MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

Executive Office
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815-5401
Phone: (916) 263-2382
Fax: (916) 263-2944
www.mbc.ca.gov

Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

April 30, 2021

Via Email Delivery

Senator Richard D. Roth, Chair
Senate Committee on Business, Professions and Economic Development
State Capitol, Room 2053
Sacramento, CA 95814

Assemblymember Evan Low, Chair
Assembly Committee on Business & Professions
1020 N Street, Room 379
Sacramento, CA 95814

Dear Senator Roth and Assemblymember Low:

Thank you for the opportunity to respond to questions and comments posed during the Medical Board of California's (Board) Joint Sunset Review Hearing (Joint Hearing) held on March 19, 2021. In addition, on behalf of the Board, and in conjunction with Board's Vice-President and executive staff, I am pleased to provide the attached additional responses to the various issues discussed in the Joint Hearing background paper.

The Board is dedicated to its mission of consumer protection and takes seriously the concerns raised by the Legislature, consumers, patient advocates, and licensees. As important context for our detailed responses, we wish to provide background on the Board's programs and procedures.

Overview of the Board and its Disciplinary Process

The Board's mission, and highest priority[1], is to protect consumers and it takes that mission very seriously. In addition, the law requires the Board, whenever possible, to take action calculated to aid in the rehabilitation[2] of the licensee or to order other restrictions as indicated by the evidence. Where physician rehabilitation and protection of the public are inconsistent, public protection is paramount.

The Board uses its Manual of Model Disciplinary Orders and Guidelines[3] (Disciplinary Guidelines) to determine the appropriate discipline based upon the charges in the accusation and relevant evidence. Every disciplinary decision of the Board takes into account multiple factors including aggravating and mitigating circumstances, the ability to meet the Board's

[1] See Business and Professions Code (BPC) Section 2229.
[2] Ibid.
[3] See Board website: https://www.mbc.ca.gov/Download/Documents/disciplinary-guidelines.pdf.

burden of proof (clear and convincing evidence to a reasonable certainty[4]), and the relevant facts of the individual case.

Each disciplinary decision of the Board is tailored to the unique facts and circumstances of that case. If the Board imposes a level of discipline or a term or condition not supported by the evidence, then the physician may seek a writ in superior court pursuant to Government Code section 11523, and have the decision vacated. If the physician is successful, the Board may be ordered to pay the physician's costs and the imposition of discipline may be delayed or denied.

How the Board Investigates Complaints

All complaints receive an initial review and are triaged by the Board. Complaints involving sexual misconduct, physician impairment – either mental or physical – or substance abuse, or another urgent matter are referred to the Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit (HQIU) for investigation.

Complaints are closed at various stages for a variety of reasons, including when no violation is found, the complaint involves circumstances outside the Board's jurisdiction, or there was insufficient evidence identified. In addition, complaints may be closed because they are redundant (i.e. the Board received multiple complaints on the same licensee) or because a statute of limitations precludes filing an accusation.

In complaints involving quality of care, the Board's Central Complaint Unit gathers medical records and other documents and sends them to a medical consultant, who is a physician practicing in the same specialty as the physician subject to investigation. The medical consultant reviews the medical records and determines whether a departure from the standard of care may have occurred. If the consultant determines a possible violation of the standard of care occurred, the matter is referred to the Division of Investigation's Health Quality Investigation (HQIU) within the Department of Consumer Affairs for a field investigation.

A typical investigation by HQIU includes interviewing witnesses and the subject physician, obtaining medical records and other pertinent documents and in some cases, the investigator may go undercover to gather information for the investigation. Once the investigation is nearing completion, the matter is sent to an expert reviewer from the same specialty area of practice as the subject. The expert will review the case and determine if departures from the standard of care occurred. If departures are identified, or violations of the Medical Practice Act are found, the matter may be sent to the Attorney General's (AG) Office for review and consideration of filing an accusation.

If the assigned Deputy Attorney General (DAG) finds that the investigation yielded sufficient evidence to prove that a violation of the Medical Practice Act occurred, the DAG will prepare an accusation. The AG's Office represents the Board's executive director, who is the complainant who signs the accusation against the physician's license.

[4] See *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856.

The law requires the Board to prove its case to the standard of "clear and convincing evidence to a reasonable certainty." This is a higher standard than is required for civil litigation cases. If the investigation does not support this standard of proof, then the complaint must be closed, or, where supported by sufficient evidence, referred for a citation and fine.

Once an accusation has been filed, the physician has 15 days to file a Notice of Defense and request an administrative hearing in front of an Administrative Law Judge (ALJ). Prior to a possible hearing, a settlement conference is typically scheduled by the ALJ and involves confidential settlement discussions between the DAG, the physician and/or their attorney, and an ALJ[5]. If a settlement can be reached that contains sufficient consumer protection, it is presented to the Board and the Board can then either adopt the settlement, reject the settlement and request another outcome (such as stronger discipline terms), or lessen the discipline and accept it.

If the DAG and the physician cannot come to a settlement agreement, or the Board members vote to reject the settlement, the matter proceeds to a hearing in front of an ALJ who hears the case, including all of the evidence from both parties. The ALJ then drafts a proposed decision for presentation to the Board members. The Board members may adopt the decision as is, reduce the discipline, non-adopt the decision, or remand the matter back to the ALJ to take additional evidence.[6] After an order is imposed, the physician has the right to appeal the decision all the way to the California Supreme Court.

Benefits of Settling a Case

Settlements are a tool that the Board uses to discipline physicians in an expeditious manner, while also meeting its consumer protection mandate. In some cases, the Board's investigation into any given complaint does not meet the burden of proof of "clear and convincing evidence to a reasonable certainty," yet the Board's investigation has yielded some evidence that a violation has occurred.

Although the Board may be unable to prove its case before an ALJ, the settlement process allows the Board to take meaningful consumer protection steps and take discipline against a physician, thereby benefiting consumers.

Ultimately, the Board members make the determination to approve a proposed settlement. If the Board members believe that a settlement reached between the DAG and the physician is not appropriate or in the best interest of consumers, the Board members may vote to non-adopt the decision and order a hearing before an ALJ.

Communication with Complainants

The Board communicates with complainants at various stages of the process. At the initial stages, the Board reviews the complaint and initial documentation received and requests authorization to obtain medical records from the complainant. If necessary, the Board

[5] See Government Code section 11511.7.
[6] See Government Code section 11517.

reaches out to complainants to get additional information about their complaint. At this stage of the enforcement process, staff assigned to do triage and gather information are analysts seeking to obtain documentation from each complainant in their own words along with the patient's medical records.

The medical consultant assigned to review a case looks at it in its entirety and is not restricted solely to what is stated in the complaint. Once the complaint has advanced to the stage of formal investigation, complainants are contacted for an interview by a trained investigator. The Board is always looking for ways to improve its communication with complainants while protecting the confidentiality of the complaint and investigation processes.

Initiation of Complaints by the Board

Complaints come to the Board in a variety of ways. The largest number of complaints are brought by members of the public (patients/next of kin), healthcare professionals, and other care providers.

Complaints also come to the Board through legally-mandated reports. In Fiscal Year (FY) 2019-2020, 542 reports were made to the Board in the medical malpractice area and 270 reports for all other areas. Beginning January 1, 2020, the Board began receiving reports of alleged sexual abuse/misconduct that occurred in healthcare facilities.

Finally, the Board is empowered to initiate complaints on its own. It opened 353 such complaints in FY 18/19 and 300 such complaints in FY 19/20. These complaints are based on information obtained by the Board from various sources, including media reports and information obtained from other Board investigations.

<u>Answers to Questions from the March 19, 2021 Joint Hearing</u>

Q: What is the timeframe and process from investigation completion to stipulated settlement?
A: Per the investigation and disciplinary process outlined, the below chart provides the average time it takes to impose discipline against a physician and surgeon via a stipulated settlement following the completion of an investigation:

Fiscal Year	Average Time from Completion of Investigation to Discipline Imposed as a Result of a Stipulated Settlement
18/19	456 Days
19/20	472 Days

Q: In reference to a certain 2011 pediatrician case, a newspaper article from 2/19/21 stated an MBC accusation was filed by the AGO to revoke their license. Why was there a delay, what took so long?
A: This is an open and active matter where an accusation is currently pending. Consequently, it is not appropriate for the Board to comment on this case at this time. Generally speaking, Business and Professions Code section 800(c) indicates that the contents of a licensee's central file are confidential except to the licensee and their attorney.

Q: In the last fiscal year, what percentage of cases that resulted in stipulated settlements for enforcement matters were the disciplinary guidelines followed?
A: Of 282 stipulated settlements, 131 or approximately 46 percent adhered to all elements recommended by the disciplinary guidelines.

Q: What percentage of all stipulated settlements involved public reprimand as a penalty?
A: The total number of stipulated settlements for FY 2019-20 is 303 and the number of stipulated settlements that resulted in a public reprimand was 80. Therefore, 26 percent of stipulated settlements ended in a public reprimand. The Board also has public letters of reprimand but they are issued prior to filing an accusation and are not included in this figure.

Q: What is the number of probation violation cases that result in license revocation vs not revoked?
A: Please see the below table that describes probation violation outcomes during the prior two fiscal years:

Probation Violation Outcomes	FY 2018-19	FY 2019-20
License Revoked	11	7
License Surrendered	10	7
Additional Suspension and Probation	1	0
Additional Probation	5	14
Public Reprimand	0	1
Petition Withdrawn	4	1

Q: How many Board-initiated inquiries on physician misconduct, without prior complaints received, were opened in the last two fiscal years?
A: Please see the below table:

Fiscal Year	Complaints opened by Board staff
18/19	353
19/20	300

Q: How many times are settlements accepted vs changed or rejected?
A: In a review of all approved stipulated settlements in FY 2019-20, 299 of 303 stipulated settlements were approved without any changes.

Q: What percentage of complaints goes to a medical consultant while in CCU?
A: Please see the following table relating to medical consultant review of complaints against physicians and surgeons:

Fiscal Year	Complaints Received	Complaints Referred for Medical Consultant Review	Percentage of Complaints Received Referred for Medical Consultant Review
FY 18/19	11,407	1,972	17%
FY 19/20	10,868	2,596	24%

Q: How many medical experts are there for each specialty?
A: The Board has 602 medical experts who have expertise in 626 specialties and sub-specialties.

Q: Is the probation monitor's information public, and how does the public find out who a probation monitor is for a physician?
A: The MBC staff that is in charge of monitoring the subject's probation status is not confidential and is available upon request.

Q: What percentage of complainants are enrolled in Medi-Cal or other types of health insurance?
A: The Board does not track this information.

Thank you for the opportunity to provide this additional information. I hope it proves helpful as the Legislature continues with the Board's Sunset Review process.

Sincerely,

Kristina D. Lawson, J.D.
President, Medical Board of California

Attachments

Cc: Members, Senate Committee on Business, Professions, and Economic Development
Members, Assembly Committee on Business & Professions
Members, Medical Board of California

ISSUE #1: (BOARD COMPOSITION.) Does MBC's composition need to be updated to include additional members of the public?

Staff Recommendation*:* The Committees may wish to amend the Act to add two additional members of the public to MBC, one appointed by the Senate Committee on Rules, and one appointed by the Speaker of the Assembly, to establish a public majority membership*.*

Board Response (April 2021):

The Medical Board of California (Board) has not considered a possible change to its composition.

ISSUE #2: (REGULATIONS.) What is the current timeframe for MBC regulatory packages to be approved and finalized?

Staff Recommendation: MBC should provide the Committees with an update on pending regulations and the current timeframes for regulatory packages. In addition, the MBC should inform the Committees of any achieved efficiencies in promulgating regulations in recent years.

Board Response (April 2021):

When first instituted, the change in the process requiring proposed rulemaking files to be pre-reviewed and approved by the Department of Consumer Affairs (DCA) and the Business, Consumer Services, and Housing Agency (BCSH) before submission to the Office of Administrative Law (OAL), posed certain challenges that have now largely been alleviated.

The Regulations Unit within DCA provides helpful and timely assistance with rulemaking files, as well as useful training, and the development of more streamlined processes. While the pre-review requirement does delay the rulemaking process, DCA has taken meaningful steps to reduce this delay, and the staff in the Regulations Unit have been providing quality collaboration on rulemaking files. Recent delays in moving regulatory packages are attributable, in part, to significant changes in Board staffing.

The Board has a number of pending regulations in different phases of development, and is pleased to report that the regulatory amendments required by Assembly Bill (AB) 2138 (Chiu, Chapter 995, Statutes of 2018), were approved by OAL and became effective on January 21, 2021.

The Board has attached a table of recently approved and pending regulations showing the timeframes as Appendix 1.

ISSUE #3: (DATA SHARING.) Data collected by other state agencies impacts MBC's knowledge of its licensee population. MBC is supposed to receive data from a number of state agencies yet does not always receive the information necessary for MBC to do its job. What is the status of MBC's efforts to obtain important data from other state agencies?

Staff Recommendation: MBC should inform the Committees on the status of DUAs and whether information is being properly shared across agencies, particularly information that could allow MBC to determine whether its enforcement actions are appropriate, necessary, or require updates based on trends gauged through data.

Board Response (April 2021): In 2015 the Board partnered with the California Department of Public Health (CDPH) and a contract was established that would allow CDPH to share data of death certificates that were possibly related to prescription drug use and opioid deaths with MBC. In late 2015, MBC received data from 2012 and 2013 where the cause of death was an opioid. This helped establish the Board's proactive enforcement program, which at the time was called the Death Certificate Project, now known as the Prescription Review Program. In November of 2020, the Board received its second data set for deaths that occurred in 2019.

The Board is also working with CDPH to monitor the issuance of medical exemptions for vaccination, as required by Health and Safety Code section 120372.

Finally, the Board is still working with the Department of Social Services and the State Department of Health Care Services on processes for investigating the possible inappropriate prescribing of psychotropic medications to foster children pursuant to BPC section 2245.

ISSUE #4: (RESEARCH PSYCHOANALYST REGISTRATION.) As noted previously, MBC registers Research Psychoanalysts (RPs), individuals who practice psychoanalysis for fees for no more than one third of the individual's total professional time (which includes time spent in practice, teaching, training or research). Why does MBC administer the RP registration program rather than the Board of Psychology which oversees those practicing in psychology and has experience administering registration programs?

Staff Recommendation: In coordination with the Board of Psychology, MBC should advise the Committees as to why RPs are under the jurisdiction of the MBC rather than the Board of Psychology. The Committees may wish to transfer registration of RPs to the Board of Psychology, which already successfully administers registration programs for individuals practicing psychology.

Board Response (April 2021):

In 1977, when the Research Psychoanalysts (RP) were established in law, the Board, then the Board of Medical Quality Assurance, was comprised of three sections: the Division of Medical Quality, the Division of Licensing, and the Division of Allied Health Professions. The Division of Allied Health Professions regulated several allied health professions, including psychologists. In 1990, when the Board of Psychology (BOP) came into existence, the RPs remained under the Board's oversight while all other psychology professions moved under the BOP.

SB 798 originally included language to transfer the regulatory authority of RPs from the Board to BOP, however, this proposal was met with opposition from psychoanalytic institutions approved by the Board. The main arguments against the move were rooted in the contentious history between psychologists and psychoanalysts and the concern that members of the BOP would not fairly evaluate psychoanalytic institutions, which is an oversight function currently carried out by the Board under BPC section 2529. Due to opposition from psychoanalytic institutes and RPs, this language was removed from SB 798 and RPs have remained under the authority of the Board.

BOP possesses the appropriate resources and expertise to regulate RPs, which is a specialty of psychology. If approved by the Legislature, the Board looks forward to collaborating with BOP to transition this profession to their jurisdiction.

ISSUE #5: (PHYSICIAN HEALTH AND WELLNESS PROGRAM.) MBC is implementing a Physician Health and Wellness Program. MBC's prior program faced significant shortfalls and raised concerns about patient protection. How will MBC ensure the program will successfully assist physicians while ensuring there is no harm to patients?

Staff Recommendation: MBC should update the Committees on the implementation of a PHWP, including the current status of regulations.

Board Response (April 2021):

The Board submitted its Initial draft regulations for the PHWP to DCA for review in April 2018. Following the submission of the draft regulations to DCA, the Substance Abuse Coordination Committee (SACC) of DCA met as required by SB 796 (Hill, Chapter 600, Statutes of 2017) and approved some changes to the Uniform Standards. This development, along with other factors, caused Board staff to reconsider the format of the draft PHWP regulations. When the SACC formally changes the Uniform Standards, the Board will be required to go through the rulemaking process to amend its own Uniform Standards set forth its regulations. If the requirements were repeated in both the Board's Uniform Standards and the PHWP regulations, then changes to multiple regulatory sections would likely be necessary every time the SACC changed the Uniform Standards, thereby causing inefficiency. Consequently, Board staff redrafted the proposed PHWP regulations to avoid this inefficiency, and the Board approved the

amended rulemaking language on November 18, 2019. Board staff is working with DCA Regulations Unit on the economic and fiscal impacts in preparation of resubmitting the rulemaking file to begin the review process.

ISSUE #6: (MENTAL HEALTH SERVICES FOR COVID-19 PROVIDERS.) Under ordinary circumstances, frontline healthcare providers and first responders often face difficult situations that are mentally and emotionally challenging. Are there new issues arising from, or ongoing issues being worsened by, the extreme conditions of the COVID-19 pandemic?

Staff Recommendation: MBC should discuss any findings related to the mental and behavioral healthcare needs of frontline healthcare providers arising from the COVID-19 pandemic.

Board Response (April 2021):

While the Board has not made any findings related to the mental and behavioral healthcare needs of the frontline healthcare providers arising from the COVID-19 pandemic, the Board is aware, anecdotally, of the tremendous challenges faced by providers during the pandemic. The Board would not be aware of any mental or behavioral healthcare needs of applicants unless they disclose it as a condition that impairs their ability to practice safely on their license application form, or if this information is discovered through the course of an investigation. Even in these situations, the Board may or may not know the impact of the pandemic on an individual's mental or behavioral health.

DCA waivers have helped ease regulatory requirements on applicants and licensees during the pandemic, such as extending the deadline to obtain a PTL and postponing the CME requirement for renewal of a license.

ISSUE #7: (LICENSED MIDWIVES.) MBC regulates licensed midwives but regulations to allow LMs to practice independently have stalled. What is the status of LM independent practice authority and what changes may be necessary to achieve the Legislature's intent?

Staff Recommendation: MBC should describe the impacts of creating a new, standalone board for a small licensing population, including costs that would be necessary to establish a LM board. MBC should inform the Committees of the benefit to patients that this proposal would result in.

Board Response (April 2021):

In FY 2020/21, the Midwifery fund had a $120,000 budget and Shared Service expenses of $160,748 in FY 2020/21. In FY 2019/20, the Midwifery fund had a total

revenue of $71,936. Current LM revenue is not sufficient to cover these expenses, therefore an increase is likely necessary whether they remain under the Board or are regulated in a new LM board. The appropriate fee amount to address the costs of a stand-alone LM board has not been determined by the Board, however, the Board is seeking an initial license fee amount of $450 and a renewal fee amount of $300 (50 percent increase compared to current amount).

The Board has been diligent in its licensing and disciplinary responsibilities and pursuing its mission with regard to consumers of LM services. A new LM board would also be able to handle these functions, thereby, at minimum, extending existing consumer protections. The Board has not studied what additional benefits there may be to patients if the Legislature approves the creation of an LM board.

ISSUE #8: (COST RECOVERY.) Current law prohibits MBC from seeking reimbursement from physicians for costs related to disciplinary action. This provision only applies to physicians and MBC still has the ability to seek cost recovery for other allied health professionals it may take disciplinary action against. In general, DCA boards are authorized to collect payment from licensees for the high costs a board pays related to disciplinary action, as investigation and prosecution charges significantly affect both fund conditions and case adjudication. Should MBC once again be authorized to seek cost recovery from physicians for disciplinary action?

Staff Recommendation: The Committees may wish to again provide MBC with cost recovery authority.

Board Response (April 2021):

In its Sunset Report, the Board requested that the Legislature restore its authority to seek cost recovery from physicians for the reasonable investigation and enforcement expenses of the case. While the Board does not expect that restoring cost recovery against physicians will lead to a significant increase in revenue, the Board believes that reauthorizing this tool may help the Board recoup a portion of its investigation costs. Further, this may provide an incentive for certain physicians to settle their case, thereby avoiding the costs associated with an administrative hearing.

ISSUE #9: (FUND CONDITION AND FEES.) MBC has not updated fees for 12 years and is now facing insolvency. Should fees be raised? Should minimum fee amounts be established in the Act?

Staff Recommendation: MBC clearly needs additional revenue to support its activities. MBC should provide an update on the status of discussions with licensees and the Department of Finance to assist the Legislature in charting a course forward that allows MBC to have resources to conduct its important work.

Board Response (April 2021):

Due to the Board's efforts to control spending through cost savings measures implemented by its divisions, temporary spending reductions due to the COVID-19 pandemic (e.g. staff salary reductions, travel limitations) and increased licensing fee revenue, the Board's fund balance is estimated to show marginal improvement over previous estimate.

These savings measures, however, are not sufficient to avoid the need for a fee increase. For example, Board staff continue to find ways to streamline and automate tasks, lessen the reliance on paper, and control certain Board expenses. Unfortunately, various external cost drivers surrounding the Board's enforcement program (e.g. Health Quality Investigation Unit (HQIU), Attorney General's Office (AGO), and hearing expenses related to the Office of Administrative Law) are outside the Board's direct control.

Therefore, a fee increase is necessary to ensure that the Board has the financial resources to protect the public while ensuring qualified medical professionals are available to California consumers. In recent months, as the Board has discussed its financial position, various stakeholders have expressed agreement with the need for increased revenue.

The Board understands that the size of the proposed fee increase may be a concern to some. To help mitigate the need for further large fee increases in future years, the Board is seeking to eliminate the requirement that it maintain a reserve amount of between two and four months. Instead, the Board seeks to have authority to have up to a 24 month reserve, in line with many other boards, per BPC 128.5. In addition, the Board is also seeking authority to add a modest future fee increase, through the rulemaking process, by up to an additional 10 percent.

These changes, combined with clear authority to decrease its fees when circumstances warrant, will better position the Board to actively manage its finances.

ISSUE #10: (LICENSING TIMEFRAMES.) MBC is processing more applications and processing times are growing. What is the impact of licensing delays on the profession and the public, and what steps is MBC taking to achieve efficiencies?

Staff Recommendation: MBC should provide an update on licensing and provide the Committees with suggestions to increase efficiencies and ensure physicians and surgeons are licensed expeditiously, including necessary amendments to the Act.

Board Response (April 2021):

The Board's current application processing timeframes are consistent with the Board's regulatory requirements of 60 working days, and are consistent with the Board's

expectation of reviewing new applications within 30 days of receipt. Licensing timeframes are not growing and have remained consistent since January 2021.

Shortly after the post-graduate training license (PTL) requirements took effect on January 1, 2020, the Board received an abnormally high number of new licensing applications, which coincided with the onset of the COVID-19 pandemic. While application processing times doubled in the second quarter of 2020, the MBC implemented staff overtime, changed some business processes to accommodate a telecommuting workforce, and heavily promoted and expanded its new Direct Online Certification Submission (DOCS) portal to allow the electronic submittal of application documents. Subsequently, application processing times began to decline by the end of October 2020 and returned to the standard 30-day average by January 2021.

The MBC Licensing Program is currently reviewing and mapping its business processes with the assistance of DCA's Organizational Improvement Office to identify efficiencies, reduce its reliance on paper-based processes, and improve the quality and efficiency of the Licensing Program. This endeavor is expected to improve the quality of the application review process and the Board's accountability to applicants, licensees, and consumers.

At its February 2021 meeting, the Board approved the Application Review and Special Program Committee's (ARSPC) recommendation to delegate Board staff the authority to grant extensions to PTL holders, pursuant to BPC section 2065(g). According to BPC section 2064.5(b), a PTL is valid up to 90 days after completion of 36 months of board-approved postgraduate training if the PTL holder is enrolled in an approved postgraduate training program. If a PTL holder does not obtain a physician's and surgeon's license by the end of 39 months, then the licensee must cease all clinical practice in California. BPC section 2065(g) states, "Upon review of supporting documentation, the board, in its discretion, may grant an extension beyond 39 months to a postgraduate training licensee to successfully complete the 36 months of required approved postgraduate training." In order to successfully complete 36 months of required approved postgraduate training to be licensed in California, this must include completing 24 months in the same program. Some applicants are not able to complete 24 months in the same program due to personal hardship or the closure of their program (which is beyond their control).

With the Board's delegation of authority, Board staff may now extend PTLs beyond 39 months after review of supporting documentation without requiring approval by the ARSPC for applicants in this situation. This has greatly decreased the amount of time for the Board to extend PTLs beyond the 39 months under BPC section 2065(g), thus preventing an unnecessary lapse in the resident's training and provision of services.

ISSUE #11: (POSTGRADUATE TRAINING LICENSE.) MBC now requires physicians to complete three years postgraduate training in order to be licensed, but issues a

postgraduate training license with full practice authority within the resident's training program and affiliated institutions, or as otherwise permitted in writing by the program director. What is the status of MBC's implementation of a postgraduate training license?

Staff Recommendation: MBC should advise the Committees on recent discussions with other agencies that impact the ability of PTL holders to fully practice. The Committees may wish to make changes to the Act in order to create efficiencies in the PTL licensing process. MBC should provide an update on discussions with stakeholders about continued barriers to practicing, allegations of program directors rejecting PTL holders' requests to practice at different facilities, and what steps need to be taken to ensure California patients receive access to quality care provided by residency program participants holding a PTL.

Board Response (April 2021):

MBC continues to engage with stakeholders regarding the issues impacting PTL holders and their ability to provide services. After communicating with stakeholders, the California Department of Public Health (CDPH) updated its registration procedures to authorize PTL holders to certify death certificates and notified appropriate entities regarding the revised registration procedure. CDPH also clarified that it currently registers birth certificates attended by PTL holders and subsequently sent a reminder of this fact to appropriate entities to prevent any inconsistencies or delays in the registration of birth certificates.

MBC continues to work with stakeholders on resolving other pending issues, such as the ability of PTL holders to bill for Medi-Cal services when moonlighting, their ability to obtain a DEA X-waiver, and specialty boards' updated leave policies that allow additional time off from residency programs without making up the training hours.

MBC participated in meetings with the California Department of Healthcare Services (DHCS), the California Academy of Family Physicians (CAFP), and the California Primary Care Association (CPCA) regarding the PTL moonlighting issue. However, the DHCS conveyed that the proposed changes would not resolve the PTL holders' inability to bill for Medi-Cal services when moonlighting, as state Medi-Cal billing policies are based on federal law.

Prior to the law change, residents could not moonlight and bill for Medi-Cal services without a Physician's and Surgeon's License, which could be obtained after completing one to two years of postgraduate training, depending on whether the resident was a U.S./Canadian graduate or an international medical graduate. A PTL holder is authorized to moonlight without any previous postgraduate training, which technically expands the allowable timeframe in which a resident may moonlight while enrolled in a California postgraduate training program, as previous to this law change a resident was required to complete at least one year of postgraduate training before obtaining the license necessary to moonlight. The new law effective January 1, 2020, only changed the type of license required to moonlight, but the actual practice of a California resident

did not change. The MBC believes it would be in the interest of California patients to examine why the state's Medi-Cal laws are impacting the same population of California residents differently with the implementation of the PTL when the PTL did not further restrict who is permitted to moonlight and whether other states with a similar training license requirement are also restricted by federal Medicaid requirements when moonlighting.

The MBC also met with the CAFP, the CPCA, and the CMA to discuss the CAFP's change in leave policy that allows a resident up to twelve weeks of leave in a given academic year without requiring an extension of training. BPC section 2065(e) requires at least 36 months of approved postgraduate training to qualify for a Physician's and Surgeon's license. Therefore, a resident that takes up to twelve weeks of leave in a given academic year under CAFP's new leave policy may not meet the 36-months of approved postgraduate training requirement. The MBC continues to discuss this issue with its stakeholders to find a resolution, including the possibility of a legislative change.

The MBC has met with the Substance Abuse and Mental Health Services Administration (SAMHSA) to discuss a PTL holder's inability to obtain a DEA x-waiver to prescribe buprenorphine and has followed up on these discussions on numerous occasions, but unfortunately the MBC has been unsuccessful in obtaining a response from SAMHSA to continue the discussion and obtain resolution.

ISSUE #12: (MEXICO PILOT PROGRAM.) Legislation passed in 2002 established a pilot program aimed at addressing primary care and dental practitioner shortages by authorizing MBC and the Dental Board of California to issue licenses for three years to physicians and dentists from Mexico who meet specified criteria. The program has not been fully implemented. What are the barriers to MBC implementing this program? What steps has MBC taken since 2003 to put the program in place?

Staff Recommendation: MBC should update the Committees on the status of The Licensed Physicians and Dentists Program, including remaining barriers to implementation and funding options. MBC should advise the Committees of statutory changes necessary to the Act in order for the program to be implemented.

Board Response (April 2021):

Although AB 1045 became effective in 2003, the law requires any funding necessary for the program, including the evaluation and oversight functions, to be secured from nonprofit, philanthropic sources. The law prohibited implementation of the program from proceeding until the appropriate funding was secured. The first installment of funding was deposited in November 2017, and the final necessary commitment letter was received on November 10, 2020.

The Board is prepared to issue licenses to the physicians who met the requirements earlier this year, but was asked by those applicants to delay issuing their licenses

pending submittal of their visa applications. Currently, out of a total of 25 applicants, 20 applicants are ready to be issued a license. The MBC is working with the five remaining applicants on their outstanding application deficiencies. The Board is in the final stages of filling the vacant MPP staff position.

The interagency agreement with UC Davis to conduct the program evaluation was fully executed in March 2021. The Board continues to work with the Department of Finance on securing the necessary appropriation to implement the program.

ISSUE #13: (AB 2138.) What is the status of MBC's implementation of Assembly Bill 2138 (Chiu/Low) and are any statutory changes needed to enable the Board to better carry out the intent of the Fair Chance Licensing Act?

Staff Recommendation: MBC should provide an update on its implementation of the Fair Chance Licensing Act, as well as relay any recommendations it has for statutory changes.

Board Response (April 2021):

The Board's regulatory changes required by AB 2138 were approved by the Office of Administrative Law and became effective on January 21, 2021. At this time, the Board does not have further recommendations.

ISSUE #14: (SPECIAL FACULTY PERMITS AND ACADEMIC MEDICAL CENTERS) MBC issues Special Faculty Permits (SFP) for individuals to practice in California who are determined to be academically eminent. AB 2273 (Bloom, Chapter 280, Statutes of 2020) authorized an academic medical center (AMC) to submit applications SFPs and authorized a SFP holder, a visiting fellow, and a holder of a certificate of registration to practice medicine within the AMC and its affiliated facilities without obtaining full licensure. Are changes necessary to ensure the quality of AMCs?

Staff Recommendation: MBC should advise on the status of expanding current options for international physicians to AMCs, as well as provide information on the numbers of applicants for SFPs and other exemptions since the passage of AB 2273. The Committees may wish to amend the Act to ensure that AMCs are properly accredited.

Board Response (April 2021):

AB 2273 added AMCs to BPC sections 2111, 2113, and 2168, which allow specified non-U.S. citizens to practice medicine in certain settings if they meet the statutory requirement. BPC section 2111 allows international physicians to provide supervised medical services as a visiting fellow in a California approved medical school or AMC. BPC section 2113 allows international physicians accepted into a full-time faculty position at an approved medical school or AMC to practice medicine as needed in

connection with their faculty position. BPC section 2168 authorizes the issuance of a special faculty permit to international physicians who have been recognized as academically eminent in their field of specialty and who have been sponsored by the Dean of a California medical school or AMC where a great need exists to fill those positions.

Since the implementation of AB 2273 on January 1, 2021, the Board has not received any SFP or Special Program permit applications from AMCs, as the Board has not yet recognized any medical centers as an AMC under the criteria set forth in statute. However, the Board is only aware of one medical center that may meet the criteria of an AMC and is currently working with this entity on the appropriate documentation to provide the Board that will determine its eligibility as an AMC. If the Board recognizes this medical center as an AMC, the Board will provide them the updated application to allow submission of new permit applications as an AMC. The Board is also working with the appropriate medical schools on transferring the approval of existing permit holders currently practicing at the proposed AMC from the medical school to the AMC.

Since January 1, 2021, the MBC has received one application under BPC section 2111, six applications under BPC section 2113, all of which were submitted by medical schools, and has not received any new SFP applications.

Further, the author and sponsor of AB 2273 agreed to propose an update to the definition of an AMC to remove the requirements that an AMC have a specified intern and resident-to-bed ratio and conduct research annually in an amount of at least one hundred million dollars ($100,000,000). The Board believes removing these changes will help ensure that other qualified facilities are eligible for this program.

ISSUE #15: (MANDATORY REPORTING TO MBC.) MBC receives reports related to physicians from a variety of sources. These reports are critical tools that ensure MBC maintains awareness about its licensees and provide important information about licensee activity that may warrant further MBC investigation. MBC may not be receiving reports as required and enhancements to the Business and Professions Code may be necessary to ensure MBC has the information it needs to effectively do its job.

Staff Recommendation: MBC should provide an update to the Committees on the status of receiving mandatory reports. The Committees may wish to enhance reporting requirements where necessary to ensure MBC is made aware of important information and actions that impact patient care which MBC may need to act upon.

Board Response (April 2021):

The Board receives mandatory reports from a number of various sources. Many of these sources appear to be complying with their respective reporting requirements, but it is not possible to verify whether the Board is receiving all reports required by law. The Board has heard anecdotally that licensees may be avoiding settlement reporting

requirements by manipulating how payments are split between their insurance company and the physician. With regard to the reports required by court clerks, coroners, and healthcare facilities, the Board intends to conduct outreach and provide regular reminders of their reporting requirements to help ensure that the required reports are submitted in a timely manner.

ISSUE #16: (COMPLAINTS.) Complaints are the heart of MBC's enforcement program. Delays in complaint processing can have grave effects on patients and the public and compound MBC's efforts to protect consumers. In consumer satisfaction surveys, MBC consistently receives unfavorable feedback and response for its handling of complaints. What efforts is MBC taking to process complaints, particularly with a rise in the number of complaints received?

Staff Recommendation: MBC should update the Committees on its complaints process, giving particular attention to the work MBC does to ensure that patients have an opportunity to provide information that may be critical in determining what next steps to take and what efforts MBC needs to take to ensure individuals who file complaints are proactively informed throughout the process. MBC should provide information on the historical rationale for treating complaints as confidential until formal action is taken, rather than investigation.

Board Response (April 2021):

All complaints need to be addressed and handled in an appropriate manner, with expediency and completeness being essential in each and every case. Certain types of complaints, such as sexual misconduct, pose a potential risk of harm to the public and should be addressed as quickly as possible. BPC section 2220.05 describes the Board's priorities in prioritizing its investigatory and prosecutorial resources.

The Board has established processes for advising complainants of the status of their complaints through a series of letters sent during the investigative process. When a complaint is first received, staff review the initial documentation and information received and request authorization to obtain medical records from complainants. If necessary, staff contact the complainant to get additional information about their complaint.

Complainants are contacted for an interview when a complaint has advanced to the stage of investigation. The Board is always looking for ways to improve its communication with complainants while protecting the confidentiality of the complaint and investigation processes. This may include additional contact with the complainant in the initial stages of the complaint.

Complaints are confidential per BPC section 800(c), among other sections. This requirement for confidentiality is not unique to California or the Board. A number of

professional boards in California and throughout the country keep complaints confidential until an accusation is filed or action is taken.

The Board keeps complaints that do not lead to an accusation or decision confidential, because it is required by law. However, some may argue that posting such complaints is inappropriate, as they may be misused or misinterpreted.

ISSUE #17: (ENFORCEMENT OPTIONS.) MBC has looked for enforcement cost savings and believes it should be authorized to have additional methods of resolving enforcement actions in what MBC calls a "non-adversarial manner". Should the Act be updated to allow MBC to have other options outside of traditional enforcement? What types of cases would benefit from these efforts? What patient and public protection impacts would these efforts have?

Staff Recommendation: MBC should update the Committees on the impacts of these additional enforcement options. The Committees may wish to authorize MBC to have new enforcement authorities as described above while ensuring that patient protection is prioritized.

Board Response (April 2021):

The Board believes that the Act should be amended to permit issuing a "letter of advice" – a new enforcement tool which can be coupled with a requirement that licensees undertake certain specified actions of remediation, including required educational courses on certain relevant topics. The cases which may benefit the most from such an approach include cases where there is only one simple departure from the standard of care, where the Board is currently unable to take enforcement action.

In addition, cases that would benefit from such an approach include ones where there is no concern regarding a licensee's fitness to practice. In such cases, early resolution would protect the public by swiftly implementing the appropriate remediation measures. As stated in the Board's sunset report, the Board identified at least 21 State Medical Boards that have such non-adversarial means of remediation. Further, international regulators are increasingly using such tools to resolve cases. Boards with this option may encourage a culture of open disclosure in relation to adverse incidents, which facilitates dialogue with licensees, helping to prevent such incidents from reoccurring in the future.

Of course, non-adversarial tools are not appropriate where the licensee's ability to practice consistent with the standard of care is in question. However, it must be noted that early resolution of less serious cases will leave more resources of the Board available to pursue the more serious cases to a successful resolution that protects the public interest.

ISSUE #18: (SETTLEMENTS.) Like many licensing boards, MBC enters into settlement agreements with most plaintiffs in enforcement cases. What is the practical impact of settlements on patients, the public, licensees, and significantly, MBC's resources?

Staff Recommendation: MBC should provide information to the Committees about the frequency of settlements entered into below the standards, terms, and conditions suggested in the Disciplinary Guidelines, as well as provide an update on the patient impacts stemming from repeated settlement agreements with violating physicians and surgeons.

Board Response (April 2021):

The Board settled approximately 84 percent of its disciplinary cases in the past year. The law encourages the consideration of settlements (see GC 11511.5 and 11511.7) which supports the efficient disposition of a case, while also protecting the public. Going to hearing is resource intensive, requiring significant time and financial expense that can be mitigated through a stipulated settlement.

In a hearing, the Board incurs expenses for AGO costs, OAH costs, court reporters, expert fees, witness fees, travel and other expenses and it may take 6-12 months to get a case to hearing. If continuances are granted, it could be two years or more to get to hearing, following the completion of an investigation.

During the COVID-19 pandemic, continuances were routinely granted, delaying the resolution of the certain cases. Reaching stipulated settlements where the terms are sufficient to protect the public, allows cases to be resolved earlier, and with certainty that the disciplinary terms the Board deems necessary are in place. When a licensee enters into a stipulated settlement, they waive the right to challenge the matter in court, thereby limiting the Board's exposure to the cost of defending a writ.

Further, when adopting appropriate stipulated settlements, the Board's resources can be directed to cases where an acceptable settlement cannot be reached. Importantly, before a stipulated settlement takes effect, it must be adopted by a panel of Board members.

Significantly, in a stipulated settlement, the respondent licensee may agree to terms required by the Board that an Administrative Law Judge (ALJ) may not impose after an administrative hearing, thereby possibly providing even stronger consumer protection measures. In a review of stipulated settlements adopted by a Board panel in the prior fiscal year, approximately 46 percent of cases strictly adhered to all aspects recommended in the disciplinary guidelines based on the facts of the case.

Settlements provide the opportunity to process a larger number of cases for discipline. The Board's resources are limited, therefore if the Board did not have the settlement option and the Board took every case to hearing, this would significantly impact the Board's ability to pursue cases for disciplinary action in a timely manner.

Not all cases are eligible for settlement. In cases where the licensee will not accept the Board's terms and conditions deemed necessary to protect the public, the matter will go to hearing and the Board will decide whether to adopt or non-adopt the ALJ's proposed decision. Likewise, when the Board determines that the only way to protect the public is through a license revocation or surrender, but the licensee is not agreeable to surrender via a stipulated settlement, the case will go to hearing.

ISSUE #19: (ENFORCEMENT ENHANCEMENTS.) Various enhancements to the Act may be necessary for MBC to ensure public protection.

Staff Recommendation: The Committees may wish to amend the Act to ensure MBC has the necessary tools to take swift action.

Board Response (April 2021):

In the Board's Sunset Report, the Board asked the Legislature to approve certain statutory changes that will enhance the Board's enforcement program.

First, the Board requests that the Legislature amend the BPC to toll the statute of limitations applicable to its cases upon the service of an order to show cause until the subpoenaed records are produced, or until the court declines to issue an order mandating release of records to the Board. This change would discourage the respondent licensee from using the subpoena enforcement action to their advantage to try to run out the statute of limitations.

Second, the Board is seeking additional inspection powers to allow investigators with the Board and the HQIU, along with medical consultants when desired, to conduct site inspections and review medical records in the licensee's professional office. Permitting such inspections would strengthen the Board's position in subpoena enforcement actions where the Board is required to establish good cause to believe that misconduct has occurred, sufficient to overcome the patient's right to privacy. This tool would improve the Board's ability to investigate cases where the patient is not the complainant, such as in inappropriate or overprescribing cases.

Third, the Board is interested in expanding the use of non-public educational letters to address deficiencies in a licensee's practice that do not rise to the level of repeated negligent acts or gross negligence. A letter of advice would be a confidential communication from the Board to a licensee and be issued where there is no concern related to fitness to practice and the action proposed therein is deemed sufficient to protect the public. These letters have proven to be useful at resolving matters efficiently and effectively in other jurisdictions (we have identified 20 state medical boards that have the power to issue such letters), thereby reducing investigative timelines. The Board would like the Medical Practice Act to be amended to more clearly grant authority to issue such letters in appropriate circumstances and to include the authority to require

the licensee to comply with the Board's directive to take remedial action, such as an educational course, to resolve the enforcement matter.

Finally, the Board is seeking a legislative change to the Business and Professions Code to provide a clear and definite timeframe for pharmacies to turn over their records to investigators to prevent delays in the investigation process.

ISSUE #20: (ENFORCEMENT DISCLOSURES.) MBC licensees are required to disclose probationary status to patients and MBC makes this available public on its website and through other means. How has the implementation of the Patient's Right to Know Act enhanced consumer awareness with MBC and licensees? Has MBC seen any changes in its disciplinary proceedings stemming from the disclosure requirement that impacts an extremely small number of MBC licensees?

Staff Recommendation: MBC should provide an update on the implementation of the Patient Right to Know Act.

Board Response (April 2021):

The Board has been able to implement the Patient's Right to Know Act without disruption to the Board's enforcement process and believes it promotes consumer awareness by requiring certain physicians to inform their patients of their probationary status.

This law also requires certain additional information about disciplined physicians to be added to each licensee's profile page on the Board's website. This information helps consumers make an informed choice for a provider appropriate to their needs.

ISSUE # 21: (DISPARITY IN ENFORCEMENT ACTIONS.) MBC commissioned a third-party study to identify whether disparity in its enforcement actions were present. Do problems still exist?

Staff Recommendation: MBC should provide an update to the Committees on its efforts to ensure that bias and disparities do not exist in any of its programs. MBC should establish a formal policy against racial discrimination.

Board Response (April 2021):

In response to the findings of the study on disciplinary demographics, MBC staff and Board members attended mandatory training on implicit bias and continue to do so every two years. Additionally, materials provided to experts and Board members have been redacted to remove information deemed likely to trigger implicit bias, such as where the individual went to school or the training program they attended. The Board recognizes that this issue requires ongoing diligence, and the Board will continue to require training and exploration of best practices to address this issue. While the Board

has not adopted its own policy on racial discrimination, it is bound by the Department of Consumer Affair's zero-tolerance non-discrimination policy. This policy pertains to discrimination based upon race and other protected group categories/characteristics.

ISSUE # 22: (ENFORCEMENT DELAYS.) Previously, MBC's investigations were simultaneously assigned to an investigator and a DAG in a system called vertical enforcement (VE). VE was ended in 2019; yet even with the removal of the statutory VE provisions, the timeframe for investigating cases has increased from 467 days in FY 2016/17, to 510 days in FY 2017/18, 547 days in FY 2018/19, and 548 days in FY 2019/20. The issue of the quality of investigations, and enforcement timelines, is a problem that the Legislature has attempted to solve through numerous reviews of MBC, investigator, and OAG activities, yet enforcement delays remain and public protection remains threatened by the lack of swift action against violating licensees.

Staff Recommendation: Now that VE has been repealed, MBC should explain whether it believes there has been any positive changes from a process perspective and whether relationships between HQIU and HQE have improved. The Committees may wish to consider whether any proposed transfer of HQIU's investigators would result in any benefit to enforcement timelines or produce more successful prosecutions.

Board Response (April 2021):

The repeal of VE has not led to a more efficient enforcement process and the current "hand off" model may require a significant amount of time for review by the AGO to determine if the case warrants proceeding with the prosecution of a case. Under VE, the AGO was involved in the process as the investigation progressed and they were able to weigh in throughout the process and determine if an ongoing investigation supported further action. Now, the matter is fully investigated and referred to the AGO for an initial review and determination.

The MBC is seeing a number of cases being returned by the AGO to the field for supplemental investigation. This has created more work and increased the need for coordination by MBC and the AGO because after a supplemental investigation is completed the matter must be reviewed again to determine if any new information supports filing an accusation. If a case is approaching the statute of limitations, there may not be time to obtain an additional investigation and thus the case may not be filed.

Another outcome from the removal of VE is the loss of certain prosecutorial coordination. Under VE, if there were multiple complaints on a licensee, the AGO could provide assistance in coordinating the investigations so that multiple matters could be addressed and reach conclusion within a relatively close timeframe and be addressed through a single accusation. In some cases, this lack of coordination has resulted in the filing of an initial accusation followed by several amended accusations or, may result in multiple cases being filed against a licensee.

The Board recently revised its MOU with HQIU, and anticipates this will lead to increased collaboration on cases assigned to HQIU for investigation, including greater efficiencies in the enforcement process.

ISSUE #23: (OVERPRESCRIBING AND THE OPIOID CRISIS.) Growing efforts to combat the opioid crisis from a public health approach have brought attention to the important role physicians and other prescribers play in identifying patients who pose a risk for abusing or diverting controlled substances. How has MBC furthered these efforts through its role as a regulator of physicians and surgeons?

Staff Recommendation: MBC should provide the Committees with insight into how it has helped to combat the opioid crisis through its oversight of physicians and surgeons and whether it believes any further statutory change would better enable CURES to function principally as a public health tool.

Board Response (April 2021):

To help address inappropriate prescribing of controlled substances, and related deaths, the Board has continued its work on the Prescription Review Program (PRP), formerly referred to as the Death Certificate Project. This program was born out of vetoed legislation that would have required coroners in California to report deaths when the cause of death is the result of prescription drug use. The Board's program uses California death record data to identify physicians who may be inappropriately prescribing opioids to their patients through a DUA with the California Department of Public Health (CDPH). Based upon this information, the Board has been investigating physicians who may have violated the law.

In the first iteration of this program, the Board initiated 520 cases against 471 licenses from data received for nearly 2,700 deaths in 2012 and 2013. Following those investigations, the Board took disciplinary action in dozens of cases.

In late 2020, the Board began reviewing 2019 death certificate data for the PRP. To date, the Board has opened more than 40 cases.

Along with the above measures, the Board recently appointed a task force to update its guidelines on prescribing controlled substances, which were published in 2014. That task force will have its first meeting soon and will engage with a wide variety of experts in pain/addiction management and treatment and the public to update these guidelines.

ISSUE #24: (IMPACTS OF THE COVID-19 PANDEMIC.) Since March 2020, there have been a number of waivers issued through Executive Orders that impact MBC operations, MBC licensees, providers, and patients throughout the state. Do any of these waivers warrant an extension or statutory changes? How has the MBC addressed issues resulting from the pandemic?

Staff Recommendation: MBC should update the Committees on the impact to licensees and patients stemming from the pandemic and potential challenges for future physicians and surgeons. MBC should discuss any statutory changes that are warranted as a result of the pandemic.

Board Response (April 2021):

The Board appreciates the waivers issued through Executive Orders, including those authorized by the Director of DCA, as they have supported the Board's licensees who responded to the health emergency. Further, those waivers adjusted certain application/renewal deadlines, providing licensees and applicants additional flexibility during these challenging times. The Board has not discussed extending or making permanent any of such waivers.

As discussed in the Board's response to Issue #10, the Board saw a temporary increase in its licensing timeframes during the initial months of the pandemic as staff transitioned to teleworking and the Board received a large volume of first-time PTL applicants. The Board developed new processes to streamline operations and continued to promote to medical schools and post-graduate training institutions the option to provide required primary source documentation electronically.

Further, the Board's enforcement program has made certain positive strides, despite the pandemic, as complaint volume decreased somewhat from FY 2018-19 (11,407) to FY 2019-20 (10,868). This facilitated the work of Board staff in the Central Complaint Unit who shortened the timeframe to process a complaint from 164 days in Q1 FY 2020-21 to 137 days in Q2 FY 2020-21.

In addition, the Board seeks to adopt as many paperless processes as possible, an effort that accelerated due to the pandemic. The Board wishes to increase options to licensees and applicants so they may, in the future, apply or renew their license through a completely paperless process. As discussed in Issue #10 of the background paper, the Board is seeking changes to certain statutes that inhibit this effort. Once completed, licensees and Board staff will enjoy a more efficient process that will also support a flexible working environment for remotely working staff.

Allowing the Board the flexibility to continue meeting online, after the end of the current state of emergency, will save the Board money and staff resources, and may facilitate public engagement among those unable to attend in person.

On the matter of telehealth – this is expected to be a growing treatment modality for patients and providers. Whether care is provided online or in-person, a physician is still expected to maintain the standard of care for their patient. The Board will continue to review complaints and conduct appropriate investigations of potential violations of the Medical Practice Act that involve care delivery through telehealth.

ISSUE #25: (TECHNICAL CHANGES MAY IMPROVE EFFECTIVENESS OF THE MEDICAL PRACTICE ACT AND MBC OPERATIONS.) There are amendments to the Act that are technical in nature but may improve MBC operations and the enforcement of the Medical Practice Act.

Staff Recommendation: The Committees may wish to amend the Act to include technical clarifications.

Board Response (April 2021):

The vast majority (about 82 percent) of the Board's physician licensees renew online. Licensees who renew via paper, however, face additional delays as staff await for documentation and checks to be delivered, which then must be keyed in by hand manually.

Eliminating or modifying the indicated requirements that paper mailings be sent at specified times would help the Board achieve its strategic goals. Staff hopes the Board will one day have an entirely online licensing process, with paper-based initial licensure and renewal application documents being sent to applicants and licensees only upon request.

In addition, the Board's Sunset Report (pages 219-220) includes certain other technical changes to BPC 2096, regarding the PTL, and changes to the Board's special permit programs contained within BPC 2111, 2112, and 2113.

ISSUE #26: (CONTINUED REGULATION BY MEDICAL BOARD OF CALIFORNIA.) Should the licensing and regulation of physicians and surgeons, licensed midwives and other allied health professionals be continued and be regulated by the current MBC membership?

Staff Recommendation: The MBC should be continued to be reviewed again on a future date to be determined.

Board Response (April 2021):

The Board looks forward to continuing in its mission of consumer protection and requests the Legislature extend its sunset date, accordingly.

MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations

Subject	Status	Date Approved by Board	Date to DCA for Initial Review	Date Returned by DCA	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption by Board	Date to DCA (other control agencies) for Final Review*	Date to OAL for Review	Date to Secretary of State
Rehabilitation/ Substantial Relationship Criteria	Submitted to OAL	05/09/19	06/21/19	11/15/19	12/06/19	01/22/20	01/22/20	03/06/20	08/12/20	01/21/21
New Postgraduate Training Requirements	Submitted to OAL	08/09/19	10/23/19	06/03/20	06/19/20	N/A	08/08/20	11/24/2020	12/30/20	
Physician and Surgeon Health and Wellness Program	Board Staff Working on Initial Review	11/08/19								
Notice to Patients (Signage)	Pending revision and Initial DCA Review	07/26/18	03/08/19	07/31/19 for revision						
Medical and Midwife Assistant Certifying Organizations	Pending Initial DCA Review	08/08/2019	01/06/2021							
Citable Offenses	Board Staff Working on Initial Review	11/08/19								
Approved Continuing Education	Board Staff Working on Initial Review	08/14/20								