Sunset Review Oversight Report 2022: Part I

The **Sunset Review Oversight Report 2022: Part I** contains the sections listed below:

Section 1: Background and Description of the Board and Regulated Profession

Section 2: Performance Measures and Customer Satisfaction Surveys

Section 4: Licensing Program

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Sections 3, 13, and allied health professionals will be published when available:

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Sunset Review Oversight Report

Section 1

Background and Description of the Board and Regulated Professions

- *History*
- *Board Composition*
- *Sunset Review Task Force*
- *Major Changes*
- *Legislation*
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BACKGROUND AND DESCRIPTION OF THE BOARD AND REGULATED PROFESSIONS

History

Provide a short explanation of the history and function of the Board. Describe the occupations/profession that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).

The Medical Board of California (Board) was the first board started for consumer protection (of those currently within the Department of Consumer Affairs (DCA)), and its history dates back to 1876 with the passage of the first Medical Practice Act. In 1901, the Medical Practice Act was completely rewritten and the former California Medical Society Board, the Eclectic Medical Society Board, and the Homeopathic Medical Society Board all became the Board of Examinations. From 1950 to 1976, the Board expanded its role beyond physician licensing[1] and discipline to oversee various allied health professionals, such as physical therapists, psychologists, etc.

The Board began to regulate research psychoanalysts (RPs) in 1977 and licensed midwives (LMs) in 1994. The Board's polysomnographic program began in 2009.

The Board formerly regulated registered contact lens dispensers, registered dispensing opticians (RDO), registered non-resident contact lens sellers, and registered spectacle lens dispensers. Beginning January 1, 2016, authority over those registrants moved to the Board of Optometry.

Core Functions of the Board

As a consumer protection agency, the Board is comprised of programs whose functions, duties, and goals are to meet the mandate of consumer protection. The Board's **Licensing Program** ensures that only qualified applicants, pursuant to the requirements in the Board's laws and regulations, receive a license or registration to practice. The Licensing Program has a Consumer Information Unit that serves as a call center for all incoming calls to the Board. The Licensing Program also processes renewals for all licensees/registrants and performs all of the maintenance necessary for licensees to remain current, including auditing the continuing education (CE) requirements, and updating the records for changes of name/address, etc.

The **Enforcement Program** investigates allegations of wrongdoing and takes disciplinary or administrative action as appropriate. The Board has a Central Complaint Unit (CCU) that receives and triages all complaints. If it appears that a violation may

[1] The BPC uses the term "physician's and surgeon's certificate", however, this report will also use the terms "physician" and "license".

have occurred, the complaint is either transferred to the DCA's Division of Investigation, Health Quality Investigation Unit (HQIU), which is comprised of sworn peace officers, or to the Board's Complaint Investigation Office (CIO), which is comprised of non-sworn special investigators.

The investigators (sworn or non-sworn) investigate the complaint and, if warranted, refer the case for disciplinary action. The Board's Discipline Coordination Unit processes all disciplinary documents and monitors the cases while they are at the Attorney General's Office (AGO). If a licensee/registrant is placed on probation, the Board's Probation Unit monitors the individual while he/she is on probation to ensure they are complying with the terms and conditions of probation. The Probation Unit is comprised of inspectors who are located throughout the state, housed within statewide offices. Having inspectors statewide eliminates excess travel and enables probationers to have face-to-face meetings with the inspectors for monitoring purposes.

The Board has its own **Information Systems Branch** (ISB) that performs information technology (IT) functions. The ISB ensures that the Board's IT systems are functioning and looks for areas where upgrades can help streamline the Board's enforcement and licensing processes. Having its own IT unit allows the Board access to trained staff when problems arise, ensures the Board maintains current hardware/software, helps staff understand and protect against cyber security attacks, and allows the Board to make changes rapidly to its website.

The Board also engages in a number of activities to educate physicians, applicants, and the public. The Board's Office of Legislative and Public Affairs provides information to physicians, as well as applicants, regarding the Board's functions, laws, and regulations. This information is provided by attending outreach events, providing articles on topics of interest to physicians and the public in the Board's quarterly newsletter, and attending licensing fairs and orientations at medical schools and teaching hospitals. The Board provides outreach to the public by participating in educational meetings/seminars on the Board's laws and regulations. In addition, information on public health, the Board's complaint/enforcement process, and Board meetings is available for all interested parties via the website, social media, and phone calls/email with Board staff.

Occupations Licensed and Regulated by the Board

Under the Medical Practice Act, the Board has jurisdiction over allopathic physicians licensed to practice in this state. In addition to the Board's authority over physicians, the Board licenses and regulates LMs, registered polysomnographic trainees, registered polysomnographic technicians, registered polysomnographic technologists, RPs, and student research psychoanalysts (SRP). Further, the Board regulates medical assistants, an unlicensed profession.

The Board approves agencies that accredit outpatient surgery settings (OSS) and issues fictitious name permits to physicians practicing under a name other than their own.

Board Composition

1. Describe the make-up and functions of each of the Board's committees (cf., Section 13, Attachment B).

Pursuant to Business and Professions Code (BPC) section 2001, the Board is comprised of fifteen (15) Board members: eight (8) physician members and seven (7) public members. The Governor appoints thirteen (13) members and two (2) are appointed by the Legislature (one each by the Senate Rules Committee and the Speaker of the Assembly). BPC section 2007 also requires that four of the physician members hold faculty appointments in a clinical department of an approved medical school in the state, but no more than four members of the Board may hold full-time appointments to the faculties of such medical schools.

See Section 13, Attachment E for the charts identifying the Board members' attendance at the Board's quarterly meetings.

Table 1b. Board Member Roster

Member Name	Date First Appointed	Date Re-appointed	Date Term Expires	Appointing Authority	Type
Michelle Anne Bholat, M.D.	06/08/22	-	06/01/25	Governor	Physician*
Ryan Brooks	02/02/21	-	06/01/24	Governor	Public
Randy Hawkins, M.D.	03/04/15	06/15/20	06/01/24	Governor	Physician
James M. Healzer, M.D.	06/25/21	-	06/01/25	Governor	Physician
Kristina D. Lawson, J.D.	10/28/15	06/08/22	06/01/26	Governor	Public
Laurie Rose Lubiano, J.D.	12/17/18	06/01/20	06/01/24	Governor	Public
Nicole A. Jeong, J.D.	04/14/22	06/24/22	06/01/26	Governor	Public

Asif Mahmood, M.D.	06/03/19	-	06/01/23	Governor	Physician
David E. Ryu	04/19/21	-	06/01/23	Assembly Speaker	Public
Richard E. Thorp, M.D.	07/26/19	-	06/01/23	Governor	Physician
Veling Tsai, M.D.	04/14/22	-	06/01/25	Governor	Physician*
Eserick "TJ" Watkins	06/01/19	-	06/01/23	Senate Rules Committee	Public
Vacant	-	-	06/01/26	Governor	Physician*
Vacant	-	-	06/01/26	Governor	Physician*
Vacant	-	-	06/01/24	Governor	Public
*** Faculty Appointments**					

The Board has seven standing committees, seven two-member task forces/committees, two panels, and one council that assist with the work of the Board. Two of the Board's committees, the two panels, and the council are statutorily mandated, while others are established by the Board to meet a specific need. The following is a list of the Board's current committees and their purpose. More information, including committee membership can be found under Section 13, Attachment B. During the Board's October 28, 2022, meeting regarding its next Strategic Plan, the Board discussed conducting an analysis of its current non-statutory committees.

Application Review and Special Programs Committee (Statutory Committee – BPC sections 2099, 2111-2112, 2135.5 and Title 16, California Code of Regulations (16 CCR) section 1301)

The purpose of this committee is to evaluate the credentials of licensure applicants where statute provides the Board to exercise discretion; and makes recommendations to the Licensing Program regarding eligibility for licensure (for example, postgraduate training hardship petitions per 16 CCR section 1321(d) and written licensing exam waiver requests per Business and Professions Code section 2113).

Editorial Committee (non-statutory)

This committee reviews the Board's *Newsletter* articles to ensure they are appropriate for publication and provides any necessary edits to the articles.

Enforcement Committee (non-statutory)

This committee's purpose is to serve as an expert resource and advisory body to members of the Board and its Enforcement Program by educating Board members and the public on enforcement processes. It also identifies program improvements in order to enhance protection of health care consumers.

Executive Committee (non-statutory)

The Executive Committee oversees various administrative functions of the Board, such as budgets and personnel, and reviews legislation, as needed; provides recommendations to the full Board; evaluates the performance of the Executive Director; and acts for the Board in emergency circumstances (as determined by the Chair) when the full Board cannot be convened.

Licensing Committee (non-statutory)

This committee's purpose is to serve as an expert resource and advisory body to members of the Board and its Licensing Program by educating Board members and the public on the licensing process; identifies program improvements; and reviews licensing regulations, policies, and procedures.

Midwifery Advisory Council (Statutory Council – BPC section 2509)

The Midwifery Advisory Council's (MAC) purpose is to develop solutions to various regulatory, policy, and procedure issues regarding the midwifery program, including challenge mechanisms, midwife assistants, and examinations, as specified by the Board. The MAC makes recommendations to the full Board and is comprised of three midwives, one physician, and two public members.

Public Outreach, Education and Wellness Committee (non-statutory)

This committee develops various informational materials for publication and internet posting; develops plans and strategies to provide outreach to physicians and patients; monitors the Board's strategic plan pertaining to communication; develops physician wellness information by identifying available activities and resources, which renew and balance a physician's life, both personal and professional.

Special Faculty Permit Review Committee (Statutory Committee – BPC section 2168.1(c))

This committee evaluates the credentials of applicants proposed by a California medical school or academic medical center to meet the requirements of Section 2168.1; determines whether the candidate meets the requirements of an academically eminent physician, or an outstanding physician in an identified area of need; and submits a recommendation to the Board for each proposed candidate for final approval or denial.

Panel A (Statutory Panel – BPC section 2008)

The purpose of this panel is to carry out disciplinary actions as stated in BPC section 2004(c).

Panel B (Statutory Panel – BPC section 2008)

The purpose of this panel is to carry out disciplinary actions as stated in BPC section 2004(c).

The Board has seven, two-person task forces/committees that the president appoints as the need arises.

Compounding Task Force

This task force receives information and input form interested parties pertaining to physician compounding activities, to promote consumer protection within the Board's authority.

Disciplinary Demographic Task Force

The Disciplinary Demographic Task Force reviews the Board's processes and finds training opportunities to eliminate implicit bias.

Midwifery Task Force

The Midwifery Task Force discusses solutions to pending regulatory issues pertaining to the practice of midwifery.

Prescribing Guidelines for Controlled Substances Task Force

This task force will review and revise the Guidelines for Prescribing Controlled Substances for Pain that were published by the Board in 2014.

Prescribing Task Force

The Prescribing Task Force identifies ways to proactively approach and find solutions to the epidemic of prescription drug overdoses through education, prevention, best practices, communication, and outreach by engaging all stakeholders in the endeavor.

Stem Cell and Regenerative Medicine Task Force

This task force receives information and input from interested parties on options pertaining to stem cell treatments, to promote consumer protection within the Board's authority.

Sunset Review Task Force

The Sunset Review Task Force reviews the sunset review questions and responses to provide input and guidance to staff.

2. In the past four years, was the Board unable to hold any meetings due to lack of quorum? If so, please describe. Why? When? How did it impact operations?

Since the Board's prior sunset review, the Board has not had any meetings canceled due to a lack of a quorum. The Board, however, attempted to organize an off-cycle meeting in the Spring of 2022 to discuss pending legislation, but was unable to find a date and time that would ensure a quorum. There was no impact to Board operations due to this circumstance.

Major Changes

3. Describe any major changes to the Board since the last Sunset Review, including, but not limited to:

a) **Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning).**

b) **All legislation sponsored by the Board and affecting the board since the last sunset review.**

c) **All regulation changes approved by the Board the last sunset review. Include the status of each regulatory change approved by the Board.**

Board Website Redesigned

In July 2021, the Board launched a redesign of its public-facing website. Board staff designed the new website to conform with the latest standards established by the California Department of Technology to build user-centered, accessible, and mobile-friendly government websites.

The website homepage now has a simple and clean design that features faster load times while maintaining compliance with the Americans with Disabilities Act (ADA). Staff retained some of the previous website's most popular features including a quick physician name search, a news section that features the top three latest Board news items, and an alert bar informing users of important developments.

Electronic Wallet Cards Introduced

To reduce the Board's printing and mail expenses, the Board rolled out in late 2021/early 2022 (available to all licensees by April 2022) a service that allows licensees to generate and print their own Pocket License Cards. Licensees will be able to generate a PDF file for their own use or to forward to employers and others, as needed. In addition to saving Board resources, licensees will have instant access to these electronic cards and not have to wait 4-6 weeks to wait for a plastic card to be printed and mailed to them. Research is being done with the goal of producing digital cards (e.g. Apple Wallet and Google Pay) that will automatically update on a licensee's device with license information changes.

Implemented Statute Changes Included in 2021 Sunset Legislation

- Senate Bill (SB) 806 (Roth, Chapter 649) of 2021 extended the Board's sunset date to January 1, 2024, and included various key statutory changes, including, but not limited to:
- Increases to all Board application, initial licensure, and renewal fees.
- Appointment of an enforcement monitor to report on the Board's enforcement program, as specified.
- Restored the Board's authority to recover costs incurred during the investigation and prosecution of a disciplined physician and surgeon (P&S).
- Changes to P&S Licensure and Renewal Requirements
    - Residents are authorized to obtain a P&S license after receiving credit for either 12 months (for graduates of U.S. or Canadian medical schools) or 24 months (for graduates of international medical schools) of board-approved postgraduate training (PGT).
    - When a P&S license holder, issued on or after January 1, 2022, first renews their license (24 months after issuance), they will be required to show evidence of receiving credit for 36 months of board-approved PGT, which includes successful progression through 24 months in the same program.
- Clarifies the existing requirement that complaints involving the quality of care provided by a licensed midwife (LM) must be reviewed by an expert with pertinent education, training, and expertise in midwifery before being referred to a field investigation.

Additional information about the impacts of SB 806 is provided on the Board's website.

Licensing Program Enhancements

The Licensing Program has significantly revised its business processes to allow license applicants to submit all required documents electronically. Documents required by the applicant may be submitted with the online application through BreEZe and documents required by the medical school or postgraduate training programs may be submitted through the Board's Direct Online Certification Submission (DOCS) portal. The Licensing Program has also reduced the number of documents required to be provided to the Board during the application process, such as only requiring license verifications upon request, as the Board already receives license information from the Federation of State Medical Boards and the American Medical Association. The Licensing Program continues to evaluate its business process to transition to a completely paperless application process.

Online Complaint Tracking System

Board staff are developing an online system to allow complainants to check on the status of submitted complaints. Staff hope to schedule up to two interested parties meetings by early 2023 to receive input and suggestions on what features should be included in the system. After the interested parties process is concluded, the features for the initial system will be finalized, including an expected timeframe to launch the system.

A presentation on possible project features was made during the Board's May 19-20 meeting, at approximately 2:38:00, during Day 1.

Redesigned Physician Survey

AB 133 of 2021 renamed the Office of Statewide Health Planning and Development as the Department of Health Care Access and Information (HCAI) and requires the Board (among others) to request certain workforce data from licensees and registrants on at least a biennial basis. The new physician survey in compliance with AB 133 was launched July 2022 and collects additional information including anticipated year of retirement, physical address of primary and secondary practice locations and types, date of birth, gender identify, National Provider Identifier (NPI), work hours, sexual orientation, and disability status. This information is reported to HCAI.

Strategic Planning Underway

In 2022, the Board discussed new strategic goals for inclusion in its next Strategic Plan, which is expected to be approved by the Board in 2023.

Updated Effort to Combat the Opioid Epidemic

The Board updated its approach to proactively investigating possible inappropriate prescribing of opioids and renamed the project as the Prescription Review Program (PRP) (formerly the Death Certificate Project). Now deaths due to opioid overdose are examined to initially assess the case for possible inappropriate prescribing prior to reviewing a prescribing report on the related physician and conducting a full field investigation. Physicians who are not considered to present a risk to the public during the initial assessment are not subject to further review. The Board has determined that the use of illegally obtained street drugs, such as fentanyl, rather than prescribed medications, are accounting for a very large portion of these overdose deaths.

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. The Board imposed 10 probations, 24 public letters of reprimand/public reprimands, and accepted 11 surrenders because of the complaints initiated related to the PRP.

In late 2020, the Board began reviewing 2019 death certificate data for the PRP. As of October 5, 2022, the Board has opened 64 cases and 31 were referred for investigation

(some of which have concluded). 36 cases are still pending and 28 have been closed due to insufficient evidence or no violation.

Updating Controlled Substances Prescribing Guidelines in Progress

The Board President appointed a task force of two Board members (Mr. Ryan Brooks and Dr. Richard Thorp) to lead the effort to update the Board's 2014 Guidelines for Prescribing Controlled Substances for Pain. The process has included a consultation with relevant medical experts and an interested parties (IP) meeting held on July 14, 2022. The task force plans on incorporating feedback taken at that IP meet, releasing a revised draft, and holding an additional IP meeting to solicit additional input.

Legislation

2021

Assembly Bill (AB) 107 (Salas, Chapter 107) – Licensure: Veterans and Military Spouses

Starting July 1, 2023, requires boards to issue temporary licenses to practice within 30 days of receiving documentation that applicant meets all the requirements of the bill. The license would be terminated immediately upon finding the applicant failed to meet any of the requirements or provided substantially inaccurate information. The temporary license shall expire 12 months after issuance or upon issuance or denial of a standard/expedited license.

Requires DCA and boards to publish certain information pertaining to licensing options for military spouses on the homepage of their website. Requires DCA to publish annually specified information related to applications for licensure from military, veteran, and spouse licensure.

AB 133 (Committee on Budget, Chapter 143) – Health

This bill renames the Office of Statewide Health Planning and Development as the Department of Health Care Access and Information (HCAI). Requires the Board (among others) to request certain workforce data from licensees and registrants on at least a biennial basis. Each board (or DCA on behalf of the board) shall, starting July 1, 2022, report on a quarterly basis, this information to HCAI.

AB 359 (Cooper, Chapter 612) – Physicians and Surgeons: Licensure: Examination

Clarifies the licensure pathways for out-of-state physicians seeking to practice in California. Authorizes a physician to obtain continuing medical education (CME) credit for certain management and medical school educational methodology related courses, as specified. Limits the amount of allowable credit hours from those courses to no more than 30 percent of the total required hours (15 out of 50 hours).

AB 361 (Rivas, Robert, Chapter 361) – Open Meetings: State and Local Agencies: Teleconferences

This allows state bodies, including the Board, to continue to hold remote meetings, that would otherwise have to be conducted in person, until January 31, 2022.

SB 607 (Min, Chapter 367) – Business and Professions

Effective July 1, 2022, all boards are required to expedite licensure and waive application and initial licensure fees for those who (1) Supplies evidence satisfactory to the board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders; and (2) Holds a current license in another state, district, or territory of the United States in the profession or vocation for which the applicant seeks a license from the board

Senate Bill (SB) 806 (Roth, Chapter 649) – Healing Arts

This was the sunset bill for the Board and had the following effects:

Administration

- Increases various application, initial licensure, and renewal fees.
- States the Legislature's intent to review physician initial licensure and renewal fees in 2022 to determine whether to further increase fees, modify board processes, or both.
- Requires all applicants and licensees to have an email address and provide it to the Board no later than July 1, 2022.
- Extends the Board's sunset to January 1, 2024.

Enforcement

- Restores authority to recover prosecution and investigation costs from disciplined physicians.
- Clarifies reporting requirements and requires licensees (or their insurer/legal counsel) to provide a copy of a malpractice settlement agreement over $30,000 to the Board.
- Requires the DCA Director to appoint an enforcement monitor who will issue two reports to the Legislature in 2023.
- Requires medical consultants reviewing complaints related midwifery quality of care to be reviewed by medical consultants.
- Authorizes a confidential letter of advice (after a rulemaking) to be issued to a licensee for minor violations of the medical practice act not related to patient care.

- Allows a licensee to stipulate to surrender their license for a 10-year period, per BPC section 2273.

Licensing

- Requires the Board to grant a physician and surgeon license to individuals who have 12/24 months credit (PGT) (depending upon location of their medical school).
    - Requires those physicians at their first renewal to show evidence of 36 months PGT credit.
    - Grants authority for the Board to issue a license to applicants who demonstrate substantial compliance with these requirements.
- Allows the elimination of paper-based licensure application forms.
    - Eliminates the requirement to send a certified mail notification to those whose licenses may expire.
    - Changes from 90 days to 30 days following license expiration when penalty and delinquency fees are owed to the Board.
    - Clarifies the circumstances whereby a special permit (per BPC 2111, 2112, and 2113) may be canceled.
    - Clarifies the criteria to be recognized as an academic medical center to sponsor special faculty permit applicants.
    - Clarifies that PTL holders can sign any forms that a physician may sign.
    - PTLs may be issued up to 15 months for US/Canadian graduates or 27 months for international graduates.

2022

AB 657 (Cooper, Chapter 560) – Healing Arts: Expedited Licensure Process: Applicants Providing Abortions
Requires the Board (and other specified licensing boards) to expedite the licensure process for an applicant who demonstrates that they intend to provide abortions in California.

AB 852 (Wood, Chapter 518) - Health Care Practitioners: Electronic Prescriptions
This is a “clean-up” bill to AB 2789 of 2018 that required health care providers to issue their prescriptions electronically. Provides to qualified prescribers additional exemptions to electronic prescribing requirements.

AB 1102 (Low, Chapter 684) - Telephone Medical Advice Services
Clarifies existing law that requires health care professionals providing telephone medical advice services from an out-of-state location to do so consistent with the laws

governing their respective licenses. The bill also specifies that a telephone medical advice service is required to comply with all directions and requests for information made by the Department of Consumer Affairs and the respective healing arts licensing board.

AB 1278 (Nazarian, Chapter 750) – Physicians and Surgeons: Payments: Disclosure: Notice
Requires a physician and surgeon to provide a patient at their initial office visit a written or electronic notice of the Open Payments database, as defined. Requires a specified related to the database to be posted in an area likely to be seen by persons who enter their office. Starting January 1, 2024, requires a physician and surgeon who have a website to post a notice on their website related to the database.

AB 1636 (Weber, Chapter 453) – Physician's and Surgeon's Certificate: Registered Sex Offenders
Authorizes the Board to deny a physician and surgeon license application due to certain prior acts of professional sexual misconduct. Requires the Board to automatically revoke physician and surgeon licensees who were convicted of certain sexual crimes or committed professional sexual misconduct and deny petitions for reinstatement to individuals convicted of, or formally disciplined for, certain sexual offenses involving their current or former patients or clients, as specified.

AB 2060 (Quirk) – Medical Board of California
Sponsored by the Board, the bill changes the composition of the Board from physician-member to a public-member majority by converting a vacant physician-member position to a public-member position. The bill failed passage in the Assembly.

AB 2098 (Low, Chapter 938) – Physicians and Surgeons: Unprofessional Conduct
The bill designates the dissemination of misinformation or disinformation by a physician and surgeon related to the SARS-CoV-2 coronavirus, or “COVID-19,” as unprofessional conduct, as defined.

AB 2178 (Bloom, Chapter 329) – Physicians and Surgeons: Special Faculty Permits: Academic Medical Center
This bill updates the definition of an academic medical center, related to certain Board special permit programs.

AB 2626 (Calderon, Chapter 565) – Medical Board of California: Licensee Discipline: Abortion
Prohibits the Board and other specified licensing boards from disciplining a licensee for performing an abortion in accordance with existing state law.

SB 189 (Committee on Budget and Fiscal Review, Chapter 48) – State Government
A budget trailer bill that, among various other provisions, authorizes state entities to hold public meetings, subject to specified notice and accessibility requirements, through

teleconferencing and making public meetings accessible telephonically or otherwise electronically to the public, as specified. The bill also sunsets these provisions on July 1, 2023.

SB 528 (Jones, Chapter 812) – Juveniles: Medication Documentation
Requires certain forms related to the provision of psychotropic medications be included within a foster youth's case plan.

SB 923 (Wiener, Chapter 822) – Gender-Affirming Care
As it pertains to the Board, it allows current continuing medical education requirements related to cultural competency to be satisfied through evidence-based training related to individuals who identify as transgender, gender diverse, or intersex.

SB 1259 (Laird, Chapter 245) – Pharmacists: Furnishing Opioid Antagonists
Updates current law to allow a pharmacist, subject to certain protocols adopted by the California State Board of Pharmacy and the Board, to independent furnish any opioid antagonist approved by the federal Food and Drug Administration.

SB 1440 (Roth, Chapter 510) – Licensed Midwifery Practice Act of 1993: Complaints
Makes clarifying changes to one section related to enforcement of the Licensed Midwifery Practice Act of 1993.

SB 1443 (Roth, Chapter 625) – Professions and Vocations
An omnibus bill that, among other provisions, corrects an outdated cross-reference related to the former Office of Statewide Health Planning and Development, for the purposes of expediting a license application for a physician and surgeon who intends to practice in a medically underserved area or served a medically underserved population.

Regulations

Substantial Relationship and Rehabilitation – Implementation of AB 2138 (Chiu, Chapter 995, Statutes of 2018) (effective January 21, 2021)

The Board approved a proposed rulemaking to update its regulations as required pursuant to AB 2138 relating to evaluating whether a crime or act was substantially related to the profession, and to evaluate the rehabilitation of an applicant or licensee when considering denying or disciplining a license based on a conviction or professional discipline.

Postgraduate Training (effective June 11, 2021)

The Board approved a proposed rulemaking to update 16 CCR sections 1320 and 1321 to make these sections consistent with statutory changes relating to postgraduate training pursuant to SB 798 (Hill, Chapter 775, Statutes of 2017). Among other significant changes, the law modified the minimum requirements for postgraduate

training so that all applicants for a physician's and surgeon's license would be required to successfully complete 36 months of Board-approved postgraduate training, with 24 continuous months in the same program, regardless of whether they attended a domestic or international medical school. This rulemaking makes conforming changes consistent with statute.

Medical and Midwife Assistant Certifying Organizations and Administration of Training for Medical Assistants (effective April 1, 2022)

The Board approved a proposed rulemaking to update the requirements for medical and midwife assistant certifying organizations to strike the requirement that such organizations be non-profit, and instead, require them to be accredited by the National Commission for Certifying Agencies as a more reliable tool for quality control under 16 CCR sections 1366.31 and 1379.07. This proposed rulemaking will also make changes to 16 CCR section 1366.3, regarding the administration of training for medical assistants to reflect the current oversight agencies and the current name for the Bureau for Private Postsecondary Education (BPPE), to update the statutory references and for internal consistency.

Notice to Consumers (pending)

The Board approved a proposed rulemaking to require its licensees and registrants to provide notice to their patients or clients that the provider is licensed or registered by the Board, that the license or registration can be checked, and that complaints against the provider can be made through the Board's website, or by contacting the Board.

Citable Offenses (pending)

The Board approved a proposed rulemaking to amend 16 CCR section 1364 to permit a Board official to issue citations, including those containing orders of abatement and/or fines, to any licensee for a violation of any statute or regulation which would be grounds for discipline by the Board.

Further, the provisions relating to fine assessment under 16 CCR section 1364.10 will be amended to indicate that the amount shall not exceed the amount specified in BPC section 125.9(b)(3). This change will update the Board's authority to assess fines to the full extent authorized under this statute.

Physician and Surgeon Health and Wellness Program (PHWP) (pending)

SB 1177 (Galgiani, Chapter 591, Statutes of 2016), authorized the Board to establish a PHWP with the goal of providing early identification of, and appropriate interventions to support rehabilitation from, substance abuse to ensure physicians remain able to practice medicine in a manner that will not endanger the public and will maintain the integrity of the medical profession. The PHWP is required to comply with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees. The Board approved

a proposed rulemaking to implement the PHWP and to repeal the outdated regulations relating to the defunct diversion program.

Approved Continuing Education for Physicians and Licensed Midwives (pending)

From time to time, the Board offers its own educational programs for which it wants to provide CE credits to physicians and LMs who attend, such as for expert reviewer training. Consequently, the Board approved a proposed rulemaking to amend 16 CCR sections 1337 and 1379.26 to clarify that programs offered by the Board for CE are approved for credit, and to make additional minor, conforming changes. These changes may increase attendance at Board-offered training.

Licensed Midwife Annual Report (pending)

Pursuant to a request by the Midwifery Advisory Council, the Board approved a proposed rulemaking to add 16 CCR section 1379.35 to require each licensed midwife who assists, or supervises a student midwife in assisting, in childbirth that occurs in an out-of-hospital setting to report each client's race and ethnicity as identified by the client as part of the Licensed Midwife Annual Report.

Major Studies/Publications

4. Describe any major studies conducted by the Board (cf. Section 13, Attachment C).

Since the Board's prior sunset review, the Board has published the following items (links are included below and the full documents are provided in Section 13, Attachment C):

Leadership Accountability Report

In accordance with the State Leadership Accountability Act, the Board authored this 2021 report to provide information regarding the adequacy of its internal control systems to minimize fraud, errors, waste, and abuse of government funds.

Board Newsletter

The Board publishes its Newsletter every quarter. The Newsletter contains useful information for both physicians and the public. The Board no longer mails this publication, but instead emails it to all physicians and subscribers who have provided email accounts to the Board. This has helped the Board save postage and printing costs and also allows for a more interactive Newsletter.

Annual Report

Every year the Board provides statistical information on all Board programs via its Annual Report. A significant amount of the data provided in this report is required to be reported pursuant to BPC section 2313.

University of California, Davis, First Annual Report on the Mexico Pilot Program (MPP)

As required by BPC section 853, the Board contracted with the University of California, Davis, to conduct annual evaluations of the MPP. The university published its 1st Annual Progress Report of the MPP in August 2022.

5. List the status of all national associations to which the Board belongs.

a) Does the Board's membership include voting privileges?

b) List committees, workshops, working groups, task forces, etc., on which Board participates.

c) How many meetings did Board representative(s) attend? When and where?

d) **If the Board is using a national exam, how is the Board involved in its development, scoring, analysis, and administration?**

Federation of State Medical Boards

The Board is a member of the Federation of State Medical Boards (FSMB) and has voting privileges (one vote) on matters that come before the FSMB. The FSMB is a national non-profit organization representing the 70 medical and osteopathic boards of the United States and its territories. During 2020, 2021, and 2022, Board members and staff attended numerous remote and in-person meetings/events.

In 2022, President Kristina Lawson began serving on the FSMB's Ethics and Professionalism Committee, including attending committee meetings. In April 2022 at the FSMB's annual meeting, Ms. Lawson received the FSMB's Award of Merit related to her leadership for upholding the Board's consumer protection mission while facing harassment, threats, and political pressure related to COVID-19 mis/disinformation. That meeting was also attended by the Board's Secretary and the Board's Public Information Manager, who led a seminar on public information practices.

Administrators in Medicine

The Board is also a member of the Administrators in Medicine (AIM). However, the AIM is not a voting body, it is a national not-for-profit organization for state medical and osteopathic board executives. Board staff attended an AIM meeting in October 2020 via teleconference.

Educational Commission for Foreign Medical Graduates

The Board is a member of the Educational Commission for Foreign Medical Graduates (ECFMG). The Board is not a voting member of this organization. ECFMG is a private,

nonprofit organization whose mission is to promote quality health care for the public by certifying international medical graduates for entry into U.S. graduate medical education (GME), and by participating in the evaluation and certification of other physicians and health care professionals nationally and internationally. Board staff attended an ECFMG meeting in August 2020.

International Association of Medical Regulatory Authorities

The Board is a member of the International Association of Medical Regulatory Authorities (IAMRA). This organization's purpose is to encourage best practices among medical regulatory authorities worldwide in the achievement of their mandate — to protect, promote and maintain the health and safety of the public by ensuring proper standards for the profession of medicine. The Board is not a voting member. The U.S. as a whole maintains the voting authority that is delegated to the FSMB. In 2021, Board staff participated in two meetings (January and April 2021) and two webinars hosted by IAMRA.

National Examination – United States Medical Licensure Examination (USMLE) Committee

The Board uses a national examination, the USMLE, to meet the examination requirements for licensure as a physician. The USMLE is jointly owned by the National Board of Medical Examiners (NBME) and the FSMB. As a member of the FSMB, the Board receives significant information regarding the USMLE, including changes being recommended, scoring data, etc.

Citizen Advocacy Center

Lastly, the Board is a member of the Citizen Advocacy Center (CAC). The Board is not a voting member. The CAC is dedicated to building democracy for the 21st century by strengthening the citizenry's capacities, resources, and institutions for self-governance. CAC is committed to make government more accountable, further the citizen's understanding, promote individual and community efforts, stimulate citizen awareness, improve access, and advance justice.

Sunset Review Oversight Report

Section 2

Performance Measures and Customer Satisfaction Surveys

- *Performance Measure Reports*
- *Consumer Satisfaction Surveys*

PERFORMANCE MEASURES AND CUSTOMER SATISFACTION SURVEYS

Performance Measure Reports

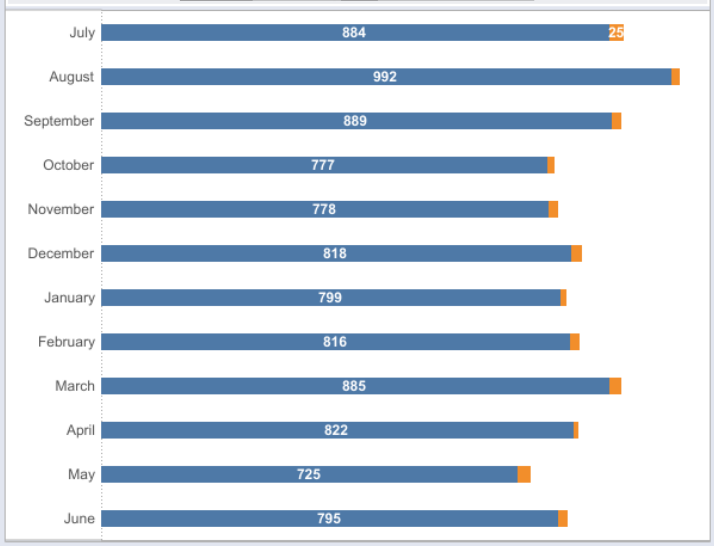
6. Provide each quarterly and annual performance measure report for the board as published on the DCA website.

All quarterly and annual Enforcement performance measure reports for FY 20/21 and FY 21/22 as published on the DCA's website are in Section 13, Attachment G.

Below are the Enforcement annual reports for FY 21/22 and the annual Licensing performance measure reports for FY 21/22 and 20/21.

Enforcement Performance Measures FY 2021-2022:

Board Name: Medical Board of California | State Fiscal Year: SFY 2022 | Enforcement Case Type: Complaints, Conviction/Arrest



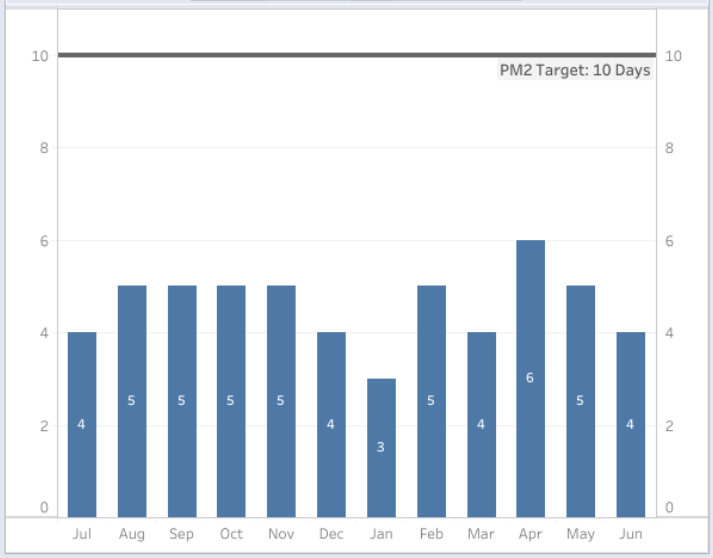
Medical Board of California
SFY 2022: 12-Month | **PM1:** Summary

	Complaints	Conviction/Arrest	Total Volume
Grand Total	**9,980**	**204**	**10,184**
July	884	25	909
August	992	15	1,007
September	889	16	905
October	777	12	789
November	778	17	795
December	818	19	837
January	799	12	811
February	816	18	834
March	885	20	905
April	822	9	831
May	725	23	748
June	795	18	813

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

Select a DCA Entity: Medical Board of California
Select a Fiscal Year: SFY 2022
Cycle Time: Actual, Target
Performance v Target: Below Target

Medical Board of California
SFY 2022: 12-Month | **PM2** - Intake Cycle Time



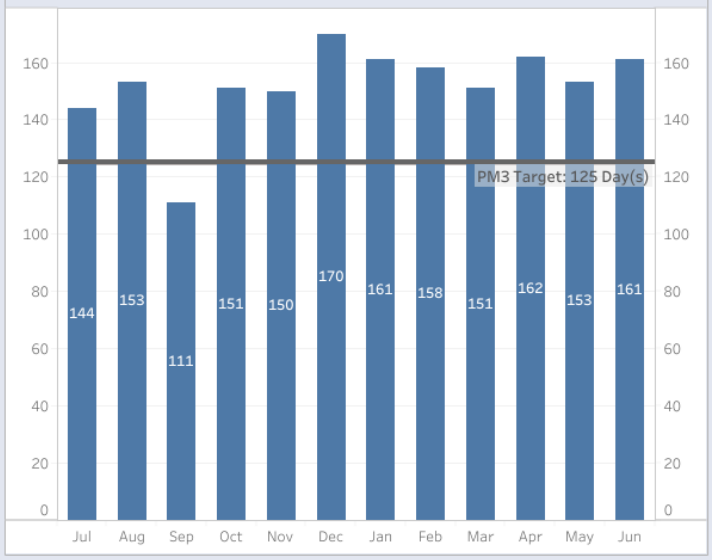
Medical Board of California
SFY 2022: 12-Month | **PM2** - Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	10,257	10 Days	5 Day(s)	▼ -5 Day(s)
July	828	10 Days	4 Day(s)	▼ -6 Day(s)
August	998	10 Days	5 Day(s)	▼ -5 Day(s)
September	932	10 Days	5 Day(s)	▼ -5 Day(s)
October	774	10 Days	5 Day(s)	▼ -5 Day(s)
November	827	10 Days	5 Day(s)	▼ -5 Day(s)
December	924	10 Days	4 Day(s)	▼ -6 Day(s)
January	730	10 Days	3 Day(s)	▼ -7 Day(s)
February	842	10 Days	5 Day(s)	▼ -5 Day(s)
March	912	10 Days	4 Day(s)	▼ -6 Day(s)
April	854	10 Days	6 Day(s)	▼ -4 Day(s)
May	729	10 Days	5 Day(s)	▼ -5 Day(s)
June	907	10 Days	4 Day(s)	▼ -6 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

Select a DCA Entity: Medical Board of California
Select a Fiscal Year: SFY 2022
Cycle Time: Actual, Target
Performance versus Target: Above Target, Below Target

Medical Board of California
SFY 2022: 12-Month | **PM3** - Investigations Cycle Time

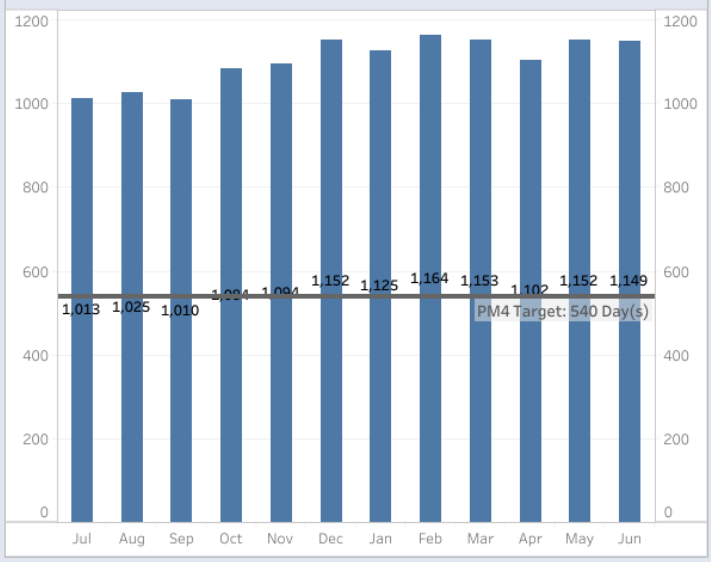


Medical Board of California
SFY 2022: 12-Month | **PM3** - Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	9,536	125 Days	153 Day(s)	▲ 28 Day(s)
July	889	125 Days	144 Day(s)	▲ 19 Day(s)
August	916	125 Days	153 Day(s)	▲ 28 Day(s)
September	751	125 Days	111 Day(s)	▼ -14 Day(s)
October	629	125 Days	151 Day(s)	▲ 26 Day(s)
November	637	125 Days	150 Day(s)	▲ 25 Day(s)
December	894	125 Days	170 Day(s)	▲ 45 Day(s)
January	814	125 Days	161 Day(s)	▲ 36 Day(s)
February	758	125 Days	158 Day(s)	▲ 33 Day(s)
March	873	125 Days	151 Day(s)	▲ 26 Day(s)
April	788	125 Days	162 Day(s)	▲ 37 Day(s)
May	629	125 Days	153 Day(s)	▲ 28 Day(s)
June	958	125 Days	161 Day(s)	▲ 36 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2022 | Cycle Time: Actual, Target | Performance versus Target: Above Target

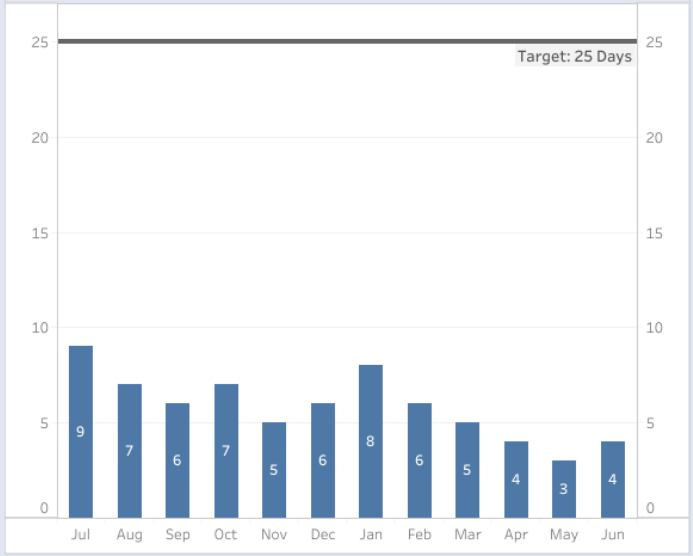


Medical Board of California
SFY 2022: 12-Month | **PM4** - Summary

	Case Volume	Target	Actual	Variance
Grand Total	534	540 Days	1,106 Day(s)	▲566 Day(s)
July	43	540 Days	1,013 Day(s)	▲473 Day(s)
August	33	540 Days	1,025 Day(s)	▲485 Day(s)
September	43	540 Days	1,010 Day(s)	▲470 Day(s)
October	40	540 Days	1,084 Day(s)	▲544 Day(s)
November	37	540 Days	1,094 Day(s)	▲554 Day(s)
December	52	540 Days	1,152 Day(s)	▲612 Day(s)
January	61	540 Days	1,125 Day(s)	▲585 Day(s)
February	50	540 Days	1,164 Day(s)	▲624 Day(s)
March	54	540 Days	1,153 Day(s)	▲613 Day(s)
April	47	540 Days	1,102 Day(s)	▲562 Day(s)
May	26	540 Days	1,152 Day(s)	▲612 Day(s)
June	48	540 Days	1,149 Day(s)	▲609 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.

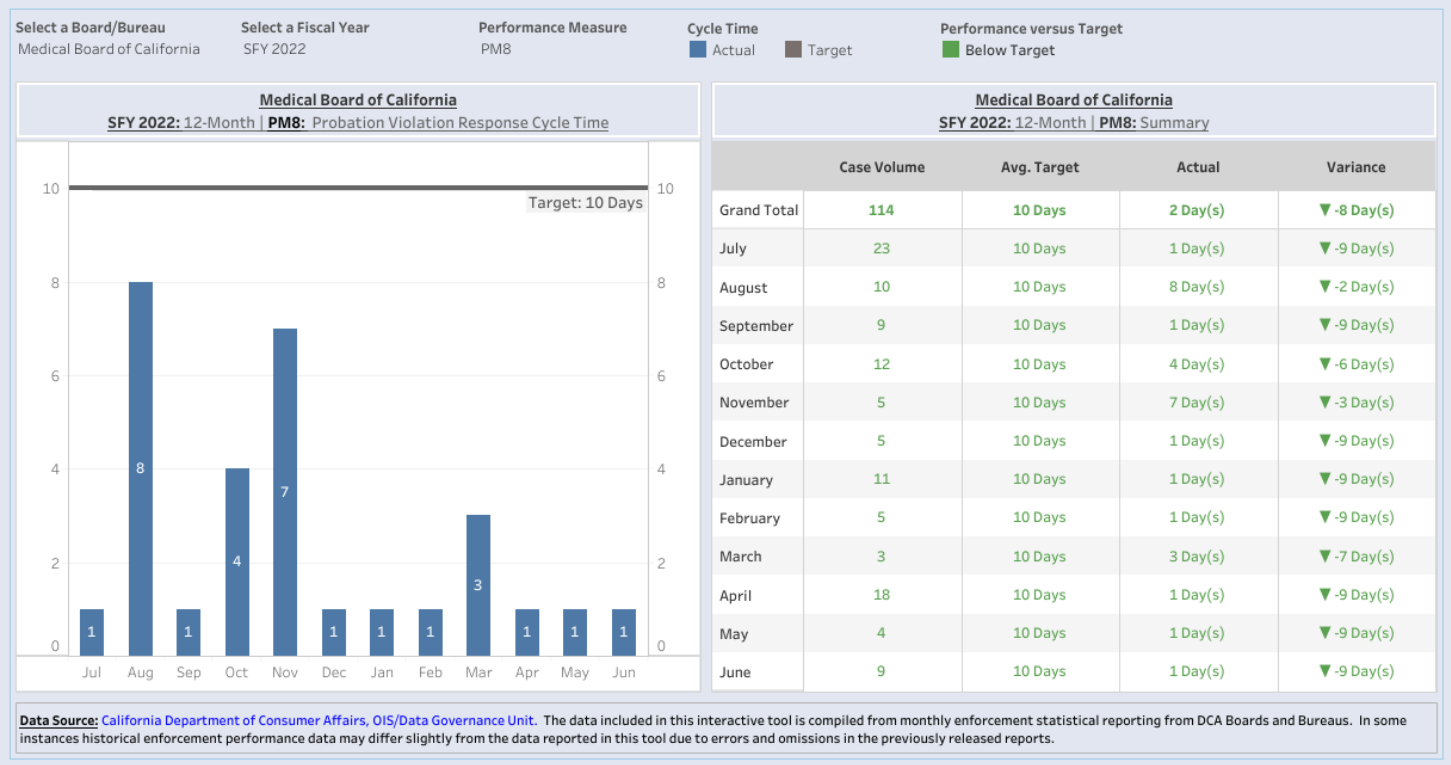
Select a Board/Bureau: Medical Board of California | Select a Fiscal Year: SFY 2022 | Performance Measure: PM7 | Cycle Time: Actual, Target | Performance versus Target: Below Target



Medical Board of California
SFY 2022: 12-Month | **PM7:** Summary

	Case Volume	Avg. Target	Actual	Variance
Grand Total	167	25 Days	6 Day(s)	▼-19 Day(s)
July	9	25 Days	9 Day(s)	▼-16 Day(s)
August	19	25 Days	7 Day(s)	▼-18 Day(s)
September	14	25 Days	6 Day(s)	▼-19 Day(s)
October	9	25 Days	7 Day(s)	▼-18 Day(s)
November	11	25 Days	5 Day(s)	▼-20 Day(s)
December	27	25 Days	6 Day(s)	▼-19 Day(s)
January	12	25 Days	8 Day(s)	▼-17 Day(s)
February	21	25 Days	6 Day(s)	▼-19 Day(s)
March	17	25 Days	5 Day(s)	▼-20 Day(s)
April	9	25 Days	4 Day(s)	▼-21 Day(s)
May	6	25 Days	3 Day(s)	▼-22 Day(s)
June	13	25 Days	4 Day(s)	▼-21 Day(s)

Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data reported in this tool due to errors and omissions in the previously released reports.



Licensing Performance Measures FY 2021-2022:

License Type	Application Type	Target Cycle Time (Complete)	Volume (Complete)	Cycle Time (Complete)	Volume (Incomplete)	Cycle Time (Incomplete)
Licensed Midwife	Initial Licensing Application	40	2	23	29	50
Postgraduate Training Authorization Letter (PTAL)	Initial PTAL Application	84	N/A	N/A	N/A	N/A
Physician and Surgeon	Initial Licensing Application (without a PTAL)	84	550	43	6272	121

Physician and Surgeon	Physician and Surgeon Initial Licensing Application (with a PTAL)	60	0	N/A	110	1235
Student Research Psychoanalyst	Initial Licensing Application	30	0	N/A	7	104
Research Psychoanalyst	Initial/ Upgrade Licensing Application	30	1	12	3	44
Special Programs (Individual)	Initial Application	45	2	10	42	93
Special Programs (Organization)	Initial Application	120	0	N/A	0	N/A
Special Faculty Permit	Initial Application	150	0	N/A	1	197
Registered Polysomnographic Trainee	Initial Application	30	3	21	20	149
Registered Polysomnographic Technician	Initial/ Upgrade Application	30	5	15	18	99
Registered Polysomnographic Technologist	Initial/ Upgrade Application	30	2	7	26	81
Postgraduate Training License (PTL)	Initial Application	84	489	38	2422	90

Licensing Performance Measures FY 2020-2021:						
License Type	**Application Type**	**Target Cycle Time (Complete)**	**Volume (Complete)**	**Cycle Time (Complete)**	**Volume (Incomplete)**	**Cycle Time (Incomplete)**
Licensed Midwife	Initial Licensing Application	40	1	16	35	47
Postgraduate Training Authorization Letter (PTAL)	Initial PTAL Application	84	N/A	N/A	N/A	N/A
Physician and Surgeon	Initial Licensing Application (without a PTAL)	84	171	59	4122	154
Physician and Surgeon	Physician and Surgeon Initial Licensing Application (with a PTAL)	60	0	N/A	48	1766
Student Research Psychoanalyst	Initial Licensing Application	30	0	N/A	2	37
Research Psychoanalyst	Initial/Upgrade Licensing Application	30	0	N/A	2	24
Special Programs (Individual)	Initial Application	45	1	27	29	119
Special Programs (Organization)	Initial Application	120	0	N/A	0	N/A
Special Faculty Permit	Initial Application	150	0	N/A	4	214

Registered Polysomnographic Trainee	Initial Application	30	0	N/A	5	68
Registered Polysomnographic Technician	Initial/Upgrade Application	30	2	14	13	69
Registered Polysomnographic Technologist	Initial/Upgrade Application	30	1	30	19	117
Postgraduate Training License (PTL)	Initial Application	84	911	68	2954	130

Consumer Satisfaction Surveys

7. Provide results for each question in the Board's customer satisfaction survey broken down by fiscal year. Discuss the results of the customer satisfaction surveys.

DCA Customer Satisfaction Survey

During the prior two fiscal years, the Board received 29 responses from the DCA customer satisfaction survey. The Board believes this low response is insufficient to draw any meaningful conclusions. Below are the results for each question by fiscal year.

1. How well did we explain the complaint process to you?	**FY 20-21**	**FY 21-22**
	11 Responses	19 Responses
Very Poor	46%	53%
Poor	36%	31%
Good	18%	16%
Very Good	0%	0%
No Response	0%	0%
2. How clearly was the outcome of your complaint explained to you?	**FY 20-21**	**FY 21-22**
	11 Responses	19 Responses

Very Poor	64%	63%
Poor	27%	32%
Good	9%	5%
Very Good	0%	0%
No Response	0%	0%
3. How well did we meet the timeframe provided to you?	**FY 20-21**	**FY 21-22**
	11 Responses	19 Responses
Very Poor	46%	68%
Poor	36%	16%
Good	18%	11%
Very Good	0%	5%
No Response	0%	0%
4. How courteous and helpful was staff?	**FY 20-21**	**FY 21-22**
	11 Responses	19 Responses
Very Poor	73%	53%
Poor	9%	16%
Good	18%	21%
Very Good	0%	10%
No Response	0%	0%
5. Overall, how well did we handle your complaint?	**FY 20-21**	**FY 21-22**
	11 Responses	19 Responses
Very Poor	73%	89%
Poor	18%	11%
Good	9%	0%
Very Good	0%	0%
No Response	0%	0%
	FY 20-21	**FY 21-22**

6. If we were unable to assist you, were alternatives provided to you?	11 Responses	19 Responses
Yes	0%	5%
No	100%	90%
Not Applicable	0%	5%
No Response	0%	0%
7. Did you verify the provider's license prior to service?	**FY 20-21**	**FY 21-22**
	11 Responses	19 Responses
Yes	55%	58%
No	45%	21%
Not Applicable	0%	21%
No Response	0%	0%

Sunset Review Oversight Report

Section 4

Licensing Program

- *Examinations*
- *School Approvals*
- *Continuing Education*
- *Specialty Faculty Permits*
- *Special Programs*
- *Fictitious Name Permits*
- *Medical Assistants*
- *Outpatient Surgery Setting Accreditation*

LICENSING PROGRAM

18. What are the Board's performance targets/expectations for its licensing[2] program? Is the Board meeting those expectations? If not, what is the Board doing to improve performance?

16 CCR section 1319.4 requires the Board to notify applicants within 60 working days of receipt of a Physician's and Surgeon's (P&S) license application whether the application is complete and accepted for licensure or deficient. Since SB 798 created BPC sections 2064.5 and 2065, which reference a Postgraduate Training License (PTL), the Board will be revising CCR section 1319.4 to include these new sections. The Board is currently meeting this mandate for its PTL and physician license applications.

Even though the Board will develop regulations to set a performance target for the PTL applications, the Board currently expects these applications to be reviewed within 45 calendar days from the date of receipt. The Board has set expectations that all mail received for the licensing program be reviewed and documented within seven business days from the date of receipt.

Due to the law change effective January 1, 2022, as a result of SB 806, the Board experienced a sharp increase in the number of P&S license applications in Quarter 3 and 4 of Fiscal Year (FY) 2021-22. The Board received 3,347 in Quarter 3 and 2,424 in Quarter 4, and a total of 7,910 for the entire fiscal year, which is a 68 percent increase from the previous fiscal year. The Board also received 2,924 PTL applications in FY 2021-22. Due to this increase in application volume, the processing time from receipt of an application to the initial review of the application increased to approximately 60 calendar days, which is still less than the regulatory timeframe.

To implement SB 806, the Legislature authorized three additional positions for the Board's Licensing Program effective July 1, 2022, which the Board is currently in the process of filling.

The Board has also made progress moving towards a paperless process by eliminating some of the documents previously required for licensure that were resulting in common deficiencies. For example, the Board eliminated the requirement for the applicant to notarize the application form, which was previously required of online and paper applicants. The Board also eliminated the photo requirement and now licensure verifications are only required upon request, as the Board already receives license information from the Federation of State Medical Boards and the American Medical Association. The Board also made significant changes to some of its online license applications in October 2022 that will allow the Board to eliminate the paper application

[2] The term "license" in this document includes a license certificate or registration.

for these applications and significantly reduce the number of paper documents mailed to the Board. The Board hopes with these changes and with application volumes expected to normalize in 2023, the application processing times will return to no more than 45 days.

19. Describe any increase or decrease in the Board's average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done by the board to address them? What are the performance barriers and what improvement plans are in place? What has the Board done and what is the Board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?

Due to law changes effective January 1, 2020, and 2022, the Board experienced increases in the total number of license applications received, resulting in the number of pending applications to increase from FY 2019/20 to FY 2020/21. However, the Board has significantly increased the number of P&S Licenses issued from FY 2020/21 to FY 2021/22, which has decreased the total number of pending P&S license applications.

The Board's average processing time to review new license applications has historically been approximately 30 calendar days. However, as indicated in the response to Question 18, the sudden increase in application volume has increased the average processing time to approximately 60 calendar days. The Board was authorized for three additional positions effective July 1, 2022, to address the increase in application volume and believes with the additional staff and a possible decrease in application volume in 2023, one year from the change in licensure requirements, processing times will decrease.

As addressed in the response to Question 18, the Board has made significant progress in transitioning to a paperless process, removing barriers in the application process, and continues to evaluate its processes to identify efficiencies. In 2022, the Board completed mapping all of its licensing business processes and analyzed the value of every step of each process. The Board also began mapping its "could-be" processes to what the paperless process would look like and any other changes that could be made to increase efficiency, such as additional BreEZe system changes.

The Board continues to register medical schools and postgraduate training programs in the Board's Direct Online Certification Submission (DOCS) portal, which allows these entities to submit documents required for license applications directly to the Board and eliminates the time and cost of mailing documents. As of September 30, 2022, 381 medical schools and 1,334 postgraduate training programs are registered in DOCS, a 39% increase since October 2020.

The number of licenses issued continued to far exceed the number of pending license applications. The Board issued 6,932 P&S licenses in FY 2021-22 and 2,627 were pending as of the end of the fiscal year. The Board issued 2,911 PTLs in FY 2021-22 and 113 were pending as of the end of the fiscal year.

20. How many licenses or registrations has the Board denied over the past four years based on criminal history that is determined to be substantially related to the qualifications, functions, or duties of the profession, pursuant to BPC § 480? Please provide a breakdown of each instance of denial and the acts the board determined were substantially related.

The Board has denied five (5) licenses over the past four fiscal years based on criminal history that the Board determined was substantially related to the qualifications, functions, or duties of the profession, pursuant to BPC section 480. The denials were as follows: Below is a breakdown of each instance of denial by fiscal year.

Criminal Conviction Denials			
FY 18/19	FY 19/20	FY 20/21	FY 21/22
4	0	0	1

FY 2018/2019

Physician and Surgeon: Denied due to applicant's criminal record history and disciplinary actions taken by the Tennessee, Pennsylvania, and Connecticut Medical Boards. Federal conviction in 2011 for healthcare fraud and failure to file income tax return.

Physician and Surgeon: Denied due to applicant's criminal record history and failure to disclose the conviction. 2017 conviction for impaired driving (alcohol related conviction).

Physician and Surgeon: Denied due to applicant's criminal record history and disciplinary actions taken by the Iowa, New York, and Missouri Medical Boards. Maryland 2016 conviction for second-degree assault.

Physician and Surgeon: Denied due to applicant's criminal record history and disciplinary actions taken by the Oklahoma and Pennsylvania Medical Boards. Oklahoma Federal conviction in 2013 for healthcare fraud.

FY 2019/2020

The Board did not deny any licenses or registrations based on criminal history that the Board determined as substantially related to the qualifications, functions, or duties of the profession in FY 2019/2020.

FY 2020/2021

The Board did not deny any licenses or registrations based on criminal history that the Board determined as substantially related to the qualifications, functions, or duties of the profession in FY 2020/2021.

FY 2021/2022

Physician and Surgeon: Offered a stipulation for probationary license due to applicant's criminal record history involving alcohol and recovery program's recommendation for inpatient treatment due to severe alcohol addiction. Criminal conviction in September 2019 for DUI that was amended in November 2019 to reckless driving with disregard of safety of person or property. Applicant rejected the offer for a probationary license, which resulted in denial of the application.

Table 6. Licensee Population

		FY 18/19	FY 19/20	FY 20/21	FY 21/22
8002 – Physician and Surgeon	Active	142873	145358	145318	146509
	Out of State	Both = 25,303	Both = 25,784	Both = 26,458	26,423
	Out of Country				564
	Delinquent/Expired	18,498	17823	18236	19461
	Retired Status *if applicable*	6328	6527	6753	6656
	Inactive	218	209	224	222
	Other=Disabled	99	98	94	87
8014 – Postgraduate Training License	Active	N/A	1925	5,655	6,735
	Out of State	N/A	Unknown	Unknown	117
	Out of Country	N/A	Unknown	Unknown	0
	Delinquent/Expired	N/A	N/A	N/A	N/A
	Retired Status *if applicable*	N/A	N/A	N/A	N/A

	Inactive	N/A	N/A	N/A	N/A
	Other	N/A	N/A	N/A	N/A
Note: 'Out of State' and 'Out of Country' are two mutually exclusive categories. A licensee should not be counted in both.					

Table 7a. Licensing Data by Type - 8002 – Physician and Surgeon

	App Type	Received	Approved/ Issued	Closed	Pending Applications			Cycle Times		
					Total (Close of FY)	Complete (within Board control)*	Incomplete (outside Board control)*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 19/20	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	5629	6072	1581	2079	-	-	36	219	-
	(Renewal)	n/a	71024	n/a	-	-	-	-	-	-
FY 20/21	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	4699	4341	597	2734	-	-	60	173	-
	(Renewal)	n/a	70802	n/a	-	-	-	-	-	-
FY 21/22	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	7910	6932	366	2627	-	-	50	152	-
	(Renewal)	n/a	70742	n/a	-	-	-	-	-	-
* Optional. List if tracked by the board.										

Table 7a. Licensing Data by Type - 8014 – Postgraduate Training License

	App Type	Received	Approved /Issued	Closed	Pending Applications			Cycle Times		
					Total (Close of FY)	Complete (within Board control)*	Incomplete (outside Board control)*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 19/20	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	4122	1925	115	2082	-	-	45	81	-
	(Renewal)	n/a	n/a	n/a	-	-	-	-	-	-

FY 20/21	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	3099	3865	94	1023	-	-	68	130	-
	(Renewal)	n/a	n/a	n/a	-	-	-	-	-	-
FY 21/22	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	2924	2911	113	601	-	-	38	90	-
	(Renewal)	n/a	n/a	n/a	-	-	--	-	-	-
* Optional. List if tracked by the board.										

Table 7b. License Denial

	FY 19/20	FY 20/21	FY 21/22
License Applications Denied (no hearing requested)		0	8
SOIs Filed		3	4
Average Days to File SOI* (from request for hearing to SOI filed)		86 Days	52 Days
SOIs Declined		1	0
SOIs Withdrawn		2	1
SOIs Dismissed (license granted)		0	0
License Issued with Probation / Probationary License Issued		19	14
Average Days to Complete (from SOI filing to outcome)		443 Days	384 Days

21. How does the Board verify information provided by the applicant?

Applicants are required to submit an application provided by the Board, which contains a legal verification to be signed by the applicant verifying under penalty of perjury that the information provided is true and correct and that any information in the supporting documents provided by the applicant is true and correct. Required supporting documents must be submitted directly to the Board by the issuing entity to be acceptable.

Applicants are required by law to truthfully answer all questions asked on the application for licensure. The applicant must complete an application and sign it under penalty of perjury that all of the information contained is true and correct. Additionally, the Board requires that documents submitted by medical schools and postgraduate training programs be notarized, unless submitted through DOCS.

The Board verifies the following information provided by applicants:

- All international graduates must be certified by the ECFMG. The applicant must provide an ECFMG Certification Status Report and an official examination history report to verify certification and passing scores.
- The Certificate of Medical Education form must be completed by each medical school attended by the applicant. To certify the form, school officials must affix their signature and the medical school seal to the form (the seal is not required if submitted through DOCS).
- Applicant must list all accredited postgraduate training programs attended in the U.S. and Canada, and answer several questions related to possible issues that occurred during training. If an affirmative response to any of the questions is provided, the applicant must provide a signed and dated detailed narrative of the events and circumstances leading to the action(s) indicated on the application.
- The Certificate of Completion of ACGME/RCPSC/CFPC (Accreditation Council for Graduate Medical Education/Royal Colleges of Physicians and Surgeons of Canada/College of Family Physicians of Canada) Postgraduate Training must be submitted for each year of accredited postgraduate training completed, whether or not the entire residency was completed. The program director must provide all of the required information and responses on the form, affix the date, add his/her original signature, include the hospital seal, and send it directly to the Board. The program director's signature must be notarized if the hospital does not have a seal. The seal and notary are not required if submitted through DOCS. If a program director provides an affirmative response to any of the questions under "Unusual Circumstances" on the form, they must provide a written explanation and supporting documents necessary to review the issue.
- The applicant must disclose all current and/or previous licenses held and upon request, provide a License Verification (LV) from each state or province, sent directly to the Board by the licensing entity, verifying the applicant's licensure information and whether any action has been taken against the license.
- The applicant must provide information about disciplinary actions by a U.S. military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province, or hospital. If an affirmative response to any of these questions is provided, the applicant and the institution or agency

must provide a detailed narrative of the events and circumstances leading to the action(s). In addition, the applicant must respond to a question inquiring whether he/she is a registered sex offender. Copies of pertinent investigatory and disciplinary documents and certified copies of all orders of discipline must be provided directly to the Board by the appropriate agency. The Board queries the National Practitioner Data Bank (NPDB) if the applicant is licensed in another state, which provides information on medical malpractice payments and certain adverse actions related to health care practitioners, providers, and suppliers. The Board also queries all applicants in the FSMB database, which provides a record of disciplinary action taken by other states or jurisdictions and any inappropriate behavior during the examination.

- The applicant must respond to questions asking about whether they have a current physical or mental health condition(s) that impacts their ability to practice medicine safely. Any positive answer does not automatically disqualify the applicant from licensure. The Board will make an individualized assessment of the nature and severity and the duration of the risks associated with an ongoing medical condition to determine whether an unrestricted license should be issued, or conditions should be imposed on the license. If an affirmative response to any of the questions is provided, the applicant must provide a detailed narrative explaining the medical conditions. The Board did not deny any licenses or issue any probationary licenses in FY 2020/21 or FY 2021/22 for reasons related to physical or mental health, except when the reason was related to alcohol or substance abuse.

Currently, if the Board is provided criminal history information by the DOJ, the Board will request information from the applicant on a voluntary basis. The Board will request documentation from the appropriate criminal justice agency as well regarding any prior arrests or convictions. The applicant may also voluntarily provide evidence of rehabilitation.

a. What process does the Board use to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant? Has the Board denied any licenses over the last four years based on the applicant's failure to disclose information on the application, including failure to self-disclose criminal history? If so, how many times and for what types of crimes (please be specific)?

All applicants must obtain fingerprint criminal record checks from both the DOJ and the Federal Bureau of Investigation (FBI) prior to the issuance of a PTL or a physician medical license in California.

The Board does not receive criminal history information from international entities, except for what is provided by DOJ and FBI on all applicants.

All reports of criminal history, prior disciplinary actions, or other unlawful acts are reviewed on a case-by-case basis to determine if an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is eligible for licensure.

Currently, if the Board is provided criminal history information by the DOJ, the Board will request information from the applicant on a voluntary basis. The Board will also request documentation from the appropriate criminal justice agency regarding any prior arrests or convictions. The applicant may also voluntarily provide evidence of rehabilitation.

Over the last four years, the Board has denied nine applications for a P&S license based on the applicant's failure to disclose information on the application. These nine denials included six applicants who failed to disclose issues and/or being placed on probation during their postgraduate training programs; two applicants failed to disclose disciplinary actions taken against their license by another licensing agency; and one applicant failed to disclose a letter of warning issued by another licensing agency.

AB 2138 (Chiu and Low, Chapter 995), effective July 1, 2020, limited discretion for boards, bureaus and committees within the DCA to apply criminal conviction history for a license denial. Among other provisions, the current law only allows a board to deny a license on the grounds that the applicant has been convicted of a crime or has been subject to formal discipline if the applicant has been convicted of a crime for which the applicant is presently incarcerated or for a conviction occurring within the preceding seven years (the seven year limitation would not apply to a conviction for a serious felony, as defined in Penal Code section 1192.7), or if the applicant has been subjected to formal discipline by a board within the preceding seven years from the date of application based on professional misconduct that would have been cause for discipline before that board and that is substantially related to the qualifications, functions, or duties of the business or profession for which the present application is made.

b. Does the Board fingerprint all applicants?

All licensure and registration applicants must be fingerprinted. Pursuant to BPC section 2082(g), if the applicant is residing outside of California, then they must submit fingerprint cards. If the applicant is residing in California, then they must visit a Live Scan Service provider. The DOJ processes fingerprint submissions, which establishes the identity of the applicant and provides the Board the applicant's criminal conviction and arrest record in California or in any other jurisdiction within the U.S. During the application process and for the life of the license, the Board receives subsequent arrest records notifying the Board of any

changes. Subsequent arrest reports are reviewed by the Board's Enforcement Program to determine if any action should be taken against the licensee.

c. Have all current licensees been fingerprinted? If not, explain.

All licensees with a current license have been fingerprinted. As fingerprinting is a requirement for licensure, a P&S license or PTL will not be issued prior to completion of this requirement.

d. Is there a national databank relating to disciplinary actions? Does the Board check the national databank prior to issuing a license? Renewing a license?

The Board queries the NPDB for applicants that hold a license in another state, territory, or province, and that disclose any issue of concern on the application or during the application process. The NPDB is a confidential information clearinghouse created by Congress to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S.

The Board does not query NPDB during the licensee's renewal process. The Board has mandatory reporting requirements from several entities to ensure it receives the necessary information on its licensees to protect the public. The following entities submit the required mandatory reporting:

- Reports of malpractice settlement, judgement or arbitration awards from professional liability insurers, self-insured governmental agencies, physicians and/or their attorneys, and employers.
- Subsequent arrest records from DOJ and FBI.
- The coroner's office reports the physician if the death of a patient may have been the result of a physician's gross negligence.
- A licensed health care facility files a report when the physician's application for staff privileges or membership is denied, or the physician's staff privileges or employment is terminated or revoked for a medical disciplinary cause.
- A licensed health care facility files a report when restrictions are imposed or voluntarily accepted on the physician's staff privileges (most of which are the same as required to be reported to the NPDB), to ensure it receives the necessary information to protect the public.

The Board is also a member of the FSMB. As a member, the Board queries all applicants in the FSMB database. This database contains a record of disciplinary actions taken by other states and jurisdictions, as well as any inappropriate behavior during an examination. The FSMB also identifies licenses held in other states or jurisdictions, which are reported by other state licensing boards. If

another state or jurisdiction takes action against a license, it reports this information to the FSMB. The FSMB sends an email to the Board indicating the action taken. The Board's Enforcement Program analyzes the information and determines the appropriate action.

e. Does the Board require primary source documentation?

The Board requires that all documentation, including an applicant's medical education, examination history, postgraduate training, and licensure history, is primary-source verified. All documents must be signed by an entity official and affixed with the entity seal. If the seal is not available, a notarized signature may be required. Medical schools and training programs submitting documents through DOCS are not required to include the seal or notary.

22. Describe the Board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.

The Board grants licensure to applicants that comply with the requirements pursuant to BPC sections 2064.5 and 2065.

Up until December 31, 2019, applicants of approved U.S./Canadian medical schools were required to have completed at least one year of approved postgraduate training to qualify for a P&S license, while international graduates were required to have completed at least two years of postgraduate training. This requirement changed effective January 1, 2020, to require all graduates of approved U.S./Canadian or international medical schools to obtain 36 months of postgraduate training, including 24 continuous months in the same program. As a result of SB 806, the law changed again on January 1, 2022, and returned to the same postgraduate training requirements in effect prior to January 1, 2020. SB 806 also requires all licenses issued January 1, 2022, or later, to provide proof of obtaining credit for 36 months of board-approved postgraduate training, including 24 continuous months in the same program, in order to renew their license for the first time.

PTL applicants have the same requirements regardless of whether or not they graduated from a U.S./Canadian or international school, except that, if the applicant graduated from an international medical school, then they must submit an ECFMG Certification Status Report.

The Board queries the NPDB for applicants who hold a license in another state, territory, or province, and disclose any issue of concern on the application or during the application process.

BPC sections 2135 and 2135.5 provide some exceptions to the minimum postgraduate training requirements or license examination minimum requirements for applicants that

hold an unrestricted, renewed and current license in another state for the specified number of years and are certified by one of the ABMS affiliate boards. Board staff reviews each application to ensure the appropriate licensing pathway.

The Board does not waive documentation requirements for applicants of U.S./Canadian or international medical schools; all required documentation must be submitted. The Board also does not waive documentation for applicants who are licensed in another state or country through reciprocity.

23. Describe the Board's process, if any, for considering military education, training, and experience for purposes of licensing or credentialing requirements, including college credit equivalency.

The Board recognizes military medical education approved by the Liaison Committee on Medical Education (LCME). Additionally, the Board recognizes postgraduate training programs conducted at military hospitals with ACGME accreditation.

a. **Does the Board identify or track applicants who are veterans? If not, when does the Board expect to be compliant with BPC § 114.5?**

   The Board identifies and tracks applicants who indicate they are veterans of the U.S. Armed Forces on the application and/or submission of official documentation proving military status.

b. **How many applicants offered military education, training or experience towards meeting licensing or credentialing requirements, and how many applicants had such education, training or experience accepted by the Board?**

   The Board does not have a mechanism to quantify the number of applicants who offered military education, training, and experience toward meeting licensing requirements, since the Board accepts all medical schools approved by the LCME and all postgraduate training approved by the ACGME, and does not differentiate between military and non-military education, training, and experience, as there are overlapping requirements.

c. **What regulatory changes has the Board made to bring it into conformance with BPC § 35?**

   The Board was not required to make any regulatory changes to conform to BPC section 35, since the Board already recognizes military medical schools based upon LCME approval and postgraduate training programs conducted at military hospitals with ACGME accreditation.

d. How many licensees has the Board waived fees or requirements for pursuant to BPC § 114.3, and what has the impact been on board revenues?

BPC section 114.3(f) states this requirement does not apply to any board that has a similar license renewal waiver process in statute. At the time BPC section 114.3 became law, the Board already operated under a similar license renewal waiver process under BPC section 2440. From FY 2020/21 through FY 2021/22, the Board approved 212 renewal applications pursuant to BPC Section 2440.

e. How many applications has the board expedited pursuant to BPC § 115.5?

The Board issued 38 PTL and P&S licenses between FY 2019/20 and 2021/22 that qualified for the expedited license process pursuant to BPC Section 115.5.

24. Does the Board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.

In the Licensing Program, the Board electronically submits No Longer Interested (NLI) notifications to the DOJ on a weekly basis. A license is added to the NLI list 180 days after all licenses associated to the licensee are in canceled, retired, deceased, surrendered, or revoked status, and there are no open or pending applications associated to the licensee. The Board also has the ability to flag an applicant or licensee to add to the NLI list. Additionally, fingerprint results received by the Board that do not match to an applicant in the Board's system for 12 months or more are also added to the NLI list. There are no backlogs at this time.

Examinations

25. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required? Are examinations offered in a language other than English?

The Board requires all applicants to pass nationally-recognized examinations. Currently, the USMLE Step 1, Step 2 Clinical Knowledge (CK) and Step 3 are required to qualify for a P&S license. PTL applicants are required to pass USMLE Steps 1 and 2CK. Applicants may take and pass both parts of the Licentiate of the Medical Council of Canada (LMCC) in Canada to qualify for a P&S license or PTL.

The NBME and the FSMB developed the USMLE examination. Examination requirements are established in BPC sections 2176, 2177 and 2184. Applicants who took and passed the NBME, Federation Licensing Examination (FLEX), and/or State

Board Exam may qualify for licensure. The specific examinations and examination combinations acceptable to satisfy California requirements are set forth in CCR section 1328. The validity of the examination is established by CCR section 1329.2.

The Board accepts the minimum passing score for each step of the required national physician and surgeon licensing examinations, as determined by NBME, USMLE, ECFMG, FSMB, and LMCC pursuant to CCR section 1328.1. The Board does not require a California-specific examination. In order for international medical school graduates to take the USMLE examinations, they must apply through the ECFMG. The examination is not offered in any language other than English since the ECFMG requires all applicants to be proficient in the English language and verifies the applicants' proficiency in English during the examination process.

26. What are pass rates for first time vs. retakes in the past four fiscal years? (Refer to Table 8: Examination Data) Are pass rates collected for examinations offered in a language other than English?

The Board does not have statistics on the pass rates for the USMLE specific to California. However, the USMLE website contains the pass rates for all individuals who take the USMLE.

USMLE Pass Rate Statistics for First Time Takers – U.S./Canadian Graduates:

	2018	2019	2020	2021*
Step 1	96%	97%	98%	96%
Step 2 CK	97%	98%	98%	98%
Step 2 CS	95%	95%	95%	N/A
Step 3	98%	98%	98%	98%

USMLE Pass Rate Statistics for Test Retakes – U.S./Canadian Graduates:

	2018	2019	2020	2021*
Step 1	67%	66%	67%	66%
Step 2 CK	66%	72%	76%	75%
Step 2 CS	87%	87%	88%	N/A
Step 3	73%	74%	73%	73%

USMLE Pass Rate Statistics for First Time Takers – Non-U.S./Canadian Graduates:

	2018	2019	2020	2021*
Step 1	80%	82%	87%	82%
Step 2 CK	83%	87%	90%	91%
Step 2 CS	75%	77%	66%	N/A
Step 3	90%	92%	90%	91%

USMLE Pass Rate Statistics for Test Retakes – Non-U.S./Canadian Graduates:

	2018	2019	2020	2021*
Step 1	44%	45%	50%	45%
Step 2 CK	52%	57%	59%	62%
Step 2 CS	61%	66%	68%	N/A
Step 3	59%	64%	57%	62%

27. Is the Board using computer-based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?

The Board delegated authority for administration of all national written examinations to the NBME and FSMB for the USMLE in 1998. These organizations are responsible for all facets of the USMLE: testing content, scoring, psychometric validity, examination integrity and administration. The USMLE offers Steps 1 and 2CK of the examination as computer-based tests. The examinations are offered world-wide on an on-going basis. USMLE Step 3 is offered only in the US and is offered as computer-based and patient-based testing.

28. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.

Any existing statute changes needed for the Board to enhance the Licensing Program have been identified in Section 12, New Issues.

School Approvals

29. Describe legal requirements regarding school approval. Who approves your schools? What role does BPPE have in approving schools? How does the Board work with BPPE in the school approval process?

The approval of U.S./Canadian medical schools differs from the recognition of international medical schools. The U.S./Canadian medical schools undergo a standardized evaluation by a nationally recognized entity, the LCME. The international medical schools previously were required to undergo an independent evaluation process created and conducted by the Board, pursuant to BPC sections 2089, 2089.5, however, these sections were repealed effective January 1, 2020.

U.S./Canadian Medical Schools

BPC sections 2084 and 2084.5 provide the basis for U.S./Canadian medical school approvals. Medical schools accredited by a national accrediting agency approved by the Board and recognized by the United States Department of Education are deemed approved by the Board. Pursuant to BPC section 2084.5, the Board approves all U.S. and Canadian medical schools accredited by the LCME. This assessment is designed to evaluate the fiscal soundness, educational curriculum and physical facilities of the medical school. The LCME is the nationally-recognized accrediting authority for allopathic medical education programs leading to the issuance of Medical Doctor (M.D.) degrees in the U.S. and Canada.

International Medical Schools

Prior to January 1, 2020, BPC sections 2084, 2089, and 2089.5 and 16 CCR sections 1314.1 and 1315 provided the basis for international medical school recognition.

Effective January 1, 2020, the Board no longer conducts an independent review of international medical schools. Rather, pursuant to BPC section 2084(b), the Board recognizes an international medical school if one of the following requirements are met:

- The international medical school has been evaluated by the ECFMG or one of the ECFMG-authorized international medical school accreditation agencies and deemed to meet the minimum requirements of medical schools accredited by the LCME, the Committee on Accreditation of Canadian Medical Schools, or the Commission on Osteopathic College Accreditation.
- The foreign medical school is listed on the World Federation for Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER) World Directory of Medical Schools joint directory or the World Directory of Medical Schools.

- The foreign medical school had been previously approved by the board. The prior approval shall only be valid for a maximum of seven years from the date of enactment of BPC section 2084.

The Board does not coordinate or consult with the BPPE in determining approved U.S./Canadian medical schools or recognized international medical schools. The BPPE is not included in any part of the Board's process for approval of medical schools, although it may be part of the process as the school obtains accreditation.

30. How many schools are approved by the board? How often are approved schools reviewed? Can the board remove its approval of a school?

Effective January 1, 2020, BPC section 2084 no longer requires the Board to approve medical schools. Currently, schools accredited by a national accrediting agency approved by the Board and recognized by the United States Department of Education shall be deemed approved by the Board. The Board accepts medical schools in the U.S. and Canada that meet the requirements of BPC section 2084(a) at the time of application. As of September 1, 2020, the LCME list of accredited medical schools for both U.S. and Canada totaled 172 allopathic medical schools. These schools are reviewed by LCME officials on a seven-year rotation; schools may be reviewed more frequently if a need is identified.

As of December 31, 2019, the Board recognized 2,056 international medical schools. Prior to January 1, 2020, some of these schools required a re-assessment every seven years as mandated in 16 CCR section 1314.1. However, due to a lack of staffing, the Board was unable to conduct these reviews on a seven-year basis. While the Board no longer approves medical schools, the Board may determine that a medical school does not meet one of the requirements listed under BPC section 2084(b) at the time of application.

31. What are the Board's legal requirements regarding approval of international schools?

Effective January 1, 2020, the Board no longer conducts an independent review of international medical schools. Pursuant to BPC section 2084(b), the Board may determine if an international medical school meets one of the following requirements:

- The international medical school has been evaluated by the ECFMG or one of the ECFMG-authorized international medical school accreditation agencies and deemed to meet the minimum requirements of medical schools accredited by the LCME, the Committee on Accreditation of Canadian Medical Schools, or the Commission on Osteopathic College Accreditation.

- The foreign medical school is listed on the WFME and the FAIMER World Directory of Medical Schools joint directory or the World Directory of Medical Schools.
- The foreign medical school had been previously approved by the board. The prior approval shall only be valid for a maximum of seven years from the date of enactment of this section.

Prior to January 1, 2020, all non-U.S./Canadian medical schools were subject to the Board's individual review and approval and were required to demonstrate that they offered a resident course of professional instruction that was equivalent, not necessarily identical, to that provided in LCME-accredited medical schools. The law further provided that only students from "recognized" medical schools could complete clinical clerkship training in California facilities and only graduates of "recognized" medical schools could qualify for licensure or complete postgraduate training in California.

Continuing Education/Competency Requirements

32. Describe the Board's continuing education/competency requirements, if any. Describe any changes made by the Board since the last review.

Pursuant to BPC section 2190, the Board adopted and administers standards for the CME of physicians. Each physician is required to complete not less than 50 hours of approved CME during each two-year period immediately preceding the expiration date of the license. One exception is permitted by 16 CCR section 1337(d), which states that any physician who takes and passes a certifying or recertifying examination administered by a recognized specialty board shall be granted credit for four consecutive years of CME credit for re-licensure purposes.

At the time of the last sunset review, the Board's CME audit program was suspended due to the waivers issued by the Department of Consumer Affairs pursuant to the Governor's Executive Order, which extended the deadline for licensees to comply with the CME requirements for over a year. The Board resumed CME audits in December 2021, which included licenses expiring in November 2021, as the last waiver was issued to licenses expiring in October 2021. Prior to the CME waivers, the Board was auditing ten percent of the licensee population annually for CME compliance. However, the Board was not able to maintain this high volume of audits on a monthly basis and therefore reduced the audits to five percent of its licensee population when audits resumed in December 2021.

a. How does the Board verify CE or other competency requirements? Has the Board worked with the Department to receive primary source verification of CE completion through the Department's cloud?

Pursuant to BPC section 2190, the Board has adopted and administers standards for the CME of physicians. Each physician is required to complete not less than 50 hours of approved CME during each two-year period immediately preceding the expiration date of the license. 16 CCR section 1337(d) provides one exception and states that any physician who takes and passes a certifying or recertifying examination administered by a recognized specialty board shall be granted credit for four consecutive years of CME credit for re-licensure purposes.

Physicians are required to certify under penalty of perjury upon renewal that they have met each of the CME requirements, that they have met the conditions which would exempt them from all or part of the requirements, or that they hold a permanent CME waiver. 16 CCR section 1338 allows the Board to audit a random sample of physicians who have reported compliance with the CME requirements. The Board requires that each physician retain records of all CME programs attended for a minimum of four years in the event of an audit by the Board.

The Board has not worked with the Department to receive primary source verification of CE completion through the Department's cloud, but the Board has contracted with the Accreditation Council for Continuing Medical Education (ACCME) to access their new data reporting system that allows medical licensing regulatory agencies to access CME documents electronically. ACCME continues to promote this free system to CME providers in California and once a significant portion of California licensees are using the system, the Board will utilize the system data as part of its CME audit process.

b. Does the Board conduct CE audits of licensees? Describe the Board's policy on CE audits.

The CME audit is performed on a monthly basis and is designed to randomly audit approximately five percent of the total number of renewing physicians per year. If selected for the audit, the licensee must submit proof of attendance at CME courses or programs. Upon receipt of the requested documents, the Board performs a manual review to determine compliance with the law.

c. What are consequences for failing a CE audit?

If a physician fails the audit by either not responding or failing to meet the requirements as set forth by BPC section 2190, the physician will be allowed to renew their license one time following the audit to make up any deficient CME hours. However, the Board will not renew the license again until all of the required hours have been documented and submitted to the Board. It is considered unprofessional conduct for a physician to misrepresent their compliance with meeting the CME requirements pursuant to 16 CCR section

1338(c). In addition, the Board has the authority to issue citations for failing to comply with CME requirements.

d. How many CE audits were conducted in the past four fiscal years? How many fails? What is the percentage of CE failure?

The Board conducted 6,074 CME audits from FY 2020/21 through FY 2021/22. Of the 6,074 audits, there were 81 failures, which is a 1.3% failure rate.

Fiscal Year	20/21	21/22
Selected for Audit	2,167	3,907
Failed Audit	3	78
Failed Audit Percentage	<1%	2%

e. What is the Board's CE course approval policy?

Approved CME consists of courses or programs designated by the American Medical Association (AMA), California Medical Association (CMA) as Category 1 credits related to one of the following: patient care, community health or public health, preventive medicine, quality assurance or improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics, or improvement of the physician-patient relationship.

The following are approved CME courses:

- Programs accredited by the CMA, the AMA, and the ACCME that qualify for *AMA PRA Category 1 Credit(s)*™;
- Programs which qualify for prescribed credit from the American Academy of Family Physicians (AAFP); and
- Other programs offered by other organizations and institutions acceptable to the Board that meet the requirements under 16 CCR section 1337.5.

f. Who approves CE providers? Who approves CE courses? If the Board approves them, what is the Board application review process?

The CMA and AMA are responsible for approving CME providers as well as designating courses as Category 1. However, the Board has provided CME credit for training that the Board provided directly to licensees on a very specific subject matter. The Board approves courses offered by other providers that meet the requirements under 16 CCR section 1337.5.

g. How many applications for CE providers and CE courses were received? How many were approved?

The Board did not receive any applications from CE providers or courses during the last four fiscal years.

h. Does the Board audit CE providers? If so, describe the Board's policy and process.

Pursuant to 16 CCR section 1337.5(b), the Board may randomly audit courses or programs submitted for credit in addition to any course or program for which a complaint is received. If an audit is made, course organizers will be asked to submit to the Board: organizer(s) facility curriculum vitae; rationale for course; course content; educational objectives; teaching methods; evidence of evaluation; and attendance records. Credit toward the required hours of CME will not be received for any courses deemed unacceptable by the Board after an audit has been made.

i. Describe the Board's effort, if any, to review its CE policy for purpose of moving toward performance-based assessments of the licensee's continuing competence.

The Board is not currently considering moving toward performance-based assessments of the licensee's continuing competence, but continues to evaluate any need for statutory or regulatory changes regarding CME requirements.

Table 8a. Continuing Education			
Type	Frequency of Renewal	Number of CE Hours Required Each Cycle	Percentage of Licensees Audited
Physician and Surgeon	Every 2 years	50	5%
Special Faculty Permit	Every 2 years	50	1%
Special Programs (Individual)	Every 2 years	n/a	n/a
Fictitious Name Permit	Every 2 years	n/a	n/a
Licensed Midwife	Every 2 years	36	1%
Polysomnographic Trainee	Every 2 years	n/a	n/a
Polysomnographic Technician	Every 2 years	n/a	n/a

Polysomnographic Technologist	Every 2 years	n/a	n/a
Research Psychoanalyst	Every 2 years	n/a	n/a
Postgraduate Training License	n/a	n/a	n/a

Special Faculty Permits

The Board is authorized to issue a SFP to a person who is deemed academically eminent under the provisions of BPC section 2168. The physician must be academically eminent, which means that the individual either holds or has been offered a full-time appointment at the level of full professor in a tenure track position, or the is clearly outstanding in a specific field of medicine or surgery and offered a full-time academic appointment at the level of full professor, or associate professor, and a great need exists to fill that position. This SFP authorizes the holder to practice medicine only within the facilities of the applicable medical school and any formally-affiliated institutions, or an academic medical center (AMC) and any affiliated institution.

All applicants for an SFP are subject to the same fingerprint and primary source document requirement as an applicant for a P&S license.

Current law establishes a review committee, the Special Faculty Permit Review Committee (SFPRC), to review SFP applications and make recommendations to the full Board for approval. The review committee consists of one representative from each of the eleven medical schools in California, two Board members (one physician member and one public member), and one individual selected pursuant to BPC section 2168.1(c)(3) to represent AMCs, for a total of fourteen members.

California currently has eleven allopathic medical schools and one academic medical center that are eligible to submit applications for an SFP:

- Loma Linda University
- Stanford University
- University of California – Davis
- University of California – Irvine
- University of California – Los Angeles
- University of California – San Diego
- University of California – San Francisco
- University of Southern California

- University of California – Riverside
- California Northstate University College of Medicine
- California University of Science and Medicine
- Cedars-Sinai Medical Center

The SFP must be renewed every two years. At the time of the SFP holder's renewal, the SFP holder must have the dean sign the following certification: "I certify under penalty of perjury under the laws of the State of California that this permit holder continues to meet the eligibility criteria set forth in section 2168, is still employed solely at the sponsoring institution, continues to possess a current medical license in another state or country, and is not subject to permit denial under section 480 of the Business and Professions Code."

The SFP holder is required to comply with the same CME requirements as licensed physicians and surgeons. In addition to the requirements set forth above, an SFP shall be renewed in the same manner as a P&S license.

Pursuant to BPC section 2168.4 and 16 CCR section 1315.02, the dean is required to report to the Board within 30 days that an SFP holder no longer meets the requirements to hold an SFP. Upon receipt of notification that an SFP holder no longer meets the requirements for an SFP, the Board will cancel the SFP.

SFP holders are listed on the Board's website with licensed physicians. The public can search the Board's website to verify an SFP holder's current status and public record. The complaint process is the same for an SFP holder as it is for any complaint the Board receives for a licensed physician and surgeon.

The Board is notified of any arrests and/or convictions of an SFP holder. An SFP may be denied, suspended, or revoked for any violation that would be grounds for denial, suspension, or revocation of a P&S license. To date, the Board has not formally disciplined any SFP holder.

16 CCR section 1319.5 requires that the Board shall, within 60 working days of receipt of an application pursuant to BPC section 2168, inform the applicant in writing whether the application is complete or is deficient. The Board is currently meeting this requirement.

Table 6. Licensee Population

		FY 18/19	FY 19/20	FY 20/21	FY 21/22
8011 – Special	Active	23	24	27	26
	Out of State	Unknown	Unknown	Unknown	0

Faculty Permit	Out of Country	Unknown	Unknown	Unknown	0
	Delinquent/Expired	3	3	3	5
	Retired Status *if applicable*	N/A	N/A	N/A	N/A
	Inactive	N/A	N/A	N/A	N/A
	Other	N/A	N/A	N/A	N/A

Table 7a. Licensing Data by Type - 8011 – Special Faculty Permit

	App Type	Received	Approved/ Issued	Closed	Pending Applications			Cycle Times		
					Total (Close of FY)	Complete (within Board control)*	Incomplete (outside Board control)*	Complete Apps	Incomplete Apps	Combined, IF unable to separate out
FY 19/20	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	4	3	1	3	-	-	n/a	161	-
	(Renewal)	n/a	7	n/a	-	-	-	-	-	-
FY 20/21	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1	4	0	0	-	-	n/a	214	-
	(Renewal)	n/a	13	n/a	-	-	-	-	-	-
FY 21/22	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	3	1	0	2	-	-	n/a	197	-
	(Renewal)	n/a	9	n/a	-	-	-	-	-	-

* Optional. List if tracked by the board.

Special Programs

The Board currently has four special programs that provide limited exemptions for practice as a physician and surgeon in California pursuant to BPC sections: 2111, 2112, 2113, and 16 CCR section 1327.

BPC section 2111 – Postgraduate medical school study by non-citizens

The dean of a California medical school, or dean or chief medical officer of an academic medical center (AMC) may sponsor an international physician to participate in a visiting

fellowship at the sponsoring medical school or AMC. The Board must approve the visiting physician prior to the visiting physician starting. The visiting physician may only practice medicine under the direct supervision of the head of the department to which they are appointed. The appointment is for one year and may be renewed annually two times for a maximum of three years. The intent is for the visiting fellow to learn a new skill to be utilized upon return to his or her country. This training will not lead to licensure in California and is used frequently by the medical schools and AMCs.

A section 2111 applicant is subject to the same fingerprint and primary source document requirements as an applicant for a P&S license. Section 2111 registration holders do not have CME requirements.

BPC section 2112 – Participation in fellowship program by non-citizens

A licensed physician in another country may be sponsored by a hospital in this state that is approved by the Joint Commission (JC). The Board must approve the visiting physician and the sponsoring hospital prior to the visiting physician starting. At all times, the visiting physician shall be under the direct supervision of a California licensed, board certified, physician, who has a clinical teaching appointment from a medical school that is approved by the Board and who is clearly an outstanding specialist in the field in which the international fellow is to be trained. Additional licensed physician faculty may be approved to provide training and supervision to the section 2112 registrant. The registration is approved for one year and may not be renewed more than four times. This training will not lead to licensure in California and is a less common registration type compared to the 2111.

A section 2112 applicant is subject to the same fingerprint and primary source document requirements as an applicant for a P&S license. Section 2112 registration holders do not have CME requirements.

BPC section 2113 – Certificate of registration to practice incident to duties as a medical school faculty member

The dean of a California medical school may apply to the Board to sponsor an international physician who is licensed in their country for a full-time faculty position. The approval is for one year and may be renewed twice. At the beginning of the third year the dean of the medical school, or dean or chief medical officer of an academic medical center (AMC) may request renewal by submitting a licensing plan. If the plan is approved by the Board, the Board may renew the appointment two more times. A section 2113 appointment may not be active for more than five years. At the end of five years the section 2113 registrant must be licensed in California or the appointment is terminated. The time spent as a BPC section 2113 registrant may be used in lieu of the ACGME-accredited postgraduate training required for licensure as a physician and surgeon if it is approved by the Board.

A section 2113 applicant is subject to the same fingerprint and primary source document requirements as an applicant for a P&S license. Section 2113 registration holders do not have CME requirements.

16 CCR section 1327 – Criteria for approval of clinical training programs for foreign medical students

Pursuant to BPC section 2064 a medical student enrolled in an international medical school recognized by the Board may practice medicine in a clinical training program in California approved by the Board. A clinical training program shall submit a written application to the Board for such approval. 16 CCR section 1327 allows a hospital that meets all of the minimum requirements and that has been approved by the Board to provide clinical clerkships to international medical school students. This section requires the hospital to have a formal affiliation agreement with the school for the specific clerkships that will be taught in the training program.

Special Programs – 16 CCR sections 1318, 1319.1, 1319.2, and 1319.3 require the Board to notify the applicant within 10 days of receipt of an application pursuant to BPC sections 2111, 2112, and 2113, and 16 CCR section 1327. The Board is currently meeting this requirement.

Below are the statistics for these programs for the last four fiscal years.

Table 6. Licensee Population

		FY 18/19	FY 19/20	FY 20/21	FY 21/22
8009 – Special Programs (Individual)	Active	276	244	176	193
	Out of State	Unknown	Unknown	Unknown	5
	Out of Country	Unknown	Unknown	Unknown	43
	Delinquent/Expired	6	13	13	19
	Retired Status *if applicable*	N/A	N/A	N/A	N/A
	Inactive	N/A	N/A	N/A	N/A
	Other	N/A	N/A	N/A	N/A

Table 7a. Licensing Data by Type - 8009 – Special Programs (Individual)										
	App Type	Received	Approved/ Issued	Closed	Pending Applications			Cycle Times		
					Total (Close of FY)	Complete (within Board control)*	Incomplete (outside Board control)*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 19/20	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	55	51	21	17	-	-	24	93	-
	(Renewal)	n/a	93	n/a	-	-	-	-	-	-
FY 20/21	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	32	30	1	20	-	-	27	119	-
	(Renewal)	n/a	105	n/a	-	-	-	-	-	-
FY 21/22	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	49	44	3	21	-	-	10	93	-
	(Renewal)	n/a	101	n/a	-	-	-	-	-	-
* Optional. List if tracked by the board.										

Fictitious Name Permits

The Board issues fictitious name permits (FNP) that allow physicians to practice medicine under a name other than their own name, e.g., XYZ Medical Group. BPC section 2285 states: "The use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious name permit obtained pursuant to section 2415 constitutes unprofessional conduct."

Performance Targets/Expectations

16 CCR section 1350.2 requires that the Board shall, within a reasonable time after an application has been filed, issue an FNP or refuse to approve the application and notify the applicant of the reasons therefor. The Board has set an internal expectation that all applications received for FNPs be reviewed within 30 days. The Board is currently meeting this expectation and is reviewing applications within 20 days.

Timeframes for Application Processing – Performance Barriers and Improvements Made

The FNP application volume has averaged out over the past four fiscal years with approximately 1,463 applications received per fiscal year. Average time to review an FNP application from the date received has remained constant: within 30 days.

Table 6. Licensee Population

		FY 18/19	FY 19/20	FY 20/21	FY 21/22
8008 – Fictitious Name Permit	Active	12,812	12981	13,082	12,991
	Out of State	0	0	0	5
	Out of Country	0	0	0	0
	Delinquent/Expired	4,870	4744	4,938	4,994
	Retired Status *if applicable*	N/A	N/A	N/A	N/A
	Inactive	N/A	N/A	N/A	N/A
	Other	N/A	N/A	N/A	N/A

Table 7a. Licensing Data by Type - 8008 – Fictitious Name Permit

	App Type	Received	Approved/ Issued	Closed	Pending Applications			Cycle Times		
					Total (Close of FY)	Complete (within Board control)*	Incomplete (outside Board control)*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 19/20	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1398	1255	148	215	-	-	37	98	-
	(Renewal)	n/a	5409	n/a	-	-	-	-	-	-
FY 20/21	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1583	1418	87	353		-	32	77	-
	(Renewal)	n/a	5415	n/a	-	-	-	-	-	-
	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

FY 21/22	(License)	1733	1502	226	353	-	-	16	64	-
	(Renewal)	n/a	5261	n/a	-	-	-	-	-	-
* Optional. List if tracked by the board.										

Medical Assistants

The Board does not license or register medical assistants. However, the Board does approve organizations that certify medical assistants and answers scope of practice questions to the public. Title 16 CCR section 1366.33 requires that within 60 working days of receipt of an application for an approval as a certifying organization, the Board shall inform the applicant in writing whether it is complete and accepted for filing or it is deficient and what specific information or documentation is required to complete the application. There are currently four approved certifying organizations. The Board has set an internal expectation that new applications are to be reviewed within 60 calendar days. The Board continues to maintain this expectation for any new certifying organization applications.

16 CCR section 1366.31 outlines the requirements for applying as an approved certifying organization. The applicant must provide information sufficient to establish that the certifying organization meets the standards set forth in regulation. Upon receipt of an application for approval, the Board establishes a team to review the application and supporting documentation. The team consists of licensing staff, legal counsel and a medical consultant, if necessary. All requirements set forth in law have to be documented by the certifying agency. Upon completion, the application is presented to the full Board for review and possible approval. The Board last approved an application for a certifying organization in May 2015.

Outpatient Surgery Setting Accreditation

Currently, California law prohibits physicians from performing some outpatient surgeries, unless they are performed in an accredited, licensed, or certified setting.

Existing law specifies that on or after July 1, 1996, no physician shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying 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, unless the setting is specified in Health and Safety Code (HSC) section 1248.1. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, 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.

As outlined in HSC section 1248.1, certain OSS are excluded from the accreditation requirement, such as ambulatory surgical centers certified to participate in the Medicare program under Title 18, health facilities licensed as general acute care hospitals, federally operated clinics, facilities on recognized tribal reservations, and facilities used by dentists or physicians in compliance with Article 2.7 or Article 2.8 of Chapter 4 of Division 2 of the BPC.

Pursuant to Health and Safety Codes, the Board has adopted standards for accreditation and approval of accreditation agencies that perform the accreditation of outpatient settings, ensuring that the certification program shall include standards for multiple aspects of the settings' operations. The Board has approved the following accreditation agencies as they have met the requirements and standards set forth by the HSC:

- American Association for Accreditation of Ambulatory Surgery Facilities Inc. (AAASF) - accredited July 1, 1996
- Accreditation Association for Ambulatory Health Care (AAAHC) - accredited July 1, 1996
- The Joint Commission (JC) accredited - July 1, 1996
- Accreditation Commission for Health Care, Inc. (ACHC) - accredited July 19, 2013

The American Osteopathic Association/Healthcare Facilities Accreditation Program (HFAP) merged with ACHC in October 2020, with ACHC being the primary accreditation agency. All OSS entities under HFAP merged under ACHC oversight.

The Institute for Medical Quality (IMQ) was accredited October 8, 1997, and ceased all accreditation operations effective July 31, 2020. As a result of IMQ's closure, there were approximately 140 OSS that lost their accredited status. In accordance with HSC section 1248.55(c)(1), these settings were authorized to continue operating for a period of 12 months in order to seek accreditation through an approved accreditation agency. During the 12-month period, those settings continued to follow all incident reporting processes as before, and reported directly to the Board until new accreditation was acquired. As of October 2022, 87 of the 140 settings are now accredited by one of the four remaining accreditation agencies. The other settings either no longer operate as outpatient surgery settings or no longer require accreditation.

Current law provides that any outpatient setting may apply to any one of the accreditation agencies 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 Chapter 1.3 of the HSC.

The Board posts information regarding OSS on its website. The information on the website includes whether the outpatient setting is accredited or whether the setting's accreditation has been revoked, suspended, or placed on probation, or if the setting has received a reprimand by the accreditation agency.

The website data also includes all of the following:

- Name, address, medical license number and telephone number of any owners;
- Name and address of the facility;
- Name of the accreditation agency; and
- Effective and expiration dates of the accreditation.

The approved accrediting agencies are required to notify and update the Board on all outpatient settings that are accredited, or if the accreditation is denied, suspended or revoked. If the Board receives a complaint regarding an accredited outpatient setting, the complaint is referred to the accrediting agency for inspection. Once the inspection report is received, the Board reviews the findings to determine if any deficiencies were identified in categories that relate to patient safety. The Board's Enforcement Program will review any patient safety deficiencies and if necessary, refer the matter for formal investigation. Inspection reports are required to be provided to the Board and posted on the website for public viewing. The lists of deficiencies, plans of correction or requirements for improvements and correction, and corrective action completed are also available to the public.

Accreditation agencies must renew every three years, at which time the Board reviews the agency's policies and procedures to ensure compliance with laws and statutes. If the Board finds any deficiencies, the agency is allowed time for correction before the renewal is approved.

BPC sections 2216.3 and 2216.4 require an accredited outpatient surgery setting to report adverse events, as defined in HSC section 1279.1 to the Board no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, no later than 24 hours after the adverse event has been detected.

The Board must ensure the accrediting agencies are following the law and performing the necessary functions for consumer protection.

Sunset Review Oversight Report

Section 5

Enforcement Program

- *Performance Target Expectations*
- *Cite and Fine*
- *Cost Recovery and Restitution*

ENFORCEMENT PROGRAM

Performance Target Expectations

33. What are the Board's performance targets/expectations for its enforcement program? Is the Board meeting those expectations? If not, what is the Board doing to improve performance?

The Board's enforcement functions are at the center of the Board's mission of consumer protection and the Board takes this role very seriously. The Board must ensure that all enforcement units within the Board are performing efficiently and effectively. In addition, the Board must work with its vendors, HQIU and the AGO, to ensure investigations are completed timely and the administrative actions are moved through the disciplinary process as expeditiously as possible. The Board's goal is to complete quality investigations in a timely manner.

BPC section 2319 states that the Board shall set as a goal that on average, no more than 180 days will elapse from the receipt of a complaint to the completion of an investigation. This section also states that if the Board believes that the case involves complex medical or fraud issues or complex business or financial arrangements then this goal should be no more than one year to investigate.

The number of complaints received in the most recent fiscal year are down over previous years. The downturn in new complaints started during the pandemic, however, the Board has experienced staff vacancies and an increase in the complexity of the cases. The overall average days to investigate a complaint was 143 days in FY 2021/2022. This is lower than the figure of 170 days in FY18/19. The Board has maintained the same staffing numbers and as of first quarter 2020, and as such, has made a number of changes internally that has reduced the Central Complaint Unit (CCU) average timeframe to 98 days in the fourth quarter of FY21/22.

BPC section 129 (b) requires that complaints be acknowledged within 10 days of receipt. In early 2020, the Board changed processes which have allowed the processing of new complaints to be at 10 days or less and therefore meeting or exceeding the mandated timeframe. In FY 2021/2022, the Board acknowledged complaints within five days, on average.

Once a complaint is initiated, a notice is sent to the complainant, if known, acknowledging receipt of the matter as well as the complaint number. The notices are sent by mail or email depending on what information the Board has received. If the complainant provides an email address, then the Board sends these notices by email. In cases where the complaint has been received from an anonymous source, no acknowledgment letter is sent.

34. Explain trends in enforcement data and the Board's efforts to address any increase in volume, timeframes, ratio of closure to pending cases, or other challenges. What are the performance barriers? What improvement plans are in place? What has the Board done and what is the Board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

The number of incoming complaints has decreased in recent years. In FY18/19, 11,407 complaints were received and in FY19/20, 10,868 complaints were received. In FY19/20 the number of incoming complaints were on track to hit a new high until the COVID19 pandemic caused a state-wide shutdown in mid- March 2020. The number of complaints received in FY20/21 was 10,103. As the state reopened, the Board received 9,943 complaints in FY21/22.

Fiscal Year Complaints Received	
18/19	11,407
19/20	10,868
20/21	10,103
21/22	9,943

Pursuant to BPC section 2220.08, the Board is required to have an upfront review by a medical expert on cases involving quality of care, with a limited exception. When a medical reviewer determines a complaint warrants referral for further investigation, CCU transfers the complaint to an internal unit of non-sworn investigators, Complaint Investigation Office (CIO), or the Health Quality Investigation Unit (HQIU) to be investigated by a sworn investigator (peace officer).

There are twelve HQIU field offices located throughout the State of California that handle these investigations. Prior to January 1, 2019, the Board's investigations that were sent to the field (HQIU) were also assigned to a Deputy Attorney General (DAG) from the AGO under a system called Vertical Enforcement (VE). The system allowed for the DAG to provide guidance and direction to the investigation performed by the investigator. As of January 1, 2019, VE ended under a statutory change. Despite the removal of VE, HQIU's timeframe for investigating cases has continued to increase each year.

HQIU's Investigation Timeframe	
FY 16/17	467 days
FY 17/18	510 days

FY 18/19	547 days
FY 19/20	572 days
FY 20/21	584 days
FY 21/22	615 days

Due to the COVID-19 pandemic, a number of processes were changed and a majority of the Board's staff began a hybrid work setting which includes teleworking. This initially created challenges as the Board is not operating on a paperless platform. However, with the drop in incoming complaints, it has allowed CCU staff to address backlogs and as a result there have been improvements in the CCU timeframes. Between January 2020 and January 2021, CCU was successful in referring a significant number of the cases for investigation or closing the cases, as appropriate. An emphasis on addressing aged cases over one year old resulted in a drop from 646 pending cases in January 2020 to 43 in January 2022.

CIO is the in-house investigation team of nonsworn investigators who investigate cases that include: physicians charged with or convicted of a criminal offense, physicians petitioning for reinstatement of a license following revocation or surrender, and certain quality of care investigations following a malpractice settlement or judgment reported to the Board pursuant to BPC section 801.01. CIO experienced exceptional progress in reducing their timeframes for handling complaints, from 315 days in FY17/18 to 179 days in FY19/20, or approximately a 56 percent drop. In FY20/21 it was 352 days and in FY21/22, 334 days. These timeframes increased because a number of their cases involved the civil courts for subpoena enforcement proceedings and during the pandemic the courts were not operating or were operating in limited capacities. As a result of the downturn in overall incoming complaints, CIO is now assisting CCU with issuing subpoenas to obtain records for various complaints and assigning medical consultants for review of the newly reported BPC section 801.01 cases.

The Board's probation unit has been ensuring that physicians who are not compliant with their probationary order have action taken expeditiously against their license, whether it is issuing a citation and fine, a cease practice order, or referring the matter to the AGO for appropriate disciplinary action which may include revocation. During the pandemic the probation team utilized virtual meetings to meet with the licensees. The meetings have returned to in-person but the virtual process continues to be used when necessary.

In FY 19/20, the Board hired a Chief Medical Consultant (CMC) to assist the Enforcement Program by providing an immediate and direct source for medical expertise. The Enforcement Program is ready to expand this position and add staff so

that there is more medical evaluation throughout the complaint process and more accessible medical input to the enforcement staff. The CMC has identified that it would be beneficial to provide a medical review of the cases earlier in the CCU process and aid CCU staff before an outside Medical Consultant is utilized. The Board intends to hire one additional part-time medical professional to assist with this process as well as all of the other duties carried out by the CMC in the Enforcement Program such as evaluating and assisting with the expert and medical consultant programs. In addition, the CMC is reviewing expert reports for cases that the Board would currently consider forwarding to the AGO for further action, provided the statute will allow for it. The CMC is providing daily review of expert reports with an emphasis on improving quality and improving the expert program. Due to volume and the number of duties currently done by the CMC, additional medical consultants would help manage this workload.

The Board is continually reviewing and making enhancements and revisions to the complaint forms, online forms, and public information to provide more accessibility, efficiency, and explanation of the process to the public.

Performance Barriers

The pandemic initially placed a spotlight on the barriers presented by the Board's paper-based complaint review system. This led to an initial loss of productivity and duplication of efforts as staff began to telework. To address that challenge, significant changes were made to reduce or eliminate the paper processes throughout the enforcement unit in FY 20/21. To facilitate workflows between the Board, HQIU, AGO, and expert reviewers, more documents were shared via email and a secure cloud-based system. This shift has provided multiple efficiencies and cost savings.

At times, the number of vacancies among Board staff has eroded overall performance in the enforcement program. When that occurs, the Board attempts to quickly fill each position and train those new employees. If it is deemed helpful to add additional Board staff to reduce processing timeframes, the Board will submit a BCP in the future.

Improvement Plans

The enforcement team has diligently attempted to keep up with the workflow and timeframes with the same number of staff in the CCU and CIO units. As noted earlier, some processes have backlogs and may benefit from additional staff. In early 2020, the distribution or assignment of cases in CCU by region was discontinued. Currently, CCU is in the process of increasing cross training and eliminating specialized desks. The changes have provided a more equitable distribution of new cases and pending cases can be reallocated as warranted as additional staff are cross trained. Staff continues to seek more options to move towards a paperless platform, including consideration of a portal for hospitals and physicians to upload medical records to the Board directly instead of sending the Board paper copies or discs. This will improve efficiency,

because it will eliminate the need for staff to scan or upload the voluminous records received.

The increased emphasis on the medical review of the cases and evaluation of expert opinions should create financial and time savings and allow the Board to target its prosecution costs more efficiently and effectively. It will also allow the Board to shorten timeframes by having a medical evaluation of the case at hand on a timely basis. The Board is working to obtain an additional medical professional who will help to evaluate cases and advise whether a case, in the final stages of an investigation, should proceed with referral to the AGO for an accusation or should be resolved by a Public Letter of Reprimand or cite and fine.

The Board and HQIU entered into a revised Memorandum of Understanding (MOU) so the Board could have additional oversight in the cases pending at HQIU. As a result of the revised MOU, in FY 20/21, Board staff began regular reviews of pending cases with each HQIU office to prioritize cases. In addition, the number of cases completed by HQIU close to or beyond the statute of limitations (SOL) has increased and many cases submitted for consideration of an accusation need additional investigation.

On January 1, 2022, legislation went into effect that reinstates cost recovery of the Board's investigative and legal expenses on cases where disciplinary action is taken. We are including recovery language and amounts due under the cost recovery provisions in each case that has been resolved in the disciplinary process with costs incurred after January 1, 2022.

In January 2022, the Board distributed a memo to the Legislature seeking legislation that would provide the Board with additional financial resources and enforcement tools to help improve the effectiveness of the Board's enforcement program and complete investigations for some cases in a more timely manner.

Table 9a. Enforcement Statistics

	FY 2019/20	FY 2020/21	FY 2021/22
COMPLAINTS			
Intake			
Received		9,892	9,745
Closed without Referral for Investigation		0	0
Referred to INV		10,059	9,797
Pending (close of FY)		48	7

Conviction / Arrest			
CONV Received		211	198
CONV Closed Without Referral for Investigation		0	0
CONV Referred to INV		213	198
CONV Pending (close of FY)		3	0
Source of Complaint[3]			
Public		6,291	6,409
Licensee/Professional Groups		277	250
Governmental Agencies		1,053	1,013
Internal		165	281
Other		773	760
Anonymous		1,544	1,230
Average Time to Refer for Investigation (from receipt of complaint / conviction to referral for investigation)		5 Days	5 Days
Average Time to Closure (from receipt of complaint / conviction to closure at intake)		0 Days	0 Days
Average Time at Intake (from receipt of complaint / conviction to closure or referral for investigation)		5 Days	5 Days
INVESTIGATION			
Desk Investigations			
Opened		9,930	9,591
Closed		11,124	9,362
Average days to close (from assignment to investigation closure)		122 Days	98 Days

[3] Source of complaint refers to complaints and convictions received. The summation of intake and convictions should match the total of source of complaint.

Pending (close of FY)		2,317	2,803
Non-Sworn Investigation			
Opened		200	235
Closed		320	263
Average days to close (from assignment to investigation closure)		351 Days	334 Days
Pending (close of FY)		188	174
Sworn Investigation			
Opened		863	814
Closed		1,446	1,044
Average days to close (from assignment to investigation closure)		584 Days	615 Days
Pending (close of FY)		1,452	1,268
All investigations[4]			
Opened		10,993	10,640
Closed		12,890	10,669
Average days for all investigation outcomes (from start investigation to investigation closure or referral for prosecution)		163 Days	175 Days
Average days for investigation closures (from start investigation to investigation closure)		176 Days	143 Days
Average days for investigation when referring for prosecution (from start investigation to referral for prosecution)		665 Days	705 Days
Average days from receipt of complaint to investigation closure		169 Days	179 Days
Pending (close of FY)		3,786	4,138
CITATION AND FINE			

Citations Issued		51	122
Average Days to Complete (from complaint receipt / inspection conducted to citation issued)		480 Days	755 Days
Amount of Fines Assessed		$31,900	$112,800
Amount of Fines Reduced, Withdrawn, Dismissed		Total: $3,450	Total: $18,750
Amount Collected		$27,450	$55,750
CRIMINAL ACTION			
Referred for Criminal Prosecution		25	19
ACCUSATION			
Accusations Filed		383	283
Accusations Declined		89	54
Accusations Withdrawn		20	11
Accusations Dismissed		9	13
Average Days from Referral to Accusations Filed (from AG referral to Accusation filed)		100 Days	82 Days
INTERIM ACTION			
ISO & TRO Issued		23	21
PC 23 Orders Issued		5	6
Other Suspension/Restriction Orders Issued		39	30
Referred for Diversion		0	0
Petition to Compel Examination Ordered		20	33
DISCIPLINE			
AG Cases Initiated (cases referred to the AG in that year)		689	538
AG Cases Pending Pre-Accusation (close of FY)		142	231

AG Cases Pending Post-Accusation (close of FY)		425	406
DISCIPLINARY OUTCOMES			
Revocation		36	29
Surrender		118	96
Suspension only		0	0
Probation with Suspension		4	5
Probation only		122	142
Public Reprimand / Public Reproval / Public Letter of Reprimand		152	118
Other		2	1
DISCIPLINARY ACTIONS			
Proposed Decision		49	62
Default Decision		29	18
Stipulations		407	358
Average Days to Complete After Accusation (from Accusation filed to imposing formal discipline)		384 Days	388 Days
Average Days from Closure of Investigation to Imposing Formal Discipline		400 Days	428 Days
Average Days to Impose Discipline (from complaint receipt to imposing formal discipline)		948 Days	1004 Days
PROBATION			
Probations Completed		76	102
Probationers Pending (close of FY)		647	644
Probationers Tolled *		90	85
Petitions to Revoke Probation / Accusation and Petition to Revoke Probation Filed		36	31

SUBSEQUENT DISCIPLINE[5]			
Probations Revoked		13	7
Probationers License Surrendered		7	10
Additional Suspension and Probation		0	2
Additional Probation Only		10	14
Suspension Only Added		0	0
Public Reprimand		2	0
Other Conditions Added Only		0	0
Other Probation Outcome		0	0
SUBSTANCE ABUSING LICENSEES			
Probationers Subject to Drug Testing		209	206
Drug Tests Ordered		7055	8497
Positive Drug Tests		788	743
PETITIONS			
Petition for Termination or Modification Granted		33	25
Petition for Termination or Modification Denied		14	4
Petition for Reinstatement Granted		5	5
Petition for Reinstatement Denied		9	8
DIVERSION			
New Participants		N/A	N/A
Successful Completions		N/A	N/A
Participants (close of FY)		N/A	N/A
Terminations		N/A	N/A
Terminations for Public Threat		N/A	N/A

[5] Do not include these numbers in the Disciplinary Outcomes section above.

Drug Tests Ordered		N/A	N/A
Positive Drug Tests		N/A	N/A
* The Board reports Probationers Tolled as probationers out of state as of June 30 of the respective fiscal year.			

Table 10. Enforcement Aging

	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22	Cases Closed	Average %
Investigations (Average %)						
Closed Within:						
90 Days			6,722	5,121	11,843	53%
91 - 180 Days			1,459	1,356	2,815	12%
181 - 1 Year			2,805	2,126	4,931	22%
1 - 2 Years			1,414	546	1,960	9%
2 - 3 Years			308	617	925	4%
Over 3 Years			8	22	30	0%
Total Investigation Cases Closed			12,716	9,788	22,504	100%
Attorney General Cases (Average %)						
Closed Within:						
0 - 1 Year			67	29	96	9%
1 - 2 Years			136	54	190	19%
2 - 3 Years			199	96	295	29%
3 - 4 Years			171	105	276	27%
Over 4 Years			87	75	162	16%
Total Attorney General Cases Closed			660	359	1,019	100%

35. What do overall statistics show as to increases or decreases in disciplinary action since last review?

FY20/21 included a high number of disciplinary actions, compared to previous years. In FY 21/22, the Board saw fewer cases resulting in revocations and surrenders (154 in FY 20/21 and 125 in FY 21/22) and more cases resulted in probation terms than in previous years. The number of public reprimands dropped from 152 in FY 20/21 to 118 in FY 21/22, which was similar to the 107 in FY 19/20.

36. How are cases prioritized? 36. What is the Board's complaint prioritization policy? Is it different from DCA's Complaint Prioritization Guidelines for Health Care Agencies (August 31, 2009)? If so, explain why.

Rather than by DCA policy, the Board's complaint priorities are outlined in BPC section 2220.05 to ensure that physicians representing the greatest threat of harm are identified and disciplined expeditiously. The Board must ensure that it is following this section of law when investigating complaints received by the Board. The statute identifies the following types of complaints as being the highest priority of the Board:

- 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 represents a danger to the public.
- Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.
- Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefore.
- Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation.
- Sexual misconduct with one or more patients during a course of treatment or an examination; and practicing medicine while under the influence of drugs or alcohol.

37. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report to the board actions taken against a licensee. Are there

problems with the board receiving the required reports? If so, what could be done to correct the problems?

a. **What is the dollar threshold for settlement reports received by the board?**

b. **What is the average dollar amount of settlements reported to the board?**

Yes, there multiple reporting requirements designed to inform the Board of possible matters for investigation. The Board shares information regarding mandatory reporting in its newsletters, presentations to various groups, and posts the information on its website. The Board continues its efforts to educate those that are mandated to report various types of items which may institute an investigation of a physician who may be a danger to the public. It appears most of these reports are being submitted to the Board; however, it is not possible to verify whether the Board receives every report that it should. The Board can provide additional outreach to the various organizations which are required to provide reporting.

BPC section 801.01 requires the reporting to the Board of settlements over $30,000 or arbitration awards or civil judgments of any amount. The report must be filed within 30 days by either the insurer providing professional liability insurance to the licensee, the state or governmental agency that self-insures the licensee, the employer of the licensee if the award is against or paid for by the licensee, or the licensee or their attorney. In general, the Board has received these reports on a timely basis.

The average dollar settlements for the past two years have been:

	FY 20/21	FY 21/22
Average Dollar Amount of settlements reported to the Board pursuant to BPC section 801	$604,911.15	$645,947.18

BPC section 802.1 requires physicians to report criminal charges as follows: the bringing of an indictment charging a felony and/or any conviction of any felony or misdemeanor, including a verdict of guilty or plea of no contest. The Board appears to be receiving these reports. The Board has an independent mechanism through the DOJ regarding subsequent arrest notifications sent directly to the Board. The Board issues citations to licensees who fail to report their criminal conviction as required by this statute and/or adds this as a charge to an accusation.

BPC section 802.5 requires a coroner who receives information, based on findings reached by a pathologist that indicates that a death may be the result of a physician's

gross negligence, to submit a report to the Board. The coroner must provide relevant information, including the name of the decedent and attending physician as well as the final report and autopsy. The Board is concerned it may not be receiving all required in accordance with this statute: the Board received one report in FY 20/21 and one report in FY 21/22.

BPC sections 803, 803.5 and 803.6 require the clerk of a court that renders a judgment that a licensee has committed a crime or is liable for any death or personal injury resulting in a judgment of any amount caused by the licensee's negligence, error or omission in practice, or their rendering of unauthorized professional services, to report that judgment to the Board within 10 days after the judgment is entered. In addition, the court clerk is responsible for reporting criminal convictions to the Board and transmitting any felony preliminary hearing transcripts concerning a licensee to the Board.

	FY 20/21	**FY 20/21**
803 (Court-Judgment) Includes 803.6 Reports (Court-Transmittal of Felony Prelim Hearing Transcript/Probation Report) as 803.6 is not tracked separately in BreEZe	0	0
803.5 (Court-Criminal)	1	1

BPC section 805 requires the chief of staff and chief executive officer, medical director, or administrator of a licensed health care facility to file a report when a physician's application for staff privileges or membership is denied or the physician's staff privileges or employment is terminated or revoked for a medical disciplinary cause or reason. The reporting entities are also required to file a report when restrictions are imposed or voluntarily accepted on the physician's staff privileges for a cumulative total of 30 days or more for any 12-month period. The report must be filed within 15 days after the effective date of the action taken by the peer review body. By comparing information with the National Practitioner Data Bank (NPDB), the Board believes it is receiving those reports where the facility believes a report should be issued. Every year the Board does a comparison with the NPDB to ensure it has received the same reports provided to the NPDB.

BPC section 805.01 requires the chief of staff and chief executive officer, medical director, or administrator of a licensed healthcare facility to file a report within 15 days after the peer review body makes a final decision or recommendation to take disciplinary action which must be reported pursuant to section 805. This reporting

requirement became effective January 2011 and is only required if the recommended action is taken for the following reasons:

- Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public.
- The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extend or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
- Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith effort prior examination of the patient and medical reason therefor.
- Sexual misconduct with one or more patients during a course of treatment or an examination.

The Board provides notification each January through its newsletter in an article entitled, “Mandatory Reporting Requirements for Physicians and Others,” that entities are required to file 805.01 reports. The subject has also been covered in presentations to various groups. However, the Board is unable to verify whether it is receiving all of the reports required by law.

BPC section 805.8 became effective on January 1, 2020. The legislation requires a health care facility or other entity that makes any arrangement under which a healing arts licensee is allowed to practice or provide care for patients shall file a report of any allegation of sexual abuse or sexual misconduct made against a healing arts licensee by a patient, if the patient or the patient’s representative makes the allegation in writing, to the agency within 15 days of receiving the written allegation of sexual abuse or sexual misconduct. New forms were created and placed on the Board’s website.

Reports Received Based Upon Legal Requirements	**FY 20/21**	**FY 21/22**
805	96	108
805.01	7	4
805.8	84	76

BPC section 2216.3 was added into statute on January 1, 2014, requiring an accredited outpatient surgery setting (OSS) to report an adverse event to the Board no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Adverse events appear to be reported as required, with the number of reports received by the Board increasing as OSS's became familiar with the law and gained an understanding of the types of events that should be reported.

BPC section 2240(a) requires a physician and surgeon who performs a medical procedure outside of a general acute care hospital that results in the death of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, to report, in writing, on a form prescribed by the Board, that occurrence to the Board within 15 days after the occurrence. The Board requested changes to this section of law to increase consumer protection. SB 1466 (Sen. B&P Comm., Chapter 316, Statutes of 2014) struck the word "scheduled" from existing law that required physicians who performed a "scheduled" medical procedure outside of a hospital, that resulted in a death to report the occurrence to the Board within 15 days. Deaths from all medical procedures outside of a general acute care hospital that result in death must be reported to the Board.

	FY 20/21	FY 20/21
Outpatient Adverse Event Reports (BPC 2216.3)	122	46
Outpatient Surgery Settings Reports (Patient Death) (BPC 2240(a))	14	8

37. Describe settlements the board, and Office of the Attorney General on behalf of the board, enter into with licensees.

a. **What is the number of cases, pre-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?**

b. **What is the number of cases, post-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?**

c. **What is the overall percentage of cases for the past four years that have been settled rather than resulted in a hearing?**

Settlements

The Board uses its Disciplinary Guidelines (16 CCR section 1361) and the Uniform Standards for Substance-Abusing Licensees (Uniform Standards) (16 CCR section 1361.5) as the framework for determining the appropriate penalty for charges filed against a physician. BPC section 2229 identifies that protection of the public shall be the highest priority for the Board, but also requires that wherever possible, the Board's actions should be calculated to aid in the rehabilitation of the licensee. While the Disciplinary Guidelines and Uniform Standards frame the recommended penalty, the facts of each individual case may support a deviation from the guidelines.

After the filing of an accusation and/or petition to revoke probation, a respondent physician must file a Notice of Defense within 15 days indicating they intend to present a defense to the accusation and/or petition to revoke probation or that they are interested in a settlement agreement. If the individual requests a hearing, existing law (Government Code sections 11511.5 and 11511.7) requires that a prehearing conference be held to explore settlement possibilities and prepare stipulations, as well as schedule a mandatory settlement conference, to possibly resolve the case through a stipulated settlement before proceeding to the administrative hearing.

The assigned DAG reviews the case, any mitigation provided, the strengths and weaknesses of the case, the Board's Disciplinary Guidelines, and, when applicable, any prior disciplinary action against the respondent physician, and drafts a settlement recommendation that frames the recommended penalty. In addition, this settlement recommendation takes into account consumer protection and BPC section 2229 (b), which states that the Board shall "take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence."

The DAG's recommendation is then reviewed and either approved or edited by the supervising DAG. Once that approval is received, the DAG submits the settlement recommendation to the Chief of Enforcement for review and consideration. The chief holds regular meetings with the Board's executive director, deputy director and chief medical consultant to review the settlement recommendations using the same criteria as the DAG and either approves or changes the settlement recommendation. The DAG then negotiates with the respondent physician and/or their counsel to settle the case with the recommended penalty, where possible. Both the prehearing settlement conference and the mandatory settlement conference have the assistance of an administrative law judge (ALJ). This ALJ reviews the case and hears information from the DAG and the respondent physician and/or their counsel and then assists in negotiating the settlement. During the settlement conference, the Board representative must be available to authorize any change to the previously agreed-upon settlement recommendation.

If a settlement agreement is reached, the stipulated settlement document must be approved by a panel of the Board, unless the settlement is for a stipulated surrender. The Board panel may adopt the settlement as written, request changes to the settlement, or reject the settlement and request the matter go to hearing. In the process to settle a case, public protection is the first priority. When deciding on a stipulation, the panel members are provided the strengths and weaknesses of the case and weigh all factors. The settlement recommendations stipulated to by the Board must provide for public protection and, when not inconsistent with public protection, rehabilitation of the licensee. Settling cases by stipulations that are agreed to by both sides facilitates consumer protection by imposing discipline more quickly. Entering into a stipulation places the individual on probation or other restriction sooner without the risk and delay of going to hearing, and it eliminates the ability of the licensee to appeal the decision in superior court. It also puts the public on notice of practice limitations and restrictions earlier than if the matter went to hearing. In addition, the Board may get more terms and conditions through the settlement process than would have been achieved if the matter went to hearing.

a.

Fiscal Year	20/21	21/22
Pre-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Settlement	104	71
Pre-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Hearing	N/A	N/A

b.

Fiscal Year	20/21	21/22
Post-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Settlement	303	287
Post-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Hearing	49	62

Post-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Default Decision	29	18

c.

Fiscal Year	20/21	21/22
Percentage of Cases resulting in a Settlement	84%	82%
Percentage of Cases resulting in a Hearing	10%	14%
Percentage of Cases resulting in a Default Decision	6%	4%

38. Does the board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases have been lost due to statute of limitations? If not, what is the board's policy on statute of limitations?

BPC section 2230.5 sets forth that an accusation against a licensee pursuant to Government Code section 11503 shall be filed within three years after the Board discovers the act or omission alleged as the grounds for disciplinary action, or within seven years after the act or omission alleged as the grounds for disciplinary action occurs, whichever occurs first.

Exceptions to this law include an accusation alleging the procurement of a license by fraud or misrepresentation, in which case there is no statute of limitation, or if it is proven that the licensee intentionally concealed from discovery their incompetence, gross negligence or repeated negligent acts which would be the basis for filing an accusation. For allegations of sexual misconduct, the accusation shall be filed within three years of when the Board discovers the act or omission or within 10 years after the act or omission occurs, whichever occurs first. If the alleged act or omission involves a minor, the seven-year statute of limitations period provided for and the 10-year limitations period provided for regarding sexual misconduct allegations shall be tolled until the minor reaches the age of majority.

The numbers below identify the number of complaints filed with the Board after the statute of limitations had elapsed or would elapse before the investigation could be completed. The Board maintains these complaints consistent with its retention schedule as a part of the physician's complaint history and advises the complainant that administrative action against the physician cannot be pursued because the statute of limitations has passed.

- FY 20/21 Physicians and Surgeons: 124
- FY 21/22 Physicians and Surgeons: 123

39. Describe the board's efforts to address unlicensed activity and the underground economy.

Unlicensed activity is investigated by HQIU investigators. In FY 12/13 a specialized group of HQIU, Operation Safe Medicine (OSM), was formed to address the unlicensed practice of medicine in California. OSM has been discontinued and no longer exists. All of the field offices of HQIU are handling unlicensed practice cases.

Unlicensed Investigations Per Fiscal Year	20/21	21/22
Referred for Criminal Prosecution*	25	19
Felony Convictions	*	*
Misdemeanor Convictions	*	*
Referred to Administrative Action for Aiding and Abetting Unlicensed Practice of Medicine	23	13

* A number of criminal cases are still pending conviction. The unlicensed practice of medicine is currently not designated as a priority by BPC section 2220.05, however, the volume and seriousness of the cases investigated by HQIU warrant continued efforts to mitigate this unscrupulous activity and to provide public protection to California patients.

In spite of the outstanding efforts of HQIU field offices to curtail unlicensed activity, there are times when a District Attorney or City Attorney will not file charges against an individual for the unlicensed practice of medicine. In these instances, the Board can issue an administrative citation for violation of BPC sections 2052 and 2054. The following chart represents the number of citations issued for the unlicensed practice of medicine.

Fiscal Year	20/21	21/22
Citations Issued for BPC sections 2052 and 2054	3	11

Cite and Fine

40. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes from last review and describe the last time regulations were updated and any changes that were made. Has the board increased its maximum fines to the $5,000 statutory limit?

A citation order can include a fine and/or order of abatement. The amount of the fine takes into consideration the violation type, factors surrounding any violation(s), cooperation of the subject and their efforts to reach compliance, prior complaint history, prior citations, and any impact on the public. In 2005, the Board amended its regulations to increase the maximum fine amount to $5,000.

During the period of FY 20/21 through FY 21/22, the Board has issued one citation with a $5,000 fine. The Board is currently seeking a rule revision that would eliminate the need to continue adding specific violations to the list of citable offenses. The new language would be more inclusive and allow for greater flexibility in issuing cite and fines to physicians and surgeons as new statutes and regulations are enacted.

	FY 20/21	FY 21/22
Number of Citations Greater than or Equal to $5,000	0	1

41. How is cite and fine used? What types of violations are the basis for citation and fine?

Citations and Fines – Types of Violations

The Board issues citations primarily for technical violations of the law, such as failing to comply with advertising statutes, failing to report criminal convictions, or failing to report a change of address to the Board. The Board also has the authority to issue citations for the unlicensed practice of medicine. This administrative remedy is used when the local district attorney chooses not to pursue criminal charges against the individual or when licensing finds unlicensed activity during the review of an application for licensure. This has been an effective tool in response to the increase in laypersons working in medical spa settings providing services that require medical knowledge and training, and for the physicians who are being charged with aiding and abetting the unlicensed practice of medicine. The Board also issues citations to licensees for minor violations of the terms and conditions of their probationary order.

The Board has increasingly issued citations for violations identified during an investigation that do not rise to the level to support disciplinary action, such as the physician failing to maintain an adequate medical record to document the treatment

provided. In these situations, the Board may require the physician complete an educational component, such as a medical recordkeeping course, to satisfy the citation. In a variety of situations, the Board can address an identified deficiency with an educational component and remediate the physician without the expense of an administrative action and hearing.

42. How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals of a citation or fine in the last 4 fiscal years?

The Board does not conduct Disciplinary Review Committees for appeals of a citation. The following chart depicts the number of requests received for an informal conference and the number of requests for hearings to appeal a citation and fine.

Fiscal Year	Requests Received for Informal Conference	Requests for Hearings to Appeal Citation and Fine
20/21	13	2
21/22	34	3

43. What are the five most common violations for which citations are issued?

The list below identifies the Board's top five most common violations for which citations are issued.

1. Title 16, CCR section 1364.11(b) – A probation violation
2. B&P 2266 – Failure to Maintain Adequate Medical Records
3. B&P 802.1 – Failure to report criminal convictions
4. B&P 2264 – Aiding and Abetting Unlicensed Practice of Medicine
5. B&P 2052 – Unlicensed Practice of Medicine

44. What is average fine pre- and post- appeal?

Please see the following table:

Fiscal Year	Pre-Appeal Average	Post-Appeal Average
20/21	$673	$646
21/22	$1,019	$992

45. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines.

Franchise Tax Board Intercept Program

The Board uses multiple strategies to collect outstanding fines. BPC section 125.9 authorizes the Board to add the amount of the assessed fine to the fee for license renewal. When the physician has not paid an outstanding fine, a hold is placed on their license, and it cannot be renewed without payment of the renewal fee and the fine amount. This same statute also authorizes the Board to pursue administrative action for failing to pay the fine within 30 days of the date of assessment if the citation has not been appealed. The Board will pursue outstanding fines through Franchise Tax Board's (FTB) intercept program; however, the two administrative sanctions available to the Board have been very successful in collecting outstanding fines from licensees. The Board also issues citations to unlicensed individuals and utilizes FTB's intercept program to collect outstanding fines in these cases.

Cost Recovery and Restitution

46. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.

On January 1, 2022, the Board received legislative authority to obtain cost recovery for investigation and legal expenses related to physicians (SB 806, Roth). Effective January 1, 2022, the Board established a time tracking system in BreEZe for HQIU and CIO staff to track their time. In addition, the Consultant Expert Management Program tracks the expert review costs, and the AGO tracks their time and expenses through their own system. When a case is transmitted for an accusation, all the investigation costs are submitted as part of the information. The AGO tracks their time as the case progresses through the prosecution process, and when it is time to discuss a settlement or go to hearing, all of the costs incurred as of January 1, 2022, are submitted.

Many of the cases currently going through the settlement process were investigated prior to January 1, 2022, and, therefore, the recoverable costs may be minimal. The Board expects to be able to recover more of its costs for cases resulting from complaints received by the Board on or after January 1, 2022.

47. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.

The Board orders probationers to pay a per annum fee for monitoring costs. A probationer cannot successfully complete probation without these costs being paid in

full, therefore there is very little money that remains uncollected. However, if a probationer's license is revoked or surrendered while on probation, the Board does not collect any outstanding fees prior to the revocation or surrender. However, should the individual petition to reinstate their license, they may be ordered to pay the outstanding probation monitoring costs if the petition for reinstatement is granted.

Likewise, if a licensee surrenders their license or has the license revoked, the Board is unable to collect cost recovery for the matter at that time. However, if the licensee petitions for reinstatement of their license, the surrender or revocation order will include language making the cost recovery amounts due if the petition for reinstatement is granted.

The Board does seek cost recovery for investigations referred for criminal prosecution. The following chart identifies the costs ordered by the courts and received by the Board for criminal prosecutions.

Table 11. Cost Recovery[6] **(list dollars in thousands)**

	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Total Enforcement Expenditures				
Potential Cases for Recovery *				
Cases Recovery Ordered			1	40
Amount of Cost Recovery Ordered			$7,425	$239,520.51
Amount Collected			$8,615	$19,287.08

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act

[4] Cost recovery may include information from prior fiscal years.

48. Are there cases for which the board does not seek cost recovery? Why?

At this point in time, the Board is seeking cost recovery on all cases. The Board, however, does not seek cost recovery in situations where that would create an extreme

[6] Cost recovery may include information from prior fiscal years.

hardship on the licensee and where there is no realistic possibility of recovery. Further, the Board does not seek cost recovery for portions of an investigation that did not substantiate a departure from the standard of care.

49. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.

The Board's authority to recover costs for physicians was restored as of January 1, 2022, and has been able to collect the amounts due under cost recovery or has established payment plans. Consequently, the Board has not had to refer matters for assistance from the Franchise Tax Board to date. If a license is revoked or surrendered, cost recovery is not paid at the time but is noted that if the licensee petitions to reinstate the license, the cost recovery amount must be paid. The Board does not use the FTB to collect unpaid probation monitoring costs, as failure to pay these costs is considered a violation of probation for which additional disciplinary action is sought.

50. Describe the board's efforts to obtain restitution for individual consumers, any formal or informal board restitution policy, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the board may seek restitution from the licensee to a harmed consumer.

Table 12. Restitution **(list dollars in thousands)**

	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Amount Ordered			$0	$0
Amount Collected			$0	$0

The Board does not seek restitution from the licensee for individual consumers. However, cases involving unlicensed practice of medicine can be referred by the Board to the local district or city attorney for prosecution and a judge may order restitution.

Sunset Review Oversight Report

Section 6

Public Information Policies

PUBLIC INFORMATION POLICIES

52. How does the Board use the internet to keep the public informed of Board activities? Does the Board post board-meeting materials online? When are they posted? How long do they remain on the Board's website? When are draft meeting minutes posted online? When does the Board post final meeting minutes? How long do meeting minutes remain available online?

The Board uses the internet to provide information to the public and licensees regarding Board meetings, initiatives, and laws and regulations regarding the practice of medicine in California. The Board's website is its main information hub and is consistently updated with fresh content related to Board activities. The Board uses its website, email subscription lists (listserv), licensee/applicant email service, podcast, iOS phone app, quarterly newsletter, and Twitter, Facebook and YouTube accounts to deliver timely, accurate, and relevant information to stakeholders.

The Board posts agendas for all Board and committee meetings, including related agenda materials, on its website. Board staff posts meeting agendas at least 10 days prior to the meeting, and meeting materials are added as they become available. The approval of Board and committee draft minutes are agenda items and therefore are posted along with other meeting materials as they become available. Once the Board/committee formally approves and adopts the minutes, the approved minutes are posted on the Board's website indefinitely.

Current and past meeting materials (since 2007) are available on the website, and once posted, are available online, indefinitely.

The Board disseminates information regarding meetings and committee hearings using multiple methods. Board staff sends an email to interested parties who subscribed to receive this information notifying them when agendas are available. By visiting the Board's website, stakeholders can sign up to receive alerts to their email inboxes pertaining to various informational topics including Board meeting information, newsletters and news releases, proposed regulations, and Board enforcement actions.

Social media is a valuable aspect of the Board's outreach program. The Board uses its Twitter, Facebook, and YouTube accounts to post information in Spanish and English pertaining Board meetings, press releases, laws and regulations, CME opportunities, public health updates, and disciplinary actions the Board takes against licensees. The Board also posts information about FDA alerts, recall information, DEA drug take back days, and other information useful to licensees and consumers. Recordings of Quarterly Board and Disciplinary Panel Meetings, including other public meetings held by the Board, are hosted on YouTube.

In May 2018, the Board launched its podcast titled “Medical Board Chat,” becoming the first licensing board under DCA to use this form of outreach. The podcast offers another forum to bring information about the Board to the public. Podcasts have been produced on multiple topics, including the Board’s Prescription Review Program (formerly the Death Certificate Project), Changes to laws surrounding PTLs, Legislation and Regulations, the Board’s Expert Reviewer Program, and more. The Board will continue to innovate when communicating with stakeholders, while leveraging existing technology to inform the public.

Since the summer of 2018, the Board has offered the public its License Alert Mobile App for Apple iOS devices. Developed entirely by Board staff, the free mobile app allows consumers to ‘follow’ the licenses of up to 16 physicians and receive notifications when there has been an update to any of their profiles. The app is the first of its kind among the medical boards in the nation and has garnered nearly 13,000 downloads. The Board also uses the app to alert the public about upcoming Board meetings, agenda posting, laws and regulations, and news.

53. Does the Board webcast its meetings? What is the board’s plan to webcast future Board and committee meetings? How long do webcast meetings remain available online?

Between July 1, 2020, and June 30, 2022, nearly all of the Board’s public meetings were webcast and conducted entirely online through the WebEx software platform.

When the Board meets in person and holds more than one meeting simultaneously (e.g. disciplinary panels) it may be unable to webcast all meetings live. In that situation, Board staff will record the meeting and later post it on the Board’s YouTube channel, where it is available indefinitely. The Board provides in-person and remote participation options, as appropriate, consistent with the meeting format. The Board intends to webcast future Board and Panel meetings, subject to limitations, if any, of a physical location where an in-person meeting is being held.

In May 2022, the Board held its first in-person meeting since the start of the COVID-19 pandemic, and due to the location’s technological capabilities, was also able to webcast it through the WebEx platform and facilitate public participation through that software.

54. Does the Board establish an annual meeting calendar, and post it on the Board’s website?

The Board approves their quarterly Board meeting calendar for the following year and posts the dates on the Board’s website. Committee and interested parties’ meetings are

held only on an as-needed basis and are not set for the entire year. The Board posts online the committee meeting dates as soon as a date is selected.

55. Is the Board's complaint disclosure policy consistent with DCA's Recommended Minimum Standards for Consumer Complaint Disclosure? Does the Board post accusations and disciplinary actions consistent with DCA's Website Posting of Accusations and Disciplinary Actions (May 21, 2010)?

The Board is committed to providing information to the public consistent with the law regarding license status and disciplinary or administrative actions against its licensees.

Regarding the first question, the Board exceeds the DCA recommended minimum standards for Consumer Complaint Disclosure. Regarding the second question, the Board posts accusations and disciplinary actions consistent with DCA's Website Posting of Accusations and Disciplinary Actions (May 21, 2010). In the event that the portion of the Board's website that enables consumers to look up a physician is not operational, the Board provides a toll-free phone number and an email address for consumer inquiries.

56. What information does the Board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

Information posted to a licensee's profile and provided to the public is specifically set forth in statute (BPC sections 803.1 and 2027). In 2018, the Legislature passed the Patient's Right to Know Act, which required the Board to add a probation summary to the profile pages of physicians on probation. The information posted on the licensee's profile page gives a quick summary of the probationary terms and informs the public about the discipline.

The Board's Apple iOS app provides users notifications on the status of up to 16 physicians. The app sends an alert directly to the smartphones of consumers, alerting them to any change to the licensee's status, including when accusations or disciplinary orders are published.

In addition to the DCA recommendations in its minimum standards for disclosure, the Board's website provides the following information:

- If a physician has been disciplined or formally accused of wrongdoing by the Board (public reprimands and public letters of reprimand are only available for 10 years on the website).

- If a physician's practice has been temporarily restricted or suspended pursuant to a court order.
- If a physician has been disciplined by a medical board of another state or federal government agency.
- If a physician has been convicted of a felony reported to the Board after January 3, 1991.
- If a physician has been convicted of a misdemeanor after January 1, 2007, that results in a disciplinary action or an accusation being filed by the Board, and the accusation is not subsequently withdrawn or dismissed.
- If a physician has been issued a citation (that has not been withdrawn or dismissed) for a minor violation of the law by the Board within the last three years.
- If a physician has been issued a public letter of reprimand at the time of licensure within the last three years.
- If a physician has been placed on probation, the licensee's probation status, the length of the probation, the probation end date, and all practice restrictions placed on the licensee by the Board pursuant to BPC section 2228.1(d).
- Any hospital disciplinary actions that resulted in the termination or revocation of the physician's privileges to provide healthcare services at a healthcare facility for a medical disciplinary cause or reason reported to the Board after January 1, 1995.
- All malpractice judgments and arbitration awards reported to the Board after January 1, 1998 (between January 1, 1993, and January 1, 1998, only those malpractice judgments and arbitration awards more than $30,000 were required to be reported to the Board).
- All malpractice settlements over $30,000 reported to the Board after January 1, 2003, that meet the following criteria:
    - Four or more in a five-year period if the physician practices in a high-risk specialty (obstetrics, orthopedic surgery, plastic surgery and neurological surgery).
    - Three or more in a five-year period if the physician practices in a low-risk specialty (all other specialties).

In addition to the information above regarding public record actions, the Board discloses the following information regarding past and current licensees/registrants: license/registration number; type; name; address/county of record; status; original issue

date; expiration date; school name; and year graduated. The Board also posts denied licensee applications on its website that users can view.

The Board provides the following voluntary survey information if supplied by the physician licensee: retired status; activities in medicine; patient care practice location; telemedicine primary and secondary practice location zip code; training status; board certifications; primary practice area(s); secondary practice area(s); post graduate training years; cultural background; foreign language(s); and gender.

Unless prohibited by law, the Board provides the actual documents on the website for the following: accusation/petition to revoke or amended accusation; public letter of reprimand; citation and fine; suspension/restriction order; and administrative/disciplinary decision.

57. What methods are used by the Board to provide consumer outreach and education?

The Board uses a variety of methods to perform consumer outreach and education functions throughout the state. The Board's quarterly meetings feature information about Board policies and procedures, including the relevant laws that govern its activities, and are attended by consumer advocacy organizations. Stakeholders are provided an opportunity to make public comments on items not on the agenda at the start of each quarterly Board meeting. In addition, the Board takes public comment for each item on the agenda, providing further opportunity for the public to weigh in. In turn, the participation of those organizations helps keep them informed of key topics, which they often use to educate their members and peers.

The Board held a first-of-its-kind Consumer Interested Parties Meeting at the close of its January 2019 quarterly Board meeting. This, and subsequent meetings, brought Board members, Board staff, patients, and consumer advocates together to discuss the Board and its enforcement process, share concerns, and look for ways to collaborate on the Board's consumer protection mission. The Board acquires helpful information during interactions with consumers and has worked to implement certain changes, including the posting of information suggested by patient advocates on the Board's website and revising the Board's complaint form.

The Board has held subsequent Interested Party Meetings, including those that focus on specific topics including, most recently, proposed revisions to its Guidelines for Prescribing Controlled Substances for Pain.

The launch of the Board's mobile app for Apple iOS devices greatly enhanced the Board's mission of consumer protection and reached nearly 13,000 downloads since its launch in July 2018. The Board vigorously promoted the app at a variety of statewide

health fairs and community events. Board staff connected with consumers about the app, demonstrated how to download and use it, and answered their questions about the Board. The Board's website contains a link to the app and has various promotional materials: fliers, a podcast, a promotional video, and a news release.

The Board employs a public information officer to direct outreach and education activities. The Board provides the following additional education and outreach activities: personal/speaking appearances; brochures and publications; licensing education outreach; and social media, subscriber alerts, and the website.

Personal/speaking appearances are one of the main ways the Board provides outreach and education. Board staff attends community events to distribute materials, provide presentations, and raise awareness about the Board. Due to budget and COVID-19-related restrictions, the Board could not attend all outreach events, but attended as many presentations as possible.

Brochures and publications are available on the Board's website (for downloading and printing locally) and provided at community outreach events.

These publications include:

- A Patient's Guide to Blood Transfusion – English and Spanish
- A Woman's Guide to Breast Cancer Diagnosis and Treatment – English, Spanish, Chinese, Japanese, Korean, Russian, Tagalog, Vietnamese
- Gynecological Cancers … What Women Need to Know – English, Spanish, Chinese, Japanese, Korean, Russian, Tagalog, Vietnamese
- Therapy Never Includes Sexual Behavior – English and Spanish
- Prostate Cancer Patient Guide – English and Spanish
- Information and Services for Consumers – English and Spanish
- Don't Wait, File a Complaint!
- A Consumer's Guide to the Complaint Process
- Medical Board of California License Alert Mobile App
- Most Asked Questions About Medical Consultants
- Questions and Answers About Investigations
- Manual of Model Disciplinary Orders and Disciplinary Guidelines
- Uniform Standards for Substance-Abusing Licensees
- Guidelines for Prescribing Controlled Substances for Pain

- Tip Sheets – English, Spanish, Chinese, Russian, Thai, Korean, Hmong, Vietnamese
- Guide to the Laws Governing the Practice of Medicine
- From Quackery to Quality Assurance
- Preserve a Treasure – Know When Antibiotics Work
- Medical Board Annual Report
- Medical Board Quarterly Newsletter
- Expert Reviewer Brochure
- Strategic Plan
- Sunset Review Report

Social Media has allowed the Board to expand its outreach efforts. The Board began using Twitter in early 2015 and it has been an excellent source of outreach. The Board can provide information quickly to those who follow the Board, including notification of outreach events, CME opportunities, Board meetings, and other timely updates. In addition, individuals can notify the Board of an issue through Twitter. The Board began using Facebook in 2018 and utilizes the social media site in the same manner it does its Twitter account. The Board also uses its YouTube channel to post various Board meetings and informational videos.

Subscriber's Alerts provide information to individuals who have subscribed to receive specific Board information. An individual can go to the Board's website and sign up to receive these alerts by submitting their email address. The different categories include Board meetings, Newsletters and news releases, enforcement actions, and regulations. When the Board posts information related to these categories, an email is sent to the subscriber with either a link to the information (such as the Board's Newsletter) or with the information itself (such as a listing of the physician's name and the disciplinary action the Board is taking against the physician's license).

The Board uses its website as the main source of communication between interested parties and the Board. The Board's website provides electronic editions of all the Board publications, Newsletters, meeting agendas, laws, regulations, and meeting materials. On the website under the "About Us" tab is information about the Board, including its history, Board members, and Board staff.

The website also includes links to helpful documents and other entities' websites. Some of these useful links/topics include, but are not limited to:

- Advanced Health Care Directive Registry
- Consumer's Guide to Healthcare Providers

- HIPAA - Protecting the Privacy of Patients' Health Information
- Medical Spas - What You Need to Know
- Patient Access to Medical Records
- Resources Available to Help Reduce Cost to Patients of Life-Saving Mammograms
- How to Choose a Doctor / Physician License Information
- Role of the Medical Board of California
- Enforcement Process
- Conviction - How it Might Affect a Medical License
- California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care
- CURES Information
- End of Life Option Act
- Public Disclosure Information

The Board also includes FAQs on numerous topics for both the public and licensees. Some of these FAQs include:

- Complaint Process
- Controlled Substances Utilization Review and Evaluation System (CURES)
- General Office Practices/Protocols
- Internet Prescribing and Practicing
- Medical Records
- Physician Credentials/Practice Specialties
- Public Information/Disclosure
- Medical Assistants
- Cosmetic Treatments
- Fictitious Name Permits
- Postgraduate Training License
- BreEZe
- Supervising Physician Assistants

- iOS App

Through the Board's website, individuals may apply for a physician license, renew their license to practice medicine, update an address of record/email address, generate an electronic wallet card, and update the physician survey.

The website links to the Board's laws and regulations, including proposed regulations, which govern the practice of medicine in California. It also provides statistics concerning the Board's Enforcement and Licensing Programs.

In addition to the above-described consumer outreach, the Board conducts outreach to applicants and licensees to help postgraduate program directors and deans assist applicants with understanding the licensure laws and how to navigate the licensing process. In early 2022, the Board held multiple webinars and performed outreach at various medical schools to prepare medical students to navigate recent changes to licensure requirements.

In addition, Board staff work one-on-one, resources permitting, with medical residents to explain the licensing process and inform them what documents are needed for licensure. This allows students and residents to meet personally (or through phone/email) with Board staff, answer questions they may have, and review their documents before submitting an application. This can help shorten the application review process and avoid a rush of last-minute applications for licensure, which can increase processing timeframes due to overwhelming application volumes at certain times of the year. When able, Board staff attend new medical student and postgraduate trainee orientation sessions. The intent is to provide information about the Board and to answer questions to help ensure a smooth application process.

Further, the Board has proposed creating a Complainant Liaison Unit that will help foster communication and understanding of the Board's complaint review and investigation/disciplinary processes. That proposal is discussed in Section 12, New Issues, of this report.

Finally, the Board's Executive Director, William Prasifka, provides presentations to various physician groups that focus on a variety of Board topics including, but not limited to, its enforcement process, update on the Guidelines for Prescribing Controlled Substances for Pain, the Board's Prescription Review Program, and the myriad of changes brought upon the Board by SB 806, the Board's sunset bill.

The groups presented to include the Midvalley Chapter of California Association Medical Staff Services (CAMSS); Greater Long Beach Chapter of CAMMS; Coalition for Physician Enhancement; and California Society of Anesthesiologists.

Sunset Review Oversight Report

Section 7

Online Practice Issues

7. ONLINE PRACTICE ISSUES

58. Discuss the prevalence of online practice and whether there are issues with unlicensed activity. How does the Board regulate online practice? Does the Board have any plans to regulate internet business practices or believe there is a need to do so?

With the onset of the COVID-19 pandemic, there was a significant increase in the use. The Board regulates telemedicine or online practice just as it does regular, in-person medical visits. Telemedicine is a tool in the practice of medicine but does not change the standard of care. Thus far, the Board has not seen a large number of complaints involving telemedicine visits and has not seen a need to undertake additional regulation.

Sunset Review Oversight Report

Section 8

Workforce Development and Job Creation

WORKFORCE DEVELOPMENT AND JOB CREATION

59. What actions has the Board taken in terms of workforce development?

The Board's ability to process the license applications it receives, and timely issue licenses to qualified applicants, allows these new licensees to apply for and/or continue working in California healthcare professions. The Board received 10,834 PTL and physician license applications in Fiscal Year (FY) 2021-2022. This was an increase of 3,036 license applications compared to FY 2020-2021. The Board issued 9,843 PTL and physician licenses in FY 2021-2022. This was an increase of 1,637 more licenses issued than in FY 2020-2021.

At the time of initial licensure and renewal of a physician license, the Board collects $25, which is transferred to the California Department of Health Care Access and Information (HCAI) to help fund the Steven M. Thompson California Physician Corps Loan Repayment Program administrated by HCAI. The program encourages recently-licensed physicians to practice in medically underserved areas in California, by authorizing a student loan repayment plan in exchange for a minimum of three years of service. There is a requirement that most participants be selected from the specialty areas of family practice, internal medicine, pediatrics, and obstetrics/gynecology. However, up to 20 percent of the participants may be selected from other specialty areas.

In addition, physicians and surgeons at the time of initial licensure or renewal may contribute money to provide training for family physicians and other primary-care providers who will serve in medically underserved areas. The funds the Board collects for the family physician training program is transferred to HCAI.

60. Describe any assessment the board has conducted on the impact of licensing delays.

SB 806 changed the licensing requirements effective January 1, 2022, requiring U.S. or Canadian medical school graduates to obtain credit for 12 months of board-approved postgraduate training, and international medical school graduates to obtain credit for 24 months of board-approved postgraduate training to qualify for a Physician's and Surgeon's (P&S) license. This law change resulted in a significant increase in the volume of P&S license applications. In FY 2021-2022, the Board received 7,910 P&S license applications compared to 4,699 received in the prior fiscal year, which is a 68 percent increase. Of the P&S license applications received in FY 2021-2022, 73 percent were received from January 1, 2022, through June 30, 2022.

This sudden and significant increase in application volume resulted in an increase in application processing times from approximately 30 days to approximately 60 days.

Since the Board anticipated an increase in application volume as a result of SB 806, the Board conducted two live webinars on January 6, 2022, and March 30, 2022, to address the license requirement changes and encourage residents to apply early, up to six months prior to the date they would need their P&S license. The Board posted the webinar on its website on January 13, 2022. In addition to the live webinars, the Board conducted over 18 outreach events with postgraduate training programs from December 2021 through September 2022.

With many PTLs set to expire by September 30, 2022, the Board prioritized the processing and review of P&S license applications for these residents to mitigate any possible disruption in the provision of care. On September 29, 2022, the Department of Consumer Affairs issued a waiver under Executive Order N-39-20 to extend the deadline for when specified P&S applicants would need to obtain their P&S license, including extending the expiration date for specified PTLs that expired on or before October 31, 2022. By September 30, 2022, there were only 17 PTL holders expiring in September 2022 that had not yet been issued a license due to outstanding application deficiencies.

The Board has not conducted a formal assessment on the impact of licensing delays, but understands from communications with applicants, postgraduate training program directors, hospitals, and professional associations that delays to issuing licenses can lead to other staff working overtime to fill unexpected vacancies, difficulty in recruiting and obtaining new hires, and impede a hospital's ability to provide health care.

The Board currently expects these applications to be reviewed within 45 calendar days from the date of receipt. The Board is currently meeting the 60-working-day timeframe for new applications received and has implemented several measures to address the increased workload and reduce processing times, including approval of staff overtime, reallocating staff, identifying process efficiencies, and working toward a paperless-licensure process. PTL and P&S license applicants can now submit all required documents electronically.

The Board continues to explore new outreach methods and develop new professional relationships with entities that can reach a large number of training programs and residents to provide information on the application process and how to most efficiently submit required application documents to the Board.

61. Describe the Board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

In March 2020, non-essential state travel was suspended due to COVID-19 and the Board was not able to conduct in-person licensing workshops or fairs. The Board was able to resume its outreach program in 2022 with both in-person and virtual events,

including live webinars, licensing fairs, and presentations. In addition to the outreach efforts described in the response to Question #60, the Board regularly sent emails starting in December 2021, to postgraduate training programs and medical schools on the changes to the licensing requirements effective January 1, 2022, and posted information on its website and in its newsletter to prepare applicants and programs for these changes.

62. Describe any barriers to licensure and/or employment the Board believes exist.

As a result of the licensure requirement changes effective January 1, 2022, PTL holders must obtain a P&S license by the time their PTL expires, which is either after 15 or 27 months, depending on whether they are U.S./Canadian or international medical school graduates. A P&S applicant must pass all steps of the United Sates Medical Licensing Examination (USMLE) to obtain a P&S license. If the PTL holder has not passed USMLE Step 3 by the time their PTL expires, they must cease all clinical practice in California until they obtain their P&S license. Refer to the “New Issues” section for proposed law changes that intend to address this issue that currently prevents California residents from continuing in their postgraduate training programs.

63. Provide any workforce development data collected by the board, such as:

a) **Workforce shortages**

b) **Successful training programs**

The Board collects data but does not have the resources to evaluate the information gathered. Instead, it provides assistance and resources to other agencies and/or official research groups, such as the HCAI, California Health Care Foundation (CHCF), and the University of California, San Francisco, that study workforce issues relative to physicians in California. This assistance includes providing statistics and staff assistance to survey California licensed physicians for workforce data collection.

The CHCF and the University of California’s Program on Access to Care provided support to UC-San Francisco staff as they analyzed the data. Multiple reports have been written using information obtained by the Board’s survey data in conjunction with other data the Board has assisted in obtaining.

The Board also collects and publishes certain information for each licensee. This is performed through an extensive survey that may be voluntarily completed by physicians when they are initially licensed and updated each renewal period as part of the renewal process. The information requested from physicians includes data on years of postgraduate training; time spent in teaching, research, patient care, telemedicine, and

administration; practice locations; areas of practice; and board certification. In addition, the survey requests information on race/ethnicity, foreign language, and gender. Even though these questions are optional, they are an important part of the efforts to examine physician demographics.

BPC section 2092 authorizes the Board to prioritize license applications where the applicant has demonstrated that they intend to practice in a medically underserved area or serve a medically underserved population as defined in the Health and Safety Code. The number of licenses issued to applicants who demonstrated their intent to practice in medically underserved areas are below.

Fiscal Year	Licenses Issued
2018/2019	180
2019/2020	164
2020/2021	123
2021/2022	322

Sunset Review Oversight Report

Section 9

Current Issues

CURRENT ISSUES

64. What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?

The Board has been using the Uniform Standards since July 1, 2015, when the Board's related regulation became effective.

65. What is the status of the Board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?

The Board previously reviewed the CPEI regulations and determined that it already possesses the relevant authority through various statutes in the Medical Practice Act and elsewhere in the BPC. Therefore, no action is required to implement them.

66. Describe how the Board is participating in development of BreEZe and any other secondary IT issues affecting the Board.

a. **Is the Board utilizing BreEZe? What Release was the board included in? What is the status of the board's change requests?**

b. **If the Board is not utilizing BreEZe, what is the Board's plan for future IT needs? What discussions has the Board had with DCA about IT needs and options? What is the Board's understanding of Release 3 boards? Is the Board currently using a bridge or workaround system?**

As of October 10, 2022, the Board has 82 Board-specific service requests and there were 95 GLOBAL service requests pending assignment to a release. Between September 2020 and September 2022, there were a total of 38 releases where approximately 101 Board specific service requests were addressed.

The Board bases the prioritization of service requests on legislative requirements and business process needs. Some service requests can sit in queue for months waiting for the space to be prioritized into the scope of a release. Just recently, the Department of Consumer Affairs (DCA) Office of Information Services (OIS) Breeze Team has changed to an AGILE development method to attempt to speed up the development to release lifecycle of BreEZe change requests. The first release using this methodology is in late October 2022 and it may help to get more changes into the system faster.

The November – December 2022 development schedule is being reserved for mandated legislation changes because of resource limitations at the same time last year. While this may delay some of the 82 items in the current MBC backlog from being worked on in this period, it will ensure that legislative changes for all boards under the DCA are implemented in time for their effective dates. Significant BreEZe changes during the September 2020 – September 2022 timeframe include:

- Increase the CURES fee from $12 to $22 biennially, with a fee increase effective date of 04/01/2021 (January 2021).
- Issuance of temporary licenses pursuant to AB 186 (spouses of military personnel) (August 2021).
- Automatic email notifications to the license holder when temporary licenses are approved (September 2021).
- Fee changes pursuant to SB 806 (November 2021).
- Text edits to the online complaint screens to reduce complaint initiation processing time and notify users of file size limitations (December 2021).
- Configuration requirements to identify when a licensee has fulfilled the postgraduate training requirements to renew their license pursuant to SB 806/BPC 2097 (January 2021).
- Automatic email notifications to the license holder when renewal transactions are approved regarding the ability to print their own Wallet License (March 2022).
- Change of Address made available online for Licensed Midwives and Polysomnography license holders (April 2022).
- Configuration allowing initial application and licensure fees to be waived for a legal partner of an active-duty person in the military, who holds an out of state license, pursuant to SB 607. (June 2022).
- Automatic email notifications to the license holder when a Physician and Surgeon renewal transaction is available to renew early online (previously a manual process) (June 2022).
- Change of Address made available online for Research Psychoanalyst license holders (June 2022).
- Implementation of the Department of Health Care Access and Information (HCAI) Workforce Data Survey pursuant to AB 133 (July 2022).
- Change of Address made available online for Special Faculty Permit and Mexico Pilot Program license holders (August 2022)

Sunset Review Oversight Report

Section 10

Board Actions and Responses to COVID-19

BOARD ACTIONS AND RESPONSES TO COVID-19.

67. In response to COVID-19, has the board implemented teleworking policies for employees and staff?

a. How have those measures affected board operations? If so, how?

The Board implemented the Department of Consumer Affair's Telework Policy OHR 22-01. The Board continues to perform essential governmental functions to license and regulate physicians and surgeons and other allied health care professionals on the front lines of the COVID-19 pandemic. The health, safety and wellbeing of the employees of the Board continue to be the daily priority of the Board's management team. Staff is of the utmost importance to the Board and many of them are telecommuting on either a full- or part-time basis. Most of the staff working in the office are on a staggered work shift to reduce the number of staff in the office at the same time.

To accommodate teleworking by a majority of staff, processes and workflows have been adjusted, modified and readjusted. The lack of a paperless platform created a unique series of challenges but thankfully staff at all levels have been creative and flexible to ensure the Board continues operating as seamlessly as possible to meet its mandate.

COVID-19 impacted the Board's everyday operations. For example, the Board moved its quarterly Board meeting and other public meetings from an in-person format to an online format through the WebEx platform until April 2022. The Board plans to hold future public meetings via WebEx on an alternate basis or as needed as long as it is allowed under the Bagley-Keene Open Meeting Act.

The Licensing Program developed new procedures to adapt to a telework-centered environment within a very short turnaround while keeping application processing times within the 60 working days regulatory timeframe.

Enforcement and investigation activities have been modified to incorporate video or telephonic means for conducting interviews and probation updates. Many more documents are being handled electronically than ever before. Systems for sharing information with HQIU and the AGO have been shifted to electronic means. Courts and county offices were closed or were on very limited hours of operation so obtaining information or documentation was difficult and at times, not possible. The Office of Administrative Hearings was closed for a period of time beginning in March 2020 but began operations and started holding remote hearings in late summer of 2020.

68. In response to COVID-19, has the board utilized any existing state of emergency statutes?

a. If so, which ones, and why?

In response to COVID-19, the Board has not utilized any existing state of emergency statutes. BPC section 900 is managed through the Emergency Medical Services Authority, and DCA waiver DCA-20-57 to restore inactive, retired, or cancelled licenses made the use of BPC section 922 unnecessary, as the waiver provided for a streamlined process.

69. Pursuant to the Governor's Executive Orders N-40-20 and N-75-20, has the board worked on any waiver requests with the Department?

Pursuant to Executive Order N-40-20, the DCA director may waive any statutory or regulatory requirements with respect to CE for licenses issued pursuant to Division 3 of the BPC. Board staff worked with DCA to submit and review the following waiver requests to assist licensees:

Postgraduate Training License and Physician's and Surgeon's License

- DCA Waiver DCA-20-50 Postgraduate Training License Deadline extended to October 31, 2020

  The order waives the requirements to obtain a PTL by June 30, 2020, for individuals who were enrolled in an approved postgraduate training program in California on January 1, 2020. This waiver was superseded by several other waivers further extending the deadline, with DCA-21-167 issuing the final extension to August 31, 2021.

- DCA Waiver DCA-20-100 Postgraduate Training License Deadline

  The order extends the 180-day deadline for individuals initially enrolled in an approved postgraduate training program between June 1, 2020, and July 31, 2020 to obtain a PTL. Individuals must obtain a PTL on or before March 31, 2021. This waiver was superseded by several other waivers further extending the deadline, with DCA-21-168 issuing the final extension to August 31, 2021.

- DCA Waiver DCA-20-65 Physician's and Surgeon's License Deadline

  This order extended the deadline to December 31, 2020, for individuals who completed at least 36 months of approved postgraduate training outside of California, were enrolled in an approved postgraduate training program in California on July 1, 2020, and who are required to obtain a physician's and surgeon's license from the Board within 90 days to continue the practice of medicine, pursuant to BPC section 2065, subdivision (h). DCA Waiver DCA-20-94 further extended this deadline to March 31, 2021.

- DCA Waiver DCA-22-218 Order Waiving Postgraduate Training License Deadlines

  This order extended the deadline for specific individuals to obtain a Physician's and Surgeon's License. For P&S License applicants who received credit for 12 months of approved postgraduate training in another state or Canada, were accepted into an approved postgraduate training program in California and are required to obtain their physician's and surgeon's license on or before October 31, 2022, the waiver extended this deadline to November 30, 2022.

  For PTL holders whose license expires on or before October 31, 2022 and received either 12 months credit of board-approved postgraduate training for graduates of medical schools in the United States and Canada, or 24 months credit of board-approved postgraduate training for graduates of other foreign medical schools approved by the board, the waiver extended this deadline to November 30, 2022.

  For individuals enrolled in a California board-approved postgraduate training program and are required to obtain a postgraduate training license on or before December 31, 2022, the waiver extended this deadline to January 31, 2023.

Physician Supervision of Nurse-Midwives, Physician Assistants, and Nurse Practitioners

DCA Waiver DCA-20-04 waives the supervision requirements and allows physicians to supervise more than four PAs at one time. Further, it waived other supervision requirements if:

a. A PA moves to a practice site or organized health care system to assist with the COVID-19 response, but does not have a practice agreement in place with any authorized physician of the site or system; or
b. as a result of the COVID-19 response, no supervising physician with whom a PA has an enforceable practice agreement is available to supervise the PA.

DCA Waiver DCA-20-05 waives supervision requirements and allows a physician to supervise more than four nurse practitioners at any one time when furnishing or ordering drugs or devices.

DCA Waiver DCA-20-06 Nurse-Midwife Supervision Requirements

The order waives supervision requirements and allows physicians to supervise more than four certified nurse-midwives at one time.

The initial waivers relating to nurse-midwives, PAs, and nurse practitioners have been extended several times. DCA Waiver DCA-20-83, terminated on February 8, 2021.

Examination Requirements

DCA Waiver DCA-20-25 Extending Time to Satisfy Examination Requirements

The order extends the timeframe for when a physician and surgeon application is deemed abandoned due to the applicant failing to pass or retake Step 3 of the USMLE from 12 months to 18 months from the date of notification by the Board. This order supports applicants unable to complete this necessary licensing examination during the COVID-19 pandemic. This waiver was superseded by several other waivers expanding the scope to more applicants, with DCA-21-197 issuing the final waiver to applications deemed abandoned through October 31, 2021.

License Renewal

DCA Waiver DCA-20-53 Waiving Licensing Renewal Requirements

This order temporarily defers the CME renewal requirement for licenses that expire between March 31, 2020, and October 31, 2020, for six months after the date of the waiver. Licensees must satisfy CE requirements within six months unless the waiver is extended. This waiver was superseded by several other waivers expanding the scope to more licensees, with DCA-21-194 issuing the final waiver to licenses expiring through October 31, 2021.

Many CME providers were forced to close or halt services due to the pandemic, which prevented licensees from meeting renewal requirements. This waiver provides additional time for licensees to obtain the required CME while providers adapt to alternate methods of providing these courses.

License Restoration

DCA Waiver DCA-20-02 Reinstatement of Licensure

This order allows licensees to temporarily restore an inactive or retired license without having to pay any fees or complete, or demonstrate compliance with, any CE requirements for a period of six months, or when the State of Emergency ceases to exist, whichever is sooner. A licensee with a cancelled status that was voluntarily surrendered within the last five years not relating to a disciplinary action may meet the waiver criteria as well.

This waiver supported the state's COVID-19 pandemic response by increasing the availability of licensed health care professionals to treat patients. This waiver was superseded by several other waivers extending the period of temporary licensure, with DCA-22-212 issuing the final waiver authorizing temporary licensure through April 1, 2022.

a. Of the above requests, how many were approved?

   All requests were approved.

b. How many are pending?
   None are pending.

c. How many were denied?
None were denied.

d. What was the reason for the outcome of each request?

Many schools closed or relocated staff due to COVID-19, which created challenges for applicants to obtain documentation required for licensure. At the onset of the pandemic, many fingerprint Livescan facilities were also closed, further delaying applicants' abilities to meet licensure requirements. These waivers provided additional time to allow applicants to meet licensure requirements.
Many CME providers were forced to close or halt services due to the pandemic, which prevented licensees from meeting renewal requirements. These waivers provided additional time for licensees to obtain the required CME while providers adapted to alternate methods of providing these courses.
These waivers supported the state's COVID-19 pandemic response by increasing the availability of licensed health care professionals to treat patients.

70. In response to COVID-19, has the board taken any other steps or implemented any other policies regarding licensees or consumers?

Due to the USMLE suspending Step 2 Clinical Skills (CS) in response to the pandemic, the Board no longer requires passage of Step 2 CS to obtain a PTL. The online and hard copy applications were updated to reflect these changes.

In response to the difficulty medical schools and training programs have experienced in providing the required documents for licensure to the Board during the COVID-19 pandemic, the Board implemented additional document submission options. Some of these options included accepting electronically notarized documents from verified third party services and no longer requiring certain documents to be notarized, electronic document submission through the Board's DOCS Portal, the acceptance of electronic transcripts through approved services, as well as the acceptance of e-diplomas.

71. Has the board recognized any necessary statutory revisions, updates or changes to address COVId-19 or any future State of Emergency Declarations?

Yes, the Board would welcome a permanent change to the Bagley-Keene Open Meeting Act to allow meetings to continue to be conducted via an online platform so that it is an option for the Board to use at any time, even when California is not in a state of emergency. This option will save the Board money and time, and will protect Board members, staff, and the public when dangerous conditions arise without the need to wait for an executive order permitting online meetings.

Sunset Review Oversight Report

Section 11

Prior Sunset Issue

PRIOR SUNSET ISSUES

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.

Board Response (December 2022):

The Board sponsored legislation in 2022 (AB 2060, Quirk) that would change the Board's composition to have a public-member majority by replacing a vacant physician board member position with a public member position. The bill was not approved by the Legislature. The Board continues to support changing the Board's composition to a public member majority.

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.

Board Response (December 2022):

The Board continues to collaborate with DCA's Regulations Unit to move its proposed rulemakings through the process. The status of the Board's pending regulations is reported in Section 1, Question 3 of this report and summarized in a chart on the final page of this section.

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 (PRP). 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 (CDSS) and the State Department of Health Care Services (DHCS) on processes for investigating the possible inappropriate prescribing of psychotropic medications to foster children pursuant to BPC section 2245.

Board Response (December 2022):

Regarding the PRP, as of October 5, 2022, the Board has opened 64 cases and 31 were referred for investigation (some of which have concluded). 36 cases are still pending and 28 have been closed due to insufficient evidence or no violation.

Regarding monitoring medical exemptions for vaccinations, under current law, CDPH notifies the Board through automatic email notification when a physician has had five issued exemptions revoked by CDPH or determines that the physician's practice is contributing to a public health risk. Board investigative staff investigate these physicians to determine if a violation of the law occurred and refer the matters to the Attorney General's Office (AGO) for prosecution when warranted. As of October 5, 2022, the Board has received 31 notifications of physicians with five or more revoked exemptions and of those, seven have been referred to the AGO for an accusation and four accusations have been filed as of October 6, 2022.

The Board continues in its work related to the evaluation of psychotropic medication prescribing data provided by the DHCS related to patients in the foster care system. The goal is to determine possible instances of inappropriate prescribing and whether further policy changes are necessary to facilitate Board investigations.

As noted in a report recently issued by CDSS, prescriptions of psychotropic and antipsychotic medications to those in the foster care system have dropped significantly during the prior several years.

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.

Board Response (December 2022):

The Board included in its January 2022 memo a proposal to transfer the RP program to the Board of Psychology. The Legislature did not take action on this topic in 2022 and the Board continues to support transferring the RP program to the Board of Psychology.

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.

Board Response (December 2022):

The Board's proposed regulatory language and related rulemaking documents were submitted to the Department of Consumer Affairs (DCA) in May 2021 for review. In August 2022, the Board approved amending the proposed regulatory language and staff is currently preparing the rulemaking file with the revised language to submit to DCA.

After the proposed regulations are reviewed and approved through DCA and the Business, Consumer Services, and Housing Agency, the rulemaking will be submitted to the Office of Administrative Law which will publish the rulemaking and commence the 45-day comment period.

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.

Board Response (December 2022):

The Board has not made any findings in this area, but adopted a Support, if Amended position on AB 852 (Low) of 2021, which would have led to the provision of new mental health services to certain healthcare providers relating to the impacts of COVID-19. AB 852 was not approved by the Legislature.

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.

Board Response (December 2022):

Following the distribution of the Board's January 2022 memo to the Legislature, AB 1767 (Boerner-Horvath) was introduced, which would have established the California Board of Licensed Midwifery. The bill was not approved by the Legislature.

The Board has not studied the impacts that a new LM board would have on consumers, nor projected the various associated costs. The Board continues to support the creation of a separate board to regulate LMs and looks forward to working with the Legislature and other stakeholders to facilitate this change.

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.

Board Response (December 2022):

SB 806 (Roth) of 2021 restored the Board's authority to recover costs incurred in the investigation and prosecution of physician and surgeon licensees and the Board has only been able to implement it since the start of 2022.

Between January 1, 2022, and June 30, 2022, the Board imposed cost recovery on 40 physician and surgeon cases for a total amount of $239,520.51 (an average of $5,988.01

per case). As of September 29, 2022, $26,286.26 have been recovered. Of those 40 cases, 24 were a result of a surrender or revocation imposed, meaning it is unlikely those costs will be paid unless and until the respondent successfully reinstates with the Board.

Those cases amount to $147,906.75 or approximately 62% of the amount imposed in the timeframe. Many of the Board's costs in these cases were incurred prior to restoration of cost recovery authority, therefore investigations that commence after January 1, 2022, may see larger cost recovery awards.

Anecdotally, the reinstatement of cost recovery appears to be encouraging earlier settlement of certain cases and reinforces the importance of promptly responding to the Board's investigation and prosecution efforts. The timely resolution of cases benefits consumers, licensees, and the Board.

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.

Board Response (December 2022):

SB 806 (Roth) of 2021 provided the fee increases requested by the Board, except for initial licensure and renewal fees charged to physician and surgeons, which accounts for approximately 90 percent[7] of funds received by the Board. That bill increased those fee amounts by $80 from $783 to $863. The Board's January 2020 fee study recommended those fee amounts be set at $1,150, a $367 increase.

Unfortunately, the Board is still facing a significant revenue shortfall and to avoid a negative fund balance was required a take a $10 million loan from the Vehicle Inspection and Repair Fund. The Board anticipates requiring an additional loan in Fiscal Year 2022-23 to avoid a negative fund balance.

The Board's requests related to its fund condition are discussed in greater detail in Section 12, New Issues.

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

[7] See p. 5 of the Board's FY 2021-2022 Annual Report.

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.

Board Response (December 2022):

Following the passage of SB 806, the Board expected very high application volumes in 2022[8]. To help address this, the Legislature authorized three additional licensing staff positions effective July 1, 2022. Further, in the beginning of 2022, the Board began outreach activities to encourage license applicants to apply six months in advance, which for PTL holders, would be six months prior to their PTL expiration date.

In the beginning of 2022, the Board received an exceptionally high volume of applications, including many from PTL holders who were required to transition to a P&S license to maintain their authority to practice medicine. As discussed in Section 12, New Issues, the Board intends to explore possible statutory changes to extend the expiration date of a PTL, without otherwise changing the requirements for licensure.

Further, the Board's Licensing Unit has been reviewing its business practices to eliminate unnecessary steps and transition to a paperless process, creating a more efficient license application process and reducing the time processing mailed documents.

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

[8] FY 2021-2022 application volume increased by approximately 59 percent from the prior year, per the Board's FY 2021-2022 Annual Report (see p.10)

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.

Board Response (December 2022):

Effective January 1, 2022, SB 806 changed the Board's licensing requirements to only require either 12 (U.S./Canadian medical school graduates) or 24 (international medical school graduates) months of postgraduate training prior to initial licensure. The bill requires licensees to obtain 36 months of postgraduate training, including 24 continuous months in the same program, prior to their initial renewal (24 months after obtaining their license). This change is expected to have resolved stakeholder concerns related to moonlighting and DEA x-waivers by PTL holders, as it initially reinstates the same postgraduate training requirements to obtain a Physician's and Surgeon's license that were in place prior to January 1, 2020.

SB 806 addressed the leave policy issue by authorizing the Board to extend a PTL expiration date as long as necessary to allow a PTL holder to obtain credit for the months of postgraduate training required for licensure.

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.

Board Response (December 2022):

As of September 2022, the Board has issued 21 licenses to qualified MPP applicants. One qualified applicant has asked the Board to delay issuing their license pending submittal of their visa applications. The Board anticipates approving a cohort of 8 additional applicants (for a total of 30, the maximum under the law) in Spring 2023. MPP physicians are authorized to practice in the following board-approved community health clinics:

- Clinica de Salud del Valle de Salinas in Monterey County
- San Benito Health Foundation in San Benito County
- Altura Centers for Health in Tulare County
- AltaMed Health Services Corporation

In August 2022, the University of California, Davis released its first annual progress report of the MPP. The goal of the MPP evaluation is to make recommendations on whether the pilot should be continued, expanded, altered, or terminated. The initial report covers fiscal years 1 (2020-2021) and 2 (2021-2022) and includes baseline data results and interpretations.

This recommendation will be based on six (6) broadly defined, multidimensional, outcomes:

- Quality of Care
- Adaptability of Physicians
- Impact on Working and Administrative Environment
- Patient Experience
- Impact on Culturally and Linguistically Appropriate Services
- Impact on Limited English-Speaking Patient Encounters

Board staff attended an event hosted by Clinica de Salud del Valle de Salinas on August 5, 2022, that included a roundtable discussion with Secretary Lourdes Castro Ramirez of the Business, Consumer Services, and Housing Agency, Senator Anna Caballero, CEOs of the participating programs, several MPP licensees, among other key individuals. That

discussion provided Board staff insight into the experiences of those involved in the development and operation of the MPP, challenges that some licensees faced in obtaining a visa from the federal government, and the impact the MPP is having in the communities being served.

Due to the additional eight program participants that will be applying for an MPP license, UC Davis' program evaluation must be extended out an additional year, which required the Board to seek a budget augmentation to pay for the evaluation an additional year. The Board is determining if additional funding is needed to support the extension of the program for this additional year.

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.

Board Response (December 2022):

The Board has no further update on this topic.

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.

Board Response (December 2022):

Senate Bill 806 updated the definition of an AMC by deleting the intern/resident bed ratio and $100,000,000 annual research AMC requirements. The bill also added a requirement that AMCs be accredited by the Western Association of Schools and Colleges and the Accreditation Council for Graduate Medical Education.

In January 2022, the Board recognized Cedars-Sinai Medical Center (Cedars) as an AMC, which authorized Cedars to submit special permit applications under BPC sections

2111, 2113, and 2168. Further, a qualified individual designated by Cedars is authorized to represent AMCs on the Special Faculty Permit Review Committee, which reviews and makes recommendations whether to grant a special faculty permit (per BPC section 2168) to a qualified applicant. No other institutions have been recognized by the Board as an AMC.

AB 2178 of 2022, which takes effect on January 1, 2023, updates the definition related to certain aspects of AMCs without substantively changing the underlying requirements.

Since Cedars was designated as an AMC, as of October 11, 2022, the Board has received the following amount of special permit applications from Cedars:

- BPC section 2111: 2
- BPC section 2112: 0
- BPC section 2113: 1
- BPC section 2168: 0

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.

Board Response (December 2022):

In January 2022, the Board sought legislation to help ensure that the Board receives appropriate reports of possible physician unprofessional conduct. The first would amend Business and Professions Code section 805.8 to clarify that "wellness committees," medical groups, health insurance providers, health care service plan providers, and locum tenens agencies are required to report complaints of alleged sexual misconduct to the Board, or other appropriate licensing agency.

The second proposal would require any organization that employs or contracts with a physician to report the Board any discipline imposed, or change in contracted services, with a physician due to a medical disciplinary cause or reason.

Together, these proposals are expected to help the Board become aware of additional suspected incidents of unprofessional conduct by physicians. The Board was unable to secure an author this year but continues to advocate for their approval. These proposals are included in Section 12, New Issues later in this report.

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.

Board Response (2022):

To help improve communication between the Board and complainants and enhance the public's understanding of the Board's enforcement program, the Board began discussing during its February 2022 meeting the creation of a Complainant Liaison Unit (Liaison Unit), which would supplement the Board's existing enforcement personnel.

[Additional details related to this proposal are pending Board action during the December 1-2, 2022, meeting. This section will be updated accordingly after that meeting.]

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.

Board Response (2022):

SB 806 provided the Board authority to issue confidential letters of advice related to alleged minor violations of the Medical Practice Act that are "not related to patient care."

Unfortunately, that qualification is very restrictive and in January 2022, the Board sought legislation to clarify that the use of these letters should be limited to minor violations that are not related to a licensee's "fitness to practice." This change will provide the Board flexibility to use these letters in appropriate situations. The Board was not able to obtain an author for this change in statute and the Board continues to advocate for its approval.

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.

Board Response (2022):

In Fiscal Year 2020-2021 and 2021-2022, the Board settled 84 and 82 percent of disciplinary cases, respectively. The Board continues to believe that the appropriate use of stipulated settlements allows the Board to take appropriate disciplinary action against

its licensees in a timely manner, especially when mitigating evidence has been provided by the respondent physician. Appropriate stipulated settlements help preserve resources and limit the Board's exposure to future litigation on that case.

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.

Board Response (2022):

Most of the Board's proposals included within its 2020 sunset report, and none within the Board's January 2022 memo, that would provide the Board with additional enforcement tools have been approved, so far. The Board's current requests for legislation are included in Section 12, New Issues, later in this report.

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.

Board Response (2022):

The Board has continued to implement this law without issues.

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.

Board Response (2022):

The Board continues to require MBC staff and Board members to attend mandatory training on implicit bias and the Board is bound by DCA's zero-tolerance non-discrimination policy.

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.

Board Response (2022):

The Board continues to work within the parameters of the updated MOU, adopted in 2021, between the Board and HQIU to collaborate on the timely and thorough completion of the Board's investigations. As discussed in Section 5 of this report, the average amount of time to complete the Board's investigations continue to exceed the statutory timeframes.

The Board looks forward to considering any recommendations from the enforcement monitor on this topic.

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.

Board Response (2022):

The Board updated its approach to proactively investigating possible inappropriate prescribing of opioids and renamed the project as the Prescription Review Program (PRP) (formerly the Death Certificate Project). Now deaths due to opioid overdose are to initially assess the case for possible inappropriate prescribing prior to reviewing a prescribing report on the related physician and conducting a full field investigation. Physicians who are not considered to present a risk to the public during the initial assessment are not subject to further review. In addition, the use of illegally obtained street drugs, such as fentanyl, rather than prescribed medications, are accounting for a very large portion of these overdose deaths.

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. The Board imposed

10 probations, 24 public letters of reprimand/public reprimands, and accepted 11 surrenders because of the complaints initiated related to the PRP.

In late 2020, the Board began reviewing 2019 death certificate data for the PRP. As of October 5, 2022, the Board has opened 64 cases and 31 were referred for investigation (some of which have concluded). 36 cases are still pending and 28 have been closed due to insufficient evidence or no violation.

The Board President appointed a task force of two Board members (Mr. Ryan Brooks and Dr. Richard Thorp) to lead the effort to update the Board's 2014 Guidelines for Prescribing Controlled Substances for Pain. The process included a consultation with relevant medical experts and an interested parties (IP) meeting held on July 14, 2022. The task force plans to incorporate feedback taken at that IP meeting, release a revised draft, and hold another IP meeting to solicit further input from stakeholders.

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.

Board Response (December 2022):

The various orders issued by the Governor and Director of the Department of Consumer Affairs provided the Board, its licensees, and applicants necessary flexibility to maintain operations and comply with licensing requirements during the pandemic.

As discussed above in Prior Issue #10 and in Section 12, New Issues, later in this report, the Board intends explore possible statutory changes to the expiration date of a PTL, as this could help provide additional flexibility to the Board when processing applications from those transitioning to a P&S license.

In addition, the Board adopted a Support position on AB 1733 (Quirk), which would have facilitated the use of online or teleconference-based public meetings. SB 189 of 2022 provides the Board flexibility to conduct public meetings in this manner until July 1, 2023.

Enacting a permanent law that allows the Board to meet without gathering in-person can reduce the staff burden and financial costs associated with planning and conducting Board meetings.

Finally, SB 806 required all licensees to provide an email address to the Board by July 1, 2022. The Board intends to continue to move towards paperless licensing processes, whenever feasible. The Licensing Program changed its application processes to allow PTL and P&S license applicants to submit all of their documents online through BreEZe,

while postgraduate training programs and medical schools may continue to submit their documents electronically through DOCS.

In early 2023, the Board intends to stop accepting paper applications for the PTL application and the application to transition from a PTL to a P&S license. This will reduce the time spent processing mailed documents, ensure all documents are received securely by the Board, and create a more streamlined application process for both the applicant and the Board.

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.

Board Response (December 2022):

SB 806 enacted the Board's requested changes to its special permit programs contained within BPC section 2111, 2112, and 2113 to facilitate the cancellation of a permit under specified circumstances. This legislation also authorized the Board to transition toward an entirely electronic based licensure process.

SB 1440 (Roth) and SB 1443 (Roth) of 2022 included technical clarifications of the Licensed Midwifery Practice Act and Medical Practice Act, respectively. Additional technical clarifications requested by the Board are included in Section 12, New Issues, later in this report.

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.

Board Response (December 2022):

The Board believes that it should continue pursuing its consumer protection mission, with appropriate statutory changes, and be extended for a four-year period.

Status of Pending Medical Board of California 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 to DCA (other control agencies) for Final Review***	**Date to OAL for Review**	**Date to Secretary of State**
Physician and Surgeon Health and Wellness Program	Board Staff Working on Initial Review	08/25/22							
Notice to Patients (Signage)	Pending revision	07/26/18	10/28/21	11/02/21	11/12/21	N/A	09/27/22	10/13/22	
Medical and Midwife Assistant Certifying Organizations	Submitted to OAL	08/08/19	01/06/21	05/24/21	06/04/21	N/A	09/22/21	12/10/21	02/01/22
Citable Offenses	Board Staff Working on Initial Review	11/08/19							

Approved Continuing Education	Board Staff Working on Initial Review	08/14/20							
Adding Regulatory Language to the Licensed Midwife Annual Report	Board Staff Working on Initial Review	08/20/21							

Updated November 9, 2022

* The Department of Consumer Affairs is allowed 30 calendar days for final review.

** The Office of Administrative Law is allowed 30 working days for review.

*** Rulemakings become effective on a quarterly basis, unless otherwise specified.

Sunset Review Oversight Report

Section 12

New Issues

- *Financial Needs*
- *Enforcement Enhancements*
- *Licensing Updates*

NEW ISSUES

The Board has identified the following issues that it requests the Legislature consider during its review of the Board. Enacting these requests into law will help ensure that the Board has the financial resources and enforcement tools necessary to pursue its consumer protection mission.

The following issues are grouped into categories: Financial Needs, Enforcement Enhancements, and Licensing and Administrative Proposals.

[Following the Board meeting, include language here to describe the Board's priorities for the Legislature's consideration]

Financial Needs

Increases to Board Fees and Maximum Reserve Amount

The Board does not receive funding from the state's General Fund and its expenses are supported by fees paid by its applicants and licensees. Unfortunately, in recent years, the Board's revenue has not kept up with its growing expenditures, drawing down the Board's reserves to extremely low levels.

To address its urgent financial needs, in June 2022, the Board received a $10 million loan from the Vehicle Inspection and Repair Fund (Bureau of Automotive Repair). This loan must be repaid with interest by June 2024.

Modest Fee Increase Approved in 2021

In January 2020, the Board approved and published a fee study conducted by an independent organization, which evaluated the Board's revenues and expenses, including the reasons why the Board's expenses have grown in recent years. The study included recommended fee increases based on the Board's operations and environmental factors.

In 2021, SB 806 was signed into law, which included multiple increases to the Board's fees. However, the Board's requested increase to physician's and surgeon's (P&S) initial licensure and renewal fees to $1,150 (which accounts for more than 90 percent of the Board's revenue) was not provided. Instead, a much smaller increase was provided, which is not sufficient to meet the Board's needs.

Accordingly, the Board is facing insolvency.

Larger Increase to Physician and Surgeon Fees Now Required

As discussed in Section 3 of this report, the Board still faces a significant annual budget deficit and is projected to require additional loans to fund its operations. The Board's key cost drivers are related to the Board staff and contractors who are vital to pursuing consumer protection.

To provide the necessary amount of funding to support all authorized operations of the Board, including repayment of principal and interest for the current and additional anticipated loans, the Board projects that the following fees will need to be increased:

- Initial License Fee – Physician and Surgeon – increase from $863 to $1,350
- Renewal Fee – Physician and Surgeon – increase from $863 to $1,350
- Reduced Initial License Fee – Physician and Surgeon – increase from $432 to $675
- Delinquent Fee – Physician and Surgeon – increase from $86 to $135

Board Reserve Requirement is Low

Statute limits the Board to maintaining a reserve fund of between two- and four-months' operating expenditures[9]. Other boards and bureaus within the Department of Consumer Affairs (DCA), including the Board of Registered Nursing, are allowed to maintain a reserve of up to 24 months' operating expenditures[10].

The current reserve limitation inhibits the Board's ability to weather unanticipated future expenses, thereby increasing the need to rely upon fee increases to balance its budget.

Requested changes in statute: To address its financial challenges, the Board requests the following:

1. Increase P&S initial licensure and renewal fees from $863 to $1,350, based upon the Board's current financial condition.
2. To reduce the need to institute large fee increases in future years and support stable levels of funding, grant the Board authority to increase all fees, through the rulemaking process, above the statutory amounts by up to an additional 10% and decrease them if the Board reaches its maximum reserve amount.
3. Delete subdivision (g) of BPC section 2435, thereby allowing the Board to establish a reserve fund of up to 24 months' operating expenses, as allowed by BPC section 128.5 (b).

Establishing a Fee for Disciplined Licensees Seeking to Modify or Terminate Probation or to Reinstate Their License

[9] See BPC section 2435 (g)
[10] Unless otherwise provided in their respective practice act (e.g. BPC section 4400 (p) – Board of Pharmacy; BPC section 7138.1 – Contractors State License Board), BPC section 128.5 limits a board or bureau within DCA to a 24-month spending reserve.

Pursuant to BPC section 2307, a disciplined licensee may petition the Board to seek reinstatement of a revoked or surrendered license or to have their probation modified or terminated early.

The process to evaluate and consider each petition involves substantial legal costs. For example, in Fiscal Year 2020-21, the Board spent nearly $1,000,000 on fees paid to the AGO and the Office of Administrative Hearings for litigation and hearing expenses for the petitions formally considered by a Board panel.

Those petitioning the Board do not have to bear any of these costs (like with the Board's licensing application/renewal fees), therefore the Board is not able to recover these costs.

Requested change in statute: To mitigate the costs the Board faces to review and adjudicate these petitions, the Board requests adding a section to the Medical Practice Act that authorizes the Board to establish an application fee for petitioners, not to exceed the Board's reasonable costs to process and adjudicate petitions for reinstatement, early termination of probation, or modification of probation.

Enforcement Enhancements

The following proposals support the effectiveness of the Board's enforcement program, including the timely and thorough investigation and prosecution of licensees who fail to meet the standard of care or otherwise act unprofessionally.

Change the Evidentiary Standard to Preponderance of Evidence

Under California law, the Board is at a significant disadvantage, in comparison to most other medical boards, when attempting to investigate and prosecute a licensee suspected of failing to properly care for their patients or otherwise act in an unprofessional manner.

Prior to taking disciplinary action, the Board must first investigate to gather evidence sufficient to prove that discipline is appropriate and necessary. Discipline is tailored to the facts and circumstances of each case and, generally, may include public reprimands, probation, suspension, or revocation.

The Board is required, under current case law[11], to obtain "clear and convincing proof to a reasonable certainty." This burden of proof is higher than what is required in the vast majority of other jurisdictions[12] throughout the U.S. and its territories, which generally apply a "preponderance of evidence" standard. As a result, California is out of step with

[11] *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856
[12] For details, see https://www.fsmb.org/siteassets/advocacy/key-issues/standard-of-proof-by-state.pdf.

most other jurisdictions, making it more difficult, time consuming, and expensive to prosecute instances of unprofessional conduct in this state.

The "clear and convincing" standard requires less evidence than the "beyond a reasonable doubt" standard which is used in criminal prosecutions, but is higher than "preponderance of evidence," which is also used in civil litigation and is defined typically as "evidence that shows it is more likely than not that a fact is true."

Requested change in statute: Add a section to the Medical Practice Act stating preponderance of evidence is the standard of proof for the Board's disciplinary proceedings.

Mandate Additional Reports to the Board Regarding Physician Misconduct

Current law[13] generally requires a report to be filed with the Board when a peer review body takes, or recommends, certain actions (e.g. change in staff privileges or termination of employment) against a P&S due to a "medical disciplinary cause or reason[14]" or other unprofessional conduct. In addition, BPC section 805.8, mandates that health care facilities and postsecondary educational institutions report certain complaints of sexual misconduct about a healing arts professional to the appropriate licensing entity. Failure to meet these reporting requirements may result in substantial penalties.

While helpful, these reporting requirements are not sufficient to ensure that the Board is aware of possible P&S unprofessional conduct. Therefore, the Board seeks to require additional appropriate organizations with knowledge of possible P&S unprofessional conduct to provide a report to the Board.

Requested changes in statute:

- First, amend BPC section 805.8 to clarify that "wellness committees," medical groups, health insurance providers, health care service plan providers, and locum tenens agencies[15] are required to report complaints of alleged sexual misconduct to the appropriate licensing entity. This proposal would include additional health care organizations involved in the coordination and delivery of health care and that are likely to become aware of alleged P&S sexual misconduct.
- Second, add or amend statute to require any organization that employs a P&S to report to the Board any employment-related discipline imposed (up to and including termination) due to a medical disciplinary cause or reason.

[13] See BPC sections 805 and 805.01.
[14] Definition: that aspect of a licensee's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.
[15] Organizations that arrange for physicians to work in a setting on a temporary basis.

- Similarly, require any organization that contracts with a P&S, or other organization (e.g. a medical group or locum tenens provider) for P&S services, to report to the Board when a P&S is dismissed from service, or the contract is terminated, due to a medical disciplinary cause or reason.

Increase Wait Times for Disciplined Licensees Seeking to Modify or Terminate Probation or to Reinstate Their License

Between July 1, 2013, and June 30, 2022, the Board has granted approximately 37 percent of the petitions requesting reinstatement of a physician's license[16]. In Fiscal Year 2019-20 (the most recent year with no pending petitions), the Board granted approximately 58 percent of the petitions for termination of probation and none of the petitions for modification for probation.

Requested changes in statute**:** Considering the low petition approval rate and associated costs, the Board proposes to amend BPC section 2307, as follows:

- Licensees revoked or surrendered: After ~~three~~ five years, may seek reinstatement of their license. In the revocation order, the Board may specify that a petition for reinstatement may be filed after ~~two~~ three years.
  - Eliminate the option to petition after one year if the license was revoked or surrendered due to mental or physical illness.
- Licensees on probation: After two years, or after more than half their probation term has elapsed, whichever is greater, a licensee may seek early termination of probation.
  - Provide for the automatic rejection of a petition for early termination of probation if the Board files a petition to revoke probation while the petition is pending.
- Repetitive Petitions: The Board may deny without hearing or argument any petition filed pursuant to BPC section 2307 within ~~two~~ three years of the effective date of a decision related to a prior petition.

Pausing the Statute of Limitations for Subpoena Enforcement[17]

With certain exemptions, the Board generally must file an accusation against a licensee either within three years after it discovers the alleged act or omission or within seven years (10 years for sexual misconduct) following the date the alleged act or omission

[16] During this time period, there were outcomes for 161 petitions, with 59 granted.
[17] Additional information surrounding this topic is discussed in the Board's 2020 Sunset Report – see p. 211

occurred. If the Board is unable to meet the statute of limitations (SOL), then the complaint must be closed, in accordance with BPC section 2230.5.

If a licensee fails to produce medical records pursuant to a lawful subpoena of the Board, the investigative process is needlessly drawn out. During this often-lengthy process, the Board faces a growing risk that it will fail to meet the SOL as the Board litigates a petition for subpoena enforcement in superior court. Even where the Board proceeds at the quickest pace possible to obtain a superior court order compelling production, this litigation often severely delays resolution of the case, sometimes leaving very little time to fully develop an investigation, obtain expert review of the subpoenaed records, and draft and file an Accusation.

Under current law, the SOL is paused (known as tolling) if the licensee is out of compliance with a court order to produce records. BPC section 2225.5(b)(1) currently reads:

> (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. (emphasis added)

Until receiving a court order to produce documents, a licensee has an incentive to delay complying with a lawful subpoena. Consequently, the Board believes that for the purposes of public protection and for evidence and resource preservation, the date of the superior court's issuance of the order to show cause would be an appropriate time to toll the statute of limitations.

Requested change in statute**:** Amend BPC section 2225.5(b)(1) to read as follows (additions shown in underline):

> (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 upon the service of an order to show cause pursuant to Government Code section 11188, until such time as the subpoenaed records are produced, including any

period the licensee is out of compliance with the court order and during any related appeals, or until the court declines to issue an order mandating release of records to the board.

Enhanced Medical Record Inspection Authority[18]

The Board is subject to significant limitations in its authority to inspect and review medical records in the possession of a licensee. Generally, the Board must obtain patient consent prior to requesting records from a licensee. However, obtaining patient consent (for example, in cases involving inappropriate prescribing of opioids) may be difficult. If the patient refuses to give consent, then the Board must establish good cause to issue a subpoena and may have to file a motion to compel in superior court to enforce the subpoena. Without quick access to records, investigations take longer to complete. In some cases, the Board is required to close complaints because its investigation cannot proceed without relevant medical records.

BPC section 2225(a) limits any in-office review of records to those that pertain to patients who have complained to the Board. Given that limitation, in most cases investigators will simply request a copy of records pursuant to a release signed by the patient, rather than inspecting the records in the office of the licensee.

To support the timely completion of investigations, the Board seeks enhanced authority to inspect patient records held by licensees without the need for patient consent or a subpoena. Like authority provided to certain Medi-Cal fraud investigators[19], this statutory change would help the Board to determine at an earlier stage if further investigation is warranted and, if necessary, to prepare more effective subpoenas to further an investigation.

The Board is not seeking this authority to unilaterally seize records, but rather to quickly identify patients from whom to seek authorization for a copy of their records or to determine whether good cause exists for a subpoena to obtain records relevant to its investigation. If a subpoena is necessary, the Board would still need to demonstrate good cause to be able to enforce it, which respects the privacy of patients and ensures that records sought are appropriately tailored to the areas at issue in the case.

The proposed legislation below is like that in Government Code section 12528.1, enacted in 2005, which permits the Bureau of Medi-Cal Fraud and Elder Abuse (BMFEA) to conduct inspections of Medi-Cal providers for the underlying purpose of carrying out the investigation and enforcement duties of the BMFEA.

[18] Ibid. – see p. 212-215 for additional background information, including proposed statutory language.
[19] See Government Code section 12528.1

This authority is expected to support the timely resolution of cases, including possibly closing a case earlier.

Requested change in statute**:** First, add a new section to the BPC:

Business and Professions Code Section 2220.1

a) Any investigator with the board or the Department of Consumer Affairs, Health Quality Investigation Unit, conducting an investigation of any individual licensed by the board, shall have the authority to inspect, at any time, with or without the assistance of a medical consultant at the investigator's discretion, the business location and records, including patient and client records, of any such licensee for the purpose of carrying out the duties of the board as set forth in Section 2220.

(b) The board and the department shall provide all investigators assigned to lead an inspection team for conducting inspections under subdivision (a) with basic training on the relevant statutes and regulations governing the types of facilities to be inspected.

(c) The board and department in conjunction with the Department of Justice, Civil Division, Health Quality Enforcement Section, shall develop protocols to ensure that inspections conducted pursuant to this section are conducted during normal business hours and are completed in the least intrusive manner possible.

Second, amend BPC section 2225, to conform to the changes proposed above and ease Board access, as follows:

(a) Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon or a doctor of podiatric medicine and ~~his or her~~ their patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and shall not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. ~~The authority of the board or the California Board of Podiatric Medicine and the Health Quality~~

~~Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.~~

(b) Notwithstanding any other law, the Attorney General and ~~his or her~~ their investigative agents, and investigators and representatives of the board, including investigators with the Department of Consumer Affairs, Health Quality Investigation Unit, or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied if relevant to an investigation of a licensee.

(c)(1) Notwithstanding subdivision (b) or any other law, in any investigation that involves the death of a patient, the board may inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely for the purpose of determining the extent to which the death was the result of the physician and surgeon's conduct in violation of the Medical Practice Act, if the board provides a written request to either the physician and surgeon or the facility where the medical records are located or the care to the deceased patient was provided, that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts, or that the patient's beneficiary or personal representative have not served the board with a written objection within 15 days of the board's request. Nothing in this subdivision shall be construed to allow the board to ~~inspect and~~ copy the medical records of a deceased patient without a court order when the beneficiary or personal representative of the deceased patient has been located and contacted ~~but has refused to consent~~ and has served a written objection on the board within 15 days of the board's request to ~~the board~~ inspect~~ing~~ and copy~~ing~~ the medical records of the deceased patient.

(2) The Legislature finds and declares that the authority created in the board pursuant to this section, and a physician and surgeon's compliance with this section, are consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA).

(d) Where patient consent is not given, an investigator with the board or the Department of Consumer Affairs, Health Quality Investigation Unit, with or without the assistance of a medical consultant at the investigator's discretion, may inspect

patient records in the office of the licensee for the limited purpose of determining whether good cause exists to support an investigative subpoena for such records.

(~~d~~e) In all cases in which documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(~~e~~f) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or ~~his or her~~ their agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(~~f~~g) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

Enrolling in the Federal Program to Receive Notice of Subsequent Arrests and Convictions

Among other provisions, Penal Code section 11105.2 requires the California Department of Justice (DOJ) to provide the Board and the Osteopathic Medical Board of California (OMBC) notification of when a licensee is arrested or convicted for state (within California) and federal (outside California) criminal activity. The Board currently receives the subsequent arrest and conviction reports for state, but not for federal arrests and convictions.

DOJ staff informed Board staff in 2022 that they are now ready to facilitate the Board's transition into the program administered by the Federal Bureau of Investigation (FBI) to receive subsequent federal arrest and conviction reports. Staff are collaborating with DOJ, OMBC, and the Department of Consumer Affairs on the necessary statutory changes that will meet FBI requirements. The Board expects to finalize the appropriate language and request the Legislature include it in the Board's 2023 sunset legislation.

Requested change in statute: Amend the appropriate statutes to authorize the Board to receive subsequent federal arrest and conviction reports.

Addressing Licensees Who Ask Patients to Rescind a Medical Records Release

According to the HQIU, some physicians under investigation have asked their patients to rescind their consent to release their medical records to HQIU investigators. Although the frequency of this is not tracked, HQIU staff suspect this has happened on numerous occasions. Without quick access to medical records, a Board investigation can be delayed, likely increasing enforcement timeframes, and possibly increasing costs if the legal action is required to pursue enforcement of a subpoena.

Pursuant to Business and Professions Code (BPC) section 2220.7, a physician is prohibited from including in a civil settlement agreement with a patient or other party any provision that prohibits anyone from:

- Contacting or cooperating with the board.
- Filing a complaint with the board.
- Withdrawing a complaint previously filed with the board.

Further, Penal Code section 136.1 states that it is a crime for anyone to knowingly and maliciously prevent or dissuade (or attempt to) any witness or victim from attending or giving testimony at any trial, proceeding, or inquiry authorized by law.

While the above code sections may address other behavior that impedes a government investigation or prosecution, current law does not state that it is unprofessional conduct for a licensee or their representative to ask an individual to rescind a release for medical records or otherwise not cooperate with a Board investigation and prosecution.

Requested change in statute: Amend BPC section 2234, related to unprofessional conduct, to add subdivision (h), to read as follows:

> (h) Any action of the licensee, or another person acting on behalf of the licensee, intended to cause their patient or their patient's authorized representative to rescind consent to release the patient's medical records to the board or the Department of Consumer Affairs, Health Quality Investigation Unit.

Add Deadline to Participate in an Investigatory Interview

Under current law[20], licensees of the Board are required to attend and participate in an interview requested by the Board when that licensee is under investigation. Failure to participate "in the absence of good cause" is considered unprofessional conduct and could result in discipline of their license. Unfortunately, allowing interviews to be postponed for "good cause" is subject to abuse, which leads, in some instances, to unacceptably long delays in a Board investigation.

[20] See BPC section 2234 (g)

Requested change in statute: Amend BPC section 2234 (g) to require a licensee to participate in an interview no later than 30 calendar days after being notified by the Board.

Limiting Letters of Advice to Minor Violations "Unrelated to Fitness to Practice"

SB 806 granted the Board authority to issue a confidential letter of advice to a physician alleged to have committed a minor violation of the law unrelated to patient care. These letters may include a requirement to take educational courses that further the knowledge of a P&S in certain areas of their practice. These letters are intended to encourage quick, non-adversarial resolution of issues of minor concern, while providing a meaningful opportunity to correct issues in the practice of a P&S before they become significant. Prior to using these letters, the Board must publish regulations that govern their use.

Unfortunately, the language approved in SB 806 of 2021 restricted the use of these letters to minor violations that are "not related to patient care." This language significantly limits their use as most types of concerning physician conduct are related to patient care in some manner.

Requested change in statute: Instead of the current restriction, the Board requests that BPC section 2227.3 be amended to state that the letters may be used in minor violations of the law that are not related to a licensee's "fitness to practice." This language will preserve the Board's flexibility to use these letters in situations where only minor remediation is necessary to address concerns the Board may have with a licensee.

Require Earlier Exchange of Expert Testimony Information

The use of expert testimony is foundational in disciplinary proceedings. Experts retained by the Board and licensees under investigation may conflict with one another, which may lead to a hearing before an administrative law judge. BPC section 2334 requires the Board and counsel for the licensee to exchange expert opinions, and related information, no later than 30 calendar days prior to the originally scheduled hearing date.

Requested change in statute: Amend BPC section 2334 to require the exchange of this information no later than 90 calendar days prior to the original hearing date. This change is expected to support the timely resolution of cases by requiring an earlier exchange of expert opinions which can result in productive settlement negotiations or provide grounds for an accusation being withdrawn. An earlier exchange of expert reports is also expected to reduce the number of delayed hearings.

Timely Access to Pharmacy Records[21]

For certain investigations, the Board may require records in the possession of a pharmacy. Unfortunately, the Board may face delays obtaining those records, as it

[21] Additional information surrounding this topic is discussed in the Board's 2020 Sunset Report – see p. 217

generally must allow a pharmacy to provide the requested records "within a reasonable time[22]." This timeframe is unclear; therefore, Board may be required to wait an unacceptably long period of time, leading to avoidable delays in an investigation.

The Board of Pharmacy[23], by contrast, may require pharmacies provide requested records within as little as three business days.

Requested change in statute**:** Add a section to the Medical Practice Act to require pharmacies comply with Board requests for records in the same timeframe as requests from the Board of Pharmacy.

Require Patient Records be Retained a Minimum of Seven Years

Current law[24] requires a P&S to maintain adequate and accurate records relating to the provision of services to their patients. In essence, this requires a P&S to maintain records for a length of time that corresponds to the standard of care (which may vary depending upon the services rendered), rather than for a specific time.

As discussed above, the SOL generally requires the Board to file an accusation against a licensee within three years after the Board becomes aware of the alleged act or omission or seven years of when the alleged act or omission occurred, whichever is sooner.

Aligning the minimum time frame to maintain records to the general SOL will help ensure records are available, if necessary, to support an investigation.

Requested change in statute: Amend BPC section 2266 to require adequate and accurate records be maintained for at least seven years after the last date of service to a patient.

Licensing Proposals

Reexamining Postgraduate Training License Expiration Timeframes

Throughout 2022, the Board received an exceptionally high volume of licensing applications. Due to this volume, application processing timeframes increased substantially. To help avoid a similar situation in the future, the Board intends to explore possible statutory changes to allow a PTL to be issued for longer than 15 or 27 months (per current law) or to allow the Board the administrative authority to extend a PTL expiration date. The goal of such a change would be to provide PTL holders a longer window of time to transition from a PTL to a P&S license. A PTL will still only be valid while the licensee is enrolled in a California Board-approved postgraduate training

[22] See BPC section 4332
[23] See BPC section 4105
[24] See BPC section 2266

program and only authorizes the licensee to engage in the practice of medicine in connection with the licensee's duties as an intern or resident in the program.

This proposal does not change the requirements for licensure, rather it proposes a solution to ease administrative challenges in the licensing application review and approval process.

Additional Time to Sit for the Final Licensing Examination

SB 806 of 2021 reduced the amount of postgraduate training required to qualify for a P&S license from 36 months to 12 months for graduates of a U.S./Canadian medical school and 24 months for graduates of an international medical school. PTL holders are required to transition to a P&S license no later than 15 or 27 months, depending upon where they completed medical school.

The Board has heard from some PTL holders who graduated from a U.S./Canadian medical school and are facing difficulty scheduling, taking, and receiving their exam scores for the United States Medical Licensing Examination (USMLE) Step 3 (which is a requirement for a P&S license) before their PTL expires. Once a PTL expires, the individual must obtain a P&S license or cease practice. The number of residents impacted by this issue is expected to increase in the coming year, as the residents issued a PTL for 15 months this year try to schedule and pass the USMLE Step 3 and submit their exam scores to the Board before their PTL expires next year.

To help a PTL holder avoid an interruption to their postgraduate training, staff propose allowing them an additional 60-day extension to meet the USMLE Step 3 requirement. This will allow the PTL holder to continue training in a Board-approved program while taking the exam and waiting for the results.

Requested change in statute: Amend BPC section 2065 (f), as follows):

> Upon review of supporting documentation, the board, in its discretion, may grant an extension beyond 15 months to a postgraduate training licensee who graduated from a medical school in the United States or Canada, or beyond 27 months to a postgraduate training licensee who graduated from a foreign medical school approved by the board pursuant to Section 2084 other than a Canadian medical school, to receive credit for the 12 months of required approved postgraduate training for graduates of medical schools in the United States and Canada and 24 months of required approved postgraduate training for graduates of foreign medical schools other than Canadian medical schools. Upon a request from the Board-approved postgraduate training program, the board, in its discretion, may grant an additional 60-day extension for a postgraduate training licensee to successfully meet the written examination requirement.

Clarifying the Names of Postgraduate Training Accrediting Organizations

Some accrediting agencies in different countries have names similar to the accrediting agencies accepted by the Board. Residents trained in these internationally accredited programs may be confused whether their training program meets the Board's requirements. For example, the Royal College of Physician's in the United Kingdom and ACGME International (ACGME-I) are accepted by other licensing bodies, but not the Board.

Requested change in statute: Amend BPC section 2096 (b) to clarify the names of the accrediting agencies recognized by the Board, as follows:

> The postgraduate training required by this section shall include at least four months of general medicine and shall be obtained in a postgraduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) *in the United States*, the Royal College of Physicians and Surgeons of Canada (RCPSC) *in Canada*, or the College of Family Physicians of Canada (CFPC) *in Canada*.

Technical Changes Related to SB 806

The Board proposes the following technical changes to the Medical Practice Act that would clarify certain aspects of SB 806 of 2021:

1. Update BPC section 2065 (c) to clarify that an individual must transition to a P&S license before their PTL expires, as follows):

Requested change in statute: Amend BPC section 2065 (c), as follows

> A graduate who has completed the first year of postgraduate training may, in an approved residency or fellowship, engage in the practice of medicine whenever and wherever required as part of that residency or fellowship, and may receive compensation for that practice. The resident or fellow shall qualify for, take, and pass the next succeeding written examination for licensure. If the resident or fellow fails to receive a license to practice medicine under this chapter ~~within 27 months from the commencement of the residency or fellowship~~ by the date their postgraduate training license expires, except as otherwise allowed under subdivision (g) or (h), or if the board denies their application for licensure, all privileges and exemptions under this section shall automatically cease.

2. Amend BPC section 2065 (g) to clarify that P&S license applicants who obtained some PGT training in another state or Canada and are accepted into a PGT program in California must obtain their license within 90 days of beginning their program, regardless of where they attended medical school.

Requested change in statute: Amend BPC section 2065 (g), as follows:

> An applicant for a physician's and surgeon's license who has either graduated from medical school in the United State or Canada and has received 12 months credit ~~for~~

~~12 months~~ of board-approved postgraduate training in another state or in Canada or, has graduated from a foreign medical school approved by the Board pursuant to Section 2084 and has received 24 months credit of board-approved postgraduate training, and who is accepted into an approved postgraduate training program in California shall obtain their physician's and surgeon's license within 90 days after beginning that postgraduate training program or all privileges and exemptions under this section shall automatically cease.

3. Amend BPC section 2096 to clarify that P&S license applicants are not limited to attending postgraduate training (PGT) in California and move language (with changes that conform to the requirements of SB 806) in subdivision (c) related to oral and maxillofacial surgery training programs to BPC section 2097.

Requested change in statute: Amend BPC section 2096, as follows:

(a) In addition to other requirements of this chapter, before a physician's and surgeon's license may be issued, each applicant, including an applicant applying pursuant to Article 5 (commencing with Section 2105), shall show by evidence satisfactory to the board that the applicant has received credit for at least 12 months of board-approved postgraduate training for graduates of medical schools in the United States and Canada or 24 months of board-approved postgraduate training for graduates of foreign medical schools approved by the board pursuant to Section 2084 other than Canadian medical schools, pursuant to the attestation of the program director, designated institutional official, or delegated authority for the approved postgraduate training program ~~in California~~ where the applicant participated.

~~(c) An applicant who has received credit for at least 12 months of board-approved postgraduate training for graduates of medical schools in the United States and Canada or 24 months of board-approved postgraduate training for graduates of foreign medical schools approved by the board pursuant to Section 2084 other than Canadian medical schools, pursuant to the attestation of the program director, designated institutional official, or delegated authority for the approved postgraduate training program in California the applicant participated in, not less than 12 months of which was completed as part of an oral and maxillofacial surgery postgraduate training program as a resident after receiving a medical degree from a combined dental and medical degree program accredited by the Commission on Dental Accreditation (CODA) or approved by the board, shall be eligible for licensure. Oral and maxillofacial surgery residency programs accredited by CODA shall be approved as postgraduate training required by this section if the applicant attended the program as part of a combined dental and medical degree program accredited by CODA. These applicants shall not have to comply with subdivision (b).~~

4. Amend BPC section 2097 to:

- Update subdivision (a) to do the following:
    - Clarify that P&S license applicants are not limited to attending postgraduate training (PGT) in California and
    - State that the requirement to provide evidence of completion of 36 months' PGT does not apply to those who obtain a Board license through the reciprocity pathways or a certain special licensing program, as these applicants would never be able to complete 36 months of PGT due to their alternate pathway to licensure.

Requested change in statute: Amend BPC section 2097 (a), as follows:

In addition to other requirements of this chapter, before a physician's and surgeon's license may be renewed, at the time of initial renewal, a physician and surgeon shall show evidence satisfactory to the board that the ~~applicant~~ licensee has received credit for at least 36 months of board-approved postgraduate training which includes successful progression through 24 months in the same program, pursuant to the attestation of the program director, designated institutional official, or delegated authority for the approved postgraduate training program where ~~in California~~ the applicant participated in, except applicants who meet the requirements of section 2135, 2135.5, 2151, 2428, or by an applicant using clinical practice in an appointment under section 2113 as qualifying time to meet the postgraduate training requirements in section 2065.

- Update BPC section 2097 (b) to do the following:
    - Clarify that 36 months of board-approved postgraduate training be completed before the licensee's initial license expires.
    - Authorize the Board to grant a one-time, 60-day extension of the initial expiration date for a P&S licensee. This would allow the Board to extend the license expiration date to provide additional time for submission of satisfactory evidence of the completion of 36 months of PGT.

Requested change in statute: Amend BPC section 2097 (b), as follows:

A physician's and surgeon's certificate shall be automatically placed in delinquent status by the board if the holder of a physician's and surgeon's certificate does not show evidence satisfactory to the board that the physician and surgeon has received credit for at least 36 months of board-approved postgraduate training which includes successful progression through 24 months in the same program before the ~~within 60 days of the date of the~~ licensee's initial license expiration. The Board may grant an additional 60 days to the initial license expiration date authorized under Section 2423.

- Update BPC section 2097 subdivision (c) to insert modified language removed from BPC section 2096 (c) related to oral and maxillofacial surgery training requirements.

Requested change in statute: Amend BPC section 2097 (c) and (d), as follows:

(c) A licensee who has received credit for at least 24 months of approved postgraduate training in an oral and maxillofacial surgery postgraduate training program after receiving a medical degree from a combined dental and medical degree program accredited by the Commission on Dental Accreditation (CODA), shall show evidence satisfactory to the board at the time of initial renewal, before their physician's and surgeon's license may be renewed, pursuant to the attestation of the program director, designated institutional official, or delegated authority for the approved postgraduate training program where the licensee participated.

(~~c~~d) Upon review of supporting documentation, the board, in its discretion, may renew a physician's and surgeon's license to an applicant who has demonstrated substantial compliance with this section.

- Reorder BPC section 2097 subdivision (d) as (e) and amend subdivision (e) to clarify that the initial license renewal requirements in BPC 2097 are still applicable to licensees, even if they have previously surrendered their license or their license was in a cancelled status.

(e) A physician whose license is cancelled or who surrenders their license prior to meeting the renewal requirements under subdivision (a) may not have their license reinstated under section 2428 of the code without meeting current renewal requirements under subdivision (a), except licenses originally issued under section 2135, 2135.5, 2151, or licensees that used qualifying time under section 2113 to meet the postgraduate training requirements in section 2065.

(~~d~~f) This section shall only apply to individuals issued a license by the board on or after January 1, 2022.

Administrative Proposals

The following proposals support the administration of the Board's operations including proposals to enhance communication with complainants and the public, change the composition of the Board's membership, provide medical records to patients, and increase the Board's focus on P&S regulation.

Creation of a Complainant Liaison Unit

To support improved communications with complainants and the public, the Board requests that the Legislature provide the Board the authority and financial resources to create a Complainant Liaison Unit (Liaison Unit), which would supplement the Board's existing enforcement personnel. The Liaison Unit is proposed to have the following areas of responsibility:

- Consumer Communication Prior to Filing a Complaint

- Complainant Communication Support After Case Referred to Field
- Support Consumer Outreach Regarding the Board's Role and Procedures
- Evaluate Complaint Closure Review Requests

Consumer Communication Prior to Filing a Complaint

The Liaison Unit would respond to all communications from the public about the complaint review and enforcement process prior to the filing of a complaint. This would include, but not be limited to, responding to emails and phone calls from those with questions about how to file a complaint and what information and documents should be included. After it is filed, the complaint, including all communication with the complainant, would be handled by the staff of the Central Complaint Unit (CCU), per current policy.

Complainant Communication Support After Case Referred to Field

After a case is referred to HQIU for further investigation, complainants will be advised to contact the Liaison Unit in case of questions. The Liaison Unit would coordinate necessary communication between the investigator and complainant.

Once a case proceeds to the Attorney General's Office (AGO), the Liaison Unit would provide the complainant with additional requested details regarding the process, expected timeframes, and answer other general questions. The Deputy Attorney General assigned to the case may also be in contact with the complainant if they are needed at a hearing as a witness. The Liaison Unit would not interfere with a complainant's interaction with the AGO, but would assist and facilitate communications, as needed.

If the Board's disciplinary decision is appealed by the licensee, the Liaison Unit would be a resource to assist the complainant through the various appeals steps and the timing involved. When a licensee asserts their due process rights and appeals a case through a writ to a superior court, and possibly to higher courts, the Liaison Unit could update the complainant on the general timeframes are for those steps to take place.

Support Consumer Outreach Regarding the Board's Role and Procedures

The Liaison Unit would partner with the Public Information Unit to update website content (e.g. narrative webpage content, podcasts, videos) that improves public understanding of the Board's enforcement process, including related laws and policies. Liaison Unit staff would participate in appropriate online and in-person outreach events to educate attendees on the Board's role and procedures. The staff may also engage with outside organizations to increase public awareness of the Board and its functions.

Evaluate Complaint Closure Review Requests

If CCU closes a complaint, the closure letter would include a "request for review" form (and appropriate instructions) that the complainant could fill out and return to MBC, if they

believe the case was closed in error or if they have additional information to support their allegations.

If a request for review is received, it would be routed to the Liaison Unit to review. The Liaison Unit would log the requests, review, and handle necessary correspondence with the complainant but would not be able to disclose confidential information.

Consumer Stakeholder Input

Following establishment of the Liaison Unit, the Board intends to direct its Executive Director to develop a process to engage with consumer stakeholders to obtain input on the operations of the Liaison Unit.

Liaison Unit Staffing Needs

Staff project that the Liaison Unit would require adding four new Board employees, including a lead or manager and three analysts. Due to the possibility of significant workload, this number may need to be revised as the program is initiated or after it is in operation.

Requested change in statute: The Board does not currently have the personnel allocation or the funding necessary to establish such a unit. Therefore, the Board requests appropriate legislative action that would provide the Board the necessary resources. The Board estimates that to initially staff the Liaison Unit, the Board would require a minimum of four additional full-time staff members at an annual cost of approximately $450,000.

Establish a Public Board Member Majority

Current law[25] states the composition of the Board is eight P&S members and seven public (non-P&S) members. The Board believes that changing the composition to a public member majority would help to restore the public's trust in the Board's operations and priorities.

Requested change in statute: The Board supports the statutory changes included within AB 2060 (Quirk) of 2022 so that public members constitute a majority of the Board's members.

Provide Access to Personal Records Contained within MBC Enforcement Files

The law generally provides that the Board's enforcement files (including records and data gathered during an investigation) are confidential and may not be released to the public unless and until such information is made public, such as through the filing of an

[25] See BPC section 2001

accusation. The Board is required to publish accusations, disciplinary orders, and other information[26] about its licensees on the Board's website.

From time-to-time, the Board receives requests from consumers seeking a copy of their medical records, and related personal information, obtained by the Board during an investigation. The Board produces copies of documents exchanged between the consumer and the Board, but under current law does not share with consumers documents that the Board obtained from other sources as part of an investigation. Without this change in law, consumers may have difficulty determining whether the records they received from their provider are different than what their provider shared with the Board or in a civil action.

Requested change in statute: Amend BPC section 800 (c) to authorize the Board to provide to a consumer a certified copy of their personal consumer records obtained during a board investigation, and maintained in the Board's central, investigative, or disciplinary files, within 30 days upon request after paying an appropriate fee, if any, for duplication of the records. The amended statute would refer to the definitions of "consumer" and "personal records" as set forth in Code of Civil Procedure section 1985.3, subdivision (a).

Establish a Licensed Midwife Board

The Board currently licenses and regulates California licensed midwives (LM). When the Licensed Midwifery Practice Act of 1993 was first enacted, LMs were required to practice under the supervision of physicians, but after subsequent legislation in 2013, LMs are practicing autonomously without any supervision requirements.

BPC section 2509 authorizes the Board to create a Midwifery Advisory Council (MAC) and appoint its members, which is comprised of three midwives, one physician, and two public members. The MAC develops solutions to various regulatory, policy, and procedure issues regarding the midwifery program, including challenge mechanisms and examinations, as specified by the Board.

Members of the MAC, individual LMs, and state midwifery professional associations have called for LMs to be regulated under a separate board within the DCA. In general, these stakeholders argue that LMs and the physician community have incompatible approaches to providing care, therefore, it is inappropriate for LMs to be regulated by the Board.

The Board agrees that, with an appropriate scope of practice and related statutory protections for consumers, LMs could be effectively regulated through a separate entity under DCA. In 2021, AB 1767 (Boerner Horvath) would have eliminated the MAC and transferred regulatory authority of LMs to a newly created California Board of Licensed Midwives. Although AB 1767 was not approved, the Board continues to believe that a

[26] See BPC section 2027

separate licensing board should be established, or an alternative regulatory structure considered, to regulate LMs in this state.

Requested change in statute: Create a separate board charged with the regulation of licensed midwives.

Transfer Research Psychoanalyst (RP) Program to the Board of Psychology[27]

According to the American Psychological Association, psychoanalysis is a specialty in psychology that is distinguished from other specialties by its body of knowledge and its intensive treatment approaches. It aims at structural changes and modifications of a person's personality. Psychoanalysis promotes awareness of unconscious, maladaptive and habitual recurrent patterns of emotion and behavior, allowing previously unconscious aspects of the self to become integrated and promoting optimal functioning, healing, and creative expression. Except for RPs, the Board of Psychology (BOP) regulates the practice of psychology in California.

In 1977, when the RPs were established in law, the Board regulated additional allied health professions, including psychologists. In 1990, when the BOP came into existence, the RPs remained under the Board's oversight while all other psychology professions moved under the BOP. Psychoanalysis is a specialty of psychology; therefore, it is appropriate for RPs to be regulated by BOP.

Requested change in statute: Transfer the RP program from the Board to BO

[27] Ibid. – see p. 218