LEGISLATIVE PACKET

MEDICAL BOARD MEETING

JULY 23, 2009
SACRAMENTO, CA

Medical Board of California
Tracker - Legislative Bill File
7/16/2009

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 120	Hayashi	Peer Review: 809 sections	Sen. Floor (#41)	Watch	7/8/2009
AB 175	Galgiani	Telemedicine: Optometrists	Sen. Approps.	Support	6/24/2009
AB 245	Ma	Disclosure Verification	Sen. Approps.	Rec: Neutral	7/1/2009
AB 252	Carter	Cosmetic surgery: employment of physicians	Sen. Floor (#134)	Support	
AB 356	Fletcher	Radiological Technology: physician assistants	Sen. Approps.	Support	6/15/2009
AB 501	Emmerson	Licensing: Limited, Use of M.D., Fee/Fund	Sen. Floor (#43)	Sponsor/Support	7/13/2009
AB 526	Fuentes	Public Protection and Physician Health Program Act of 2009	Sen. Approps.	Rec: Oppose	6/1/2009
AB 583	Hayashi	Disclosure of Education and Office Hours	Sen. Floor (#202)	Support (if amended*)	7/8/2009
AB 646	Swanson	Physician employment: district hospital pilot project	Sen. B&P	Support in Concept	5/5/2009
AB 648	Chesbro	Rural Hospitals: physician employment	Sen. B&P	Support in Concept	5/28/2009
AB 718	Emmerson	Electronic Prescribing Pilot Program	Sen. Approps.	Support	7/8/2009
AB 933	Fong	Workers' Compensation: utilization review	Sen. L. & I.R.	Support	
AB 1070	Hill	Enforcement Enhancements: reporting, public reprimand	Sen. Jud. (7/14)	Sponsor/Support	6/23/2009
AB 1116	Carter	Cosmetic Surgery: physical examination prior to surgery	Sen. Floor (#130)	Support	
AB 1310	Hernandez	Healing Arts: database	Sen. Approps.	Support (if amended*)	6/29/2009

* Board Sponsored Bills * Bills for Discussion *Amendments Taken

Medical Board of California
Tracker - Legislative Bill File
7/16/2009

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
SB 132	Denham	Polysomnographic Technologists (urgent)	Asm. Approps. (7/15)	Support	7/6/2009
SB 389	Negrete McLeod	Fingerprinting	Asm. Pub. S.	Support	6/1/2009
SB 470	Corbett	Prescriptions: labeling	Asm. Floor (#137)	Support	4/30/2009
SB 674	Negrete McLeod	Outpatient settings/Advertising	Asm. Approps.	Support	6/1/2009
SB 726	Ashburn	Hospitals: employment of physician; pilot project revision	Asm. Health	Support in concept Rec: Support	5/6/2009
SB 819	B&P Comm.	Omnibus: provisions from 2008	Asm. Approps. (7/15)	Support MBC provisions	6/22/2009
SB 820	Negrete McLeod and Aanestad	Peer Review	Asm. Approps.	Rec. Support	7/6/2009
SB 821	B&P Comm.	Omnibus: MBC provisions	Asm. Approps. (7/15)	Support MBC provisions	7/6/2009

* Board Sponsored Bills * Bills for Discussion

AB 120

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 120
Author: Hayashi
Bill Date: July 8, 2009, amended
Subject: Peer Review: 809 sections
Sponsor: California Medical Association

STATUS OF BILL:

This bill is currently on the Senate Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill declares the importance of external per review in California. This bill addresses only Business and Professions Code section 809. The bill does not include the areas of peer review that are directly related to the Medical Board (Board).

This bill was amended to specify that it will only be operative if SB 820 is signed. SB 820 is the vehicle carrying the peer review provisions from other 800 sections that pertain to the Board. Some of the provisions are those that were previously in SB 700.

ANALYSIS:

This bill addresses the 809 sections of the Business and Professions Code. This bill would revise the hearing process pertaining to peer review cases. The provisions in this bill attempt to change and revise portions of the peer review process but they do not directly affect the Board.

FISCAL: None to the Board

POSITION: Watch

July 13, 2009

AMENDED IN SENATE JULY 8, 2009

AMENDED IN SENATE JUNE 22, 2009

AMENDED IN ASSEMBLY JUNE 1, 2009

AMENDED IN ASSEMBLY MAY 18, 2009

AMENDED IN ASSEMBLY MAY 7, 2009

AMENDED IN ASSEMBLY APRIL 13, 2009

AMENDED IN ASSEMBLY MARCH 26, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 120

Introduced by Assembly Member Hayashi
(Coauthor: Assembly Member Emmerson)

January 15, 2009

An act to amend Sections 809, 809.2, and 809.3 of, and to add Sections 809.04, 809.07, and 809.08 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 120, as amended, Hayashi. Healing arts: peer review.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process conducted by peer review bodies, as defined.

This bill would encourage a peer review body to obtain external peer review, as defined, for the evaluation or investigation of an applicant, privilegeholder, or member of the medical staff in specified circumstances.

This bill would require a peer review body to respond to the request of another peer review body and produce the records reasonably requested concerning a licentiate under review, as specified. The bill would specify that the records produced pursuant to this provision are not subject to discovery, as specified, and may only be used for peer review purposes.

Existing law requires the governing body of acute care hospitals to give great weight to the actions of peer review bodies and authorizes the governing body to direct the peer review body to investigate in specified instances. Where the peer review body fails to take action in response to that direction, existing law authorizes the governing body to take action against a licentiate.

This bill would prohibit a member of a medical or professional staff from being required to alter or surrender staff privileges, status, or membership solely due to the termination of a contract between that member and a health care facility, except as specified. The bill would specify that a peer review body is entitled to review and make timely recommendations to the governing body of a health care facility, and its designee, if applicable, regarding quality considerations relating to clinical services when the selection, performance evaluation, or any change in the retention or replacement of licensees with whom the facility has a contract occurs. The bill would require the governing body to give great weight to those recommendations.

Existing law provides various due process rights for licentiates who are the subject of a final proposed disciplinary action of a peer review body, including authorizing a licensee to request a hearing concerning that action. Under existing law, the hearing must be held before either an arbitrator selected by a process mutually acceptable to the licensee and the peer review body or a panel of unbiased individuals, as specified. Existing law prohibits a hearing officer presiding at a hearing held before a panel from, among other things, gaining direct financial benefit from the outcome.

This bill would additionally require the hearing officer to be an attorney licensed in California, except as specified, and to disclose all actual and potential conflicts of interest, as specified. The bill would specify that the hearing officer is entitled to determine the procedure for presenting evidence and argument and would give the hearing officer authority to make all rulings pertaining to law, procedure, or the admissibility of evidence. The bill would authorize the hearing officer to recommend termination of the hearing in certain circumstances.

Existing law gives parties at the hearing certain rights, including the right to present and rebut evidence. Existing law requires the peer review body to adopt written provisions governing whether a licensee may be represented by an attorney and prohibits a peer review body from being represented by an attorney where a licensee is not so represented, except as specified.

This bill would give both parties the right to be represented by an attorney but would prohibit a peer review body from being represented if the licensee notifies the peer review body within a specified period of time that he or she has elected to not be represented, except as specified.

The bill would also provide that it shall become operative only if SB 820 is also enacted and becomes operative.

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 809 of the Business and Professions Code is amended to read:

809. (a) The Legislature hereby finds and declares the following:

(1) In 1986, Congress enacted the Health Care Quality Improvement Act of 1986 (Chapter 117 (commencing with Section 11101) of Title 42 of the United States Code), to encourage physicians to engage in effective professional peer review, but giving each state the opportunity to "opt-out" of some of the provisions of the federal act.

(2) Because of deficiencies in the federal act and the possible adverse interpretations by the courts of the federal act, it is preferable for California to "opt-out" of the federal act and design its own peer review system.

(3) Peer review, fairly conducted, is essential to preserving the highest standards of medical practice.

(4) It is essential that California's peer review system generate a culture of trust and safety so that health care practitioners will participate robustly in the process by engaging in critically important patient safety activities, such as reporting incidents they believe to reflect substandard care or unprofessional conduct and

serving on peer review, quality assurance, and other committees necessary to protect patients.

(5) Peer review that is not conducted fairly results in harm both to patients and healing arts practitioners by wrongfully depriving patients of their ability to obtain care from their chosen practitioner and by depriving practitioners of their ability to care for their patients, thereby limiting much needed access to care.

(6) Peer review, fairly conducted, will aid the appropriate state licensing boards in their responsibility to regulate and discipline errant healing arts practitioners.

(7) To protect the health and welfare of the people of California, it is the policy of the State of California to exclude, through the peer review mechanism as provided for by California law, those healing arts practitioners who provide substandard care or who engage in professional misconduct, regardless of the effect of that exclusion on competition.

(8) It is the intent of the Legislature that peer review of professional health care services be done efficiently, on an ongoing basis, and with an emphasis on early detection of potential quality problems and resolutions through informal educational interventions. It is further the intent of the Legislature that peer review bodies be actively involved in the measurement, assessment, and improvement of quality and that there be appropriate oversight by the peer review bodies to ensure the timely resolution of issues.

(9) Sections 809 to 809.8, inclusive, shall not affect the respective responsibilities of the organized medical staff or the governing body of an acute care hospital with respect to peer review in the acute care hospital setting. It is the intent of the Legislature that written provisions implementing Sections 809 to 809.8, inclusive, in the acute care hospital setting shall be included in medical staff bylaws that shall be adopted by a vote of the members of the organized medical staff and shall be subject to governing body approval, which approval shall not be withheld unreasonably.

(10) (A) The Legislature thus finds and declares that the laws of this state pertaining to the peer review of healing arts practitioners shall apply in addition to Chapter 117 (commencing with Section 11101) of Title 42 of the United States Code, because the laws of this state provide a more careful articulation of the protections for both those undertaking peer review activity and

those subject to review, and better integrate public and private systems of peer review. Therefore, California exercises its right to opt out of specified provisions of the Health Care Quality Improvement Act relating to professional review actions, pursuant to Section 11111(c)(2)(B) of Title 42 of the United States Code. This election shall not affect the availability of any immunity under California law.

(B) The Legislature further declares that it is not the intent or purposes of Sections 809 to 809.8, inclusive, to opt out of any mandatory national databank established pursuant to Subchapter II (commencing with Section 11131) of Chapter 117 of Title 42 of the United States Code.

(b) For the purpose of this section and Sections *809.1* to *809.8*, inclusive, "healing arts practitioner" or "licentiate" means a physician and surgeon, podiatrist, clinical psychologist, marriage and family therapist, clinical social worker, or dentist; and "peer review body" means a peer review body as specified in paragraph (1) of subdivision (a) of Section 805, and includes any designee of the peer review body.

SEC. 2. Section 809.04 is added to the Business and Professions Code, to read:

809.04. (a) It is the public policy of the state that licentiates who may be providing substandard care be subject to the peer review hearing and reporting process set forth in this article.

(b) To ensure that the peer review process is not circumvented, a member of a medical or professional staff, by contract or otherwise, shall not be required to alter or surrender staff privileges, status, or membership solely due to the termination of a contract between that member and a health care facility. However, with respect to services that may only be provided by members who have, or who are members of a medical group that has, a current exclusive contract for those identified services, termination of the contract, or termination of the member's employment by the medical group holding the contract, may result in the member's ineligibility to provide the services covered by the contract.

(c) The peer review body of a health care facility shall be entitled to review and make timely recommendations to the governing body of the facility and its designee, if applicable, regarding quality considerations relating to clinical services whenever the selection, performance evaluation, or any change in the retention or

replacement of licentiates with whom the health care facility has a contract occurs. The governing body shall give great weight to those recommendations.

(d) This section shall not impair a governing body's ability to take action against a licentiate pursuant to Section 809.05.

SEC. 3. Section 809.07 is added to the Business and Professions Code, to read:

809.07. (a) It is the policy of the state that in certain limited circumstances, external peer review may be necessary to promote and protect patient care in order to eliminate perceived bias, obtain needed medical expertise, or respond to other particular circumstances.

(b) A peer review body is encouraged to obtain external peer review for the evaluation or investigation of an applicant, privilegeholder, or member of the medical staff in the following circumstances:

(1) Committee or department reviews that could affect a licentiate's membership or privileges do not provide a sufficiently clear basis for action or inaction.

(2) No current medical staff member can provide the necessary expertise in the clinical procedure or area under review.

(3) To promote impartial peer review.

(c) For purposes of this section, the following definitions apply:

(1) "Peer review body" has the meaning provided in paragraph (1) of subdivision (a) of Section 805.

(2) "External peer review" means peer review provided by licentiates who do not practice in the same health care facility as the licentiate under review, who are impartial, and who have the necessary expertise in the clinical procedure or area under review.

SEC. 4. Section 809.08 is added to the Business and Professions Code, to read:

809.08. (a) The Legislature hereby finds and declares that the sharing of information between peer review bodies is essential to protect the public health.

(b) Upon receipt of reasonable copying and processing costs, a peer review body shall respond to the request of another peer review body and produce the records reasonably requested concerning a licentiate under review to the extent not otherwise prohibited by state or federal law. The responding peer review body shall have the discretion to decide whether to produce minutes

from peer review body meetings. The records produced by a peer review body pursuant to this section shall be used solely for peer review purposes and shall not be subject to discovery to the extent provided in Sections 1156.1 and 1157 of the Evidence Code and any other applicable provisions of law. The peer review body responding to the request shall be entitled to all confidentiality protections and privileges provided by law as to the information and records disclosed pursuant to this section. The licentiate under review by the peer review body requesting records pursuant to this section shall, upon request, release the responding peer review body, its members, and the health care entity for which the responding peer review body conducts peer review, from liability for the disclosure of records, and the contents thereof, in compliance with this section. If the licentiate does not provide a reasonable release that is acceptable to the responding peer review body, the responding peer review body shall not be obligated to produce records pursuant to this section.

SEC. 5. Section 809.2 of the Business and Professions Code is amended to read:

809.2. If a licentiate timely requests a hearing concerning a final proposed action for which a report is required to be filed under Section 805, the following shall apply:

(a) The hearing shall be held, as determined by the peer review body, before a trier of fact, which shall be an arbitrator or arbitrators selected by a process mutually acceptable to the licentiate and the peer review body, or before a panel of unbiased individuals who shall gain no direct financial benefit from the outcome, who have not acted as an accuser, investigator, factfinder, or initial decisionmaker in the same matter, and which shall include, where feasible, an individual practicing the same specialty as the licentiate.

(b) (1) If a hearing officer is selected to preside at a hearing held before a panel, the hearing officer shall gain no direct financial benefit from the outcome, shall disclose all actual and potential conflicts of interest within the last five years reasonably known to the hearing officer, shall not act as a prosecuting officer or advocate, and shall not be entitled to vote.

(2) The hearing officer shall be an attorney licensed to practice law in the State of California. This paragraph shall not apply to a

hearing held before a panel of a dental professional society peer review body.

(3) Except as otherwise agreed by the parties, an attorney from a firm utilized by the hospital, the medical staff, or the involved licentiate within the preceding two years shall not be eligible to serve as a hearing officer.

(4) The hearing officer shall endeavor to ensure that all parties maintain proper decorum and have a reasonable opportunity to be heard and present all relevant oral and documentary evidence. The hearing officer shall be entitled to determine the order of, or procedure for, presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions pertaining to matters of law, procedure, or the admissibility of evidence. The hearing officer shall also take all appropriate steps to ensure a timely resolution of the hearing, but may not terminate the hearing process. However, in the case of flagrant noncompliance with the procedural rules governing the hearing process or egregious interference with the orderly conduct of the hearing, the hearing officer may recommend that the hearing panel terminate the hearing, provided that this activity is authorized by the applicable bylaws of the peer review body.

(c) The licentiate shall have the right to a reasonable opportunity to voir dire the panel members and any hearing officer, and the right to challenge the impartiality of any member or hearing officer. Challenges to the impartiality of any member or hearing officer shall be ruled on by the presiding officer, who shall be the hearing officer if one has been selected.

(d) The licentiate shall have the right to inspect and copy at the licentiate's expense any documentary information relevant to the charges which the peer review body has in its possession or under its control, as soon as practicable after the receipt of the licentiate's request for a hearing. The peer review body shall have the right to inspect and copy at the peer review body's expense any documentary information relevant to the charges which the licentiate has in his or her possession or control as soon as practicable after receipt of the peer review body's request. The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to

individually identifiable licentiates, other than the licentiate under review. The arbitrator or presiding officer shall consider and rule upon any request for access to information, and may impose any safeguards the protection of the peer review process and justice requires.

(e) When ruling upon requests for access to information and determining the relevancy thereof, the arbitrator or presiding officer shall, among other factors, consider the following:

(1) Whether the information sought may be introduced to support or defend the charges.

(2) The exculpatory or inculpatory nature of the information sought, if any.

(3) The burden imposed on the party in possession of the information sought, if access is granted.

(4) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(f) At the request of either side, the parties shall exchange lists of witnesses expected to testify and copies of all documents expected to be introduced at the hearing. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least 10 days before the commencement of the hearing shall constitute good cause for a continuance.

(g) Continuances shall be granted upon agreement of the parties or by the arbitrator or presiding officer on a showing of good cause.

(h) A hearing under this section shall be commenced within 60 days after receipt of the request for hearing, and the peer review process shall be completed within a reasonable time, after a licentiate receives notice of a final proposed action or an immediate suspension or restriction of clinical privileges, unless the arbitrator or presiding officer issues a written decision finding that the licentiate failed to comply with subdivisions (d) and (e) in a timely manner, or consented to the delay.

SEC. 6. Section 809.3 of the Business and Professions Code is amended to read:

809.3. (a) During a hearing concerning a final proposed action for which reporting is required to be filed under Section 805, both parties shall have all of the following rights:

(1) To be provided with all of the information made available to the trier of fact.

(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 preparation thereof.

(3) To call, examine, and cross-examine witnesses.

(4) To present and rebut evidence determined by the arbitrator or presiding officer to be relevant.

(5) To submit a written statement at the close of the hearing.

(6) To be represented by an attorney of the party's choice at the party's expense, subject to subdivision (c).

(b) The burden of presenting evidence and proof during the hearing shall be as follows:

(1) The peer review body shall have the initial duty to present evidence which supports the charge or recommended action.

(2) Initial applicants shall bear the burden of persuading the trier of fact by a preponderance of the evidence of their qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for staff privileges, membership, or employment. Initial applicants shall not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(3) Except as provided above for initial applicants, the peer review body shall bear the burden of persuading the trier of fact by a preponderance of the evidence that the action or recommendation is reasonable and warranted.

(c) (1) Except as provided in paragraph (3), a peer review body shall not be represented by an attorney if the licentiate notifies the peer review body in writing no later than 15 days prior to the hearing that he or she has elected to not be represented by an attorney. Except as otherwise agreed by the parties, this election shall be binding.

(2) If the licentiate does not provide the written notice described in paragraph (1) within the required timeframe, the peer review body may be represented by an attorney even if the licentiate later elects to not be represented by an attorney.

(3) Dental professional society peer review bodies may be represented by an attorney, even if the licentiate declines to be represented by an attorney.

SEC. 7. This act shall become operative only if Senate Bill 820 of the 2009–10 Regular Session is also enacted and becomes operative.

O

AB 175

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 175
Author: Galgiani
Bill Date: June 24, 2009, amended
Subject: Telemedicine: optometrists
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill further defines "telephthalmology and teledermatology by store and forward."

ANALYSIS:

Under current law, "teleophthalmology and teledermatology by store and forward" under the Medi-Cal program is defined as asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology. This information is reviewed by a physician without the patient present.

This bill would allow optometrists to perform telemedicine within their scope of practice.

This bill would specify that in the case that a reviewing optometrist identifies a disease or condition requiring consultation or referral, that consultation or referral must be with an appropriate physician or ophthalmologist.

FISCAL: None to the Board

POSITION: Support

July 11, 2009

AMENDED IN SENATE JUNE 24, 2009

AMENDED IN ASSEMBLY APRIL 21, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 175

Introduced by Assembly Member Galgiani
(Principal coauthor: Senator Florez)
(Coauthors: Assembly Members Tom Berryhill, Block, Fuller, and Monning)
(Coauthor: Senator Maldonado)

January 29, 2009

An act to amend Section 14132.725 of the Welfare and Institutions Code, relating to telemedicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 175, as amended, Galgiani. Medical telemedicine: optometrists.

Existing law, the Medical Practice Act, regulates the practice of telemedicine, defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

Existing law, until January 1, 2013, authorizes "teleophthalmology and teledermatology by store and forward" under the Medi-Cal program, to the extent that federal financial participation is available. Existing law defines "teleophthalmology and teledermatology by store and forward" as an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology, where the physician at the distant site reviews the medical information without the patient being present in real time.

This bill would expand the definition of "teleophthalmology and teledermatology by store and forward" to include an asynchronous transmission of medical information to be reviewed at a later time, for teleophthalmology, by a licensed optometrist.

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 14132.725 of the Welfare and Institutions Code is amended to read:

14132.725. (a) Commencing July 1, 2006, to the extent that federal financial participation is available, face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for teleophthalmology and teledermatology by store and forward. Services appropriately provided through the store and forward process are subject to billing and reimbursement policies developed by the department.

(b) For purposes of this section, "teleophthalmology and teledermatology by store and forward" means an asynchronous transmission of medical information to be reviewed at a later time by a physician at a distant site who is trained in ophthalmology or dermatology or, for teleophthalmology, by an optometrist who is licensed pursuant to Chapter 7 (commencing with Section 3000) of Division 2 of the Business and Professions Code, where the physician or optometrist at the distant site reviews the medical information without the patient being present in real time. A patient receiving teleophthalmology or teledermatology by store and forward shall be notified of the right to receive interactive communication with the distant specialist physician or optometrist, and shall receive an interactive communication with the distant specialist physician or optometrist, upon request. If requested, communication with the distant specialist physician or optometrist may occur either at the time of the consultation, or within 30 days of the patient's notification of the results of the consultation. If the reviewing optometrist identifies a disease or condition requiring consultation or referral pursuant to Section 3041 of the Business and Professions Code, that consultation or referral shall be with an *ophthalmologist or other* appropriate physician and surgeon ~~or ophthalmologist~~, as required.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, and make specific this section by means of all county letters, provider bulletins, and similar instructions.

(d) On or before January 1, 2008, the department shall report to the Legislature the number and type of services provided, and the payments made related to the application of store and forward telemedicine as provided, under this section as a Medi-Cal benefit.

(e) The health care provider shall comply with the informed consent provisions of subdivisions (c) to (g), inclusive, of, and subdivisions (i) and (j) of, Section 2290.5 of the Business and Professions Code when a patient receives teleophthalmology or teledermatology by store and forward.

(f) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

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AB 245

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 245
Author: Ma
Bill Date: July 1, 2009, amended
Subject: Disclosure Verification
Sponsor: Union of American Physicians and Dentists

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board (Board) to verify the accuracy of the information posted on its Website regarding enforcement actions or other items required to be posted. This bill would require the Board to remove any expunged convictions within 30 days.

This bill was amended to remove all requirements for verification of information by the Board. This bill was amended to change the number of days the Board has to remove any expunged convictions from the Web site from 30 days to 90 days.

ANALYSIS:

Currently the Board is required to post on its Web site specified information regarding license status, enforcement actions, and specified information reported to the Board. This bill would require the Board to verify all of the information prior to posting it on the website and would require the Board to remove information that is incorrect, inaccurate, or unsubstantiated.

The Board would be required to verify that all of the biographical information on its licensees is accurate. This bill would require the Board to establish a process for addressing complaints received from licensees regarding inappropriate information posted by the Board.

The sponsor states the reason for the bill is due to 31 physicians members who had false reports of medical discipline transmitted to the Board which caused damage to their careers. This is 805 reporting, and to force the Board to verify those reports prior to posting is against the public policy established in the peer review reporting laws. This issue should be dealt with in the peer review bills.

Amendments to the bill taken June 1, 2009 remove all requirements to the Board and increase the number of days that the Board has to remove expunged convictions from the Board's Web site from 30 days to 90 days.

The Executive Committee voted to take a 'neutral if amended' position on this bill if the bill was amended to include a requirement for the appropriate documentation of an expungement to be submitted by the licensee in order to have it removed from the website. These amendments were taken and have been included in the bill.

FISCAL: None to MBC

POSITION: **Executive Committee Recommendation: Neutral**
Staff Recommendation: Neutral

AMENDED IN SENATE JULY 1, 2009

AMENDED IN ASSEMBLY JUNE 1, 2009

AMENDED IN ASSEMBLY APRIL 27, 2009

AMENDED IN ASSEMBLY MARCH 26, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 245

Introduced by Assembly Member Ma

February 10, 2009

An act to amend Section 2027 of the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 245, as amended, Ma. Physicians and surgeons.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires the board to post certain information on the Internet regarding licensed physicians and surgeons, including, but not limited to, felony convictions, certain misdemeanor convictions, and whether or not the licensees are in good standing. Existing law requires that certain information remain posted for 10 years and prohibits the removal of certain other information.

This bill would require the board to remove expunged misdemeanor or felony convictions, posted pursuant to those provisions, within 90 days of receiving ~~notice~~ *a copy* of the expungement *order from the licensee*.

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 2027 of the Business and Professions Code is amended to read:

2027. (a) The board shall post on the Internet the following information in its possession, custody, or control regarding licensed physicians and surgeons:

(1) With regard to the status of the license, whether or not the licensee is in good standing, subject to a temporary restraining order (TRO), subject to an interim suspension order (ISO), or subject to any of the enforcement actions set forth in Section 803.1.

(2) With regard to prior discipline, whether or not the licensee has been subject to discipline by the board or by the board of another state or jurisdiction, as described in Section 803.1.

(3) Any felony convictions reported to the board after January 3, 1991.

(4) All current accusations filed by the Attorney General, including those accusations that are on appeal. For purposes of this paragraph, "current accusation" shall mean an accusation that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an administrative law judge and the board unless an appeal of that decision is pending.

(5) Any malpractice judgment or arbitration award reported to the board after January 1, 1993.

(6) Any hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason.

(7) Any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed.

(8) Appropriate disclaimers and explanatory statements to accompany the above information, including an explanation of what types of information are not disclosed. These disclaimers and statements shall be developed by the board and shall be adopted by regulation.

(9) Any information required to be disclosed pursuant to Section 803.1.

(b) (1) From January 1, 2003, the information described in paragraphs (1) (other than whether or not the licensee is in good standing), (2), (4), (5), (7), and (9) of subdivision (a) shall remain

posted for a period of 10 years from the date the board obtains possession, custody, or control of the information, and after the end of that period shall be removed from being posted on the board's Internet Web site. Information in the possession, custody, or control of the board prior to January 1, 2003, shall be posted for a period of 10 years from January 1, 2003. Settlement information shall be posted as described in paragraph (2) of subdivision (b) of Section 803.1.

(2) The information described in paragraphs (3) and (6) of subdivision (a) shall not be removed from being posted on the board's Internet Web site. Notwithstanding the provisions of this paragraph, if a licensee's hospital staff privileges are restored and the licensee notifies the board of the restoration, the information pertaining to the termination or revocation of those privileges, as described in paragraph (6) of subdivision (a), shall remain posted for a period of 10 years from the restoration date of the privileges, and at the end of that period shall be removed from being posted on the board's Internet Web site.

(c) Notwithstanding subdivision (b), the board shall remove an expunged misdemeanor or felony conviction posted pursuant to this section within 90 days of receiving ~~notice of the expungement~~ *a copy of the expungement order from the licensee.*

(d) The board shall provide links to other Web sites on the Internet that provide information on board certifications that meet the requirements of subdivision (b) of Section 651. The board may provide links to other Web sites on the Internet that provide information on health care service plans, health insurers, hospitals, or other facilities. The board may also provide links to any other sites that would provide information on the affiliations of licensed physicians and surgeons.

O

AB 252

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 252
Author: Carter
Bill Date: February 11, 2009, introduced
Subject: Cosmetic surgery: employment of physicians
Sponsor: American Society for Dermatological Surgery

STATUS OF BILL:

This bill is currently on the Senate Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill:

1) Declares it illegal for physicians to be employed by a corporation or artificial entity to practice cosmetic procedures, as prohibited by Business and Professions (B&P) Code section 2400 (restating current law).

2) Adds 2417.5 to the B&P Code, which:
   - Codifies that it is grounds for license revocation for physicians who knowingly violate the corporate practice prohibitions by working for or contracting with a business providing cosmetic medical treatments or procedures.
   - Establishes the legal presumption that physicians "knowingly" are violating the corporate practice prohibitions by contracting to serve as a medical director or otherwise become employed by an organization that they do not own related to cosmetic medical procedures or treatments.
   - Makes it a felony for an entity to provide cosmetic medical treatments or hire or contract with physicians for the providing of treatments, establishing that such a practice violates Penal Code section 550.

ANALYSIS:

Current law already prohibits the corporate practice of medicine, that is to say, lay entities employing or contracting with physicians to practice medicine. Current law also grants authority to the Board to take disciplinary actions, including revocation, against physicians who violate the law. There are two provisions of this bill, however, that are significant:

1) Violations by entities of the corporate practice bar are deemed to be a violation of Penal Section 550, thereby making it a felony punishable up to 5 years in prison, as well as other penalties, and;

2) Establishes the legal presumption that physicians violating the law by becoming employees or contractors of cosmetic surgery or treatment businesses that they do not own "knowingly" are violating the law; thus, removing the difficult burden to prosecutors to provide evidence to establish that physicians knew they were breaking the law.

In summary, this bill addresses violations of the corporate practice of medicine in the cosmetic medicine industry. It specifies that non-physician entities owning cosmetic medicine practices providing medical treatments (laser hair removal, laser resurfacing, Botox and filler injections) are in violation of the corporate practice prohibition of B&P Code Section 2400. This bill would make a violation of the corporate practice bar a felony for the (non-medically owned) entities, and grounds for license revocation for physicians who knowingly work or contract with these entities.

FISCAL: Unknown, but some increase in enforcement costs

POSITION: Support

July 11, 2009

ASSEMBLY BILL No. 252

Introduced by Assembly Member Carter
(Principal coauthor: Senator Correa)

February 11, 2009

An act to add Section 2417.5 to the Business and Professions Code, relating to the practice of medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 252, as introduced, Carter. Practice of medicine: cosmetic surgery: employment of physicians and surgeons.

Existing law, the Medical Practice Act, establishes the Medical Board of California under the Department of Consumer Affairs, which licenses physicians and surgeons and regulates their practice.

The Medical Practice Act restricts the employment of licensed physicians and surgeons and podiatrists by a corporation or other artificial legal entity, subject to specified exemptions. Existing law makes it unlawful to knowingly make, or cause to be made, any false or fraudulent claim for payment of a health care benefit, or to aid, abet, solicit, or conspire with any person to do so, and makes a violation of this prohibition a public offense.

This bill would authorize the revocation of the license of a physician and surgeon who practices medicine with, or serves or is employed as the medical director of, a business organization that provides outpatient elective cosmetic medical procedures or treatments, as defined, knowing that the organization is owned or operated in violation of the prohibition against employment of licensed physicians and surgeons and podiatrists. The bill would also make a business organization that provides outpatient elective cosmetic medical procedures or treatments, that is

owned and operated in violation of the prohibition, and that contracts with or employs a physician and surgeon to facilitate the offer or provision of those procedures or treatments that may only be provided by a licensed physician and surgeon, guilty of a violation of the prohibition against knowingly making or causing to be made any false or fraudulent claim for payment of a health care benefit. Because the bill would expand a public offense, it would impose a state-mandated local program.

This bill would state that its provisions are declaratory of existing law.

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. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares that the Medical Practice Act restricts the employment of physicians and surgeons by a corporation or other artificial legal entity, as described in Article 18 (commencing with Section 2400) of Chapter 5 of Division 2 of the Business and Professions Code, and that the prohibited conduct described in subdivisions (a) and (b) of Section 2417.5 of the Business and Professions Code, as added by this act, is declaratory of existing law.

SEC. 2. Section 2417.5 is added to the Business and Professions Code, to read:

2417.5. (a) In addition to any other remedies for a violation of Section 2400 involving any other types of medical procedures, a physician and surgeon who practices medicine with a business organization that offers to provide, or provides, outpatient elective cosmetic medical procedures or treatments, knowing that the organization is owned or operated in violation of Section 2400, may have his or her license to practice revoked. A physician and surgeon who contracts to serve as, or otherwise allows himself or herself to be employed as, the medical director of a business organization that he or she does not own and that offers to provide

or provides outpatient elective cosmetic medical procedures or treatments that may only be provided by the holder of a valid physician's and surgeon's certificate under this chapter shall be deemed to have knowledge that the business organization is in violation of Section 2400.

(b) A business organization that offers to provide, or provides, outpatient elective cosmetic medical procedures or treatments, that is owned or operated in violation of Section 2400, and that contracts with, or otherwise employs, a physician and surgeon to facilitate its offers to provide, or the provision of, outpatient elective cosmetic medical procedures or treatments that may only be provided by the holder of a valid physician's and surgeon's certificate is guilty of violating paragraph (6) of subdivision (a) of Section 550 of the Penal Code.

(c) For purposes of this section, "outpatient elective cosmetic medical procedures or treatments" means a medical procedure or treatment that is performed to alter or reshape normal structures of the body solely in order to improve appearance.

SEC. 3. 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.

O

AB 356

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 356
Author: Fletcher
Bill Date: June 15, 2009, amended
Subject: Radiological Technology: physician assistants
Sponsor: California Association of Physician Assistants (CAPA)

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow physician assistants to take the appropriate licensing exams for fluoroscopy licentiate permits issued by the Radiologic Health Branch of the California Department of Public Health (DPH).

ANALYSIS:

Current law allows physician assistants to perform a variety of delegated medical services including ordering and performing various diagnostic tests under physician supervision, taking patient histories, performing physical examinations, ordering X-rays and diagnostic studies, instituting treatment procedures, initiating hospital admissions, ordering medications, and performing surgical procedures which do not require general anesthesia.

The Radiologic Health Branch of the DPH regulates the performance of medical imaging by various health professions, including specific certification of a Radiological Technologist (RT). Certain "licentiates of the healing arts" are exempt from needing an RT certification in order to perform various forms of medical imaging. These "licentiates of the healing arts" include physicians, podiatrists, and chiropractors.

This bill would allow physician assistants to take the appropriate licensing exams for fluoroscopy. This would include physician assistants as "licentiates of the healing arts" who are not required to obtain an RT certification.

Amendments to this bill added 40 hours of course work before a physician assistant would be allowed to perform procedures. Amendments also included an additional 10 hours of biennial continuing education.

FISCAL: None to the Board

POSITION: Support

July 11, 2009

AMENDED IN SENATE JUNE 15, 2009

AMENDED IN ASSEMBLY APRIL 23, 2009

AMENDED IN ASSEMBLY APRIL 21, 2009

AMENDED IN ASSEMBLY APRIL 13, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 356

Introduced by Assembly Member Fletcher

February 19, 2009

An act to amend Section 114850 of the Health and Safety Code, relating to radiologic technology.

LEGISLATIVE COUNSEL'S DIGEST

AB 356, as amended, Fletcher. Radiologic technology: licentiates of the healing arts.

Existing law sets forth the duties of various agencies relating to the protection of the public health and safety from the harmful effects of radiation, including, among others, the duties of the State Department of Public Health regarding the licensing and regulation of radiologic technology.

Existing law requires the department to provide for the certification of licentiates of the healing arts to supervise the operation of X-ray machines or to operate X-ray machines, or both, to prescribe minimum standards of training and experience for these licentiates of the healing arts, and to prescribe procedures for examining applicants for certification. Under existing law, licentiates of the healing arts is defined to include any person licensed under the Medical Practice Act, the

Osteopathic Act, or a specified initiative act that created the State Board of Chiropractic Examiners, as provided.

Existing law, the Physician Assistant Practice Act, separately establishes the Physician Assistant Committee of the Medical Board of California, and provides for the licensure of physician assistants meeting specified criteria and for the regulation of their practice. Under that act, a physician assistant is authorized to perform certain medical services under the supervision of a physician and surgeon, subject to certain exceptions.

This bill would revise the definition of licentiates of the healing arts to also include a physician assistant who is licensed pursuant to the Physician Assistant Practice Act and who practices under the supervision of a qualified physician and surgeon, as provided. The bill would require a physician assistant who is issued a licentiate fluoroscopy permit to meet specified continuing education requirements. The bill would also require the supervising physician and surgeon to have, or be exempt from having, a licentiate fluoroscopy permit to perform the functions that he or she is supervising, as provided.

This bill would also allow a physician and surgeon to delegate to a licensed physician assistant *specified* procedures using fluoroscopy. The bill would specify training requirements that must be met in order for a physician assistant to be delegated this task.

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 114850 of the Health and Safety Code is amended to read:

114850. As used in this chapter:

(a) "Department" means the State Department of Public Health.

(b) "Committee" means the Radiologic Technology Certification Committee.

(c) "Radiologic technology" means the application of X-rays on human beings for diagnostic or therapeutic purposes.

(d) "Radiologic technologist" means any person, other than a licentiate of the healing arts, making application of X-rays to human beings for diagnostic or therapeutic purposes pursuant to subdivision (b) of Section 114870.

(e) "Limited permit" means a permit issued pursuant to subdivision (c) of Section 114870 to persons to conduct radiologic technology limited to the performance of certain procedures or the application of ~~X-ray~~ *X-rays* to specific areas of the human body, except for a mammogram.

(f) "Approved school for radiologic technologists" means a school that the department has determined provides a course of instruction in radiologic technology that is adequate to meet the purposes of this chapter.

(g) "Supervision" means responsibility for, and control of, quality, radiation safety, and technical aspects of all X-ray examinations and procedures.

(h) (1) "Licentiate of the healing arts" means a person licensed under the provisions of the Medical Practice Act, the provisions of the initiative act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the State Board of Chiropractic Examiners and declaring its powers and duties, prescribing penalties for violation thereof, and repealing all acts and parts of acts inconsistent herewith," approved by electors November 7, 1922, as amended, the "Osteopathic Act," or a person licensed under the Physician Assistant Practice Act (Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code) who practices under the supervision of a qualified physician and surgeon pursuant to the act and pursuant to Division 13.8 of Title 16 of the California Code of Regulations.

(2) In order to supervise a physician assistant in performing the functions authorized by ~~this chapter~~ *the Radiologic Technology Act (Section 27)*, a physician and surgeon shall either hold, or be exempt from holding, a licentiate fluoroscopy permit required to perform the functions being supervised.

(3) A physician and surgeon may delegate to a licensed physician assistant procedures using fluoroscopy. A physician assistant to whom a physician and surgeon has delegated the use of fluoroscopy shall demonstrate successful completion of 40 hours of total coursework, including *fluoroscopy* radiation safety and protection, recognized by the department. Documentation of completed coursework shall be kept on file at the practice site and available to the department upon request. Notwithstanding any other provision of law, the department shall accept applications

for a fluoroscopy permit from a licensed physician assistant who meets the requirements of this section. *Nothing in this section shall be construed to remove the need for a physician assistant to pass a department-approved examination in fluoroscopy radiation safety and protection pursuant to Article 1 (commencing with Section 30460) of Group 5 of Subchapter 4.5 of Chapter 5 of Division 1 of Title 17 of the California Code of Regulations.*

(4) A licensed physician assistant who is issued a fluoroscopy permit pursuant to the requirements of this section shall, in the two years preceding the expiration date of the permit, earn 10 approved continuing education credits. *The department shall accept continuing education credits approved by the Physician Assistant Committee.*

(5) Nothing in this section shall be construed to authorize a physician assistant to perform any other procedures utilizing ionizing radiation except those authorized by holding a licentiate fluoroscopy permit.

(6) Nothing in this section shall be construed to remove the need for a physician assistant to be subject to the licentiate fluoroscopy permit requirements approved by the department pursuant to Subchapter 4.5 (commencing with Section 30400) of Chapter 5 of Division 1 of Title 17 of the California Code of Regulations.

(i) "Certified supervisor or operator" means a licentiate of the healing arts who has been certified under subdivision (e) of Section 114870 or ~~107115~~ *107111* to supervise the operation of X-ray machines or to operate X-ray machines, or both.

(j) "Student of radiologic technology" means a person who has started and is in good standing in a course of instruction that, if completed, would permit the person to be certified a radiologic technologist or granted a limited permit upon satisfactory completion of any examination required by the department. "Student of radiologic technology" does not include any person who is a student in a school of medicine, chiropractic, podiatry, dentistry, dental radiography, or dental hygiene.

(k) "Mammogram" means an X-ray image of the human breast.

(*l*) "Mammography" means the procedure for creating a mammogram.

O

AB 501

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 501
Author: Emmerson
Bill Date: July 13, 2009, amended
Subject: Licensing: Limited, Use of M.D., Fee/Fund
Sponsor: Medical Board of California

STATUS OF BILL:

This bill is currently on the Senate Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a graduate of an approved medical school, who is enrolled in post graduate training in California, to use the initials M.D. only while that post graduate trainee is under the supervision of a licensed physician from that program. It will allow others who hold an unrestricted license to use these initials as long as they are not representing themselves as physicians who are allowed to practice in California.

This bill would allow the Medical Board (Board) to issue an initial limited license to an applicant for licensure who is otherwise eligible for a medical license in California but is unable to practice all aspects of medicine safely due to a disability.

This bill would establish a cap on the licensing fee imposed by the Medical Board. The cap would be fixed by the Board at a fee equal to or less than seven hundred ninety dollars ($790). This bill would increase the amount of reserve allowed in the Contingent Fund of the Board.

Amendments to this bill further clarify the use of the initials M.D. In addition to graduates of an approved medical school while enrolled in post graduate training in California, a graduate of an approved medical school who has not had their license revoked or suspended may use the initials M.D. as long as they do not represent themselves as a physician who is entitled to practice medicine, do not engage in any of the acts prohibited by Section 2060. All medical schools are in support of this provision.

This bill was amended July 13, 2009 to direct the Office of State Audits and Evaluations within the Department of Finance to perform a review of the Board's financial status instead of the Bureau of State Audits (BSA). The Office of State Audits and Evaluations must make the results of its review available by June 1, 2012. The funding for the review will come from the existing resources of the Office of State Audits and Evaluations within the Department of Finance.

ANALYSIS:

Amends Business and Professions Code section 2054:

This bill would allow a graduate of an approved medical school, who is enrolled in post graduate training in California, to use the initials M.D. only while that post graduate trainee is under the supervision of a licensed physician from that program. The post graduate trainee would be permitted to use the initials only while he or she is under the supervision of a licensed physician from that program.

This bill would allow physicians licensed in other states or countries to participate in events in California using the initials M.D. as long as they are not practicing medicine as physicians.

This section was amended to include graduates of approved medical schools who, if issued a license, have not had that license revoked or suspended and persons authorized to practice medicine under Sections 2111 and 2113.

Amends Business and Professions Code section 2088:

Currently the Board does not have the authority to issue a limited medical license at the time of initial licensure. The law allows the Board to issue a probationary license initially with restrictions against engaging in certain types of practice. Although the Board is authorized to limit a license of an existing licensee, there are various individuals who wish to practice in California and are not eligible to obtain a full and unrestricted medical license but can practice safely with a limited license.

All applicants for a limited license would be required to sign a statement agreeing to limit his or her practice to whatever areas are recommended by a reviewing physician who may be recommended by the Board. Several other states have laws that allow for the initial issuance of limited, restricted, or special licenses to address applicants with disabilities. There are qualified applicants who wish to be licensed in California, who will be able to practice safely with a limited license.

Amends Business and Professions Code section 2435:

This bill would establish a cap on the licensing fee imposed by the Medical Board. The cap would be fixed by the Board at a fee equal to or less than seven hundred ninety dollars ($790). Currently the law requires the fee to be exactly seven hundred ninety dollars ($790), leaving the Medical Board without the option to lower the fee when needed in order to comply with the limits on the reserve allowed in the Contingent Fund of the Medical Board. The fee cap would allow the Board to adjust the fee as needed.

This bill would increase the amount of reserve allowed in the Contingent Fund of the Medical Board to not less than two months and not more than four months' operating expenditures. The current two month limit on the reserve is rigid in that it limits the

Board's ability to implement programs. A reserve fund of two to four months would allow more room to effectively maintain compatibility with the state audit while also allowing the Board to implement programs as necessary.

This bill no longer requires an audit of the Board's financial status by the Bureau of State Audits. The Office of State Audits and Evaluations within the Department of Finance is now required to perform a review of the Board's financial status. The Office of State Audits and Evaluations must make the results of its review available by June 1, 2012. The funding for the review will come from the existing resources of the Office of State Audits and Evaluations within the Department of Finance.

FISCAL: None to MBC

POSITION: Sponsor/ Support

July 11, 2009

AMENDED IN SENATE JULY 13, 2009

AMENDED IN ASSEMBLY MAY 26, 2009

AMENDED IN ASSEMBLY APRIL 13, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 501

Introduced by Assembly Member Emmerson

February 24, 2009

An act to amend Sections 2054 and 2435 of, and to add Section 2088 to, the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 501, as amended, Emmerson. Physicians and surgeons.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law makes it a misdemeanor for a person who is not licensed as a physician and surgeon under the act to use certain words, letters, and phrases or any other terms that imply that he or she is authorized to practice medicine as a physician and surgeon.

This bill would authorize certain persons who are not licensed as physicians and surgeons under the act to use the words "doctor" or "physician," the letters or prefix "Dr.," or the initials "M.D.," as specified.

Existing law authorizes the board to issue a probationary license subject to specified terms and conditions, including restrictions against engaging in certain types of medical practice. Existing law authorizes a licensee who demonstrates that he or she is unable to practice medicine due to a disability to request a waiver of the license renewal fee. Under existing law, a licensee granted that waiver is prohibited from practicing

medicine until he or she establishes that the disability no longer exists or signs an agreement, under penalty of perjury, agreeing to limit his or her practice in the manner prescribed by the reviewing physician. *Existing law authorizes the board to commence disciplinary actions relating to physicians and surgeons including, but not limited to, unprofessional conduct, as defined, and to issue letters of reprimand, and suspend and revoke licenses.*

This bill would authorize an applicant for a license who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability to receive a limited license if the applicant pays the license fee and signs an agreement~~, under penalty of perjury,~~ agreeing to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board. ~~By requiring that the agreement be signed under penalty of perjury, the bill would expand the scope of a crime, thereby imposing a state-mandated local program.~~ *The bill would provide that any person who knowingly provides false information in this agreement shall be subject to any sanctions available to the board.* The bill would authorize the board to require the applicant to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving the limited license.

Under existing law, licensees of the board are required to pay licensure fees, including an initial licensing fee of $790 and a biennial renewal fee of $790. Existing law authorizes the board to increase those fees in certain circumstances and states the intent of the Legislature that, in setting these fees, the board seek to maintain a reserve in the Contingent Fund of the Medical Board equal to 2 months' operating expenditures.

This bill would require those fees to be fixed by the board at a maximum of $790, while retaining the authority of the board to raise those fees in certain circumstances. The bill would state the intent of the Legislature that, in setting those fees, the board seek to maintain a reserve in the Contingent Fund of the Medical Board in an amount not less than 2 nor more than 4 months' operating expenditures. The bill would also require the ~~Bureau of State Audits~~ *Office of State Audits and Evaluations within the Department of Finance* to commence a *preliminary* review of the board's financial status by January 1, 2012, and to ~~report its findings and recommendations to the Joint Legislative Audit Committee~~ *make its findings available upon request* by June 1, 2012, as specified.

~~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. State-mandated local program: ~~yes~~ *no*.

The people of the State of California do enact as follows:

SECTION 1. 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) 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 another jurisdiction, has not had that license revoked or suspended by any 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. 2. Section 2088 is added to the Business and Professions Code, to read:

2088. (a) An applicant for a physician's and surgeon's license who is otherwise eligible for that license but is unable to practice some aspects of medicine safely due to a disability may receive a limited license if he or she does both of the following:

(1) Pays the initial license fee.

(2) Signs an agreement on a form prescribed by the board~~, signed under penalty of perjury,~~ in which the applicant agrees to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board.

(b) The board may require the applicant described in subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving a limited license under this section.

(c) Any person who knowingly provides false information in the agreement submitted pursuant to subdivision (a) shall be subject to any sanctions available to the board.

SEC. 3. 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) Notwithstanding Section 163.5, the delinquency fee shall be 10 percent of the biennial renewal fee.

(g) 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) 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) Not later than January 1, 2012, the ~~Bureau of State Audits (BSA) shall commence a~~ *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 BSA shall, on the basis of the review, report its findings and recommendations to the Joint Legislative Audit Committee~~ *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 ~~board~~ *office* during the 2011–12 fiscal year.

~~SEC. 4. 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.~~

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AB 526

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 526
Author:	Fuentes
Bill Date:	June 1, 2009, amended
Subject:	Public Protection and Physician Health Program Act of 2009
Sponsor:	California Medical Association

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Public Protection and Physician Health Committee (Committee) within the State and Consumer Services Agency (SCSA) with the intent of creating a program in California that will permit physicians to obtain treatment and monitoring of alcohol or substance abuse/dependency, or of mental disorder recovery so that physicians do not treat patients while impaired.

This bill was amended to require the Board to increase licensing fees by $22 for the purposes of funding the physician health program.

ANALYSIS:

This bill would establish the Public Protection and Physician Health Committee. The Committee would be comprised of 14 members and would be under the SCSA. This bill would require that the committee must be appointed and hold its first meeting no later than March 1, 2010. The Committee would be required to prepare regulations that provide clear guidance and measurable outcomes to ensure patient safety and the health and wellness of physicians by June 30, 2010. These rules and regulations shall include:

- Minimum standards, criteria, and guidelines for the acceptance, denial, referral to treatment, and monitoring of physicians and surgeons in the physician health program;

- Standards for requiring that a physician and surgeon agree to cease practice to obtain appropriate treatment services;

- Criteria that must be met prior to a physician and surgeon returning to practice;

- Standards, requirements, and procedures for random testing for the use of banned substances and protocols to follow if that use has occurred;

- Worksite monitoring requirements and standards;

- The manner, protocols, and timeliness of reports required;

- Appropriate requirements for clinical diagnostic evaluations of program participants;

- Requirements for a physician and surgeon's termination from, and reinstatement to, the program;

- Requirements that govern the ability of the program to communicate with a participant's employer or organized medical staff about the participant's status and condition;

- Group meeting and other self-help requirements, standards, protocols, and qualifications;

The Committee would be required to recommend one or more non-profit physician health programs to the SCSA. The physician health programs would be required to report annually to the committee on the number of participants served, the number of compliant participants, the number of participants who have successfully completed their agreement period, and the number of participants reported to the board for suspected noncompliance. The physician health programs would also have to agree to submit to periodic audits and inspections of all operations, records, and management related to the physician health program to ensure compliance.

This bill would require the SCSA, in conjunction with the committee, to monitor compliance of the physician health programs, including making periodic inspections and onsite visits.

This bill would permit a physician to enter into a voluntary agreement with a physician health program that must include a jointly agreed upon treatment program and mandatory conditions and procedures to monitor compliance with the treatment program. The physicians' voluntary participation in a physician health program would be confidential unless waived by the physician.

This bill would prohibit any voluntary agreement from being considered a disciplinary action or order by the Board and would prohibit the agreement from being disclosed to the Board nor to the public. Each participant, prior to entering into a voluntary agreement, would be required to disclose to the Committee whether he or she is under investigation by the Board. If a participant fails to disclose such an investigation, upon enrollment or at any time while a participant, the participant shall be terminated from the program.

Physician health programs would be permitted to report to the committee the name of and results of any contact or information received regarding a physician who is suspected of being, or is, impaired and, as a result, whose competence or professional conduct is reasonably likely to be detrimental to patient safety or to the delivery of patient care. The programs would be required to report to the committee if the physician fails to cooperate with any of the requirements of the physician health program, fails to cease practice when required, fails to submit to evaluation, treatment, or biological fluid testing when required, or whose impairment is not substantially alleviated through treatment, or who, in the opinion of the physician health program, is unable to practice medicine with reasonable skill and safety, or who withdraws or is terminated from the physician health program prior to completion.

The participating physician in a voluntary agreement would be responsible for all expenses relating to chemical or biological fluid testing, treatment, and recovery as provided in the written agreement between the physician and the physician health program.

This bill would permit, not require, the Board to increase licensing fees to no less than $22 and not to exceed 2.5% of the license fee. This fee would be expended solely for the purposes of the physician health programs. If the board included this surcharge, it would be collected and transferred to a trust established by this bill. The Board would be required to separately identify, on the licensing fee statement, the amount being collected for the program. If the Board were to opt to increase the licensing fees to fund this program, the bill states that the Board would be allowed to include a statement indicating to licensees that the Public Protection and Physician Health Program is not a program of the Board and that, by collecting this fee, the Board does not necessarily support, endorse, or have any control of or affiliation with the program. The SCSA would be required to contract for a biennial audit to assess the effectiveness, efficiency, and overall performance of the program and make recommendations.

Amendments to this bill taken June 1, 2009 require the Board to increase licensing fees by not less than $22 or 2.5% of the license fee, whichever is greater, to be used solely for the purposes of the physician health programs.

FISCAL: Generate revenue for program of approximately 1.5 million.

POSITION: **Executive Committee Recommendation:** Oppose
Staff Recommendation: Oppose

July 11, 2009

AMENDED IN ASSEMBLY JUNE 1, 2009

AMENDED IN ASSEMBLY APRIL 16, 2009

AMENDED IN ASSEMBLY APRIL 14, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 526

Introduced by Assembly Member Fuentes

February 25, 2009

An act to add and repeal Article 14 (commencing with Section 2340) of Chapter 5 of Division 2 of the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 526, as amended, Fuentes. Public Protection and Physician Health Program Act of 2009.

Existing law establishes in the Department of Consumer Affairs the Substance Abuse Coordination Committee, comprised of the executive officers of the department's healing arts boards, as specified, and a designee of the State Department of Alcohol and Drug Programs. Existing law requires the committee to formulate, by January 1, 2010, uniform and specific standards in specified areas that each healing arts board shall use in dealing with substance-abusing licensees. The Medical Practice Act establishes in the Department of Consumer Affairs the Medical Board of California, which provides for the licensure and regulation of physicians and surgeons.

This bill would enact the Public Protection and Physician Health Program Act of 2009, which would, until January 1, 2021, establish within the State and Consumer Services Agency the Public Protection and Physician Health Committee, consisting of 14 members appointed

by specified entities, ~~and~~ would require the committee to be appointed and to hold its first meeting by March 1, 2010, and would require agency adoption of related rules and regulations by June 30, 2010. The bill would require the committee to recommend to the agency one or more physician health programs, and would authorize the agency to contract, including on an interim basis, as specified, with any qualified physician health program for purposes of care and rehabilitation of physicians and surgeons with alcohol or drug abuse or dependency problems or mental disorders as specified. The bill would impose requirements on the physician health program relating to, among other things, monitoring the status and compliance of physicians and surgeons who enter treatment for a qualifying illness, as defined, pursuant to written, voluntary agreements, and would require the agency and committee to monitor compliance with these requirements. The bill would provide that a voluntary agreement to receive treatment would not be subject to public disclosure or disclosure to the Medical Board of California, except as specified. The bill would ~~authorize~~ *require* the board to increase physician and surgeon licensure and renewal fees for purposes of the act, and would establish the Public Protection and Physician Health Program Trust Fund for deposit of those funds, which would be subject to appropriation by the Legislature. The bill would also require specified performance audits.

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 hereby finds and declares that:

(a) California has long valued high quality medical care for its citizens and, through its regulatory and enforcement system, protects health care consumers through the proper licensing and regulation of physicians and surgeons to promote access to quality medical care. The protection of the public from harm by physicians and surgeons who may be impaired by alcohol or substance abuse or dependence or by a mental disorder is paramount.

(b) Nevertheless, physicians and surgeons experience health-related problems at the same frequency as the general population, and many competent physicians and surgeons with illnesses may or may not immediately experience impairment in their ability to serve the public. It has been estimated that at least

10 percent of the population struggles with alcohol or substance abuse or dependence during their lifetime, which may, at some point, impact approximately 12,500 of the state's 125,000 licensed physicians and surgeons.

(c) It is in the best interests of the public and the medical profession to provide a pathway to recovery for any licensed physician and surgeon that is currently suffering from alcohol or substance abuse or dependence or a mental disorder. The American Medical Association has recognized that it is an expression of the highest meaning of professionalism for organized medicine to take an active role in helping physicians and surgeons to lead healthy lives in order to help their patients, and therefore, it is appropriate for physicians and surgeons to assist in funding such a program.

(d) While nearly every other state has a physician health program, since 2007 California has been without any state program that monitors physicians and surgeons who have independently obtained, or should be encouraged to obtain, treatment for alcohol or substance abuse or dependence or for a mental disorder, so that they do not treat patients while impaired.

(e) It is essential for the public interest and the public health, safety, and welfare to focus on early intervention, assessment, referral to treatment, and monitoring of physicians and surgeons with significant health impairments that may impact their ability to practice safely. Such a program need not, and should not necessarily, divert physicians and surgeons from the disciplinary system, but instead focus on providing assistance before any harm to a patient has occurred.

(f) Therefore, it is necessary to create a program in California that will permit physicians and surgeons to obtain referral to treatment and monitoring of alcohol or substance abuse or dependence or a mental disorder, so that they do not treat patients while impaired.

SEC. 2. Article 14 (commencing with Section 2340) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 14. Public Protection and Physician Health Program

2340. This article shall be known and may be cited as the Public Protection and Physician Health Program Act of 2009.

2341. For purposes of this article, the following terms have the following meanings:

(a) "Agency" means the State and Consumer Services Agency.

(b) "Board" means the Medical Board of California.

(c) "Committee" means the Public Protection and Physician Health Committee established pursuant to Section 2342.

(d) "Impaired" or "impairment" means the inability to practice medicine with reasonable skill and safety to patients by reason of alcohol abuse, substance abuse, alcohol dependency, any other substance dependency, or a mental disorder.

(e) "Participant" means a physician and surgeon enrolled in the program pursuant to an agreement entered into as provided in Section 2345.

(f) "Physician health program" or "program" means the program for the prevention, detection, intervention, monitoring, and referral to treatment of impaired physicians and surgeons, and includes vendors, providers, or entities contracted with by the agency pursuant to this article.

(g) "Physician and surgeon" means a holder of a physician's and surgeon's certificate.

(h) "Qualifying illness" means "alcohol or substance abuse," "alcohol or chemical dependency," or a "mental disorder" as those terms are used in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or subsequent editions.

(i) "Secretary" means the Secretary of State and Consumer Services.

(j) "Treatment program" or "treatment" means the delivery of care and rehabilitation services provided by an organization or persons authorized by law to provide those services.

2342. (a) (1) There is hereby established within the State and Consumer Services Agency the Public Protection and Physician Health Committee. The committee shall be appointed and hold its first meeting no later than March 1, 2010. The committee shall be comprised of 14 members who shall be appointed as follows:

(A) Eight members appointed by the secretary, including the following:

(i) Two members who are licensed mental health professionals with knowledge and expertise in the identification and treatment of substance abuse and mental disorders.

(ii) Six members who are physicians and surgeons with knowledge and expertise in the identification and treatment of alcohol dependence and substance abuse. One member shall be a designated representative from a panel recommended by a nonprofit professional association representing physicians and surgeons licensed in this state with at least 25,000 members in all modes of practice and specialties. The secretary shall fill one each of the remaining appointments from among those individuals as may be recommended by the California Society of Addiction Medicine, the California Psychiatrist Association, and the California Hospital Association.

(B) Four members of the public appointed by the Governor, at least one of whom shall have experience in advocating on behalf of consumers of medical care in this state.

(C) One member of the public appointed by the Speaker of the Assembly.

(D) One member of the public appointed by the Senate Committee on Rules.

(2) (A) For the purpose of this subdivision, a public member may not be any of the following:

(i) A current or former physician and surgeon or an immediate family member of a physician and surgeon.

(ii) Currently or formerly employed by a physician and surgeon or business providing or arranging for physician and surgeon services, or have any financial interest in the business of a licensee.

(iii) An employee or agent or representative of any organization representing physicians and surgeons.

(B) Each public member shall meet all of the requirements for public membership on the board as set forth in Chapter 6 (commencing with Section 450) of Division 1.

(b) Members of the committee shall serve without compensation, but shall be reimbursed for any travel expenses necessary to conduct committee business.

(c) Committee members shall serve terms of four years, and may be reappointed. By lot, the committee shall stagger the terms of the initial members appointed.

(d) The committee shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code), and shall prepare any additional recommended rules and

regulations necessary or advisable for the purpose of implementing this article, subject to the Administrative Procedures Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The rules and regulations shall include appropriate minimum standards and requirements for referral to treatment, and monitoring of participants in the physician health program, and shall be written in a manner that provides clear guidance and measurable outcomes to ensure patient safety and the health and wellness of physicians and surgeons. The agency shall adopt regulations for the implementation of this article, taking into consideration the regulations recommended by the committee.

(e) The rules and regulations required by this section shall be adopted not later than June 30, 2010, and shall, at a minimum, be consistent with the uniform standards adopted pursuant to Section 315, and shall include all of the following:

(1) Minimum standards, criteria, and guidelines for the acceptance, denial, referral to treatment, and monitoring of physicians and surgeons in the physician health program.

(2) Standards for requiring that a physician and surgeon agree to cease practice to obtain appropriate treatment services.

(3) Criteria that must be met prior to a physician and surgeon returning to practice.

(4) Standards, requirements, and procedures for random testing for the use of banned substances and protocols to follow if that use has occurred.

(5) Worksite monitoring requirements and standards.

(6) The manner, protocols, and timeliness of reports required to be made pursuant to Section 2345.

(7) Appropriate requirements for clinical diagnostic evaluations of program participants.

(8) Requirements for a physician and surgeon's termination from, and reinstatement to, the program.

(9) Requirements that govern the ability of the program to communicate with a participant's employer or organized medical staff about the participant's status and condition.

(10) Group meeting and other self-help requirements, standards, protocols, and qualifications.

(11) Minimum standards and qualifications of any vendor, monitor, provider, or entity contracted with by the agency pursuant to Section 2343.

(12) A requirement that all physician health program services shall be available to all licensed physicians and surgeons with a qualifying illness.

(13) A requirement that any physician health program shall do all of the following:

(A) Promote, facilitate, or provide information that can be used for the education of physicians and surgeons with respect to the recognition and treatment of alcohol dependency, chemical dependency, or mental disorders, and the availability of the physician health program for qualifying illnesses.

(B) Offer assistance to any person in referring a physician and surgeon for purposes of assessment or treatment, or both, for a qualifying illness.

(C) Monitor the status during treatment of a physician and surgeon who enters treatment for a qualifying illness pursuant to a written, voluntary agreement.

(D) Monitor the compliance of a physician and surgeon who enters into a written, voluntary agreement for a qualifying illness with the physician health program setting forth a course of recovery.

(E) Agree to accept referrals from the board to provide monitoring services pursuant to a board order.

(F) Provide a clinical diagnostic evaluation of physicians and surgeons entering the program.

(14) Rules and procedures to comply with auditing requirements pursuant to Section 2348.

(15) A definition of the standard of "reasonably likely to be detrimental to patient safety or the delivery of patient care," relying, to the extent practicable, on standards used by hospitals, medical groups, and other employers of physicians and surgeons.

(16) Any other provision necessary for the implementation of this article.

2343. (a) On and after July 1, 2010, upon adoption of the rules and regulations required by Section 2342, the committee shall recommend one or more physician health programs to the agency, and the agency may contract with any qualified physician health program. The physician health program shall be a nonprofit corporation organized under Section 501(c)(3) of Title 26 of the United States Code. The chief executive officer shall have expertise in the areas of alcohol abuse, substance abuse, alcohol dependency,

other chemical dependencies, and mental disorders. In order to expedite the delivery of physician health program services established by this article, the agency may contract with an entity meeting the minimum standards and requirements set forth in subdivision (e) of Section 2342 on an interim basis prior to the adoption of any additional rules and regulations required to be adopted pursuant to subdivision (d) of Section 2342. The agency may extend the contract when the rules and regulations are adopted, provided that the physician health program meets the requirements in those rules and regulations.

(b) Any contract entered into pursuant to this article shall comply with all rules and regulations required to be adopted pursuant to this article. No entity shall be eligible to provide the services of the physician health program that does not meet the minimum standards, criteria, and guidelines contained in those rules and regulations.

(c) The contract entered into pursuant to this article shall also require the contracting entity to do both of the following:

(1) Report annually to the committee statistics, including the number of participants served, the number of compliant participants, the number of participants who have successfully completed their agreement period, and the number of participants reported to the board for suspected noncompliance; provided, however, that in making that report, the physician health program shall not disclose any personally identifiable information relating to any physician and surgeon participating in a voluntary agreement as provided in this article.

(2) Agree to submit to periodic audits and inspections of all operations, records, and management related to the physician health program to ensure compliance with the requirements of this article and its implementing rules and regulations.

(d) In addition to the requirements of Section 2348, the agency, in conjunction with the committee, shall monitor compliance of the physician health program with the requirements of this article and its implementing regulations, including making periodic inspections and onsite visits with any entity contracted to provide physician health program services.

2344. The agency has the sole discretion to contract with a physician health program for licensees of the board and no provision of this article may be construed to entitle any physician

and surgeon to the creation or designation of a physician health program for any individual qualifying illness or group of qualifying illnesses.

2345. (a) In order to encourage voluntary participation in monitored alcohol or chemical dependency or mental disorder treatment programs, and in recognition of the fact that mental disorders, alcohol dependency, and chemical dependency are illnesses, a physician and surgeon, certified or otherwise lawfully practicing in this state, may enter into a voluntary agreement with a physician health program. The agreement between the physician and surgeon and the physician health program shall include a jointly agreed upon treatment program and mandatory conditions and procedures to monitor compliance with the treatment program, including, but not limited to, an agreement to cease practice, as defined by the rules and regulations adopted pursuant to Section 2342. Except as provided in subdivisions (b), (c), (d), and (e), a physician and surgeon's participation in the physician health program pursuant to a voluntary agreement shall be confidential unless waived by the physician and surgeon.

(b) (1) Any voluntary agreement entered into pursuant to this section shall not be considered a disciplinary action or order by the board, shall not be disclosed to the board, and shall not be public information if all of the following are true:

(A) The voluntary agreement is the result of the physician and surgeon self-enrolling or voluntarily participating in the physician health program.

(B) The board has not referred a complaint against the physician and surgeon to a district office of the board for investigation for conduct involving or alleging an impairment adversely affecting the care and treatment of patients.

(C) The physician and surgeon is in compliance with the treatment program and the conditions and procedures to monitor compliance.

(2) (A) Each participant, prior to entering into the voluntary agreement described in paragraph (1), shall disclose to the committee whether he or she is under investigation by the board. If a participant fails to disclose such an investigation, upon enrollment or at any time while a participant, the participant shall be terminated from the program. For those purposes, the committee shall regularly monitor recent accusations filed against physicians

and surgeons and shall compare the names of physicians and surgeons subject to accusation with the names of program participants.

(B) Notwithstanding subparagraph (A), a participant who is under investigation by the board and who makes the disclosure required in subparagraph (A) may participate in, and enter into a voluntary agreement with, the physician health program.

(c) (1) If a physician and surgeon enters into a voluntary agreement with the physician health program pursuant to this article, the physician health program shall do both of the following:

(A) In addition to complying with any other duty imposed by law, report to the committee the name of and results of any contact or information received regarding a physician and surgeon who is suspected of being, or is, impaired and, as a result, whose competence or professional conduct is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

(B) Report to the committee if the physician and surgeon fails to cooperate with any of the requirements of the physician health program, fails to cease practice when required, fails to submit to evaluation, treatment, or biological fluid testing when required, or whose impairment is not substantially alleviated through treatment, or who, in the opinion of the physician health program, is unable to practice medicine with reasonable skill and safety, or who withdraws or is terminated from the physician health program prior to completion.

(2) Within 48 hours of receiving a report pursuant to paragraph (1), the committee shall make a determination as to whether the competence or professional conduct of the physician and surgeon is reasonably likely to be detrimental to patient safety or to the delivery of patient care, and, if so, refer the matter to the board consistent with rules and regulations adopted by the agency. Upon receiving a referral pursuant to this paragraph, the board shall take immediate action and may initiate proceedings to seek a temporary restraining order or interim suspension order as provided in this division.

(d) Except as provided in subdivisions (b), (c), and (e), and this subdivision, any oral or written information reported to the board pursuant to this section, including, but not limited to, any physician and surgeon's participation in the physician health program and any voluntary agreement entered into pursuant to this article, shall

remain confidential as provided in subdivision (c) of Section 800, and shall not constitute a waiver of any existing evidentiary privileges under any other provision or rule of law. However, this subdivision shall not apply if the board has referred a complaint against the physician and surgeon to a district office of the board for investigation for conduct involving or alleging an impairment adversely affecting the care and treatment of patients.

(e) Nothing in this section prohibits, requires, or otherwise affects the discovery or admissibility of evidence in an action against a physician and surgeon based on acts or omissions within the course and scope of his or her practice.

(f) Any information received, developed, or maintained by the agency regarding a physician and surgeon in the program shall not be used for any other purpose.

2346. The committee shall report to the agency statistics received from the physician health program pursuant to Section 2343, and the agency shall, thereafter, report to the Legislature the number of individuals served, the number of compliant individuals, the number of individuals who have successfully completed their agreement period, and the number of individuals reported to the board for suspected noncompliance; provided, however, that in making that report the agency shall not disclose any personally identifiable information relating to any physician and surgeon participating in a voluntary agreement as provided herein.

2347. (a) A physician and surgeon participating in a voluntary agreement shall be responsible for all expenses relating to chemical or biological fluid testing, treatment, and recovery as provided in the written agreement between the physician and surgeon and the physician health program.

(b) In addition to the fees charged for the initial issuance or biennial renewal of a physician and surgeon's certificate pursuant to Section 2435, and at the time those fees are charged, the board ~~may~~ *shall* include a surcharge of not less than twenty-two dollars ($22) ~~and not to exceed~~, *or* an amount equal to 2.5 percent of the fee set pursuant to Section 2435, *whichever is greater, and* which shall be expended solely for the purposes of this article. ~~If the board includes a surcharge, the~~ *The* board shall collect this surcharge and cause it to be transferred monthly to the trust fund established pursuant to subdivision (c). This amount ~~shall~~ *may* be separately identified on the fee statement provided to physicians

and surgeons as being imposed pursuant to this article. The board may include a conspicuous statement indicating that the Public Protection and Physician Health Program is not a program of the board and the collection of this fee does not, nor shall it be construed to, constitute the board's endorsement of, support for, control of, or affiliation with, the program.

(c) There is hereby established in the State Treasury the Public Protection and Physician Health Program Trust Fund into which all funds collected pursuant to this section shall be deposited. These funds shall be used, upon appropriation in the annual Budget Act, only for the purposes of this article.

(d) Nothing in this section is intended to limit the amount of funding that may be provided for the purposes of this article. In addition to funds appropriated in the annual Budget Act, additional funding from private or other sources may be used to ensure that no person is denied access to the services established by this program due to a lack of available funding.

(e) All costs of the committee and program established pursuant to this article shall be paid out of the funds collected pursuant to this section.

2348. (a) The agency shall biennially contract to perform a thorough audit of the effectiveness, efficiency, and overall performance of the program and its vendors. The agency may contract with a third party to conduct the performance audit, except the third party may not be a person or entity that regularly testifies before the board. This section is not intended to reduce the number of audits the agency or board may otherwise conduct.

(b) The audit shall make recommendations regarding the continuation of this program and this article and shall suggest any changes or reforms required to ensure that individuals participating in the program are appropriately monitored and the public is protected from physicians and surgeons who are impaired due to alcohol or drug abuse or dependency or mental disorder. Any person conducting the audit required by this section shall maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and shall not disclose any information that is identifiable to any program participant.

(c) If, during the course of an audit, the auditor discovers that a participant has harmed a patient, or a patient has died while being treated by a participant, the auditor shall include that information

in his or her audit, and shall investigate and report on how that participant was dealt with by the program.

(d) A copy of the audit shall be made available to the public by posting a link to the audit on the agency's Internet Web site homepage no less than 10 business days after publication of the audit. Copies of the audit shall also be provided to the Assembly and Senate Committees on Business and Professions and the Assembly and Senate Committees on Health within 10 business days of its publication.

2349. This article shall remain in effect only until January 1, 2021, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2021, deletes or extends that date.

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AB 583

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 583
Author: Hayashi
Bill Date: July 8, 2009, amended
Subject: Disclosure of Education and Office Hours
Sponsor: CA Medical Association and CA Society of Plastic Surgeons

STATUS OF BILL:

This bill is currently on the Senate Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require health care practitioners to disclose their license type and highest level of educational degree to patients and physicians would additionally be required to disclose their board certification. Physicians who supervise locations outside their primary office would be required to post the hours they are present at each location.

ANALYSIS:

Existing law requires health care practitioners to either wear a name tag or prominently display their license status in their office. This bill requires health care practitioners to disclose certain information to help the public better understand the qualifications of the health care practitioner they are considering.

This bill intends to make consumers aware of the exact educational level and particular specialty certifications of their health care practitioner. Providing the public with more complete information on health care practitioners will help to alleviate any confusion about the exact qualifications of health care practitioners.

These provisions can be satisfied by either wearing the required information on a name tag, prominently posting the information in the health care practitioner's office (diploma, certificate), or by giving the information to the patient in writing at the initial patient encounter.

This bill will also require a physician, when supervising more than one location, to post the hours the physician is present. In addition, the public may not know that when they seek care at a physician's office, the physician may not be

present. By requiring physicians to post when they are present in the office it will help the patient better understand the physician's availability.

FISCAL: Minor and absorbable enforcement costs

POSITION: Support

July 14, 2009

AMENDED IN SENATE JULY 8, 2009

AMENDED IN SENATE JUNE 22, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 583

Introduced by Assembly Member Hayashi

February 25, 2009

An act to amend Section 680 of the Business and Professions Code, relating to health care practitioners.

LEGISLATIVE COUNSEL'S DIGEST

AB 583, as amended, Hayashi. Health care practitioners: disclosure of education and office hours.

Existing law requires a health care practitioner to disclose, while working, his or her name and practitioner's license status on a name tag in at least 18-point type or *to* prominently display his or her license in his or her office, except as specified.

This bill would require each of those health care practitioners to also display the type of license and, except for nurses, the highest level of academic degree he or she holds either on a name tag in at least 18-point type, in his or her office, or in writing given to patients. The bill would require a physician and surgeon, osteopathic physician and surgeon, and doctor of podiatric medicine who is certified in a medical specialty, as specified, to disclose the name of the certifying board or association either on a name tag in at least 18-point type, in writing given to the patient on the patient's first office visit, or in his or her office. The bill would require a physician and surgeon who supervises an office in addition to his or her primary practice location to conspicuously post in each office a schedule of the regular hours when he or she will be

present in that office and the office hours during which he or she will not be present. The bill would also require an office that is part of a group practice with more than one physician and surgeon to post a current schedule of the hours when a physician and surgeon is present. The bill would exempt health care practitioners working in certain licensed laboratories and health care facilities, as specified, from the requirements to disclose license type, highest level of academic degree, and name of certifying board or association providing certification in the practitioner's specialty or subspecialty.

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 680 of the Business and Professions Code is amended to read:

680. (a) (1) Except as otherwise provided in this section, a health care practitioner shall disclose, while working, his or her name, practitioner's license status, license type, as granted by this state, and the highest level of academic degree he or she holds, by one of the following methods:

(A) On a name tag in at least 18-point type.

(B) In writing to a patient at the ~~patent's~~ *patient's* initial office visit.

(C) In a prominent display in his or her office.

(2) If a health care practitioner or a licensed clinical social worker is working in a psychiatric setting or in a setting that is not licensed by the state, the employing entity or agency shall have the discretion to make an exception from the name tag requirement for individual safety or therapeutic concerns.

(3) (A) In the interest of public safety and consumer awareness, it shall be unlawful for any person to use the title "nurse" in reference to himself or herself in any capacity, except for an individual who is a registered nurse or a licensed vocational nurse, or as otherwise provided in Section 2800. Nothing in this section shall be deemed to prohibit a certified nurse assistant from using his or her title.

(B) An individual licensed under Chapter 6 (commencing with Section 2700) is not required to disclose the highest level of academic degree he or she holds.

(b) Facilities licensed by the State Department of Social Services, the State Department of Mental Health, or the State Department of Public Health shall develop and implement policies to ensure that health care practitioners providing care in those facilities are in compliance with subdivision (a). The State Department of Social Services, the State Department of Mental Health, and the State Department of Public Health shall verify through periodic inspections that the policies required pursuant to subdivision (a) have been developed and implemented by the respective licensed facilities.

(c) For purposes of this article, "health care practitioner" means any person who engages in acts that are the subject of licensure or regulation under this division or under any initiative act referred to in this division.

(d) An individual licensed under Chapter 5 (commencing with Section 2000) or under the Osteopathic Act, who is certified by (1) an American Board of Medical Specialties member board, (2) a board or association with equivalent requirements approved by that person's medical licensing authority, or (3) 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, shall disclose the name of the board or association by one of the following methods:

(1) On a name tag in at least 18-point type.

(2) In writing to a patient at the patient's initial office visit.

(3) In a prominent display in his or her office.

(e) A physician and surgeon who supervises an office in addition to his or her primary practice location shall prominently display in each of those offices a current schedule of the regular hours when he or she is present in the respective office, and the hours during which each office is open and he or she is not present. If the office is a part of a group practice with more than one physician and surgeon, the office shall post a current schedule of the hours when a physician and surgeon is present in the office.

(f) Subdivisions (d) and (e) shall not apply to a health care practitioner working in a facility licensed under Section 1250 of

the Health and Safety Code or in a clinical laboratory licensed under Section 1265.

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AB 646

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 646
Author: Swanson
Bill Date: May 5, 2009, amended
Subject: Authorizing District Hospitals to Employ Physicians
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Business and Professions Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill eliminates a current pilot program which allows for the limited direct employment of physicians by district hospitals, and instead, this bill allows for the direct employment of physicians by 1) rural health care districts, to work at any district facility or clinic, or 2) by any public or non-profit hospitals or clinics located in health care districts which serve medically underserved urban populations and communities.

ANALYSIS:

Current law (commonly referred to as the "Corporate Practice of Medicine" - B&P Code section 2400) generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine, to ensure that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians.

The Board presently administers a pilot project to provide for the direct employment of physicians by qualified district hospitals; this project is set to expire on January 1, 2011. (Senate Bill 376/Chesbro, Chap. 411, Statutes of 2003). The Board supported SB 376 because the program was created as a limited pilot program, and required a final evaluation to assess whether this exemption will promote access to health care.

SB 376 was sponsored by the Association of California Healthcare Districts to enable qualified district hospitals to recruit, hire and employ physicians as full-time paid staff in a rural or underserved community meeting the criteria contained in the bill. Support for this bill was premised upon the belief that the employment of physicians could improve the ability of district hospitals to attract the physicians required to meet the needs of those communities and also help to ensure the continued survival of healthcare district hospitals in rural and underserved communities, without any cost to the state.

Although it was anticipated that this pilot program would bring about significant improvement in access to healthcare in these areas, only five hospitals throughout all of California have participated, employing a total of six physicians. The last date for physicians to enter into or renew a written employment contract with the qualified district hospital was December 31, 2006, and for a term not in excess of four years.

Current law required the Board to evaluate the program and to issue a report to the Legislature no later than October 1, 2008. In March, 2008, staff sent letters to the six physicians and five hospital administrators participating in the program, asking each to define the successes, problems, if any, and overall effectiveness of this program for the hospital and on consumer protection. Additional input was sought as to how the program could be strengthened, and the participating physicians were asked to share thoughts on how the program impacted them personally.

The Board was challenged in evaluating the program and preparing the required report because the low number of participants did not afford us sufficient information to prepare a valid analysis of the pilot. In summary, while the Board supports the ban on the corporate practice of medicine, it also believes there may be justification to extend the pilot so that a better evaluation can be made. However, until there is sufficient data to perform a full analysis of an expanded pilot, the Board's position as spelled out in the report to the Legislature (September 10, 2008) was that the statutes governing the corporate practice of medicine should not be amended as a solution to solve the problem of access to healthcare.

The pilot provided safeguards and limitations. That program provided for the direct employment of no more than 20 physicians in California by qualified district hospitals at any time and limited the total number of physicians employed by such a hospital to no more than two at a time. The Medical Board was notified of any physicians hired under the pilot, and the contracts were limited to four years of service.

This bill eliminates the pilot program and instead would allow *carte blanche* for the direct employment of physicians by 1) rural health care districts, to work at any district facility or clinic, or 2) by any public or non-profit hospitals or clinics located in health care districts which serve medically underserved urban populations and communities.

In this bill, there are no limitations as to which hospitals could participate. As an example, in the current pilot program: 1) the hospital must be located in smaller counties (a population of less than 750,000); 2) the hospital must provide a majority of care to underserved populations; 3) the hospital must notify the Medical Board.

Also, the intent of the original pilot was to recruit physicians and surgeons to provide medically necessary services in rural and medically underserved communities. This was seen as one avenue through which to improve access to care for underserved populations. Since this bill does not include such intent, it appears to be an unwarranted infringement on the prohibition of the corporate practice of medicine.

Although this bill offers limited parameters for implementation, it appears to lack adequate constraints to ensure public protections. Patients would be unaware that the physician is an employee. Information about the atypical employment relationship should be provided to patients so they can make an informed decision; informed consent is a cornerstone of patient care. Additional signage should clearly indicate that physicians are licensed by the State (with contact information for the Board) in case a patient has a need to contact the Board.

An important element of the current pilot is missing from this bill – an independent evaluation should be required to define the successes, problems, if any, and overall effectiveness of this program for the hospital, employed physicians, and on consumer protection. Additional input should be sought as to how the program could be strengthened.

Until a pilot program can be extended and evaluated, this bill seems premature with an unwarranted expansion. Further, although under current law and under this bill the participating hospital is prohibited from interfering with, controlling, or otherwise directing the physician's professional judgment, it is still of concern that there would be an unlimited number of physicians in California who could be employed.

FISCAL: Unknown

POSITION: Support in Concept

July 13, 2009

AMENDED IN ASSEMBLY MAY 5, 2009

AMENDED IN ASSEMBLY APRIL 13, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 646

Introduced by Assembly Member Swanson
(Coauthors: Assembly Members Beall, Buchanan, Chesbro, Coto, De Leon, *Evans,* Fong, Fuentes, *Furutani,* Hall, Jeffries, Lieu, Bonnie Lowenthal, Ma, Mendoza, Nava, Portantino, Price, ~~Ruskin,~~ Salas, Skinner, and Torres)
(Coauthors: Senators DeSaulnier and Wiggins)

February 25, 2009

An act to amend Section 2401 of, and to repeal Section 2401.1 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 646, as amended, Swanson. Physicians and surgeons: employment.

Existing law, the Medical Practice Act, restricts the employment of licensed physicians and surgeons and podiatrists by a corporation or other artificial legal entity, subject to specified exemptions, and makes it a crime to practice medicine without a license. Existing law establishes, until January 1, 2011, a pilot project to allow qualified district hospitals that, among other things, provide more than 50 percent of patient days to the care of Medicare, Medi-Cal, and uninsured patients, to employ a physician and surgeon, if the hospital does not interfere with, control, or otherwise direct the professional judgment of the physician and surgeon. The pilot project authorizes the direct employment of a total of 20 physicians and surgeons by those hospitals

to provide medically necessary services in rural and medically underserved communities, and specifies that each qualified district hospital may employ up to 2 physicians and surgeons, subject to specified requirements.

This bill would delete ~~the~~ *that* pilot project; and would instead authorize a health care district, as defined, ~~or a public or an independent community nonprofit hospital or clinic located in a medically underserved area, as specified,~~ to employ physicians and surgeons if ~~specified requirements are met and the district, hospital, or clinic does not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon~~ *the health care district's service area includes a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP), or has been federally designated as a Health Professional Shortage Area (HPSA); and the chief executive officer of the district provides specified documentation to the Medical Board of California. Upon receipt of that documentation, the bill would require the board to approve the employment of up to 5 primary or specialty care physicians and surgeons by the district, and, upon receipt of additional documentation after that employment, to approve an additional 5 primary or specialty care physicians and surgeons. The bill would provide that a district may, until December 31, 2020, enter into, renew, or extend any employment contract with a physician and surgeon for up to 10 years. The bill would require the Office of Statewide Health Planning and Development, in consultation with the State Department of Public Health and the board, to report to the Legislature by June 1, 2018, with regard to the efficacy of the employment of physicians and surgeons by health care districts, as specified.*

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 2401 of the Business and Professions Code is amended to read:

2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the Division of Licensing or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments

on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Alcohol and Drug Programs, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(d) *(1)* Notwithstanding Section 2400, a health care district ~~that is~~ operated pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code may employ physicians and surgeons, and may charge for professional services rendered by a physician and surgeon, if the physician and surgeon in whose name the charges are made approves the charges. ~~However, the district shall not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law.~~

~~(e) Notwithstanding Section 2400, a public or an independent community nonprofit hospital or clinic located in a medically underserved area, as generally described in Part 5 of Chapter 1 of Title 42 of the Code of Federal Regulations, or an area where unmet priority needs for physicians and surgeons exist, as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225 of the Health and Safety Code, with a patient census that consists of more than 50 percent medically underserved populations, as defined in Section 127928 of the Health and Safety Code, may employ physicians and surgeons, and may charge for professional services rendered by a physician and surgeon, if the physician and surgeon in whose name the charges are made approves the charges.~~ *, and if all of the following conditions are met:*

(A) The service area of the health care district includes a Medically Underserved Area (MUA) or a Medically Underserved Population (MUP), or has been federally designated as a Health Professional Shortage Area (HPSA).

(B) (i) The chief executive officer of the health care district documents that the district has been actively attempting and unable to recruit a primary or specialty care physician and surgeon for any 12 consecutive month period, beginning on or after July 1, 2008.

(ii) The chief executive officer submits an application to the board certifying the district's inability to recruit one or more physicians and surgeons, including all relevant documentation, certifying that the inability to recruit primary or specialty care physicians and surgeons has negatively impacted patient care in the community, and that the employment of physicians and surgeons by the district would meet a critical, unmet need in the community based upon a number of factors, including, but not limited to, the number of patients referred for care outside of the community, the number of patients who experienced delays in treatment, the length of treatment delays, and negative patient outcomes.

(2) Upon receipt and review of the certification of the district's inability to recruit a physician and surgeon as specified in subparagraph (B) of paragraph (1), the board shall approve and authorize the employment of up to five primary or specialty care physicians and surgeons by the district.

(3) Upon receipt and review of subsequent certification of the need for additional primary or specialty care physicians and surgeons by the district, the board shall approve and authorize the employment of up to five additional primary or specialty care physicians and surgeons by the district.

(4) Employment contracts with physicians and surgeons issued pursuant to this subdivision shall be for a period of not more than 10 years, but may be renewed or extended. Districts may enter into, renew, or extend employment contracts with physicians and surgeons pursuant to this subdivision until December 31, 2020.

(5) The Office of Statewide Health Planning and Development, in consultation with the State Department of Public Health and the board, shall conduct an efficacy study of the program under this subdivision to evaluate improvement in physician and surgeon

recruitment and retention in the districts participating in the program, impacts on physician and surgeon and health care access in the communities served by these districts, impacts on patient outcomes, degree of patient and participating physician and surgeon satisfaction, and impacts on the independence and autonomy of medical decisionmaking by employed physicians and surgeons. This study shall be completed and its results reported to the Legislature no later than June 1, 2018.

~~(f) The hospitals or clinics~~

(e) A health care district authorized to employ physicians and surgeons pursuant to subdivision ~~(e)~~ *(d)* shall not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law. Violation of this prohibition is punishable as a violation of Section 2052, by a fine not exceeding ten thousand dollars ($10,000), by imprisonment in the state prison, by imprisonment in a county jail not exceeding one year, or by both the fine and either imprisonment. This subdivision is declaratory of existing law, and, as such, does not create a new crime or expand the scope of any existing crime.

SEC. 2. Section 2401.1 of the Business and Professions Code is repealed.

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AB 648

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 648
Author: Chesbro
Bill Date: May 28, 2009, amended
Subject: Authorizing Rural Hospitals to Employ Physicians
Sponsor: California Hospital Association

STATUS OF BILL:

This bill is currently in the Senate Business and Professions Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows rural hospitals, as defined, to employ physicians and surgeons to provide medical services at the hospital or any other health facility that the rural hospital owns or operations.

ANALYSIS:

Current law (commonly referred to as the "Corporate Practice of Medicine" - B&P Code section 2400) generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine, to ensure that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians.

The Board presently administers a pilot project to provide for the direct employment of physicians by qualified district hospitals; this project is set to expire on January 1, 2011. (Senate Bill 376/Chesbro, Chap. 411, Statutes of 2003). The Board supported SB 376 because the program was created as a limited pilot program, and required a final evaluation to assess whether this exemption will promote access to health care.

SB 376 was sponsored by the Association of California Healthcare Districts to enable qualified district hospitals to recruit, hire and employ physicians as full-time paid staff in a rural or underserved community meeting the criteria contained in the bill. Support for this bill was premised upon the belief that the employment of physicians could improve the ability of district hospitals to attract the physicians required to meet the needs of those communities and also help to ensure the continued survival of healthcare district hospitals in rural and underserved communities, without any cost to the state.

Although it was anticipated that this pilot program would bring about significant improvement in access to healthcare in these areas, only five hospitals throughout all of California have participated, employing a total of six physicians. The last date for

physicians to enter into or renew a written employment contract with the qualified district hospital was December 31, 2006, and for a term not in excess of four years.

Current law required the Board to evaluate the program and to issue a report to the Legislature no later than October 1, 2008. In March, 2008, staff sent letters to the six physicians and five hospital administrators participating in the program, asking each to define the successes, problems, if any, and overall effectiveness of this program for the hospital and on consumer protection. Additional input was sought as to how the program could be strengthened, and the participating physicians were asked to share thoughts on how the program impacted them personally.

The Board was challenged in evaluating the program and preparing the required report because the low number of participants did not afford sufficient information to prepare a valid analysis of the pilot. In summary, while the Board supports the ban on the corporate practice of medicine, it also believes there may be justification to extend the pilot so that a better evaluation can be made. However, until there is sufficient data to perform a full analysis of an expanded pilot, the Board's position as spelled out in the report to the Legislature (September 10, 2008) was that the statutes governing the corporate practice of medicine should not be amended as a solution to solve the problem of access to healthcare.

The current pilot provided safeguards and limitations. That program provided for the direct employment of no more than 20 physicians in California by qualified district hospitals at any time and limited the total number of physicians employed by such a hospital to no more than two at a time. The Medical Board was notified of any physicians hired under the pilot, and the contracts were limited to four years of service.

This bill allows rural hospitals, as defined, to employ physicians and surgeons to provide medical services at the hospital or any other health facility that the rural hospital owns or operations. None of the safeguards and limitations of the pilot are included in this bill. Instead, this bill includes few parameters:

1) The rural hospital that employs a physician shall develop and implement a written policy to ensure that each employed physician exercises his or her independent medical judgment in providing care to patients.

2) Each physician employed by a rural hospital shall sign a statement biennially indicating that the physician and surgeon:

a) Voluntarily desires to be employed by the hospital.

b) Will exercise independent medical judgment in all matters relating to the provision of medical care to his or her patients.

c) Will report immediately to the Medical Board of California any action or event that the physician reasonably and in good faith believes constitutes a compromise of his or her independent medical judgment in providing patient care

3) The signed statement shall be retained by the rural hospital for a period of at least three years. A copy of the signed statement shall be submitted by the rural hospital to the Board within 10 working days after the statement is signed by the physician.

4) If a report is filed per 2) c), above, and the Board believes that a rural hospital has violated this prohibition, the Board shall refer the matter to the Department of Public Health (DPH), which shall investigate the matter. If the department believes that the rural

hospital has violated the prohibition, it shall notify the rural hospital. Certain due process procedures are set forth and penalties are outlined.

Although this bill offers limited parameters for implementation, it appears to lack adequate constraints to ensure public protections. Patients would be unaware the physician is an employee. Information about the atypical employment relationship should be provided to patients so they can make an informed decision; informed consent is a cornerstone of patient care. Additional signage should clearly indicate that physicians are licensed by the State (with contact information for the Board) in case a patient has a need to contact the Board.

The written policy and statement (required per Items 1) and 2), above) should be more appropriately submitted to both the Board and the DPH, so both agencies are aware of the policy the hospital has established for the physicians as it relates to public protection.

Further, employment protection must be provided for all employed physicians, so that any report filed per Item 4), above, does not lead to retaliatory action by the hospital.

Lastly, an important element of the current pilot is missing from this bill – an independent evaluation should be required to define the successes, problems, if any, and overall effectiveness of this program for the hospital, employed physicians, and on consumer protection. Additional input should be sought as to how the program could be strengthened.

Until a pilot program as originally envisioned by SB 376 is fully functional and evaluated, this bill seems premature with an unwarranted expansion. Further, it is still of concern that there would be an unlimited number of physicians in California who could be employed, even if the participating hospital is prohibited from interfering with, controlling, or otherwise directing the physician's professional judgment.

FISCAL: Unknown

POSITION: Support in Concept

AMENDED IN ASSEMBLY MAY 28, 2009

AMENDED IN ASSEMBLY MAY 5, 2009

AMENDED IN ASSEMBLY APRIL 15, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 648

Introduced by Assembly Member Chesbro
(Principal coauthor: Assembly Member Nielsen)
(Principal coauthor: Senator Cox)
(~~Coauthor: Assembly Member Buchanan~~ *Coauthors: Assembly Members Buchanan, Fuentes, and Miller*)
(Coauthor: Senator ~~Cox~~ *Ducheny*)

February 25, 2009

An act to add and repeal Chapter 6.5 (commencing with Section 124871) of Part 4 of Division 106 of the Health and Safety Code, relating to rural hospitals.

LEGISLATIVE COUNSEL'S DIGEST

AB 648, as amended, Chesbro. Rural hospitals: physician services.

Existing law generally provides for the licensure of health facilities, including rural general acute care hospitals, by the State Department of Public Health.

Existing law requires the department to provide expert technical assistance to strategically located, high-risk rural hospitals, as defined, to assist the hospitals in carrying out an assessment of potential business and diversification of service opportunities. Existing law also requires the department to continue to provide regulatory relief when appropriate through program flexibility for such items as staffing, space, and physical plant requirements.

This bill would, until January 1, 2020, establish a demonstration project authorizing a rural hospital, as defined, that meets specified conditions, to employ up to 10 physicians and surgeons at one time, except as provided, to provide medical services at the rural hospital or other health facility that the rural hospital owns or operates, and to retain all or part of the income generated by the physicians and surgeons for medical services billed and collected by the rural hospital if the physician and surgeon in whose name the charges are made approves the charges. The bill would require a rural hospital that employs a physician and surgeon pursuant to those provisions to develop and implement a policy regarding the independent medical judgment of the physician and surgeon.

The bill would require these physicians and surgeons to biennially sign a specified statement.

The bill would impose various duties on the department and the Medical Board of California including, not later than January 1, 2019, a requirement that the board deliver a report to the Legislature regarding the demonstration project.

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) Many hospitals in the state are having great difficulty recruiting and retaining physicians.

(b) There is a shortage of physicians in communities across California, particularly in rural areas, and this shortage limits access to health care for Californians in these communities.

(c) The average age of physicians in rural and underserved urban communities is approaching 60 years of age, with many of these physicians planning to retire within the next two years.

~~(c)~~

(d) Allowing rural hospitals to directly employ physicians will allow rural hospitals to provide economic security adequate for a physician to relocate and reside in the communities served by the rural hospitals and will help rural hospitals recruit physicians to provide medically necessary services in these communities and

further enhance technological developments such as the adoption of electronic medical records.

~~(d)~~

(e) Allowing rural hospitals to directly employ physicians will provide physicians with the opportunity to focus on the delivery of health services to patients without the burden of administrative, financial, and operational concerns associated with the establishment and maintenance of a medical office, thereby giving the physicians a reasonable professional and personal lifestyle.

~~(e)~~

(f) It is the intent of the Legislature by enacting this act to establish a demonstration project authorizing a rural hospital that meets the conditions set forth in Chapter 6.5 (commencing with Section 124871) of the Health and Safety Code to employ physicians directly and to charge for their professional services.

~~(f)~~

(g) It is the further intent of the Legislature to prevent a rural hospital that employs a physician from interfering with, controlling, or otherwise directing the physician's medical judgment or medical treatment of patients.

SEC. 2. Chapter 6.5 (commencing with Section 124871) is added to Part 4 of Division 106 of the Health and Safety Code, to read:

CHAPTER 6.5. RURAL HOSPITAL PHYSICIAN AND SURGEON SERVICES DEMONSTRATION PROJECT

124871. For purposes of this chapter, a rural hospital means all of the following:

(a) A general acute care hospital located in an area designated as nonurban by the United States Census Bureau.

(b) A general acute care hospital located in a rural-urban commuting area code of 4 or greater as designated by the United States Department of Agriculture.

(c) A rural general acute care hospital, as defined in subdivision (a) of Section 1250.

124872. (a) Notwithstanding Article 18 (commencing with Section 2400) of Chapter 5 of Division 2 of the Business and Professions Code and in addition to other applicable laws, a rural hospital whose service area includes a medically underserved area,

a medically underserved population, or that has been federally designated as a health professional shortage area may employ one or more physicians and surgeons, not to exceed 10 physicians and surgeons at one time, except as provided in subdivision (c), to provide medical services at the rural hospital or other health facility, as defined in Section 1250, that the rural hospital owns or operates. The rural hospital may retain all or part of the income generated by the physician and surgeon for medical services billed and collected by the rural hospital, if the physician and surgeon in whose name the charges are made approves the charges.

(b) A rural hospital may participate in the program if both of the following conditions are met:

(1) The rural hospital can document that it has been unsuccessful in recruiting one or more primary care or speciality physicians for at least 12 continuous months beginning July 1, 2008.

(2) The chief executive officer of the rural hospital certifies to the Medical Board of California that the inability to recruit primary care or speciality physicians has negatively impacted patient care in the community and that there is a critical unmet need in the community, based on a number of factors, including, but not limited to, the number of patients referred for care outside the community, the number of patients who experienced delays in treatment, and the length of the treatment delays.

(c) The total number of licensees employed by the rural hospital at one time shall not exceed 10, unless the employment of additional physicians and surgeons is deemed appropriate by the Medical Board of California on a case-by-case basis. In making this determination the board shall take into consideration whether access to care is improved for the community served by the hospital by increasing the number of physicians and surgeons employed.

124873. (a) A rural hospital that employs a physician and surgeon pursuant to Section 124872 shall develop and implement a written policy to ensure that each employed physician and surgeon exercises his or her independent medical judgment in providing care to patients.

(b) Each physician and surgeon employed by a rural hospital pursuant to Section 124872 shall sign a statement biennially indicating that the physician and surgeon:

(1) Voluntarily desires to be employed by the hospital.

(2) Will exercise independent medical judgment in all matters relating to the provision of medical care to his or her patients.

(3) Will report immediately to the Medical Board of California any action or event that the physician and surgeon reasonably and in good faith believes constitutes a compromise of his or her independent medical judgment in providing care to patients in a rural hospital or other health care facility owned or operated by the rural hospital.

(c) The signed statement required by subdivision (b) shall be retained by the rural hospital for a period of at least three years. A copy of the signed statement shall be submitted by the rural hospital to the Medical Board of California within 10 working days after the statement is signed by the physician and surgeon.

(d) A rural hospital shall not interfere with, control, or direct a physician's and surgeon's exercise of his or her independent medical judgment in providing medical care to patients. If, pursuant to a report to the Medical Board of California required by paragraph (3) of subdivision (a), the Medical Board of California believes that a rural hospital has violated this prohibition, the Medical Board of California shall refer the matter to the State Department of Public Health, which shall investigate the matter. If the department concludes that the rural hospital has violated the prohibition, it shall notify the rural hospital. The rural hospital shall have 20 working days to respond in writing to the department's notification, following which the department shall make a final determination. If the department finds that the rural hospital violated the prohibition, it shall assess a civil penalty of five thousand dollars ($5,000) for the first violation and twenty-five thousand dollars ($25,000) for any subsequent violation that occurs within three years of the first violation. If no subsequent violation occurs within three years of the most recent violation, the next civil penalty, if any, shall be assessed at the five thousand dollar ($5,000) level. If the rural hospital disputes a determination by the department regarding a violation of the prohibition, the rural hospital may request a hearing pursuant to Section 131071. Penalties, if any, shall be paid when all appeals have been exhausted and the department's position has been upheld.

(e) Nothing in this chapter shall exempt a rural hospital from a reporting requirement or affect the authority of the board to take action against a physician's and surgeon's license.

124874. (a) Not later than January 1, 2019, the board shall deliver a report to the Legislature regarding the demonstration project established pursuant to this chapter. The report shall include an evaluation of the effectiveness of the demonstration project in improving access to health care in rural and medically underserved areas and the demonstration project's impact on consumer protection as it relates to intrusions into the practice of medicine.

(b) This chapter shall remain in effect only until January 1, 2020, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2020, deletes or extends that date.

O

AB 718

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 718
Author: Emmerson
Bill Date: July 8, 2009, amended
Subject: Electronic Prescribing Pilot Program
Sponsor: Reed Elsevier Inc.

STATUS OF BILL:

This bill is on the Senate Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would create the Inland Empire Health Plan E-Prescribing Pilot Program to promote the exchange of health care information.

ANALYSIS:

Electronically created and transmitted prescriptions can reduce or eliminate errors both at the physician's office, at the point of prescribing, and at the pharmacy when a written or oral prescription is entered into a pharmacy's computer system. An electronic prescribing system in California would greatly increase safety and efficiency within the practices of medicine and pharmacy, and would streamline the prescribing process and enhance communication among health care professionals.

In addition to increased patient safety, there are several other benefits to electronic prescribing. Physicians will know which pharmacy a prescription has been sent to and have the ability to track whether the patient has picked it up. This will offer opportunities for physicians and pharmacists to better ensure patient compliance. Prescriptions will be completely legible and physicians will have an electronic record of what has been prescribed. This will make pharmacy prescription records immediately retrievable. Prescriptions will be received only through trusted partners or agents and will be securely authorized with electronic signatures.

E-prescribing will make improvements in health care quality and efficiency overall by ensuring that patients with multiple physicians are not being over prescribed or taking medications that are contradictory in nature. This will also ensure that only Medi-Cal approved medications are prescribed to those on Medi-Cal as a physician will be immediately notified if the medication is not on the formulary.

Originally this was a statewide mandatory program that has now been reduced to a pilot project to test the implementation of a program.

As amended, this bill would create the Inland Empire Health Plan E-Prescribing Pilot Program in order to promote health care quality and the exchange of health care information. This program would be administered by an entity with at least five years experience electronically prescribing under the Medi-Cal program. This program would include various components such as integrated clinical decisions support alerts for allergies, drug-drug interactions, duplications in therapy and elderly alerts. The pilot program would work to create cost-effective prescribing at the point of care and include approved drug compendia.

FISCAL: None to the Board

POSITION: Support

July 13, 2009

AMENDED IN SENATE JULY 8, 2009

AMENDED IN SENATE JUNE 30, 2009

AMENDED IN SENATE JUNE 16, 2009

AMENDED IN SENATE MAY 27, 2009

AMENDED IN ASSEMBLY APRIL 22, 2009

AMENDED IN ASSEMBLY APRIL 13, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 718

Introduced by Assembly Member Emmerson
(Coauthor: Senator Negrete McLeod)

February 26, 2009

An act to add and repeal Section 14087.521 of the Welfare and Institutions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 718, as amended, Emmerson. Inland Empire Health Plan E-Prescribing Pilot Program.

Existing law establishes the Medi-Cal program, administered by the State Department of Health Care Services, under which basic health care services are provided to qualified low-income persons. Existing law authorizes the California Medical Assistance Commission to negotiate exclusive contracts with any county that seeks to provide, or arrange for the provision of health care services provided under the Medi-Cal program. Existing law authorizes the Board of Supervisors of San Bernardino County to, by ordinance, establish a commission to

negotiate the above-described exclusive contract and to arrange for the supervision of certain health care services.

The Pharmacy Law regulates, among other matters, the dispensing by prescription of dangerous devices and dangerous drugs, which include controlled substances. Existing law authorizes the electronic transmission of prescriptions under specified circumstances.

This bill would, until January 1, 2013, create the Inland Empire Health Plan E-Prescribing Pilot Program and would require the program to promote health care quality and the exchange of health care information and to include specified components, including electronic prescribing, as defined. The bill would require the Inland Empire Health Plan, a joint powers agency, to select, through a competitive bid process, an entity whose product has specified certification to administer the program and would require this entity to submit a report to the Legislature, by January 1, 2012, regarding the goals and results of the program and whether the program should be extended, as specified. *The bill would provide that a physician who contracts with the Inland Empire Health Plan shall not be required to participate in the pilot program.* The bill would provide that the above-described provisions shall be funded by funds made available by the federal American Recovery and Reinvestment Act of 2009. By imposing a new requirement on a joint powers agency, the bill would impose a state-mandated local program.

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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 14087.521 is added to the Welfare and Institutions Code, to read:

14087.521. (a) The Inland Empire Health Plan E-Prescribing Pilot Program is hereby created. For purposes of this section,

"program" means the Inland Empire Health Plan E-Prescribing Pilot Program.

(b) The program shall be administered by an entity whose product has been certified by the Certification Commission for Health Information Technology *or another certifying entity authorized by the federal Department of Health and Human Services*, either as a stand-alone electronic prescribing product or service or as part of an electronic health record product or service. This entity shall be selected by the Inland Empire Health Plan through a competitive bid process.

(c) The program shall promote health care quality and the exchange of health care information consistent with applicable law, including, but not limited to, applicable state and federal confidentiality and data security requirements and applicable state record retention and reporting requirements. The program shall include all of the following components:

(1) Integrated clinical decision support alerts for allergies, drug-drug interactions, duplications in therapy, and elderly alerts.

(2) Current payer formulary information.

(3) Appropriate alternatives, when needed, to support cost-effective prescribing at the point of care, except that nothing in this section shall be construed to authorize the program to establish a drug formulary.

(4) Drug compendia approved by the federal Centers for Medicare and Medicaid Services.

(5) Electronic prescribing consistent with applicable state and federal law.

(6) Patient drug history.

(d) *(1)* Electronic prescribing pursuant to the program shall not interfere with a patient's existing freedom to choose a pharmacy and shall not interfere with the prescribing decision at the point of care.

(2) A physician who contracts with the Inland Empire Health Plan shall not be required to participate in the pilot program.

(e) The entity administering the program shall, on or before January 1, 2012, submit a report to the Legislature on the goals and results of the program and whether the program should be extended. This report shall include quantifiable data on all of the following:

(1) The number of prescribers enrolled in the program who use electronic prescribing.

(2) The number of pharmacies participating in the program.

(3) The number and percentage of prescriptions sent electronically as a percentage of the overall number of prescriptions reimbursed by the plan.

(4) Expenditures on the program.

(5) Data on whether and to what extent the program achieved the following goals:

(A) Reduced medication errors.

(B) Reduced prescription fraud.

(C) Reduced health care costs, including, but not limited to, inpatient hospitalization, by reducing medication errors, increasing patient medication compliance, and identifying medication contraindications.

(f) For purposes of this section, "electronic prescribing" shall have the same meaning as "electronic data transmission prescription" as defined in subdivision (c) of Section 4040 of the Business and Professions Code.

(g) This section shall be funded by funds made available by the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5).

(h) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

O

AB 933

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 933
Author:	Fong
Bill Date:	February 26, 2009, introduced
Subject:	Workers' Compensation: utilization review
Sponsor:	California Society of Industrial Medicine and Surgery California Society of Physical Medicine and Rehabilitation Union of American Physicians and Dentists (AFSCME)

STATUS OF BILL:

This bill is in the Senate Committee on Labor and Industrial Relations.

DESCRIPTION OF CURRENT LEGISLATION:

This bill clarifies current law to provide that physicians performing utilization review for injured workers must be licensed in California.

ANALYSIS:

Current law does not require physicians who perform utilization reviews of workers' compensation claims to be license in California as long as the physicians are licensed in another state. However, current law does state that performing an evaluation that leads to the modification, delay, or denial of medical treatment is an act of diagnosing for the purpose of providing a different mode of treatment for the patient. Only a licensed physician is allowed to override treatment decisions.

The author and proponents of this bill believe that out-of-state physicians are making inappropriate decisions regarding these utilization reviews in part because there is no regulatory agency holding them accountable.

This bill would ensure that any physician performing a utilization review in California would be regulated by the Medical Board (Board) by requiring all physicians performing these reviews to be licensed in this state.

This bill is similar to last year's AB 2969 (Lieber) which was vetoed. The Board has supported that legislation in the past.

FISCAL: None to the Board

POSITION: Support

July 11, 2009

ASSEMBLY BILL No. 933

Introduced by Assembly Member Fong

February 26, 2009

An act to amend Sections 3209.3 and 4610 of the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 933, as introduced, Fong. Workers' compensation: utilization review.

Existing workers' compensation law generally requires employers to secure the payment of workers' compensation, including medical treatment, for injuries incurred by their employees that arise out of, or in the course of, employment.

Existing law, for purposes of workers' compensation, defines "psychologist" to mean a licensed psychologist with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology, as specified, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

This bill would require the psychologist to be licensed by California state law.

Existing law requires every employer to establish a medical treatment utilization review process, in compliance with specified requirements, either directly or through its insurer or an entity with which the employer or insurer contracts for these services. Existing law provides that no person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services,

and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

This bill would require the physician to be licensed by California state law.

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 3209.3 of the Labor Code is amended to read:

3209.3. (a) "Physician" ~~includes~~ *means* physicians and surgeons holding an M.D. or D.O. degree, psychologists, acupuncturists, optometrists, dentists, podiatrists, and chiropractic practitioners licensed by California state law and within the scope of their practice as defined by California state law.

(b) "Psychologist" means a ~~licensed~~ psychologist *licensed by California state law* with a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, and who either has at least two years of clinical experience in a recognized health setting or has met the standards of the National Register of the Health Service Providers in Psychology.

(c) When treatment or evaluation for an injury is provided by a psychologist, provision shall be made for appropriate medical collaboration when requested by the employer or the insurer.

(d) "Acupuncturist" means a person who holds an acupuncturist's certificate issued pursuant to Chapter 12 (commencing with Section 4925) of Division 2 of the Business and Professions Code.

(e) Nothing in this section shall be construed to authorize acupuncturists to determine disability for the purposes of Article 3 (commencing with Section 4650) of Chapter 2 of Part 2, or under Section 2708 of the Unemployment Insurance Code.

SEC. 2. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that

prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a ~~licensed~~ physician *licensed by California state law* who is competent to evaluate the specific

clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. Prior to adoption of the schedule, these policies and procedures shall be consistent with the recommended standards set forth in the American College of Occupational and Environmental Medicine Occupational Medical Practice Guidelines.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements must be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, the decision shall be communicated to the

individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4062. If a request to perform spinal surgery is denied, disputes shall be resolved in accordance with subdivision (b) of Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be

resolved pursuant to Section 4062, except in cases involving recommendations for the performance of spinal surgery, which shall be governed by the provisions of subdivision (b) of Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

O

AB 1070

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1070
Author:	Hill
Bill Date:	June 23, 2009, amended
Subject:	Enforcement Enhancements: reporting, public reprimand
Sponsor:	Medical Board of California

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle carrying enforcement enhancements for the Medical Board (Board). This bill finds and declares the importance of the required reporting under Business and Professions Code section 801.01 and makes various technical changes to this section to enhance the Board's ability to effectively protect consumers.

This bill would allow the Board President to sit on a disciplinary panel when the Board does not have a full complement of members. This bill would require all medical records requested by the Board to be certified.

This bill would allow an administrative law judge to recommend that a licensee be issued a public reprimand that includes additional requirements for education and training.

This bill would require all licensees to report to the Board information regarding any specialty board certifications held and his or her practice status. Licensees would be allowed to report his or her cultural background and foreign language proficiencies. Reporting would occur both at the time of renewal or upon initial licensure.

This bill extends the sunset date of the vertical enforcement and prosecution model from July 1, 2010 to July 1, 2012. This bill also requires the Board to establish and implement a plan to assist in team building between the Board's staff and the Health Quality Enforcement Section of the Department of Justice. (These amendments accepted in committee, bill not yet in print.)

ANALYSIS:

Amends Business and Professions Code section 801.01:

1. Finds and declares the importance of the required reporting under this section for public protection and clarifies the interpretation of the reporting requirements. This is necessary because there are entities that are not reporting, either due to finding ways around it or misinterpreting the law. The Board cannot effectively protect consumers if reporting is not consistent and enforced.

2. Specifies that the University of California is included in the definition of "state governmental agency." This is a technical amendment to make clear that all state and local hospitals are considered state agencies and are bound by the same reporting requirements.

3. Removes section (e) due to the changes made in (f) rendering (e) duplicative.

4. Requires not only physicians, but the entities with which the physicians are affiliated to send a copy of any report filed to the claimant or his or her counsel. Current law states that the physician is required to send a copy of the report to the claimant. The word 'entity' is being added to cover a broader spectrum of individuals who may be reporting. This allows for the burden to be shared by all involved, rather than just the physician.

5. Puts the responsibility for any failure to comply with the reporting requirements on all parties, not just the physician. If an entity, rather than an individual physician, is responsible for making the decision in a case, that entity is responsible for the reporting. However, if the physician is not affiliated with a larger entity, the burden of reporting would be on the physician. Additionally, the fines for failing to comply are increased to not less than five hundred dollars ($500) and not more than five thousand dollars ($5,000).

6. Adds that a copy of a judgment must be submitted to the Board to be consistent with the requirement for a copy of an arbitration award.

7. Requires that any self insured entity providing a report to a licensing Board must also notify the licensee within a reasonable amount if time, within the 30 day requirement, that such report is being filed with that Board.

Adds Business and Professions Code section 804.5:

1. Recognizes that various entities are implementing risk management programs in the interest of early intervention to address known complications and other unanticipated events. Prohibits these programs from including provisions that

prohibit patients from contacting or cooperating with the Board or from filing or withdrawing a complaint.

Amends Business and Professions Code section 2006:

1. Extends the sunset date of the vertical enforcement and prosecution model from July1, 2010 to July 1, 2012.

Amends Business and Professions Code section 2008:

1. Allows the Board President to sit on a disciplinary panel when the Board does not have a full complement of members. Currently, the Board President is not permitted to sit on a panel. When the Board does not have enough members to fill both panels, usually due to term expirations, it is often the case that Board members must serve on two disciplinary panels at the same time in order to have a quorum with which to take action. Allowing the Board President to sit on a panel would expedite the process of decision making and reduce the workload for the members who are sitting on more than one panel.

Amends Business and Professions Code section 2225.5:

1. Requires all medical records requested by the Board to be certified. When the Board requests medical records upon initial complaint, certified records are requested but not always provided. The initial review can be performed without certified records, however, if the complaint goes to investigation, the Board will need certified medical records. Currently, the Board often has to request medical records more than once, which prolongs the process of investigation. Requiring the requested medical records to be certified would expedite the process of review and investigation of complaints. The board has a form that can be filled out to certify the records and the provider of the records can ask the board to send its copy service thus reducing the cost to the physician or entity. (form attached)

2. Puts a cap of ten thousand dollars ($10,000) on the penalty that can be assessed a physician for not complying with the Board's request for medical records. Currently the penalty is one thousand dollars ($1,000) a day for not complying with the request for medical records. This cap is the same as what is in current law for hospitals.

3. Defines certified medical records as a copy of the patient's medical records authenticated by the licensee or health care facility, as appropriate, on a form prescribed by the board.

Amends Business and Professions Code section 2227:

1. Allows an administrative law judge to recommend the issuance of a public reprimand that includes additional education and training in a proposed decision. Currently, when the Board feels the appropriate level of discipline for a physician is a public letter of reprimand with required training or education, prior to the filing of an Accusation, the Board may issue the physician a public letter of reprimand that includes the additional education or training requirements. However, if the Board has filed an accusation against a physician and the accusation is heard by an administrative law judge, the law does not allow the administrative law judge to recommend a public reprimand to be issued to the physician with a training or education requirement.

Amends Business and Professions Code section 2425.3:

1. Specifies that licensees must report to the Board information regarding any specialty board certifications he or she holds that is issued by a member of the American Board of Medical Specialties or approved by the Board, his or her practice status, and may report his or her cultural background and foreign language proficiency both at the time of renewal and at upon initial licensure. Current law states that a physician must report the required information to the Board at renewal, but does not specify that the physician report the required information to the Board at the time of initial licensure.

Amends Government Code section 12925, 12925.5, 12529.6, 12529.7:

1. Extends the sunset date of the vertical enforcement and prosecution model from July1, 2010 to July 1, 2012.

2. Adds to the provisions relating to the vertical enforcement and prosecution model, a requirement that the Board establish and implement a plan to assist in team building between the Board's staff and the Health Quality Enforcement Section of the Department of Justice. This was a recommendation of the 2009 report. Requires a new evaluation report by March 1, 2011.

FISCAL: None to the Board

POSITION: Sponsor/ Support

July 16, 2009

AMENDED IN SENATE JUNE 23, 2009

AMENDED IN ASSEMBLY APRIL 22, 2009

AMENDED IN ASSEMBLY MARCH 31, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1070

Introduced by Assembly Member Hill

February 27, 2009

An act to amend Sections 801.01, *2006,* 2008, 2225.5, 2227, and 2425.3 of, and to add Section 804.5 to, the Business and Professions Code, *and to amend Sections 12529, 12529.5, 12529.6, and 12529.7 of the Government Code,* relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1070, as amended, Hill. Healing arts.

(1) Existing law provides for the licensure and regulation of osteopathic physicians and surgeons by the Osteopathic Medical Board of California, physicians and surgeons by the Medical Board of California *(Medical Board)*, and podiatrists by the California Board of Podiatric Medicine. Existing law requires those licensees, insurers providing professional liability insurance to those licensees, and governmental agencies that self-insure those licensees to report specified settlements, arbitration awards, or civil judgments to the licensee's board if based on the licensee's alleged negligence, error, or omission in practice or his or her rendering of unauthorized professional services.

This bill would specify that the reporting requirements apply to the University of California, as specified. *With respect to a governmental agency required to submit a report, the bill would require the agency to, prior to submitting a report, provide written notice of its intention*

to file a report to the affected licensee and provide the licensee with an opportunity to respond to the agency, as specified.

Existing law requires licensees and insurers required to make these reports to send a copy of the report to the claimant or his or her counsel and requires a claimant or his or her counsel who does not receive a copy of the report within a specified time period to make the report to the appropriate board. Existing law makes a failure of a licensee, claimant, or counsel to comply with these requirements a public offense punishable by a specified fine.

This bill would require any entity or person required to make a report to send a copy of the report to the claimant or his or her counsel. The bill would also require an entity that makes a report to notify the licensee within 15 days of the filing of the report.

The bill would also make a failure to comply with any of the reporting requirements an infraction punishable by a specified fine. By expanding the scope of a crime, the bill would impose a state-mandated local program.

Existing law requires these reports to include certain information, including a brief description of the facts of each claim, charge, or allegation, and the amount of the judgment or award and the date of its entry or service.

This bill would eliminate the requirement that this description be brief and would require the description to also include the role of each physician and surgeon or podiatrist in the care or professional services provided to the patient, as specified. The bill would also require the report to include a copy of the judgment or award.

(2) The Medical Practice Act provides for the regulation of physicians and surgeons by the Medical Board ~~of California~~, and provides that the protection of the public is the highest priority for the board in exercising its licensing, regulatory, and disciplinary functions.

This bill would prohibit any entity that provides early intervention, patient safety, or risk management programs to patients, or contracts for those programs for patients, from requiring that a patient waive his or her rights to contact or cooperate with the board, or to file a complaint with the board.

(3) Existing law authorizes the Medical Board ~~of California~~ to appoint panels from its members for the purposes of fulfilling specified obligations and prohibits the president of the board from serving as a member of a panel.

This bill would allow the president of the board to serve as a member of a panel if there is a vacancy in the membership of the board.

(4) Under existing law, a physician and surgeon or podiatrist who fails to comply with a patient's medical record request, as specified, within 15 days, or who fails or refuses to comply with a court order mandating release of records, is required to pay a civil penalty of $1,000 per day, as specified.

This bill would place a limit of $10,000 on those civil penalties and would make other related changes, including providing a definition of "certified medical records," as specified.

(5) Existing law prescribes the disciplinary action that may be taken against a physician and surgeon or podiatrist. Among other things, existing law authorizes the licensee to be publicly reprimanded.

This bill would authorize the public reprimand to include a requirement that the licensee complete educational courses approved by the board.

(6) Existing law requires the ~~board~~ *Medical Board* to request a licensed physician and surgeon to report, at the time of license renewal, any specialty board certification he or she holds, as specified. Existing law also authorizes a licensed physician and surgeon to report to the board, at the time of license renewal, information regarding his or her cultural background and foreign language proficiency.

This bill would instead require licensees to provide that information at the time of license renewal and immediately upon issuance of an initial license.

Existing law requires a licensed physician and surgeon to also report, at the time of license renewal, his or her practice status, as specified.

This bill would also require that this information be provided immediately upon issuance of an initial license.

(7) Existing law creates the Health Quality Enforcement Section within the Department of Justice with the primary responsibility of investigating and prosecuting proceedings against licensees and applicants within the jurisdiction of the Medical Board and various other boards. Existing law simultaneously assigns a complaint received by the Medical Board to an investigator and a deputy attorney general, as specified. Existing law makes these provisions inoperative on July 1, 2010, and repeals them on January 1, 2010, unless a later enacted statute deletes or extends those dates. Existing law also requires the Medical Board, in consultation with specified agencies, to report and

make recommendations to the Governor and the Legislature on this prosecution model by July 1, 2009.

This bill would make those provisions inoperative on July 1, 2012, and repeal them on January 1, 2013. The bill would require the Medical Board to 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. The bill would also require the Medical Board to, in consultation with specified agencies, report and make recommendations to the Governor and the Legislature on this enforcement and prosecution model by March 1, 2011. The bill would make other related changes.

~~(7)~~

(8) 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. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 801.01 of the Business and Professions Code is amended to read:

801.01. The Legislature finds and declares that the filing of reports with the applicable state agencies required under this section is essential for the protection of the public. It is the intent of the Legislature that the reporting requirements set forth in this section be interpreted broadly in order to expand reporting obligations.

(a) A complete report shall be sent to the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine, with respect to a licensee of the board as to the following:

(1) A settlement over thirty thousand dollars ($30,000) or arbitration award of any amount or a civil judgment of any amount, whether or not vacated by a settlement after entry of the judgment, that was not reversed on appeal, of a claim or action for damages for death or personal injury caused by the licensee's alleged

negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(2) A settlement over thirty thousand dollars ($30,000), if the settlement is based on the licensee's alleged negligence, error, or omission in practice, or on the licensee's rendering of unauthorized professional services, and a party to the settlement is a corporation, medical group, partnership, or other corporate entity in which the licensee has an ownership interest or that employs or contracts with the licensee.

(b) The report shall be sent by the following:

(1) The insurer providing professional liability insurance to the licensee.

(2) The licensee, or his or her counsel, if the licensee does not possess professional liability insurance.

(3) A state or local governmental agency that self-insures the licensee. For purposes of this section "state governmental agency" includes, but is not limited to, the University of California.

(c) The entity, person, or licensee obligated to report pursuant to subdivision (b) shall send the complete report if the judgment, settlement agreement, or arbitration award is entered against or paid by the employer of the licensee and not entered against or paid by the licensee. "Employer," as used in this paragraph, means a professional corporation, a group practice, a health care facility or clinic licensed or exempt from licensure under the Health and Safety Code, a licensed health care service plan, a medical care foundation, an educational institution, a professional institution, a professional school or college, a general law corporation, a public entity, or a nonprofit organization that employs, retains, or contracts with a licensee referred to in this section. Nothing in this paragraph shall be construed to authorize the employment of, or contracting with, any licensee in violation of Section 2400.

(d) The report shall be sent to the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine, as appropriate, within 30 days after the written settlement agreement has been reduced to writing and signed by all parties thereto, within 30 days after service of the arbitration award on the parties, or within 30 days after the date of entry of the civil judgment.

(e) The entity, person, or licensee required to report under subdivision (b) shall send a copy of the report to the claimant or

to his or her counsel if he or she is represented by counsel. If the claimant or his or her counsel has not received a copy of the report within 45 days after the settlement was reduced to writing and signed by all of the parties or the arbitration award was served on the parties or the date of entry of the civil judgment, the claimant or the claimant's counsel shall make the report to the appropriate board.

(f) Failure to comply with this section is a public offense punishable by a fine of not less than five hundred dollars ($500) and not more than five thousand dollars ($5,000).

(g) (1) The Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine may develop a prescribed form for the report.

(2) The report shall be deemed complete only if it includes the following information:

(A) The name and last known business and residential addresses of every plaintiff or claimant involved in the matter, whether or not the person received an award under the settlement, arbitration, or judgment.

(B) The name and last known business and residential address of every licensee who was alleged to have acted improperly, whether or not that person was a named defendant in the action and whether or not that person was required to pay any damages pursuant to the settlement, arbitration award, or judgment.

(C) The name, address, and principal place of business of every insurer providing professional liability insurance to any person described in subparagraph (B), and the insured's policy number.

(D) The name of the court in which the action or any part of the action was filed, and the date of filing and case number of each action.

(E) A description or summary of the facts of each claim, charge, or allegation, including the date of occurrence and the licensee's role in the care or professional services provided to the patient with respect to those services at issue in the claim or action.

(F) The name and last known business address of each attorney who represented a party in the settlement, arbitration, or civil action, including the name of the client he or she represented.

(G) The amount of the judgment, the date of its entry, and a copy of the judgment; the amount of the arbitration award, the date of its service on the parties, and a copy of the award document; or

the amount of the settlement and the date it was reduced to writing and signed by all parties. If an otherwise reportable settlement is entered into after a reportable judgment or arbitration award is issued, the report shall include both the settlement and a copy of the judgment or award.

(H) The specialty or subspecialty of the licensee who was the subject of the claim or action.

(I) Any other information the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine may, by regulation, require.

(3) Every professional liability insurer, self-insured governmental agency, or licensee or his or her counsel that makes a report under this section and has received a copy of any written or electronic patient medical or hospital records prepared by the treating physician and surgeon or podiatrist, or the staff of the treating physician and surgeon, podiatrist, or hospital, describing the medical condition, history, care, or treatment of the person whose death or injury is the subject of the report, or a copy of any deposition in the matter that discusses the care, treatment, or medical condition of the person, shall include with the report, copies of the records and depositions, subject to reasonable costs to be paid by the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine. If confidentiality is required by court order and, as a result, the reporter is unable to provide the records and depositions, documentation to that effect shall accompany the original report. The applicable board may, upon prior notification of the parties to the action, petition the appropriate court for modification of any protective order to permit disclosure to the board. A professional liability insurer, self-insured governmental agency, or licensee or his or her counsel shall maintain the records and depositions referred to in this paragraph for at least one year from the date of filing of the report required by this section.

(h) If the board, within 60 days of its receipt of a report filed under this section, notifies a person named in the report, that person shall maintain for the period of three years from the date of filing of the report any records he or she has as to the matter in question and shall make those records available upon request to the board to which the report was sent.

(i) Notwithstanding any other provision of law, no insurer shall enter into a settlement without the written consent of the insured, except that this prohibition shall not void any settlement entered into without that written consent. The requirement of written consent shall only be waived by both the insured and the insurer.

~~(j) Any entity that makes a report pursuant to this section shall, within 15 days after filing the report, notify the licensee that the report was filed with the appropriate licensing board.~~

(j) (1) A state or local governmental agency that self-insures licensees shall, prior to sending a report pursuant to this section, do all of the following with respect to each licensee who will be identified in the report:

(A) Provide written notice to the licensee that the agency intends to submit a report in which the licensee will be identified. This notice shall describe the specific reasons for identifying the licensee and the specific reasons for the amount of the settlement the agency apportioned to the licensee. The agency shall include with this notice a copy of all records used by the agency in deciding to identify the licensee in the report.

(B) Advise the licensee that he or she may, within 10 days of receiving the notice described in subparagraph (A), provide a written response to the agency and written materials in support of the licensee's position. The agency shall include this response and materials in the report submitted to a board under this section.

(C) Provide the licensee, after giving at least five days prior written notice, with the opportunity to personally present his or her arguments to the body that will make the final decision on behalf of the agency regarding identification of the licensee in the report.

(2) Nothing in this subdivision shall be construed to modify either the content of a report required under this section or the timeframe for filing that report.

(k) For purposes of this section, "licensee" means a licensee of the Medical Board of California, the Osteopathic Medical Board of California, or the California Board of Podiatric Medicine.

SEC. 2. Section 804.5 is added to the Business and Professions Code, to read:

804.5. The Legislature recognizes that various types of entities are creating, implementing, and maintaining patient safety and risk management programs that encourage early intervention in

order to address known complications and other unanticipated events requiring medical care. The Legislature recognizes that some entities even provide financial assistance to individual patients to help them address these unforeseen health care concerns. It is the intent of the Legislature, however, that such financial assistance not limit a patient's interaction with, or his or her rights before, the Medical Board of California.

Any entity that provides early intervention, patient safety, or risk management programs to patients, or contracts for those programs for patients, shall not include, as part of any of those programs or contracts, any of the following:

(a) A provision that prohibits a patient or patients from contacting or cooperating with the board.

(b) A provision that prohibits a patient or patients from filing a complaint with the board.

(c) A provision that requires a patient or patients to withdraw a complaint that has been filed with the board.

SEC. 3. Section 2006 of the Business and Professions Code is amended to read:

2006. (a) ~~On and after January 1, 2006, any~~ *Any* reference in this chapter to an investigation by the board~~, or one of its divisions,~~ shall be deemed to refer to ~~an~~ *a joint* investigation ~~directed~~ *conducted* by employees of the Department of Justice *and the board under the vertical enforcement and prosecution model, as specified in Section 12529.6 of the Government Code.*

(b) This section shall become inoperative on July 1, ~~2010~~ *2012*, and as of January 1, ~~2011~~ *2013*, is repealed, unless a later enacted statute, that becomes operative on or before January 1, ~~2011~~ *2013*, deletes or extends the dates on which it becomes inoperative and is repealed.

~~SEC. 3.~~

SEC. 4. 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. 4.~~

SEC. 5. Section 2225.5 of the Business and Professions Code is amended to read:

2225.5. (a) (1) A licensee who fails or refuses to comply with a request for the certified medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the licensee is unable to provide the documents within this time period for good cause.

(2) A health care facility shall comply with a request for the certified medical records of a patient that is accompanied by that patient's written authorization for release of records to the board together with a notice citing this section and describing the penalties for failure to comply with this section. Failure to provide the authorizing patient's certified medical records to the board within 30 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 30th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. This paragraph shall not require health care facilities to assist the board in obtaining the patient's authorization. The board shall pay the reasonable costs of copying the certified medical records.

(b) (1) A licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the date by which the court order requires the documents to be produced, up to ten thousand dollars ($10,000), unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period

the licensee is out of compliance with the court order and during any related appeals.

(2) Any licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). The fine shall be added to the licensee's renewal fee if it is not paid by the next succeeding renewal date. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(3) A health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of patient records to the board, that is accompanied by a notice citing this section and describing the penalties for failure to comply with this section, shall pay to the board a civil penalty of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced, up to ten thousand dollars ($10,000), after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(4) Any health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(c) Multiple acts by a licensee in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) or by imprisonment in a county jail not exceeding six months, or by both that fine and imprisonment. Multiple acts by a health care facility in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) and shall be reported to the State Department of Public Health and shall be considered as grounds for disciplinary action with respect

to licensure, including suspension or revocation of the license or certificate.

(d) A failure or refusal of a licensee to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board constitutes unprofessional conduct and is grounds for suspension or revocation of his or her license.

(e) Imposition of the civil penalties authorized by this section shall be in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Division 3 of Title 2 of the Government Code).

(f) For purposes of this section, "certified medical records" means a copy of the patient's medical records authenticated by the licensee or health care facility, as appropriate, on a form prescribed by the board.

(g) For purposes of this section, a "health care facility" means a clinic or health facility licensed or exempt from licensure pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

~~SEC. 5.~~

SEC. 6. Section 2227 of the Business and Professions Code is amended to read:

2227. (a) A licensee whose matter has been heard by an administrative law judge of the Medical Quality Hearing Panel as designated in Section 11371 of the Government Code, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the board, may, in accordance with the provisions of this chapter:

(1) Have his or her license revoked upon order of the board.

(2) Have his or her right to practice suspended for a period not to exceed one year upon order of the board.

(3) Be placed on probation and be required to pay the costs of probation monitoring upon order of the board.

(4) Be publicly reprimanded by the board. The public reprimand may include a requirement that the licensee complete relevant educational courses approved by the board.

(5) Have any other action taken in relation to discipline as part of an order of probation, as the board or an administrative law judge may deem proper.

(b) Any matter heard pursuant to subdivision (a), except for warning letters, medical review or advisory conferences,

professional competency examinations, continuing education activities, and cost reimbursement associated therewith that are agreed to with the board and successfully completed by the licensee, or other matters made confidential or privileged by existing law, is deemed public, and shall be made available to the public by the board pursuant to Section 803.1.

~~SEC. 6.~~

SEC. 7. Section 2425.3 of the Business and Professions Code is amended to read:

2425.3. (a) A licensed physician and surgeon shall report to the board, immediately upon issuance of an initial license and at the time of license renewal, any specialty board certification he or she holds that is issued by a member board of the American Board of Medical Specialties or approved by the Medical Board of California.

(b) A licensed physician and surgeon shall also report to the board, immediately upon issuance of an initial license and at the time of license renewal, his or her practice status, designated as one of the following:

(1) Full-time practice in California.

(2) Full-time practice outside of California.

(3) Part-time practice in California.

(4) Medical administrative employment that does not include direct patient care.

(5) Retired.

(6) Other practice status, as may be further defined by the board.

(c) (1) A licensed physician and surgeon shall report to the board, immediately upon issuance of an initial license and at the time of license renewal, and the board shall collect, information regarding his or her cultural background and foreign language proficiency.

(2) Information collected pursuant to this subdivision shall be aggregated on an annual basis based on categories utilized by the board in the collection of the data, and shall be aggregated into both statewide totals and ZIP code of primary practice location totals.

(3) Aggregated information under this subdivision shall be compiled annually and reported on the board's Internet Web site on or before October 1 of each year.

(d) The information collected pursuant to subdivisions (a) and (b) may also be placed on the board's Internet Web site.

SEC. 8. Section 12529 of the Government Code, as amended by Section 19 of Chapter 33 of the Statutes of 2008, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is 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 ~~or a division of the board~~.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the ~~division or~~ board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, and the committees under the jurisdiction of the Medical Board of California ~~or a division of the board~~, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become inoperative on July 1, ~~2010~~ *2012*, and, as of January 1, ~~2011~~ *2013*, is repealed, unless a later enacted statute, that becomes operative on or before January 1, ~~2011~~ *2013*, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 9. Section 12529 of the Government Code, as amended by Section 20 of Chapter 33 of the Statutes of 2008, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to 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 ~~or a division of the board~~, and to provide ongoing review of the investigative activities conducted in support of those prosecutions, as provided in subdivision (b) of Section 12529.5.

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the ~~division or~~ board.

(d) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, and the committees under the jurisdiction of the Medical Board of California ~~or a division of the board~~, with the intent that the expenses be proportionally shared as to services rendered.

(e) This section shall become operative July 1, ~~2010~~ *2012*.

SEC. 10. Section 12529.5 of the Government Code, as amended by Section 21 of Chapter 33 of the Statutes of 2008, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the

Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section 12529 to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards~~, division,~~ or committees in designing and providing initial and in-service training programs for staff of the ~~division,~~ boards~~,~~ or committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of ~~the division or~~ the boards shall be made by the executive officer of the ~~division,~~ boards~~,~~ or committees as appropriate in consultation with the senior assistant.

(e) This section shall become inoperative on July 1, ~~2010~~ *2012*, and, as of January 1, ~~2011~~ *2013*, is repealed, unless a later enacted statute, that becomes operative on or before January 1, ~~2011~~ *2013*, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 11. Section 12529.5 of the Government Code, as amended by Section 22 of Chapter 33 of the Statutes of 2008, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to assist ~~the division and~~ the boards in intake and investigations and to direct discipline-related prosecutions. Attorneys shall be assigned to work closely with each major intake and investigatory unit of the boards, to assist in the evaluation and screening of complaints from receipt through disposition and to assist in developing uniform standards and procedures for the handling of complaints and investigations.

A deputy attorney general of the Health Quality Enforcement Section shall frequently be available on location at each of the working offices at the major investigation centers of the boards, to provide consultation and related services and engage in case review with the boards' investigative, medical advisory, and intake staff. The Senior Assistant Attorney General and deputy attorneys general working at his or her direction shall consult as appropriate with the investigators of the boards, medical advisors, and executive staff in the investigation and prosecution of disciplinary cases.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards~~, division,~~ or committees in designing and providing initial and in-service training programs for staff of the ~~division,~~ boards~~,~~ or committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of ~~the division or~~ the boards shall be made by the executive officer of the ~~division,~~ boards~~,~~ or committees as appropriate in consultation with the senior assistant.

(e) This section shall become operative July 1, ~~2010~~ *2012*.

SEC. 12. Section 12529.6 of the Government Code is amended to read:

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 ~~both~~ *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.

(f) This section shall become inoperative on July 1, ~~2010~~ *2012*, and, as of January 1, ~~2011~~ *2013*, is repealed, unless a later enacted statute, that is enacted before January 1, ~~2011~~ *2013*, deletes or extends the dates on which it becomes inoperative and is repealed.

SEC. 13. Section 12529.7 of the Government Code is amended to read:

12529.7. By ~~July 1, 2009~~ *March 1, 2011*, the Medical Board of California, in consultation with the Department of Justice~~,~~ *and* the Department of Consumer Affairs, ~~the Department of Finance, and the Department of Personnel Administration~~, shall report and make recommendations to the Governor and the Legislature on

the vertical enforcement and prosecution model created under Section 12529.6.

~~SEC. 7.~~

SEC. 14. 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.

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AB 1116

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1116
Author:	Carter
Bill Date:	February 27, 2009, introduced
Subject:	Cosmetic surgery: Physical examination prior to surgery
Sponsor:	Author

STATUS OF BILL:

This bill is currently on the Senate Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill enacts the Donda West Law, and would require that physicians or dentists conduct a physical examination on patients prior to performing elective cosmetic surgery, including liposuction.

The legislation adds Business and Professions Code sections 1638.2 (dentists) and 2259.8 (physicians) which would prohibit performing cosmetic surgery unless the patient has received a physical examination and written clearance from one of the following:

- A licensed physician and surgeon, which may be the surgeon performing the surgery;
- A nurse practitioner;
- A physician assistant, or;
- A dentist licensed to perform surgery under section 1634 of the Business and Professions Code.

The examination must include the taking of a complete medical history.

ANALYSIS:

Donda West was a patient that, prior to finding a surgeon willing to perform her procedures, was rejected as a candidate for surgery by several practitioners due to existing physical conditions. She died shortly after undergoing surgery.

This bill is identical to AB 2968 (Carter), passed in 2008, but vetoed by the Governor. (The reason for the veto was that due to the budget negotiations there was insufficient time for review.) The Medical Board took a "support" position on that legislation.

Under the current standard of care, surgeons should be taking a complete history and performing a physical examination prior to performing any surgery to ensure the patient is sufficiently healthly to undergo the procedure. Unfortunately, some surgeons' practices do not rise to this standard of care. While probably unnecessary, stating this standard in law may serve to protect patients by clarifying that a prior examination is part of the cosmetic surgery process.

FISCAL: Minor and absorbable.

POSITION: Support

July 11, 2009

ASSEMBLY BILL No. 1116

Introduced by Assembly Member Carter

February 27, 2009

An act to add Sections 1638.2 and 2259.8 to the Business and Professions Code, relating to cosmetic surgery.

LEGISLATIVE COUNSEL'S DIGEST

AB 1116, as introduced, Carter. Cosmetic surgery.

Existing law, the Dental Practice Act, establishes the Dental Board of California in the Department of Consumer Affairs, which licenses dentists and regulates their practice, including dentists who hold a permit to perform oral and maxillofacial surgery. Existing law, the Medical Practice Act, establishes the Medical Board of California in the Department of Consumer Affairs, which licenses physicians and surgeons and regulates their practice.

The Medical Practice Act requires specified disclosures to patients undergoing procedures involving collagen injections, and also requires the Medical Board of California to adopt extraction and postoperative care standards in regard to body liposuction procedures performed by a physician and surgeon outside of a general acute care hospital. Existing law makes a violation of these provisions a misdemeanor.

This bill would enact the Donda West Law, which would prohibit the performance of an elective cosmetic surgery procedure on a patient unless, prior to surgery, the patient has received a physical examination by, and has received written clearance for the procedure from, the licensed physician and surgeon or dentist performing the cosmetic surgery or another licensed physician and surgeon, or a certified nurse practitioner or a licensed physician assistant, as specified. The bill would

require the physical examination to include the taking of a complete medical history. The bill would also provide that a violation of these provisions would not constitute a crime.

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. This act shall be known and may be cited as the Donda West Law.

SEC. 2. Section 1638.2 is added to the Business and Professions Code, to read:

1638.2. (a) Notwithstanding any other provision of law, a person licensed pursuant to Section 1634 who holds a permit to perform elective facial cosmetic surgery issued pursuant to this article may not perform elective facial cosmetic surgery on a patient, unless the patient has received a physical examination by, and written clearance for the procedure from, either of the following:

(1) A licensed physician and surgeon.

(2) The person licensed pursuant to Section 1634 who holds a permit to perform elective facial cosmetic surgery issued pursuant to this article and who will be performing the surgery.

(b) The physical examination described in subdivision (a) shall include the taking of a complete medical history.

(c) A violation of this section shall not constitute a crime.

SEC. 3. Section 2259.8 is added to the Business and Professions Code, to read:

2259.8. (a) Notwithstanding any other provision of law, a cosmetic surgery procedure may not be performed on a patient unless, prior to surgery, the patient has received a physical examination by, and written clearance for the procedure from, any of the following:

(1) The physician and surgeon who will be performing the surgery.

(2) Another licensed physician and surgeon.

(3) A certified nurse practitioner, in accordance with a certified nurse practitioner's scope of practice, unless limited by protocols or a delegation agreement.

(4) A licensed physician assistant, in accordance with a licensed physician assistant's scope of practice, unless limited by protocols or a delegation agreement.

(b) The physical examination described in subdivision (a) shall include the taking of a complete medical history.

(c) "Cosmetic surgery" means an elective surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance, including, but not limited to, liposuction and elective facial cosmetic surgery.

(d) Section 2314 shall not apply to this section.

O

AB 1310

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1310
Author: Hernandez
Bill Date: June 29, 2009, amended
Subject: Healing Arts: database
Sponsor: Author

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Office of Statewide Health Planning (OSHPD) to obtain additional information from all healing arts boards.

Amendments to this bill made the collecting of the information permissive instead of mandatory.

ANALYSIS:

Under current law, a healthcare workforce clearinghouse, created by SB 139 (Scott), is charged with collecting data from the various health boards. The intent is to establish an ongoing data stream of changes in California's health workforce and provide the necessary information needed to make complex policy changes to meet California's health workforce needs. Currently, healing arts boards are not mandated to provide any information to the clearinghouse which makes it difficult for the Office of Statewide Health Planning and Development (OSHPD) to produce the necessary results.

This bill would require all of the health licensing boards to collect and submit specific data on age, race, gender, practice location, type of practice to the clearinghouse, etc. This will enhance the state's ability to address health workforce shortages and also identify communities that have the highest need for health professionals.

The Medical Board (Board) already requests much of the data collection required in this bill. According to the author, it was this good work being done by the Board that prompted the drafting of this bill to require the same efforts from all other healing arts boards.

New requirements that are not maintained on our computer system include location of high school, description of primary practice setting, and additional practice locations.

This bill was amended to make the collecting of the information permissive rather than mandatory. This addresses the concerns raised by the Board allowing the position on this bill to transition to 'support' from 'support if amended.'

FISCAL: Unknown

POSITION: Support

July 13, 2009

AMENDED IN SENATE JUNE 29, 2009

AMENDED IN ASSEMBLY JUNE 2, 2009

AMENDED IN ASSEMBLY APRIL 2, 2009

CALIFORNIA LEGISLATURE—2009–10 REGULAR SESSION

ASSEMBLY BILL No. 1310

Introduced by Assembly Member Hernandez

February 27, 2009

An act to add Section 857 to the Business and Professions Code, *and to add Section 128051.5 to the Health and Safety Code,* relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1310, as amended, Hernandez. Healing arts: database.

Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. Under existing law, there exists the Healthcare Workforce Development Division within the Office of Statewide Health Planning and Development (OSHPD) that supports health care accessibility through the promotion of a diverse and competent workforce and provides analysis of California's health care infrastructure. Under existing law, there is also the Health Care Workforce Clearinghouse, established by OSHPD, that serves as the central source for collection, analysis, and distribution of information on the health care workforce employment and educational data trends for the state.

This bill would require ~~the Medical Board of California and the Board of Registered Nursing~~ *certain healing arts boards* to ~~add and label as "mandatory" specified fields on an application for initial licensure or~~

~~a renewal form for applicants applying to those boards~~ *collect specified information from their licensees and would require those boards and the Department of Consumer Affairs to, as much as practicable, work with OSHPD to transfer that data to the Health Care Workforce Clearinghouse.* The bill would *further* require ~~the department~~ *OSHPD*, in consultation with the division and the ~~clearinghouse~~ *department*, to select a database and to *also* add ~~some of~~ the *collected* data ~~collected in these applications and renewal forms~~ to the database ~~and to submit the data to the clearinghouse annually on or before January 1~~. The bill would require the clearinghouse to prepare a written report relating to the data and to submit the report annually to the Legislature no later than March 1, commencing March 1, 2012.

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 857 is added to the Business and Professions Code, to read:

857. (a) ~~Each~~ *Every* healing arts board specified in subdivision ~~(c) shall add and label as "mandatory" the following fields on an application for initial licensure or renewal for a person applying to that board:~~

~~(1) First name, middle name, and last name.~~

~~(2) Last four digits of social security number.~~

~~(3) Complete mailing address.~~ *(f) shall, in a manner deemed appropriate by the board, collect the following information from persons licensed, certified, registered, or otherwise subject to regulation by that board:*

~~(4)~~

(1) Educational background and training, including, but not limited to, degree, related school name and location, and year of graduation, and, as applicable, the highest professional degree obtained, related professional school name and location, and year of graduation.

~~(5)~~

(2) Birth date and place of birth.

~~(6)~~

(3) Sex.

~~(7)~~

(4) Race and ethnicity.

~~(8)~~

(5) Location of high school.

~~(9) Mailing address of primary practice, if applicable.~~

~~(10)~~

(6) Number of hours per week spent at primary practice location, if applicable.

~~(11)~~

(7) Description of primary practice setting, if applicable.

~~(12)~~

(8) Primary practice information, including, but not limited to, primary specialty practice, practice location ZIP Code, and county.

~~(13)~~

(9) Information regarding any additional practice, including, but not limited to, a description of practice setting, practice location ZIP Code, and county.

~~(b) The department, in consultation with the Healthcare Workforce Development Division and the Health Care Workforce Clearinghouse, shall select a database and shall add the data specified in paragraphs (5) to (13), inclusive, of subdivision (a) to that database.~~

~~(c) The following boards are subject to subdivision (a):~~

~~(1) The Medical Board of California.~~

~~(2) The Board of Registered Nursing.~~

~~(d) (1) The department shall collect the specified data in the database pursuant to subdivision (b) and shall submit that data to Health Care Workforce Clearinghouse annually on or before January 1.~~

~~(2) The Health Care Workforce Clearinghouse shall prepare a written report containing the findings of this data and shall submit the written report annually to the Legislature no later than March 1, commencing March 1, 2012.~~

(b) The information collected pursuant to this section shall be used for the purpose of measuring and evaluating the state's health care workforce development needs. For this purpose, the department and the boards specified in subdivision (f) shall, as much as practicable, work with the Office of Statewide Health Planning and Development to transfer the data collected pursuant to this section to the Health Care Workforce Clearinghouse.

(c) Personally identifiable information collected pursuant to this section shall be confidential and not subject to public inspection.

(d) A board that collects information pursuant to this section shall state in a conspicuous manner that reporting the information is not a condition of license renewal, and that no adverse action will be taken against any licensee that does not report any information.

(e) A board that collects information pursuant to this section shall do so in a manner that minimizes any fiscal impact, which may include, but is not limited to, sending the request for information in a renewal notice, a regular newsletter, via electronic mail, or posting the request on the board's Internet Web site, and by allowing licensees to provide the information to the board electronically.

(f) The following boards are subject to this section:

(1) The Acupuncture Board.

(2) The Dental Hygiene Committee of California.

(3) The Dental Board of California.

(4) The Medical Board of California.

(5) The Bureau of Naturopathic Medicine.

(6) The California Board of Occupational Therapy.

(7) The State Board of Optometry.

(8) The Osteopathic Medical Board of California.

(9) The California State Board of Pharmacy.

(10) The Physical Therapy Board of California.

(11) The Physician Assistant Committee, Medical Board of California.

(12) The California Board of Podiatric Medicine.

(13) The Board of Psychology.

(14) The Board of Registered Nursing.

(15) The Respiratory Care Board of California.

(16) The Speech-Language Pathology and Audiology Board.

(17) The Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(18) The Board of Behavioral Sciences.

SEC. 2. Section 128051.5 is added to the Health and Safety Code, to read:

128051.5. (a) The Office of Statewide Health Planning and Development shall, in consultation with the Healthcare Workforce

Development Division and the Department of Consumer Affairs, select a database and shall add the data collected pursuant to Section 857 of the Business and Professions Code to that database.

(b) The Health Care Workforce Clearinghouse shall prepare a written report containing the findings of this data and shall submit the written report annually to the Legislature no later than March 1, commencing March 1, 2012.

O

SB 132

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 132
Author: Denham
Bill Date: July 6, 2009, amended
Subject: Polysomnographic Technologists (urgent)
Sponsor: California Sleep Society

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require registration for individuals assisting physicians in the practice of sleep medicine. This bill further requires such individuals to meet certain qualifications including educational requirements, background checks, and other consumer protections.

ANALYSIS:

Sleep medicine has been recognized as a specialty by the American Medical Association since 1996. Physician sleep specialists are board certified, and the American Board of Sleep Medicine is one of the specialty boards officially recognized and approved by the Medical Board.

Recently, the California Respiratory Care Board has threatened to issue significant fines against those involved in assisting with the practice of sleep medicine. This has threatened the availability of these important medical services.

On August 24, 2007 the California Respiratory Care Board passed a motion to move forward with issuing citations against the unlicensed individuals engaged in the practice of sleep medicine. This has caused a great deal of concern and uncertainty amongst medical professionals who treat patients with sleep disorders.

This bill would provide consumer protections to patients seeking sleep disorder treatment, and helps clarify existing law as it relates to polysomnography. Specifically this bill:

a) establishes the criteria necessary for becoming a certified polysomnographic technologist;

b) requires that the polysomnographic technologists work under the supervision and direction of a licensed physician;
c) requires background checks for polysomnographic technologists;
d) defines the term "polysomnography" and permits polysomnographic technologists to engage in the practice of polysomnography as long as they satisfy the criteria in the bill (this bill places no limitations on other health care practitioners acting within their own scope of practice); and
e) Defines the terms "polysomnographic technician" and "polysomnographic trainee" and permits those individuals to act under the supervision of a certified polysomnographic technologist or licensed physician.

This bill requires the Board to develop regulations relative to the qualifications for registration of these three classifications. This must be done within a year of the effective date of the legislation. According to staff, the Board should be able to meet this requirement for adoption since most of the preliminary work on qualifications was done in the previous year.

In addition, within one year, the Board must adopt regulations regarding the employment of technicians and trainees by the physician. This may include the scope of services and level of supervision. This will require some work with the sponsor and interested parties but should be able to be accomplished in the time frame specified.

Amendments taken in June to this bill change the $100 registration fee to a $50 application fee and a $50 registration fee. This amendment is to make this registration program similar to other licensure and registration programs that are operated on a neutral cost basis. This process will allow the Board to cover the cost of application review and then registration. Fees are split as some applications may be denied registration as a result of the fingerprint or background check thereby allowing the Board to be compensated for its work but not over collecting for work that may not be necessary.

This bill was amended July 6, 2009 to require each applicant to pay a registration fee of no more than $100 with a biennial renewal of $100. This increase from $50 is expected to make the cost of the program "cost neutral" after the initial one year start up.

FISCAL: Expenditure of approximately $88,000 for the first year and $58,000 ongoing. Revenue of approximately $54,600 for the first year, $1,200 for the second year, and then $27,800 per year ongoing.

POSITION: Support

July 13, 2009

AMENDED IN ASSEMBLY JULY 6, 2009

AMENDED IN ASSEMBLY JUNE 24, 2009

AMENDED IN SENATE MAY 14, 2009

AMENDED IN SENATE APRIL 27, 2009

SENATE BILL No. 132

Introduced by Senator Denham

February 9, 2009

An act to add Chapter 7.8 (commencing with Section 3575) to Division 2 of the Business and Professions Code, relating to healing arts, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 132, as amended, Denham. Polysomnographic technologists: sleep and wake disorders.

Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Committee of the Medical Board of California. Existing law prescribes the medical services that may be performed by a physician assistant under the supervision of a licensed physician and surgeon.

Existing law, the Respiratory Care Practice Act, provides for the licensure and regulation of respiratory professionals by the Respiratory Care Board of California. Existing law defines the practice of respiratory therapy and prohibits its practice without a license issued by the board, subject to certain exceptions.

This bill would require the Medical Board of California to adopt regulations within one year after the effective date of this act relative to the qualifications for certified polysomnographic technologists,

including requiring those technologists to be credentialed by a board-approved national accrediting agency, to have graduated from a board-approved educational program, and to have passed a board-approved national certifying examination, with a specified exception for that examination requirement for a 3-year period. The bill would prohibit a person from using the title "certified polysomnographic technologist" or engaging in the practice of polysomnography unless he or she undergoes a Department of Justice background check, as specified, is registered as a certified polysomnographic technologist, is supervised and directed by a licensed physician and surgeon, and meets certain other requirements. The bill would define polysomnography to mean the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders, as specified. The bill would further require the board, within one year after the effective date of this act, to adopt regulations related to the employment of polysomnographic technicians and trainees.

This bill would require polysomnographic technologists to apply to and register with the Medical Board of California for fees to be fixed by the board at no more than $100 each, and to renew their registration biennially for a fee of no more than $100. The bill would require the deposit of those fees in the Contingent Fund of the Medical Board of California, a continuously appropriated fund, thereby making an appropriation. The bill would further set forth specified disciplinary standards and procedures.

The bill would specify that these provisions do not apply to diagnostic electroencephalograms conducted in accordance with the guidelines of the American Clinical Neurophysiology Society.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: 2/3. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Chapter 7.8 (commencing with Section 3575) is added to Division 2 of the Business and Professions Code, to read:

CHAPTER 7.8. POLYSOMNOGRAPHIC TECHNOLOGISTS

3575. (a) For the purposes of this chapter, the following definitions shall apply:

(1) "Board" means the Medical Board of California.

(2) "Polysomnography" means the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. Polysomnography shall include, but not be limited to, the process of analysis, monitoring, and recording of physiologic data during sleep and wakefulness to assist in the treatment of disorders, syndromes, and dysfunctions that are sleep-related, manifest during sleep, or disrupt normal sleep activities. Polysomnography shall also include, but not be limited to, the therapeutic and diagnostic use of oxygen, the use of positive airway pressure including continuous positive airway pressure (CPAP) and bilevel modalities, adaptive servo-ventilation, and maintenance of nasal and oral airways that do not extend into the trachea.

(3) "Supervision" means that the supervising physician and surgeon shall remain available, either in person or through telephonic or electronic means, at the time that the polysomnographic services are provided.

(b) Within one year after the effective date of this chapter, the board shall promulgate regulations relative to the qualifications for the registration of individuals as certified polysomnographic technologists, polysomnographic technicians, and polysomnographic trainees. The qualifications for a certified polysomnographic technologist shall include all of the following:

(1) He or she shall have valid, current credentials as a polysomnographic technologist issued by a national accrediting agency approved by the board.

(2) He or she shall have graduated from a polysomnographic educational program that has been approved by the board.

(3) He or she shall have passed a national certifying examination that has been approved by the board, or in the alternative, may submit proof to the board that he or she has been practicing polysomnography for at least five years in a manner that is acceptable to the board. However, beginning three years after the effective date of this chapter, all individuals seeking to obtain certification as a polysomnographic technologist shall have passed

a national certifying examination that has been approved by the board.

(c) In accordance with Section 144, any person seeking registration from the board as a certified polysomnographic technologist, a polysomnographic technician, or a polysomnographic trainee shall be subject to a state and federal level criminal offender record information search conducted through the Department of Justice as specified in paragraphs (1) to (5), inclusive, of this subdivision.

(1) The board shall submit to the Department of Justice fingerprint images and related information required by the Department of Justice of all polysomnographic technologist, technician, or trainee certification candidates for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information received pursuant to this subdivision. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and disseminate a response to the board.

(3) The Department of Justice shall provide state and federal responses to the board pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(4) The board shall request from the Department of Justice subsequent arrest notification service, pursuant to Section 11105.2 of the Penal Code, for persons described in this subdivision.

(5) The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this subdivision. The individual seeking registration shall be responsible for this cost.

~~(d) Notwithstanding any other provision of law, an individual~~

(d) An individual may use the title "certified polysomnographic technologist" and may engage in the practice of polysomnography only under the following circumstances:

(1) He or she is registered with the board and has successfully undergone a state and federal level criminal offender record information search pursuant to subdivision (c).

(2) He or she works under the supervision and direction of a licensed physician and surgeon.

(3) He or she meets the requirements of this chapter.

(e) Within one year after the effective date of this chapter, the board shall adopt regulations that establish the means and circumstances in which a licensed physician and surgeon may employ polysomnographic technicians and polysomnographic trainees. The board may also adopt regulations specifying the scope of services that may be provided by a polysomnographic technician or polysomnographic trainee. Any regulation adopted pursuant to this section may specify the level of supervision that polysomnographic technicians and trainees are required to have when working under the supervision of a certified polysomnographic technologist or licensed health care professional.

(f) This section shall not apply to California licensed allied health professionals, including, but not limited to, respiratory care practitioners, working within the scope of practice of their license.

(g) Nothing in this chapter shall be interpreted to authorize a polysomnographic technologist, technician, or trainee to treat, manage, control, educate, or care for patients other than those with sleep disorders or to provide diagnostic testing for patients other than those with suspected sleep disorders.

3576. (a) A registration under this chapter may be denied, suspended, revoked, or otherwise subjected to discipline for any of the following by the holder:

(1) Incompetence, gross negligence, or repeated similar negligent acts performed by the registrant.

(2) An act of dishonesty or fraud.

(3) Committing any act or being convicted of a crime constituting grounds for denial of licensure or registration under Section 480.

(4) Violating or attempting to violate any provision of this chapter or any regulation adopted under this chapter.

(b) Proceedings under 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, and the board shall have all powers granted therein.

3577. (a) Each person who applies for registration under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars ($100).

(b) Each person to whom registration is granted under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars ($100).

(c) The registration shall expire after two years. The registration may be renewed biennially at a fee which shall be paid into the Contingent Fund of the Medical Board of California to be fixed by the board at a sum not in excess of one hundred dollars ($100).

(d) The money in the Contingent Fund of the Medical Board of California that is collected pursuant to this section shall be used for the administration of this chapter.

~~3578. Notwithstanding any other provision of law, nothing in~~ *3578. Nothing in* this chapter shall prohibit a clinic or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code from employing a certified polysomnographic technologist.

~~3579. Notwithstanding any other provision of law, nothing in~~ *3579. Nothing in* this chapter shall apply to diagnostic electroencephalograms conducted in accordance with the guidelines of the American Clinical Neurophysiology Society.

SEC. 2. 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 Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the health and safety of the general public by providing needed qualifications for, and oversight of, the practice of polysomnography at the earliest possible time, it is necessary that this act take effect immediately.

O

SB 389

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 389
Author: Negrete McLeod
Bill Date: June 1, 2009, amended
Subject: Fingerprinting
Sponsor: Author

STATUS OF BILL:

This bill is in the Assembly Public Safety Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill will require a licensee who has not been previously fingerprinted or for whom a record does not exist, to successfully complete a fingerprint record search at time of renewal. It will require notification by the licensee at time of renewal if he or she has been convicted of a felony or misdemeanor since the last renewal.

Staff has researched the requirements in this bill related to our licensees and has determined that the Board has fingerprints on licensees dating back to 1945. Therefore, the Board is already in compliance with the provisions in this bill.

ANALYSIS:

The Medical Board has been fingerprinting its licensees for many years. Staff is in the process of verifying how far back this requirement has been in place, as it was a requirement prior to being placed in law. For purposes of this bill, staff will need to determine what records no longer exist at the Department of Justice (DOJ).

Staff has reported to the board that the number of physicians not fingerprinted may be up to 45,000, although through licensing record searches, this number may be lower than 11,000. The issue will be whether the DOJ still has a flag on the file of those licensed prior to 1986.

The Medical Board passed a motion in November of 2008 to have fingerprint records for all physicians who are licensed in this state.

Staff has further researched and discovered that the Board currently maintains fingerprints on licensees dating back to 1945. There would be no new

requirement in this bill, as the Board is already compliant as any physician licensed after 1945 would be at least 80 years old and more likely 85+ years.

FISCAL: None to MBC

POSITION: Support

July 11, 2009

AMENDED IN SENATE JUNE 1, 2009

AMENDED IN SENATE MAY 5, 2009

SENATE BILL No. 389

Introduced by Senator Negrete McLeod

February 26, 2009

An act to amend Section 144 of, and to add Sections 144.5 and 144.6 to, the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

SB 389, as amended, Negrete McLeod. Professions and vocations.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law authorizes a board to suspend or revoke a license on various grounds, including, but not limited to, conviction of a crime, if the crime is substantially related to the qualifications, functions, or duties of the business or profession for which the license was issued. Existing law requires applicants to certain boards to provide a full set of fingerprints for the purpose of conducting criminal history record checks.

This bill would make that fingerprinting requirement applicable to the Dental Board of California, the Dental Hygiene Committee of California, the Professional Fiduciaries Bureau, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the State Board of Chiropractic Examiners. The bill would require *new* applicants for a license ~~and,~~ *and petitioners for reinstatement of a revoked, surrendered, or canceled license, to successfully complete a state and federal level criminal record information search. The bill would also require,* commencing January 1, 2011, licensees who have

not previously submitted fingerprints, or for whom a record of the submission of fingerprints no longer exists, to ~~successfully~~ complete *the process necessary for* a state and federal level criminal offender record information search, as specified. The bill would require licensees *applying for license renewal* to certify compliance with that requirement, as specified, and would subject a licensee to disciplinary action for making a false certification. The bill would also require a licensee to, as a condition of renewal of the license, notify the board on the license renewal form if he or she, *or any member of the personnel of record of the licensee,* has been convicted, as defined, of a felony or misdemeanor since ~~his or her~~ *the* last renewal, or if this is the licensee's first renewal, since the initial license was issued. *The bill would provide that the Contractors' State License Board shall implement the provisions pertaining to renewal licenses on a specified schedule, after an appropriation is made for this purpose, utilizing its applicable fees.*

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 144 of the Business and Professions Code is amended to read:

144. (a) Notwithstanding any other provision of law, an agency designated in subdivision (b) shall require an applicant for a license *or a petitioner for reinstatement of a revoked, surrendered, or canceled license* to furnish to the agency a full set of fingerprints for purposes of conducting criminal history record checks and shall require the applicant *or petitioner* to successfully complete a state and federal level criminal offender record information search conducted through the Department of Justice as provided in subdivision (c) or as otherwise provided in this code.

(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) Registered Veterinary Technician Committee.
(10) Board of Vocational Nursing and Psychiatric Technicians.
(11) Respiratory Care Board of California.
(12) Hearing Aid Dispensers Bureau.
(13) Physical Therapy Board of California.
(14) Physician Assistant Committee of the Medical Board of California.
(15) Speech-Language Pathology and Audiology Board.
(16) Medical Board of California.
(17) State Board of Optometry.
(18) Acupuncture Board.
(19) Cemetery and Funeral Bureau.
(20) Bureau of Security and Investigative Services.
(21) Division of Investigation.
(22) Board of Psychology.
(23) California Board of Occupational Therapy.
(24) Structural Pest Control Board.
(25) Contractors' State License Board.
(26) Bureau of Naturopathic Medicine.
(27) Dental Board of California.
(28) Dental Hygiene Committee of California.
(29) Professional Fiduciaries Bureau.
(30) California Board of Podiatric Medicine.
(31) Osteopathic Medical Board of California.
(32) State Board of Chiropractic Examiners.

(c) Except as otherwise provided in this code, each agency listed in subdivision (b) shall direct applicants for a license *or a petitioner for reinstatement of a revoked, surrendered, or canceled license* to submit to the Department of Justice fingerprint images and related information required by the Department of Justice for the purpose of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal. The Department of Justice shall forward the fingerprint images and related information received to the Federal Bureau of Investigation and request federal criminal history information. The Department of Justice shall compile and disseminate state and federal responses to the agency

pursuant to subdivision (p) of Section 11105 of the Penal Code. The agency shall request from the Department of Justice subsequent arrest notification service, pursuant to Section 11105.2 of the Penal Code, for each person who submitted information pursuant to this subdivision. The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section.

SEC. 2. Section 144.5 is added to the Business and Professions Code, to read:

144.5. (a) Notwithstanding any other provision of law, an agency designated in subdivision (b) of Section 144 shall require a licensee who has not previously submitted fingerprints or for whom a record of the submission of fingerprints no longer exists to, as a condition of license renewal, ~~successfully complete~~ *complete the process necessary for* a state and federal level criminal offender record information search *to be* conducted through the Department of Justice as provided in subdivision (d).

~~(b) (1) A licensee described in subdivision (a) shall, as a condition of license renewal, certify on the renewal application that he or she has successfully completed a state and federal level criminal offender record information search pursuant to subdivision (d).~~

~~(2) The licensee shall retain for at least three years, as evidence of the certification made pursuant to paragraph (1), either a receipt showing that he or she has electronically transmitted his or her fingerprint images to the Department of Justice or, for those licensees who did not use an electronic fingerprinting system, a receipt evidencing that the licensee's fingerprints were taken.~~

(b) (1) As a condition of license renewal, a licensee described in subdivision (a) shall complete the process necessary for a state and federal level criminal offender record information search to be conducted as provided in subdivision (d).

(2) No license of a licensee described in subdivision (a) shall be renewed until certification by the licensee is received by the agency verifying that the licensee has complied with this subdivision. The certification shall be made on a form provided by the agency not later than the renewal date of the license.

(3) As evidence of the certification made pursuant to paragraph (2), the licensee shall retain either of the following for at least three years:

(A) The receipt showing that the fingerprint images required by this section were electronically transmitted to the Department of Justice.

(B) For those licensees who did not use an electronic fingerprinting system, the receipt evidencing that the fingerprint images required by this section were taken.

(c) Failure to provide the certification required by subdivision (b) renders an application for *license* renewal incomplete. An agency shall not renew the license until a complete application is submitted.

(d) Each agency listed in subdivision (b) of Section 144 shall direct licensees described in subdivision (a) to submit to the Department of Justice fingerprint images and related information required by the Department of Justice for the purpose of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her recognizance pending trial or appeal. The Department of Justice shall forward the fingerprint images and related information received to the Federal Bureau of Investigation and request federal criminal history information. The Department of Justice shall compile and disseminate state and federal responses to the agency pursuant to subdivision (p) of Section 11105 of the Penal Code. The agency shall request from the Department of Justice subsequent arrest notification service, pursuant to Section 11105.2 of the Penal Code, for each person who submitted information pursuant to this subdivision. The Department of Justice shall charge a fee sufficient to cover the cost of processing the request described in this section.

(e) An agency may waive the requirements of this section if the license is inactive or retired, or if the licensee is actively serving in the military. The agency ~~may~~ *shall* not activate an inactive license or return a retired license to full licensure status for a licensee described in subdivision (a) until the licensee has successfully completed a state and federal level criminal offender record information search pursuant to subdivision (d).

~~(f) With respect to licensees that are business entities, each agency listed in subdivision (b) of Section 144 shall, by regulation, determine which owners, officers, directors, shareholders,~~

~~members, agents, employees, or other natural persons who are representatives of the business entity are required to submit fingerprint images to the Department of Justice and disclose the information on its renewal forms, as required by this section.~~

~~(g)~~

(f) A licensee who falsely certifies completion of a state and federal level criminal record information search under subdivision ~~(b) may be subject to disciplinary action by his or her licensing agency.~~ *(b) shall be subject to disciplinary action.*

(g) (1) As it relates to the Contractors' State License Board, the provisions of this section shall become operative on the date on which an appropriation is made in the annual Budget Act to fund the activities of the Contractors' State License Board to accommodate a criminal history record check pursuant to this section. If this section becomes operative with respect to the Contractors' State License Board on or before July 1, 2012, the Contractors' State License Board shall implement this section according to the following schedule, and shall utilize the fees under its fee cap accordingly:

(A) For licenses initially issued between January 1, 2000, and December 31, 2005, inclusive, the certification required under subdivision (b) shall be submitted during the license renewal period that commences on January 1, 2013.

(B) For licenses initially issued between January 1, 1990, and December 31, 1999, inclusive, the certification required under subdivision (b) shall be submitted during the license renewal period that commences on January 1, 2015.

(C) For licenses initially issued prior to January 1, 1990, the certification required under subdivision (b) shall be submitted during the license renewal period that commences on January 1, 2017.

(2) If this section becomes operative with respect to the Contractors' State License Board after July 1, 2012, the license renewal period commencement dates specified in subparagraphs (A), (B), and (C) of paragraph (1) shall be delayed one year at a time until this section becomes operative with respect to the Contractors' State License Board.

(h) This section shall become operative on January 1, 2011.

SEC. 3. Section 144.6 is added to the Business and Professions Code, to read:

144.6. (a) An agency described in subdivision (b) of Section 144 shall require a licensee, as a condition of license renewal, to ~~notify the board on the license renewal form if he or she has been~~ *notify the agency on the license renewal form if he or she, or any member of the personnel of record of the licensee, has been* convicted, as defined in Section 490, of a felony or misdemeanor ~~since his or her last renewal, or if this is the licensee's first renewal, since the initial license was issued.~~ *since the license was last renewed, or since the license was initially issued if it has not been previously renewed.*

(b) The reporting requirement imposed under this section shall apply in addition to any other reporting requirement imposed under this code.

O

SB 470

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 470
Author: Corbett
Bill Date: April 30, 2009, amended
Subject: Prescriptions: labeling
Sponsor: Author

STATUS OF BILL:

This bill is currently on the Assembly Floor.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require every prescription to include on the label, the purpose for which the drug is prescribed, if requested by the patient.

ANALYSIS:

Under current law, Section 4076 of the Business and Professions Code, a prescription drug container label is required to contain certain information in addition to the drug name including: the names of the patient, prescriber and pharmacy; the date of issue; directions for use; strength and quantity of the drug dispensed; and expiration date. The condition for which the drug was prescribed may be indicated on the label, but only if the patient asks for the prescriber to include it on the prescription. This bill would change the word "condition" to "purpose."

Many patients are unaware of their right to ask the prescriber to have the intended purpose included on the label. Individuals, including seniors, who have multiple prescriptions, have difficulty remembering the purpose of each medication and would greatly benefit from having it listed on the label.

According to the Medical Errors Panel report, "Prescription for Improving Patient Safety: Addressing Medication Errors," an estimated 150,000 Californians are sickened, injured or killed each year by medication errors, with an annual cost of $17.7 billion. One of the recommendations by the panel is to require the intended purpose of medication to be indicated on all prescriptions and included on the container label.

Adding the purpose of the drug to the label, for those who wish it, will help the patient, the care-giver and any other person who helps administer medications prevent illness or death due to medication errors.

If the condition or purpose of the drug is not included on the prescription, the patient may request of the pharmacist that it be included. Pharmacists may include the information once they have consulted with the physician or prescriber. The consultation may be conducted verbally or electronically.

This concept has been introduced in previous legislative sessions. The Board has supported the concept in the past because it did not require the purpose to be listed, but allowed for a physician to ask as long as there was no penalty if the provider forgets to ask the patient. In this bill, it still allows the patient to ask but the physician will put the purpose of the drug on the label instead of the condition for which it is prescribed and continues to have no penalty for the provider.

FISCAL: None to the Board

POSITION: Support

July 11, 2009

AMENDED IN SENATE APRIL 30, 2009

AMENDED IN SENATE APRIL 27, 2009

SENATE BILL No. 470

Introduced by Senator Corbett

February 26, 2009

An act to amend Sections 4040 and 4076 of the Business and Professions Code, relating to pharmacy.

LEGISLATIVE COUNSEL'S DIGEST

SB 470, as amended, Corbett. Prescriptions.

Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy and provides that a knowing violation of the law is a crime. Existing law requires a prescription, as defined, to include a legible, clear notice of the condition for which the drug is prescribed, if requested by the patient. Existing law prohibits a pharmacist from dispensing any prescription unless it is in a specified container that is correctly labeled to include, among other information, the condition for which the drug was prescribed if requested by the patient and the condition is indicated on the prescription.

This bill would instead require that every prescription include a legible, clear notice of the condition or purpose for which the drug is prescribed, ~~and would delete the requirement that a patient request the inclusion of that information~~ *if requested by the patient*. The bill would also require that every prescription container be correctly labeled to include that information if so ~~included~~ *indicated* on the prescription, ~~and would provide a process for inclusion of that information on the label if it is not included on the prescription and is requested by the patient~~.

By revising these requirements, the knowing violation of which would be a crime, the bill would impose a state-mandated local program.

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. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 4040 of the Business and Professions Code is amended to read:

4040. (a) "Prescription" means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition or purpose for which the drug is being prescribed, *if requested by the patient or patients*.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(2) Issued by a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7 or, if a drug order is issued pursuant to Section 2746.51, 2836.1, 3502.1, or 3460.5, by a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor licensed in this state,

or pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 by a pharmacist licensed in this state.

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (3) of subdivision (b) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail.

(c) "Electronic transmission prescription" includes both image and data prescriptions. "Electronic image transmission prescription" means any prescription order for which a facsimile of the order is received by a pharmacy from a licensed prescriber. "Electronic data transmission prescription" means any prescription order, other than an electronic image transmission prescription, that is electronically transmitted from a licensed prescriber to a pharmacy.

(d) The use of commonly used abbreviations shall not invalidate an otherwise valid prescription.

(e) Nothing in the amendments made to this section (formerly Section 4036) at the 1969 Regular Session of the Legislature shall be construed as expanding or limiting the right that a chiropractor, while acting within the scope of his or her license, may have to prescribe a device.

SEC. 2. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except where the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, the physician assistant who functions pursuant to

Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the ~~prescription. If the patient requests the condition or purpose on the container label but it is not included on the prescription, the pharmacist may include this information only after consulting with the prescriber. The consultation may be conducted orally or electronically.~~ *prescription.*

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to either subparagraph (D) of paragraph (4) of, or clause (iv) of subparagraph (A) of paragraph (5) of, subdivision (a) of Section 4052.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety

Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

SEC. 3. 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.

O

SB 674

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 674
Author: Negrete McLeod
Bill Date: June 1, 2009, amended
Subject: Outpatient settings/Advertising
Sponsor: Author

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill covers a variety of subjects, including advertising, outpatient setting accreditation requirements, supervision of laser and IPL device procedures, the wearing of name tags for healthcare professionals, and public information.

ANALYSIS:

This bill makes some significant changes to sections of the Business and Professions (B&P) Code and the Health and Safety (H&S) Code that may benefit the public.

Amends B&P Code section 651, which would require, effective January 1, 2011, advertising to include the license designation following the licensee's name:

- Chiropractors -"DC"
- Dentists - "DDS" or "DMD"
- Physicians - "MD" or "DO", as appropriate;
- Podiatrists – "DPM"
- Registered Nurses – "RN"
- Vocational Nurses – "LVN"
- Psychologists – "Ph.D."
- Optometrists – "OD"
- Physician Assistants – "PA"
- Naturopathic doctor – "ND"

This bill also defines advertising as virtually any promotional communications, including direct mail, television, radio, motion picture, newspaper, book, Internet, or any other form of communication. It does not include insurance provider directories, billing statements, or appointment reminders.

Amends B&P Code section 2023.5:

This amendment would require that the Nursing and Medical Boards adopt regulations by July 1, 2010 relating to the "appropriate level of physician availability" needed for use of prescriptive lasers or intense pulse light devices.

These two Boards held three public forums to study this subject as mandated by B&P Code section 2023.5 (added to statutes by SB 1423; Figueroa, Chap 873, Statutes of 2006). As a result of that study, it was determined that current law and regulations were sufficient related to supervision --- it was lack of enforcement that was contributing to the problems occurring in the use of lasers and IPL devices, among other cosmetic procedures. These forums did not address physician availability.

Adds B&P Code section 2027.5:

This new section requires the Board to post on its Web site a comprehensive fact sheet on cosmetic surgery. This will enhance consumer awareness and protection.

Amends H&S Code section 1248:

This section clarifies that any references to Division of Licensing are deemed to refer to the Medical Board. More importantly is adds in vitro fertilization facilities or other assisted reproduction technology services to the definition of "Outpatient setting."

Amends H&S Code section 1248.15:

This section makes technical changes and adds the requirement for accreditation agencies that they not only require of the settings emergency plans for outpatient settings, but also require the inclusion of standardized procedures and protocols to be followed in the event of emergencies or complications that place patients at risk of injury or harm. This is added to address concerns that detailed procedures were not in place at these settings. This section, as amended, allows the Board to adopt standards for outpatient settings that offer in vitro fertilization or assisted reproduction technology. Facilities providing these services would be required to meet accreditation standards that the board deems necessary, different than existing standards for current outpatient settings.

Amends H&S Code section 1248.2:

This section replaces "Division" or "Division of Licensing" with "Board" to reflect the current organization of the Medical Board. This section requires the Medical Board to disclose to the public if an outpatient setting has been suspended, placed on probation, or received a reprimand by the approved accreditation agency. This will allow the public access to the status of all outpatient settings.

Amends H&S Code sections 1248.25 and 1248.35, and 1248.5:

These sections make do the following:

- Requires the Board or the Board's approved accreditation agencies to periodically inspect accredited outpatient settings. Inspections must be performed no less than once every three years. This will help the settings remain in compliance with the law, thus providing enhanced consumer protection. It is not clear who will pay for these inspections.

- Current law requires accreditation agencies to provide outpatient settings a notice of deficiencies and a reasonable time to remedy them before revoking accreditation. This legislation would require the outpatient setting to prominently post the notice of deficiencies. This will allow the public access to issues that the settings may have or had to remedy.
- Requires that reports on the results of outpatient setting inspections be kept on file by the Board or accrediting agency, along with proposed corrective action and recommendations for reinspection. These reports will be public information - disclosable to the public.
- Requires the approved accrediting agencies to immediately inform the Board when they issue a reprimand, suspend or revoke accreditation, or place an outpatient setting on probation. This will alert the Board of an issue that may need action.
- Requires the Board to:
    1. Evaluate the accreditation agencies every three years;
    2. Evaluate in response to complaints against an agency;
    3. Evaluate complaints against the accreditation of outpatient settings.

This bill was amended to require the Department of Public Health, while conducting regular period state inspections of acute care hospitals, to inspect the peer review process in that hospital as well.

FISCAL: Unknown, but could be substantial if the Board does the inspections, although they are no longer required to be performed by the Board.

POSITION: Support

AMENDED IN SENATE JUNE 1, 2009

AMENDED IN SENATE MAY 20, 2009

AMENDED IN SENATE APRIL 28, 2009

AMENDED IN SENATE APRIL 2, 2009

SENATE BILL No. 674

Introduced by Senator Negrete McLeod

February 27, 2009

An act to amend Sections 651 and 2023.5 of, and to add Section 2027.5 to, the Business and Professions Code, and to amend Sections 1248, 1248.15, 1248.2, 1248.25, 1248.35, 1248.5, and 1279 of the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 674, as amended, Negrete McLeod. Healing arts.

(1) Existing law provides that it is unlawful for healing arts licensees to disseminate or cause to be disseminated any form of public communication, as defined, containing a false, fraudulent, misleading, or deceptive statement, claim, or image to induce the rendering of services or the furnishing of products relating to a professional practice or business for which he or she is licensed. Existing law authorizes advertising by these healing arts licensees to include certain general information. A violation of these provisions is a misdemeanor.

This bill would impose specific advertising requirements on certain healing arts licensees. By changing the definition of a crime, this bill would impose a state-mandated local program.

(2) Existing law requires the Medical Board of California, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field,

to review issues and problems relating to the use of laser or intense light pulse devices for elective cosmetic procedures by their respective licensees.

This bill would require the board to adopt regulations by January 1, 2011, regarding the appropriate level of physician availability needed within clinics or other settings using certain laser or intense pulse light devices for elective cosmetic procedures.

(3) Existing law requires the board to post on the Internet specified information regarding licensed physicians and surgeons.

This bill would require the board to post on its Internet Web site an easy-to-understand factsheet to educate the public about cosmetic surgery and procedures, as specified.

(4) Existing law requires the Medical Board of California, as successor to the Division of Licensing of the Medical Board of California, to adopt standards for accreditation of outpatient settings, as defined, and, in approving accreditation agencies to perform this accreditation, to ensure that the certification program shall, at a minimum, include standards for specified aspects of the settings' operations.

This bill would include, among those specified aspects, the submission for approval by an accreditation agency at the time of accreditation, a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery. The bill would also modify the definition of "outpatient setting" to include facilities that offer in vitro fertilization, as defined~~, and assisted reproduction technology treatments~~.

(5) Existing law also requires the Medical Board of California to obtain and maintain a list of all accredited, certified, and licensed outpatient settings, and to notify the public, upon inquiry, whether a setting is accredited, certified, or licensed, or whether the setting's accreditation, certification, or license has been revoked.

This bill would require the board, absent inquiry, to notify the public whether a setting is accredited, certified, or licensed, or the setting's accreditation, certification, or license has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency.

(6) Existing law requires accreditation of an outpatient setting to be denied if the setting does not meet specified standards. Existing law authorizes an outpatient setting to reapply for accreditation at any time after receiving notification of the denial.

This bill would require the accreditation agency to immediately report to the Medical Board of California if the outpatient setting's certificate for accreditation has been denied.

(7) Existing law authorizes the Medical Board of California, as successor to the Division of Medical Quality of the Medical Board of California, or an accreditation agency to, upon reasonable prior notice and presentation of proper identification, enter and inspect any accredited outpatient setting to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of the specified law.

This bill would delete the notice and identification requirements. The bill would require that every outpatient setting that is accredited be inspected by the accreditation agency, as specified, and would specify that it may also be inspected by the board, as specified. The bill would require the board to ensure that accreditation agencies inspect outpatient settings.

(8) Existing law authorizes the Medical Board of California to evaluate the performance of an approved accreditation agency no less than every 3 years, or in response to complaints against an agency, or complaints against one or more outpatient settings accreditation by an agency that indicates noncompliance by the agency with the standards approved by the board.

This bill would make that evaluation mandatory.

(9) Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health and requires the department to periodically inspect those facilities, as specified.

This bill would require the department, when conducting an inspection of an acute care hospital, to inspect the peer review process utilized by the hospital.

(10) 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. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. 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.

(i) For the purposes of this section, a dentist licensed under Chapter 4 (commencing with Section 1600) may not hold himself or herself out as a specialist, or advertise membership in or specialty recognition by an accrediting organization, unless the practitioner has completed a specialty education program approved by the American Dental Association and the Commission on Dental Accreditation, is eligible for examination by a national specialty board recognized by the American Dental Association, or is a diplomate of a national specialty board recognized by the American Dental Association.

(ii) A dentist licensed under Chapter 4 (commencing with Section 1600) shall not represent to the public or advertise accreditation either in a specialty area of practice or by a board not meeting the requirements of clause (i) unless the dentist has attained membership in or otherwise been credentialed by an accrediting organization that is recognized by the board as a bona

fide organization for that area of dental practice. In order to be recognized by the board as a bona fide accrediting organization for a specific area of dental practice other than a specialty area of dentistry authorized under clause (i), the organization shall condition membership or credentialing of its members upon all of the following:

(I) Successful completion of a formal, full-time advanced education program that is affiliated with or sponsored by a university based dental school and is beyond the dental degree at a graduate or postgraduate level.

(II) Prior didactic training and clinical experience in the specific area of dentistry that is greater than that of other dentists.

(III) Successful completion of oral and written examinations based on psychometric principles.

(iii) Notwithstanding the requirements of clauses (i) and (ii), a dentist who lacks membership in or certification, diplomate status, other similar credentials, or completed advanced training approved as bona fide either by an American Dental Association recognized accrediting organization or by the board, may announce a practice emphasis in any other area of dental practice only if the dentist incorporates in capital letters or some other manner clearly distinguishable from the rest of the announcement, solicitation, or advertisement that he or she is a general dentist.

(iv) 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.

(B) 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, 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.

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, 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.

(C) A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California 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 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. A doctor of podiatric medicine 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.

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) (1) Advertising by the following licensees shall include the designations as follows:

(A) Advertising by a chiropractor licensed under Chapter 2 (commencing with Section 1000) shall include the designation "DC" immediately following the chiropractor's name.

(B) Advertising by a dentist licensed under Chapter 4 (commencing with Section 1600) shall include the designation "DDS" or "DMD" immediately following the dentist's name.

(C) Advertising by a physician and surgeon licensed under Chapter 5 (commencing with Section 2000) shall include the

designation "MD" immediately following the physician and surgeon's name.

(D) Advertising by an osteopathic physician and surgeon certified under Article 21 (commencing with Section 2450) shall include the designation "DO" immediately following the osteopathic physician and surgeon's name.

(E) Advertising by a podiatrist certified under Article 22 (commencing with Section 2460) of Chapter 5 shall include the designation "DPM" immediately following the podiatrist's name.

(F) Advertising by a registered nurse licensed under Chapter 6 (commencing with Section 2700) shall include the designation "RN" immediately following the registered nurse's name.

(G) Advertising by a licensed vocational nurse under Chapter 6.5 (commencing with Section 2840) shall include the designation "LVN" immediately following the licensed vocational nurse's name.

(H) Advertising by a psychologist licensed under Chapter 6.6 (commencing with Section 2900) shall include the designation "Ph.D." immediately following the psychologist's name.

(I) Advertising by an optometrist licensed under Chapter 7 (commencing with Section 3000) shall include the designation "OD" immediately following the optometrist's name.

(J) Advertising by a physician assistant licensed under Chapter 7.7 (commencing with Section 3500) shall include the designation "PA" immediately following the physician assistant's name.

(K) Advertising by a naturopathic doctor licensed under Chapter 8.2 (commencing with Section 3610) shall include the designation "ND" immediately following the naturopathic doctor's name.

(2) For purposes of this subdivision, "advertisement" includes communication by means of mail, television, radio, motion picture, newspaper, book, directory, Internet, or other electronic communication.

(3) Advertisements do not include any of the following:

(A) A medical directory released by a health care service plan or a health insurer.

(B) A billing statement from a health care practitioner to a patient.

(C) An appointment reminder from a health care practitioner to a patient.

(4) This subdivision shall not apply until January 1, 2011, to any advertisement that is published annually and prior to July 1, 2010.

(5) This subdivision shall not apply to any advertisement or business card disseminated by a health care service plan that is subject to the requirements of Section 1367.26 of the Health and Safety Code.

(j) 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.

(k) 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.

(*l*) 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. 2. Section 2023.5 of the Business and Professions Code is amended to read:

2023.5. (a) The board, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, shall review issues and problems surrounding the use of laser or intense light pulse devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants. The review shall include, but need not be limited to, all of the following:

(1) The appropriate level of physician supervision needed.

(2) The appropriate level of training to ensure competency.

(3) Guidelines for standardized procedures and protocols that address, at a minimum, all of the following:

(A) Patient selection.

(B) Patient education, instruction, and informed consent.

(C) Use of topical agents.

(D) Procedures to be followed in the event of complications or side effects from the treatment.

(E) Procedures governing emergency and urgent care situations.

(b) On or before January 1, 2009, the board and the Board of Registered Nursing shall promulgate regulations to implement changes determined to be necessary with regard to the use of laser or intense pulse light devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants.

(c) On or before January 1, 2011, the board shall adopt regulations regarding the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures. However, these

regulations shall not apply to laser or intense pulse light devices approved by the federal Food and Drug Administration for over-the-counter use by a health care practitioner or by an unlicensed person on himself or herself.

SEC. 3. Section 2027.5 is added to the Business and Professions Code, to read:

2027.5. The board shall post on its Internet Web site an easy-to-understand factsheet to educate the public about cosmetic surgery and procedures, including their risks. Included with the factsheet shall be a comprehensive list of questions for patients to ask their physician and surgeon regarding cosmetic surgery.

SEC. 4. Section 1248 of the Health and Safety Code is amended to read:

1248. For purposes of this chapter, the following definitions shall apply:

(a) "Division" means the Medical Board of California. All references in this chapter to the division, the Division of Licensing of the Medical Board of California, or the Division of Medical Quality shall be deemed to refer to the Medical Board of California pursuant to Section 2002 of the Business and Professions Code.

(b) (1) "Outpatient setting" means any facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined in Section 1250, and where anesthesia, except local anesthesia or peripheral nerve blocks, or both, is used in compliance with the community standard of practice, in doses that, when administered have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes.

(2) "Outpatient setting" also means facilities that offer in vitro fertilization, as defined in subdivision (b) of Section 1374.55~~, or facilities that offer assisted reproduction technology treatments.~~.

(3) "Outpatient setting" does not include, among other settings, any setting where anxiolytics and analgesics are administered, when done so in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

(c) "Accreditation agency" means a public or private organization that is approved to issue certificates of accreditation

to outpatient settings by the board pursuant to Sections 1248.15 and 1248.4.

SEC. 5. Section 1248.15 of the Health and Safety Code is amended to read:

1248.15. (a) The board shall adopt standards for accreditation and, in approving accreditation agencies to perform accreditation of outpatient settings, shall ensure that the certification program shall, at a minimum, include standards for the following aspects of the settings' operations:

(1) Outpatient setting allied health staff shall be licensed or certified to the extent required by state or federal law.

(2) (A) Outpatient settings shall have a system for facility safety and emergency training requirements.

(B) There shall be onsite equipment, medication, and trained personnel to facilitate handling of services sought or provided and to facilitate handling of any medical emergency that may arise in connection with services sought or provided.

(C) In order for procedures to be performed in an outpatient setting as defined in Section 1248, the outpatient setting shall do one of the following:

(i) Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff.

(ii) Permit surgery only by a licensee who has admitting privileges at a local accredited or licensed acute care hospital, with the exception that licensees who may be precluded from having admitting privileges by their professional classification or other administrative limitations, shall have a written transfer agreement with licensees who have admitting privileges at local accredited or licensed acute care hospitals.

(D) Submission for approval by an accrediting agency of a detailed procedural plan for handling medical emergencies that shall be reviewed at the time of accreditation. No reasonable plan shall be disapproved by the accrediting agency.

(E) Submission for approval by an accreditation agency at the time of accreditation of a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery that would place a patient at high risk for injury or harm and to govern emergency and urgent care situations.

(F) All physicians and surgeons transferring patients from an outpatient setting shall agree to cooperate with the medical staff peer review process on the transferred case, the results of which shall be referred back to the outpatient setting, if deemed appropriate by the medical staff peer review committee. If the medical staff of the acute care facility determines that inappropriate care was delivered at the outpatient setting, the acute care facility's peer review outcome shall be reported, as appropriate, to the accrediting body, the Health Care Financing Administration, the State Department of Public Health, and the appropriate licensing authority.

(3) The outpatient setting shall permit surgery by a dentist acting within his or her scope of practice under Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code or physician and surgeon, osteopathic physician and surgeon, or podiatrist acting within his or her scope of practice under Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act. The outpatient setting may, in its discretion, permit anesthesia service by a certified registered nurse anesthetist acting within his or her scope of practice under Article 7 (commencing with Section 2825) of Chapter 6 of Division 2 of the Business and Professions Code.

(4) Outpatient settings shall have a system for maintaining clinical records.

(5) Outpatient settings shall have a system for patient care and monitoring procedures.

(6) (A) Outpatient settings shall have a system for quality assessment and improvement.

(B) Members of the medical staff and other practitioners who are granted clinical privileges shall be professionally qualified and appropriately credentialed for the performance of privileges granted. The outpatient setting shall grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting.

(C) Clinical privileges shall be periodically reappraised by the outpatient setting. The scope of procedures performed in the outpatient setting shall be periodically reviewed and amended as appropriate.

(7) Outpatient settings regulated by this chapter that have multiple service locations governed by the same standards may elect to have all service sites surveyed on any accreditation survey. Organizations that do not elect to have all sites surveyed shall have a sample, not to exceed 20 percent of all service sites, surveyed. The actual sample size shall be determined by the board. The accreditation agency shall determine the location of the sites to be surveyed. Outpatient settings that have five or fewer sites shall have at least one site surveyed. When an organization that elects to have a sample of sites surveyed is approved for accreditation, all of the organizations' sites shall be automatically accredited.

(8) Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.

(9) Outpatient settings shall post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff.

(10) Outpatient settings shall have a written discharge criteria.

(b) Outpatient settings shall have a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care. Transfer to an unlicensed setting of a patient who does not meet the discharge criteria adopted pursuant to paragraph (10) of subdivision (a) shall constitute unprofessional conduct.

(c) An accreditation agency may include additional standards in its determination to accredit outpatient settings if these are approved by the board to protect the public health and safety.

(d) No accreditation standard adopted or approved by the board, and no standard included in any certification program of any accreditation agency approved by the board, shall serve to limit the ability of any allied health care practitioner to provide services within his or her full scope of practice. Notwithstanding this or any other provision of law, each outpatient setting may limit the privileges, or determine the privileges, within the appropriate scope of practice, that will be afforded to physicians and allied health care practitioners who practice at the facility, in accordance with credentialing standards established by the outpatient setting in compliance with this chapter. Privileges may not be arbitrarily restricted based on category of licensure.

(e) The board may adopt standards *that it deems necessary* for outpatient settings that offer in vitro fertilization ~~or assisted reproduction technology that it deems necessary~~.

SEC. 6. Section 1248.2 of the Health and Safety Code is amended to read:

1248.2. (a) Any outpatient setting may apply to an accreditation agency for a certificate of accreditation. Accreditation shall be issued by the accreditation agency solely on the basis of compliance with its standards as approved by the board under this chapter.

(b) The board shall obtain and maintain a list of all accredited, certified, and licensed outpatient settings from the information provided by the accreditation, certification, and licensing agencies approved by the board, and shall notify the public whether a setting is accredited, certified, or licensed, or the setting's accreditation, certification, or license has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency.

SEC. 7. Section 1248.25 of the Health and Safety Code is amended to read:

1248.25. If an outpatient setting does not meet the standards approved by the board, accreditation shall be denied by the accreditation agency, which shall provide the outpatient setting notification of the reasons for the denial. An outpatient setting may reapply for accreditation at any time after receiving notification of the denial. The accreditation agency shall immediately report to the board if the outpatient setting's certificate for accreditation has been denied.

SEC. 8. Section 1248.35 of the Health and Safety Code is amended to read:

1248.35. (a) Every outpatient setting which is accredited shall be inspected by the accreditation agency and may also be inspected by the Medical Board of California. The Medical Board of California shall ensure that accreditation agencies inspect outpatient settings.

(b) Unless otherwise specified, the following requirements apply to inspections described in subdivision (a).

(1) The frequency of inspection shall depend upon the type and complexity of the outpatient setting to be inspected.

(2) Inspections shall be conducted no less often than once every three years by the accreditation agency and as often as necessary by the Medical Board of California to ensure the quality of care provided.

(3) The Medical Board of California or the accreditation agency may enter and inspect any outpatient setting that is accredited by an accreditation agency at any reasonable time to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of this chapter.

(c) If an accreditation agency determines, as a result of its inspection, that an outpatient setting is not in compliance with the standards under which it was approved, the accreditation agency may do any of the following:

(1) Issue a reprimand.

(2) Place the outpatient setting on probation, during which time the setting shall successfully institute and complete a plan of correction, approved by the board or the accreditation agency, to correct the deficiencies.

(3) Suspend or revoke the outpatient setting's certification of accreditation.

(d) Except as is otherwise provided in this subdivision, before suspending or revoking a certificate of accreditation under this chapter, the accreditation agency shall provide the outpatient setting with notice of any deficiencies and the outpatient setting shall agree with the accreditation agency on a plan of correction that shall give the outpatient setting reasonable time to supply information demonstrating compliance with the standards of the accreditation agency in compliance with this chapter, as well as the opportunity for a hearing on the matter upon the request of the outpatient center. During that allotted time, a list of deficiencies and the plan of correction shall be conspicuously posted in a clinic location accessible to public view. The accreditation agency may immediately suspend the certificate of accreditation before providing notice and an opportunity to be heard, but only when failure to take the action may result in imminent danger to the health of an individual. In such cases, the accreditation agency shall provide subsequent notice and an opportunity to be heard.

(e) If the board determines that deficiencies found during an inspection suggests that the accreditation agency does not comply

with the standards approved by the board, the board may conduct inspections, as described in this section, of other settings accredited by the accreditation agency to determine if the agency is accrediting settings in accordance with Section 1248.15.

(f) Reports on the results of any inspection conducted pursuant to subdivision (a) shall be kept on file with the board or the accreditation agency along with the plan of correction and the outpatient setting comments. The inspection report may include a recommendation for reinspection. All inspection reports, lists of deficiencies, and plans of correction shall be public records open to public inspection.

(g) The accreditation agency shall immediately report to the board if the outpatient setting has been issued a reprimand or if the outpatient setting's certification of accreditation has been suspended or revoked or if the outpatient setting has been placed on probation.

SEC. 9. Section 1248.5 of the Health and Safety Code is amended to read:

1248.5. The board shall evaluate the performance of an approved accreditation agency no less than every three years, or in response to complaints against an agency, or complaints against one or more outpatient settings accreditation by an agency that indicates noncompliance by the agency with the standards approved by the board.

SEC. 10. Section 1279 of the Health and Safety Code is amended to read:

1279. (a) Every health facility for which a license or special permit has been issued shall be periodically inspected by the department, or by another governmental entity under contract with the department. The frequency of inspections shall vary, depending upon the type and complexity of the health facility or special service to be inspected, unless otherwise specified by state or federal law or regulation. The inspection shall include participation by the California Medical Association consistent with the manner in which it participated in inspections, as provided in Section 1282 prior to September 15, 1992.

(b) Except as provided in subdivision (c), inspections shall be conducted no less than once every two years and as often as necessary to ensure the quality of care being provided.

(c) For a health facility specified in subdivision (a), (b), or (f) of Section 1250, inspections shall be conducted no less than once every three years, and as often as necessary to ensure the quality of care being provided.

(d) During the inspection, the representative or representatives shall offer such advice and assistance to the health facility as they deem appropriate.

(e) For acute care hospitals of 100 beds or more, the inspection team shall include at least a physician, registered nurse, and persons experienced in hospital administration and sanitary inspections. During the inspection, the team shall offer advice and assistance to the hospital as it deems appropriate.

(f) The department shall ensure that a periodic inspection conducted pursuant to this section is not announced in advance of the date of inspection. An inspection may be conducted jointly with inspections by entities specified in Section 1282. However, if the department conducts an inspection jointly with an entity specified in Section 1282 that provides notice in advance of the periodic inspection, the department shall conduct an additional periodic inspection that is not announced or noticed to the health facility.

(g) Notwithstanding any other provision of law, the department shall inspect for compliance with provisions of state law and regulations during a state periodic inspection or at the same time as a federal periodic inspection, including, but not limited to, an inspection required under this section. If the department inspects for compliance with state law and regulations at the same time as a federal periodic inspection, the inspection shall be done consistent with the guidance of the federal Centers for Medicare and Medicaid Services for the federal portion of the inspection.

(h) During a state periodic inspection of an acute care hospital, including, but not limited to, an inspection required under this section, the department shall inspect the peer review process utilized by the hospital.

(i) The department shall emphasize consistency across the state and in its district offices when conducting licensing and certification surveys and complaint investigations, including the selection of state or federal enforcement remedies in accordance with Section 1423. The department may issue federal deficiencies

and recommend federal enforcement actions in those circumstances where they provide more rigorous enforcement action.

SEC. 11. 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.

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SB 726

SB 726

Analysis to Follow

AMENDED IN ASSEMBLY JULY 15, 2009

AMENDED IN SENATE MAY 6, 2009

AMENDED IN SENATE APRIL 23, 2009

SENATE BILL No. 726

Introduced by Senator Ashburn
(Principal coauthors: Assembly Members Chesbro and Swanson)

February 27, 2009

An act to amend Sections 2401 and 2401.1 of the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

SB 726, as amended, Ashburn. ~~District~~ *Health care districts: rural* hospitals: employment of physicians and surgeons.

Existing law, the Medical Practice Act, restricts the employment of licensed physicians and surgeons and podiatrists by a corporation or other artificial legal entity, subject to specified exemptions. Existing law establishes, until January 1, 2011, a pilot project to allow qualified district hospitals to employ a physician and surgeon if certain conditions are satisfied. ~~Existing law defines a qualified district hospital as a district hospital that provides a certain percentage of care to Medicare, Medi-Cal, and uninsured patients, that is located in a county with a certain population, and that has net losses from operations in a specified fiscal year.~~ The pilot project authorizes the direct employment of a total of 20 physicians and surgeons by those hospitals, and specifies that each qualified district hospital may employ up to 2 physicians and surgeons, subject to certain requirements. The pilot project requires that the term of a contract with a licensee not exceed 4 years. Existing law

requires the Medical Board of California to report to the Legislature not later than October 1, 2008, on the effectiveness of the pilot project.

This bill would revise the pilot project to authorize the direct employment by qualified ~~district~~ *health care districts and qualified rural* hospitals, *as defined,* of an unlimited number of physicians and surgeons under the pilot project, and would authorize such a *district or* hospital to employ up to 5 ~~licensees~~ *physicians and surgeons* at a time if certain requirements are met. ~~The bill would revise the definition of a qualified district hospital to a hospital that, among other things, is operated by the district itself and is either a small and rural hospital, as defined, or is located within a medically underserved area, as specified. The bill would further revise the pilot project to authorize a qualified district hospital to directly employ a physician and surgeon specializing in family practice, internal medicine, general surgery, or obstetrics and gynecology, and would authorize the hospital to request permission from the board to employ a physician and surgeon specializing in a different field if certain requirements are met.~~ The bill would require that the term of a contract with a ~~licensee~~ *physician and surgeon* not exceed 10 years. ~~The bill~~ *and* would extend the pilot project until January 1, 2018. The bill would require the board to provide a preliminary report to the Legislature not later than July 1, 2013, and a final report not later than July 1, 2016, evaluating the effectiveness of the pilot project, and would make conforming changes.

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 2401 of the Business and Professions Code is amended to read:

2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the Division of Licensing or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code

may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Alcohol and Drug Programs, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(d) Notwithstanding Section 2400, a qualified ~~hospital-owned and operated by a health care district~~ *health care district organized and governed* pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code *or a qualified rural hospital* may employ a licensee pursuant to Section 2401.1, and may charge for professional services rendered by the licensee, if the physician and surgeon in whose name the charges are made approves the charges. However, the *district or* hospital shall not interfere with, control, or otherwise direct the physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law.

SEC. 2. Section 2401.1 of the Business and Professions Code is amended to read:

2401.1. (a) The Legislature finds and declares as follows:

(1) Due to the large number of uninsured and underinsured Californians, a number of California communities are having great difficulty recruiting and retaining physicians and surgeons.

(2) In order to recruit physicians and surgeons to provide medically necessary services in rural and medically underserved communities, many ~~district~~ *qualified health care districts and qualified rural* hospitals have no viable alternative but to directly employ physicians and surgeons in order to provide economic security adequate for a physician and surgeon to relocate and reside in their communities.

(3) The Legislature intends that a ~~district~~ *qualified health care district or qualified rural* hospital meeting the conditions set forth

in this section be able to employ physicians and surgeons directly, and to charge for their professional services.

(4) The Legislature reaffirms that Section 2400 provides an increasingly important protection for patients and physicians and surgeons from inappropriate intrusions into the practice of medicine, and further intends that a ~~district~~ *qualified health care district or qualified rural* hospital not interfere with, control, or otherwise direct a physician and surgeon's professional judgment.

(b) A pilot project to provide for the direct employment of physicians and surgeons by qualified ~~district~~ *health care districts and qualified rural* hospitals is hereby established in order to improve the recruitment and retention of physicians and surgeons in rural and other medically underserved areas.

(c) For purposes of this section, ~~a qualified district hospital means a hospital that meets all of the following requirements:~~

~~(1) Is a district hospital organized and governed pursuant to~~ *"qualified health care district" means a health care district organized and governed pursuant to* the Local Health Care District Law (Division 23 (commencing with Section 32000) of the Health and Safety Code). *A qualified health care district shall be eligible to employ physicians and surgeons pursuant to this section if all of the following requirements are met:*

(1) The district health care facility at which the physician and surgeon will provide services meets both of the following requirements:

~~(2)~~

(A) Is operated by the district itself, and not by another entity.

~~(3)~~

(B) Is located within a medically underserved population or medically underserved area, so designated by the federal government pursuant to Section 254b or 254c-14 of Title 42 of the United States Code, or ~~is a small and rural hospital as defined in Section 124840 of the Health and Safety Code.~~ *within a federally designated Health Professional Shortage Area.*

~~(4) (A) The chief executive officer of the hospital has provided certification to the board and the medical staff that the hospital has been unsuccessful, using commercially reasonable efforts, in recruiting a core physician and surgeon for at least 12 consecutive months during the period beginning on July 1, 2008, and ending on July 1, 2009.~~

(2) The chief executive officer of the district has provided certification to the board that the district has been unsuccessful, using commercially reasonable efforts, in recruiting a physician and surgeon to provide services at the facility described in paragraph (1) for at least 12 continuous months beginning on or after July 1, 2008. This certification shall specify the commercially reasonable efforts, including, but not limited to, recruitment payments or other incentives, used to recruit a ~~core~~ physician and surgeon that were unsuccessful and shall specify the reason for the lack of success, if known.

~~(B) For purposes of this paragraph, "core physician and surgeon" means a physician and surgeon specializing in family practice, internal medicine, general surgery, or obstetrics and gynecology.~~

~~(C) Notwithstanding subparagraph (A), a hospital may request permission from the board to hire a physician and surgeon in a specialized field other than the fields listed in subparagraph (B) if all of the following requirements are met:~~

~~(i) The hospital can demonstrate a pervasive inability to meet the needs of the health care district in that specialized field.~~

~~(ii) The chief medical officer of the hospital provides the certification described in subparagraph (A) regarding the hospital's efforts to recruit a physician and surgeon in the specialized field during the period of time specified in subparagraph (A).~~

~~(iii) The other applicable requirements of this subdivision are satisfied.~~

~~(5) Except as provided in subparagraph (B) of paragraph (7), the medical staff and the elected trustees of the hospital concur by an affirmative vote of each body that the physician and surgeon's employment is in the best interest of the communities served by the hospital.~~

(3) The chief executive officer of the district certifies to the board that the hiring of a physician and surgeon pursuant to this section shall not supplant physicians and surgeons with current privileges or contracts with the facility described in paragraph (1).

~~(6) The hospital~~

(4) The district enters into or renews a written employment contract with the physician and surgeon prior to December 31, 2017, for a term not in excess of 10 years. The contract shall provide for mandatory dispute resolution under the auspices of the

board for disputes directly relating to the ~~licensee's~~ *physician and surgeon's* clinical practice.

~~(7) (A) Except as provided in subparagraph (B), the total number of licensees employed by the hospital does not exceed two at any time.~~

~~(B) The board shall authorize the hospital to hire no more than three additional licensees if both of the following requirements are met:~~

~~(i) The hospital makes a showing of clear need in the community~~

(5) The total number of physicians and surgeons employed by the district does not exceed two at any time. However, the board shall authorize the district to hire no more than three additional physicians and surgeons if the district makes a showing of clear need in the community following a public hearing duly noticed to all interested parties, including, but not limited to, those involved in the delivery of medical care.

~~(ii) The medical staff concurs by an affirmative vote that employment of the additional licensee or licensees is in the best interest of the communities served by the hospital.~~

~~(8) The hospital~~

(6) The district notifies the board in writing that the ~~hospital~~ *district* plans to enter into a written contract with the ~~licensee~~ *physician and surgeon*, and the board has confirmed that the ~~licensee's~~ *physician and surgeon's* employment is within the maximum number permitted by this section. The board shall provide written confirmation to the ~~hospital~~ *district* within five working days of receipt of the written notification to the board.

(7) The chief executive officer of the district certifies to the board that the district did not actively recruit or employ a physician and surgeon who, at the time, was employed by a federally qualified health center, a rural health center, or other community clinic not affiliated with the district.

(d) (1) For purposes of this section, "qualified rural hospital" means any of the following:

(A) A general acute care hospital located in an area designated as nonurban by the United States Census Bureau.

(B) A general acute care hospital located in a rural-urban commuting area code of four or greater as designated by the United States Department of Agriculture.

(C) A rural hospital located within a medically underserved population or medically underserved area, so designated by the federal government pursuant to Section 254b or 254c-14 of Title 42 of the United States Code, or within a federally designated Health Professional Shortage Area.

(2) To be eligible to employ physicians and surgeons pursuant to this section, a qualified rural hospital shall meet all of the following requirements:

(A) The chief executive officer of the hospital has provided certification to the board that the hospital has been unsuccessful, using commercially reasonable efforts, in recruiting a physician and surgeon for at least 12 continuous months beginning on or after July 1, 2008. This certification shall specify the commercially reasonable efforts, including, but not limited to, recruitment payments or other incentives, used to recruit a physician and surgeon that were unsuccessful and shall specify the reason for the lack of success, if known.

(B) The chief executive officer of the hospital certifies to the board that the hiring of a physician and surgeon pursuant to this section shall not supplant physicians and surgeons with current privileges or contracts with the hospital.

(C) The hospital enters into or renews a written employment contract with the physician and surgeon prior to December 31, 2017, for a term not in excess of 10 years. The contract shall provide for mandatory dispute resolution under the auspices of the board for disputes directly relating to the physician and surgeon's clinical practice.

(D) The total number of physicians and surgeons employed by the hospital does not exceed two at any time. However, the board shall authorize the hospital to hire no more than three additional physicians and surgeons if the hospital makes a showing of clear need in the community following a public hearing duly noticed to all interested parties, including, but not limited to, those involved in the delivery of medical care.

(E) The hospital notifies the board in writing that the hospital plans to enter into a written contract with the physician and surgeon, and the board has confirmed that the physician's and surgeon's employment is within the maximum number permitted by this section. The board shall provide written confirmation to

the hospital within five working days of receipt of the written notification to the board.

(F) The chief executive officer of the hospital certifies to the board that the hospital did not actively recruit or employ a physician and surgeon who, at the time, was employed by a federally qualified health center, a rural health center, or other community clinic not affiliated with the hospital.

~~(d)~~

(e) The board shall provide a preliminary report to the Legislature not later than July 1, 2013, and a final report not later than July 1, 2016, evaluating the effectiveness of the pilot project in improving access to health care in rural and medically underserved areas and the project's impact on consumer protection as it relates to intrusions into the practice of medicine. *The board shall include in the report an analysis of the impact of the pilot project on the ability of nonprofit community clinics and health centers located in close proximity to participating health care district facilities and participating rural hospitals to recruit and retain physicians and surgeons.*

~~(e)~~

(f) Nothing in this section shall exempt ~~the district~~ *a qualified health care district or qualified rural* hospital from any reporting requirements or affect the board's authority to take action against a physician and surgeon's license.

~~(f)~~

(g) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute that is enacted before January 1, 2018, deletes or extends that date.

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SB 819

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 819
Author: Committee on Business, Professions, and Economic Development
Bill Date: June 22, 2009, amended
Subject: Omnibus
Sponsor: Committee

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business and Professions Committee. Some provisions, although non-substantive, impact statutes governing the Medical Practices Act. The provisions in this bill were those previously carried in SB 1779 (2008) which was vetoed.

ANALYSIS:

This bill proposes non-substantive and non-controversial changes to law. The provisions relating to the Medical Board are in the Business and Professions Code and are as follows (only these sections of the bill are attached):

- 801.01 – Clarifying whether or not malpractice actions have to be in California to be reported. **(This section has been deleted, as AB 1070 passed out of the Assembly)**
- 2089.5 – Specifying the type of residency programs; and technical changes.
- 2096 – Specifying the type of residency programs; and technical changes.
- 2102 – Since the Federation of State Medical Boards (FSMB) will not test anyone without a state license, this eliminates this option and makes technical changes.
- 2107 – Technical changes.
- 2135 – Technical changes as follows:
  - *Subdivision (a)(1)* – Specifying degree of Medical Doctor to clarify and ensure understanding.
  - *Subdivision (d)* – Maintaining consistency among all licensing pathways.

- 2168.4 & 2169 – Making the renewal requirements for the special faculty permit the same as those for the physician's certificate renewal.

- 2172 – Repeal; board no longer administers examinations.

- 2173 – Repeal; board no longer administers examinations.

- 2174 – Repeal; board no longer administers examinations.

- 2175 – Requiring the Board to maintain examination records until June 1, 2070.

- 2221 – Making the process by which an applicant's probationary certificate can be modified or terminated consistent with the process that a licensee on probation must follow to modify or terminate probation.

- 2307 – Specify that recommendations can come from physicians licensed in any state; and technical changes.

- 2335 – Re-amending section from AB 253 (2007), the Board's restructuring bill, due to subsequent section amendments in a bill that was signed afterward. This section was included in a bill that was signed after ours, which did not include the amendments we were requesting. Our amendments add 10 days to the 90-day period by which provisions and proposed decisions must be issued by the Board. This provision will make the requirements consistent with the Administrative Procedures Act.

This bill was amended to remove section 801.01 from the provisions as this section is included in AB 1070 (Hill) as part of the Board's enforcement enhancements.

FISCAL: None to the Board

POSITION: Support MBC provisions.

AMENDED IN ASSEMBLY JUNE 22, 2009

AMENDED IN SENATE MAY 28, 2009

AMENDED IN SENATE MAY 5, 2009

AMENDED IN SENATE APRIL 20, 2009

AMENDED IN SENATE APRIL 13, 2009

SENATE BILL **No. 819**

Introduced by Committee on Business, Professions and Economic Development (Negrete McLeod (chair), Aanestad, Corbett, Correa, Florez, Oropeza, Romero, Walters, Wyland, and Yee)

March 10, 2009

An act to amend Sections 27, 101, 128.5, 144, 146, 149, 683, 733, 800, 801, ~~801.01,~~ 803, 2089.5, 2096, 2102, 2107, 2135, 2168.4, 2175, 2221, 2307, 2335, 2486, 2488, 2570.5, 2570.6, 2570.7, 2570.185, 2760.1, 3503, 3517, 3518, 3625, 3635, 3636, 3685, 3753.5, 4022.5, 4027, 4040, 4051, 4059.5, 4060, 4062, 4076, 4081, 4110, 4111, 4126.5, 4161, 4174, 4231, 4301, 4305, 4329, 4330, 4857, 4980.30, 4980.43, 4996.2, 4996.17, 4996.18, 5801, 6534, 6536, 6561, 7616, 7629, 8030.2, 8740, and 8746 of, to add Sections 2169, 2570.36, 4036.5, 4980.04, 4990.09, ~~5515.5,~~ and 9855.15 to, and to repeal Sections 2172, 2173, 2174, 4981, 4994.1, 4996.20, 4996.21, and 6761 of, the Business and Professions Code, to amend Section 8659 of the Government Code, to amend Sections 8778.5, 11150, and 11165 of the Health and Safety Code, and to amend Section 14132.100 of the Welfare and Institutions Code, relating to professions and vocations, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

Medical Board sections on pages 28-39

Behavioral Sciences or from an agency mentioned in subdivision (a) of Section 800 (except a person licensed pursuant to Chapter 3 (commencing with Section 1200)) has committed a crime, or is liable for any death or personal injury resulting in a judgment for an amount in excess of thirty thousand dollars ($30,000) caused by his or her negligence, error or omission in practice, or his or her rendering unauthorized professional services, the clerk of the court that rendered the judgment shall report that fact to the agency that issued the license, certificate, or other similar authority.

(b) For purposes of a physician and surgeon, osteopathic physician and surgeon, or doctor of podiatric medicine, who is liable for any death or personal injury resulting in a judgment of any amount caused by his or her negligence, error or omission in practice, or his or her rendering unauthorized professional services, the clerk of the court that rendered the judgment shall report that fact to the agency that issued the license.

~~SEC. 13.~~

SEC. 12. Section 2089.5 of the Business and Professions Code is amended to read:

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, 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. 14.~~

SEC. 13. Section 2096 of the Business and Professions Code is amended to read:

2096. 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), shall show by evidence satisfactory to the board that he or she has satisfactorily completed at least one year of postgraduate training, which includes at least four months of general medicine, in a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC).

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. 15.~~

SEC. 14. Section 2102 of the Business and Professions Code is amended to read:

2102. Any 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 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) Pass 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.

Nothing in this section prohibits the board from disapproving any 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. 16.~~

SEC. 15. Section 2107 of the Business and Professions Code is amended to read:

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. 17.~~

SEC. 16. 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).

(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.

(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. 18.~~

SEC. 17. 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, 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. 19.~~

SEC. 18. Section 2169 is added to the Business and Professions Code, to read:

2169. A person who holds a special faculty permit shall meet the continuing medical education requirements set forth in Article 10 (commencing with Section 2190).

~~SEC. 20.~~

SEC. 19. Section 2172 of the Business and Professions Code is repealed.

~~SEC. 21.~~

SEC. 20. Section 2173 of the Business and Professions Code is repealed.

~~SEC. 22.~~

SEC. 21. Section 2174 of the Business and Professions Code is repealed.

~~SEC. 23.~~

SEC. 22. Section 2175 of the Business and Professions Code is amended to read:

2175. State examination records shall be kept on file by the board until June 1, 2070. Examinees shall be known and designated by number only, and the name attached to the number shall be kept secret until the examinee is sent notification of the results of the examinations.

~~SEC. 24.~~

SEC. 23. 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 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; or, 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. 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. 25.~~

SEC. 24. Section 2307 of the Business and Professions Code is amended to read:

2307. (a) A person whose certificate has been surrendered while under investigation or while charges are pending or whose certificate has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the certificate or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a license surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from physicians and surgeons licensed in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. 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 or the California Board of Podiatric Medicine, as applicable, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the certificate was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a certificate or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

(h) This section is applicable to and may be carried out with regard to licensees of the California Board of Podiatric Medicine. In lieu of two verified recommendations from physicians and surgeons, the petition shall be accompanied by at least two verified recommendations from doctors of podiatric medicine licensed in any state who have personal knowledge of the activities of the petitioner since the date the disciplinary penalty was imposed.

(i) Nothing in this section shall be deemed to alter Sections 822 and 823.

~~SEC. 26.~~

SEC. 25. Section 2335 of the Business and Professions Code is amended to read:

2335. (a) All proposed decisions and interim orders of the Medical Quality Hearing Panel designated in Section 11371 of the

Government Code shall be transmitted to the executive director of the board, or the executive director of the California Board of Podiatric Medicine as to the licensees of that board, within 48 hours of filing.

(b) All interim orders shall be final when filed.

(c) A proposed decision shall be acted upon by the board or by any panel appointed pursuant to Section 2008 or by the California Board of Podiatric Medicine, as the case may be, in accordance with Section 11517 of the Government Code, except that all of the following shall apply to proceedings against licensees under this chapter:

(1) When considering a proposed decision, the board or panel and the California Board of Podiatric Medicine shall give great weight to the findings of fact of the administrative law judge, except to the extent those findings of fact are controverted by new evidence.

(2) The board's staff or the staff of the California Board of Podiatric Medicine shall poll the members of the board or panel or of the California Board of Podiatric Medicine by written mail ballot concerning the proposed decision. The mail ballot shall be sent within 10 calendar days of receipt of the proposed decision, and shall poll each member on whether the member votes to approve the decision, to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of additional evidence, to defer final decision pending discussion of the case by the panel or board as a whole, or to nonadopt the decision. No party to the proceeding, including employees of the agency that filed the accusation, and no person who has a direct or indirect interest in the outcome of the proceeding or who presided at a previous stage of the decision, may communicate directly or indirectly, upon the merits of a contested matter while the proceeding is pending, with any member of the panel or board, without notice and opportunity for all parties to participate in the communication. The votes of a majority of the board or of the panel, and a majority of the California Board of Podiatric Medicine, are required to approve the decision with an altered penalty, to refer the case back to the administrative law judge for the taking of further evidence, or to nonadopt the decision. The votes of two members of the panel or board are required to defer final decision pending discussion of the case by

the panel or board as a whole. If there is a vote by the specified number to defer final decision pending discussion of the case by the panel or board as a whole, provision shall be made for that discussion before the 100-day period specified in paragraph (3) expires, but in no event shall that 100-day period be extended.

(3) If a majority of the board or of the panel, or a majority of the California Board of Podiatric Medicine vote to do so, the board or the panel or the California Board of Podiatric Medicine shall issue an order of nonadoption of a proposed decision within 100 calendar days of the date it is received by the board. If the board or the panel or the California Board of Podiatric Medicine does not refer the case back to the administrative law judge for the taking of additional evidence or issue an order of nonadoption within 100 calendar days, the decision shall be final and subject to review under Section 2337. Members of the board or of any panel or of the California Board of Podiatric Medicine who review a proposed decision or other matter and vote by mail as provided in paragraph (2) shall return their votes by mail to the board within 30 days from receipt of the proposed decision or other matter.

(4) The board or the panel or the California Board of Podiatric Medicine shall afford the parties the opportunity to present oral argument before deciding a case after nonadoption of the administrative law judge's decision.

(5) A vote of a majority of the board or of a panel, or a majority of the California Board of Podiatric Medicine, are required to increase the penalty from that contained in the proposed administrative law judge's decision. No member of the board or panel or of the California Board of Podiatric Medicine may vote to increase the penalty except after reading the entire record and personally hearing any additional oral argument and evidence presented to the panel or board.

~~SEC. 27.~~

SEC. 26. 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, 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:

SB 820

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 820
Author: Negrete McLeod and Aanestad
Bill Date: July 6, 2009, amended
Subject: Peer Review
Sponsor: Authors

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill was gutted and amended to carry many of the provisions regarding peer review that were originally contained in SB 700 (Negrete McLeod).

ANALYSIS:

Business and Professions Code section 800 – Central File

1. Allows the physician to submit into the central file exculpatory or explanatory statements related to an 805 report and any court findings that an 805 report was submitted in bad faith. This provision allows physicians to have in his or her central file, maintained by the Board, additional information explaining the physician's or court's point of view.

Business and Professions Code section 803.1 – Disclosure of Information

1. 805 reports for termination or revocation are disclosable. This provision adds that any exculpatory or explanatory statements submitted by the licensee will also be disclosed.

2. If a court finds that the peer review resulting in disciplinary action was conducted in bad faith and the licensee notifies the board of that finding, the 805 report and any accompanying exculpatory or explanatory statements will no longer be disclosed.

Business and Professions Code section 805 – Peer Review

1. Adds a definition of what peer review is by specifying that it is the process in which the basic qualifications, staff privileges, employment, outcomes and

conduct of licentiates are reviewed to determine if licensees may continue to practice in the facility and if so, under any parameters. This bill clarifies that the definition of a peer review body includes any clinic specified in the Health and Safety Code. This clarification is needed in order to makes clear all the entities and individuals who are required to conduct peer review.

2. Rewrites for clarity the section that requires an 805 report to be filed within 15 days from the date when a physician, after receiving notice of a pending investigation:

    a. resigns or takes a leave of absence from staff privileges, membership or employment;
    b. withdraws or abandons his or her application for staff privileges, membership, or employment;
    c. withdraws or abandons his or her request for renewal of staff privileges, membership, or employment.

Business and Professions Code section 805.01 – New Required Peer Review Reports

1. This section requires, in addition to reports required under section 805, the filing of a report after a formal investigation and prior to an 809.2 hearing if a physician is accused of any of the following:

    a. 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 represent a danger to the public.
    b. Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.
    c. Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without good faith effort prior examination of the patient and medical reason.
    d. Sexual misconduct with one or more patients during a course of treatment or an examination.

2. This section authorizes the board to inspect and copy the following documents in the record of any informal investigation:

    a. Any statement of charges.
    b. Any document, medical chart, or exhibit.
    c. Any opinions, findings, or conclusions.
    d. Certified medical records.

Business and Professions Code section 805.5 – Granting and Renewing Staff Privileges

1. Adds that any additional information furnished by a licensee related to an 805 shall be provided by the board to the agency granting or renewing staff privileges.

2. The board shall not send a copy of an 805 report is a court finds that the peer review resulting in disciplinary action was conducted in bad faith and the licensee notifies the board of that finding.

Business and Professions Code section 2027 – Posting on the Web

1. Adds that hospital disciplinary actions that are posted on the web shall provide a link to any exculpatory or explanatory statements submitted by the licensee.

2. If a court finds that the peer review resulting in disciplinary action was conducted in bad faith and the licensee notifies the board of that finding, the posting shall be immediately removed from the web.

FISCAL: Minor and absorbable.

POSITION: **Staff Recommendation:** Support

AMENDED IN ASSEMBLY JULY 6, 2009

AMENDED IN ASSEMBLY JUNE 22, 2009

AMENDED IN SENATE APRIL 21, 2009

SENATE BILL No. 820

Introduced by ~~Committee on Business, Professions and Economic Development (Negrete McLeod (chair), Aanestad, Corbett, Correa, Florez, Oropeza, Romero, Walters, Wyland, and Yee)~~ *Senators Negrete McLeod and Aanestad*

March 10, 2009

~~An act to amend Sections 139, 146, 1632.5, 1634.2, 2493, 4200.3, 4200.4, 4938, 5016, 5021, 5022, 5023, 5651, 7028.7, 7044, 7159, 7159.5, 7159.14, 7303.2, 7500.1, 7505.5, 7507.9, 7507.12, 7606, 7616, 7641, 7643, 7646, 7647, 7662, 7665, 7666, 7671, 7725.5, 7729, 9884.2, 9884.7, 9884.12, 9889.3, and 10146 of, to add Sections 5515.5, 7044.01 and 7507.115 to, and to to repeal Section 6763.1 of, repeal and add Section 7108.5 of, the Business and Professions Code, to amend Sections 44014.2, 44017.3, 44072.1, 44072.2, and 44095 of the Health and Safety Code, and to amend Sections 28, 5201, and 24603 of the Vehicle Code, relating to consumer affairs.~~ *An act to amend Sections 800, 803.1, 805, 805.1, 805.5, and 2027 of, and to add Section 805.01 to, the Business and Professions Code, relating to healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

SB 820, as amended, ~~Committee on Business, Professions and Economic Development~~ *Negrete McLeod.* ~~Consumer affairs: professions and vocations.~~ *Healing arts: peer review.*

Existing law provides for the professional review of specified healing arts licentiates through a peer review process. Existing law defines the

term "peer review body" as including a medical or professional staff of any health care facility or clinic licensed by the State Department of Public Health.

This bill would define the term "peer review."

Under existing law, specified persons are required to file a report, designated as an "805 report," with a licensing board within 15 days after a specified action is taken against a person licensed by that board, including imposition of a summary suspension of staff privileges, membership, or employment if the summary suspension stays in effect for a period in excess of 14 days. Existing law provides various due process rights for licentiates who are the subject of a final proposed disciplinary action of a peer review body, including authorizing a licentiate to request a hearing concerning that action.

This bill would also require specified persons to file a report with a licensing board within 15 days after a peer review body makes a decision or recommendation regarding the disciplinary action to be taken against a licentiate of that board based on the peer review body's determination, following formal investigation, that the licentiate engaged in various acts, including gross negligence, incompetence, substance abuse, excessive prescribing or furnishing of controlled substances, or sexual misconduct, among other things. The bill would authorize the board to inspect and copy certain documents in the record of that investigation.

Existing law requires the board to maintain an 805 report for a period of 3 years after receipt.

This bill would require the board to maintain the report electronically.

Existing law authorizes the Medical Board of California, the Osteopathic Medical Board of California, and the Dental Board of California to inspect and copy certain documents in the record of any disciplinary proceeding resulting in action that is required to be reported in an 805 report.

This bill would specify that the boards have the authority to also inspect any certified copy of medical records in the record of the disciplinary proceeding.

Existing law requires specified healing arts boards to maintain a central file of their licensees containing, among other things, disciplinary information reported through 805 reports.

Under this bill, if a court finds 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 would be required to include that finding in the licensee's central file.

Existing law requires the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine to disclose an 805 report to specified health care entities and to disclose certain hospital disciplinary actions to inquiring members of the public. Existing law also requires the Medical Board of California to post hospital disciplinary actions regarding its licensees on the Internet.

This bill would prohibit those disclosures, and would require the Medical Board of California to remove certain information posted on the Internet, if a court finds that the peer review resulting in the 805 report or the hospital disciplinary action was conducted in bad faith and the licensee notifies the board of that finding. The bill would also require the Medical Board of California to post on the Internet a factsheet that explains and provides information on the 805 reporting requirements.

Existing law also requires 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 information regarding enforcement actions taken against a licensee by the board or by another state or jurisdiction.

This bill would also require those boards to make those disclosures regarding enforcement actions taken against former licensees.

The bill would make related nonsubstantive changes.

The bill would also provide that it shall become operative only if AB 120 is also enacted and becomes operative.

~~Existing law provides for the licensure and regulation of various professions and vocations by boards and bureaus within the Department of Consumer Affairs. Existing law requires that certain examinations for licensure be developed by or in consultation with the Office of Examination Resources in the department, as specified.~~

~~This bill would rename that office the Office of Professional Examination Services.~~

~~Existing law prohibits a person from holding himself or herself out to the public as a professional fiduciary without a license. Existing law specifies that a violation of certain requirements to be registered, licensed, or certified to engage in certain businesses is punishable as an infraction subject to specified procedures and fines.~~

~~This bill would make a violation of the professional fiduciary licensure requirement punishable as an infraction, thereby imposing a state-mandated local program.~~

~~Existing law, the Bagley-Keene Open Meeting Act, requires a state body, as defined, to provide prescribed notice of its meetings to any person who requests that notice in writing. Existing law provides for the licensure and regulation of accountants by the California Board of Accountancy and requires the executive officer of the board to give at least 7 days' notice of board meetings. Existing law authorizes the board to appoint an administrative committee and an advisory committee for certain purposes and requires members of the administrative committee to hold office for one year.~~

~~This bill would designate the advisory committee as the qualifications committee and would require members of that committee and the administrative committee to hold office for 2 years. The bill would require notice of each meeting of the board to be given in accordance with the Bagley-Keene Open Meeting Act.~~

~~Existing law, the Architects Practice Act, provides for the licensure and regulation of architects by the California Architects Board. Under existing law, the board is composed of 5 architect members and 5 public members. Existing law requires that each appointment to the board expire on June 30 of the 4th year following the year in which the previous term expired.~~

~~This bill would modify the term length for certain members of the board.~~

~~Existing law provides for the licensure and regulation of landscape architects by the California Architects Board. Existing law requires the board to ascertain the qualifications of applicants for a license by means of written examination. Under existing law, the board may waive the written examination for a person licensed out of state, as specified, if the person has passed an equivalent examination and a supplemental examination, as specified.~~

~~This bill would also require an out-of-state licensee to submit proof of job experience equivalent to that required of California applicants in order to waive the written examination.~~

~~Existing law, the Professional Engineers Act, provides for the licensure and regulation of professional engineers by the Board for Professional Engineers and Land Surveyors within the department. Under existing law, in order to use the title "structural engineer," a person must successfully pass a written test incorporating a national~~

~~examination for structural engineering by a nationally recognized entity approved by the board, and a supplemental California specific examination.~~

~~This bill would eliminate the requirement to successfully pass a California specific examination, so that only one board-prescribed examination is required.~~

~~Existing law, the Contractors' State License Law, provides for the licensure and regulation of contractors by the Contractors' State License Board. Existing law imposes specified requirements on home improvement contracts and service and repair contracts and requires contractors to pay subcontractors within a specified period of time. Existing law makes it a misdemeanor for a person to engage in the business or act in the capacity of a contractor without a license and provides certain exemptions from that licensure requirement, including exemptions for owner-builders, as specified. Existing law authorizes the Registrar of Contractors to issue citations for violations of that licensure requirement, as specified.~~

~~This bill would make various technical, nonsubstantive changes to those provisions.~~

~~Under existing law, a person who violates the law by engaging in work as an owner-builder without a contractor's license or an exemption from licensure is prohibited from obtaining a contractor's license for a period of one year following the violation.~~

~~This bill would delete that prohibition.~~

~~Existing law, the Collateral Recovery Act, provides for the licensure and regulation of repossession agencies by the Bureau of Security and Investigative Services under the supervision and control of the Director of Consumer Affairs. The act defines "collateral" as any vehicle, boat, recreational vehicle, motor home, appliance, or other property that is subject to a security agreement. Under the act, a person may be actively in charge of only one repossession office at a time. A violation of the act is a misdemeanor.~~

~~This bill would specify that the act also applies to trailers and would authorize a person to be actively in charge of 2 repossession offices at a time. The bill would prohibit a licensee from appraising the value of any collateral. Because a violation of that prohibition would be a crime, the bill would impose a state-mandated local program.~~

~~Existing law sets forth a procedure for the removal, inventory, and storage of personal effects from repossessed collateral. Existing law allows a debtor to waive the preparation and presentation of an inventory~~

~~in certain circumstances and authorizes a repossession agency to release those personal effects to someone other than the debtor when authorized by the debtor or legal owner. Existing law requires specified special interest license plates that remain the personal effects of the debtor to be removed from the collateral and inventoried and requires the destruction of those plates and notification to the Department of Motor Vehicles if the plates are not claimed by the debtor within 60 days.~~

~~This bill would authorize a debtor to make that waiver only with the consent of the licensee and would authorize the release of personal effects to someone other than the debtor only when authorized by the debtor. The bill would also authorize a licensee to retain those special interest license plates indefinitely for return to the debtor, as specified.~~

~~Existing law provides that whenever possession is taken of any vehicle by or on behalf of any legal owner under the terms of a security agreement or lease agreement, the person taking possession is required to notify specified law enforcement agencies within one hour after taking possession of the vehicle and by the most expeditious means available. Failure to provide that notice is an infraction.~~

~~This bill would require separate notifications for multiple vehicle repossessions. By changing the definition of a crime, the bill would impose a state-mandated local program.~~

~~Existing law, the Funeral Directors and Embalmers Law, provides for the licensure and regulation of embalmers and funeral directors by the Cemetery and Funeral Bureau. Existing law requires an applicant for an embalmer's license to, among other things, have successfully completed a course of instruction in a specified embalming school and to either furnish proof of completion of a high school course or evidence of licensure and practice for a certain period of time prior to application.~~

~~This bill would instead require the applicant to have graduated from a specified mortuary science program and to furnish official transcripts from that program. The bill would make other conforming changes.~~

~~Existing law requires the applicant to pass an examination including specified subjects and requires the bureau to examine applicants at least once annually.~~

~~This bill would require the applicant to pass the sciences section of a specified national examination and an examination on the state's laws and the rules and regulations of the bureau and would delete the requirement that the board examine applicants at least once annually. The bill would, until June 30, 2010, authorize an applicant who failed~~

~~the examination previously administered by the bureau to retake that examination.~~

~~Existing law, the Real Estate Law, provides for the licensure and regulation of real estate brokers and salespersons by the Real Estate Commissioner. Existing law authorizes the commissioner to issue rules and regulations he or she deems necessary to regulate the method of accounting and to accomplish certain purposes related to advance fees, as specified.~~

~~This bill would make certain nonsubstantive, technical changes to those provisions.~~

~~Existing law, the Automotive Repair Act, provides for the registration, licensure, and regulation of automotive repair dealers, lamp and brake adjusting stations, and smog check stations and technicians by the Bureau of Automotive Repair in the Department of Consumer Affairs and requires the Director of Consumer Affairs to validate an automotive repair dealer registration upon receipt of a specified form and fee. Existing law authorizes the director to refuse to validate or invalidate that registration for, among other things, a conviction for providing consideration to insurance agents for referrals. Under existing law, the director may deny, suspend, revoke, or take other disciplinary action against lamp and brake adjusting station or smog check station and technician applicants and licensees for, among other things, the conviction of a crime substantially related to the qualifications, functions, and duties of the licensee.~~

~~This bill would require the director to issue an automotive repair dealer registration upon receipt of a specified form and fee and would authorize the director to deny, suspend, revoke, or place on probation a registration for, among other things, conviction of a crime that is substantially related to the qualifications, functions, or duties of an automotive repair dealer. The bill would also authorize the director to deny, suspend, revoke, or take other disciplinary action against lamp and brake adjusting station and smog check station and technician applicants and licensees for the conviction of a crime substantially related to the qualifications, functions, or duties of that licensee.~~

~~Existing law establishes the vehicle inspection and maintenance (smog check) program, administered by the Department of Consumer Affairs and prescribes certain cost limits for repairs under the program. Existing law requires a smog check station where smog check inspections are performed to post a sign advising customers of those cost limits.~~

~~This bill would instead require the department to provide licensed smog check stations with a sign informing customers about their options when a vehicle fails a smog check inspection, as specified.~~

~~The bill would revise provisions relating to repair assistance agreements and would make other technical, nonsubstantive changes.~~

~~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. State-mandated local program: ~~yes~~ *no*.

The people of the State of California do enact as follows:

SECTION 1. Section 800 of the Business and Professions Code is amended to read:

800. (a) The Medical Board of California, the Board of Psychology, the Dental Board 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, 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, and the Speech-Language Pathology and Audiology 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 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 Section 805.01.

(b) 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.

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.

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) 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.

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.

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.

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

SEC. 2. 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, and the California Board of Podiatric Medicine shall disclose to an inquiring member of the public information regarding any enforcement actions taken against a licensee ~~by either~~ , *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, and the California Board of Podiatric Medicine 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 Specialty 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 that the peer review resulting in the disciplinary action was conducted in bad faith and the licensee notifies the board of that finding. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805. In addition, any exculpatory or explanatory statements submitted by the licentiate electronically pursuant to subdivision (f) of Section 805 shall be disclosed.*

(c) Notwithstanding any other provision of law, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine 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, and the California Board of Podiatric Medicine 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, and the California Board of Podiatric Medicine 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, and the California Board of Podiatric Medicine 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, and the California Board of Podiatric Medicine 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, and the California Board of Podiatric Medicine 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.

SEC. 3. 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 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, to determine whether the 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.

~~(1)~~

(B) "Peer review body" includes:

~~(A)~~

(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.

~~(B)~~

(ii) A health care service plan registered 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.

~~(C)~~

(iii) Any medical, psychological, marriage and family therapy, social work, dental, 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.

~~(D)~~

(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, or dentist. "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113.

(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 ~~of~~ *on which* any of the following ~~that occur~~ *are imposed on a licentiate* 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) ~~The~~ *If a licentiate undertakes 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, staff privileges, or employment 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 ~~shall file an 805 report with the relevant agency within 15 days after any of the following occur after notice of either an impending investigation or the denial or rejection of the application for a medical disciplinary cause or reason~~ *where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges, membership, or employment, or sought the renewal thereof, shall file an 805 report with the relevant agency within 15 days after the licentiate undertakes the action*:

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

(2) ~~The withdrawal or abandonment of a licentiate's application for staff privileges or membership~~ *Withdraws or abandons his or her application for membership, staff privileges, or employment.*

(3) ~~The~~ *Withdraws or abandons his or her* request for renewal of ~~those privileges or membership is withdrawn or abandoned~~ *membership, staff privileges, or employment.*

(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~~ *report.* 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.

(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 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. 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. 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 registered 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.

SEC. 4. Section 805.01 is added to the Business and Professions Code, 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) 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 represent a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon 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 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) Certified medical records.

(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.

SEC. 5. Section 805.1 of the Business and Professions Code is amended to read:

805.1. (a) The Medical Board of California, 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) Certified copy of medical records.

(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. 6. 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, or any health care service plan or medical care foundation, or the medical staff of the institution shall request a report from the Medical Board of California, the Board of Psychology, 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, ~~which is received on or after January 1, 1980,~~ the board shall furnish a copy of any report made pursuant to Section 805 *as well as any additional information submitted electronically to the board by the licensee.* 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, ~~or~~ (3) *if a court finds 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. ~~In the event~~ *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.

~~In the event~~

If that 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. 7. Section 2027 of the Business and Professions Code is amended to read:

2027. (a) ~~On or after July 1, 2001, the~~ *The* board shall post on the Internet the following information in its possession, custody, or control regarding licensed physicians and surgeons:

(1) With regard to the status of the license, whether or not the licensee is in good standing, subject to a temporary restraining order (TRO), subject to an interim suspension order (ISO), or subject to any of the enforcement actions set forth in Section 803.1.

(2) With regard to prior discipline, whether or not the licensee has been subject to discipline by the board or by the board of another state or jurisdiction, as described in Section 803.1.

(3) Any felony convictions reported to the board after January 3, 1991.

(4) All current accusations filed by the Attorney General, including those accusations that are on appeal. For purposes of this paragraph, "current accusation" shall mean an accusation that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an administrative law judge and the Medical Board of California unless an appeal of that decision is pending.

(5) Any malpractice judgment or arbitration award reported to the board after January 1, 1993.

(6) Any hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason. *The posting shall also provide a link to any additional explanatory or exculpatory information submitted electronically by the licentiate.*

(7) Any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed.

(8) Appropriate disclaimers and explanatory statements to accompany the above information, including an explanation of what types of information are not disclosed. These disclaimers and statements shall be developed by the board and shall be adopted by regulation.

(9) Any information required to be disclosed pursuant to Section 803.1.

(b) (1) From January 1, 2003, the information described in paragraphs (1) (other than whether or not the licensee is in good standing), (2), (4), (5), (7), and (9) of subdivision (a) shall remain posted for a period of 10 years from the date the board obtains

possession, custody, or control of the information, and after the end of that period shall be removed from being posted on the board's Internet Web site. Information in the possession, custody, or control of the board prior to January 1, 2003, shall be posted for a period of 10 years from January 1, 2003. Settlement information shall be posted as described in paragraph (2) of subdivision (b) of Section 803.1.

(2) The information described in paragraphs (3) and (6) of subdivision (a) shall not be removed from being posted on the board's Internet Web site. ~~Notwithstanding the provisions of this paragraph~~

(3) Notwithstanding paragraph (2) and except as provided in paragraph (4), if a licensee's hospital staff privileges are restored and the licensee notifies the board of the restoration, the information pertaining to the termination or revocation of those privileges, as described in paragraph (6) of subdivision (a), shall remain posted for a period of 10 years from the restoration date of the privileges, and at the end of that period shall be removed from being posted on the board's Internet Web site.

(4) Notwithstanding paragraph (2), if a court finds that peer review resulting in a hospital disciplinary action was conducted in bad faith and the licensee notifies the board of that finding, the information concerning that hospital disciplinary action posted pursuant to paragraph (6) of subdivision (a) shall be immediately removed from the board's Internet Web site. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(c) The board shall also post on the Internet a fact sheet that explains and provides information on the reporting requirements under Section 805.

~~(c)~~

(d) The board shall provide links to other Web sites on the Internet that provide information on board certifications that meet the requirements of subdivision (b) of Section 651. The board may provide links to other Web sites on the Internet that provide information on health care service plans, health insurers, hospitals, or other facilities. The board may also provide links to any other sites that would provide information on the affiliations of licensed physicians and surgeons.

SEC. 8. This act shall only become operative if Assembly Bill 120 of the 2009–10 Regular Session is also enacted and becomes operative.

All matter omitted in this version of the bill appears in the bill as amended in the Assembly, June 22, 2009. (JR11)

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SB 821

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 821
Author: Committee on Business, Professions, and Economic Development
Bill Date: July 6, 2009, amended
Subject: Omnibus
Sponsor: Committee

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business and Professions Committee. Some provisions, although non-substantive, impact statutes governing the Medical Practices Act.

ANALYSIS:

This bill proposes non-substantive and non-controversial changes to law. The provisions relating to the Medical Board are in the Business and Professions Code and are as follows (only these sections of the bill are attached):

- **805(a)(2)** – Add the category of Special Faculty Permit holders to the definition of "Licentiate."
- **821.5** – Repeal, board no longer needs the reporting coming to the diversion program administrator due to the sunset of the program.
- **821.6** – Repeal, board no longer needs the reporting coming to the diversion program administrator due to the sunset of the program.

FISCAL: None to the Board

POSITION: Support MBC provisions.

July 11, 2009

AMENDED IN ASSEMBLY JULY 6, 2009

AMENDED IN ASSEMBLY JUNE 15, 2009

AMENDED IN SENATE MAY 20, 2009

AMENDED IN SENATE APRIL 30, 2009

AMENDED IN SENATE APRIL 16, 2009

SENATE BILL **No. 821**

Introduced by Committee on Business, Professions and Economic Development (Senators Negrete McLeod (Chair), Aanestad, Corbett, Correa, Florez, Oropeza, Romero, Walters, Wyland, and Yee)

March 10, 2009

An act to amend Sections ~~805,~~ *139, 146, 805, 1632.5, 1634.2, 2493,* 2530.2, 2532.2, 2532.7, 2570.2, 2570.3, 2570.4, 2570.5, 2570.6, 2570.7, 2570.9, 2570.10, 2570.13, 2570.16, 2570.18, 2570.20, 2570.26, 2570.28, 2571, 2872.2, 3357, 3362, 3366, 3456, 3740, 3750.5, 3773, 4101, 4112, 4113, 4160, 4196, *4200.3, 4200.4,* 4510.1, 4933, *4938,* 4980.45, 4980.48, 4982, 4982.2, 4989.22, 4989.54, 4992.1, 4992.3, 4996.23, 4996.28, 4996.5, ~~and 4999.2~~ *4999.2, 5016, 5021, 5022, 5023, 5651, 7028.7, 7044, 7159, 7159.5, 7159.14, 7303.2, 7500.1, 7505.5, 7507.9, 7507.12, 7606, 7616, 7641, 7643, 7646, 7647, 7662, 7665, 7666, 7671, 7725.5, 7729, 9884.2, 9884.7, 9884.12, 9889.3, and 10146* of, to add Sections 2532.25, 2570.17, 4013, 4146, 4989.49, 4992.2, ~~and 4996.24~~ *4996.24, 5515.5, 7044.01, and 7507.115* to, ~~and~~ to repeal Sections ~~821.5 and 821.6~~ *821.5, 821.6, and 6763.1 of, and to repeal and add Section 7108.5 of,* of, the Business and Professions Code, to amend ~~Section~~ *Sections 44014.2, 44017.3, 44072.1, 44072.2, 44095, and* 123105 of the Health and Safety Code, *to amend Sections 28, 5201, and 24603 of*

Medical Board sections on pages 15-20

~~(22)~~

(23) Section 9681.

~~(23)~~

(24) Section 9840.

~~(24)~~

(25) Subdivision (c) of Section 9891.24.

~~(25)~~

(26) Section 19049.

(d) Institutions that are required to register with the Bureau for Private Postsecondary and Vocational Education pursuant to Section 94931 of the Education Code.

(e) Notwithstanding any other provision of law, a violation of any of the sections listed in subdivision (c) or (d), 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 which was the basis for his or her conviction.

~~SECTION 1.~~

SEC. 3. 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) "Peer review body" includes:

(A) 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.

(B) A health care service plan registered 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.

(C) Any medical, psychological, marriage and family therapy, social work, dental, 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.

(D) 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, or dentist. "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 of any of the following that 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) 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 any of the following occur after notice of either an impending investigation or the denial or rejection of the application for a medical disciplinary cause or reason:

(1) Resignation or leave of absence from membership, staff, or employment.

(2) The withdrawal or abandonment of a licentiate's application for staff privileges or membership.

(3) The request for renewal of those privileges or membership is withdrawn or abandoned.

(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 pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report.

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.

(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 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 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. 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. 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 registered 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.

~~SEC. 2.~~

SEC. 4. Section 821.5 of the Business and Professions Code is repealed.

~~SEC. 3.~~

SEC. 5. Section 821.6 of the Business and Professions Code is repealed.

SEC. 6. Section 1632.5 of the Business and Professions Code is amended to read:

1632.5. (a) Prior to implementation of paragraph (2) of subdivision (c) of Section 1632, the department's Office of *Professional* Examination ~~Resources~~ *Services* shall review the Western Regional Examining Board examination to ~~assure~~ *ensure* compliance with the requirements of Section 139 and to certify that the examination process meets those standards. If the department determines that the examination process fails to meet those standards, paragraph (2) of subdivision (c) of Section 1632 shall not be implemented. The review of the Western Regional Examining Board examination shall be conducted during or after the Dental Board of California's occupational analysis scheduled for the 2004–05 fiscal year, but not later than September 30, 2005. However, an applicant who successfully completes the Western Regional Examining Board examination on or after January 1, 2005, shall be deemed to have met the requirements of subdivision (c) of Section 1632 if the department certifies that the Western Regional Examining Board examination meets the standards set forth in this subdivision.

(b) The Western Regional Examining Board examination process shall be regularly reviewed by the department pursuant to Section 139.

(c) The Western Regional Examining Board examination shall meet the mandates of subdivision (a) of Section 12944 of the Government Code.

(d) As part of its next scheduled review by the Joint Committee on Boards, Commissions, and Consumer Protection, the Dental Board of California shall report to that committee and the department on the pass rates of applicants who sat for the Western Regional Examining Board examination, compared with the pass rates of applicants who sat for the state clinical and written

TRACKER II

Medical Board of California
2008 Tracker II - Legislative Bills
7/15/2009

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 52	Portantino	Unbilical Cord Blood Collection Program	Sen. Health	06/24/09
AB 82	Evans	Dependent Children: psychotropic medications	Sen. Approps.	06/25/09
AB 159	Nava	Perinatal Mood and Anxiety Disorders: task force	2-year bill	03/25/09
AB 259	Skinner	Health Care Coverage: certified nurse-midwives: direct access	2-year bill	
AB 361	Lowenthal	Workers' Compensation: treatment authorization	Sen. Floor (#163)	06/16/09
AB 417	Beall	Medi-Cal Drug Treatment Program: buprenorphine	Sen. Approps.	05/19/09
AB 445	Salas	Use of X-ray Equipment: prohibition: exemptions	2-year bill	
AB 452	Yamada	In-home Supportive Services: CA Independence Act of 2009	2-year bill	
AB 456	Emmerson	State Agencies: period review	Sen. B&P	05/28/09
AB 497	Block	Vehicles: HOV lanes: used by physicians	Sen. T&H	05/14/09
AB 520	Carter	Public Records: limiting requests	2-year bill	
AB 542	Feuer	Adverse Medical Events: expanding reporting	Sen. Health	06/18/09
AB 602	Price	Dispensing Opticians	Sen. Rules	06/18/09
AB 657	Hernandez	Health Professions Workforce: task force	Sen. Approps. (7/20)	06/02/09
AB 681	Hernandez	Confidentiality of Medical Information: psychotherapy	Enrolled	06/23/09
AB 721	Nava	Physical Therapists: scope of practice	2-year bill	04/13/09
AB 830	Cook	Drugs and Devices	Sen. Health (7/15)	07/06/09
AB 832	Jones	Ambulatory surgical clinics: workgroup	2-year bill	05/05/09
AB 834	Solorio	Health Care Practitioners: peer review	2-year bill	04/14/09
AB 867	Nava	California State University: Doctor of Nursing Practice Degree	Sen. Ed. (7/15)	04/14/09
AB 877	Emmerson	Healing Arts: DCA Director to appoint committee	2-year bill	04/14/09
AB 931	Fletcher	Emergency Supplies: increase amount	Sen. Floor (#272)	06/17/09
AB 950	Hernandez	Hospice Providers: licensed hospice facilities	Sen. Health	06/02/09
AB 977	Skinner	Pharmacists: immunization protocols with physicians	2-year bill	04/23/09
AB 1005	Block	CA Board of Accountancy: live broadcast of board meetings	Sen. Approps.	07/08/09

Medical Board of California
2008 Tracker II - Legislative Bills
7/15/2009

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1083	Perez	Health Facilities: security plans	Sen. Floor (#10)	06/17/09
AB 1094	Conway	Disposal of Personal Information	Enrolled	06/30/09
AB 1113	Lowenthal	Prisoners: professional mental health providers: MFTs	Sen. Floor (#176)	05/14/09
AB 1140	Niello	Healing Arts (spot)	Sen. Health (7/15)	04/14/09
AB 1152	Anderson	Professional Corporations: licensed physical therapists	Sen. B&P	07/08/09
AB 1162	Carter	Health Facilities: licensure	2-year bill	
AB 1168	Carter	Professions and Vocations (spot)	2-year bill	
AB 1194	Strickland	State Agency Internet Web Sites: information	2-year bill	
AB 1317	Block	Assisted Oocute Production: advertisment	Sen. Floor (#193)	07/06/09
AB 1458	Davis	Drugs: adverse effects: reporting	2-year bill	05/05/09
AB 1478	Ammiano	Written Acknowledgment: medical nutrition therapy	2-year bill	
AB 1518	Anderson	State Government: Boards, Commissions, Committees, repeal	2-year bill	05/11/09
AB 1540	Health Comm.	Health	Sen. Approps.	07/02/09
AB 1542	Health Comm.	Medical Records: centralized location	Sen. Health	07/01/09
AB 1544	Health Comm.	Health Facilities: licensure	Sen. Health (7/15)	
SB 26	Simitian	Home-generated Pharmaceutical Waste	2-year bill	04/15/09
SB 33	Correa	Marriage and Family Therapy: licensure and registration	Sen. Floor (#73)	06/08/09
SB 39	Benoit	Torts: personal liability immunity	Sen. Floor (#275)	06/26/09
SB 58	Aanestad	Physicians and Surgeons: peer review	2-year bill	05/19/09
SB 92	Aanestad	Health care reform	2-year bill	03/11/09
SB 112	Oropeza	Hemodialysis Technicians	Asm. Floor (#118)	06/03/09
SB 158	Wiggins	Health Care Coverage: human papillomavirus vaccination	Asm. Approps. (susp.)	06/17/09
SB 171	Pavley	Certified Employees: physician assistants: medical certificates	Sen. Floor (#278)	06/17/09
SB 186	DeSaulnier	Workers' Compensation: treatment: predesignationof physician	Asm. Floor (#116)	

Medical Board of California
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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 238	Calderon	Medical Information: prescription refil requirements	2-year bill	04/23/09
SB 294	Negete McLeod	Nurse Practitioners	Asm. Approps. (7/15)	07/01/09
SB 303	Alquist	Nursing Facility Residents: informed consent	Asm. Approps.	07/07/09
SB 341	DeSaulnier	Pharmaceuticals: adverse drug reactions	2-year bill	05/14/09
SB 368	Maldonado	Confidential Medical Information: unlawful disclsure	2-year bill	04/01/09
SB 374	Calderon	Health Care Providers: resonable disclosure: reproductive choices	Asm. Approps. (7/15)	06/24/09
SB 395	Wyland	Medical Practice	2-year bill	
SB 442	Ducheny	Clinic Corporation: licensing	2-year bill	05/06/09
SB 482	Padilla	Healing Arts: Medical Practice	2-year bill	04/14/09
SB 484	Wright	Ephedrine and Pseudoephedrine: classification as Schedule V	Asm. Approps.	05/12/09
SB 502	Walters	State Agency Web Sites: information posting: expenditures	2-year bill	
SB 599	Negrete McLeod	Licensing Boards: disciplinary actions: posting	Asm. Approps.	07/09/09
SB 606	Ducheny	Physicians and Surgeons: loan repayment	Asm. Approps.	06/18/09
SB 620	Wiggins	Healing Arts: osteopaths	Asm. Floor (#122)	06/23/09
SB 630	Steinberg	Health Care Coverage: reconstructive surgery: dental	Asm. Approps.	06/22/09
SB 638	Negrete McLeod	Regulatory boards: operations	2-year bill	
SB 700	Negrete McLeod	Healing Arts: peer review	2-year bill	05/20/09
SB 719	Huff	State Agency Internet Web Sites: information searchability	2-year bill	
SB 743	Health Comm.	Health Facilities: psychiatric patient release	Sen. Floor (#71)	06/01/09
SB 744	Strickland	Clinical Laboratories: public health labs	Asm. Approps.	07/14/09
SB 761	Aanestad	Health Manpower Pilot Projects	Asm. Health	05/06/09
SB 762	Aanestad	Professions and Vocations: healing arts	Chaptered #16	05/05/09
SB 788	Wyland	Licensed Professional Clinical Counselors	Asm. Approps.	06/22/09
SB 810	Leno	Single-Payer Health Care Coverage	2-year bill	04/23/09
SJR 14	Leno	Medical Marijuana	Sen. Health (7/15)	
SJR 15	Leno	Public Health Laboratories	Sen. Health (7/15)	