure

B & P 2274 MISUSE OF TITLE

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 1 year probation and

1. Medical Ethics Course
2. Education Course
3. Community Service

B & P 2275 USE OF "M.D."

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 1 year probation and

1. Medical Ethics Course
2. Education Course
3. Community Service

B & P 2276 MISUSE OF "D.O. "

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 1 year probation and

1. Medical Ethics Course
2. Education Course
3. Community Service

B & P 2280 INTOXICATION WHILE TREATING PATIENTS

Note: Because this cause of action involves licensee use of alcohol or substance abuse, the probation must include an order by the Board for a clinical evaluation and entry into the Board's Diversion

Program and the remaining provisions of the Uniform Standards for Substance Abusing Licensees may apply contingent upon the finding of the clinical diagnostic evaluation that the licensee is a substance abusing licensee.

Maximum Discipline: Revocation.

Minimum Discipline: Stayed revocation, 5 years probation, standard terms, Uniform Standards for Substance Abuse terms and conditions (31-42), and

_____ 1. Suspension: 10 calendar days or more
_____ 2. Controlled Drugs: Total Restriction
_____ 3. DEA: Surrender of DEA Permit
_____ 4. Controlled Drugs: Partial Restriction
_____ 5. Controlled Drugs: Maintain Record
_____ 6. Psychiatric Evaluation/ Psychotherapy
_____ 7. Worksite Monitor
_____ 8. Monitor Practice
_____ 9. Ethics Course
_____ 10. Conditions Applying to the Uniform Standards (31-42), including:
_____ a. Substance Abuse and Addiction Evaluation
_____ b. Drugs: Abstain from Use
_____ c. Alcohol: Abstain from Use
_____ d. Random Bodily Fluid Testing
_____ e. Diversion Program

B & P 2285 USE OF FICTITIOUS NAME WITHOUT PERMIT

Maximum Discipline: Revocation.

Minimum Discipline: 90 calendar days suspension, 1 year probation and

1. Medical Ethics Course
2. Education Course
3. Community Service

B & P 2235 OBTAINING LICENSE BY FRAUD

Maximum Discipline: Revocation.

Minimum Discipline: Revocation

B & P 2288 IMPERSONATION OF APPLICANT IN EXAM

Maximum Discipline: Revocation

Minimum Discipline: Revocation

B & P 2306 PRACTICE DURING SUSPENSION

Maximum Discipline: Revocation

Minimum Discipline: Revocation

B & P 2305 DISCIPLINE BY ANOTHER STATE OR FEDERAL AGENCY

Minimum penalty: add actual period of suspension
Maximum penalty: impose penalty that is stayed

VIOLATION OF PROBATION: REPEATED VIOLATIONS

A repeated similar offense or a violation of probation evidencing an unreformed attitude should call for the maximum Discipline. Other violations of probation should call for at least a meaningful period of actual suspension, preferably 90 days or more, as well as other appropriate terms and conditions.

~~OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA~~
~~DISCIPLINARY GUIDELINES OF 1996~~

~~[LOGO]~~

~~Osteopathic Medical Board of California~~
~~2720 Gateway Oaks Drive, Suite 350~~
~~Sacramento, CA 95833~~

~~(916)263-3100~~

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

DISCIPLINARY GUIDELINES OF 1996

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Section I

I. Disciplinary Penalties

The following disciplinary penalties for selected Business and Professions Code violations are guidelines for use by administrative law judges at hearings as well as for use in settlement of cases. Individual penalties may vary depending upon the particular circumstances of the case resulting in aggravation or mitigation of offenses alleged. If probation is imposed as part of a penalty, the probation should include: (1) standard conditions, which will appear in all cases; and (2) the optional conditions, which will be tailored according to the nature of the offense.

A. STANDARD CONDITIONS OF PROBATION

The standard of probation conditions are as follows:

(1) Obey all laws (1) *;

(2) File quarterly reports (2);

(3) Probation surveillance program (3);

(4) Interviews with medical consultants (4);

(5) Cost Recovery (5);

(6) License Surrender (6);

(7) Tolling of probation, if out of state (7); and

(8) Probation violation/completion of probation (8)

** The number in parentheses refers to the sample model orders found in Part II: Sample Model Orders*

B. OPTIONAL CONDITIONS OF PROBATION

The following conditions of probation, generally listed by statute order as set forth by Business and Professions Code, are recommended by the Board for proven or stipulated violations. In all circumstances, the maximum penalty for any violation of the Business and Professions Code will be revocation. Additionally, violations of Business and Professions Code Sections 2235 (obtaining license by fraud), 2288 (impersonation of an applicant in an examination), and 2306 (practice under suspension) shall all result in an order of revocation.

B & P 725 – EXCESSIVE PRESCRIBING

Minimum penalty: Stayed revocation, 5 years probation

~~1. Drugs Total DEA restriction (10)~~
~~Surrender DEA (11)~~
~~(or) Partial DEA restriction (12)~~
~~2. Pharmacology course (18)~~
~~3. If warranted, education course (19)~~
~~4. If warranted, supervised structured environment (29)~~
~~5. If warranted, oral/practical examination (22)~~
~~6. If warranted, suspension of at least 90 days (9)~~
~~7. If warranted, maintain drug records for review (13)~~

~~B & P 725 – EXCESSIVE TREATMENTS~~

~~Minimum penalty: Stayed revocation, 5 years probation~~

~~1. Education course (20)~~
~~2. If warranted, supervised structured environment (29)~~
~~3. If warranted, oral/practical examination (22)~~
~~4. If warranted, suspension of at least 90 days (9)~~

~~B & P 726 – SEXUAL MISCONDUCT~~

~~Minimum penalty: Stayed revocation, 10 years probation~~

~~1. Education course (19)~~
~~2. Psychiatric evaluation (25)~~
~~Or, psychotherapy (26)~~

~~3. If warranted, supervised structured environment (29)~~
~~4. Required third part present when examining patients (23)~~

~~B & P 820 – MENTAL OR PHYSICAL ILLNESS~~

~~Minimum penalty: Stayed revocation, 5 years probation~~

~~1. If warranted, restricted practice (24)~~
~~2. If warranted, monitoring (29)~~

~~B & P 2234 (b) – GROSS NEGLIGENCE~~

~~B & P 2234 (c) – REPEATED NEGLIGENT ACTS~~

~~B & P 2234 (d) – INCOMPETENCE~~

~~Minimum penalty: Stayed revocation, 5 years probation~~

~~1. Pharmacology course (18)~~
~~2. Education course (19)~~

Clinical training program (21)(where deficiency is noted by the physician is not a present danger to the public)
3. Oral/practical examination (22)
4. If warranted, supervised structured environment (29)
5. If warranted, restricted practice (24)
6. If warranted, medical evaluation (27)
7. If warranted, medical treatment (28)

B & P 810 – INSURANCE FRAUD

B & P 2234 (e) – DISHONESTY

B & P 2261 – MAKING OR SIGNING FALSE DOCUMENT

B& P 2262 – FALSE MEDICAL RECORDS

B & P 2263 - VIOLATION OF PROFESSIONAL CONFIDENCE

Minimum penalty: Stayed revocation, 5 years probation

1. If warranted, community service program (30)
2. If warranted, actual suspension (9)
3. If warranted, restitution (31)
4. Education course (19)

B & P 2236 – CRIMINAL CONVICTION
Minimum penalty: Stayed revocation, 5 years probation

Terms and conditions depend on the underlying facts of the criminal offense.

B & P 2237 – DRUG RELATED CONVICTION

B & P 2238 – VIOLATION OF DRUG STATUTE

B & P 2241 – FURNISHING DRUGS TO AN ADDICT

B & P 2242 – PRESCRIBING DRUGS WITHOUT PRIOR EXAMINATION

Minimum penalty: Stayed revocation, 5 years probation

1. Drugs – total DEA restriction (10)
Or surrender DEA permit (11)
Partial DEA permit (11)
2. Pharmacology course (18)
3. Education Course (19) and/ or a clinical training program (21)
4. If warranted, oral/ practical examination (22)
5. If warranted, supervised structured environment (29)
6. If self-user or drugs: See B & P 2239

~~7. If warranted, suspension of at least 90 days (9)~~
~~8. If warranted, maintain drug records for review (13)~~
~~9. If warranted, monitoring (29)~~

~~*NOTE: Unless there is extensive mitigation, outright revocation for conviction of illegal sales of controlled drugs is the proper penalty.*~~

~~B & P 2239 – SELF-ABUSE OF DRUGS OR ALCOHOL~~

~~B & P 2250 – FAILURE TO COMPLY WITH STERILIZATION CONSENT PROVISIONS~~

~~B & P 2251 – USE OF SILICONE~~

~~B & P 2252 – ILLEGAL CANCER TREATMENT~~

~~Minimum penalty: Stayed revocation, 5 years probation~~

~~1. If warranted, period of actual suspension (9)~~
~~2. Community service (30)~~
~~3. Education (19)~~
~~4. If warranted, monitoring (29)~~

~~B & P 2264 – AIDING AND ABETTING UNLICENSED PRACTICE~~

~~Minimum penalty: Stayed revocation, at least 3 years probation~~

~~1. If warranted, suspension of at least 60 days (9)~~
~~2. If warranted, oral/practical or written examination (22)~~
~~3. If warranted, monitoring (29)~~
~~4. If warranted, restricted practice (24)~~

~~B & P 2265 – USE OF QUALIFIED PHYSICIAN ASSISTANT WITHOUT APPROVAL~~

~~Minimum penalty: 90 days stayed suspension, one year probation~~

~~1. If warranted, period of actual suspension (9)~~
~~2. If warranted, community services (30)~~

~~B & P 2271, 651 – DECEPTIVE ADVERTISING~~

~~B & P 2272 – ANONYMOUS ADVERTISING~~

~~B & P 2273 – EMPLOYMENT OF RUNNERS, CAPPERS AND STEERERS~~

~~B & P 2274 – MISUSE OF TITLE~~

~~B & P 2275 – USE OF "M.D."~~

B & P 2276 – MISUSE OF "D.O."

B & P 2280 – INTOXICATION WHILE TREATING PATIENTS

Minimum penalty: Stayed revocation, 5 years probation

1. If drugs – total DEA restriction (10)
   Or surrender or DEA permit (11)
   Partial DEA restriction (12)
2. If alcohol – abstain from alcohol (16)
3. If warranted, in case of drug abuse, abstain from alcohol (16)
4. Drugs – abstain from use (15)
5. Biological fluid testing (17)
6. Psychiatric evaluation (25)
7. If warranted, psychiatric treatment (26)
8. If warranted, drug or alcohol rehabilitation program (14)
9. Medical evaluation (27) and/or medical treatment (28)
10. Pharmacology course (18)
11. Education course (19)
12. If warranted, oral/practical examination (22)
13. If warranted, supervised structured environment (29)
14. If warranted, maintain drug records for review (13)

B & P 2285 – USE OF FICTITIOUS NAME WITHOUT PERMIT

Minimum penalty: 90 days stayed suspension, 3 years probation

1. If warranted, actual suspension (9)
2. If warranted, community service (30)
3. If warranted, restitution (31)
4. If warranted, education course (19)

B & P 2305 – DISCIPLINE BY ANOTHER STATE OR FEDERAL AGENCY

Minimum penalty: add actual period of suspension
Maximum penalty: impose penalty that was stayed

A repeated similar offense or a violation of probation evidencing an unreformed attitude should call for the maximum penalty. Other violations of probation should call for at least a meaningful period of actual suspension, preferably 90 days or more.

II. SAMPLE MODEL ORDERS

A. STANDARD CONDITIONS OF PROBATION

1. Obey all laws –

Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California, and remain in full compliance with any court ordered criminal probation, payments and other orders.

2. Quarterly reports –

Respondent shall submit to the Board quarterly declaration under penalty of perjury on the Quarterly Report of Compliance Form, OMB 10 (5/97) which is hereby incorporated by reference, stating whether there has been compliance with all the conditions of probation.

3. Probation surveillance program –

Respondent shall comply with the Board's probation surveillance program. Respondent shall, at all times, keep the Board informed of his or her addresses of Business and residence, which shall both serve as addresses of record. Changes of such addresses shall be immediately communicated in writing to the Board. Under no circumstance shall a post office box serve as an address of record.

Respondent shall also immediately inform the Board, in writing, of any travel to any areas outside the jurisdiction of California, which lasts, or is contemplated to last, more than thirty (30) days.

4. Interviews with medical consultants –

Respondent shall appear in person for interviews with the Board's medical consultants upon request at various intervals and with reasonable notice.

5. Cost recovery –

The respondent is hereby ordered to reimburse the Board the amount $_____ within 90 days from the effective date of this decision for its investigative and prosecution costs. Failure to reimburse the Board's cost of its investigation and prosecution shall constitute a violation of the probation order, unless the Board agrees in writing to payment by an installment plan because of financial hardship.

6. License surrender –

Following the effective date of this decision, if respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, respondent may voluntarily tender his/her certificate to the Board. The Board reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the tendered license, respondent will no longer be subject to the terms and conditions of probation.

7. Tolling for out-of-state practice or residence, or in-state non-practice (inactive license).

In the event respondent shall leave California to reside or to practice outside the State or for any reason should respondent stop practicing medicine in California, respondent shall notify the Board or its designee in writing within ten days of the dates of departure and return or the dates of non-compliance within California. Non-practice is defined as any period of time exceeding thirty days in which respondent is not engaging in any activities defined in Section 2051 and /or 2052 of the Business

and Professions Code. All time spent in an intensive training program approved by the Board or its designee in or out of the state shall be considered as time spent in the practice of medicine. Periods of temporary or permanent residence or practice outside California or of non-practice within California, as defined in this condition shall not apply to the reduction of the probationary period.

8. Probation violation/completion of probation –

If respondent violates probation in any respect, the Board may revoke probation and carry out the disciplinary order that was stayed after giving respondent notice and opportunity to be heard. If an Accusation and/or Petition to revoke is filed against respondent during probation, the Board shall continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final. Upon successful completion of probation, respondent's certificate will be fully restored.

B. OPTIONAL CONDITIONS OF PROBATION

9. Actual suspension –

Respondent shall be suspended from the practice of medicine for _____ beginning the effective date of this decision.

10. Controlled drugs – total restriction.

Respondent shall not prescribe, administer, dispense, order, or possess any controlled substances as defined in the California Uniform Controlled Substance Act except for ordering or possessing medications lawfully prescribed to respondent for a bona fide illness or condition by another practitioner.

11. Controlled drugs – surrender of DEA permit –

Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Board or its designee that the respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any triplicate prescription forms and federal order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the Board.

12. Controlled drugs – partial restriction –

Respondent shall not prescribe, administer, dispense, order or possess any controlled substance as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s) _____ of the Act and prescribed to respondent for a bona fide illness or condition by another practitioner.

_____ (or)

Respondent is permitted to prescribe, administer, dispense or order controlled substances listed in Schedule(s)_____ of the Act for in-patients in a hospital setting, and not otherwise.

Note: Use the following paragraph only if there is an actual elimination of authority to prescribe a Scheduled Controlled Substance.

~~Respondent shall immediately surrender his/her current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order.~~

~~13. Controlled drugs – maintain record –~~

~~Respondent shall maintain a record of all controlled substances prescribed, dispensed or administered by respondent during probation, showing the following: (1) the name and address of the patient (2) the date, (3) the character and quantity of controlled substances involved and (4) the pathology and purpose for which the controlled substance was furnished.~~

~~Respondent shall keep these records in a separate file or ledger, in chronological order and shall make them available for inspection and copying by the Board or its designee, upon request.~~

~~14. Diversion program – alcohol and drugs –~~

~~Within 30 days of the effective date of this decision, respondent shall enroll and participate in the Board's Diversion Program until the Board determines that further treatment and rehabilitation is no longer necessary. Quitting the program without permission or being expelled for cause shall constitute a violation by respondent.~~

~~15. Drugs – abstain from use –~~

~~Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, and dangerous drugs as defined the Business and Professions Code, or any drugs requiring a prescription except for ordering or possessing medications lawfully prescribed to respondent for a bona fide illness or condition by another practitioner.~~

~~16. Alcohol – abstain from use –~~

~~Respondent shall abstain from the use of alcoholic beverages.~~

~~17. Biological fluid testing –~~

~~Respondent shall immediately submit to biological fluid testing, at respondent's cost, upon the request of the Board or its designee.~~

~~18. Pharmacology course –~~

~~Within 60 days of the effective date of this decision, respondent shall enroll in a course in Pharmacology course, approved in advance by the Board or its designee, and shall successfully complete the course during the first year of probation.~~

~~19. Education course –~~

Within 90 days of the effective date of this decision, and on an annual basis thereafter, respondent shall submit to the Board for its prior approval an education program or course related to the violations charged in the accusation. This shall be completed during the first year of probation. This program shall be in addition to the Continuing Medical Education requirements for re-licensure. Following the completion of each course, the Board or its designee may administer an examination to test the respondent's knowledge of the course. Respondent shall provide proof of attendance for both continuing medical education requirements and education course on a yearly basis.

20. Medical ethics course –

Within 60 days of the effective date of this decision, respondent shall submit to the Board for its prior approval a course in medical ethics which respondent shall successfully complete during the first year of probation.

21. Clinical training program –

Within 90 days of the effective date of this decision, respondent shall submit to the Board for its prior approval, an intensive clinical training program. The exact number of hours and the specific content of the program shall be determined by the Board or its designee and shall be related to the violations charged in the accusation. Respondent shall successfully complete the training program and may be required to pass an examination administered by the Board or its designee related to the program's contents.

22. Oral/practical or written examination –

Within 60 days of the effective date of this decision, (or upon completion of the required education course)(or upon completion of the required clinical training program) respondent shall take and pass a(n) oral/practical and/or written) examination to be administered by the Board or its designee. Written examination may be the Special Purpose Exam. If respondent fails this examination, respondent must wait three months between re-examinations, except that after three failures respondent must wait one year to take each necessary re-examination thereafter. The respondent shall pay the costs of all examinations.
(Use either of the following two options with the above paragraph)

OPTION #1: Condition precedent

Respondent shall not practice medicine until respondent has passed this examination and has been so notified by Board in writing.

OPTION # 2: Condition subsequent

If respondent fails to take and pass this examination by the end of the first six months of probation, respondent shall cease the practice of medicine until this examination has been successfully passed and respondent has been so notified by the Board in writing.

23. Third party presence –

During probation, respondent shall have a third party present while examining or treating (male, female, minor) patients. Respondent shall within 30 days of the effective date of the decision, submit to the Board or its designee for its approval name(s) of persons who will act as the third party present. The respondent shall execute a release authorizing the third party(s) present to divulge any information that the Board may request during interviews by the probation monitor on a periodic basis.

NOTE: Sexual transgressors should normally be placed in a supervised structured environment.

24. Prohibited practice –

During probation, respondent is prohibited from practicing_____.

25. Psychiatric evaluation –

Within 30 days of the effective date of this decision, and on a periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo a psychiatric evaluation by a Board appointed psychiatrist who shall furnish a psychiatric report to the Board or its designee. The respondent shall pay the cost of the psychiatric evaluation.

If respondent is required by the Board or its designee to undergo psychiatric treatment, respondent shall within 30 days of the requirement notice submit to the Board for its prior approval the name and qualifications of a psychiatrist of respondent's choice. Upon approval of the treating psychiatrist, respondent shall undergo and continue psychiatric treatment until further notice from the Board. Respondent shall have the treating psychiatrist submit quarterly status report to the Board indicating whether the defendant is capable of practicing medicine safely.

(OPTIONAL)

Respondent shall not engage in the practice of medicine until notified by the Board of its determination that respondent is mentally fit to practice safely.

26. Psychotherapy –

Within 60 days of the effective date of this decision, respondent shall submit to the Board for its prior approval the name and qualifications of a psychotherapist of respondent's choice. Upon approval, respondent shall undergo and continue treatment until the Board deems that no further psychotherapy is necessary. Respondent shall have the treating psychotherapist submit quarterly status report to the Board. The Board may require response to undergo psychiatric evaluation by a Board appointed psychiatrist. Respondent shall pay all cost of the psychiatric evaluation.

NOTE: This condition is for those cases where the evidence demonstrated that the respondent has had impairment (impairment by mental illness, alcohol abuse and drug self-abuse) related to the violations but is not at present a danger to his/her patients.

27. Medical evaluation –

Within 30 days of the effective date of this decision, and on a periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo a medical evaluation by a Board appointed physician who shall furnish a medical report to the Board or its designee. Respondent shall pay all costs of the medical evaluation.

If respondent is required by the Board or its designee to undergo medical treatment, respondent shall within 30 days of the requirement notice submit to the Board for its prior approval the name and qualifications of a physician of the respondent's choice. Upon approval , respondent shall undergo and continue treatment until the Board deems that no further medical treatment is necessary. Respondent shall not engage in the practice of medicine until notified by the Board of its determination that the respondent is medically fit to practice safely. Respondent shall pay the costs of such medical treatment.

NOTE: This condition is for those cases where the evidence demonstrates drug or alcohol impairment or medical illness or disability was a contributing cause of the violations.

28. Medical treatment –

Within 60 days of the effective date of this decision, respondent shall submit to the Board for its prior approval the name and qualifications of a physician of respondent's choice. Upon approval, response shall undergo and continuing treatment until the Board deems that no further medical treatment is necessary. Respondent shall have the treating physician submit quarterly status reports of the periodic medical evaluations by a Board appointed physician. Respondent shall pay the cost of such medical treatments.

29. Supervised structured environment –

Respondent is prohibited from engaging in solo practice. With 30 days of the effective date of this decision, respondent shall submit to the Board and receive its prior approval, for a plan of practice limited to a supervised structured environment in which respondent's activities will be overseen and supervised by another physician, who shall provide reports to the Board.

30. Community services –

Within 60 days of the effective date of this decision, respondent shall submit to the Board for its prior approval a community service program in which respondent shall provide free medical services on a regular basis to a community or charitable facility or agency for at least _____hours a month for the first _____months of probation.

NOTE: Not for quality of care issues.

31. Restitution –

Respondent shall provide restitution to _____in the amount of _____ prior to the completion of the first year of probation.

NOTE: For patients only.

Quarterly Report of Compliance
(rev. 05/97)
(*Current*)

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991
P (916) 928-8390 F (916) 928-8392 | www.ombc.ca.gov

QUARTERLY REPORT OF COMPLIANCE

(Please print or type)

NAME: LAST FIRST MIDDLE

RESIDENCE ADDRESS: NUMBER STREET CITY STATE PHONE:

OFFICE ADDRESS: NUMBER STREET CITY STATE PHONE:

NAME OF EMPLOYER, PARTNER, OR ASSOCIATE (if any, and as may be appropriate):
LAST FIRST MIDDLE

ADDRESS: NUMBER STREET CITY STATE

Since the last quarterly report have you had any problem securing or maintaining employment? ☐ YES ☐ NO
Explain in detail, if answer is YES:

1. SINCE YOUR LAST QUARTERLY REPORT, HAVE YOU BEEN ARRESTED, CHARGED, OR CONVICTED OF ANY VIOLATION OF:

   (a) Federal or State statute, county, or city ordinance? . ..... ☐ YES ☐ NO

   (b) Federal or State law pertaining to the furnishing or using of narcotics or dangerous drugs?..... ☐ YES ☐ NO

2. Have you complied with each and every condition of the terms of probation? ..... ☐ YES ☐ NO

Explain any YES answer to question (1) or any NO answer to question (2):

I hereby submit this Quarterly Report of Compliance as required by the Osteopathic Medical Board of California and its order and terms of probation thereof, and declare under penalty of perjury under the laws of the State of California that I have read the foregoing report in its entirety and know its contents and that all statements made are true in every respect, and understand that misstatements or omissions of material fact may be cause for revocation of probation.

Your Signature Date

Quarterly Declaration
(rev. 08/17)
(*Proposed*)

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QUARTERLY DECLARATION

INTSRUCTIONS: Please type and print neatly. ALL requested information and questions on this form must be answered. When space provided is insufficient, attach additional sheets of paper. All attachments are considered part of the Declaration. You may wish to make and retain a copy of the material submitted to the Osteopathic Medical Board. Submit the completed Declaration to your assigned probation monitor.

Check Appropriate Box for Reporting Period Covered

Reporting Period	Due to the Board by:
☐ January - March (First Quarter)	April 10
☐ April - June (Second Quarter)	July 10
☐ July - September (Third Quarter)	October 10
☐ October – December (Fourth Quarter)	January 10

Name: First	Middle	Last		Alias
Home Address: Number & Street	City	State	Zip	Phone
Primary Place of Practice (Include addition places of practice on reverse)				
Address: Number & Street	City	State	Zip	Phone
Work Email	Personal			Mobile Phone
Number of hours worked this period at your primary place of practice?		Per Week		Per Month
What is your work schedule at your primary place of practice?				

The following questions refer to the time period since your last quarterly Declaration

1.	Have you violated any court of city ordinances, been arrested, charged, convicted of, pled nolo contendere in any state or federal court or foreign country to any misdemeanor, felony, or other offense? (If yes, specify which one in your explanation. Exclude parking tickets).	☐Yes ☐No
2.	Have you violated, been arrested, convicted of, or received a citation for driving under the influence of alcohol or drugs, reckless driving, or any other vehicle code violation involving alcohol or drugs?	☐Yes ☐No
3.	Are you required to undergo biological fluid testing by any directive other than what is in your Order? If yes, when were you lasted tested and what is the frequency of testing?	☐Yes ☐No
4.	Is there any government, civil suit, malpractice, or peer review proceeding pending against you?	☐Yes ☐No
5.	Have you resigned from any employment or has your employment been terminated?	☐Yes ☐No
6.	Are you in the process of applying for any other business or professional license or certificate?	☐Yes ☐No
7.	Have you had to report any theft or loss of controlled substances to the Department of Justice?	☐Yes ☐No
8.	Have you had to report a patient death in an outpatient surgery setting pursuant to Business and Professions Code section 2240(a)?	☐Yes ☐No
9.	Did you cease practicing since your last report? If yes, give the date you ceased practice.	☐Yes ☐No
10.	Have you been denied, had a license or certificate to practice a business or profession suspended, revoked or surrendered or otherwise disciplined by any other federal, state, government agency or other country?	☐Yes ☐No
11.	Have you maintained a current and valid license?	☐Yes ☐No
12.	Are you in compliance with the Cost Recovery requirement of your probationary order?	☐Yes ☐No
13.	Have you complied with each term and condition of your probation?	☐Yes ☐No

***If you answered YES to the above questions numbered 1-11 and NO to questions numbered 11-13, you must explain in detail on an attached sheet of paper.**

List the name, address and work schedule (hours/days) of any other locations where you practiced medicine. (i.e. convalescent/nursing homes etc.) Provide the phone number of the Medical Director or Chief of Staff, if applicable.
If you are required to complete additional continuing education courses, please indicate the courses you completed this quarter, if any. Attach a copy of the CME certificate.
If you are required to have a practice monitor please provide the name of the individual and how many times you met during this last quarter.
List any new staff and include their title and specialty, if applicable.
What question(s), if any, do you have for your probation monitor regarding your probation?

Executed on_____**, 20**___**, at**_____**,** _____
(City) (State)

I hereby submit this Quarterly Declaration as required by the Osteopathic Medical Board of California and its Order of probation thereof and declare under penalty of perjury under the laws of the State of California that I have read the foregoing declaration and any attachments in their entirety and know their contents and that all statements made are true in every respect and I understand and acknowledge that any misstatements, misrepresentations, or omissions of material fact may be cause for further disciplinary action.

_____ _____
Probationer (Print Name) Signature

TAB 9

Osteopathic Medical Board

Future Agenda Items

Agenda Item	Requestor

TAB 10

Osteopathic Medical Board

Future Meeting Dates

Date	Place	Time
Thursday October 19, 2017	Sacramento, CA	10:00 am
Thursday January 2018 **(*4th, 11th, 18th, or 25th*)**	Sacramento, CA	10:00 am

**Please note that all meetings should be held in the best interest of the Board. Meetings in resorts or vacation areas should not be made. Using Conference areas that do not require contracts and or payment is the best option for the Board. No overnight travel. If an employee chooses a mode of transportation which is more costly than another mode, a Cost Comparison form must be completed. Reimbursement by the State will be made at the lesser of the two costs. Taxi Service should be used for trips within but not over a 10-mile radius. Receipts are required for taxi expenses of $10.00 and over. Tips are not reimbursable.*