MEDICAL BOARD
OF CALIFORNIA

Protecting Consumers by Advancing High Quality, Safe, Medical Care.

Sunset Review Oversight Report 2020

State of California
Governor Gavin Newsom
Kimberly Kirchmeyer, Director, Department of Consumer Affairs

Medical Board of California
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Additional copies of this report can be obtained from: www.mbc.ca.gov

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

December 31, 2020

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

The Honorable Evan Low, Chair
Assembly Committee on Business and Professions
1020 N Street, Room 379
Sacramento, CA 95814

Dear Senator Roth and Assemblymember Low:

On behalf of the Medical Board of California (Board), it is my honor and privilege to present to you the Board's 2020 Sunset Review Report. This report was created at the direction of the Senate Committee on Business, Professions and Economic Development and the Assembly Committee on Business and Professions in preparation for the Board's 2021 sunset review by the California Legislature.

Every day, as we perform our statutorily directed duties, our mission inspires and directs the actions of the Board Members and staff:

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

Our commitment to this mission is driven by the difficult and sometimes tragic circumstances that some consumers, and their loved ones, have endured when they have not received a diagnosis or treatment consistent with the appropriate standard of care. We hear the complaints and concerns expressed by the public and patient advocates and they help inform our ongoing efforts to continually improve our processes and seek appropriate discipline against the Board's licensees.

The Board views the sunset review process as an opportunity to collaborate with the Legislature, Governor's Administration, and other interested parties to ensure that the Board has the necessary financial resources and statutory authority to match its mandate. Therefore, the attached report includes ten new issues for the Legislature's consideration.

We look forward to working with the Legislature on this important process. Should you have any questions regarding this report, please contact Bill Prasifka, Executive Director, or Aaron Bone, Chief of Legislation and Public Affairs at (916) 263-2389.

Sincerely,

Kristina D. Lawson
Board President

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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 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,

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

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 functions. The ISB ensures that the Board's computer systems are functioning and looks for areas where technological improvements can help streamline the Board's enforcement and licensing processes. Having an ISB unit allows the Board to have immediate access to trained staff when problems arise, ensures the Board maintains current hardware/software, assists staff in understanding and protecting against cyber security attacks, and allows the Board to make changes to its website within a very short period of time.

Although these programs are the Board's core functions, 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 or through the mail.

Occupations Licensed and Regulated by the Board
Under the Medical Practice Act, the Board has jurisdiction over physicians licensed to practice in this state. The Board also has authority over individuals who are not licensed by the Board, but meet a special licensure exemption pursuant to statute that allows them to perform duties in certain settings. These are called special program registrants/organizations and special faculty permits (SFPs).

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 (FNPs) 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 (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
Alejandra Campoverdi	10/12/20	-	06/01/24	Governor	Public
Dev GnanaDev, M.D.	12/21/11	06/01/19	06/01/22	Governor	Physician
Randy Hawkins, M.D.	03/04/15	06/15/20	06/01/24	Governor	Physician
Howard Krauss, M.D.	08/20/13	06/01/17	06/01/21	Governor	Physician*
Kristina D. Lawson, J.D.	10/28/15	06/01/18	06/01/22	Governor	Public
Ronald H. Lewis, M.D.	08/20/13	06/01/17	06/01/21	Governor	Physician
Laurie Rose Lubiano, J.D.	12/17/18	06/01/20	06/01/24	Governor	Public
Asif Mahmood, M.D.	06/03/19	-	06/01/23	Governor	Physician
Richard E. Thorp, M.D.	07/26/19	-	06/01/23	Governor	Physician*
Cinthia Tirado, M.D.	06/15/20	-	06/01/21	Governor	Physician*
Eserick "TJ" Watkins	06/01/19	-	06/01/23	Senate Rules Committee	Public
Felix C. Yip, M.D.	01/30/13	06/01/18	06/01/22	Governor	Physician*
Vacant	-	-	06/01/22	Governor	Public
Vacant	-	-	06/01/23	Speaker of the Assembly	Public
Vacant	-	-	06/01/24	Governor	Public

* Faculty appointments

The Board has six 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.

Executive Committee (non-statutory)
This committee's purpose is to oversee various administrative functions of the Board, such as budgets and personnel, the strategic plan, and the review of legislation. The Executive

Committee provides recommendations to the full Board, annually evaluates the performance of the executive director, and acts for the Board in emergency circumstances (as determined by the chair, and as allowed by law) 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. It also serves to identify program improvements and review licensing regulations, policies, and procedures. The committee provides recommendations to the full Board.

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 serves to identify program improvements in order to enhance protection of healthcare consumers and review enforcement regulations, policies and procedures. The committee provides recommendations to the full Board.

Public Outreach, Education and Wellness Committee (non-statutory)
This committee's purpose is to develop various informational materials on issues the Board deems important for publication and Internet posting; develop and monitor the Board's outreach plan; monitor the Board's strategic communication plan; develop physician wellness information by identifying available activities and resources that renew and balance a physician's personal and professional life.

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 certain licensure applicants regarding eligibility for licensure. The committee also provides guidance, recommendations and expertise regarding special program laws and regulations, specific applications, and issues of concern. The committee makes recommendations to the chief of licensing.

Special Faculty Permit Review Committee (Statutory Committee – BPC section 2168.1(c))
The purpose of this committee is to evaluate the credentials of applicants proposed by a California medical school or Academic medical center (AMC) to meet the requirements of BPC section 2168.1. The committee must determine whether the candidate meets the requirements of an academically eminent physician, or an outstanding physician in an identified area of need. The committee submits a recommendation to the Board for each proposed candidate for final approval or denial.

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. This council makes recommendations to the full Board.

Panel A (Statutory Committee – BPC section 2008)
The purpose of this panel is to carry out disciplinary actions as stated in BPC section 2004(c).

Panel B (Statutory Committee – 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.

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

Midwifery Task Force
This task force reviews the current laws and regulations pertaining to LMs and acts as a liaison with the MAC on issues that may come before the Board.

Prescribing Task Force
This task force identifies ways to proactively approach and find solutions to the epidemic of prescription drug misuse, abuse, and overdoses, as well as inappropriate prescribing of prescription drugs, through education, prevention, best practices, communication and outreach by engaging all stakeholders in the endeavor.

Sunset Review Task Force
This task force meets with the Board's executive director and deputy director to review sunset review questions and responses.

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.

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 goal of this task force is to evaluate claims of discrimination and the findings of the California Research Bureau's demographic study in order to proactively prevent bias in any and all Board processes and any actions of anyone who may be involved in the investigative or disciplinary process.

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?

In the past four years, the Board has not had any meetings canceled due to a lack of a quorum.

The Board establishes its meetings for the following calendar year at its April/May meeting. This allows the Members to review their calendars and determine if the proposed dates work for them in the following year. In addition, it provides the Board staff with enough time to secure meeting space. The full Board holds quarterly meetings throughout the state to allow

for public and physician participation in areas all over the state. The Board holds its quarterly meetings in the Los Angeles, San Francisco, San Diego, and Sacramento areas.

With the emergence of COVID-19, the Board transitioned to online-only meetings using WebEx technology and making the meetings available to the public. The meetings are livestreamed on the Board's website and the public is encouraged to participate in the meeting via phone and WebEx link.

The committees of the Board meet on an as-needed basis and may meet off-cycle of the quarterly Board meetings. This allows all interested parties to weigh in on the issues, for the committee members to have an expanded discussion, and for a decision to be made, if needed. That issue then moves forward in the form of a recommendation to the full Board at its next meeting.

Major Changes

3. **Describe any major changes to the board since the last Sunset Review, including, but not limited to:**
   - **Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)**
   - **All legislation sponsored by the board and affecting the board since the last sunset review.**
   - **All regulation changes approved by the board the last sunset review. Include the status of each regulatory change approved by the board.**

Changes in Leadership
In November 2020, the Board selected Kristina D. Lawson, J.D. to succeed Ms. Pines as president. Ms. Lawson's priorities include extending the Board's ongoing efforts to strengthen the relationships between consumer and patient advocates and the Board.

In July 2018, Denise Pines became president of the Board. As Board president, Ms. Pines emphasized outreach, communication and out-of-the-box thinking, challenging the Board and its staff to live up to the Board's mission of consumer protection. One of her first actions as Board president was to establish a Consumer Advocate Interested Parties Meeting that brought to the table several consumer advocates, Board members, and staff to talk about the Board, and its enforcement process, and to welcome constructive suggestions for improvement.

In June 2020, William Prasifka was appointed as Executive Director of the Board. Mr. Prasifka previously held the position of Chief Executive Officer for the Medical Council of Ireland, which regulates the country's 23,000 physicians. Prior to leading the Medical Council of Ireland, Mr. Prasifka worked as the financial services ombudsman for Ireland's Financial Services Ombudsman Bureau, Chief Executive Officer/Chair of the Competition Authority, and as a commissioner for the Commission for Aviation Regulation.

End of Vertical Enforcement
The sunset of the Board's vertical enforcement (VE) model transformed the way that the Board investigates cases. VE required the simultaneous assignment of both an investigator from the

DCA's HQIU and a deputy attorney general (DAG) from the AGO for investigations conducted by the Board. The law requiring the joint assignment was sunset, and investigations are conducted similarly to how they were prior to 2006. However, if a case is determined to be a matter where a joint assignment would assist in the processing of the investigation, the Board and the AGO have devised a protocol where a DAG will be assigned to the case along with the HQIU investigator. The cases currently being worked in joint assignment model typically involve allegations of sexual misconduct, impairment, or any case where there is an imminent threat to the public.

Postgraduate Training Requirements
The passing of Senate Bill (SB) 798 (Hill, Chapter 775, Statutes 2017), the Board's sunset bill, changed the postgraduate training requirements for California physician applicants. Starting January 1, 2020, physician applicants must complete 36 months of Board-approved postgraduate training, with 24 continuous months in the same program, regardless of where the applicant attended medical school. Prior to this change, graduates of U.S. and Canadian medical schools were required to complete one year of approved postgraduate training, and graduates of international medical schools were required to complete two years of approved postgraduate training. SB 798 also created a postgraduate training license (PTL) for residents who participate in an approved postgraduate training program in California.

Strategic Planning
In January 2018, the Board adopted a new Strategic Plan. The Board receives updates annually on the progress of the Strategic Plan at the full Board meeting.

Cannabis Guidelines
The Board updated and expanded its Guidelines for the Recommendation of Cannabis for Medical Purposes. The purpose of the guidelines is to provide guidance and information to physicians who choose to recommend cannabis for medical purposes to their patients. This update was done in collaboration with the Center for Medicinal Cannabis Research at the University of California, San Diego, and in accordance with SB 643 (McGuire, Chapter 719, Statutes of 2015).

License Alert Mobile App
The development of the Board's License Alert Mobile App for Apple iOS devices continued the Board's outreach efforts and enhanced transparency to consumers. 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 sends alerts to users whenever a physician's name, address, practice status, license expiration, or survey data changes, or when disciplinary actions or enforcement documents are added to the physician's profile.

With the release of this new mobile app, the Board became the first medical board in the nation to utilize such technology to notify patients about their physicians. To date, the app has garnered close to 12,000 downloads.

Other Improvements
In the last four years, the Board has made significant strides in consumer protection including but not limited to its fight against the opioid epidemic, ensuring the state has a well-trained

physician/surgeon workforce, outreach and public information, and the streamlining of the licensing process.

Beginning October 2018, physicians are required to consult the Controlled Substance Utilization Review and Evaluation System (CURES) prior to prescribing, ordering, administering or furnishing schedule II-IV controlled substances, under specific criteria. To prepare physicians statewide for the change in the law, the Board focused its outreach efforts to various physician groups (hospitals, medical centers, and physician organizations) to provide education regarding the new requirement and to ensure compliance. The Board also established a dedicated CURES page on its website that contains information about CURES including Frequently Asked Questions (FAQs) regarding the mandatory use of CURES, a CURES user guide, an explanation of the law and information on registration and direct dispensing.

The Board continued its proactive approach at combatting the opioid epidemic through its Death Certificate Project. The Board obtained 2012-2013 death certificate data in which the death was linked to opioids and reviewed them for possible inappropriate prescribing. The Board reviewed approximately 2,700 public death certificates provided by the California Department of Public Health (CDPH) attributable to prescription opioid use and identified 450 patients who may have been inappropriately prescribed to by physicians. The Board referred 72 additional cases to other licensing board such as the Osteopathic Medical Board of California (OMB) and the Board of Registered Nursing. The Board then obtained medical records for the patients and began investigating the deaths using its normal enforcement process. Approximately 23 percent of the cases that the Board opened based on the project resulted in the filing of an accusation, disciplinary action, or action had already been taken against the physician for inappropriate prescribing issues.

A first-of-its kind meeting designed to connect with consumer advocates was established in January 2019. The Consumer Interested Parties Meeting brought Board staff, Board members, and members of various consumer advocacy groups together to talk about the Board’s enforcement process, share concerns, and collaborate on ways to improve consumer protection. The Board acquired helpful information from the meeting and has been working 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 modernized the look and feel of its publications with the design of a new seal and logo. The new design replaced the caduceus, a short staff entwined by two serpents under a set of wings, with the Rod of Asclepius, which traditionally represents healing and medicinal arts. The layout and design of the Board’s newsletter, one of its main outreach tools, also received a complete redesign using a modern approach. The Board also instituted a column dedicated to consumers in its newsletter called Consumer Corner.

Since the last Sunset Review, the Board launched its podcast entitled “Medical Board Chat.” The podcast is an innovative way for the Board to provide relevant, timely and useful information to its licensees and the public alike. The Board’s public information manager interviews a variety of the Board’s subject matter experts and leaders to talk about the Board and its licensing and enforcement functions.

As a way to provide opportunities for physicians to give back to their communities and volunteer their services, the Board launched its Volunteer Physician Registry (VPR) with resounding success. The registry allows physicians to sign up to volunteer their services in underserved areas statewide. Over 800 physicians have signed up to volunteer their services through the VPR.

The Board launched a new web page focusing on pending legislation that affects the practice of medicine in California. Visitors can check out the Board's position on bills being considered in the Legislature impacting the Board and its jurisdiction.

In support of the statewide effort to go green, and to make the renewal process as efficient as possible, the Board began sending electronic courtesy renewal notices to physicians 180 days prior to the license expiration date. This significantly reduces the number of paper renewal notices mailed and saves on postage costs because physicians who renew early will not be mailed a paper renewal form.

The Board enhanced its social media profile by launching a Facebook page to use in conjunction with its Twitter page. The Facebook page is used in a similar way to the Board's Twitter page, and empowers the Board to use technologies such as Facebook Live to provide information to stakeholders. The Board also increased the number of posts it executes on its Twitter page, boosting the number of Twitter users who follow the Board.

Legislation

2016

Assembly Bill (AB) 2745 (Holden, Chapter 303) – Healing Arts: Licensing and Certification
This Board-sponsored bill clarifies the Board's authority for the allied health licensees/registrants overseen by the Board. It allows the Board to revoke or deny a license/registration for registered sex offenders, allows the Board to take disciplinary action for excessive use of drugs or alcohol, allows allied health licensees/registrants to petition the Board for license/registration reinstatement, and allows the Board to use probation as a disciplinary option for allied health licensees/registrants. This bill allows physician licensees to apply for a limited practice license at any time. This bill clarifies that the Board can deny a postgraduate training authorization letter (PTAL) for the same reasons it can deny a physician applicant's license in existing law. This bill clarifies existing law related to investigations of a deceased patient. This bill allows the Board to send a written request for medical records to the facility where the care occurred or where the records are located.

AB 2859 (Low, Chapter 473) – Professions and Vocations: Retired Category: Licenses
This bill authorizes any of the boards within the DCA to establish, by regulation, a system for a retired category of licensure for persons not actively engaged in the practice of their profession, as specified.

SB 482 (Lara, Chapter 708) – Controlled Substances: CURES Database
This bill requires a health care practitioner that is authorized to prescribe, order, administer or furnish a controlled substance to consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every four months thereafter, if the prescribed controlled

substance remains part of the patient's treatment, with specified exceptions. This bill requires a health care practitioner to obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before the medication is prescribed, ordered, administered, furnished or dispensed.

SB 1039 (Hill, Chapter 799) – Professions and Vocations
Among other provisions, this bill requires certain businesses that provide telephone medical advice services (TMAS) to a patient at a California address to be registered as a TMAS and further requires TMAS to comply with the requirements established by DCA. This bill specifies that the respective healing arts licensing boards (including the Medical Board) shall be responsible for enforcing the TMAS laws and any other laws and regulations affecting California licensed health care professionals providing TMAS.

SB 1139 (Lara, Chapter 786) – Health Professionals: Medical Degree Programs: Healing Arts Residency Training Programs: Undocumented Immigrants: Nonimmigrant Aliens: Scholarships, Loans and Loan Repayment
This bill prohibits a student, including a person without lawful immigration status, and/or a person who is exempt from nonresident tuition, who meets the requirements for admission to a medical degree program at any public or private postsecondary educational institution that offers such a program, or who meets the requirements for admission to a healing arts residency training program whose participants are not paid, from being denied admission based on their citizenship or immigration status. This bill prohibits specified grant and loan repayment and forgiveness programs from denying an application based on an applicant's citizenship or immigration status.

SB 1174 (McGuire, Chapter 840) – Medi-Cal: Foster Children: Prescribing Patterns: Psychotropic Medications
This bill adds to the Board's priorities, repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to children without a good faith prior exam and medical reason. This bill requires the Board to take certain actions related to data submitted by the California Department of Health Care Services (DHCS) and the Department of Social Services (DSS), related to physicians prescribing psychotropic medications to foster children. This bill would remain in effect until January 1, 2027, unless a later enacted statute deletes or extends that date.

SB 1177 (Galgiani, Chapter 591) – Physician and Surgeon Health and Wellness Program
This bill authorizes the establishment of a Physician and Surgeon Health and Wellness Program (PHWP) within the Board. The PHWP will provide for early identification of, and appropriate interventions to support a licensee in the rehabilitation from substance abuse to ensure that the licensee remains able to practice medicine in a manner that will not endanger the public health and safety.

SB 1261 (Stone, Chapter 239) – Physicians and Surgeons: Fee Exemption: Residency
This bill deletes the California residency requirement for voluntary status licenses. This bill allows an out-of-state individual to apply for a California license and ask for it to be put in voluntary status, or a current California licensee who resides out of state can request that their license be placed in voluntary status.

SB 1478 (Bus., Prof. and Economic Dev. Comm.) – Healing Arts
This bill was the vehicle by which omnibus legislation was carried by the Senate Business, Professions and Economic Development Committee. Among other provisions, this bill deletes outdated BPC sections (852, 2029 and 2380-2392) that are related to the Board. This bill also clarifies that the annual fee for the CURES shall not be applied to licensees in retired or inactive status, beginning July 1, 2017.

2017

SB 798 (Hill, Chapter 775) – Healing Arts: Boards
This bill extended the Board's sunset date until January 1, 2022 and contained numerous other provisions.

AB 40 (Santiago, Chapter 708) – CURES Database: Health Information Technology
This bill requires the California Department of Justice (DOJ) to make electronic prescription drug records contained in CURES accessible through integration with a health information technology system, beginning no later than October 1, 2018, if that system meets certain information security and patient privacy requirements.

AB 508 (Santiago, Chapter 195) – Health Care Practitioners: Student Loans
This bill repeals provisions of law authorizing boards to cite and fine, or deny licensure or licensure renewal, to a health care practitioner if he or she is in default on a United States Department of Health and Human Services education loan.

AB 1340 (Maienschein, Chapter 759) – Continuing Medical Education: Mental and Physical Health Care Integration
This bill allows for an optional continuing medical education (CME) course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues and exposure to trauma in children and young adults and their appropriate care and treatment.

SB 512 (Hernandez, Chapter 428) – Health Care Practitioners: Stem Cell Therapy
This bill requires a health care practitioner that performs a stem cell therapy not approved by the U.S. Food and Drug Administration (FDA), to communicate this to their patients on a notice displayed in their office. This bill requires the Board to report citations issued and discipline imposed, with regard to licensees who provide stem cell therapies, in its Annual Report, beginning with the 2018-19 Annual Report.

2018

AB 505 (Caballero, Chapter 469) – Medical Board of California: Adjudication: Expert Testimony
This bill allows an administrative law judge (ALJ) to extend the deadline for the exchange of expert witness reports, upon a motion and based upon a showing of good cause. This bill specifies that the ALJ may extend the timeline for the exchange for a period not to exceed 100 calendar days cumulatively, but in no case would this bill allow the exchange to take place less than 30 calendar days before the hearing date, whichever comes first.

AB 1751 (Low, Chapter 478) – Controlled Substances: CURES Database
This bill allows for information sharing between California's prescription drug monitoring program (PDMP), the CURES, and other states' PDMPs. This bill requires the DOJ to adopt regulations, by July 1, 2020, regarding the access and use of information within CURES. This bill allows DOJ to enter into an interstate data sharing agreement, as specified.

AB 1791 (Waldron and Gipson, Chapter 122) – Physicians and Surgeons: Continuing Education
This bill allows for an optional CME course in integrating HIV/AIDS pre-exposure prophylaxis and post-exposure prophylaxis medication maintenance and counseling in primary care settings.

AB 2086 (Gallagher, Chapter 274) – Controlled Substances: CURES Database
This bill allows a prescriber to access the CURES database for a list of patients for whom that prescriber is listed as a prescriber.

AB 2138 (Chiu and Low, Chapter 995) – Licensing Boards: Denial of Application: Revocation or Suspension of Licensure: Criminal Conviction
This bill, which became effective July 1, 2020, limits discretion for boards, bureaus and committees within the DCA to apply criminal conviction history for a license denial. Among other provisions, this bill 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.

AB 2311 (Arambula, Chapter 144) – Medicine: Trainee: International Medical Graduates
This bill removes the pilot program status in existing law for the University of California Los Angeles International Medical Graduate Program, which allows trainees to engage in supervised patient care activities.

AB 2487 (McCarty, Chapter 301) - Physicians and Surgeons: Continuing Education; Opiate-Dependent Patient Treatment and Management
This bill allows all physicians licensed after January 1, 2019, to opt to complete a one-time mandatory 12-hour CME course on the treatment and management of opiate-dependent patients, which must include eight hours of training in buprenorphine treatment, or other similar medicinal treatment, for opioid use disorders, in lieu of the existing required CME on pain management. Physicians are required to take one of these CME courses.

AB 2789 (Wood, Chapter 438) – Health Care Practitioners: Prescriptions: Electronic Data Transmission
This bill requires all prescriptions issued by licensed prescribers, on or after January 1, 2022, to be issued as electronic data transmission prescriptions (e-prescriptions), with specified exemptions.

AB 2968 (Levine, Chapter 778) – Psychotherapist-Client Relationship: Victims of Sexual Behavior and Sexual Contact: Informational Brochure
This bill updates and modernizes the informational brochure for victims of psychotherapist-patient sexual impropriety by removing obsolete language, including currently recognized forms of sexual exploitation and modern modes of communication, and more clearly articulating to consumers the most effective course of action when reporting these types of allegations. This bill requires the Board, the Board of Behavioral Sciences, the Board of Psychology (BOP), and the OMB to prepare and disseminate this brochure.

SB 1109 (Bates, Chapter 693) – Controlled Substances: Schedule II Drugs: Opioids
This bill requires existing pain management CE courses to include the risks of addiction associated with the use of Schedule II drugs. This bill also requires a warning label on all Schedule II controlled substance prescription bottles on the associated addiction and overdose risks. This bill requires a prescriber to discuss specified information with the minor or the minor's parent or guardian before prescribing an opioid for the first time. Lastly, this bill requires a youth sports organization to annually give the Opioid Factsheet for Patients to each athlete, and for the athlete's parent or guardian to sign a document acknowledging receipt before participation in an organized sports team.

SB 1448 (Hill, Chapter 570) – Healing Arts Licensees: Probation Status: Disclosure
This bill, the Patient's Right to Know Act of 2018, requires, on and after July 1, 2019, physicians and osteopathic physicians to notify patients of their probationary status under specified circumstances. This bill also requires the Board to provide certain information for licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the Board's website.

SB 1480 (Hill, Chapter 571) – Professions and vocations
This was an omnibus bill that, among other provisions, contains technical and clarifying changes to the three year postgraduate training requirement that was passed in the previous year in the Board's sunset bill and became effective January 1, 2020. This bill also makes technical changes to the sections of law regarding RPs.

2019

AB 149 (Cooper, Chapter 4) – Controlled Substances: Prescriptions
This bill allows for a transition period, until January 1, 2021, before the new requirement becomes effective that requires prescription forms for controlled substances to include a uniquely serialized number.

AB 241 (Kamlager-Dove, Chapter 417) – Implicit Bias: Continuing Education: Requirements
This bill requires, beginning January 1, 2022, all CME courses for physicians to contain curriculum that includes the understanding of implicit bias. This bill specifies that a CME course dedicated solely to research or other issues that does not have a direct patient care component or a course offered by a CME provider that is not located in California is not required to contain curriculum that includes implicit bias in the practice of medicine. This bill requires associations that accredit CME courses to develop standards before January 1, 2022 for compliance with this bill.

AB 528 (Low, Chapter 677) – Controlled Substances: CURES Database
Effective January 1, 2021, this bill changes the timeframe for dispensers to report dispensed prescriptions to CURES from seven days to the following working day and adds Schedule V drugs to CURES. Effective July 1, 2021, this bill allows delegates to access information in CURES and allows a prescriber to check information obtained from the CURES database to meet existing mandates, instead of requiring the prescriber to check the CURES database, among other changes.

AB 845 (Maienschein, Chapter 220) – Continuing Education: Physicians and Surgeons: Maternal Mental Health
This bill allows for an optional CME course in maternal mental health.

AB 1264 (Petrie-Norris, Chapter 274) – Medical Practice Act: Dangerous Drugs: Appropriate Prior Examination
This bill expressly clarifies that the requirement to provide an "appropriate prior examination" before prescribing, dispensing, or furnishing dangerous drugs does not require a synchronous interaction between a patient and the licensee and can be achieved through the use of telehealth, including, but not limited to, a self-screening tool or a questionnaire, provided that the licensee complies with the appropriate standard of care. This bill includes an urgency clause and became effective on October 11, 2019, when the Governor signed this bill into law.

AB 1519 (Low, Chapter 865) – Healing Arts
Among other provisions, this bill clarifies that oral and maxillofacial surgery residency programs accredited by the Commission on Dental Accreditation (CODA) count toward the 36 months of required Board-approved postgraduate training. This bill also specifies that all laws and regulations that apply to a health care provider also apply while providing telehealth services.

SB 377 (McGuire, Chapter 547) – Juveniles: Psychotropic Medications: Medical Information
This bill requires judicial council forms to be revised, by September 1, 2020, to include a request for authorization by the foster youth or the foster youth's attorney to release the foster youth's medical information to the Board, in order to ascertain whether there is excessive prescribing of psychotropic medications that is inconsistent with the standard of care.

SB 425 (Hill, Chapter 849) – Health Care Practitioners: Licensee's File: Probationary Physician's and Surgeon's Certificate: Unprofessional Conduct
This bill requires health facilities and entities that allow a licensed health care professional to provide care for patients, to report allegations of sexual abuse and sexual misconduct made by a patient in writing against a licensed health care practitioner to that practitioner's licensing board within 15 days, and imposes a fine for failure to report. This bill also amends existing law that requires the Board to provide a "comprehensive" summary to a licensee upon request, and now just requires the Board to provide a summary. This bill requires probationary license information to stay on the Board's website for a period of 10 years. This bill amends existing law regarding physician interviews to include in the definition of unprofessional conduct the failure of a licensee, in the absence of good cause, to attend and participate in an interview by the Board, whereas current law requires the failure to be repeated.

SB 697 (Caballero, Chapter 707) – Physician Assistants; Practice Agreement: Supervision
This bill revises the Physician Assistant Practice Act to allow multiple physicians and surgeons

to supervise a physician assistant (PA), replaces the delegation of services agreement (DSA) with a practice agreement, eliminates the existing medical records review requirement, and makes other substantive and technical changes.

SB 276 (Pan, Chapter 278) - Immunizations: medical exemptions and
SB 714 (Pan, Chapter 281) - Immunizations
These bills require the CDPH, by January 1, 2021, to develop and make available for use by physicians an electronic, standardized, and statewide medical exemption certification form, which must include an authorization to release medical records to CDPH, the Board and the OMB. This bill, among other provisions, specifies that medical exemptions issued prior to January 1, 2021, are exempt from the requirements in this bill, as specified, unless the exemption was issued by a physician that has been subject to disciplinary action by the Board or the OMB. This bill requires CDPH to annually review immunization reports from all schools and institutions. This bill specifies that if CDPH determines that a physician's practice is contributing to a public health risk in one or more communities, CDPH shall report the physician to the Board or the OMB, as appropriate. This bill specifies that if there is a pending accusation against a physician with the Board or the OMB relating to immunization standards of care, CDPH shall not accept a medical exemption from the physician unless and until the accusation is resolved in favor of the physician. This bill specifies if a physician licensed with the Board or the OMB is on probation for action relating to immunization standards of care, CDPH and the governing authority shall not accept a medical exemption form from the physician unless and until the probation has been terminated.

SB 786 (Comm. on Business, Professions and Economic Development) – Healing Arts
This is an omnibus bill that updates inconsistent language in BPC section 803.1, including changing "physicians and surgeons" to "licensees." This bill deletes BPC section 2234(g), which becomes operative upon implementation of the proposed registration program described in BPC section 2052.5, as this subdivision is no longer needed because BPC section 2052.5 has been repealed. This bill deletes BPC sections 2155-2167 (Loans to Medical Students) and 2200-2213 (Physician and Surgeon Incentive Pilot Program), as these programs are not active.

2020

AB 2113 (Low, Chapter 186) – Refugees, Asylees, and Special Immigrant Visa Holders: Professional Licensing: Initial Licensure Process.
This bill, notwithstanding any other law, would require a board within the department to expedite, and authorize it to assist, the initial licensure process for an applicant who supplies satisfactory evidence to the board that they are a refugee, have been granted asylum, or have a special immigrant visa, as specified. The bill would authorize a board to adopt regulations necessary to administer these provisions.

AB 2273 (Bloom, Chapter 280) – Approvals and Certificates of Registration: Special Faculty Permits
This bill allows qualified individuals to obtain a special permit, via existing Board programs currently available only to medical schools, to practice medicine in an AMC, as defined.

AB 3330 (Calderon, Chapter 359) – Department of Consumer Affairs: Board: Regulatory Fees
This bill increases the fees for certain boards within DCA. In addition, beginning April 1, 2021, the annual fee paid by certain licensees associated with the costs to operate and maintain the CURES system will increase from $6 to $11. Beginning April 1, 2023, that fee would decrease to $9.

SB 878 (Jones, Chapter 131) – Department of Consumer Affairs: Application Processing
This bill, beginning July 1, 2021, would require each board within the department that issues licenses to prominently display on its internet website, on at least a quarterly basis, either the current average timeframes for processing initial and renewal license applications or the combined current average timeframe for processing both initial and renewal license applications. The bill would also require each board to prominently display on its internet website, on at least a quarterly basis, either the current average timeframes for processing each license type that the board administers or the combined current average timeframe for processing all license types that the board administers.

SB 1474 (Comm. on Business, Professions and Economic Development, Chapter 312) – Business and Professions
This is an "omnibus" bill that includes various legislative proposals submitted by various boards within DCA. The bill will also extend the sunset date of certain boards and bureaus due to expire in 2020 and 2021. SB 1474 would also prohibit any licensee regulated by a DCA board from including in a contract or proposed contract a provision that limits a consumer's ability to initiate, or participate in, a board investigation of that licensee.

Regulations

Manual of Model Disciplinary Orders and Disciplinary Guidelines (effective January 5, 2017)
The prior (11th Edition/2011) Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines), incorporated by reference in 16 CCR section 1361, were amended to be made consistent with current law. Additionally, the Disciplinary Guidelines were amended to reflect changes that had occurred in the educational and probationary environments since the last update to clarify some conditions of probation, and to strengthen consumer protection.

Midwife Assistants - Implementation of SB 408 (Morrell, Chapter 280) (effective September 21, 2017)
SB 408 required midwife assistants to meet minimum training requirements and set forth the duties that a midwife assistant could perform, which are technical support services only. This bill allowed the Board to adopt regulations and standards for any additional midwife technical support services.

Requirements for Physicians on Probation (effective January 1, 2018)
A petition to amend regulations pertaining to the requirements for Physicians on Probation. The regulation amends the current regulation to strike the words "division," "Probation Surveillance Compliance Program," and "laboratory testing," which are obsolete. The regulation replaces the terms "division," and "Probation Surveillance Compliance Program," with the terms "Board," and "Probation Program," respectively. The word "laboratory" is replaced with "biological fluid testing." The regulation further specifies that probationers are required to bear the costs and be in compliance with all of the terms and conditions of the order placing them on probation.

Cite and Fine of Allied Health Professionals (effective January 1, 2018)
A petition to authorize the Board official to use citations containing orders of abatement and fines to individuals, partnerships, corporations or associations, who are performing or who have performed services for which licensure as a LM or registration as a polysomnographic technologist, technician is required.

Substantial Relationship and Rehabilitation – Implementation of AB 2138 (Chiu, Chapter 995, Statutes of 2018) (pending)
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 (pending)
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.

Notice to Patients (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. With this change, the need for the list of statutes and regulations subject to citation under 16 CCR section 1364.11(a) will be eliminated.

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.

Medical and Midwife Assistant Certifying Organizations and Administration of Training for Medical Assistants (pending)
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.

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.

Major Studies/Publications

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

The Board has completed numerous studies and publications in the last four years, some mandated by law, and some as requested by the Board. The links to the studies and publications have been listed below and are provided in Section 13, Attachment C. Below is a synopsis for each study and publication.

Medical Board of California Fee Study
The Board requested this study to determine if an increase in licensing fees was supported by fiscal data. The report provided the Board information pertaining to Board expenditures and revenues, the Board's fund, as well as the causes of the Board's fiscal challenges. The report was presented to the Board during its January 2020 meeting and the Board voted to support the recommended fee increase.

Leadership Accountability Report
In accordance with the State Leadership Accountability Act, the Board authored this 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 to all physicians every quarter, with the exception of its winter edition, but instead emails it to all physicians 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.

Demographics Study
The Board partnered with the California Research Bureau (CRB) to conduct an observational report pertaining to its disciplinary process. The report was requested by the Board in response to concerns about bias in the Board's disciplinary process. The CRB report was an independent and broad analysis of the Board's disciplinary process over a 10-year period.

Cannabis Guidelines
The Board updated and expanded its Guidelines for the Recommendation of Cannabis for Medical Purposes.

Strategic Plan
The Board updated its Strategic Plan in 2018.

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.

A Consumer's Guide to the Complaint Process
The Board redesigned its brochure to give consumers a sense of how the Board's complaint process works. The brochure was published on the Board's website and features information regarding the Board's jurisdiction, what to expect when filing a complaint with the Board, how to file a complaint, and how a complaint is investigated.

Medical Board Chat Podcast
Medical Board Chat is the Board's official podcast and features interviews with Board members and staff who provide information on a variety of topics.

Expert Reviewer Program Brochure
A brochure designed to recruit qualified physicians to serve as expert reviewers for the Board. The Board's expert reviewer program is a critical component of the Board's enforcement process. The brochure features information regarding the Expert Reviewer program and the requirements that doctors must meet to become an expert reviewer.

License Alert Mobile App Marketing Materials
In conjunction with the release of the Board's License Alert Mobile App for Apple iOS devices, the Board developed various marketing materials for the app including a pamphlet, flier, podcast and video. The Board also developed a dedicated webpage on the Board's website which included a FAQ, news release, and associated materials pertaining to the app. The Board is currently working on an Android version of the app.

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

- **Does the board's membership include voting privileges?**
- **List committees, workshops, working groups, task forces, etc., on which board participates.**
- **How many meetings did board representative(s) attend? When and where?**
- **If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?**

In order to remain current with the national trends in medicine, the Board involves itself in national associations/organizations. In addition, several of the Board members and the executive director sit on committees for these entities in order to provide input and perspective from the State of California. As California has the largest number of licensed physicians in the United States, the activities and functions of the Board are very important on a national level. Not only does the Board receive valuable information from other states' processes and procedures, but other states also benefit from hearing about the methods and policies of the California board. Additionally, there are several issues impacting the nation, e.g. opioid misuse and abuse, marijuana for medical purposes, telehealth and the ability to practice medicine across state lines without a license in each state (license portability) and international standards, etc., that warrant input by leadership from all state medical boards. The Board needs to be involved in these discussions because the impact of these national decisions could have an effect on California consumers, licensees, and the Board. The Board's perspective and opinions need to be relayed to these entities that may not otherwise understand the impact of their decisions on California, and, more importantly, on consumer protection.

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. The Board has several members that participate in committees at the FSMB.

Meetings of the FSMB attended:
April 2017 – Fort Worth, TX
April 2018 – Charlotte, NC, attended via Webinar and teleconference
April 2019 – Fort Worth, TX, attended via teleconference

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.

Meetings of the AIM attended:
April 2017 – Fort Worth, TX
April 2018 – Charlotte, NC, attended via teleconference
April 2019 – Fort Worth, TX, attended 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.

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.

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.

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.

Section 2

Performance Measures and Customer Satisfaction Surveys

- Performance Measure Reports
- Consumer Satisfaction Surveys

Attachments

- Attachment G – Performance Measures

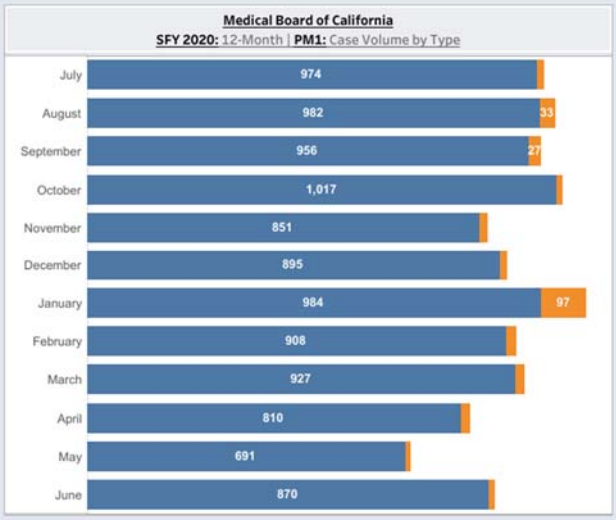
Performance Measure Reports

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 and annual Licensing performance measure reports for FY 16/17, FY 17/18, FY 18/19, and FY 19/20 as published on the DCA's website are in Section 13, Attachment G. Below are the annual reports for FY 19/20.

Enforcement Performance Measures FY 2019/2020:

Board Name: Medical Board of California | State Fiscal Year: SFY 2020 | Enforcement Case Type: Complaints, Conviction/Arrest

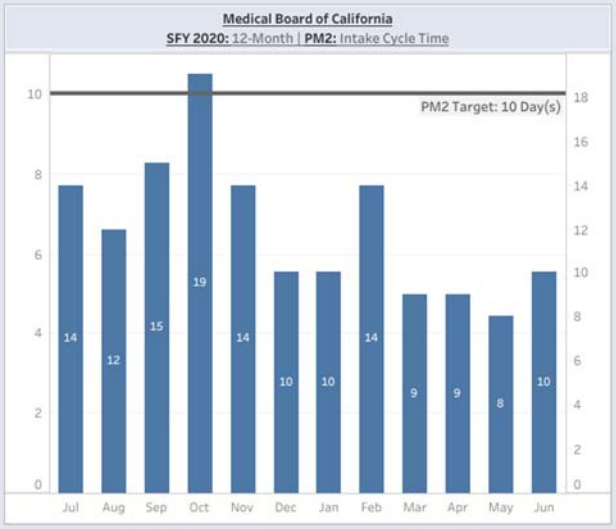


Medical Board of California
SFY 2020: 12-Month | **PM1:** Summary

	Complaints	Conviction/Arrest	Total Volume
Grand Total	10,865	304	11,169
July	974	16	990
August	982	33	1,015
September	956	27	983
October	1,017	13	1,030
November	851	16	867
December	895	15	910
January	984	97	1,081
February	908	23	931
March	927	20	947
April	810	20	830
May	691	11	702
June	870	13	883

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 2020 | Processing Time: Actual, Target | Performance v Target: Above Target, At Target, Below Target

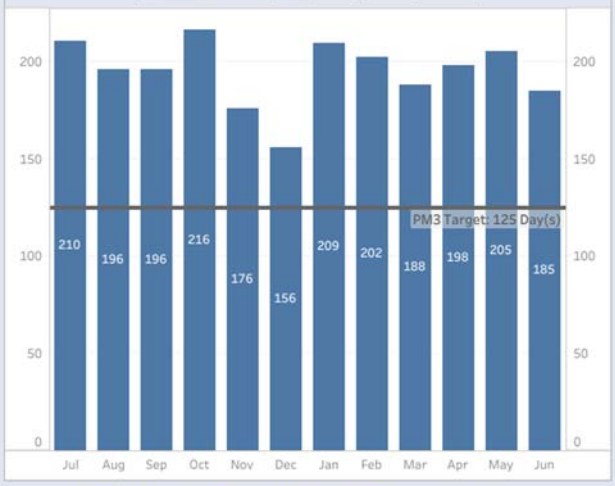


Medical Board of California
SFY 2020: 12-Month | **PM2:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	11,389	10 Days	12 Days	▲2 Days
July	988	10 Days	14 Days	▲4 Days
August	1,025	10 Days	12 Days	▲2 Days
September	937	10 Days	15 Days	▲5 Days
October	906	10 Days	19 Days	▲9 Days
November	1,123	10 Days	14 Days	▲4 Days
December	1,075	10 Days	10 Days	0
January	899	10 Days	10 Days	0
February	1,009	10 Days	14 Days	▲4 Days
March	993	10 Days	9 Days	▼-1 Days
April	931	10 Days	9 Days	▼-1 Days
May	667	10 Days	8 Days	▼-2 Days
June	836	10 Days	10 Days	0

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 2020 | Processing Time: Actual, Target | Performance versus Target: Above Target

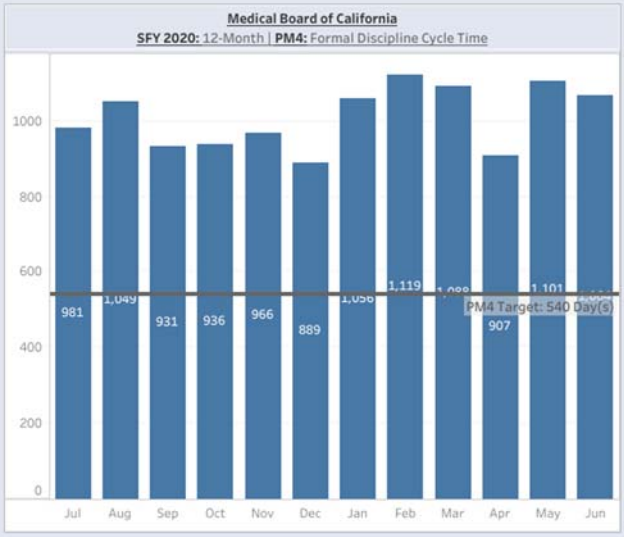


Medical Board of California
SFY 2020: 12-Month | **PM3:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	12,699	125 Days	196 Days	▲71 Days
July	869	125 Days	210 Days	▲85 Days
August	1,122	125 Days	196 Days	▲71 Days
September	1,189	125 Days	196 Days	▲71 Days
October	1,084	125 Days	216 Days	▲91 Days
November	844	125 Days	176 Days	▲51 Days
December	822	125 Days	156 Days	▲31 Days
January	932	125 Days	209 Days	▲84 Days
February	1,112	125 Days	202 Days	▲77 Days
March	972	125 Days	188 Days	▲63 Days
April	1,439	125 Days	198 Days	▲73 Days
May	1,245	125 Days	205 Days	▲80 Days
June	1,069	125 Days	185 Days	▲60 Days

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 | State Fiscal Year: SFY 2020 | Processing Time: Actual, Target | Performance versus Target: Above Target



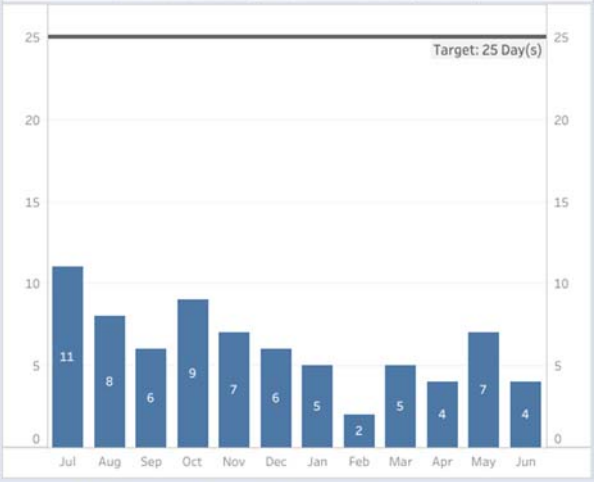
Medical Board of California
SFY 2020: 12-Month | **PM4:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	555	540 Days	1,010 Days	▲470 Days
July	54	540 Days	981 Days	▲441 Days
August	57	540 Days	1,049 Days	▲509 Days
September	47	540 Days	931 Days	▲391 Days
October	46	540 Days	936 Days	▲396 Days
November	55	540 Days	966 Days	▲426 Days
December	46	540 Days	889 Days	▲349 Days
January	40	540 Days	1,056 Days	▲516 Days
February	41	540 Days	1,119 Days	▲579 Days
March	61	540 Days	1,088 Days	▲548 Days
April	26	540 Days	907 Days	▲367 Days
May	48	540 Days	1,101 Days	▲561 Days
June	34	540 Days	1,064 Days	▲524 Days

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 2020 | Performance Measure: PM7 | Processing Time: Actual, Target | Performance versus Target: Below Target

Medical Board of California
SFY 2020: 12-Month | **PM7:** Probation Intake Cycle Time



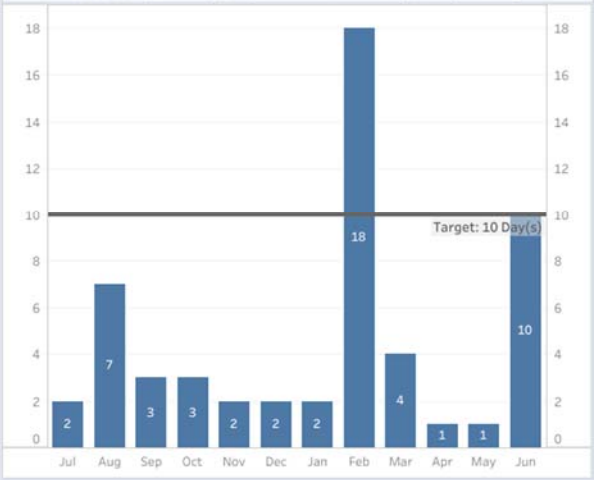
Medical Board of California
SFY 2020: 12-Month | **PM7:** Summary

	Case Volume	Target	Actual	Variance
Grand To..	175	25 Days	6 Days	▼ -19 Days
July	18	25 Days	11 Days	▼ -14 Days
August	16	25 Days	8 Days	▼ -17 Days
September	10	25 Days	6 Days	▼ -19 Days
October	13	25 Days	9 Days	▼ -16 Days
November	10	25 Days	7 Days	▼ -18 Days
December	20	25 Days	6 Days	▼ -19 Days
January	16	25 Days	5 Days	▼ -20 Days
February	10	25 Days	2 Days	▼ -23 Days
March	21	25 Days	5 Days	▼ -20 Days
April	8	25 Days	4 Days	▼ -21 Days
May	14	25 Days	7 Days	▼ -18 Days
June	19	25 Days	4 Days	▼ -21 Days

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 2020 | Performance Measure: PM8 | Processing Time: Actual, Target | Performance versus Target: Above Target, At Target, Below Target

Medical Board of California
SFY 2020: 12-Month | **PM8:** Probation Violation Response Cycle Time

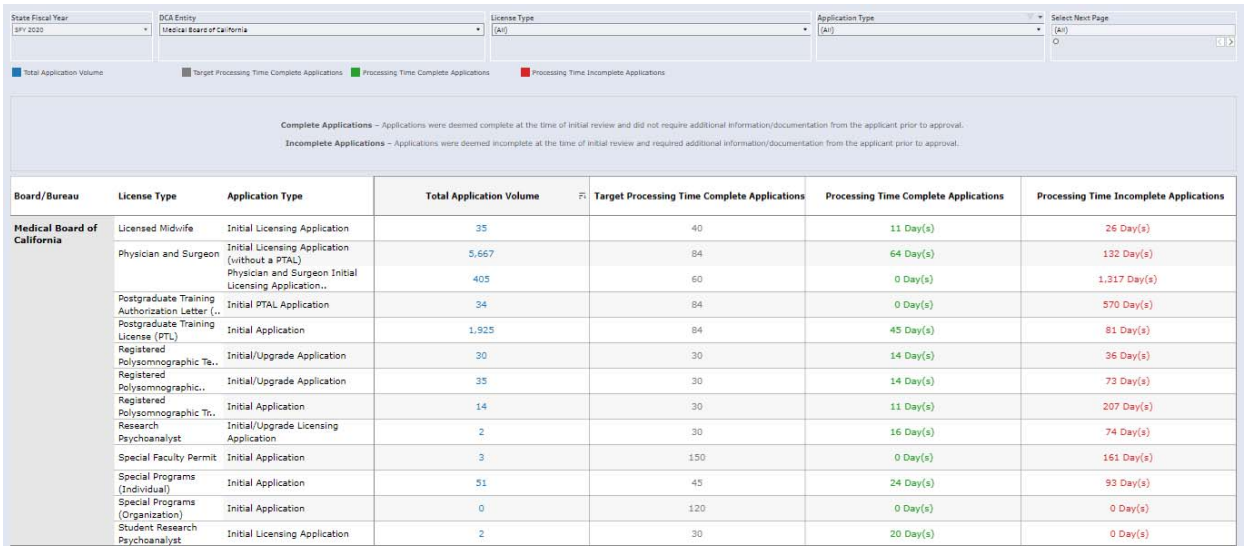


Medical Board of California
SFY 2020: 12-Month | **PM8:** Summary

	Case Volume	Target	Actual	Variance
Grand To..	120	10 Days	4 Days	▼ -6 Days
July	10	10 Days	2 Days	▼ -8 Days
August	7	10 Days	7 Days	▼ -3 Days
September	10	10 Days	3 Days	▼ -7 Days
October	24	10 Days	3 Days	▼ -7 Days
November	11	10 Days	2 Days	▼ -8 Days
December	4	10 Days	2 Days	▼ -8 Days
January	15	10 Days	2 Days	▼ -8 Days
February	9	10 Days	18 Days	▲ 8 Days
March	10	10 Days	4 Days	▼ -6 Days
April	7	10 Days	1 Days	▼ -9 Days
May	8	10 Days	1 Days	▼ -9 Days
June	5	10 Days	10 Days	0 Days

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 2019/2020:



Board/Bureau	License Type	Application Type	Total Application Volume	Target Processing Time Complete Applications	Processing Time Complete Applications	Processing Time Incomplete Applications
Medical Board of California	Licensed Midwife	Initial Licensing Application	35	40	11 Day(s)	26 Day(s)
	Physician and Surgeon	Initial Licensing Application (without a PTAL)	5,667	84	64 Day(s)	132 Day(s)
		Physician and Surgeon Initial Licensing Application..	405	60	0 Day(s)	1,317 Day(s)
	Postgraduate Training Authorization Letter (..	Initial PTAL Application	34	84	0 Day(s)	570 Day(s)
	Postgraduate Training License (PTL)	Initial Application	1,925	84	45 Day(s)	81 Day(s)
	Registered Polysomnographic Te..	Initial/Upgrade Application	30	30	14 Day(s)	36 Day(s)
	Registered Polysomnographic..	Initial/Upgrade Application	35	30	14 Day(s)	73 Day(s)
	Registered Polysomnographic Tr..	Initial Application	14	30	11 Day(s)	207 Day(s)
	Research Psychoanalyst	Initial/Upgrade Licensing Application	2	30	16 Day(s)	74 Day(s)
	Special Faculty Permit	Initial Application	3	150	0 Day(s)	161 Day(s)
	Special Programs (Individual)	Initial Application	51	45	24 Day(s)	93 Day(s)
	Special Programs (Organization)	Initial Application	0	120	0 Day(s)	0 Day(s)
	Student Research Psychoanalyst	Initial Licensing Application	2	30	20 Day(s)	0 Day(s)

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.

Below are the results from five customer satisfaction surveys: one DCA customer satisfaction survey, and four surveys conducted by the Board. The Board conducted satisfactions surveys for physician license applicants, PTL applicants, newsletter readers, and Website users.

DCA Customer Satisfaction Survey
During the prior four fiscal years, the Board received 85 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 2016/2017**	**FY 2017/2018**	**FY 2018/2019**	**FY 2019/2020**
	10	29	26	20
Very Poor	40%	31%	38%	25%
Poor	10%	14%	23%	30%
Good	30%	45%	27%	35%
Very Good	10%	10%	12%	10%
No Response	10%	0%	0%	0%
2. How clearly was the outcome of your complaint explained to you?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	10	29	26	20
Very Poor	60%	52%	54%	70%
Poor	20%	17%	27%	15%
Good	20%	28%	12%	10%
Very Good	0%	3%	7%	5%
No Response	0%	0%	0%	0%
3. How well did we meet the timeframe provided to you?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	10	29	26	20
Very Poor	60%	45%	62%	55%
Poor	30%	17%	27%	15%
Good	10%	24%	11%	25%
Very Good	0%	14%	0%	5%
No Response	0%	0%	0%	0%

4. How courteous and helpful was staff?	**FY 2016/2017**	**FY 2017/2018**	**FY 2018/2019**	**FY 2019/2020**
	10	29	26	20
Very Poor	50%	31%	27%	25%
Poor	30%	28%	27%	35%
Good	20%	24%	23%	30%
Very Good	0%	7%	15%	5%
No Response	0%	10%	8%	5%
5. Overall, how well did we handle your complaint?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	10	29	26	20
Very Poor	80%	69%	69%	70%
Poor	20%	25%	19%	25%
Good	0%	3%	0%	5%
Very Good	0%	3%	7%	0%
No Response	0%	0%	5%	0%
6. If we were unable to assist you, were alternatives provided to you?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	10	29	26	20
Yes	0%	4%	11%	0%
No	100%	86%	62%	75%
Not Applicable	0%	0%	0%	0%
No Response	0%	10%	27%	25%
7. Did you verify the provider's license prior to service?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	10	29	26	20
Yes	50%	65%	62%	70%
No	30%	14%	23%	10%
Not Applicable	20%	21%	15%	20%
No Response	0%	0%	0%	0%

Board Physician License Applicants Survey

1. Did the application instructions clearly state how to complete the application?	**FY 2016/2017**	**FY 2017/2018**	**FY 2018/2019**	**FY 2019/2020**
	824	891	718	632
Yes	91%	92%	94%	93%
No	9%	8%	6%	7%
2. If you visited the Medical Board's website for assistance, was the information helpful?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	824	891	718	632
Yes	87%	89%	93%	91%
No	13%	11%	7%	9%
3. If you used the BreEZe online system, how satisfied were you with the information it provided?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	824	891	718	632
Very satisfied	39%	41%	42%	41%
Somewhat satisfied	38%	39%	41%	38%
Somewhat dissatisfied	8%	8%	5%	7%
Very dissatisfied	3%	3%	2%	3%
Not Applicable	12%	9%	10%	11%
4. How satisfied were you with the courteousness, helpfulness, and responsiveness of the staff person who processed your application?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	824	891	718	632
Very satisfied	59%	65%	65%	66%
Somewhat satisfied	21%	18%	18%	17%
Somewhat dissatisfied	7%	4%	4%	5%
Very dissatisfied	5%	3%	2%	3%
Not applicable	8%	10%	11%	9%

5. How satisfied were you with the application process?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	824	891	718	632
Very satisfied	44%	50%	51%	51%
Somewhat satisfied	40%	37%	36%	35%
Somewhat dissatisfied	10%	9%	10%	10%
Very dissatisfied	6%	4%	3%	4%

Board Postgraduate Training License Applicants Survey

1. Did the application instructions clearly state how to complete the application?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	n/a			71
Yes				85%
No				15%
2. If you visited the Medical Board's website for assistance, was the information helpful?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	n/a			71
Yes				63%
No				17%
Not Applicable				20%
3. If you used the BreEZe online system, how satisfied were you with the information it provided?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	n/a			71
Very satisfied				35%
Somewhat satisfied				23%
Somewhat dissatisfied				10%
Very dissatisfied				8%
Not Applicable				24%

4. **How satisfied were you with the courteousness, helpfulness, and responsiveness of the staff person who processed your application?**	**FY 2016/2017**	**FY 2017/2018**	**FY 2018/2019**	**FY 2019/2020**
	n/a			71
Very satisfied				46%
Somewhat satisfied				20%
Somewhat dissatisfied				6%
Very dissatisfied				8%
Not applicable				20%
5. How satisfied were you with the application process?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	n/a			71
Very satisfied				48%
Somewhat satisfied				29%
Somewhat dissatisfied				13%
Very dissatisfied				10%

Board Newsletter Survey

1. My overall satisfaction about the content of the Medical Board's Newsletter is:	**FY 2016/2017**	**FY 2017/2018**	**FY 2018/2019**	**FY 2019/2020**
	49	111	31	5
Excellent	20%	24%	16%	60%
Very Good	46%	35%	29%	40%
Good	8%	24%	35%	0%
Average	14%	9%	10%	0%
Disappointed	12%	8%	10%	0%
2. Please rate the usefulness of the Annual Report (fall issue):	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	48	111	30	5
Very Useful	10%	21%	13%	20%
Informative	58%	45%	47%	40%
Somewhat Informative	13%	22%	30%	40%
Not Useful At All	19%	12%	10%	0%

3. I prefer to receive the Newsletter:	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	46	106	30	4
Via Email	70%	74%	67%	100%
Hard copy via Regular Mail	30%	25%	23%	0%
Social Media (when it becomes available)	0%	1%	10%	0%
4. My main interest in the Newsletter is as a:	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	46	105	30	4
Physician / Surgeon	94%	93%	80%	75%
Associated Medical Professional	4%	2%	0%	0%
Interested Reader	0%	0%	14%	0%
Member of the Media	2%	0%	3%	0%
Government Member	0%	0%	0%	0%
Other	0%	5%	3%	25%

Board Website Survey

1. Which of the following best describes you?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	640	1307	1443	1378
Applicant	11%	12%	13%	15%
Consumer/Patient	28%	27%	24%	24%
Current Licensee	37%	37%	42%	41%
Educator	2%	2%	2%	3%
Employer/Recruiter	6%	5%	5%	4%
Media	1%	0%	0%	0%
Other	15%	17%	14%	13%

2. During your most recent visit to the Board's website, which of the following best describes the information you were seeking?*	**FY 2016/2017**	**FY 2017/2018**	**FY 2018/2019**	**FY 2019/2020**
	640	1307	1443	1378
Application for Licensure	9%	10%	11%	14%
Board Publications/Media	2%	2%	2%	2%
Continuing Education	2%	2%	2%	2%
Filing a Complaint	10%	13%	10%	11%
Legislation/Regulation	2%	3%	3%	3%
License Renewal	33%	29%	38%	32%
Name/Address Change	4%	3%	3%	4%
Public Documents	8%	8%	6%	7%
Verifying a License	31%	28%	25%	26%
Other	17%	19%	16%	15%
* Results exceeding 100% is attributed to raters having the option to choose multiple answers.				
3. Were you successful in finding the information you were seeking?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	640	1307	1443	1378
Yes	58%	58%	56%	60%
No	42%	42%	44%	40%
4. Overall, how satisfied are you with the Board's website?	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
	640	1307	1443	1378
Extremely satisfied	29%	32%	32%	31%
Somewhat satisfied	25%	24%	23%	26%
Neither satisfied nor dissatisfied	14%	12%	12%	12%
Somewhat dissatisfied	13%	13%	14%	13%
Extremely dissatisfied	19%	19%	19%	18%

Section 3

Fiscal and Staff

- Fiscal Issues
- Staffing Issues

Attachments

- Attachment D – Year-End Organizational Charts
- Attachment F – Revenue and Fee Schedule

Fiscal Issues

8. Is the board's fund continuously appropriated? If yes, please cite the statute outlining this continuous appropriation.

The Board's fund is not continuously appropriated. The DCA prepares the Board's annual budget for inclusion in the Governor's proposed budget and the Board's appropriation is part of the Budget Act.

9. Describe the board's current reserve level, spending, and if a statutory reserve level exists.

Pursuant to BPC section 2435, the Board's statutory reserve should be between two to four months. However, since the last fee increase in 2006, the Board has experienced minimal revenue growth and significant expenditure increases, therefore, the Boards expenditures are continuously exceeding revenues.

The cost of doing business has increased, with most costs being outside the Board's control. Several factors impacting the Board's fund include: the AGO's 30 percent fee increase, the statewide General Administrative Expenses, the Financial Information System for California (FI$Cal), the Supplemental Pension Payments, HQIU budget increase, the Employee Compensation and Retirement Rate Adjustments, and the BreEZe System Maintenance and Credit Card Services.

The Outpatient Setting Fund is also under the purview of the Board. Table 2a shows the revenue and expenditures for the Outpatient Settings Program. Chapter 1276, Statutes of 1994 established the Outpatient Setting Fund and authorized a loan of $150,000 from the Contingent fund of the Medical Board of California to be repaid with interest by January 1, 2003. This loan was repaid in FY 2000/2001.

10. Describe if/when a deficit is projected to occur and if/when fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the board.

In looking at the Board's current and projected fund condition, it appears the Board will not be within its statutory mandate of two to four months' reserve by the end of FY 20/21.
At the end of FY 19/20, the Board had a fund reserve of $18,919,000 which equates to a 3.1 months' reserve, just keeping the Board within its statutory mandate. However, it is projected by the end of FY 20/21 the Board will have a fund reserve of $7,388,000 equating to 1.1 months' reserve, and by the end of FY 21/22 the Board will have a negative fund reserve of -$14,384,000 equating to a -2.2 months' reserve, resulting in the Board not being within its statutory mandate (see Section 12 - New Issues, #1). The fund includes a Control Section 14.00 loan (loan between Department special funds) of $12 million to the Medical Board Contingent Fund in FY 21/22 to ensure the Board has enough cash flow to continue operations until a fee increase can be secured.

In November 2019, the Board contracted with CPS HR Consulting to perform the required fee study to determine the appropriate levels for licensing fees for the Board to conduct its business at a service level that is efficient for licensees and ensures public protection. The

fees reviewed in the study include: Physician and Surgeon, Special Faculty, LM, Polysomnographic Trainee/Technician/Technologist, Research Psychoanalyst and Fictitious Name Permit fees. The Board requested the fee increase approval through the May Revision process. However, the Budget Act of 2020 did not include a fee increase for the Board. The Board presents a fund condition report at each of its quarterly Board meetings so the members and the public are aware of the Board's budget.

Table 2. Fund Condition

(Dollars in Thousands)	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22
Beginning Balance[1]	$27,242	$28,728	$33,739	$26,297	$18,919	$7,388
Revenues and Transfers	$64,863	$65,928	$59,892	$59,761	$66,036	$58,002
Inter-departmental Loan	$0	$0	$0	$0	$0	$12,000
Total Revenue	**$92,105**	**$94,656**	**$93,631**	**$86,058**	**$84,955**	**$65,390**
1111 Expenditures[2]	$60,307	$62,689	$62,072	$62,755	$73,554	$75,761
Direct to Fund Pro Rata	$3,070	$3,802	$4,404	$4,384	$4,013	$4,013
Loans to General Fund	$0	$0	$0	$0	$0	$0
Accrued Interest, Loans to General Fund	$0	$0	$0	$0	$0	$0
Loans Repaid From General Fund	$0	$0	$0	$0	$0	$0
Fund Balance	**$28,728**	**$28,165**	**$27,155**	**$18,919**	**$7,388**	**-$14,384**
Months in Reserve	**5.2**	**5.1**	**4.7**	**3.1**	**1.1**	**-2.2**

[1] Beginning balance is the Adjusted Beginning Balance of the Fund Condition Statement which includes the prior year adjustment and fund assessment adjustments.

[2] Expenditures are net of the state operations, scheduled and unscheduled reimbursements, and statewide assessments. FYs 2020/2021 and 2021/22 expenditures (and revenues) are projections.

Table 2a. Fund Condition (Outpatient Setting Fund of the Medical Board of California)

(Dollars in Thousands)	FY 16/17	FY 17/18	FY 18/19	FY 19/20	FY 20/21	FY 21/22
Beginning Balance*	$334	$448	$454	$475	$558	$660
Revenues and Transfers	$115	$6	$23	$86	$130	$133
Total Revenue	**$449**	**$454**	**$477**	**$561**	**$688**	**$791**
Budget Authority	$26	$26	$26	$26	$26	$26
Expenditures**	$1	$2	$2	$3	$28	$27
Loans to General Fund	$0	$0	$0	$0	$0	$0
Accrued Interest, Loans to General Fund	$0	$0	$0	$0	$0	$0
Loans Repaid From General Fund	$0	$0	$0	$0	$0	$0
Fund Balance	**$448**	**$452**	**$475**	**$558**	**$660**	**$782**

* Beginning balance is the Adjusted Beginning Balance of the Fund Condition Statement which includes the prior year adjustment and fund assessment adjustments.

** Expenditures are net of the state operations, scheduled and unscheduled reimbursements, and statewide assessments.

11. Describe the history of general fund loans. When were the loans made? When have payments been made to the board? Has interest been paid? What is the remaining balance?

The Board has made two loans to the general fund. The first loan was in FY 2008/2009 for $6 million and repayment was made in FY 2016/2017. The second loan was for $9 million in FY 2011/2012 and repayment was made in FY 2017/2018.

12. Describe the amounts and percentages of expenditures by program component. Use *Table 3. Expenditures by Program Component* to provide a breakdown of the expenditures by the board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.

Table 3 below indicates the amount of expenditures in each of the Board's programs. In addition, the Budget Distribution chart, which is in the Board's Annual Report every year, reflects the budgeted (not actual) expenditures and percentage in each of the Board's Programs (including pro rata) for FY 2019/2020. The Enforcement Program (including the AGO, the Office of Administrative Hearings (OAH), the HQIU, and Probation Monitoring) makes up approximately 80 percent of the Board's overall expenditures. Although the Board cannot order cost recovery for investigation and prosecution of a case, the Board can order that probation monitoring costs be reimbursed. The Licensing Program accounts for approximately nine percent of the Board's expenditures, while the ISB accounts for approximately four percent. The Executive and Administrative Programs make up the remaining seven percent of the Board's overall expenditures.

Table 3. Expenditures by Program Component (dollars in thousands)

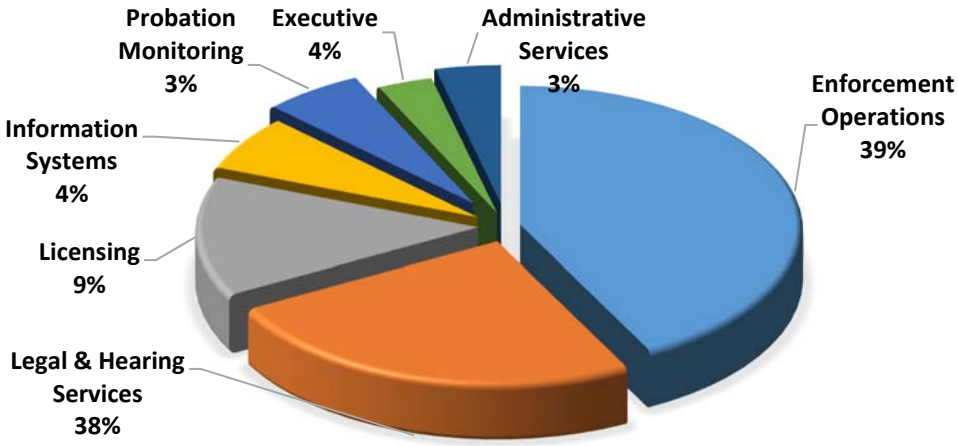
	FY 2016/2017		FY 2017/2018		FY 2018/2019		FY 2019/2020	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	$6,651	$37,846	$6,914	$40,275	$6,869	$40,339	$7,504	$38,547
Examination	$0	$0	$0	$0	$0	$0	$0	$0
Licensing	$4,564	$2,043	$4,269	$2,034	$4,402	$1,853	$4,548	$2,188
Administration *	$2,532	$616	$2,690	$666	$3,009	$709	$2,692	$2,749
Information Systems	$1,826	$662	$2,221	$352	$2,242	$509	$2,052	$614
DCA Pro Rata	$0	$6,278	$0	$4,906	$0	$5,140	$0	$5,251
Diversion (N/A)	$0	$0	$0	$0	$0	$0	$0	$0
TOTALS	**$15,573**	**$47,445**	**$16,094**	**$48,233**	**$16,522**	**$48,550**	**$16,796**	**$49,349**

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

Budget Distribution *(budgeted, not actual)*		
Enforcement Operations*	$30,114,000	39%
Legal & Hearing Services**	29,764,000	38%
Licensing*	6,747,000	9%
Information Systems	3,330,000	4%
Probation Monitoring*	2,634,000	3%
Administrative Services	2,190,000	3%
Executive	3,077,000	4%
Total	**$77,856,000**	**100%**

* Budget amounts were adjusted for Attorney General Services, OAH, and Court Reporter Services.

** Includes Attorney General Services, OAH, and Court Reporter Services.



13. Describe the amount the board has contributed to the BreEZe program. What are the anticipated BreEZe costs the board has received from DCA?

The BreEZe program was approved in 2009 and was intended to address legacy systems deficiencies. The Board was one of ten DCA boards and bureaus scheduled for Release 1 of Breeze in October 2013. The actual costs incurred by the Board from FY 2016/2017 through FY 2021/2022 total over $7 million and are inclusive of vendor costs, DCA staff and other related costs. The Board is anticipating project costs of $869,000 in FY 2020/2021. Funding will be requested for projected ongoing maintenance costs of $802,000 for FY 2021/2022 and FY 2022/2023. A summary of actual expenditures and projected future costs can be found in the table below. It is important to note that these costs do not capture the numerous Board staff hours spent on the project.

BreEZe Program Costs					
Project					Maintenance
FY 16/17 Actual	FY 17/18 Actual	FY 18/19 Actual	FY 19/20 Actual	FY 20/21 Budget	FY 21/22 Budget
$1,610,179	$1,488,365	$1,341,570	$1,074,919	$869,000	$802,000

14. Describe license renewal cycles and history of fee changes in the last 10 years. Give the fee authority (Business and Professions Code and California Code of Regulations citation) for each fee charged by the board.

The Board's main source of revenue is from the physician's renewal fees. This is illustrated below in the Revenues and Reimbursements chart, which is included in the Board's Annual Report. Both the fees for the allied health programs and physician's renewal fee have remained the same since the last Sunset Report. Prior to that, the Board's physician's and surgeon's initial licensure and renewal fees were increased effective January 1, 2006, from $600 to $790, its first increase since 1994, in order to support the VE/Prosecution model. Effective January 1, 2007, the physician's initial licensure and renewal fees were increased by $15 to $805 based upon the average amount of cost recovery that the Board had received in the prior three fiscal years that would no longer be received by the Board. Effective July 1, 2009, the physician's initial licensure and renewal fees were decreased by $22 to $783, a reduction mandated as a result of the elimination of the Board's Diversion Program on July 1, 2008. This is the current physician's initial licensure and renewal fee.

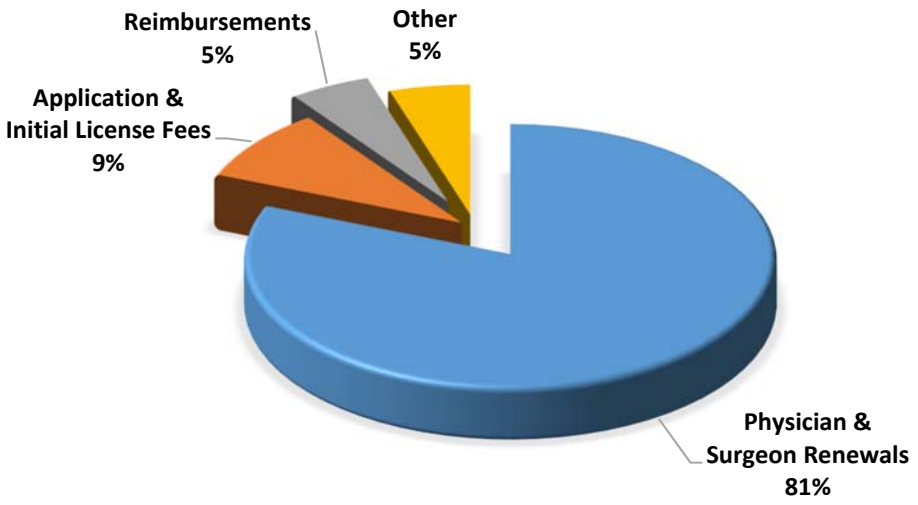
The full schedule is in Section 13, Attachment F. Below is a list of the significant funding sources.

Table 4. Fee Schedule and Revenue (revenue dollars in thousands)

Fee	Current Fee Amount	Statutory Limit	FY 2016/2017 Revenue	FY 2017/2018 Revenue	FY 2018/2019 Revenue	FY 2019/2020 Revenue	% of Total Revenue
CONTINGENT FUND OF THE MEDICAL BOARD OF CALIFORNIA **PHYSICIANS AND SURGEONS ONLY**							
Application Fee (BPC 2435)	442.00	442.00	3,514	3,543	3,342	2,481	5.66%
Initial License Fee (BPC 2435) (16 CCR 1351.5)	790.00	790.00	2,046	1,956	2,000	2,159	3.59%
Initial License Fee (Reduced) (BPC 2435)	395.00	395.00	1,672	1,716	1,680	1,255	2.78%
Biennial Renewal Fee (BPC 2435) (16 CCR 1352)	790.00	790.00	48,537	50,278	50,602	50,612	87.97%

Revenues and Reimbursements		
Physician & Surgeon Renewals	$50,612,000	81%
Application & Initial License Fees	5,901,000	9%
Reimbursements	3,096,000	5%
Other Regulatory Fees, Delinquency/Penalty/ Reinstatement Fees, Interest on Fund, Miscellaneous	3,247,000	5%
Total [1]	**$ 62,856,000**	**100%**

1 Includes revenues and reimbursements. In Table 2, reimbursements are reflected as a reduction in Expenditures.



15. Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

The Board knows that in order to meet its mandatory functions, it must have the staff and resources to perform the necessary duties. However, the Board is also mindful of the State's economic situation and the efforts not to increase position authority unless there is a justifiable workload. With all of this in mind, the Board only requested BCPs when it was absolutely necessary based upon an increase in workload or due to new legislation. Table 6 provides information on the requested data and the specifics on each BCP submitted in the last four fiscal years.

Table 5. Budget Change Proposals (BCPs)								
BCP ID #	FY	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested	# Staff Approved	$ Requested	$ Approved	$ Requested	$ Approved
1110 -014	16/17	Requested additional resources to address BreEZe workload	2.0 OT(T) 3.0 MST 1.0 SSA 1.0 AGPA 1 SISA	1.0 AGPA	$579,000	$93,000	$163,000	$20,000
1110 -015	16/17	Increase appropriation for Expert Reviewers	NA	NA	NA	NA	$735,000	$206,000
1111 -007	17/18	Requested additional resources to address increase in number of complaints	4.0 SSA 1.0 SSM I	2.0 SSA	$411,000	$151,000	$87,000	$36,000
1111 -043	17/18	Requested budget and positions (SB 1177)	1.0 AGPA	1.0 AGPA	$99,000	$99,000	$15,000 in 17-18 $250,000 in 18-19 (one-time)	$15,000 in 17-18 $250,000 in 18-19 (one-time)
1111 -065	18/19	Increase Midwifery Program for Board Services	NA	NA	NA	NA	$107,000	$107,000
1111 -002	19/20	Reduced due to elimination of vertical enforcement	NA	NA	NA	NA	($1.9M)	($1.9M)
1111 -002	19/20	Implement Mexico Pilot Program	.1 Med Consultant 1.0 SSA	.1 Med Consultant 1.0 SSA	$97,000	$97,000	$240,000	$240,000
1111 -003	19/20	Increase in appropriation as a result of the hourly rate increase for trained Expert Reviewers	NA	NA	NA	NA	$499,000	$499,000

Staffing Issues

16. Describe any board staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.

Vacancy Rates
The Board continues its efforts both recruiting and retaining employees in each of its programs. In FY 2016/2017 and FY 2017/2018, the Board had an eight percent vacancy rate. In FY 2018/2019 the Board saw an increase to 10 percent. This past year, in FY 2019/2020 the Board had a slight increase to 12 percent. The Board's vacancy rate is currently at 11 percent, which equates to 21 vacant positions. The Board continues to advertise its vacant positions, schedule interviews and process hiring packages as quickly as possible.

Reclassification Efforts
As the duties for particular positions evolve due to operational need, the Board works with the DCA Office of Human Resources to reclassify its positions to ensure the efficient utilization of resources to enhance Licensing and Enforcement operations and facilitate the Board's mission statement, objectives, and goals.

The Board regularly conducts a review of its staff and will reclassify the positions as needed. Furthermore, over the past few years, the Board has reclassified some positions in order to address the increased complexity of assignments; levels of responsibility and consequences involved; and, the need for staff oversight and professional development. Overall, the Board's reclassification efforts have addressed changes needed due to legislation, business processes, and operational efficiencies. As a result, the Board is better equipped to fulfill its mission of consumer protection.

Succession Planning
The Board uses policy and procedure manuals to ensure succession planning. Additionally, when available, the Board has the individuals leaving a position provide training to new staff and ensure the knowledge base is being transferred. The Board does everything it can with its existing resources to ensure that new staff receive the training needed to be successful.

The Board recognizes that the key to succession planning is developing staff to fill key leadership positions by developing their knowledge, skills and abilities in preparation for advancement into ever more challenging roles and positions of leadership. Individual Development Plans (IDP) are utilized to set reasonable goals for employees, assess job-related strengths, and aid in the development of employees to reach career goals resulting in both improved employee and organizational performance.

17. Describe the board's staff development efforts and how much is spent annually on staff development (cf., Section 13, Attachment D).

Staff Development
The Board's staff must be trained adequately and effectively in order for the Board to be able to meet its mission and mandates. For all staff, Board managers are held responsible for meeting with staff and discussing with them any needed or recommended training. Managers not only recommend training to the employee, but also discuss with the employee any training he/she may wish to pursue. The Board believes that providing staff with training opportunities will enhance the employee's performance and bring efficiencies to the work of the Board. The Board understands the importance of staff and is very supportive of every effort to keep staff knowledgeable and performing at their best.

The Board works with the DCA internal training department, Strategic Organizational Leadership and Individual Development (SOLID) Training and Planning Solutions. SOLID's mission is to develop an effective workforce by creating a foundation to drive change, guide learning and achieve DCA's strategic vision. SOLID offers a range of training and services from individual development, workgroup development, leadership development and board development.

Over the past four fiscal years, the Board has spent the following on training outside of SOLID:

FY 16/17 - $2,455
FY 17/18 - $43,397
FY 18/19 - $32,754
FY 19/20 - $15,549

The Board's year-end organization charts for the last four fiscal years are provided in Section 13, Attachment D.

Section 4

Licensing Program

- Physicians
  - Performance Targets
  - Examinations
  - School Approvals
  - Continuing Education/Compentency Requirements
- Fictitious Name Permits
- Special Faculty Permits
- Special Programs
- Medical Assistants
- Outpatient Surgery Setting Accreditation

The Licensing Program provides public protection by ensuring the Board issues licenses or registrations only to applicants who meet the minimum requirements of current statutes and regulations and who have not done anything that would be grounds for denial. The Board has the responsibility to enforce the Medical Practice Act and other related statutes and regulations.

In addition to issuing physician licenses and PTLs, the Board issues licenses/registrations/ permits and/or regulates the following:

- Fictitious Name Permits
- Special Faculty Permits – BPC section 2168
- Special Programs – BPC sections 2111, 2112, 2113, and 16 CCR section 1327
- Medical Assistants
- Outpatient Surgery Setting Accreditation

This section on the Licensing Program will not include information on other allied healthcare professionals. These license/registration types are discussed in this report as follows:

- Licensed Midwives (See Part II)
- Polysomnographic Trainees, Technicians, and Technologists (See Part III)
- Research Psychoanalysts/Student Research Psychoanalysts (See Part IV)

The Licensing Program has undergone some significant changes since the last sunset review. SB 798, the Board's sunset review bill, made a number of changes to the Board's licensing statutes. Beginning January 1, 2020, all physician license applicants are required to successfully complete 36 months of approved postgraduate training. In addition, all medical school graduates who match into an Accreditation Council for Graduate Medical Education (ACGME)-accredited postgraduate training program in California are required to obtain a PTL in order to practice medicine as part of their training program. If the medical school graduate fails to obtain the PTL within 180 days after enrollment in a Board-approved training program, or the Board denies the PTL application, all privileges and exemptions under BPC section 2064.5 will automatically cease. The PTL is valid for the duration of the training program for up to 39 months and may not be renewed; however, the Board may grant an extension under specified conditions.

The COVID-19 pandemic created some challenges in implementing the PTL. Any resident participating in an ACGME-accredited postgraduate training program on January 1, 2020, and is not eligible for licensure, is required to obtain the PTL by June 30, 2020, to continue in the program. The DCA issued DCA Waiver DCA-20-93, which extended this deadline to March 31, 2021.

At the Board's request, SB 798, also removed the Board's authority to approve specialty boards. Prior to January 1, 2019, the Board had established a review process to recognize specialty boards that were not member boards of the American Board of Medical Specialties (ABMS) for purposes of advertising pursuant to BPC section 651.

Physicians

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

Performance Targets

16 CCR section 1319.4 requires the Board to notify applicants within 60 working days of receipt of a physician and surgeon 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 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 is developing 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.

The Board experienced the highest number of PTL applications received in February, March, and April 2020, ranging from 836 to 970 per month. This recent spike in applications received can be partly attributed to 2020 being a transition year for the Board. Residents who were enrolled in an ACGME-accredited training program in California on January 1, 2020, must obtain a PTL by June 30, 2020, and new residents must obtain a PTL within 180 days of commencement of their training program. However, Executive Order N-39-20 allowed the Director of DCA to extend the deadline to March 31, 2021.

Due to this significant increase in the PTL applications received, which coincided with the onset of the COVID-19 pandemic, the Board is currently reviewing new initial PTL and physician license applications approximately 60 calendar days from receipt. The Board's high volume of hard copy documents received presented challenges when trying to implement telework schedules due to COVID-19. The Board was forced to quickly evaluate and change some of its procedures to allow more tasks to be completed remotely while continuing to process a higher volume of paper applications.

The Board has identified several options to help reduce the processing time, including expanding overtime opportunities and identifying additional process efficiencies. The Board reallocated staff to assist with processing applications and continues to evaluate workload needs and identify additional staff to reallocate. The Board is also training newly hired application reviewers, who will be able to assist with reducing the current processing times. These measures have led to an increase in licensing capacity. In Quarter 4 of FY 2018/2019, the Board issued 1,661 physician licenses. In Quarter 4 of FY 2019/2020, the Board issued a total of 2,261 physician licenses and PTLs, which is a 36 percent increase in the number of licenses issued during the same time period in FY 2018/2019.

The Licensing Program anticipates the volume of applications received to begin to normalize in 2021 and will evaluate resource needs once it establishes a new baseline. Assuming

application volume decreases, the Board's efforts to identify process efficiencies, reallocate staff, and onboard new application reviewers should result in a reduction in current timeframes. The Board will continue to closely monitor licensing processing times and is prepared to take further action as needed.

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?

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 coinciding with the onset of the pandemic has increased the average processing time to approximately 60 calendar days.

The Board experienced a 22 percent increase in the number of initial license applications received between FY 2016/2017 and FY 2019/2020. The total number of physician initial license applications received in the beginning of 2020 declined due to the new PTL and elimination of the requirement that international graduates obtain a PTAL in order to participate in the residency match process for the upcoming academic year.

In Quarter 4 of FY 2018/2019, the Board received approximately 1,640 physician license applications. In Quarter 4 of FY 2019/2020, the Board received approximately 2,861 license applications, which includes PTL and physician license applications. This is a 74 percent increase in the number of license applications received during the same quarter in the previous year.

The Board has implemented several measures to address the increased workload, including approving staff overtime, reallocating staff, identifying process efficiencies, and adjusting procedures to accommodate a telework-centered office structure while working toward a paperless licensure process. The Board is evaluating its licensure requirements and the utilization of IT solutions to address the obstacles created by hard copy documents, especially when most organizations must rely on teleworking and less office-based services during the current pandemic.

In January 2020, the Licensing Program deployed the Direct Online Certification Submission (DOCS) portal. DOCS allows medical school and residency program staff registered with the Board to submit the required documentation electronically, which significantly reduces the overall processing time and limits the potential misdirection and loss of mail. The Board significantly expanded the utilization of DOCS across medical schools and training programs during the pandemic by increasing outreach to applicants, medical schools and postgraduate training programs. In May 2020, DOCS supported seven medical schools, 330 postgraduate training programs, and 118 registered users. By August 2020, DOCS supported 61 medical schools, 877 postgraduate training programs, and 349 users. Total medical schools and training programs utilizing DOCS increased by 56 percent from May 2020 to August 2020. As

of October 21, 2020, there are 1,150 training programs, 87 medical schools, and 517 users registered in DOCS.

Since FY 2019/2020 was the first year the Board began capturing the number of pending applications at the close of the fiscal year, the Board will continue to monitor trends in the number of applications pending compared to the number of applications approved.

The Board is currently evaluating application processes to identify efficiencies through IT solutions and less reliance on hard copy documents in order to improve overall processing times.

In order to increase the number of licensees that renew online rather than mailing in a renewal form, the Board began notifying licensees 180 days prior to their license expiration compared to the previously established 120 days. This change followed Governor Newsom's Going Green edict and increased online renewals.

20. How many licenses or registrations does the board issue each year? How many renewals does the board issue each year?

The Board issues approximately 7,047 licenses and 70,335 renewals each year.

Table 6. Licensee Population

		FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
8002 – Physician's and Surgeon's	Active	144,441	147,494	149,765	152,402
	Delinquent	17,701	18,342	18,498	17,823
	Retired	11,511	12,461	13,401	14,318
	Out-of-State	28,463	29,068	29,019	29,580
	Out-of-Country	778	782	756	703
8014 – Postgraduate Training License	Active	-	-	-	1,925
	Delinquent	-	-	-	-
	Retired	-	-	-	-
	Out-of-State	-	-	-	-
	Out-of-Country	-	-	-	-

Table 7a. Licensing Data by Type – Physician's and Surgeon's

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 16/17	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	7,763	6,802	448	6,802	unk[a]	-	-	62	235	223
	(Renewal)	67,043	67,043	n/a	67,043	-	-	-	-	-	-
FY 17/18	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	8,031	6,694	-	6,694	unk[a]	-	-	52	223	209
	(Renewal)	70,297	70,297	-	70,297	-	-	-	-	-	-
FY 18/19	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	7,720	6,694	-	6,694	unk[a]	-	-	34	210	192
	(Renewal)	72,974	72,974	-	72,974	-	-	-	-	-	-
FY 19/20	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	5,629	6,072	-	6,072	2,079	-	-	36	219	197
	(Renewal)	71,024	71,024	-	71,024	-	-	-	-	-	-

* Optional. List if tracked by the board.
[a] Data not captured in previous years

Table 7a. Licensing Data by Type – Postgraduate Training License (Eff. 1/1/2020)

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within 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	n/a
	(License)	4,122	1,925	-	1,925	2,082	-	-	45	81	67
	(Renewal)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data – Physician and Surgeon				
	FY 16/17	FY 17/18	FY 18/19	FY 19/20
Initial Licensing Data:				
Initial License/Initial Exam Applications Received	7,763	8,031	7,720	5,629
Initial License/Initial Exam Applications Approved	6,802	6,694	6,694	6,072
Initial License/Initial Exam Applications Closed	448	490	603	1,581
License Issued	6,802	6,694	6,694	6,072
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	Unknown	Unknown	Unknown	2,079
Pending Applications (outside of board control)*	Unknown	Unknown	Unknown	Unknown
Pending Applications (within the board control)*	Unknown	Unknown	Unknown	Unknown
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	223	209	192	197
Average Days to Application Approval (incomplete applications)*	235	223	210	219
Average Days to Application Approval (complete applications)*	62	52	34	36
License Renewal Data:				
License Renewed	67,043	70,297	72,974	71,024

Note: The values in Table 7b are the aggregates of values contained in Table 7a.
* Optional. List if tracked by the board.

Table 7b. Total Licensing Data – Postgraduate Training License				
	FY 16/17	FY 17/18	FY 18/19	FY 19/20
Initial Licensing Data:				
Initial License/Initial Exam Applications Received	N/A	N/A	N/A	4,122
Initial License/Initial Exam Applications Approved	N/A	N/A	N/A	1,925
Initial License/Initial Exam Applications Closed	N/A	N/A	N/A	115
License Issued	N/A	N/A	N/A	1,925
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	N/A	N/A	N/A	2,082
Pending Applications (outside of board control)*	N/A	N/A	N/A	Unknown
Pending Applications (within the board control)*	N/A	N/A	N/A	Unknown
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	N/A	N/A	N/A	67
Average Days to Application Approval (incomplete applications)*	N/A	N/A	N/A	81
Average Days to Application Approval (complete applications)*	N/A	N/A	N/A	45
License Renewal Data:				
License Renewed	N/A	N/A	N/A	N/A
Note: The values in Table 7b are the aggregates of values contained in Table 7a. * Optional. List if tracked by the board.				

21. 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 12 licenses or registrations 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: Nine physician licenses, two polysomnography registrations. The Board also denied one PTAL. Below is a breakdown of each instance of denial by fiscal year.

Criminal Conviction Denials			
FY 16/17	FY 17/18	FY 18/19	FY 19/20
3	5	4	0

FY 2016/2017
Polysomnography Technologist: Denied due to applicant's criminal record history involving alcohol and recovery program's recommendation for immediate inpatient treatment due to alcohol addiction. Three convictions: driving under the Influence (DUI) with alcohol or drugs (2001), reckless driving (2006), and drunk in public (2014).

Physician and Surgeon: Denied due to applicant's criminal record history. Conviction in 2010 for insurance fraud and using another persons' contractor license number.

Physician and Surgeon: Denied due to applicant's criminal record history. Conviction in 2012 felony conspiracy to pay kickbacks for patient referrals.

FY 2017/2018
Physician and Surgeon: Denied due to applicant's criminal record history and disciplinary actions taken by the Washington and Oregon Medical Boards. Conviction in 2016 for violation of Revised Code of Washington 9A.88.080(1)(b) - Promoting Prostitution 2nd Degree.

Polysomnography Technologist: Denied due to applicant's failure to disclose a license denial with the California Respiratory Care Board and criminal record history. Three convictions in 1990 for theft; felony, evading officer and battery on emergency personnel with injury; and felony possession of narcotic/controlled substance. Conviction in 2011 for DUI and two convictions in 2012, first one for driving while license is suspended and one month later for driving without a license.

Physician and Surgeon: Denied due to applicant's criminal record history. Conviction in 2016 for DUI of Alcohol.

Physician and Surgeon: Denied due to applicant's history of addictive disorder (alcohol); criminal record history related to alcohol; and disciplinary actions taken by the Oregon, Alaska, Arizona, and Washington Medical Boards. Conviction in 2007 for violation of Arizona Revised Statute, Sections 28-1381(A)(2), 28-1382, 13-707, and 13-802 (Extreme DUI, DUI above 0.08 percent, and DUI).

PTAL: Denied due to applicant's history of substance abuse with alcohol/drugs, history of mental health disorders, and prior criminal record history relating to alcohol and drugs. Misdemeanor conviction in 2008 for DUI of alcohol/drugs and driving while having a blood alcohol of 0.08 percent or higher. After completing probationary term, the court dismissed both of these misdemeanor convictions. Felony conviction in 2013 for giving away and/or using any controlled substance. The court dismissed this felony conviction, reduced it to a misdemeanor, and granted early dismissal of probation.

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.

22. 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 and the form requires notarization. Additionally, the Board requires that all applications be notarized, except for documents submitted through DOCS by a medical school or training program.

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.
- 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. 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 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 several questions related to possible medical conditions. 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.

License applications previously requested information about convictions, including those that may have been deferred, set aside, dismissed, expunged or issued a stay of execution, however, these questions were removed from the application on July 1, 2020, pursuant to AB 2138 (Chiu, Statutes of 2018). 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 physician license based on the applicant's failure to disclose information on the application. These nine denials included five 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; one applicant failed to disclose a letter of warning issued by another licensing agency; and one applicant failed to self-disclose criminal conviction history. The Board also denied one polysomnography technologist application for failure to disclose the denial of a license by another licensing agency.

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 physician 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.

23. 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. California has some of the most stringent requirements for medical school education to ensure consumer protection.

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 physician license, while international graduates were required to have completed at least two years of postgraduate training.

Effective January 1, 2020, all graduates of approved U.S./Canadian, or international medical schools are required to obtain 36 months of postgraduate training, which includes 24 months successfully completed in the same program, and submit documentation codified in statute and regulation to obtain a physician license. 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 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.

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.

24. 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 2016/2017 through FY 2019/2020, the Board approved 45 renewal applications pursuant to BPC section 2440.

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

The Board issued 45 physician licenses between FY 2016/2017 and 2018/2019 that qualified for the expedited license process pursuant to BPC Section 115.5.

25. 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.

In the Enforcement Program, the Board sends NLI notifications to DOJ on a regular and ongoing basis by fax. There is a backlog of 23 NL notifications for registrants of the RDO. The RDO program moved to the Board of Optometry in 2016. Upon the transition, the Board's DOJ Originating Agency Identifier (ORI) number for the RDO program did not transfer to the Board of Optometry. Therefore, the Board is still receiving subsequent arrest notification for the RDO program. When the Board discovered this issue in 2018, DOJ instructed the Board not to submit NLI notifications for the RDO program until they could get the issue resolved. DOJ cautioned that doing so would remove the registrant from the DOJ's system and neither the

Board nor the Board of Optometry would receive subsequent arrest notifications. The Board continues to work with DOJ staff and the Board of Optometry to resolve this issue.

Examinations

26. 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 Skills (CS), Step 2 Clinical Knowledge (CK) and Step 3 are required to qualify for a physician license. PTL applicants were required to pass USMLE Step 1, 2CK, and 2CS, but due to the COVID-19 pandemic and the USMLE's suspension of Step 2CS, the Board temporarily does not require passage of Step 2CS to obtain a PTL. Applicants may take and pass both parts of the Licentiate of the Medical Council of Canada (LMCC) in Canada to qualify for a physician 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.

27. What are pass rates for first time vs. retakes in the past 4 fiscal years? 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:

	2016	2017	2018	2019
Step 1	96%	96%	96%	97%
Step 2 CK	97%	96%	97%	98%
Step 2 CS	97%	96%	95%	95%
Step 3	97%	98%	98%	98%

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

	2016	2017	2018	2019
Step 1	64%	67%	67%	66%
Step 2 CK	71%	66%	66%	72%
Step 2 CS	85%	90%	87%	87%
Step 3	70%	73%	73%	74%

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

	2016	2017	2018	2019
Step 1	78%	78%	80%	82%
Step 2 CK	80%	81%	83%	87%
Step 2 CS	82%	82%	75%	77%
Step 3	85%	88%	90%	92%

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

	2016	2017	2018	2019
Step 1	39%	41%	44%	45%
Step 2 CK	53%	50%	52%	57%
Step 2 CS	71%	72%	61%	66%
Step 3	53%	60%	59%	64%

28. 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 2 CS and Step 3 are offered only in the US, and are offered as computer-based and patient-based testing. Due to the coronavirus pandemic, the USMLE suspended Step 2 CS until at least June 1, 2021.

29. 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

30. 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.

31. 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.

32. 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

33. 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.

Effective January 1, 2019, pursuant to AB 2487 (McCarty, Chapter 301, Statutes of 2018), all physicians licensed after January 1, 2019, may opt to complete a one-time mandatory 12-hour CME course on the treatment and management of opiate-dependent patients, which must include eight hours of training in buprenorphine treatment, or other similar medicinal treatment, for opioid use disorders, in lieu of the existing required CME on pain management under BPC section 2190.5. Physicians are required to take one of these CME courses.

Three bills passed since the last sunset review authorized optional CME courses. AB 1340 (Maienschein, Chapter 759, Statutes of 2017) allows for an optional CME course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues and exposure to trauma in children and young adults and their appropriate care and treatment. AB 1791 (Waldron and Gipson, Chapter 122, Statutes of 2018) allows for an optional CME course in integrating HIV/AIDS pre-exposure prophylaxis and post-exposure prophylaxis medication maintenance and counseling in primary care settings. AB 845 (Maienschein, Chapter 220, Statutes of 2019) allows for an optional CME course in maternal mental health.

As a result of AB 241 (Kamlager-Dove, Chapter 417, Statutes of 2019), beginning January 1, 2022, all CME courses for physicians are required to contain curriculum that includes the understanding of implicit bias. A CME course dedicated solely to research or other issues that does not have a direct patient care component or a course offered by a CME provider that is not located in California is not required to contain curriculum that includes implicit bias in the practice of medicine. Associations that accredit CME courses must ensure compliance with this requirement starting January 1, 2023.

At the time of the last sunset review, the Board was auditing one percent of the licensee population annually for CME compliance. In October 2018, the Board increased these audits to ten percent of the licensee population annually. However, the Board was not able to maintain this high volume of audits on a monthly basis and therefore will be reducing the audit percentage to five percent. Due to COVID-19, the Board's CME audit program is on hold while the Board's resources are directed to essential services and DCA Waiver DCA-20-53 defers CE requirements for specified licensees.

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 been in contact with the Accreditation Council for Continuing Medical Education (ACCME) on their data reporting system that would allow medical licensing regulatory agencies to access CME documents electronically.

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 10 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. Due to COVID-19, the Board's CME audit program is on hold while the Board's resources are directed to essential services and DCA Waiver DCA-20-53 defers CE requirements for specified licensees. Once audits resumes, the Board plans to randomly audit approximately five percent of the total number of renewing physicians per year to better manage workload.

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 15,484 CME audits from FY 2016/2017 through FY 2019/2020. Of the 15,484 audits, there were 1,606 failures, which is a ten (10) percent failure rate.

Fiscal Year	Selected	Failed	Failed %
16/17	1,365	196	14%
17/18	1,371	178	13%
18/19	9,456	756	8%
19/20	3.292	476	14%

e. What is the board's 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.

Fictitious Name Permits

The Board issues 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 – Fictitious Name Permit

		FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
8008 – Fictitious Name Permit	Active	12,131	12,504	12,812	12,981
	Delinquent	5,502	5,555	4,870	4,744
	Out of State	0	0	0	0
	Out of Country	0	0	0	0

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

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control	Within Board control*	Complete Apps	Incom-plete Apps	combined, If unable to separate out
FY 16/17	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1331	1221	200	1221	unk[a]	-	-	33	87	55
	(Renewal)	5058	n/a	n/a	5058	-	-	-	-	-	-
FY 17/18	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1505	1350	0	1350	unk[a]	-	-	29	60	43
	(Renewal)	5703	5703	n/a	5703	-	-	-	-	-	-

Table 7a. Licensing Data by Type – Fictitious Name Permit											
						Pending Applications			Cycle Times		
	Application Type	Received	Approved	Closed	Issued	Total (Close of FY)	Outside Board control	Within Board control*	Complete Apps	Incom-plete Apps	combined, If unable to separate out
FY 18/19	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1490	1344	0	1344	unk[a]	-	-	29	98	52
	(Renewal)	5364	5364	n/a	5364	-	-	-	-	-	-
FY 19/20	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1398	1255	0	1255	215	-	-	37	98	55
	(Renewal)	5409	5409	n/a	5409	-	-	-	-	-	-
[a] Data not captured in previous years.											

Table 7b. Total Licensing Data – Fictitious Name Permit				
	FY 16/17	FY 17/18	FY 18/19	FY 19/20
Initial Licensing Data:				
Initial License/Initial Exam Applications Received	1,331	1,505	1,490	1,398
Initial License/Initial Exam Applications Approved	1,221	1,350	1,344	1,255
Initial License/Initial Exam Applications Closed	200	154	221	148
License Issued	1,221	1,350	1,344	1,255
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	N/A	N/A	N/A	215
Pending Applications (outside of board control)	N/A	N/A	N/A	N/A
Pending Applications (within the board control)	N/A	N/A	N/A	N/A
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	55	43	52	55
Average Days to Application Approval (incomplete applications)	87	60	98	98
Average Days to Application Approval (complete applications)	33	29	29	37
License Renewal Data:				
License Renewed	5,058	5,703	5,364	5,409
Note: The values in Table 7b are the aggregates of values contained in Table 7a.				

The Board is continuously striving to review and approve FNP applications within the set timeframes to ensure compliance with the law. Staff ensures that this occurs by reviewing policies and procedures within the Program for best practices and efficiencies.

Verification of Applicant Information – Criminal History Information/Prior Disciplinary Action
The Board checks the license status and enforcement actions of all FNP applicants, including every medical corporation shareholder, before issuing the FNP. If a licensee has an open or pending enforcement action, the enforcement staff is notified of the pending FNP application. Further, if the licensee does not have a renewed and current California medical license, the FNP application is denied. All FNP physician applicants are fingerprinted during the initial physician license application process. FNP permits are ineligible for renewal without a current and renewed physician license.

FNP applicants must disclose the type of business that they are applying for, such as a professional medical corporation, individual, partnership, or medical group. For medical corporations, the applicant must provide a copy of the endorsed Articles of Incorporation. The FNP applicant's medical corporation is verified against the Secretary of State website for "Active" status. This confirms that the medical corporation is in good standing.

Primary Source Verification
Board staff verifies with the Secretary of State that the medical corporation in is good standing and meeting the requirements of BPC Section 2406.

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 meet the eligibility requirements for issuance of an SFP: must be clearly outstanding in a specific field of medicine or surgery and offered a full-time academic appointment at the level of full professor, or, a great need exists and has been offered a full-time academic appointment at the level of associate professor. This SFP authorizes the holder to practice medicine only within the facilities of the applicable medical school and any formally-affiliated institutions. Effective January 1, 2021, with the passage of AB 2273 (Bloom, Chapter 80, Statutes of 2020), AMCs, as defined under BPC section 2168(a)(2), may also sponsor an academically eminent international physician for an SFP to practice medicine in the AMC and its affiliated institutions.

All applicants for an SFP are subject to the fingerprint requirement as an applicant for a physician license. Primary source document requirements are the same for an SFP as an applicant for a physician 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 and two Board members (one physician member and one public member) for a total of thirteen members. As of January 1, 2021, AB 2273 also authorizes one individual selected pursuant to BPC section 2168.1(c)(3) to represent AMCs on the SFPRC.

California currently has eleven allopathic medical schools 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

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 physician'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.

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 physician 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.

The Board sent a survey in March 2016 to nine of the ten medical schools in California (at the time of the survey only nine of the medical schools had a representative on the SFPRC) asking for input regarding whether the SFP is still needed. The survey results were presented at the May 2016 Licensing Committee meeting and at the September 2016 SFPRC Meeting. The SFPRC Members determined there were no statutory changes needed for the SFP.

Table 6. Licensee Population – Special Faculty Permit					
		FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
8011 – Special Faculty Permit	Active	25	25	23	24
	Delinquent	0	2	3	3

Table 7a. Licensing Data by Type – Special Faculty Permit											
						Pending Applications			Cycle Times		
	Application Type	Received	Approved	Closed	Issued	Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incom-plete Apps	combined, If unable to separate out
FY 16/17	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	3	2	0	2	unk[a]	-	-	n/a	293	293
	(Renewal)	8	n/a	n/a	8	-	-	-	-	-	-
FY 17/18	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	4	2	0	2	unk[a]	-	-	n/a	285	285
	(Renewal)	7	7	n/a	7	-	-	-	-	-	-
FY 18/19	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1	2	1	2	unk[a]	-	-	n/a	223	223
	(Renewal)	12	12	n/a	12	-	-	-	-	-	-
FY 19/20	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	4	3	1	3	3	-	-	n/a	161	161
	(Renewal)	7	7	n/a	7	-	-	-	-	-	-

* Optional. List if tracked by the board.
[a] Data not captured in previous years.

Table 7b. Total Licensing Data – Special Faculty Permit				
	FY 16/17	FY 17/18	FY 18/19	FY 19/20
Initial Licensing Data:				
Initial License/Initial Exam Applications Received	3	4	1	4
Initial License/Initial Exam Applications Approved	2	2	2	3
Initial License/Initial Exam Applications Closed	0	0	1	1
License Issued	2	2	2	3
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	N/A	N/A	N/A	3
Pending Applications (outside of board control)	N/A	N/A	N/A	N/A
Pending Applications (within the board control)	N/A	N/A	N/A	N/A
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	293	285	223	161
Average Days to Application Approval (incomplete applications)	293	285	223	161

Table 7b. Total Licensing Data – Special Faculty Permit				
Average Days to Application Approval (complete applications)	N/A	N/A	N/A	N/A
License Renewal Data:				
License Renewed	8	7	12	7
Note: The values in Table 7b are the aggregates of values contained in Table 7a.				

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 may sponsor an international physician to participate in a visiting fellowship at the sponsoring medical school. 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.

Primary source document requirements are the same as an applicant for a physician license. In addition, a section 2111 applicant is subject to the same fingerprint requirement as an applicant for a physician license. Section 2111 registration holders do not have CME requirements.

Effective January 1, 2021, the dean or chief medical officer of an AMC may also sponsor an international physician to participate in the professional activities of the AMC.

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.

Primary source document requirements are the same as an applicant for a physician license. In addition, a section 2112 applicant is subject to the same fingerprint requirement as an applicant for a physician 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 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.

Primary source document requirements are the same as an applicant for a physician license. In addition, a section 2113 applicant is subject to the same fingerprint requirement as an applicant for a physician license. Section 2113 registration holders do not have CME requirements.

Effective January 1, 2021, the dean or chief medical officer of an AMC may also sponsor an international physician who is licensed in their country for a full-time faculty position.

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 – Special Programs (Individual)

		FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
8009 – Special Programs (Individual)	Active	296	291	276	244
	Delinquent	10	10	6	13
	Out of State	0	0	0	0
	Out of Country	0	0	0	0

Table 7a. Licensing Data by Type – Special Programs (Individual)

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 16/17	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	26	49	0	49	unk[a]	-	-	33	125	113
	(Renewal)	92	n/a	n/a	92	-	-	-	-	-	-
FY 17/18	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	57	56	1	56	unk[a]	-	-	32	107	82
	(Renewal)	90	90	n/a	90	-	-	-	-	-	-
FY 18/19	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	47	47	1	47	unk[a]	-	-	21	135	103
	(Renewal)	96	96	n/a	96	-	-	-	-	-	-
FY 19/20	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	55	51	21	51	17	-	-	24	93	85
	(Renewal)	93	93	n/a	93	-	-	-	-	-	-

* Optional. List if tracked by the board.
[a] Data not captured in previous years.

Table 7b. Total Licensing Data – Special Programs (Individual)

	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Initial Licensing Data:				
Initial License/Initial Exam Applications Received	26	57	47	55
Initial License/Initial Exam Applications Approved	49	56	47	51
Initial License/Initial Exam Applications Closed	0	1	1	21
License Issued	49	56	47	51
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	N/A	N/A	N/A	17
Pending Applications (outside of board control)*	N/A	N/A	N/A	N/A
Pending Applications (within the board control)*	N/A	N/A	N/A	N/A
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	113	82	103	85
Average Days to Application Approval (incomplete applications)*	125	107	135	93
Average Days to Application Approval (complete applications)*	33	32	21	24
License Renewal Data:				
License Renewed	92	90	96	93

Note: The values in Table 7b are the aggregates of values contained in Table 7a.
* 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. 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
- American Osteopathic Association/Healthcare Facilities Accreditation Program (HFAP) - accredited July 19, 2013

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 are approximately 140 OSS that have lost their accredited status. In accordance with HSC section 1248.55(c)(1), these settings are authorized to continue to operate for a period of 12 months in order to seek accreditation through an approved accreditation agency. During the 12-month period, these settings must continue to follow all incident reporting processes as before, and will be reporting directly to the Board until new accreditation is acquired.

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.

Section 5

Enforcement Program

- Performance Targets/Expectations
- Cite and Fine
- Cost Recovery and Restitutions

Enforcement Program

34. 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?

Performance Targets/Expectations

The Board's enforcement functions are at the core of the Board's mission of consumer protection. 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 in conjunction with the HQIU and the AGO to ensure investigations are completed timely and administrative actions are moved through the disciplinary process as expeditiously as possible. The Board's goal is to complete 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. Due to an increase in the number of complaints received, staff vacancies affecting both desk and field investigation workloads, and complexity of the cases, the overall average days to investigate a complaint was 202 days in FY 2019/2020. This is higher than the figure of 170 days in FY18/19 but it should be noted, these past two years the Board has recorded all-time highs in receipt of new investigations. The Board has maintained the same staffing numbers and as of first quarter 2020, has made a number of changes that should reduce this timeframe for the next fiscal year.

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. 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.

The Board has been proactive in addressing problems in overprescribing. In 2016, the Board partnered with CDPH to obtain public death certificates for individuals who overdosed. This material was gathered and sorted to evaluate if a physician may have played a role in the overprescribing of medications that led to the overdose. The Board will be addressing more current data in the near future to determine if a continuing overprescribing problem exists.

35. 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 continued to rise. In FY15/16 the Board received 8,679 complaints. In FY18/19 11,407 complaints were received and in FY19/20 10,868. In FY19/20 the number of incoming complaints were on track to hit a new high until the COVID-19 pandemic caused a state-wide shutdown in mid- March 2020. The number of complaints dropped off significantly during the 4th quarter of FY19/20 and the year-end number for new complaints was down approximately 500 from the previous year. As the state reopens, the Board is seeing a return to the pre-COVID-19 number of incoming complaints.

Fiscal Year	Complaints Received
15/16	8,679
16/17	9,619
17/18	10,888
18/19	11,407
19/20	10,868

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. In early 2020, there were over 500 cases awaiting this type of review. As of July 2020, this backlog has been eliminated and the cases are being followed up on by CCU staff within 30 days of assignment to a medical reviewer to assure timely resolution.

When a medical reviewer determines a complaint warrants referral for further investigation, CCU transfers the complaint to the 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 DAG from the AGO under a system called VE. The system allowed for the DAG to provide direction to the investigation performed by the investigator. As of 1/1/2019, VE was ended under a statutory change. Even with the removal of the VE provisions, the field's timeframe for investigating cases has increased from FY 16/17 467 days, FY 17/18 510 days, FY 18/19 547 and FY 19/20 572 days.

As a result of the COVID-19 situation, a number of processes have been changed and a majority of the Board's staff is teleworking. This has created challenges as the Board is not operating on a paperless platform. Workloads have shifted and staff is addressing the pending cases. Between January and June 2020, the CCU was successful in addressing and closing 19 percent of the pending cases in CCU. We have placed an emphasis on addressing the aged cases in CCU and in the CIO. Since January 2020, CCU has addressed 73 percent of the cases over one year of age. The number in January was 646 and it is now 176.

CIO has made 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. The entire CIO unit is teleworking as a result of COVID 19. CIO is the in-house investigation team of non-sworn investigators who investigate cases that include: physicians who have been 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.

Probation has been well under their timeframes in each reporting period for the past two years. 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 or a cease practice order, or referring the matter to the AGO for appropriate action.

In FY19/20, the Board hired a Chief Medical Consultant (CMC) to assist the Enforcement Program by providing an immediate and direct source for medical expertise. We plan 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, before an outside Medical Consultant is utilized. This should result in a reduction of costs for expert reviews by 85 to 90 percent. As such, the Board is seeking the approval to hire two additional part-time medical professionals to assist with this process. In addition, the CMC will be used to review expert submissions for cases that the Board would currently consider forwarding to the AGO for further action.

The Board has made a number of 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. The complaint forms were revised to allow for more specific information from the complainant. The form was also revised to include a release for the patient's records to allow for a quicker processing time of the complaint. The online forms were set up to mirror the paper forms and allow for the release(s) to be sent at the time of submission of the complaint. In 2019, the Board created a new brochure outlining the complaint process that is available to the public in print or on the website.

Performance barriers

The COVID-19 state of emergency has placed a spotlight on the barriers that the Board's paper-based complaint system presents. A loss of productivity and duplication of efforts is created due to the paper-based system as staff that is teleworking must make weekly trips into the office to print or scan information to work from home. For work with the HQIU, AGO, and experts, there is more reliance on email or the use of a cloud based system that allows for the sharing of confidential materials and for transmitting information, this shift to the cloud-based platform has provided a number of efficiencies and cost savings. The Board continues to encourage the use of email or the cloud-based system to reduce the use of paper.

The CMC has identified that it would be beneficial to provide a medical review of the cases earlier in the CCU process, before an outside Medical Consultant is utilized. This should result in a reduction of costs for expert reviews by 85 to 90 percent. As such, we are seeking the approval to hire two additional part-time medical professionals to assist with this process. In

addition, the CMC will be used to review expert submissions for cases that the Board would currently consider forwarding to the AGO for further action.

Improvement plans
As the number of complaints received has risen each year, the Board has diligently attempted to keep up with the workflow and timeframes with the same number of staff in the CCU and CIO units. The number of cases pending per staff are higher than desired. As a result, in early 2020, the distribution or assignment of cases by region was discontinued. It is anticipated that this change should provide a more equitable distribution of new cases and pending cases can be reallocated as warranted.

The staff is working with ISB to seek more options with our current platform with the goal in mind to move to a fully paperless complaint system. We plan to continue the use of email and the cloud platforms with our vendors and experts. We have also requested the creation of a portal so that hospitals and physicians can upload medical records to our system directly instead of sending us paper copies or discs which then require staff time to scan or upload to the various cases.

The increased emphasis on the medical review of the cases and evaluation of the expert opinions should create financial and time savings and allow the Board to target our prosecution costs more efficiently and effectively. It will also allow us to shorten the timeframes by having a medical evaluation of the case at hand on a timely basis.

If the additional positions are approved, the Board will include the use of more medical evaluation during the investigation process to determine if an investigation should proceed and to which degree the level of a possible violation may be, thereby determining if the case should be referred to the AGO or resolved by a Public Letter of Reprimand or cite and fine.

The Board believes that its ability to efficiently manage its cases would be improved if its regulatory tool kit was expanded to include powers typically available to similarly constituted boards in other jurisdictions. This includes a Physician and Surgeon Health and Wellness Program. Primary legislation constituting such a program has in fact already been enacted and the Board is in the process of finalizing the regulations in order to establish the program. In addition, the Board seeks the power to issue “Letters of Advice” (see Section 12 – New Issues, #6), noting that at least 20 other state medical boards have the power to issue such letters. This will enhance the ability of the Board to resolve certain cases quickly and efficiently, freeing up resources needed to resolve more difficult/serious cases.

Legislative enhancements/amendments

FY2019/2020
***Medical Expert Reviewers,* Budget Request Name: 1111-004-BCP-2019-GB**
To increase the hourly rates for expert reviewers. The rates increased from $150 to $300 for neurosurgery case review, $200 to $400 for neurosurgery testimony, and from $150 to $200 per hour for all other specialty case reviews, and $200 to $250 for all other specialties testimony.

***Increased Workload Related Health Care Practitioners and Unprofessional Conduct – Medical Board* (SB425), Budget Request Name: 1111-066-BCP-2020-GB**
Effective July 1, 2020, the CCU received one and a half positions (1.0 AGPA and 0.5 MST) and the HQIU received additional investigators to assist with the anticipated workload increase related to the 805.8 reporting requirements in SB 425.

Addition of 805.8 report requirement – As of January 1, 2020,
SB 425 (Hill), added section 805.8 to the BPC, and requires health facilities and entities to report allegations of sexual abuse or sexual misconduct made against licensed healthcare professionals to the appropriate licensing agency.

In accordance with the law, the patient allegation must be made in writing to the health facility or other entity to trigger the reporting requirements under the bill. It imposes a fine up to $100,000 per violation for willful failure to file the required report and specifies that any other failure to file the report is punishable by a fine not exceeding $50,000.

- **SB 425 also amended BPC section 800, subdivision (c)(1)**, by striking the requirement for the Board to provide a "comprehensive" summary of a licensee's central file upon the licensee's request, and instead requires the Board to simply provide a summary.

- **The bill also amended BPC section 2234, subdivision (g)** to include in the definition of unprofessional conduct the failure of a licensee, in the absence of good cause, to attend and participate in an interview with the Board. Prior to this amendment, the law required the licensee's failure to attend and participate in an interview with the Board to be repeated to fall within the definition of unprofessional conduct.

- **With the passing of SB 425, probationary license information will stay on the Board's website for 10 years.** Prior to this change, probationary license information came off the licensee's online profile as soon as the period of probation ended.

Table 9a, b, and c. Enforcement Statistics
Physicians and Surgeons
(including Special Faculty Permits)

	FY 2017/2018	FY 2018/2019	FY 2019/2020
COMPLAINT			
Intake			
Received	10888	11407	10868
Closed	0	0	0
Referred to INV	10329	10883	10949
Average Time to Close	0 days	0 days	0 days
Pending (close of FY)	328	402	219
Source of Complaint			
Public	6632	7039	6526
Licensee/Professional Groups	372	340	308
Governmental Agencies	1379	1389	1231
Conviction / Arrest	274	357	292
Other	2231	2282	2511
Conviction / Arrest			
CONV Received	274	357	292
CONV Closed	0	0	0
Referred to INV	268	340	309
Average Time to Close	0 days	0 days	0 days
CONV Pending (close of FY)	5	18	2
LICENSE DENIAL			
License Applications Denied	9	6	3
Statements of Issues (SOI) Filed	22	23	13
SOIs Withdrawn	3	5	1
SOIs Dismissed	0	0	0
SOIs Declined	0	1	1
Average Days SOI	126 days	127 days	134 days
ACCUSATION			
Accusations Filed	381	396	308
Accusations Withdrawn	9	14	16
Accusations Dismissed	7	13	3
Accusations Declined	7	28	63
Average Days Accusations	713 days	656 days	752 days
Pending (close of FY)	64	114	125
DISCIPLINE			
Disciplinary Actions			
Proposed(PD)/Default (DD) Decisions	64 PD 38 DD 102 Total	63 PD 40 DD 103 Total	44 PD 22 DD 66 Total
Stipulations	291	320	323
Average Days to Complete	1045 days	974 days	1020 days
AG Cases Initiated	567	693	613
AG Cases Pending (close of FY)	481	471	459
Disciplinary Outcomes			
Revocation	43	49	28

Table 9a, b, and c. Enforcement Statistics
Physicians and Surgeons
(including Special Faculty Permits)

	FY 2017/2018	FY 2018/2019	FY 2019/2020
Surrender	87	85	89
Suspension	0	0	0
Probation with Suspension	5	1	4
Probation	122	153	130
Probationary License Issued	16	22	22
Public Reprimands	74	86	87
Other	0	0	0
PROBATION			
New Probationers	143	176	178
Probations Successfully Completed	68	91	103
Probationers (close of FY)	606 In State 37 Out of State 643 Total	582 In State 93 Out of State 675 Total	528 In State 68 Out of State 596 Total
Petitions to Revoke Probation Filed	37	32	30
Probations Revoked	16	11	7
Probations Surrendered	11	10	7
Probation Extended with Suspension	0	1	0
Probation Extended	17	5	14
Public Reprimands	0	0	1
Petitions to Revoke Probation Withdrawn	0	4	1
Petitions to Revoke Probation Dismissed	0	0	0
Probations Modified	1	1	5
Probations Terminated	16	30	32
Probationers Subject to Drug Testing	212	225	228
Drug Tests Ordered	8153	7778	7359
Positive Drug Tests	666[1]	772[1]	759[1]
Petition for Reinstatement Granted	5	6	9

[1] These totals include positive tests for over-the-counter, non-prohibited drugs like Dextromethorphan; alcohol positives from participants who are not ordered to abstain from alcohol; naltrexone or other drugs lawfully prescribed; and instances where there is alcohol in the urine, but not the metabolite for alcohol (which does not indicate consumption but a medical condition). Positive tests that were violations of a probationers' order were as follows: FY 2017/2018 – 14; FY 2018/2019 – 7; and FY 2019/2020 – 9.

DIVERSION – Not Applicable			
INVESTIGATION			
All Investigations			
First Assigned	10596	11223	11258
Closed	9527	9910	13199
Average days to close	222 days	170 days	202 days
Pending (close of FY)	6320	7402	5994
Desk Investigations			
Closed	7539	7768	11078
Average days to close	104 days	167 days	166 days
Pending (close of FY)	4112	5025	3809
Non-Sworn Investigation			

Table 9a, b, and c. Enforcement Statistics
Physicians and Surgeons
(including Special Faculty Permits)

	FY 2017/2018	FY 2018/2019	FY 2019/2020
Closed	307	477	384
Average days to close	315 days	235 days	179 days
Pending (close of FY)	287	216	273
Sworn Investigation			
Closed	1107	1272	1305
Average days to close	509 days	548 days	548 days
Pending (close of FY)	1921	2161	1912
COMPLIANCE ACTION			
ISO & TRO Issued	ISO=39 TRO=0 Total=39	ISO=22 TRO=0 Total=22	ISO=14 TRO=0 TOTAL=14
PC 23 Orders Granted/Issued	15	2	7
Court Orders	3	10	3
Other Suspension Orders	38	46	32
Public Letter of Reprimand[2]	59	49	20
Cease & Desist/Warning	0	0	0
Referred for Diversion	n/a	n/a	n/a
Compel Examination (Filed)	24	17	30
CITATION AND FINE			
Citations Issued	150	158	62
Average Days to Complete	219 days	201 days	371 days
Amount of Fines Assessed	$126,050	$134,500	$47,800
Reduced, Withdrawn, Dismissed	$2,050 reduced; $29,800 dismissed; $24,000 withdrawn; Total $55,850	$1,250 reduced; $45,800 dismissed; $84,550 withdrawn, Total $131,600	$350 reduced; $3,550 dismissed; $5,400 withdrawn; Total $9,300
Amount Collected	$66,950	$80,950	$27,000
CRIMINAL ACTION			
Referred for Criminal Prosecution	36	39	36

[2] These public letters of reprimand are issued prior to an accusation being filed, but are considered disciplinary action and are issued pursuant to BPC section 2233.

Table 10. Enforcement Aging
Physicians and Surgeons
(including Special Faculty Permits)

	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
0 - 1 Year	42	13	62	37	154	11%
1 - 2 Years	81	43	61	66	251	19%
2 - 3 Years	86	80	92	84	342	25%
3 - 4 Years	118	94	108	88	408	30%
Over 4 Years	42	27	61	70	200	15%
Total Cases Closed	369	257	384	338	1348	100%
Investigations (Average %)						
Closed Within:						
90 Days	4629	5158	3077	5257	18121	42%
91 - 180 Days	2361	1665	2455	2407	8888	21%
181 - 1 Year	2026	1382	2672	3162	9424	22%
1 - 2 Years	846	833	1192	1829	4700	11%
2 - 3 Years	300	464	479	524	1767	4%
Over 3 Years	11	25	35	20	91	<1%
Total Cases Closed	10173	9527	9910	13199	42809	100%

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

The number of disciplinary actions have been relatively stable over the three year period. In FY19/20 there was a decrease in the number of default decisions, down to 66 versus 102 and 103 in the previous two years. The number of stipulated settlements were up, 323 versus 291 and 320. The number of revocations were down in FY 19/20 when compared to the other two years but no administrative hearings were held from mid-March through the end of the fiscal year, June 30, 2020, due to COVID-19.

37. How are cases prioritized? 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.

The Board's complaint priorities are outlined in BPC section 2220.05 in order 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 therefor;
- 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; and
- 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.

38. 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?

There are a number of 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 the Board receives 100 percent of the reports.

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 if not covered by professional liability insurance. In general, the Board has received these reports on a timely basis.

The average dollar settlements for the past three years has been:

FY 17/18 – $671,365.39
FY 18/19 – $760,911.79
FY 19/20 – $543,831.41

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.

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 does not believe that it is receiving reports from coroners in accordance with this statute as during the FY19/20 we received one report.

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 his or her 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. The Board relies on outreach to assure we are receiving this information.

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. 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 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 health care facility to file a report within 15 days after the peer review body makes a final decision or recommendation to take disciplinary action which must be reported 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 believes entities are not submitting 805.01 reports as required.

BPC section 805.8 law 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 website.

BPC section 2216.3 was added into statute on January 1, 2014, requiring accredited 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 became familiar with the law and gained an understanding of the types of events that should be reported. Many OSS were closed due to COVID-19 from March 2020 through June 2020.

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, whether or not they were "scheduled," have to be reported to the Board.

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

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 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, in an attempt to 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 CE 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 Board's executive director for review and consideration.

The Board's executive director (and/or deputy director and/or chief of enforcement) reviews the settlement recommendation 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. Both the prehearing settlement conference and the mandatory settlement conference have the assistance of an 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 then has the ability to adopt the settlement as written, request changes to the settlement, or request the matter go to hearing. In the process to settle a case, public protection is the first priority, and must be weighed with rehabilitation of the physician. When making a decision 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 an appropriate level of public protection and rehabilitation. Settling cases by stipulations that are agreed to by both sides facilitates consumer protection by rehabilitating the physician in a more expeditious manner. By entering into a stipulation, it puts the individual on probation or restriction sooner and the public is able to see the action taken by the Board more timely 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. 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?

Fiscal Year	16/17	17/18	18/19	19/20
Pre-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Settlement	37	95	90	67
*Pre-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Hearing	N/A	N/A	N/A	N/A

*The Board only has the ability to settle a pre-accusation/petition to revoke probation/ statement of issues matter. It cannot have a hearing on a matter prior to the filing of an accusation/petition to revoke probation/statement of issues. In addition, the Board only has the authority to offer a public letter of reprimand (BPC sections 2233 and 2221.05), a probationary license to an applicant (BPC section 2221) or a surrender as a disposition of a pre-accusation/petition to revoke probation/statement of issues matter. In all other cases, an accusation/petition to revoke probation/statement of issues must be filed and it must follow the Administrative Procedure Act. Therefore, there are no cases that went to hearing for a pre-accusation/petition to revoke probation/statement of issues case.

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?

Fiscal Year	16/17	17/18	18/19	19/20
Post-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Settlement	322	284	290	281
Post-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Hearing	87	47	76	44
*Post-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Default Decision	35	38	40	22

*Default decisions are included as they represent another method through which a disciplinary action can be taken and should be considered in the types of case resolutions.

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

Fiscal Year	16/17	17/18	18/19	19/20
Percentage of Cases resulting in a Settlement	75%	82%	77%	84%
Percentage of Cases resulting in a Hearing	18%	10%	15%	11%
*Percentage of Cases resulting in a Default Decision	7%	8%	8%	5%

*Default decisions are included as they represent another method through which a disciplinary action can be taken and should be considered in the types of case resolutions

40. 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 his or her 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 17/18 Physicians and Surgeons – 150
FY 18/19 Physicians and Surgeons – 213
FY 19/20 Physicians and Surgeons – 176

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

The Board continues to investigate unlicensed activity through the efforts of investigators from HQIU. 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	17/18	18/19	19/20
Referred for Criminal Prosecution*	38	39	37
Felony Convictions	3	3	3
Misdemeanor Convictions	1	1	3
Referred to Administrative Action for Aiding and Abetting Unlicensed Practice of Medicine	7	13	22

* 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	17/18	18/19	19/20
Citations Issued for BPC section 2052 and 2054	12	8	2

Cite and Fine

42. 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 his or her 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 FY2017/18 through FY2019/20, the Board has issued one citation with a $5,000 fine.

The Board is currently seeking a rule revision that would eliminate listing the specific violations for which a cite and fine can be issued. The new language would be more inclusive and allow for greater flexibility in issuing cite and fines to physicians and surgeons.

43. 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 the course of 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, in order to satisfy the citation. In a variety of situations, the Board is able to address an identified deficiency with an educational component and remediate the physician without the expense of an administrative action and hearing.

44. 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?

Informal Conferences or Administrative Procedure Act Appeals
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
17/18	52	6
18/19	75	9
19/20	16	4

45. What are the 5 most common violations for which citations are issued?

Common Citation and Fine Violations
This chart identifies the Board's top five most common violations for which citations are issued. The top five are all violations of the BPC.

	Top Five Violations Charged
1	Section 2266 – Failure to Maintain Adequate and Accurate Medical Records
2	Section 802.1 – Failure to Report Criminal Convictions
3	Section 2021(b) – Failure to Report Change of Address
4	Section 2052 – Unlicensed Practice of Medicine
5	Section 2264 – Aiding and Abetting Unlicensed Practice of Medicine

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

Citation and Fine Average Amounts – Pre- and Post-Appeal
The Board is utilizing its citation authority to gain compliance with existing statutes or to improve the physician's skills by requiring the completion of educational courses in order to rectify the citation. During the FY 18/19 and FY 19/20, there were 18 informal conferences requested. Eight citation recommendations were affirmed, nine were withdrawn, and one is pending at the AGO.

Fiscal Year	Pre-Appeal Average	Post-Appeal Average
16/17	$1070	$350
17/18	$900	$675
18/19	$859	$1392
19/20	$798	$925

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

Franchise Tax Board Intercept Program
The Board utilizes a number of 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

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

Effective January 1, 2006, the Legislature eliminated the Board's ability to recover costs for administrative prosecutions against physicians. However, if a physician's license was revoked or surrendered through the administrative process and this individual petitions to reinstate their license, some ALJs will order cost recovery for unpaid balances incurred prior to January 1, 2006, if the petition for reinstatement is granted.

49. 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 his or her license, some ALJs will order cost recovery for the outstanding probation monitoring costs upon reinstatement, if reinstatement of the license occurs.

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.

Fiscal Year	16/17	17/18	18/19	19/20
Criminal Cost Recovery Ordered	$52,217	$6,325	$0	$0
Criminal Cost Recovery Received	$5,727	$0	$0	$0

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

In 2006, the Legislature removed the Board's authority to seek cost recovery against physicians.

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

Because the legislature eliminated the Board's ability to recover investigation costs in physician cases, those physicians whose licenses are revoked, surrendered, or ordered to serve probation do not pay any cost recovery costs.

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.

52. 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.

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.

Table 11. Cost Recovery (dollars in thousands)

	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Total Enforcement Expenditures[1]	$45,726,767	$44,233,288	$45,379,703	$43,407,370
Potential Cases for Recovery[2]	n/a	n/a	n/a	n/a
Cases Recovery Ordered	0	0	1	1
Amount of Cost Recovery Ordered	$0	$0	$8,155	$5,000
Amount Collected	$2,625	$500	$12,055	$11,300

[1] Includes Health Quality Investigation expenditures of $17,218,939 in FY 16/17, $21,139,146 in FY 17/18, $19,848,961 in FY 18/19 and $21,524,727 in FY 19/20 and Pro Rata. Excludes both scheduled and unscheduled reimbursements.

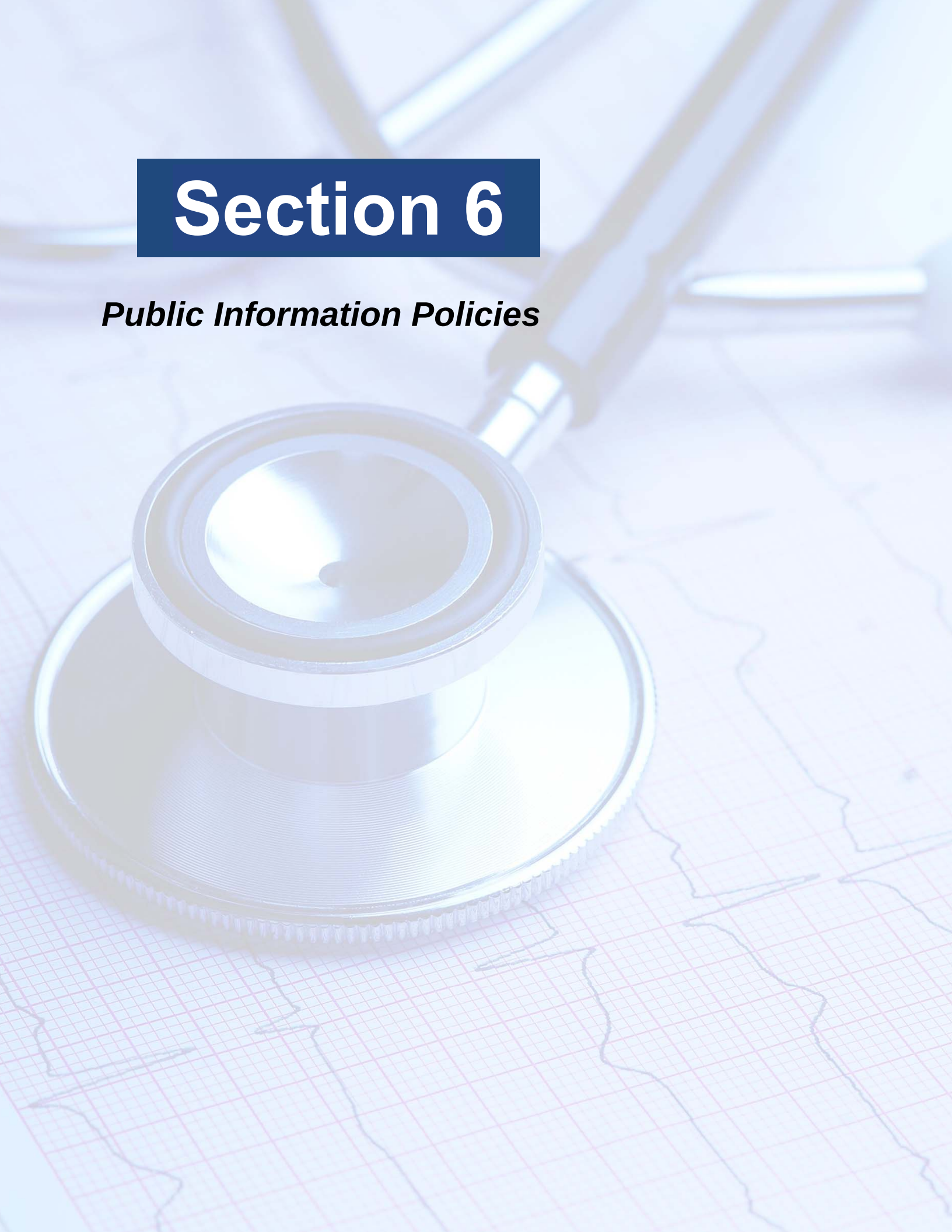
[2] "Potential Cases for Recovery" are those cases in which the Board takes disciplinary action based on violation of the license practice act. Since the Board cannot order investigative cost recovery, this is not applicable.

Table 12. Restitution (dollars in thousands)

	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Amount Ordered	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

Section 6

Public Information Policies



Public Information Policies

53. 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 in innovative ways 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, subscription list, 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 Board and committee draft minutes are posted on the Board's website as an agenda item for the next Board/committee meeting, and as such, are posted at least 10 days prior to the Board/committee meeting. Once the Board/committee formally approves and adopts the minutes, the Board posts the final minutes on the Board's website where they remain 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 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 has proven to be a valuable aspect of the Board's outreach program. The Board uses its Twitter, Facebook, and YouTube accounts to post information pertaining Board meetings, press releases, laws and regulations, CME opportunities, public health updates, and disciplinary actions that 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.

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 a new and innovative way to bring information about the Board to the public. Podcasts have been produced on such topics as the Board's Death Certificate Project, Changes in PTLs, Legislation and Regulations, and several other topics. The Board will continue to find innovative ways of communicating with stakeholders, while leveraging existing technology to inform the public.

In summer 2018, the Board successfully launched its License Alert Mobile App for Apple iOS devices, creating a new method to inform licensees and consumers about Board activities. 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 12,000 downloads. The Board also uses the app to alert the public about upcoming Board meetings, agenda posting, laws and regulations, and news.

54. 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?

During this reporting period, the Board webcasted most of its quarterly/committee meetings. When DCA staff is not available to webcast a meeting, Board staff will record the meeting and subsequently post it on the Board's YouTube channel. Webcasts remain on the Board's website indefinitely. The public is able to participate in-person or remotely by phone.

With the emergence of COVID-19, the Board began holding its quarterly Board meetings online via the WebEx platform, beginning with its May 2020 meeting. The public is able to participate in these meeting through the meeting software.

55. Does the board establish an annual meeting calendar, and post it on the board's web site?

The Board approves their meeting calendar for the following year during their April/May Board meeting and posts the dates on the Board's website. Due to committee meetings held only on an as-needed basis, they are not set for the entire year. The Board posts the committee meeting dates as soon as a date is selected.

56. 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 *Web Site Posting of Accusations and Disciplinary Actions* (May 21, 2010)?

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

With regard to the first question, the Board exceeds the DCA recommended minimum standards for Consumer Complaint Disclosure. With regard to the second question, the Board posts accusations and disciplinary actions consistent with DCA's Web Site 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 phone number and an email address for consumer inquiries.

57. 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 for acts of serious misconduct. 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 time of licensure within the last three years.
- If a physician has been placed on probation for serious acts of misconduct as outlined in BPC section 2228.1 including 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.
- Any hospital disciplinary actions that resulted in the termination or revocation of the physician's privileges to provide health care 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 5-year period if the physician practices in a high-risk specialty (obstetrics, orthopedic surgery, plastic surgery and neurological surgery).

- Three or more in a 5-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 provides the following voluntary survey information as 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.

58. 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 held a first-of-its-kind Consumer Interested Parties Meeting at the close of its January 2019 quarterly Board meeting. The meeting brought Board members, Board staff, patients, and consumer advocates together to discuss the Board and its enforcement process, share concerns, and collaborate on ways to improve consumer protection. The Board acquired helpful information from the meeting and 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 launch of the Board's mobile app for Apple iOS devices greatly enhanced the Board's mission of consumer protection and reached nearly 12,000 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. In addition, the Board has a Public Outreach, Education and Wellness Committee that discusses and makes recommendations on needed outreach and education. 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 made an effort to do as many presentations as possible. The Board has turned to social media to perform outreach. The Board's quarterly newsletter features a notice offering a Board presenter to both public and licensee groups.

The Board made numerous presentations to physician groups regarding the mandatory use of CURES, changes to the postgraduate training requirements, and opioid misuse and abuse utilizing the Board's *Guidelines for Prescribing Controlled Substances*. The Board also provides education to licensee groups/organizations on the Board's complaint and disciplinary process and provides information about the Board's statutes and regulations. Consumer education presentations include information on how to verify a physician's license and how to file a complaint with the Board.

Brochures and publications are available on the Board's website and provided at community outreach events (all can be easily downloaded and printed locally). For events that staff are unable to participate in, the Board supplies brochures to the event organizers for distribution.

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

Licensing Education Outreach allows Board staff to work directly with postgraduate program directors and deans to assist them in understanding the licensure laws and the issues their "interns/residents" might face during the licensing process. The Board held several webinars and performed outreach at various medical schools to prepare medical students for the changes to postgraduate training requirements. In addition, Board staff works one-on-one with medical residents to explain the licensing process and to inform them what documents are needed for licensure. This allows students and residents to meet personally with Board staff, to

answer questions they may have, and review their documents before they submit an application. This saves the Board both time and labor, and avoids the rush of last-minute applications for licensure, which can create a situation that delays licensing due to the overwhelming volume of applications received by the Board at one time. When able to, Board staff attends new medical student and postgraduate trainee orientation sessions. The intent is to provide information about the Board and to answer questions about the licensing process and other matters.

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 is able to 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.

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 w*ebsite* 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 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
- 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, and update the physician survey.

The website also includes 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 the last fiscal year, the Board had almost two million hits to its website.

Fiscal Year	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Website Hits	1,874,869	1,944,184	2,089,009	1,994,439

Section 7

Online Practice Issues

Online Practice Issues

59. 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?

The Board actively investigates complaints regarding inappropriate online practice and telehealth. These types of complaints follow the same investigative and prosecutorial process as all other complaints received by the Board. The Board has seen an increase in the number of complaints regarding the use of telehealth, including the online aspect of telehealth.

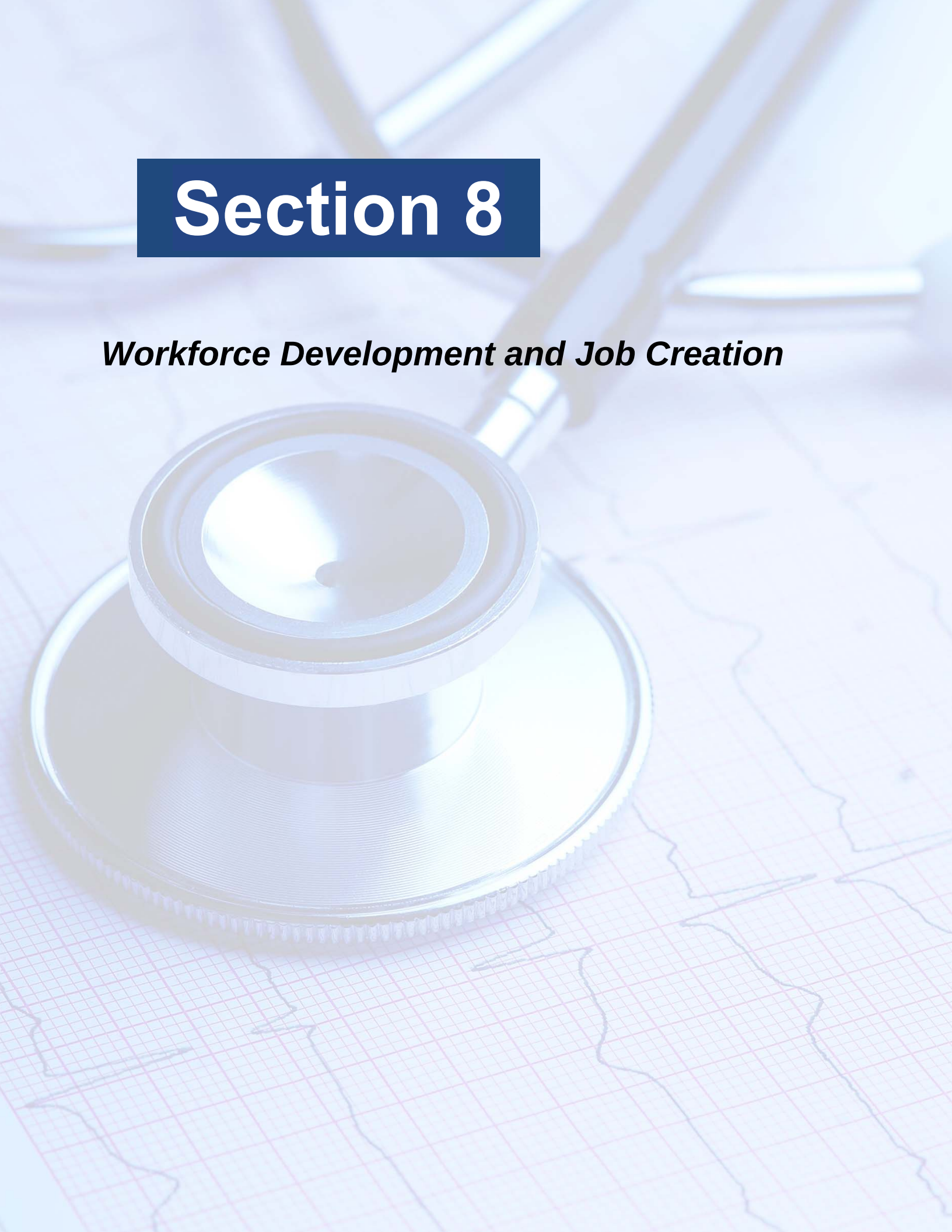
Telehealth includes several components, one of which is online practice. As technology advances, the Board must be aware of situations where physicians are not complying with telehealth laws and not following the standard of care in providing services to patients. One of the most frequent violations involves physicians treating California patients via telehealth from another state without having a California license. In the past, complaints regarding telehealth were not prevalent. However, as technology advanced over the last few years, more complaints have been received regarding care provided via telehealth, including complaints of unlicensed practice, inappropriate care, and the corporate practice of medicine. With future advances in technology, including applications available on electronic devices, etc., this will continue to be an issue that the Board needs to be vigilant about to ensure consumer protection.

Individuals using telehealth technologies to provide care to patients located in California must be licensed in California. Pursuant to BPC section 2290.5, licensees are held to the same standard of care, and retain the same responsibilities of providing informed consent, ensuring the privacy of medical information, and any other duties associated with practicing medicine regardless of whether they are practicing via telehealth or face-to-face, in-person visits. Board staff attends conferences regarding telehealth practices and have discussions with other state regulatory boards to develop best practices regarding telehealth as this new technology expands and becomes more widespread within California.

Telehealth is simply a tool to provide patient care that has been especially useful to California physicians during the age of COVID-19. The global pandemic has placed an emphasis on telehealth services, and is likely to require physicians to adopt at least some form of telehealth services for their patients. There definitely is a need to regulate telehealth, just as there is a need to regulate in-person medical examinations. Without ensuring physicians are following the standard of care in every practice setting, the patients in California can be put at risk.

Section 8

Workforce Development and Job Creation



Workforce Development and Job Creation

60. What actions has the board taken in terms of workforce development?

The Board does not specifically create jobs or provide training to the citizens of California to learn specific job skills. However, the Board's ability to process the license applications it receives, and timely issue licenses to those applicants who have met the appropriate qualifications, allows these new licensees to apply for and/or continue working in California healthcare professions. The Board received 9,751 PTL and physician license applications in FY 19/20. This was an increase of 2,031 license applications compared to FY 18/19. The Board issued 7,997 PTL and physician licenses in FY 19/20. This was an increase of 1,303 more licenses issued than in FY 18/19.

At the time of initial licensure and renewal of a physician license, the Board collects $25, which is transferred to the Health Professions Education Foundation (HPEF) to help fund the Steven M. Thompson California Physician Corps Loan Repayment Program that is administrated by HPEF. This Program encourages recently-licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans in exchange for their service in a designated medically underserved area for a minimum of three years. 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 the Office of Statewide Health Planning and Development (OSHPD).

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

Effective January 1, 2020, all first and second year residents, whether U.S./Canadian or international graduates, that were currently enrolled in an ACGME-accredited postgraduate training program in California were required to obtain their PTL by June 30, 2020, which was extended to December 31, 2020 through the DCA Waiver process due to COVID-19. The implementation of the PTL requirement dramatically increased the number of new applications received by the Board. Additionally, medical school graduates who matched into a California program to start training on July 1, 2020, submitted their PTL applications early during the fourth quarter of FY 19/20 due to the new requirement to obtain a PTL within 180 days from the commencement of the program.

During the fourth quarter of FY 18/19, the Board received approximately 1,640 physician license applications. In the fourth quarter of FY 19/20, the Board received approximately 2,861 license applications, which includes physician license applications and PTL applications. This is a 74 percent increase in the number of license applications received during the same time period in the previous year.

To ensure PTL applicants that are required to obtain a PTL by October 31, 2020, were issued licenses timely, the Board tracked and prioritized these applications, communicated

deficiencies regularly to applicants, and worked closely with program directors to ensure applicants were submitting documents timely to the Board to allow for processing and to prevent any unnecessary delays.

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 adjusting procedures to accommodate a telework-centered office structure while working toward a paperless-licensure process.

In January 2020, the Licensing Program deployed the DOCS portal. DOCS allows medical school and residency program staff registered with the Board to submit the required documentation electronically, which significantly reduces the overall processing time and limits the potential misdirection and loss of mail. The Board significantly expanded the utilization of DOCS across medical schools and training programs during the pandemic by increasing outreach to applicants, medical schools and postgraduate training programs. In May 2020, DOCS supported seven medical schools, 330 postgraduate training programs, and 118 registered users. By August 2020, DOCS supported 61 medical schools, 877 postgraduate training programs, and 349 users. Total medical schools and training programs utilizing DOCS increased by 56 percent from May 2020 to August 2020.

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.

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

Licensing education and outreach program – In 2001, the Board created a licensing education and outreach program. The purpose of the program is to build improved working relationships with California's teaching hospitals, the GME staff, and applicants who need a license to move forward with their postgraduate training or fellowship. Since its inception, the program has expanded across all geographic regions of the state, including small and large hospitals, private and public hospitals, and those governed by the University of California, Office of the President and now includes hospital recruiters, credentialing staff, medical groups, community clinics and health centers, professional societies, etc.

The goals of the program are mainly achieved through three avenues at teaching hospitals: (1) participation in licensing workshops, (2) presentations at resident orientation and/or during grand rounds, and (3) at the medical student level. Then, when Board staff is planning to be in

a certain geographic area, contact is made with other nearby entities that could benefit from a workshop, and visits to those multiple sites are included.

Licensing workshops or "licensing fairs" – Without these events, applicants may not have the impetus to start the application process and submit the required materials in a timely manner. The licensing fairs provide residents with an opportunity to get photos taken for the application, utilize a mobile fingerprinting service (directly tied to the DOJ's Live Scan service), copy and/or reduce the diploma, package and ship their diplomas to the Board, and pay for the services of a notary. This is a "one-stop shop" opportunity for applicants to complete much of the application process.

Additionally, outreach staff that visit the licensing workshops and fairs provide one-on-one assistance to applicants and walk them through the application requirements, answering any questions. Staff can also respond to questions from applicants regarding the type of documentation needed to continue the application process if the applicant has a criminal history, substance abuse problems, encountered problems during their medical school or postgraduate careers, or any other unusual circumstances. Naturally, most applicants are not comfortable discussing these issues in front of their colleagues, so the outreach staff will spend extra time in a private setting to discuss the process. In March 2020, non-essential state travel was suspended due to COVID-19 and the Board has not been able to conduct in-person licensing workshops or fairs. However, the Board will be providing more outreach through webinars, podcasts, and other digital formats to continue to help applicants navigate the licensing process.

Participation at "new resident orientation" and during grand rounds – Medical school students generally graduate in May or June of each year; the postgraduate training year runs from July 1 of one year to June 30 of the following year. As part of a teaching hospital's new resident orientation held in mid-June to early-July, the Board's outreach manager is typically one of several guest speakers. Staff offers an introduction to the Board and its mission and roles, outlines the licensing process, and offers information about licensing deadlines, requirements, the consequences of inappropriate personal behaviors, training/performance issues, professionalism, and ethics.

These new medical school graduates (generally called "first year postgraduate residents" or "PGY1s") assume that once they have graduated from medical school, they officially are a fully-functioning physician. They are unaware of the other statutory requirements they must meet before a license can be granted. Effective January 1, 2020, all applicants, regardless of the medical school attended are required to successfully complete 36 months of approved postgraduate training. An applicant will need to complete 24 consecutive months of training in the same program in order to be eligible for a physician license in California. Further, a PTL is required for all residents participating in an approved training program in California in order to practice medicine as part of their training program. The PTL must be obtained within 180 days after enrollment into the approved California program. PGY-1's may be unaware of the deadlines to obtain a PTL and the ramifications of failing to meet those deadlines — they must cease all clinical training and may be subject to termination of employment. Either option is an extreme hardship to the teaching hospitals, which would suddenly be faced with a vacancy in the training program and in the provision of health care services.

While Board staff can no longer participate in the new resident orientations due to the travel restrictions, the Board's website includes detailed information about licensure requirements, deadlines, and FAQs for applicants. The Board also regularly communicates application requirements and deadline reminders to medical schools and training programs through email and the Board's list serve.

Presentations to medical students – The Board recognizes that a significant number of students who attend medical school in California will commence their postgraduate training in other states. But the problematic issues facing applicants in our state will be issues of concern for other licensing jurisdictions. Therefore, when the Board's staff is present at a teaching hospital affiliated with one of California's medical schools, arrangements are made to present an informative and advisory talk to the students.

This outreach (primarily the review of applications before they are submitted, providing an explanation of what other training, educational, and criminal history, documents are needed, etc.) is preventative in nature and helps keep the workload of the Board's staff consistent. With the convenience of having all services provided at the licensing fair, it seems that many residents are applying earlier in the year, thus getting licensed earlier. This allows Board staff more time to work with applicants on remediating deficiencies well in advance of any licensure deadlines and also serves to benefit the teaching hospitals and other health care facilities.

In past years, the Board has had to perform numerous hours of overtime in the spring and early-summer months in order to meet the June 30 deadline. The reason for this overtime was, in part, due to the fact that applicants submitted their applications late in the academic year, and, therefore, there was a significant increase in applications, which staff was unable to process in a timeframe that met the applicants' expectations and needs. If the Board did not have this outreach program, the Board would not be able to meet the needs of the applicants or the hospitals providing health care in California. The cost of supporting this education and outreach program are significantly less than the cost of delayed healthcare services to California patients/consumers due to delays in the issuance of PTLs and physician licenses within a reasonable timeframe.

63. Describe any barriers to licensure and/or employment the board believes exist.

The Board does not believe there are any barriers to licensure.

64. 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 OSHPD, 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 is 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 Section 128565 of 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
2016/2017	3
2017/2018	117
2018/2019	180
2019/2020	164

Section 9

Current Issues

- Uniform Standards for Substance-Abusing Licensees
- Consumer Protection Enforcement Initiative
- BreEZe

Current Issues

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

Uniform Standards for Substance-Abusing Licensees

On March 25, 2015, Office of Administrative Law (OAL) approved the Board's regulations implementing the Uniform Standards with an effective date of July 1, 2015. The Board has been using the Uniform Standards since they became effective and is fully compliant with them.

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

Consumer Protection Enforcement Initiative

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.

67. 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?

BreEZe

Between March 2017 and August 2020, there have been 32 minor releases for BreEZe, with many emergency/fix releases in between those releases. A total of 366 enhancements and defects have been addressed during this timeframe, ranging from minor template updates to new license types. Enhancements of note include the Mexico Pilot Program License Type (January 2019), PTL and Physician and Surgeon Enhancements (October 2019 and January 2020), Early Electronic Renewal Notice Email Notifications (March 2019), and Displaying Probation Summaries Online (July 2019). Since March 2017, 491 BreEZe service requests have been submitted for the Board. As the Board continues to work with DCA's Office of Information Services (OIS) to enhance BreEZe to streamline processes, while maintaining the system based on legislative and business process changes, new BreEZe service requests will most likely outpace implemented BreEZe services requests during most release cycles. There are many enhancements that the Board is pursuing via pending service requests and others that still need to be documented and submitted, but are awaiting changes to business processes and resources. With each release, the Board continues to work with OIS to enhance BreEZe and improve it for applicants, licensees, consumers, and staff.

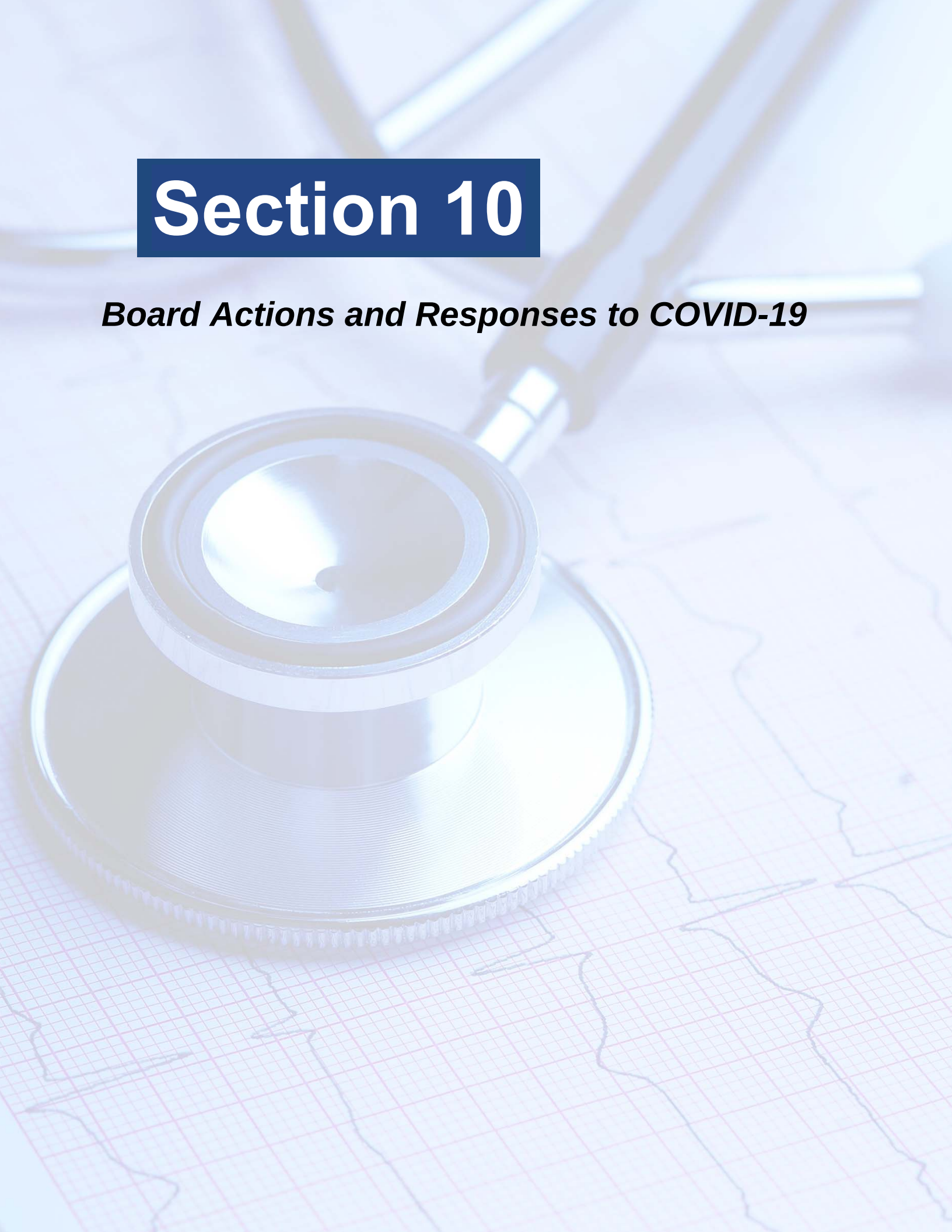
As of August 14, 2020, the Board had 51 Board-specific service requests and there were 40 GLOBAL service requests pending assignment to a release. There are a total of nine minor releases scheduled for 2020 and OIS is working to reduce the amount of time between each release to shorten the amount of time it takes for less complex requests. 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.

Report development is an ongoing effort and will be as reporting metrics and business processes continue to evolve. Reports can be developed quicker and easier now using DCA's Quality Business Interactive Reporting Tool (QBIRT).

The same issue described in March 2017 of legislatively-mandated changes requiring high-priority services requests to cause pre-existing service requests to be delayed is still relevant. The resources consumed for the Mexico Pilot Program and PTL development took up most of the Board's allotted BreEZe maintenance hours for 2019. This means that other requests to enable online transactions for less populated license types have been delayed further. The vendor that provides code enhancements to the BreEZe application, which the Board does not have access to by contract, was schedule to exit from the project in 2020 but that exit date has been extended. The Board requires vendor enhancements to the code to remove the Physician Survey functionality from BreEZe so that the Board can develop a custom solution that will allow flexibility for modifications to the survey for the duration of BreEZe's use.

Section 10

Board Actions and Responses to COVID-19



Board Actions and Responses to COVID-19

68. In response to COVID-19, has the board implemented teleworking policies for employees and staff?
a. How have those measures impacted board operations? If so, how?

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.

In order 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 from an in-person format to an online format through the WebEx platform. The Board plans to hold future meetings via WebEx until the State of Emergency is lifted.

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. Staff stopped traveling in mid-March 2020 and has not resumed as of October 2020. 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 have been closed or are on very limited hours of operation so obtaining information or documentation has been difficult and at times, not possible. The OAH was closed for a period of time beginning in March 2020 but began operations and started holding hearings by remote means in late summer.

69. 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.

70. 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 has been working with DCA to submit and review the following waiver requests to assist licensees:

Postgraduate Training License

DCA Waiver DCA-20-50 Postgraduate Training License Deadline
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. Individuals must obtain a PTL on or before October 31, 2020, unless the waiver is extended. DCA Waiver DCA-20-93 extended this deadline until March 31, 2021.

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. This waiver provided additional time to allow applicants to meet licensure requirements.

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, unless the waiver is extended.

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. This waiver provided additional time to allow applicants to meet licensure requirements.

Physician's and Surgeon's License

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.

These applicants experienced the similar challenges as the PTL applicants in obtaining required documents for licensure. This waiver provided additional time to allow applicants to meet licensure requirements.

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 (1) 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 (2) 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, terminates 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 expanded by DCA Waiver DCA-20-66.

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. DCA Waiver DCA-20-69 further extended the deadline another six months until April 22, 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-20-57 Restore Inactive, Retired, or Cancelled License
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 until January 1, 2021, 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.

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?

Please see answer to question number 70 above.

71. 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 CS for 12-18 months 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 include accepting electronically notarized documents from Notary Cam, electronic document submission through the Board's DOCS Portal, the acceptance of electronic transcripts through approved services such as Credentials Solutions, Inc., ScripSafe, Parchment, and the National Student Clearinghouse, as well as the acceptance of e-diplomas from CeCredential Trust and Parchment.

72. 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 change to the 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 the Board to hold meetings via an online platform.

Section 11

Board Action and Response to Prior Sunset Issues

Prior Sunset Issues

This section differs from other sections to accommodate the format of the response requested by the Senate Business, Professions, and Economic Development Committee. The issue stated is the issue raised during the Board's 2016 Sunset Review. The background section is a synopsis of why the issue arose, or in many cases, the issues raised by the Board through the 2016 Sunset Review Report. The staff recommendation is from the Sunset Review Committee itself. The Board Response (March 2017) provides the Board's actions and responses that were provided after the 2017 Sunset Review hearing. The Board Response 2020 provides an update on the actions taken to address the issue raised since the last Sunset Review.

ISSUE #1: (BreEZe.) MBC transitioned to BreEZe in October 2013 as one of the first entities at DCA utilizing the new system. MBC has faced challenges in meeting timeline goals and implementing processes and has paid vast sums of money for the project, in addition to countless hours of staff resources. What is the status of BreEZe? How many of MBC's service requests are still pending? Does BreEZe track enforcement statistics in a meaningful way for MBC?

Background: The DCA has been working since 2009 on replacing multiple antiquated standalone IT systems with one fully integrated system. In September 2011, the DCA awarded Accenture LLC with a contract to develop and implement a commercial off-the- shelf customized IT system, which it calls BreEZe. BreEZe is intended to provide applicant tracking, licensing, renewals, enforcement, monitoring, cashiering, and data management capabilities. In addition, BreEZe is web-enabled and designed to allow licensees to complete and submit applications, renewals, and the necessary fees through the internet. The public also will be able to file complaints, access complaint status, and check licensee information if/when the program is fully operational.

The project plan called for BreEZe to be implemented in three releases. The first release was scheduled for July 2012 but delayed until late 2013. MBC transitioned to BreEZe during Release One in October 2013. MBC reports that since 2013, there have been 118 releases that included major, minor, and emergency service request changes, which have been implemented. Unlike many other entities at DCA, MBC is fortunate to have its own Information System Branch (ISB) which is able to work with the DCA Office of Information Services and vendor analysts and developers to define, prioritize, test, and implement service requests for MBC.

MBC reports that once the system went live, MBC's Consumer Information Unit received requests for BreEZe support from applicants, licensees and consumers, leading to ISB's internal technical support Help Desk to also provide technical support for BreEZe online users. In FY 13/14, the ISB Help Desk received 14,403 public support requests via phone or email; in FY 14/15, 16,678 requests; and in FY 15/16, 17,353 requests.

Like other DCA entities transitioning to the new BreEZe system, MBC staff adjusted to new business processes and requirements which delayed timeframes. Licensing processing timelines grew as the initial deployment of BreEZe resulted in a need for all business processes to be reviewed. Changes were required for staff activity as well as the BreEZe system itself, all of which impacted every facet of processing of applications, from the receipt of initial fees and application forms through the final issuance of a license. MBC reports that

staff is now trained and more comfortable with the system and new business processes and timeframes have since stabilized.

MBC's ability to access monthly caseload reports and track complaint processing and enforcement timelines was significantly impacted by BreEZe. Staff at MBC's Central Complaint Unit were not able to receive these reports, an important tool for MBC to effectively monitor the progress and timeframe for cases.

MBC CME audits have also been impacted by BreEZe. The prior tools utilized to automate the process for CME auditing and tracking CME audit information for a licensee were not initially available in BreEZe, resulting in MBC's inability to perform CME audits. MBC did not conduct **any** CME audits until May 2016 when the system change went into effect.

MBC reports that ISB and other MBC staff are working on requests for system updates to further streamline the processes for applicants, licensees, consumers and staff and to make more transactions available online.

It would be helpful for the Committees to understand the continuing cost impacts of BreEZe to MBC's budget as well as the status of requests for technical fixes and larger change improvements.

Staff Recommendation: ***MBC should advise the Committees how much it is projected to pay in BreEZe costs for FY 17/18. MBC should update the Committees on the number of pending tickets and how swiftly MBC requests for system upgrades and changes are being processed. MBC should advise the Committees of any major updates anticipated based on the passage of recent legislation.***

Board Response (March 2017):
The Medical Board of California (Board) is projected to spend at least $2.235 million in FY 17/18 on the BreEZe project. This figure includes the credit card fees associated with online payments. In FY 18/19, the Board is projected to spend $2.342 million.

BreEZe Release R2.1.6.0 went into effect on February 21, 2017. As part of BreEZe Release R2.1.6.0, the Board had eight Board-specific updates implemented in BreEZe. Some of these updates included changes due to the passage of Senate Bill (SB) 1478, which waived the CURES $12 fee at renewal for physician and surgeon licensees in inactive, retired, or disabled status. Since January 11, 2017 (Breeze's R2.1.5.0 release date), the Board has submitted eleven additional BreEZe service requests. As the Board continues to work with the Department of Consumer Affairs' (DCA) Office of Information Services (OIS) to enhance BreEZe to streamline processes, while maintaining the system based on legislative and business process changes, new BreEZe service requests will most likely outpace implemented BreEZe services requests during most release cycles. There are many enhancements that the Board is pursuing via pending service requests and others that still need to be documented and submitted, but are awaiting changes to business processes and resources. With each release, the Board continues to work with OIS to enhance BreEZe and improve it for applicants, licensees, consumers, and staff.

As of February 17, 2017, the Board had 52 Board-specific service requests and there were 115 GLOBAL service requests pending assignment to a release. Along with the service

requests closed as they were implemented in recent releases, the Board consolidated several service requests and also transferred ownership of several service requests to the California Board of Optometry (CBO) when the Registered Dispensing Optician (RDO) program was transferred. The criteria for an emergency release is strictly defined by OIS. Most requests do not quality for an emergency release and therefore go through the normal BreEZe Maintenance and Operations Release Lifecycle. The Board's priorities for the next BreEZe Release R2.1.7.0, which is tentatively scheduled for release on March 29, 2017, were due to OIS on January 17, 2017. This means that a minimum of 10 weeks was required to develop, implement, test, and deploy the service requests for this release cycle once it was assigned to a release based on the Board's priority and BreEZe development resources. 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.

The BreEZe system does not have the same check and balance capabilities available in the legacy system, which was a custom coded solution. As enforcement statistical reports are developed by Board and OIS staff, data quality issues are discovered. Quality assurance reports are developed to assist in the cleaning of the data so it can be extracted in a meaningful way. This quality assurance report development and data cleanup may slow down the process of developing enforcement statistical reports and generating meaningful data. Board enforcement staff and the OIS reports team are constantly testing and updating enforcement performance measure reports. There is still a queue of reports that are waiting to be developed, but the Board and OIS staff are working on these requests with all available resources.

Recent and upcoming legislation can result in additional, high priority service requests being created. The priority of these new service requests could cause pre-existing service requests to be delayed to later releases because of resource limitations. However, at this time, the Board does not have any major updates pending due to recent legislation.

Board Response (2020):

The Board is projected to spend at least $869,000 in FY 20/21 on the BreEZe project. This figure does not include the credit card fees associated with online payments. The BreEZe project expenses for the Board were $1,341,570 in FY18/19 and $1,074,919 in FY19/20.

Between March 2017 and August 2020, there have been 32 minor releases for BreEZe, with many emergency/fix releases in between those releases. A total of 366 enhancements and defects have been addressed during this timeframe, ranging from minor template updates to new license types. Enhancements of note include the Mexico Pilot Program License Type (January 2019), PTL and Physician and Surgeon Enhancements (October 2019 and January 2020), Early Electronic Renewal Notice Email Notifications (March 2019), and Displaying Probation Summaries Online (July 2019). Since March 2017, 491 BreEZe service requests have been submitted for the Board. As the Board continues to work with the DCA's OIS to enhance BreEZe to streamline processes, while maintaining the system based on legislative and business process changes, new BreEZe service requests will most likely outpace implemented BreEZe services requests during most release cycles. There are many enhancements that the Board is pursuing via pending service requests and others that still need to be documented and submitted, but are awaiting changes to business processes and resources. With each release, the Board continues to work with OIS to enhance BreEZe and

improve it for applicants, licensees, consumers, and staff.

As of August 14, 2020, the Board had 51 Board-specific service requests and there were 40 GLOBAL service requests pending assignment to a release. There are a total of nine minor releases scheduled for 2020 and OIS is working to reduce the amount of time between each release to shorten the amount of time it takes for less complex requests. 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.

Report development is an ongoing effort and will be as reporting metrics and business processes continue to evolve. Reports can be developed quicker and easier now using the QBIRT.

The same issue described in March 2017 regarding legislatively mandated changes requiring high priority service requests which in turn delays pre-existing service requests is still relevant. The resources consumed for the Mexico Pilot Program and PTL development took up most of the Board's allotted BreEZe maintenance hours for 2019. This means that other requests to enable online transactions for less populated license types have been delayed further. The vendor that provides code enhancements to the Breeze application, that we do not have access to by contract, was schedule to exit from the project in 2020, but that exit date has been extended. We require vendor enhancements to the code to remove the Physician Survey functionality from Breeze so that we can develop a custom solution that will allow flexibility for modifications to the survey for the duration of Breeze's use.

ISSUE #2: (DATA SHARING WITH OTHER STATE AGENCIES.) 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?

Background: Various state agencies collect and receive health related data that may be connected to activities of MBC licensees. For example, the Department of Public Health (DPH) Office of Vital Records maintains certificates for vital events in California, including death certificates. The Department of Health Care Services (DHCS) and Department of Social Services (DSS) work together to track psychotropic medication prescription data for children in foster care. DPH's Laboratory Field Services program is supposed to inspect and subsequently track information related to the outcome of inspections of laboratories.

In each of these instances, MBC's work may be improved by having access to data from other agencies. For example, MBC could gauge prescribing trends for certain populations and conditions if it has timely access to psychotropic medication prescriptions for foster youth. With data, MBC can both set guidelines and advise on best practices as well as take enforcement action when necessary in events of demonstrated overprescribing. MBC's receipt of death certificates for deaths involving prescription drug overdose, could similarly allow MBC to assess trends that may inform best practices for controlled substances prescribing, or lead MBC to conduct investigations in instances where a death could be connected to the prescribing by an MBC licensee. If MBC received timely information from DPH about laboratories providing inducements to physicians, it would be better positioned to take action

against those licensees violating Business and Professions Code Section 650 which prohibits these activities.

While MBC does have data use agreements with some agencies for information, there have historically been delays in MBC receiving information that could in turn allow MBC to make administrative decisions to inform its licensees of best practices or in some cases, allow MBC to take important enforcement action.

It would be helpful for the Committees to understand what state agencies MBC could benefit from receiving data from, what state agencies MBC has data use agreements with and where challenges persist for MBC to gain often critical information about the role of its licensees.

Staff Recommendation: ***MBC should advise the Committees of its data sharing efforts and relationships with other state agencies. MBC should provide information to the Committees about necessary statutory changes that would enhance MBC's ability to safely and securely access data related to its licensees.***

Board Response (March 2017):
In the last two years, the Board has entered into data use agreements (DUA) with other state agencies in order to receive information that will assist the Board in obtaining data regarding physicians who may be violating the law or to obtain information that assists the Board in its regulatory functions. The Board entered into a data use agreement with the California Department of Public Health (CDPH) to receive death certificate data when the death was related to opioids. The Board received the data from CDPH and is in the process of analyzing the information to identify physicians who may be inappropriately prescribing opioids. In addition, the Board has a long standing agreement with CDPH to receive death certificate information on deceased physicians on an ongoing basis in order to update physician license records.

The Board also entered into a DUA with the Department of Health Care Services (DHCS) and Department of Social Services (DSS) to receive information on physicians who had prescribed three or more psychotropic medications to foster care children for 90 days or more during July 1, 2014 to December 31, 2014. This data was received by the Board and is going through the enforcement process. This DUA was codified in statute (SB 1174, McGuire, Statutes of 2016) and the data is now required to be provided to the Board on an ongoing basis for ten years. The updated DUA was recently finalized and the Board received data for calendar year 2015 on March 2, 2017. This information will be sent to our expert reviewer(s) to review the data to identify physicians who may be inappropriately prescribing. Through a review of the data received from DHCS and DSS for the 2014 time frame, the Board identified numerous patients who may have been inappropriately prescribed psychotropic medications that needed further investigation. The next step in this process is for the Board to obtain authorization to request medical records for the patients identified. The Board has requested the assistance of DSS in obtaining the medical records for these patients. At this time, Board staff is awaiting assistance from DSS and the counties to identify who needs to be contacted to request authorization for the records and to establish a process to receive these records. Without receiving authorization to obtain the medical records, the Board will not be able to move forward with investigating these physicians.

In addition to these agreements, there are other state agencies and other data that could be

obtained to assist the Board with its enforcement role. DHCS Audits and Investigations Unit (AIU) performs billing audits and may identify physicians who may be violating the law. The Board needs to receive enough information to be able to pursue an investigation and these should always be sent to the Board.

On December 9, 2016, the Board, the DCA's Health Quality Investigative Unit (HQIU), and the Physician Assistant Board provided a presentation to the DHCS AIU on the Board's enforcement process, including its investigation and disciplinary process. During this presentation, the Board identified the information that would be necessary in order to open a complaint and perform an investigation. In addition, on March 10, 2017, the DHCS AIU provided a presentation to staff of the Board and the HQIU on the AIU's investigation process and its review process. During the meeting, discussions began regarding a DUA between DHCS AIU and the Board. The Board will work with DHCS to determine what information should be provided to the Board in order for the Board to be able to perform an appropriate investigation of a physician who may be violating the law.

CDPH audits hospitals and other facilities and during an audit may obtain information regarding a physician who may be in violation of the law. In addition, CDPH, through its review of laboratories, may identify a physician who is receiving inducements. While the Board does receive some referrals from CDPH, there is no requirement to provide this information to the Board. If information is obtained by CDPH regarding a physician who may be in violation of the law, that information should be provided to the Board with enough background information and evidence that the Board can pursue an investigation.

The Board agrees with the Committees that this information is useful to the Board. The Board would support any legislation that would require data sharing between state agencies, thereby assisting the Board in identifying physicians who may be violating the Medical Practice Act. Such legislation should also ensure that the Board receives enough information to perform an adequate investigation.

Board Response (2020):

The Board continues to welcome legislation that would require data sharing between state agencies to assist the Board in meeting its mission of public protection.

The Board has successfully engaged in a data sharing project with the CDPH to investigate possible overprescribing cases resulting in deaths. The CDPH provided death record information for individuals that died as a result of overdose or possible overprescribing. In 2016, the Board received data for 2012 and 2013 which indicated 2,694 deaths during that two year period. This resulted in 520 investigations of 471 prescribers. As of October 1, 2020, the project has resulted in 75 accusations on 66 physicians. To date, there have been 11 surrenders, 20 probation terms, and 21 letters of public reprimand. In 14 cases the subject physicians died and in 5 cases the physician's license was already revoked.

The Board recently received data related to 2,666 individuals who died in 2019 as a result of overdose or possible overprescribing of opioids. The project will operate in a similar manner to the prior project, but various processes have been revised and enhanced to overcome difficulties encountered in the last project.

Further, the Board has received data from DSS and DHCS related to the possible inappropriate prescribing of psychotropic medications to foster children. Following receipt of that information, the Board has been able to obtain medical records and conduct investigations in a limited number of cases but has not yet discovered evidence sufficient to file an accusation or discipline a physician.

ISSUE #3: (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). Psychoanalysis is a discipline of psychology. 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?

Background: According to the American Psychological Association (APA), 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 habitually recurrent patterns of emotion and behavior, allowing previously unconscious aspects of the self to become integrated and promoting optimal functioning, healing and creative expression. The APA states that psychoanalytic training typically requires four to eight years of advanced study after completion of a doctoral degree in psychology acceptable to the American Board of Professional Psychology and further requires specialized training at free-standing psychoanalytic institutes, postdoctoral university programs, or an equivalent training secured independently that is acceptable to the American Board and Academy of Psychoanalysis.

In California, the Board of Psychology licenses psychologists and registers psychologists and psychological assistants. Licensed psychologists may practice independently in any private or public setting. Psychological assistants are those individuals who have an advanced degree in psychology and provide limited psychological services under direct supervision. Registered psychologists are authorized to engage in psychological activities under direct supervision only at nonprofit community agencies that receive a minimum of 25 percent of their funding from a governmental source.

The Board of Psychology previously had a member who served as president of the Northern California Society for the Psychoanalytic Psychology Board of Directors and was an assistant editor for a psychoanalytics publication. It appears that the Board of Psychology may have more expertise in this discipline and may be a more appropriate entity to register RPs who engage in a psychology based practice.

Staff Recommendation: ***MBC should advise the Committees why it registers RPs rather than the Board of Psychology. Upon receipt of information from MBC and 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 (March 2017):
In 1977, when the research psychoanalysts 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. Several allied health professions were within the jurisdiction of the Division of Allied Health Professions, including audiologists, acupuncturists, hearing aid dispensers, physical therapists, medical assistants, physician assistants, podiatrists, ***psychologists***, registered dispensing opticians, and speech pathologists. In 1990 when the Board of Psychology (BOP) came into existence, the research psychoanalysts remained under the Board's oversight.

Although the Board has not fully discussed this issue, Board staff does not believe there would be any adverse effect to transfer this program to the BOP. The Board looks forward to working with the BOP, the Committees, and interested parties to determine the impact of this transfer and to draft any language necessary for the transition.

Board Response (2020):
Since the Board's prior sunset review, no legislation has been enacted that would remove the RP program from the Board's jurisdiction. The Board is unaware of any adverse impacts associated with the transfer of the RP program to the BOP and looks forward to future conversations with relevant stakeholders to effectuate this change. The Board is requesting RPs be transferred to BOP (see new issues section of this report).

ISSUE #4: (LICENSED MIDWIVES.) MBC regulates licensed midwives. Are certain clarifications to the law necessary to reflect these providers' role? How does MBC work with LMs and LM stakeholder groups?

Background: MBC received regulatory authority over licensed midwives in 1994. A licensed midwife (LM) is an individual who has been issued a license to practice midwifery by MBC. The Midwifery Practice Act, contained in BPC Sections 2505 to 2521, authorizes a licensee to attend cases of normal pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother and immediate care for the newborn. LMs can practice in a home, birthing clinic or hospital environment.

MBC receives guidance on midwifery issues through a Midwifery Advisory Council (MAC). The MAC is made up of LMs (pursuant to BPC 2509, at least half of the MAC members are LMs), a physician, and two non-physician public members. MBC is working with stakeholders through the MAC and a specified task force in order to define "normal" in regulations, for purposes of clarifying births an LM can attend, as required under AB 1308. Until MBC adopts regulations, LMs are not able to be a "comprehensive perinatal provider" for purposes of providing comprehensive perinatal services to Medi-Cal beneficiaries in the Comprehensive Perinatal Services Program (CPSP). SB 407 (Morrell, Chapter 313, Statutes of 2015) authorized a health care provider to employ or contract with licensed midwives for the purpose of providing comprehensive perinatal services in the CPSP.

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

Professional Corporations. Corporations Code 13401.5 authorizes the formation of various healing arts professional corporations and establishes which healing arts licensees who are

not of the same license type as the corporation may be shareholders, officers, and directors of that corporation. Any person licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act may be employed by these professional corporations. Thus, the services of professional corporations are not limited to the named profession. For example, a nursing corporation may have a director who is a chiropractor, a shareholder who is an acupuncturist, and employ an accountant, podiatrist, and a marriage and family therapist, none of which would traditionally be seen as providing the professional services of nursing.

Current law authorizes a medical corporation to have a number of health licensees as officers, directors, and shareholders. *LMs should be added to the list.*

Peer Review. Under BPC Section 805, specified health-related professional societies, duly-appointed committees of a medical specialty society, duly-appointed committees of a state or local health related professional society or duly-appointed members of a committee of a professional staff of a licensed hospital that undertakes peer review, must provide reports to the MBC or other state licensing board under certain circumstances. LMs are not currently included in this requirement and should be added. Existing law also provides that there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, specified health professional societies, members of a duly appointed committee of a medical specialty society, or any member of a duly appointed committee of a state or local health professional society, or duly appointed member of a committee of a professional staff of a licensed hospital for acts performed within the scope of the functions of peer review.

Existing law also provides that the proceedings and actions of specified health professional societies, committees of a medical specialty society or other health professional society, or a committee of the professional staff of a licensed hospital, that have responsibility for the evaluation and improvement of the quality of care provided by the members of the professional society, are not subject to discovery in civil actions. Likewise, persons in attendance at any meeting of any such committee cannot be compelled to testify regarding what transpired at the meeting. *LM professional societies and LM review committees are not included and should be added. Peer review provisions should include LMs.*

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

Board Response (March 2017):
Although the Board has not discussed the issues in the background paper related to changes in the corporations code and the peer review section relating to licensed midwives, these suggestions are in the interests of consumer protection. Regarding outreach to licensed midwives, as issues arise, the Board solicits input from licensed midwives on certain issues. For example, they were contacted to provide input into the Licensed Midwife Annual Report (LMAR) and sent a letter regarding authorized testing. The Board notifies all subscribers of MAC meetings and reaches out to LM stakeholders on specific issues. In addition, the MAC Chair provides an update to the Board at each Board meeting after a MAC meeting.

The Board has held several interested parties meetings on the regulations to implement Assembly Bill (AB) 1308. In addition, the Board has been working with both the California Association of Midwives/California Association of Licensed Midwives (CAM/CALM) and the American College of Obstetricians and Gynecologists (ACOG) on these regulations. However, there has not been agreement on the issue of putting prior cesarean sections on the list of preexisting conditions requiring a physician and surgeon examination and determination that the risk factors presented by the woman's disease or condition are not likely to significantly affect the course of pregnancy and childbirth prior to the licensed midwife continuing to provide care pursuant to Business and Professions Code section 2507. Therefore, the Board established a Midwifery Task Force, made up of two Board Members to assist with these regulations. The Midwifery Task Force met on Monday, March 6, 2017, with representatives from ACOG and CAM/CALM to discuss the current status of regulations to define "preexisting maternal disease or condition likely to affect the pregnancy," and "significant disease arising from the pregnancy" under Business and Professions Code section 2507.

At the meeting, the parties discussed the challenges created by the current language under 2507(b)(2) requiring a licensed midwife to refer a client with a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy to a physician and surgeon for an examination and a determination by the physician that the risk factors presented by the woman's disease or condition are not likely to significantly affect the course of pregnancy and childbirth. It was acknowledged that this issue could not be resolved through regulations.

The Midwifery Task Force determined that a legislative fix is necessary, so that if the woman has a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy, the midwife will still be required to refer the woman to a physician trained in obstetrics for an assessment of the risk factors that may adversely affect the outcome of the pregnancy or childbirth. The midwife would have to include the assessment in evaluating whether the woman's disease or condition are likely to significantly affect the course of the pregnancy or childbirth. Thus, it would be the midwife making that determination within the midwifery standard of care, rather than the physician, as to whether the woman should continue with midwifery care. If the woman does have a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy likely to significantly affect the course of pregnancy or childbirth, the midwife would have to refer the woman to a physician and surgeon for care, with the midwife providing collaborative care, as appropriate.

Should the statute be changed, the Board will move forward with proposed regulations to define "preexisting maternal disease or condition likely to affect the pregnancy," and "significant disease arising from the pregnancy." Conditions falling with the definitions put forth in regulations would prompt the referral to the physician for the assessment of the risk factors, and when appropriate, for the transfer of care.

The Midwifery Task Force will provide the proposed legislative amendment to the Board at its next meeting in April 2017. If the language is approved, the Board will provide the language to the Committees. This change should resolve the issue that has been hindering the regulations moving forward.

Board Response (2020):
At its quarterly meeting on April 28, 2017, the Board approved a proposed legislative fix to change the requirements under BPC section 2507. Under the proposed changes to section 2507, if the client has a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy, the midwife will still be required to refer the client to a physician trained in obstetrics for an assessment of the risk factors that may adversely affect the outcome of the pregnancy or childbirth. The midwife would have to include the physician's assessment in evaluating whether the client's disease or condition is likely to significantly affect the course of the pregnancy or childbirth. It would ultimately be the midwife making the determination within the midwifery standard of care, rather than the physician, as to whether the client should continue with midwifery care.

If the client does have a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy likely to significantly affect the course of pregnancy or childbirth, the midwife would have to refer the client to a physician and surgeon for care, with the midwife providing collaborative care, as appropriate. The Legislature did not include the proposed language in 2017.

At its quarterly meeting on November 7, 2019, the Board considered and rejected a legislative proposal to prohibit LMs from attending home births if the mother has had a prior cesarean delivery; change the term "likely;" and change the language requiring a physician to make a "determination" consistent with what was supported by the Board in 2017.

Given that physician supervision has been removed from LMs, the Board does not believe that they should be licensed and regulated by the Medical Board, and is supportive of LMs establishing their own board (see "new issues" section).

ISSUE #5: (BOARD OF PODIATRIC MEDICINE [BPM].) While the BPM was once housed within the MBC, it has been a board since 1986 and relies on the MBC only for contractually specified duties, which the MBC provides for other boards as well. The BPM is independently responsible for determining the eligibility of its licensees and making final disciplinary decisions. Should statutory clarifications be made to reflect the actual nature of MBC and BPM's relationship?

Background: MBC provides certain services to other entities at the DCA that were formerly committees under MBC. MBC provides shared services for the BPM and the Physician Assistant Board, smaller programs that do not have near the infrastructure and administrative wherewithal that a large board like MBC does, in order to assist these boards in efficiently conducting their business. Confusion has arisen as to the exact nature of MBC's role with regards to BPM operations as outlined in BPM presentations and discussions at its public meetings.

Through shared services agreements, MBC solely performs administrative functions for independent boards like BPM. In essence, MBC is contracted to do certain work and MBC in turn charges BPM for the time MBC staff work on behalf of BPM to do tasks like processing complaints and handling other disciplinary functions.

When the Podiatry Examining Committee was first created under MBC, terminology describing the relationship between the two entities, as well as the relationship itself was entirely different.

In 1980, BPC Section 2460 “created within the jurisdiction of the Division of Allied Health Professions of the Board of Medical Quality Assurance, a Podiatry Examining Committee.” BPC 2460 today reads that there is “created within the jurisdiction of the Medical Board of California the California Board of
Podiatric Medicine.” It appears that the Act has not always been updated to reflect changes in both the relationship, as well as terminology of these two entities, but rather has only been amended over the years to acknowledge changed names of the two entities and sunset dates and extensions.

Historically, MBC issued certificates to practice podiatric medicine to qualified applicants because the committee was under MBC’s jurisdiction. The only changes to BPC 2479 related to the issuance of certificates (since the codes were restructured in 1980 and Article 22 related to Podiatric Medicine was placed where it is in the Act) reflect MBC internal reorganization, specifically that that MBC’s Division of Licensing issues licenses on MBC’s behalf instead of prior language that referred to MBC. This code section does not appear to have been updated at all to reflect the creation of BPM as a board in 1986. The Act defines “podiatric medicine” as all medical treatment of the foot, ankle, and tendons that insert into the foot, including diagnosis, surgery, and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot. Therefore, a DPM’s scope of practice is similar to that of a physician and surgeon who specializes in the foot and ankle. However, unlike a physician and surgeon, whose scope is only limited by the licensee’s own area of competence, a DPM’s scope is statutorily limited to the foot and ankle.

BPM determines the qualifications for licensure, reviews applications and subsequently makes all decisions about DPM licensure and until 2016, issued its own licenses to its own licensees. However, for these licensees, the actual pieces of paper included a Medical Board of California seal, despite being separate from the licenses issued by MBC for physicians and surgeons due to the lack of proper code cleanup recognizing BPM as an independent entity. Once this proposal was discussed and concerns were raised it was determined that MBC staff, again through a shared services agreement, would update the BreEZe system to issue a DPM license on behalf of BPM. MBC does nothing more than update the system to reflect the independent licensure decision made by BPM. For instance, existing law specifies that the MBC issues the podiatric medicine license.

MBC has requested, and legislation was proposed last year (SB 1039, Hill), to clarify that BPM is its own board that performs its own licensing functions so that the law accurately reflects the true nature of each independent entity and each board’s actual responsibilities. In response to concerns raised by the BPM, California Podiatric Medical Association and California Medical Association, SB 1039 was amended in the Assembly to remove the provisions related to BPM. CPMA advised the Committees this year that any changes stemming from those conversations last year should continue to place BPM in the Act. CPMA also noted that “there are various rules, regulations and codes that refer to ‘licensees of the Medical Board’, which have included DPM licensees…CPMA would ask that any new laws consider this and address wording to include DPMs where appropriate.”

It does not appear that technical statutory changes to the Act will impact the two boards’ shared services agreement, as that is separate from statute and clarifies the contractual services MBC provides to BPM. Further, it does not appear that any code cleanup will impact either of the boards’ role in effectively operating, nor does it appear that additional cost will

arise from changes to the Act, since the administrative shared services agreement delineates the services MBC provides on behalf of BPM and specifically outlines the cost to BPM for those services.

Staff Recommendation: ***The Act should be amended according to the following below, in addition to other code sections identified that clarify the nature of DPM licensure by BPM:***

BPC 2423. (a) Notwithstanding Section 2422:
(1) All physician and surgeon's ~~certificates, certificates to practice podiatric medicine, registrations of spectacle lens dispensers and contact lens dispensers,~~ ***certificates*** and certificates to practice midwifery shall expire at 12 midnight on the last day of the birth month of the licensee during the second year of a two-year term if not renewed.
(2) Registrations of dispensing opticians will expire at midnight on the last day of the month in which the license was issued during the second year of a two-year term if not renewed.
(b) The ~~Division of Licensing~~ ***board*** shall establish by regulation procedures for the administration of a birth date renewal program, including, but not limited to, the establishment of a system of staggered license expiration dates such that a relatively equal number of licenses expire monthly.
(c) To renew an unexpired license, the licensee shall, on or before the dates on which it would otherwise expire, apply for renewal on a form prescribed by the licensing authority and pay the prescribed renewal fee.

2460. (a) There is created within the ~~jurisdiction of the Medical Board of California the~~ ***Department of Consumer Affairs a*** California Board of Podiatric Medicine.
(b) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date. Notwithstanding any other provision of law, the repeal of this section renders the California Board of Podiatric Medicine subject to review by the appropriate policy committees of the Legislature.

2461. As used in this article:

~~(a)"Division" means the Division of Licensing of the Medical Board of California.~~

~~(b)~~

(a) "Board" means the California Board of Podiatric Medicine.

~~(c)~~

(b) "Podiatric licensing authority" refers to any officer, board, commission, committee, or department of another state that may issue a license to practice podiatric medicine.

2475. Unless otherwise provided by law, no postgraduate trainee, intern, resident postdoctoral fellow, or instructor may engage in the practice of podiatric medicine, or receive compensation therefor, or offer to engage in the practice of podiatric medicine unless he or she holds a valid, unrevoked, and unsuspended certificate to practice podiatric medicine issued by the ~~division.~~ ***board.*** However, a graduate of an approved college or school of podiatric medicine upon whom the degree doctor of podiatric medicine has been conferred, who is issued a resident's license, which may be renewed annually for up to eight years for this purpose by the ~~division upon recommendation of the~~ board, and who is enrolled in a postgraduate training program

approved by the board, may engage in the practice of podiatric medicine whenever and wherever required as a part of that program and may receive compensation for that practice under the following conditions:
(a) A graduate with a resident's license in an approved internship, residency, or fellowship program may participate in training rotations outside the scope of podiatric medicine, under the supervision of a physician and surgeon who holds a medical doctor or doctor of osteopathy degree wherever and whenever required as a part of the training program, and may receive compensation for that practice. If the graduate fails to receive a license to practice podiatric medicine under this chapter within three years from the commencement of the postgraduate training, all privileges and exemptions under this section shall automatically cease.
(b) Hospitals functioning as a part of the teaching program of an approved college or school of podiatric medicine in this state may exchange instructors or resident or assistant resident doctors of podiatric medicine with another approved college or school of podiatric medicine not located in this state, or those hospitals may appoint a graduate of an approved school as such a resident for purposes of postgraduate training. Those instructors and residents may practice and be compensated as provided in this section, but that practice and compensation shall be for a period not to exceed two years.

2479. The ~~division shall issue, upon the recommendation of the board,~~ ***board shall issue*** a certificate to practice podiatric medicine to each applicant who meets the requirements of this chapter. Every applicant for a certificate to practice podiatric medicine shall comply with the provisions of Article 4 (commencing with Section 2080) which are not specifically applicable to applicants for a physician's and surgeon's certificate, in addition to the provisions of this article.

2486.
The ~~Medical Board of California shall issue, upon the recommendation of the board,~~ ***board shall issue*** a certificate to practice podiatric medicine if the applicant has submitted directly to the board from the credentialing organizations verification that he or she meets all of the following requirements:
(a) The applicant has graduated from an approved school or college of podiatric medicine and meets the requirements of Section 2483.
(b) The applicant, within the past 10 years, has passed parts I, II, and III of the examination administered by the National Board of Podiatric Medical Examiners of the United States or has passed a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States.
(c) The applicant has satisfactorily completed the postgraduate training required by Section 2484.
(d) The applicant has passed within the past 10 years any oral and practical examination that may be required of all applicants by the board to ascertain clinical competence.
(e) The applicant has committed no acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475).
(f) The board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.
(g) A disciplinary databank report regarding the applicant is received by the board from the Federation of Podiatric Medical Boards.

2488. Notwithstanding any other ~~provision of~~ law, the ~~Medical Board of California shall issue, upon the recommendation of the board,~~ ***board shall issue*** a certificate to practice podiatric medicine by credentialing if the applicant has submitted directly to the board from the credentialing organizations verification that he or she is licensed as a doctor of podiatric medicine in any other state and meets all of the following requirements:
(a) The applicant has graduated from an approved school or college of podiatric medicine.
(b) The applicant, within the past 10 years, has passed either part III of the examination administered by the National Board of Podiatric Medical Examiners of the United States or a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States.
(c) The applicant has satisfactorily completed a postgraduate training program approved by the Council on Podiatric Medical Education.
(d) The applicant, within the past 10 years, has passed any oral and practical examination that may be required of all applicants by the board to ascertain clinical competence.
(e) The applicant has committed no acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475).
(f) The board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.
(g) A disciplinary databank report regarding the applicant is received by the board from the Federation of Podiatric Medical Boards.

2492. (a) The board shall examine every applicant for a certificate to practice podiatric medicine to ensure a minimum of entry-level competence at the time and place designated by the board in its discretion, but at least twice a year.
(b) Unless the applicant meets the requirements of Section 2486, applicants shall be required to have taken and passed the examination administered by the National Board of Podiatric Medical Examiners.
(c) The board may appoint qualified persons to give the whole or any portion of any examination as provided in this article, who shall be designated as examination commissioners. The board may fix the compensation of those persons subject to the provisions of applicable state laws and regulations.
(d) The provisions of Article 9 (commencing with Section 2170) shall apply to examinations administered by the board except where those provisions are in conflict with or inconsistent with the provisions of this article. ~~In respect to applicants under this article any references to the "Division of Licensing" or "division" shall be deemed to apply to the board.~~

2499. There is in the State Treasury the Board of Podiatric Medicine Fund. Notwithstanding Section 2445, the ~~division~~ ***board*** shall report to the Controller at the beginning of each calendar month for the month preceding the amount and source of all revenue received by ~~it on behalf of~~ the board, pursuant to this chapter, and shall pay the entire amount thereof to the Treasurer for deposit into the fund. All revenue received by the board ~~and the division~~ from fees authorized to be charged relating to the practice of podiatric medicine shall be deposited in the fund as provided in this section, and shall be used to carry out the provisions of this chapter relating to the regulation of the practice of podiatric medicine.

Section 2499.7 is added to the Business and Professions Code, to read:

2499.7. (a) Certificates to practice podiatric medicine shall expire at 12 midnight on the last day of the birth month of the licensee during the second year of a two-year term. (b) To renew an unexpired certificate, the licensee, on or before the date on which the certificate would otherwise expire, shall apply for renewal on a form prescribed by the board and pay the prescribed renewal fee.

Board Response (March 2017):
The Board agrees with the Committees' recommendation and the legislative changes proposed by the Committees.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) included all requested legislative changes. These technical, clarifying changes make clear that the BPM is its own board preforming its own licensing functions. There is no further action needed.

ISSUE #6: (PANEL MEMBERSHIP.) MBC is authorized to create panels pursuant to BPC 2008 to evaluate appropriate disciplinary actions. The structure of these panels is potentially hindered by a statutory prohibition for the MBC president to serve as a panel member unless MBC has a vacancy, while at the same time providing that the number of physicians on a panel cannot outweigh the number of public members. Should the law be clarified to account for the realities of MBC membership?

Background: MBC is comprised of 15 members, eight physicians and seven public members. In addition, BPC Section 2004(c) states that MBC's responsibilities include carrying out the disciplinary actions appropriate to the findings made by a panel or an administrative law judge. BPC Section 2008 authorizes MBC to establish panels to fulfill section 2004(c). In establishing panels, the law specifies that the panel must be comprised of a minimum of four members, with the number of public members not to exceed the number of licensed physician and surgeon members, but that the MBC president can only be a member of a panel if there is a vacancy in MBC membership.

According to MBC, this inability for the MBC president to serve on a panel has caused a conflict. Depending on the MBC's appointed membership at any given time, the number of individuals on a panel could vary from four to seven. When all MBC members have been appointed, MBC should have two panels, each comprised of seven members. However, if the MBC president happens to be a physician member, and the president is prohibited from sitting on a panel, the result is more public members than physician members, also specifically prohibited under the law. One resolution could be to prohibit a public member from serving on a panel during the tenure of a physician MBC president.
However, eliminating the physician member from eligibility as a panel member due to their appointment as president then leaves only seven physicians and seven public members to be divided between two panels. One panel could be made up of four physicians and four public members, but the other panel would be made up of four public members and three physicians, thus violating of the requirement in BPC 2008 that the number of public members not exceed the number of physician members on a panel.

Staff Recommendation: ***The Act should be amended to allow the MBC president to be on a panel to resolve this unintended conflict according to the following:***

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

Board Response (March 2017):
The Board agrees with the Committees' recommendation and the legislative changes proposed by the Committees.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) removed the requirement that the Board President not be on a panel. There is no further action needed.

ISSUE #7: (ROLE OF MBC AND HEALTH PROFESSIONALS AND EDUCATION FOUNDATION [HPEF].) MBC has always played a formal role in the administration of the Steven M. Thompson Physician Corps Loan Repayment Program but currently does not have authority to appoint members to the board of the HPEF. Should MBC once again be able to appoint members to the board of the entity that administers this important program?

Background: The Steven M. Thompson Physician Corps Loan Repayment Program (Program) exists within the Health Professions Education Fund, administered by the Office of Statewide Health Planning and Development (OSHPD), as a means of providing educational loans repayment for physicians and surgeons who practice in medically underserved areas of the state. The program was established through legislation in 2002, (AB 982, Firebaugh, Chapter 1131, Statutes of 2002) in response to the physician shortage problem in underserved areas. The program encourages recently licensed physicians to practice in health professional shortage areas (HPSA) in California, repaying up to $105,000 in educational loans in exchange for full-time service for at least three years. To be considered eligible for an award, applicants must:

- Be an allopathic or osteopathic physician
- Be free of any contractual service obligations (i.e. the National Health Service Corps Federal Loan Repayment Program or other financial incentive programs)
- Have outstanding educational debt from a government or commercial lending institution
- Have a valid, unrestricted license to practice medicine in California
- Be employed or have accepted employment in a HPSA in California and commit to providing full-time direct patient care in a HPSA.

Currently, up to 20 percent of the available Program funds may be awarded to program applicants from specialties outside of the primary care specialties.

The Program was previously housed at MBC until legislation in 2005 (AB 920, Aghazarian, Chapter 317, Statutes 2005) moved the Program to the Health Professions and Education Foundation (HPEF), a 501(c)(3) public benefit corporation, which receives administrative support from OSHPD. Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health- profession students and recent graduates and is funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, corporations, and individuals, as well as through a surcharge on the renewal fees of various health professionals. This transfer helped the Program seek donations and secure funding through writing grants and enabled it to grow and increase access to care for Californians.

Although the Program moved to the HPEF, AB 920 also required that two members of the HPEF Board be appointed by MBC. However, that bill also provided a sunset date of January 1, 2011 for the provision related to MBC appointees. AB 1767 (Hill, Chapter 451, Statutes of 2010) extended the date for MBC to appoint members to the HPEF from January 1, 2011, to January 1, 2016, but there was no subsequent legislation to extend the sunset date from January 1, 2016. As a result, MBC's HPEF appointees were removed effective January 1, 2016.

MBC believes that representation on the HPEF is still necessary, noting that physician licensees each provide a mandatory $25 to the HPEF to fund the program and the assistance MBC staff provides in the award process.

Staff Recommendation: ***The Health and Safety Code statutes governing the Program should be amended to ensure participating by MBC in the Program according to the following:***

HSC 128335. (a) The office shall establish a nonprofit public benefit corporation, to be known as the Health Professions Education Foundation, that shall be governed by a board consisting of nine members appointed by the Governor, one member appointed by the Speaker of the Assembly, and one member appointed by the Senate Committee on Rules ***and two members appointed by the Medical Board of California***. The members of the foundation board appointed by the Governor, Speaker of the Assembly, and Senate Committee on Rules may include representatives of minority groups which are underrepresented in the health professions, persons employed as health professionals, and other appropriate members of health or related professions. All persons considered for appointment shall have an interest in health programs, an interest in health educational opportunities for underrepresented groups, and the ability and desire to solicit funds for the purposes of this article as determined by the appointing power. The chairperson of the commission shall also be a nonvoting, ex officio member of the board.
(b) The Governor shall appoint the president of the board of trustees from among those members appointed by the Governor, the Speaker of the Assembly, ~~and~~ the Senate Committee on Rules, and ***Medical Board of California***.
(c) The director, after consultation with the president of the board, may appoint a council of advisers comprised of up to nine members. The council shall advise the director and the board on technical matters and programmatic issues related to the Health Professions Education Foundation Program.
(d) Members of the board and members of the council shall serve without compensation but shall be reimbursed for any actual and necessary expenses incurred in connection with their

duties as members of the board or the council. ***Members appointed by the Medical Board of California shall serve without compensation, but shall be reimbursed by the Medical Board of California for any actual and necessary expenses incurred in connection with their duties as members of the foundation board.***
(e) The foundation shall be subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), except that if there is a conflict with this article and the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), this article shall prevail.
(f) This section shall become operative January 1, 2016.

Board Response (March 2017):
The Board agrees with the Committees' recommendation and the legislative changes proposed by the Committees.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) required two members of HPEF be appointed by the Medical Board. There is no further action needed.

ISSUE #8: (NOTICE TO CONSUMERS.) Business and Professions Code Section 138 requires DCA entities to adopt regulations requiring licensees to provide notice to consumers that the individual is licensed by the State of California. MBC is concerned that this notification does not accurately represent information consumers may need. Should the notification be expanded?

Background: Pursuant to legislation passed in 1998 (SB 2238, Senate Committee on Business and Professions, Chapter 879, Statutes of 1998), DCA entities were required to promulgate regulations outlining how licensees should provide notice to consumers that the individual is licensed. BPC Section 138 states:

> 138. Every board in the department, as defined in Section 22, shall initiate the process of adopting regulations on or before June 30, 1999, to require its licentiates, as defined in Section 23.8, to provide notice to their clients or customers that the practitioner is licensed by this state. A board shall be exempt from the requirement to adopt regulations pursuant to this section if the board has in place, in statute or regulation, a requirement that provides for consumer notice of a practitioner's status as a licensee of this state.

MBC advises that the regulations it adopted only reflect this limited notification that an individual is licensed and notes in its Sunset Report "that consumer protection will be furthered by expanding the statutory language as to what is to be included in the notice, and how it is to be delivered to consumers." Specifically, MBC notes that BPC 138 does not necessarily provide consumers with sufficient information about what MBC does. MBC is concerned this this limited notice does not encourage consumers to access information from MBC or to contact MBC.

While the general provisions of BPC could be enhanced for improved notification to consumers by all DCA licensees, for purposes of MBC, it may be appropriate to include language in the Act to outline the notification MBC licensees should provide consumers.

Staff Recommendation: ***The Committees may wish to amend the Act to specify additional information about MBC and how to access MBC services that should be provided to patients and the public. MBC should work with the Committees and stakeholders in order to determine the information consumers should receive and provide suggested statutory language to fulfill this important mission of arming the public with information about MBC.***

Board Response (March 2017):
Language was submitted on March 10, 2017 to Senate Business, Professions, and Economic Development (BPC) Committee staff that would amend the notice that is required to be posted, thereby providing consumers with more information.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) added BPC section 2026. This section requires the Board to adopt regulations requiring its licentiates to provide notice to their patients that the board licenses the practitioner, that patients can check the practitioner's license, and that complaints against the practitioner can be made through the board's Internet Website or by contacting the board. The Board approved draft regulatory language and authorized staff to proceed with rulemaking in July 2018. The Board submitted a draft rulemaking file to DCA in March 2019. DCA sent the file back to the Board in July 2019 and is still pending board review. The Board anticipates the rulemaking process will be finalized in 2021. No further action needed.

ISSUE #9: (PHYSICIAN HEALTH AND WELLNESS PROGRAM.) MBC is considering 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 patients are not harmed?

Background: SB 1177 (Galgiani, Chapter 591, Statutes of 2016) authorizes MBC to establish a Physician and Surgeon Health and Wellness Program (PHWP) for the early identification and appropriate interventions to support a licensee in his or her rehabilitation from substance abuse and authorizes MBC to contract with an independent entity to administer the PHWP. The bill requires MBC, if it establishes a PHWP, to contract for administration with an independent administering entity selected by MBC through a request for proposals process. SB 1177 also establishes requirements for a PHWP and provides that MBC shall determine the appropriate fee that a participant shall pay to cover all costs for participating in the PHWP, including any costs to administer the PHWP.

Proponents of the bill were concerned that California physicians are the only licensed medical professionals without a wellness and treatment program aimed at providing support and rehabilitation for substance abuse, stress, and other health issues. The MBC previously administered a Physician Diversion Program (PDP), created in 1980 to rehabilitate doctors with mental illness and substance abuse problems without endangering public health and safety. Under this concept, physicians who abuse drugs and/or alcohol or who are mentally or physically ill may be "diverted" from the disciplinary track into a program that monitors their compliance with terms and conditions of a contract that is aimed at ensuring their recovery. The PDP monitored participants' attendance at group meetings, facilitated random drug testing, and required reports from work-site monitors and treatment providers. Many of the

physicians in the PDP retained full and unrestricted medical licenses during their participation and enjoyed complete confidentiality. In recognition that patient safety could not continue to be compromised, as numerous audits pointed out about the PDP, the MBC voted unanimously on July 26, 2007 to end the PDP. The PDP was allowed to sunset on June 30, 2008.

While MBC housed its diversion program, other boards outsource these functions. The DCA currently manages a master contract with MAXIMUS, Inc. (MAXIMUS), a publicly traded corporation for the healing arts boards that have a diversion program. Under this model, the individual boards oversee the programs, but services are provided by MAXIMUS. These diversion programs generally follow the same general principles of the MBC's former PDP. Health practitioners with substance abuse issues may be referred in lieu of discipline or self-refer into the programs and receive help with rehabilitation. After an initial evaluation, individuals accept a participation agreement and are regularly monitored in various ways, including random drug testing, to ensure compliance.

SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) required the DCA to develop uniform and specific standards that shall be used by each healing arts board in dealing with substance-abusing licensees in 16 specified areas, including requirements and standards for: (1) clinical and diagnostic evaluation of the licensee; (2) temporary removal of the licensee from practice; (3) communication with licensee's employer about licensee status and condition; (4) testing and frequency of testing while participating in a diversion program or while on probation; (5) group meeting attendance and qualifications for facilitators; (6) determining what type of treatment is necessary; (7) worksite monitoring; (8) procedures to be followed if a licensee tests positive for a banned substance; (9) procedures to be followed when a licensee is confirmed to have ingested a banned substance; (10) consequences for major violations and minor violations of the standards and requirements; (11) return to practice on a full-time basis; (12) reinstatement of a health practitioner's license; (13) use and reliance on a private-sector vendor that provides diversion services; (14) the extent to which participation in a diversion program shall be kept confidential; (15) audits of a private-sector vendor's performance and adherence to the uniform standards and requirements; and (16) measurable criteria and standards to determine how effective diversion programs are in protecting patients and in assisting licensees in recovering from substance abuse in the long term. The Uniform Substance Abuse Standards (Uniform Standards) were finally adopted in early 2010, with the exception of the frequency of drug testing which was finalized in March 2011. The MBC formally implemented the Uniform Standards in July 2015.

Currently, impaired physicians with substance abuse issues must find their own treatment facility for assistance. MBC is not made aware that the physician received treatment unless a complaint is received, and the physician may present the treatment as evidence in a disciplinary proceeding only if he or she wishes. When MBC is made aware of substance abuse, licensees are placed on formal probation, with terms customized to fit the licensee's individual need. Typical terms include participation in support group meetings, random testing for drug and alcohol use, practice restrictions, and/or medical or psychiatric treatment, including psychotherapy. MBC still retains the power to currently order biological fluid testing as a condition of probation. If the physician tests positive, MBC issues a cease practice order, if allowed in the condition of probation, until MBC investigates and takes subsequent action. If the condition does not authorize a cease practice order, MBC investigates whether the physician is safe to practice medicine. If not, MBC staff will seek an ISO or ask the physician to agree not to practice via a stipulated agreement.

It appears that MBC is preparing to implement a PHWP. MBC held an interested parties meeting in January to discuss regulatory steps necessary for any program. The Governor's 2017/2018 budget includes a request for MBC to add one position to its staff dedicated to administration of a program (despite a program not being in place). It would be helpful for the Committees to understand what steps MBC is taking to implement a PHWP, how the PHWP will conform to the Uniform Standards, how MBC will assure robust accountability for and oversight of the PHWP and how MBC will ensure there are no conflicts of interest in the administration a PHWP should MBC implement a program.

Staff Recommendation: ***MBC should update the Committees on the implementation of a PHWP, including the status of implementation and steps MBC plans to take to ensure the PHWP does not repeat the mistakes of the former PDP.***

Board Response (March 2017):
SB 1177 authorized the Board to establish a Physician Health and Wellness Program. At the October 2016 Board Meeting, the Board approved moving forward with a Physician Health and Wellness Program. On January 11, 2017, the Board held an interested parties meeting to obtain stakeholder input on language for the regulations for the program. The Board is drafting these regulations and will hold another interested parties meeting to discuss these regulations. Once the language has been finalized, it will be provided to the Board for approval. Once the language is approved, the Board will proceed with the regulatory process. Once the regulations are approved, the Board will send out a request for proposal for a third-party vendor. After the contract is awarded, the Board will have to do regulations to set the participation fee. The Board anticipates having all the activities completed so a program could start in the fall of 2018.

This program, as established in the law, is very different than the Board's prior Diversion Program. Physicians will not be able to divert the disciplinary process by entering and successfully completing this program. In addition, the program will have to comply with regulations that are based upon the law, as well as the Uniform Standards. These regulations are going to follow the Uniform Standards as written, which in most circumstances does not allow for deviations. The program will also be run by a third-party entity, not Board staff. This third-party entity will have more expertise and will not be under civil service requirements. The Board will be able to have an independent auditor review the program at least every three years. This will provide the Board with information as to the compliance of this program with the regulations and Uniform Standards. Lastly, the program will provide updates to the Board on the status of individuals in the program. Reports have not yet been established, but this will be part of the process to establish this program. All of these safeguards will assist the Board in ensuring that the program is in compliance with the regulations and Uniform Standards and in line with the Board's mission of consumer protection.

Board Response (2020):
Draft regulations for the PHWP were submitted 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. The SACC has not yet officially incorporated and disseminated the revised Uniform Standards, but 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. The Board is in the process of sending amended draft regulations to DCA.

ISSUE #10: (INPUT FROM INTERESTED PARTIES.) MBC invites stakeholders to participate in meetings and provides formal opportunities for representatives of various state agencies, organizations and professions to present to MBC. Should representatives for the Naturopathic Medicine Committee be allowed to provide information to MBC in a formal MBC meeting setting to better inform members and staff about the role of naturopathic physicians as licensees in California?

Background: According to the Naturopathic Medicine Committee (NMC), naturopathic medicine is a distinct and comprehensive system of primary health care that uses natural methods and substances to support and stimulate the body's self-healing process. Naturopathic medicine includes the combination of a variety of natural medicines and treatments. Naturopathic doctors (NDs) are clinically trained in both natural and conventional approaches to medicine and can prescribe all natural and synthetic hormones, epinephrine, and vitamins, minerals, and amino acids independent of physician supervision. California NDs complete 72 pharmacology course hours in school and are required to complete a minimum of 20 hours of pharmacotherapeutic training every two years as part of their 60 hour continuing education requirement. NDs attend four year, graduate-level, accredited naturopathic medical schools, are trained as primary care providers, and take a national, standardized licensing examination. NDs have limited opportunities to complete hospital residencies, but perform at least 1500 hours of clinical rotations at clinics and private doctors' offices during their education program. California is one of 17 states that license NDs, and over 500 ND licenses have been issued to date.

Stemming from complaints received by MBC about NDs, NMC believes it could be helpful for MBC to receive a presentation about the legal abilities for NDs to practice in California. The NMC cites a 2010 case that MBC dedicated enforcement staff resources and eventually arrested a ND for practicing medicine without a license, however, charges were dropped when a better understanding of the Naturopathic Doctors Act was gained by both MBC investigators and OAG.

It would be helpful for MBC members and their staff to learn more about the legal practices NDs are authorized to perform in California.

Staff Recommendation: ***MBC should have representatives of NMC attend an upcoming MBC meeting to better inform MBC staff and members about the profession.***

Board Response (March 2017):
The Board always welcomes other boards and state agencies to provide presentations at Medical Board meetings on areas of interest to the Board. The Board was unaware of the concerns about enforcement actions or a desire to provide a presentation by the Naturopathic Medicine Committee (NMC). The Board will contact the NMC to request a presentation be provided to the Board at either the April or July 2017 Board meeting. In addition, the Board will

recommend that the NMC provide a presentation to the Board's Enforcement and HQIU's staff.

Board Response (2020):
The NMC provided a presentation to the Board at its July 28, 2017 and August 13, 2020 meeting. Discussion included an overview of Naturopathic Medicine, NDs, education, safety records, malpractice, formularies, and scopes.

ISSUE #11: (BOARD CERTIFICATION.) BPC Section 651 requires MBC to review and approve specialty boards who are not approved by the American Board of Medical Specialties (ABMS) but believe they have equivalent requirements. The law also prohibits a physician from advertising that he or she is "board certified" unless the individual holds a certification from a specialty board approved by the ABMS, a specialty board with an Accreditation Council for Graduate Medical Education (ACGME) accredited post graduate training program, or a specialty board with equivalent requirements approved by MBC. MBC is required, then, to approve or disapprove these specialty boards based upon their equivalency. The discussion of MBC's continued role in approving specialty boards has been raised in previous reviews of MBC and remains an issue. Is MBC really the most appropriate entity to determine board certification equivalency? What is the impact to California patients if MBC no longer performs these reviews?

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

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

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

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

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

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

MBC has denied approval to the American Academy of Pain Management and American Board of Cosmetic Surgery.

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

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

The law addresses advertising and does not in any way require physicians to be board certified or formally trained to practice in a specialty or in the specialty of which they practice. Physicians only need to possess a valid physician's license to practice in any specialty. Health insurance companies typically only choose board-certified physicians for their panels or those physicians whose credentials they have vetted. Hospitals grant privileges to physicians after conducting a review of qualifications through a process called "credentialing" which includes determining a physician's accredited training and board certification. Thus, most physicians granted hospital privileges are board-certified in the specialty for which they are granted privileges, or similarly highly, formally trained.

The "board certification" advertising prohibition is primarily meaningful for elective procedures – those procedures that are not reimbursed by insurance or those performed outside of hospitals or hospital clinic settings.

MBC does not appear to face significant cost pressure for its actual review of these boards, as there have been few applications in recent years. Non-ABMS certifying boards may be deterred from filing applications due to the law, the strict regulations, the demanding review process and MBC's $4030 application fee. While processing an application to determine if the minimum information has been provided can be completed by an MBC analyst, the actual evaluation of the medical training must be performed by an expert physician consultant with academic experience. Generally the consultant used is an emeritus professor of medicine and former training program director who has served on residency review committees. (Residency

review committees are part of the ACGME/ABMS review process.) MBC then must pay for the services of a medical education expert to perform a review of the specialty board's formal training program, cost for which varies but runs in the general range of $5,000 to $11,000. MBC has statutory authority to increase the application fee as necessary to cover its review costs.

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

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

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

The California Society of Plastic Surgeons (CSPS) agrees with this request by MBC, noting that MBC does not have the resources or expertise to determine equivalency, that this role should be eliminated but also agrees that boards that have already been approved by MBC should be grandfathered into law as recognized. CSPS notes that the law does not restrict the ability for a physician to state they have a specialty in a certain area of their practice but rather is specific to advertisements using the term "board certified".

According to the American Society of Plastic Surgeons (ASPS), MBC's objectives of reducing its legal exposure and protecting patients by prohibiting diplomats of substandard board from advertising their certification to consumers can be continued through changes to BPC 651 proposed by ASPS.

The American Board of Pain Medicine (ABPM), one of the current MBC approved non-ABMS entities states that "the existing MBC process has served as an important tool for the state in weeding out less rigorous certification entities." ABPM would like to ensure that non-ABMS boards approved by MBC remain approved by being grandfathered and states concerns that

the elimination of MBC's role, "without an appropriate process to vet alternate boards may lower the bar for use of the term 'board certified' which will ultimately put patients at risk for negative health outcomes."

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

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

Board Response (March 2017):
The Board is recommending that the statute be amended to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the Board. On March 8, 2017, the Board submitted language to Senate BPC Committee staff to amend the statutes in this regard. Due to the fact Business and Professions Code section 651 only pertains to advertising, and since the advertisement requirements will remain the same, the Board does not believe there will be any impact to patients if the Board does not approve non-ABMS specialty boards for equivalency.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) addressed this issue and there is no further action needed.

ISSUE #12: (ACCESS TO CARE.) California law prohibits physicians from being directly employed by corporations as a means of ensuring that corporations are not practicing medicine, and in order to preserve the independence of physician judgment while preventing an employer's interests from interfering with physician decisions or the physician-patient relationship. Healthcare has evolved significantly since the inception of this ban and it is unclear whether these legal prohibitions are still achieving the original purpose. Is the ban on the corporate practice of medicine still appropriate for healthcare today?

Background: The ban on the corporate practice of medicine, or CPM doctrine, is usually referred to in the context of a prohibition, banning hospitals from employing physicians. The ban on CPM evolved in the early 20th century when mining companies had to hire physicians directly to provide care for their employees in remote areas. However, problems arose when physicians' loyalty to the mining companies conflicted with patients' needs. Eventually, physicians, courts and legislatures prohibited CPM in an effort to preserve physicians' autonomy and improve patient care.

Over the years, various state and federal statutes have weakened the CPM prohibition. According to a 2007 report prepared by the California Research Bureau (CRB), "California's CPM doctrine has been defined largely through lawsuits and Attorney General opinions over

decades, and then riddled by HMO and other legislation; its power and meaning are now inconsistent…. Although some non-profit clinics may employ physicians, California applies the CPM doctrine to most other entities…. Teaching hospitals may employ physicians, but other hospitals, including most public and non-profit hospitals, may not employ physicians. Professional medical corporations are expressly permitted to engage in the practice of medicine, and may employ physicians. [However, t]hese medical corporations may operate on a for-profit basis, although the profit motive was one of the original rationales of the CPM prohibition."

A 2016 CRB report notes that "since 2007, the provision of healthcare has undergone changes in California. The Affordable Care Act is responsible for an increase in insured patients across the state. In 2016-2017, 13.5 million Californians are expected to have enrolled in Medi-Cal, up from 7.9 million in 2012-2013, and 1.5 million people will be enrolled in Covered California at the end of 2015- 2016. As a result, more insured patients than ever are accessing healthcare services without a commensurate increase in healthcare practitioners." The report suggested assessing changing financial incentives; considering whether other methods of protecting physician autonomy are sufficient; increasing patient access to data about physician-hospital relationships and hospital metrics; determining whether the current alignment strategies used by physicians and hospitals are more costly than direct employment models; and collecting additional data to better understand the impact of CPM.

Throughout the years, a number of exceptions to the CPM ban have been established statutorily, thereby allowing certain types of facilities to employ physicians, including:

- Clinics operated primarily for the purpose of medical education by a public or private nonprofit university medical school, to charge for professional services rendered to teaching patients by licensed physicians who hold academic appointments on the faculty of the university, if the charges are approved by the physician in whose name the charges are made;

- Certain nonprofit clinics organized and operated exclusively for scientific and charitable purposes, that have been conducting research since before 1982, and that meet other specified requirements, to employ physicians and charge for professional services. Prohibits, however, these clinics from interfering with, controlling, or otherwise directing a physician's professional judgment in a manner prohibited by the CPM prohibition or any other provision of law;

- A narcotic treatment program regulated by the Department of Alcohol and Drug Programs to employ physicians and charge for professional services rendered by those physicians. Prohibits, however, the narcotic clinic from interfering with, controlling, or otherwise directing a physician's professional judgment in a manner that is prohibited by the CPM prohibition or any other provision of law; and,

- A hospital that is owned and operated by a licensed charitable organization that offers only pediatric subspecialty care, as specified.

- Until 2024, a federally certified critical access hospital which is a small (25 or less beds) hospital located in a remote, rural area.

California currently has a physician shortage. As the 2016 CRB report notes, “AMA figures show that, on average, California has 80 primary care physicians and 138 specialty physicians per 100,000 residents. This is in the upper range for primary care physicians (60-80) and above the range for specialty care physicians (85-105) recommended by the Department of Health and Human Services. However, when disaggregated by region, there is a coverage disparity. California’s rural regions have lower numbers of physicians than its urban areas. For instance, the San Joaquin Valley has only 45 primary care physicians and 74 specialty physicians per 100,000 residents, compared with the Bay Area’s 78 primary care physicians and 155 specialists per 100,000 residents. The number of healthcare providers, including primary care physicians, in California is not anticipated to dramatically increase soon.”

The nationwide trend in healthcare is toward direct employment. According to a 2011 survey from the consulting firm Accenture:

> “U.S. physicians continue to sell their private practices and seek employment with healthcare systems, according to a new survey from Accenture. As physicians migrate from private practice to larger health systems, the new landscape will require healthcare information technology (IT), medical device manufacturers, pharmaceutical companies and payers to revise their business models and offerings. At the same time, hospitals will need to determine how to retain and recruit the correct mix of physicians, especially in high-growth service lines, including cardiovascular care, orthopedics, cancer care and radiology. Patients will increasingly move to large health systems, as opposed to the current trend of visiting doctors in private, small practice settings.
>
> “’Health reform is challenging the entire system to deliver improved care through insight driven health,’ said Kristin Ficery, senior executive, Accenture Health. ‘We see an increasing number of physicians leaving private practice to join hospital systems, which will force all stakeholders to revise and refine their business models, product offerings and service
> strategies.’”

Benefits to direct employment include:

- Relief from administrative responsibilities, especially those relating to insurance billing.
- Malpractice insurance.
- Greater access and support for healthcare IT tools, facilities, and medical equipment.
- A predictable work week.
- Economic stability.

The law provides for protections against retaliation for health care practitioners who advocate for appropriate health care for their patients, pursuant to Wickline v. State of California (192 Cal. App. 3d 1630): (BPC Section 510) by stating:

a) It is the public policy of the State of California that a health care practitioner be encouraged to advocate for appropriate health care for his or her patients. For purposes of this section, “to advocate for appropriate health care” means to appeal a payer’s decision to deny payment for a service pursuant to the reasonable grievance or appeal procedure established by a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff and governing body, or payer, or to protest a decision, policy, or practice that the health care practitioner, consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care, reasonably believes impairs the health care practitioner’s ability to provide appropriate health care to his or her patients.

b) The application and rendering by any individual, partnership, corporation, or other organization of a decision to terminate an employment or other contractual relationship with or otherwise penalize a health care practitioner principally for advocating for appropriate health care consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care violates the public policy of this state.

c) This law shall not be construed to prohibit a payer from making a determination not to pay for a particular medical treatment or service, or the services of a type of health care practitioner, or to prohibit a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff, hospital governing body, or payer from enforcing reasonable peer review or utilization review protocols or determining whether a health care practitioner has complied with those protocols.

As noted in the 2016 CRB report and reflected in broad legislative discussion on the topic, stakeholder groups have weighed in on CPM. The report cites a 2007 document from the California Medical Association (CMA) which notes that the CMA considers the CPM doctrine “a fundamental protection against the potential that the provision of medical care and treatment will be subject to commercial exploitation.” The report noted that in this document, CMA’s Legal Counsel defines the CPM bar broadly, as a prohibition on lay entities hiring or employing physicians or other health care practitioners, or interfering with physicians or other health care practitioners’ practice of medicine. Lay entities are also prohibited from contracting with health care professionals to render services. The CMA further notes that the CPM Bar “…is designed to protect the public from possible abuses stemming from the commercial exploitation of the practice of medicine,” and that California’s courts and legislature have upheld the CPM Bar to protect physicians from the “pressures of the commercial marketplace”.

Staff Recommendation: ***The Committees may wish to discuss changes for greater patient access to care. The Committees may wish to consider the pros and cons for patients if physicians were permitted to be employed by corporations.***

Board Response (March 2017):
Current law under Business and Professions Code section 2400 (commonly referred to as the "ban on the corporate practice of medicine"), generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine. This prohibition ensures that lay persons are not controlling or influencing the professional judgment and practice of medicine

by physicians.

The purpose of the ban on the corporate practice of medicine is to minimize the undue influence or interference with physician's judgment and the physician-patient relationship. Physicians should not be forced to choose between the dictates of the employer and the best interest of the patient. The ban protects consumers so that those physicians who make decisions that affect the provision of medical services understand the medical implications of those decisions, have an ethical obligation to place the patient's interests ahead of their own, and are subject to the enforcement powers of the Board. The Board has always believed that the ban on the corporate practice of medicine provides a very important protection for patients and physicians from inappropriate intrusions into the practice of medicine.

The Board believes that removal of the ban on the corporate practice of medicine would have a significant impact on consumer protection. While the Board has taken a neutral position on bills that have allowed certain hospitals to hire physicians, an overall removal of this ban outside of these settings would not be in the interest of consumer protection.

Board Response (2020):
The Board maintains its view that removing the ban on the corporate practice of medicine would not be in the interest of consumer protection.

ISSUE #13: (PRESCRIBER GUIDELINES). Current, appropriate guidelines outlining safe prescribing practices for certain types of medication, or medication prescribed to certain patient populations, are an important tool for physicians and MBC alike. While MBC recently updated its guidelines for prescribing pain medication, it is unclear what MBC does to ensure physicians read and use these guidelines. Guidance to physicians about prescribing psychotropic medication to foster youth and recommending medical cannabis could also be beneficial. How has MBC promoted its guidelines for prescribing controlled substances? Is MBC issuing guidelines related to the appropriate prescribing of psychotropic medication to foster youth or medical cannabis?

Background: MBC licensees issue prescriptions to patients for medication through the course of care, according to professional judgment and within the appropriate standard of care. For certain types of medication, and certain types of medication prescribed to certain types of patients, guidelines on appropriate and safe prescribing practices can serve as a helpful tools for the providers, patients and MBC alike.

Prescription medicine used to treat pain has been the focus of ongoing discussions in the Legislature, particularly in the years since MBC's last review as California and the nation face an epidemic of prescription drug abuse and related overdose deaths. In 1994, MBC unanimously adopted a policy statement entitled "Prescribing Controlled Substances for Pain." Stemming from studies and discussions about controlled substances, this policy statement was designed to provide guidance to improve prescriber standards for pain management, while simultaneously undermining opportunities for drug diversion and abuse. The guidelines outlined appropriate steps related to a patient's examination, treatment plan, informed consent, periodic review, consultation, records, and compliance with controlled substances laws. Subsequent to MBC's 1994 action, legislation that took effect in 2002 (AB 487, Aroner, Chapter 518, Statutes of 2001) created a task force to revisit the 1994 guidelines to develop standards assuring competent review in cases concerning the under-treatment and under-

medication of a patient's pain and also required continuing education courses for physicians in the subjects of pain management and the treatment of terminally ill and dying patients. The intent of the bill was to broaden and update the knowledge base of all physicians related to the appropriate care and treatment of patients suffering from pain, and terminally ill and dying patients. The passage of AB 2198 in 2006 (Houston, Chapter 350, Statutes of 2006) updated California law governing the use of drugs to treat pain by clarifying that health care professionals with a medical basis, including the treatment of pain, for prescribing, furnishing, dispensing, or administering dangerous drugs or prescription controlled substances, may do so without being subject to disciplinary action or prosecution.

MBC currently encourages all licensees to consult the policy statement and Guidelines for Prescribing Controlled Substances for Pain which were updated in 2014 based on input from a MBC Prescribing Task Force that held multiple meetings to identify best practices. According to the MBC website, “The board strongly urges physicians and surgeons to view effective pain management as a high priority in all patients, including children, the elderly, and patients who are terminally ill. Pain should be assessed and treated promptly, effectively and for as long as pain persists. The medical management of pain should be based on up-to-date knowledge about pain, pain assessment and pain treatment. Pain treatment may involve the use of several medications and non-pharmacological treatment modalities, often in combination. For some types of pain, the use of medications is emphasized and should be pursued vigorously; for other types, the use of medications is better de- emphasized in favor of other therapeutic modalities. Physicians and surgeons should have sufficient knowledge or utilize consultations to make such judgments for their patients. Medications, in particular opioid analgesics, are considered the cornerstone of treatment for pain associated with trauma, surgery, medical procedures, or cancer.” MBC intends for the guidelines to educate physicians on effective pain management in California by avoiding under treatment, overtreatment, or other inappropriate treatment of a patient’s pain. Reduction of prescription overdose deaths is also an objective of the updated guidelines. *It would be helpful for the Committees to understand what steps MBC takes to ensure licensees consult the updated guidelines.*

Concern over the use of psychotropic medications among children have also been the subject of recent Legislative consideration and discussion, and have been well-documented in research journals and the mainstream media for more than a decade. The category of psychotropic medication is fairly broad, intending to treat symptoms of conditions ranging from attention deficit hyperactivity disorder (ADHD) to childhood schizophrenia. Some of the drugs used to treat these conditions are FDA-approved, however only about 31 percent of psychotropic medications have been approved by the FDA for use in children or adolescents. It is estimated that more than 75 percent of the prescriptions written for psychiatric illness in this population are “off label” in usage, meaning they have not been approved by the FDA for the prescribed use, though the practice is legal and common across all manner of pharmaceuticals. Studies have found that the off- label use of these anti-psychotics among children is high, particularly among foster children.

In 2012, the DHCS and DSS convened a statewide Quality Improvement Project (QIP) to design, pilot, and evaluate effective practices to improve psychotropic medication use among children and youth in foster care. The QIP’s Clinical Workgroup released a set of guidelines to assist prescribers and caregivers in maintaining compliance with State and county regulations and guidelines pertaining to Medi-Cal funded mental health services and psychotropic prescribing practices for foster homes, group homes, and residential treatment centers. In

addition, the guidelines include prescriber and caregiver expectations regarding developing and monitoring treatment plans for behavioral health care, principles for informed consent to medications, and governing medication safety. These guidelines are designed as a statement of best practice for the treatment of children and youth in out-of-home care.

MBC reported during conversations about SB 1174 (McGuire, Chapter 840, Statutes of 2016) that it has made the QIP's Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care available to all licensees on its website as well as through an email to its licensee listserv. MBC's responsibilities in overseeing their licensees' prescribing habits of psychotropic medications to foster youth were also a component of an audit conducted by the California State Auditor pertaining to the oversight and monitoring of children in foster care who have been prescribed psychotropic medications. The audit revealed that some foster children were prescribed psychotropic medications in amounts and dosages that exceeded state guidelines and counties did not follow up with prescribers to ensure the appropriateness of these prescriptions. The audit also found that many foster children did not receive follow-up visits or recommended psychosocial services in conjunction with their prescriptions for psychotropic medications. *It would be helpful for the Committees to understand what additional steps MBC takes to ensure licensees consult the QIP's guidelines.*

MBC licensees are also authorized to recommend the use of cannabis for medical purposes. Since the approval of the Compassionate Use Act (contained in Proposition 215) by voters in 1996, state law has allowed Californians access to marijuana for medical purposes, and prohibited punitive action against physicians for making medical marijuana recommendations. The CUA established the right of patients to obtain and use marijuana to treat specified illnesses and any other illness for which marijuana provides relief. Three laws enacted in 2015 (AB 243, Wood, Chapter 688 Statutes of 2015; AB 266, Bonta, Chapter 689, Statutes of 2015 and; SB 643, McGuire, Chapter 719, Statutes of 2015), known collectively as the Medical Cannabis Regulation and Safety Act (MCRSA), provide a statutory framework to regulate medical cannabis. Under MCRSA, MBC is required to consult with the California Marijuana Research Program, known as the Center for Medicinal Cannabis Research, in order to develop and adopt medical guidelines for the appropriate administration and use of medical marijuana. MBC has a page on its website titled *Marijuana for Medical Purposes* which MBC notes was adopted by the full MBC in 2004 and amended in October 2014. This information page refers to the former CUA in defining the role of physicians and surgeons related to medical marijuana, but does note that MBC "developed this statement since marijuana is an emerging treatment modality. The Medical Board wants to assure physicians who choose to recommend marijuana for medical purposes to their patients, as part of their regular practice of medicine, that they WILL NOT be subject to investigation or disciplinary action by the Medical Board if they arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility. The mere receipt of a complaint that the physician is recommending marijuana for medical purposes will not generate an investigation absent additional information indicating that the physician is not adhering to accepted medical standards." MBC clarifies that a physician's written recommendation to a patient will not trigger action by MBC and notes that a patient need not have failed on all standard medications in order for a physician to recommend or approve the use of marijuana for medical purposes. Rather than direct licensees and the public to MBC guidelines, it refers physicians to links for other organizations' websites. It appears that the FSMB developed model policy guidelines regarding the recommendation in patient care for state boards to utilize, but those are also not provided to California physicians. *While MBC reports that it has a Marijuana Task Force, it*

would be helpful for the Committees to understand the status of the Task Force's work, the status of MBC guidelines and MBC's plan for dissemination of guidelines when they are adopted.

Staff Recommendation: ***MBC should update the Committees on its efforts related to guidelines for prescriptions of controlled substances for pain, psychotropic medication to foster youth and medical cannabis.***

Board Response (March 2017):
The Board released its new Guidelines for Prescribing Controlled Substances for Pain in November 2014. Upon approval by the Board, the Board emailed a link to this document to all licensed physicians and applicants encouraging them to review the document and use it when prescribing controlled substances. The Board also prominently displayed this link on its website. In addition, the Board sent it out to all subscribers on the Board's subscription list. The Board also enlisted the assistance of the Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup, which is made up of numerous state agencies, to disseminate the guidelines via their distribution lists and on their websites. The Board also discussed the guidelines in an article in the Board's Newsletter that came out in January 2015. This Newsletter is not only emailed out to physicians who have an email, but it is mailed to all physicians who do not have an email. The guidelines have also been discussed and provided in other organization's and association's newsletters. Most importantly, the Board has made numerous presentations on the guidelines to physician groups across California. All of these efforts are conducted to ensure physicians consult these updated guidelines.

When DHCS and DSS' Quality Improvement Project released its California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care, the Board followed a similar release format. This information was emailed to all physicians and applicants, a link was posted on the Board's website and a subscriber's email was sent. In addition, the Board wrote an article in its summer 2015 Newsletter about the guidelines with a link to the document. The Board also has a page devoted to these guidelines on its website. Based upon the information in these guidelines and the process this document went through, including significant input from experts in the field, the Board did not develop its own guidelines.

In 2004, the Board developed a statement on recommending marijuana for medicinal purposes, which is on the Board's website. In 2014, the Board updated this statement to make some edits related to the use of telemedicine. Last year, the Federation of State Medical Boards released its guidelines on recommending marijuana. Upon release of these guidelines, the Board directed staff to review the Board's current statement and determine if changes needed to be made. In addition, SB 643, authored by Senator McGuire, also directed the Board to develop guidelines.

The Board has established a Marijuana Task Force to develop these guidelines with assistance from experts in this field. The Task Force held an interested parties meeting on February 8, 2017, to review the current statement and the Federation guidelines, and to hear input from experts on needed changes to the document. Board staff is in the process of updating its current statement and turning it into Board guidelines for recommending marijuana for medicinal purposes. The Board anticipates a completed document by fall of 2017. Once the document is finalized, the Board will follow the same dissemination process as conducted with the other guidelines.

Board Response (2020):
The Board produced, "Guidelines for the Recommendation of Cannabis for Medical Purposes – April 2018", disseminated this information to interested parties, and posted on the Board's Website. These Guidelines were developed to assist physicians who choose to recommend cannabis for medical purposes to their patients. These Guidelines are not intended to mandate the standard of care and deviations from these Guidelines may occur and may be appropriate depending upon the unique needs of individual patients.

ISSUE #14: (COST RECOVERY.) MBC is statutorily prohibited from seeking reimbursement from physicians for costs related to disciplinary action. MBC is only prohibited from collecting reimbursement from physicians and 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 impact fund conditions. Should MBC once again be authorized to seek cost recovery from physicians for disciplinary action?

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

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

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

Board Response (March 2017):
Most boards within DCA do not obtain full cost recovery on their enforcement cases. Prior to the elimination of the Board's ability to obtain cost recovery, the Board was not receiving full costs on their cases. This occurred for two reasons: 1) cost recovery was used as a negotiation tool during the settlement process; and 2) Administrative Law Judges would not order full costs in most cases. Therefore, the Board was not receiving full cost recovery.

In 2006, when the Board's ability to obtain cost recovery was eliminated, the Board was able to adopt regulations to increase the physician and surgeon fee to make this elimination cost

neutral. At that time, the Board determined that the renewal fee would be increased by $15 to recuperate the funds that were eliminated due to cost recovery. This $15 fee increase was not based upon what the Board had spent, nor was it based upon the amount that had been ordered. It was based upon what the Board had received in cost recovery each year for the prior three fiscal years.

Based upon this fee increase of $15, last year the Board received approximately $927,585 in funds due to the elimination of cost recovery. Since 2006, the Board's budget has increased from 42 million to 62 million dollars. Therefore, the Board's current $15 fee may not be commensurate with what the Board would have received in cost recovery should it be available.

Because of the $15 fee increase, the elimination of cost recovery did not have a significant impact to the Board's budget. However, based upon the increase in the Board's budget, this amount may need to be increased. The committee may wish to either authorize the Board to increase licensing fees to obtain the difference in cost recovery from 2006 to 2017 or again allow the Board to obtain cost recovery from those physicians found in violation of the law.

The inability to receive cost recovery has not impacted the case outcomes. It was thought that more cases would go to hearing with the elimination of cost recovery; however, the Board still continues to settle approximately 70-80% of its cases. The inability to recover costs has no impact on whether the Board determines to settle a case or not. The Board reviews the violations the physician has committed, reviews the disciplinary guidelines, and on a case-by-case basis, offers a settlement that ensures consumer protection and rehabilitation of the physician. The Board does not resist going to hearing based upon the costs that may be incurred should the matter go to hearing. If the physician does not agree to the recommended settlement from the Board, the matter will proceed to hearing.

Board Response (2020):
Cost recovery continues to be a high priority for the Board as it is a tool that has been taken away to help resolve cases expeditiously. The Board does not believe that cost recovery will bring a significant source of revenue to its fund, however, the Board believes it may see savings in the money spent on any given case due to the length of time it takes for a settlement. The Board is requesting cost recovery be reinstated (see new issues section of this report).

ISSUE #15: (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 implemented. What are the barriers to MBC implementing this program? What steps has MBC taken since 2003 to put the program in place?

Background: As noted in a Senate Business and Professions Committee analysis in 2002, The Licensed Physicians and Dentists Program established by AB 1045 (Firebaugh, Chapter 1157, Statutes of 2002) was designed to bring physicians and dentists from Mexico who have rural experience, speak the language, understand the culture and know how to apply this knowledge in serving the large Latino communities in rural areas who have limited or no access to primary health care services. Bill proponents were concerned about addressing

primary care physician and dentist shortages while maintaining a high quality of care. The bill authorized up to 30 licensed physicians specializing in family practice, internal medicine, pediatrics and obstetrics and gynecology and up to 30 licensed dentists from Mexico to practice medicine or dentistry in California for up to three years and required the individuals to meet certain requirements related to training and education. Program participants are required to undergo a six month orientation program approved by MBC addressing medical protocol, community clinic history and operations, medical administration, hospital operations and protocol, medical ethics, the California medical delivery system, health maintenance organizations and managed care practices and pharmacology differences.

AB 1045 tasked MBC with oversight review of both the implementation of the program and an evaluation of the program. MBC was supposed to consult with medical schools applying for funding to implement and evaluate this program, executive and medical directors of nonprofit community health centers wanting to employ program participants and hospital administrators who would have program participants practicing in their hospital. The bill specified that any funding necessary for the implementation of the program, including the evaluation and oversight functions, was to be secured from nonprofit philanthropic entities and stated that implementation of the program could not move forward unless appropriate funding was secured from nonprofit philanthropic entities. AB 1045 also required MBC to report to the Legislature every January during which the program is operational regarding the status of the program and the ability of the program to secure the funding necessary to carry out its required provisions.

At its October 2016 quarterly meeting, MBC's E.D. reported on discussions surrounding implementation of the pilot program. The E.D. outlined the program as defined in BPC Section 853 and informed MBC that there had been several discussions regarding the program for the past 13 years but that funding had remained a barrier to implementation. The E.D. noted that when funds became available, MBC staff would begin implementing the program.

Given access to care issues, particularly those related to residents of rural communities and stemming from language barriers, remain a concern these many years following passage of the bill, it would be helpful for the Committees to understand remaining barriers to program implementation. It would also be helpful for the Committees to understand where program funding will come from and whether statutory changes are necessary to allow MBC to receive funding to implement the program.

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, considering the significant passage of time since its statutory creation and potential implementation.***

Board Response (March 2017):
Business and Professions Code section 853 became effective in 2003 and established the Licensed Physicians and Dentists from Mexico Pilot Program (Program). This Program allows up to 30 licensed physicians from Mexico specializing in family practice, internal medicine, pediatrics, and obstetrics and gynecology to practice medicine in California for a period not to exceed three years, if they meet specified requirements. The Program is also required to be

affiliated with a medical school in California.

The Board's role in this Program is to provide oversight review of the implementation, as specified. However, this law requires that all of the funding necessary for the implementation of this Program, including the evaluation and oversight functions, to be secured from nonprofit philanthropic entities. This law expressly states that implementation of this Program shall not proceed unless appropriate funding is secured from nonprofit philanthropic entities. Funding has never been secured for this Program, so it has not yet been implemented. Once funding is secured and other requirements are met, the Board will begin the process of establishing this Program.

The Board had meetings last year with interested parties and provided a fiscal estimate of the funding that would be needed to implement the Program from the Board's perspective, but to the Board's knowledge, that funding has not yet been secured. In order to implement this Program without funding from nonprofit philanthropic entities, the law would need to be amended to delete this requirement and identify a new funding source.

Board Response (2020):
The Board continues to meet with the Business, Consumer Services and Housing Agency, DCA, and program representatives on outstanding requirements of the pilot program. Significant progress has been made toward implementing this program, but there are still outstanding items that must be achieved before licenses are issued. First, the Board has to ensure that appropriate funding is in place to cover all costs for this program. Pursuant to BPC section 853(c)(8), "[a]ny funding necessary for the implementation of this program, including the evaluation and oversight functions, shall be secured from nonprofit philanthropic entities. Implementation of this program may not proceed unless appropriate funding is secured from nonprofit philanthropic entities." Second, and related to the funding issue, the contract for the evaluation of the pilot program that is required pursuant to BPC section 853(j) must have sufficiently progressed through the approval process of both the participating medical school and the DCA to ensure that the contract will be approved and that appropriate funding is in place as required before issuing the licenses. The Board has received and evaluated approximately 29 applications and will issue the medical licenses to applicants meeting licensing criteria once all program requirements are in place.

ISSUE #16: (POSTGRADUATE TRAINING AND MBC APPROVAL OF INTERNATIONAL MEDICAL SCHOOLS.) The Act specifies requirements for postgraduate training that MBC physician applicants must undertake and outlines what graduates of international medical schools must do in terms of postgraduate training. MBC approves all schools applicants for licensure must attend, including medical schools located in other countries. Are there amendments to the Act to ensure proper clinical training? Should MBC be in the business of approving international medical schools?

Background: The Act treats graduates of international medical schools and those located in the U.S. differently in terms of the clinical training required for MBC licensure. Applicants for licensure who graduated from an LCME-approved domestic medical school (domestic includes the U.S. and Canada) are required to complete one year of either ACGME (U.S.) or Royal College of Physicians and Surgeons of Canada (RCPSC) (Canada) accredited postgraduate training. Applicants for licensure who graduated from a MBC approved international medical school must complete two years of ACGME or RCPSC accredited postgraduate training.

ACGME and RCPSC accredited schools must meet the same educational and experience requirements, all programs are accredited by the same entity, all programs undergo specified re-accreditation assessments, and all programs are judged by the same standards. According to MBC, graduates of domestic medical schools meet the minimum undergraduate clinical requirements (four weeks psychiatry, four weeks family medicine, eight weeks medicine, six weeks obstetrics and gynecology, six weeks pediatrics, eight weeks surgery, plus another four weeks from one of the clinical core subjects, and 32 weeks of electives) by virtue of attending a LCME-approved medical school.

Graduates of international medical schools must meet the same undergraduate clinical requirements, however, due to the lack of any international accreditation organization like the LCME, and lack of an LCME-like organization in many countries, MBC has attempted to recognize postgraduate training of these applicants but many are still not eligible for licensure by MBC. MBC has proposed solving this problem by amending the Act to require all applicants, regardless of school of graduation, to satisfactorily complete a minimum of three years of ACGME/RCPSC postgraduate training prior to the issuance of a full unrestricted license to practice. MBC proposes issuing training permits and identifying the scopes of practice for each training year, in conjunction with the postgraduate training programs. Three years comes from the industry-recognized standard of three years of training required for board certification by ABMS boards in specialties family medicine, internal medicine, pediatrics and others. According to MBC, this equitable evaluation process ensures the programs set the same criteria, requirements and standards and ensures that all participants in these programs meet the same criteria, requirements, and standards. MBC believes this approach will result in a more effective assessment of an applicant's eligibility for licensure than where he or she attended medical school and completed undergraduate clinical rotations. According to MBC, this new process will ensure physicians satisfactorily completing three years of ACMGE or RCPSC postgraduate training, in any specialty, have developed and demonstrated competency in the same skill sets of patient care in a monitored and structured setting.

The Act currently requires MBC to approve all medical schools it accepts graduate applicants for licensure from. MBC approves medical schools in the U.S. and Canada that are accredited by the LCME. For schools not located in the U.S., MBC recognizes schools with historic approval from the World Health Organization and schools MBC itself approves, as there is no foreign equivalent to LCME.

In 2003, MBC adopted regulations establishing a standard review process and minimum standards for international medical schools whose graduates wish to apply for licensure in California. Medical schools located in another country are divided into two categories: schools that are owned and operated by the government of the country in which the school is domiciled whose primary purpose is to educate citizens to practice medicine in that country (also known as "(a)(1) schools") and schools with a primary purpose of educating non-citizens to practice medicine in other countries ("(a)(2) schools"). MBC's evaluation and assessment process for all international schools includes many steps, various protocols and copious amounts of staff time. "(a)(1)" schools are not required to undergo the same in- depth individual review of "(a)(2)" schools, as MBC has determined that free-standing for profit medical schools are less likely to satisfy MBC's minimal quality standards. MBC states that it relies on the expertise of individuals experienced in medical academies to determine whether or not "(a)(2)" schools are sufficient to meet quality requirements. Many "(a)(2)" schools are required to undergo a MBC staff site visit which allows MBC to verify information a school submits to MBC in its initial

application and self-assessment report. According to MBC, the process can take as little as 30 days or as long as three or more years, depending on factors like when documentation is received, when staff is approved to travel out of the country for inspection and when a site visit report is completed.

MBC currently recognizes 1,882 international medical schools, some of which require a reassessment every seven years, modeled after LCME requirements for domestic schools. Yet MBC reports that it is not able to conduct these reviews due to a lack of staffing and the fact that only a very limited number of MBC staff have the experience to review international medical schools. According to MBC, it does not have sufficient resources with appropriate knowledge of how medical education is developed and delivered, nor sufficient numbers of highly-trained and educated medical consultants to properly and adequately conduct these assessments and render decisions. Given the historic challenges for MBC to conduct quality review of international medical schools and the high cost for this activity, MBC suggests in its 2016 Sunset Report that the Act should be amended to eliminate requirements for MBC recognition of international medical schools and that MBC should instead require individuals to have graduated from a medical school listed in the World Health Organization's directory as an approved school. MBC advises that this change will speed up the timeframe for applications from graduates of foreign schools to be processed. MBC asserts that this will also allow the staff dedicated to international school approval to work on assisting with the processing of postgraduate training authorization letters and issuing licenses.

Staff Recommendation: ***The Committees should consider MBC's suggestion to eliminate requirements for approval of international medical schools by MBC. Given that other states rely on MBC approval of international medical schools in lieu of there being an international organization equivalent to LCME, MBC should advise the Committees of any potential impacts.***

Board Response (March 2017):
As a consumer protection agency, the Board does not believe that one year (for US/Canadian medical school graduates) or two years (for international medical school graduates) of postgraduate training is sufficient. Therefore, the Board recommended changing the postgraduate training requirements for licensure from one or two years of postgraduate training to three years of postgraduate training. With this change, the Board also recommended a change to the school recognition/approval process.

The Board does not believe that the elimination of the Board's review of international schools would have an impact on other states due to the fact that changes are being made to the approval process under the World Federation for Medical Education (WFME) and the Foundation for Advancement of International Medical Education and Research (FAIMER) who, in collaboration with the World Health Organization and the University of Copenhagen, develop the World Directory of Medical Schools. All states should be able to use the World Directory. Because this change would enhance consumer protection with the increase in the number of years of postgraduate training, the Board supports it and will work with interested parties to eliminate any unforeseen issues that have been brought forward. The Board will provide suggested statutory language to Committee staff on this issue by April 3, 2017.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) addressed these issues and there is no further action needed. Effective January 1, 2020, all applicants, regardless of whether the medical school attended was domestic or international, will be required to successfully complete 36 months of approved postgraduate training. Further, the Board no longer approves medical schools.

ISSUE #17: (LICENSE CYCLES.) Concerns have been raised about the way that MBC determines when licenses expire. Does it make more sense for MBC to issue two-year term licenses rather than having licenses expire based on a physician's date of birth?

Background: The birth date renewal system is used by many DCA boards to establish licensure cycle. Licenses are issued for a period of time ranging between 12 and 24 months depending on the licensee's birth month. If, for example, a licensee has a February birth date and his or her license is issued in March 2014, the license will expire at midnight on February 29, 2016. If, however, a licensee has a March birthday and his or her license is issued in March 2014, the license will expire at midnight on March 31, 2015.

In these examples, the license in the first scenario will expire after nearly 2 years, but in the second scenario, the license will expire after 12 months and 5 days. Despite the varying expiration dates, both licensees would need to pay the same initial license fee. This system has been perceived as unfair to first-time licensees because all licenses pay the same fee, regardless of how long the license lasts.

MBC uses a physician's birth date to calculate license expiration dates. According to MBC, the purpose of the birth date renewal initially was to ensure that the MBC did not have to process a large number of applications or renewals during peak times. However, now that MBC conducts outreach to medical school graduates and potential applicants, licenses are issued throughout the year. MBC advises that it offers applicants the option of waiting until their birth month for their physician and surgeon license to be issued but some applicants cannot wait until their birth month, resulting in a license not being valid for a full two years and overpayment of licensure fees to MBC. MBC has requested that the Act be amended to clarify it can issue licenses on a two-year cycle.

Staff Recommendation: ***The Act should be amended to reflect changes to the way MBC establishes license cycles.***

Board Response (March 2017):
Language was submitted on March 10, 2017 to Senate BPC Committee staff that would amend the Board's expiration date for its licensees.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) addressed this issue and there is no further action needed.

ISSUE #18: (RETURNING TO PRACTICE AFTER A LAPSE IN LICENSURE.) MBC continues to study the issue of whether allowing a physician to return to practice after a lapse in licensure or practice for more than 18 months without completing additional training provides adequate public protection. MBC held an interested parties meeting to

discuss this issue and is continuing to explore, along with partners and stakeholders throughout the nation, whether statutory changes are necessary to require additional training past a certain timeframe of practice inactivity.

Background: During the prior review of MBC, the Committees believed there should be consistency in the amount of time a physician and surgeon should be allowed to remain out of practice without receiving additional clinical training before renewing their license and/or allowing them to continue practice.

For a physician who has let his or her license expire, BPC Section 2456.3 states, in part, “a license which has expired may be renewed at any time within 5 years after its expiration.” In order to renew the license, the physician must simply submit the renewal paperwork, CME verifications and pay the fees and penalties. This can result in a licensee returning to active status even if the physician has not practiced medicine for up to five or more years. For example, a physician who, during the last two renewal cycles, did not practice clinical medicine, and then allowed the license to lapse four years prior to renewing, could go back into some sort of clinical practice. That physician who has not practicedfor eight years can just renew, pay fees, demonstrate that CME has been obtained and go back into practice. MBC is still looking into this issue of how long an individual should be eligible to remain out of practice before having to undergo training.

MBC states that it continues to receive applications for medical licensure from individuals who have not practiced clinical medicine for many years. In addition, BPC Section 2428 authorizes a previous California licensee to apply for issuance of the former license, provided all requirements and criteria set forth in the statute are met. MBC states that most applicants satisfy these requirements yet not all of these applicants have updated their clinical competency by practicing in a monitored or supervised clinical setting. While MBC requires individuals who have not practiced medicine for five or more years to undertake a recognized national assessment of their knowledge and clinical skills, California does not have a provision requiring clinical practice in a monitored and/or supervised setting.

MBC believes it could be helpful to issue a Limited Educational Permit for a certain time period to allow individuals to receive a limited license to practice while they continue to undergo important clinical work. During the time an individual holds this permit, patient encounters would need to be supervised, patient records would need to be audited and a formal assessment of clinical skills would need to be provided to MBC by a supervisor at the end of the time period of this permit, with a determination of whether the applicant is safe to practice medicine or if additional clinical training is needed. MBC believes that this will ensure it has oversight for these individuals and will also ensure that the applicant has met minimum requirements to safely and competently practice as an independent physician.

Staff Recommendation: ***MBC should provide an update to the Committees on the length of time an individual should be eligible to remain out of practice without additional training. MBC should advise the Committees of stakeholder meetings it has held on the Limited Educational Permit proposal and advise the Committees whether this is a trend other states are following. Based on a review of proposed statutory language and additional information about the impact such a permit would have on physicians and the public, the Committees may wish to amend the Act to allow MBC to implement this option.***

Board Response (March 2017):
The Committees may want to consider separating this issue into two different issues. The first issue is the length of time a licensee should be allowed to be out of practice before some type of refresher course is necessary. At this time, the Board does not have any statutory authority that limits the amount of time a licensee can be out of practice before an additional requirement is met. As stated in the background paper, should a physician not renew their license for five years, then the license is automatically canceled. However, during any of the preceding years before their license is automatically cancelled, they can pay fees and renew that license, even if they have not been practicing. The Board would need to ask the licensee at the time of renewal whether they have been practicing and if not, the licensee would need to do some type of refresher course. What is required by the individual to come back into practice may need to be determined by the length of time the individual is out of practice. For example, a licensee who has not been practicing for three years may need to just take a clinical competence assessment and training, while a licensee who has been out of practice over five years may need to have not only an assessment, but also may need to be required to perform clinical practice in a monitored or supervised setting. While the Board held one interested parties meeting regarding physician reentry (2015) the attendance was not sufficient to obtain input.

Therefore, this will be an item on the Board's Licensing Committee agenda for the April 2017 meeting. After that time, the Board can provide language to the Committees on the length of time and the assessment needed.

The second issue relates to individuals who have either let their license lapse or are applying for licensure in California for the first time and have not been in practice for three to four years preceding the application. The individual may apply for licensure, and the Board can request a clinical competence assessment, however, the Board is unable to have this individual actually perform proctored, monitored or supervised training because they cannot practice on a patient in California without a license. Currently, the only way the Board can ensure this individual can practice safely while re-entering the practice of medicine would be to place the individual on probation, which carries negative connotations. Therefore, the Board is recommending a limited educational permit to allow individuals to come into California to begin working again and practice in a supervised setting. Once the individual has shown that he/she can practice safely, the Board would issue a full and unrestricted license. The Board has not held an interested parties meeting specifically on the limited educational permit. However, there are other states that have a similar limited educational permit. The Board believes that consumer protection would be improved by ensuring that physicians who are applying to the Board and who have not practiced medicine within the last three to four years are required to be in a proctored, supervised and monitored setting for a length of time prior to being able to have a full and unrestricted license. The Board will provide suggested statutory language to Committee staff on this issue by April 3, 2017.

Board Response (2020):
Legislation has not been authored regarding these issues. The Board believes that limited educational permits may help enhance consumer protection, but that more research and development is necessary before it can put forth additional recommendations on this matter.

ISSUE #19: (UTILIZATION REVIEW.) In the workers' compensation system, an insurer or self-insured employer is entitled to retain a physician to conduct "utilization review" of treatment recommendations made by the injured worker's physician, which can determine what treatment the injured worker will receive. Concerns about standard of care by UR physicians have been raised over the years, complaints for which MBC should have jurisdiction and should take action when necessary. Is MBC properly investigating complaints it receives based on UR decisions?

Background: California's workers' compensation system requires employers to secure the payment of workers' compensation for injuries incurred by their employees. Employers are required to establish a medical treatment utilization review (UR) process, in compliance with specified requirements, either directly or through its workers' compensation insurer or an entity with which the employer or insurer contracts for these services. UR refers to reviewing whether recommended treatment by physicians, based on medical guidelines, should be approved, modified, delayed or denied. The law specifies that only a licensed physician who is competent to evaluate the specific clinical issues involved in medical treatment services (and where these services are within the scope of the physician's practice) requested by the physician may modify, delay or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

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

As such, MBC notes that a decision to delay, modify or deny a medical treatment constitutes the practice of medicine under MBC's jurisdiction. The issue of who then can legally perform UR has been raised, specifically whether, because the treatment at issue is to be provided (in most cases) to a California resident, only a California-licensed physician can do UR. Proponents of legislation on this topic argued that physicians conducting UR who are not licensed in California may be unfamiliar with the specifics of California workers' compensation law and/or the details of the requirements of UR and in turn could be more likely to not properly follow California workers' compensation law. Proponents argued that out-of-state utilization review physicians made inappropriate decisions and thus a physician conducting UR should be licensed in California so that in the event practice standards are violated, MBC could take action against the physician.

During the prior review of MBC, the Committees questioned whether MBC should investigate complaints related to UR decisions, noting that complaints alleging UR decisions made by California- licensed physicians that violate the standard of care and cause significant harm had been rejected by MBC staff as being outside MBC's jurisdiction. In response, MBC placed this issue on the agenda for several MBC meetings and confirmed that UR is the practice of medicine. MBC asserts that it does not close UR-related complaints as non-jurisdictional and has worked to inform physicians and the public of this authority.

Staff Recommendation: ***MBC should advise the Committees of remaining barriers to timely enforcement of UR cases related to the standard of care.***

Board Response (March 2017):
From the Board's perspective, the remaining barriers to enforcement of utilization review (UR) cases are that all UR physicians are not required to be licensed in California. While the Board believes that UR is the practice of medicine and that a physician providing UR for California patients should be licensed in California, the systems that utilize UR do not require all UR physicians to be licensed in California. In addition, the Board sometimes has difficulty obtaining patient authorization for release of medical records for UR cases. Lastly, there are some cases where the Board does not know the identity of the physician performing the UR, as Independent Medical Reviewers are not required to include their names on UR reports.

Board Response (2020):
The Board's response provided in March 2017 addressed this issue. The Information previously provided is still applicable. The Board continues to believe UR is the practice of medicine and only a California-licensed physician should perform UR on individuals located in California.

ISSUE #20: (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.

Background: There are a significant number of reporting requirements outlined in BPC designed to inform MBC about possible matters for investigation. MBC includes information in its Newsletter regarding mandatory reporting, conducts presentations regarding requirements for reporting and posts information on its website regarding the submission of required reports. Mandatory reports to MBC include:

> *BPC 801.01* requires MBC to receive reports 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 if not covered by professional liability insurance.
>
> MBC reports that in general, these reports appear to be submitted to MBC within the 30 day timeframe. MBC states that it has reminded insurers of the reporting requirements and the importance of providing correct data. During the last four fiscal years the average settlement amount was $478,112.
>
> *BPC 802.1* requires physicians to report indictments charging a felony and/or any convictions of any felony or misdemeanor, including a guilty verdict or plea of no contest.
>
> MBC states that it appears to be receiving these incidents as required. MBC confirms

that licensees are reporting these criminal charges through its receipt of arrest and conviction notifications that come to MBC from DOJ. MBC states that it also conducts Lexis/Nexis searches to identify any arrests reported in the media. Failure to report a criminal conviction to MBC results in a citation – MBC issued 36 citations in FY 12/13, 17 citations in FY 13/14, zero citations in FY 14/15 (due to the transfer of sworn investigators to HQIU and MBC's inability to issue citations until it promulgated regulations in 2015) and 4 citations in FY 15/16.

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 MBC. The coroner must provide relevant information, including the name of the decedent and attending physician as well as the final report and autopsy.

As was the case during the prior review, MBC reports that it is not receiving these reports as required, citing the submission of only 11 total reports between FY 13/14 and 15/16. Gross negligence may be a hard cause of death for a coroner to determine, which may lead to the low number of reports MBC receives. However, increased reporting by coroners to MBC when cause of death may be related to a physician could enhance MBC's enforcement efforts. The issue of coroners' reports is particularly salient for deaths related to prescription drug overdose. In those instances where a coroner determines cause of death is drug toxicity, and where the coroner findings deal with a young person, who is not a cancer patient on hospice or someone in a health facility setting, who was found dead in possession of various opioid combinations, the prescribing doctor and his or her practices may need to be looked into. MBC should receive coroner's reports as required by law and may benefit from receiving coroners reports where cause of death is expanded, beyond just gross negligence.

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 his or her rendering of unauthorized professional services, to report that judgment to MBC within 10 days after the judgment is entered. In addition, the court clerk is responsible for reporting criminal convictions to MBC and transmitting any felony preliminary hearing transcripts concerning a licensee to MBC.

MBC does not believe that it is receiving reports from the court clerks as required by statute. The total number of reports filed pursuant to 803 and 803.6 between FY 13/14 and FY 15/16 is 31.

BPC Section 805 is one of the most important reporting requirements that allows MBC to learn key information about a physician or surgeon. 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. 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 a health

facility peer review body.

In FY 15/16, MBC received 127 reports. However, MBC compared the reports it received to information contained in the National Practitioners Databank and determined it is likely receiving reports when a facility believes a report should be issued. MBC has attempted to enhance knowledge of this requirement.

MBC notes that a number of explanations may account for the observed decline in 805 reporting, including: hospitals finding problems earlier and sending physicians to remedial training prior to an event occurring that would require an 805 report; with the implementation of electronic health records and the mining of medical record data by the health entities, early identification is a real possibility; the growing use of hospitalists providing care to hospitalized patients, concentrating the care in the hands of physicians who specialize in inpatient care and who are less prone to errors than physicians who provide the care on only an occasional basis; or health facilities may simply just not be reporting information.

However, because the MBC does not have jurisdiction over the hospitals, it has no way of knowing the exact reason it does not receive reports. As CDPH and other hospital accrediting agencies have the authority to review hospital records and conduct inspections of the hospitals, MBC could benefit from being provided reportable peer review incidents detected during an inspection by CDPH or a hospital accrediting agency.

BPC Section 805.01 is a similarly extremely important requirement. The law requires the chief of staff and chief executive officer, medical director, or administrator of a licensed health care facility to file a report within 15 days after the peer review body makes a final decision or recommendation to take disciplinary action which must be reported 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 BPC 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 purpose of 805.01 reports is to provide MBC with early information about these serious charges so that MBC may investigate and take appropriate action to further consumer protection at the earliest possible moment. Accordingly, for any allegations listed above, the Legislature determined that an 805.01 report must be filed once a formal investigation has been completed, and a final decision or recommendation regarding the disciplinary action to be taken against a physician has been determined by the peer review body, even when the physician has not yet been afforded a hearing to contest the findings.

The statistics below show the incredibly low number of 805.01 reports that have been filed per fiscal year since the requirement came into place:

FY 2011/2012	FY 2012/2013	FY 2013/2014	FY 2014/2015	FY 2015/2016
16	9	2	4	5

MBC has attempted to enhance knowledge of this requirement but is not receiving reports as required. In FY 15/16, five reports were received pursuant to BPC 805.01, while in this same fiscal year, 127 BPC section 805 reports were received.

According to MBC, it writes an article every January in its Newsletter, “Mandatory Reporting Requirements for Physicians and Others,” that reminds entities they required to file 805.01 reports. MBC reports that it also wrote a separate article for the Fall 2015 Newsletter, “Patient Protection is Paramount: File Your 805.01 Reports,” in an effort to boost compliance with the requirement.

In addition to amending the law to require MBC to receive peer review reports, MBC believes that enhanced penalties for not providing 805.01 reports to MBC may yield additional compliance. MBC notes that if an entity fails to file an 805 report, they could receive a fine of up to $50,000 per violation, or $100,000 per violation if it is determined that the failure to file the 805 report was willful. In contrast, there is no penalty for an entity’s failure to file an 805.01 report, despite the serious nature of the charges involved. MBC recommends amending BPC Section 805.01 to allow MBC to fine an entity up to $50,000 per violation for failing to submit an 805.01 report, or $100,000 per violation if it is determined that the failure to report was willful.

BPC Section 2216.3 requires accredited outpatient surgery settings to report an adverse event to MBC 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.

In FY 14/15 the Board received 104 adverse event reports. In FY 15/16 the Board received 111 adverse event reports. Adverse events appear to be reported as required, with the number of reports received by MBC increasing, as outpatient surgery settings became familiar with the law and gained an understanding of the types of events that should be reported. Enhancements to this requirement are discussed in Issue # 21 below.

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 MBC, that occurrence to MBC within 15 days after the occurrence.

In FY 14/15 the Board received nine patient death reports and in FY 15/16, ten reports were received. MBC has worked with the Legislature to ensure that deaths from all procedures, rather just scheduled procedures, are reported.

Staff Recommendation: ***The Committees should amend the Act to enhance MBC's ability to receive important reports that inform MBC about its licensees.***

Board Response (March 2017):
Language was submitted on March 10, 2017 to Senate BPC Committee staff that would implement penalties for failure to notify the Board pursuant to Business and Professions Code section 805.01 and would require state agencies and hospital accrediting agencies to report to the Board any peer review incidents subject to Business and Professions Code sections 805 or 805.01 reporting that are found during an inspection of a health care facility or clinic.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) addressed these issues and there is no further action needed.

ISSUE #21: (OUTPATIENT SETTINGS.) California law prohibits physicians from performing some outpatient procedures unless they are performed in an accredited, licensed or certified setting. MBC approves agencies that accredit outpatient settings. MBC is required to receive information about incidents in these settings. Should MBC be provided additional data and should additional reporting be required to ensure MBC has the best information, provided in a timely manner, about incidents in these settings?

Background: Physicians are prohibited from performing some outpatient surgeries unless they are performed in an accredited, licensed, or certified setting. Specifically, the law specifies that 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 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. This exclusion includes certain outpatient surgery settings, 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 various sections of law in the Act and Dental Practice Act.

MBC is required to approve accreditation agencies that accredit outpatient settings. As such, MBC adopted standards for the approval of these accreditation agencies. MBC has approved five accreditation agencies, the American Association for Accreditation of Ambulatory Surgery Facilities Inc., the Accreditation Association for Ambulatory Health Care, the Joint Commission, the Institute for Medical Quality and the American Osteopathic Association/Healthcare Facilities Accreditation Program. An 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 MBC.

MBC posts information regarding outpatient surgery settings 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 the name, address, medical license number and telephone number of any owners, the name and address of the facility, the name and telephone number of the accreditation agency and the effective and expiration dates of the accreditation.

Accrediting agencies approved by MBC are required to notify and update MBC on all outpatient settings that are accredited. If MBC receives a complaint regarding an accredited outpatient setting, the complaint is referred to the accrediting agency for inspection. Once the inspection report is received, MBC reviews the findings to determine if any deficiencies were identified in categories that relate to patient safety and if patient safety deficiencies are detected, the complaint may be referred for formal investigation.

Per existing law (Health and Safety Code Section 1216), clinics licensed by CDPH, including surgical clinics, are required to report aggregate data to the Office of Statewide Health Planning and Development (OSHPD). This data includes number of patients served and descriptive background, number of patient visits by type of service, patient charges, and any additional information required by CDPH and OSHPD. Both a June 2013 report by the CHCF (“Ambulatory Surgery Centers: Big Business, Little Data”) and CHCF’s 2015 follow-up report, (“Outpatient Surgery Services in California: Oversight, Transparency and Quality”) noted that physician-owned outpatient settings, which fall under the jurisdiction of MBC, are not providing this important data as that required by CDPH and OSHPD.

MBC believes that it is important to require both accredited and licensed outpatient settings to report data to OSHPD, as this data will provide important information on procedures being done in ambulatory surgery centers and will allow MBC and other regulatory agencies to be aware of any issues or areas of concern. Language was contained in 2015 legislation (SB 396 (Hill, Chapter 287, Statutes of 2015) that would have required the same data reporting for accredited outpatient settings as what is required for surgical clinics. However, due to concerns raised by stakeholders that the proposed data requirement was too broad and would not provide the appropriate health outcome information, the language was removed. MBC believes this information is still necessary and important to be reported.

MBC also believes that enhancements are necessary to current mandatory reporting by accredited outpatient settings of adverse events, as outlined in BPC Section 2216.3 and discussed above. These adverse events required to be reported are the same adverse events that hospitals are required to report to CDPH. The issue is that while accredited outpatient

settings have been reporting these adverse events to MBC, just pointing to the hospital adverse events reporting section as the law does has proven to be problematic. Some of the adverse events hospitals have to report do not necessarily apply to accredited outpatient settings. MBC also believes that there are adverse events that occur in accredited outpatient settings that do not apply to hospitals, but should be added to the adverse event reporting requirements for accredited outpatient settings.

MBC states that there is confusion for some outpatient settings in terms of what adverse events should then be reported to MBC, particularly when an adverse event doesn't really fit into a specific category outlined in HSC 1279.1. MBC believes clarifications may be necessary.

Staff Recommendation: ***MBC should update the Committees on its efforts to engage stakeholders and interested parties about the information MBC needs to receive from and about outpatient settings. Consideration should be granted to ensuring MBC has the information it needs about outpatient settings in order to protect patients and that the law is clear on what adverse events need to be reported to MBC.***

Board Response (March 2017):
In order to provide more information on outpatient surgery settings (OSS), accredited OSSs should be required to report data to OSHPD, as this data will provide important information on procedures being done in OSSs and will make the Board and other regulatory agencies aware of any issues of concern so that consumer protection enhancements can be addressed if they are needed. Language to require data reporting was included in SB 396 (Hill) from 2015, however it was taken out because of concerns raised by interested parties. An interested parties meeting was held on May 26, 2016, to discuss this issue and suggested language was provided to the interested parties that included changes addressing the concerns raised. The interested parties were asked to submit suggested amendments and language on this issue, however, no language was submitted. The Board provided the language from the interested parties meeting to Senate BPC Committee staff on March 10, 2017.

In addition, the Board is suggesting changes to the reporting requirements for adverse events, as the law currently requires an OSS to report the same adverse events as hospitals, which in some cases may not pertain to an OSS and results in confusion regarding what should be reported. On December 13, 2016, Board staff met with the California Ambulatory Surgery Association to develop proposed amendments to the adverse event reporting. The Board provided the statutory language to Senate BPC Committee staff on March 20, 2017.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) amended BPC section 2216.3 to address the issue of adverse events reporting to the Board.

The Board submitted statutory language to the Committee to require OSS to report certain events to OSHPD. The requested language was included in the April 18, 2017 version of SB 798, however, it was removed from the bill on September 5, 2017. The Board continues to believe that this change would assist in the Board's role of consumer protection.

ISSUE #22: (ENFORCEMENT ENHANCEMENTS.) Various enhancements to the Act may be necessary for MBC to ensure public protection from dangerous physicians.

Background: MBC may be assisted in its ability to take swift disciplinary action when necessary and warranted through amendments to the Act.

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

Specifically, as BPC 2232 is currently written, obtaining a prompt revocation has proven to be difficult for MBC. Once MBC learns that a doctor has been convicted of a crime requiring that he or she register as a sex offender, the MBC requests OAG to file an accusation on its behalf. This accusation, along with several other documents, is served on the respondent physician, and he or she has 15 days to file a Notice of Defense (NOD). MBC and OAG are then required to wait to receive that NOD before requesting to set a hearing with the Office of Administrative Hearings (OAH). Once the hearing is set, pursuant to the APA, OAG is then required to send the respondent physician a Notice of Hearing no less than 10 days prior to the date of the hearing. Therefore, over a month will have passed before a hearing can even be set from the time MBC is notified that a physician has registered as a sex offender. If OAH does not quickly set the hearing after a request has been filed, a prompt revocation can actually turn into a several-month delay. In the meantime, because there are no restrictions on the license, the offending doctor may practice medicine and the public is at risk for possible further harm, unless MBC has been able to successfully take other action like obtaining an Interim Suspension Order.

MBC notes that without a definition of "prompt" in the Act and without tools for "prompt revocation", MBC is actually not able to take quick action. According to MBC, an automatic revocation of a license would make more sense for these situations. MBC notes that automatic revocations are not new to professional licensees and cites the example of teachers who have been convicted of certain sex offenses who are suspended by the Commission on Teacher Credentialing, without having a hearing beforehand. Once the conviction becomes final, the teacher's license is revoked. Specifically, Education Code Section 44425(a) provides that when a holder of a teacher credential has been convicted of certain sex offenses as defined in Education Code section 44010, the Commission on Teacher Credentialing immediately shall suspend the credential. When the conviction becomes final or when imposition of sentence is suspended, the commission immediately shall revoke the credential. Subdivision (c) provides that the revocation shall be final without possibility of reinstatement of the credential if the conviction is for a felony sex offense as defined in section 44010.

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

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

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

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

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

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

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

Board Response (March 2017):
Language was submitted on March 10, 2017 to Senate BPC Committee staff that would amend the Business and Professions Code and Government Code to enhance the Board's enforcement authority and provide clarification to the law.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) addressed two of the three issues of concern. SB 798 amended BPC section 2232 to address the challenges in revoking the license of physician required to register as a sex offender. SB 798 also amended Government Code section 11529 and BPC section 2232 to address the issue of ISO filing versus petition to revoke probation.

The Board submitted language to the Committee to amend BPC section 2225 to address the challenges in obtaining patient records and key documents. The requested language was included in the April 18, 2017 version of SB 798 but the language was removed from the bill on August 24, 2017. A recent court decision clarified that invocation of the psychotherapist-patient privilege is not a barrier to the Board obtaining psychotherapy records via a subpoena upon a showing of good cause, and no further action is needed on this particular issue at this time. The Board is, however, seeking additional enforcement enhancements, as identified in the New Issues section, and proposes amending BPC section 2225 and adding a new section under the BPC to improve the Board's record inspection authority. The Board is also seeking to amend BPC section 2230.5 to toll the statute of limitations while it is taking subpoena enforcement action.

ISSUE #23: (EXPERT WITNESS REPORTS.) MBC may be hindered by provisions in the Administrative Procedure Act related to discovery, specifically the ability of MBC to receive expert witness reports prepared for a respondent. Are amendments necessary to ensure MBC can respond in a timely fashion to information provided in expert witness reports?

Background: As noted during the prior MBC review and raised in MBC's 2016 report to the Legislature, MBC is concerned that provisions outlined in the Administrative Procedure Act (APA) limit MBC's ability to access, through discovery, information provided by experts who are used by a licensee, or his or her attorney, who is the subject of disciplinary action. A key tool for accessing information used in civil action is to depose individuals, however, APA provisions (Government Code Section 11511) only authorize depositions in extreme circumstances, circumstances that typically do not apply to MBC cases. While it may not be appropriate to amend and expand general discovery provisions under the APA, as the APA applies to all administrative hearings and any amendments could impact disciplinary proceedings of other administrative agencies and perhaps add costs or delay proceedings, it may be appropriate to amend the Act to deal specifically with expert testimony for MBC cases.

BPC Section 2334 specifically relates to expert testimony for MBC disciplinary cases. According to MBC the provisions in this section are beneficial to DAGs prosecuting MBC cases for a number of reasons. Upon receipt of an expert witness disclosure, DAGs can assess the qualifications of the respondent's expert in relation to the expert MBC may be using. Further, DAGs are able to provide a respondent's expert's narrative for a case and opinions to the expert used by MBC to determine whether the expert's previously expressed opinions change. Information contained in the expert witness reports can also assist MBC in determining necessary next steps for a case or can assist MBC's own expert in their testimony before an ALJ. Since discovery is so limited in proceedings governed by the APA, this section of the BPC provides at least some information to MBC and DAGs that impact proceedings in these important quality-of-care cases.

According to MBC, in some instances, once MBC receives these reports, amendments to an

initial accusation filed may be necessary, thus increasing the timeframe for disciplinary action to be taken and that consumer protection can be enhanced through changes to this section in the Act.

Staff Recommendation: ***The Committees should consider amending the Act to ensure MBC has important information related to an enforcement case, according to a timeline that assists MBC in taking swift action.***

Board Response (March 2017):
In an effort to enhance consumer protection, section 2334 of the Business and Professions Code should be amended. The Board submitted language on March 10, 2017 to Senate BPC Committee staff to clarify the date and require the complete expert report be produced by the respondent.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) addressed this issue. This section was further amended by AB 505 (Caballero, Chapter 469, Statutes of 2018). The Board is not seeking a further amendment at this time.

ISSUE #24: (CEASE PRACTICE ORDERS.) MBC has the authority to seek an Interim Suspension Order from an Administrative Law Judge when MBC believes the public may be at risk due to physical or mental impairment. Does the Act need to be amended to ensure MBC can take swift action when physicians delay or refuse to comply with orders to undergo a physical or mental examination?

Background: BPC Section 820 authorizes MBC to order a physician to undergo a physical or mental health examination when MBC determines, through the course of an investigation, that a licensee's ability to practice may be impaired by physical or mental illness. Failure to comply with an examination order constitutes grounds for suspension or revocation of the individual's certificate or license (pursuant to BPC Section 821). However, the process for suspension or revocation for refusal to submit to a duly-ordered examination can be lengthy, as demonstrated by a recent court case in which a Board of Registered Nursing licensee refused a psychiatric examination yet continued to practice for months thereafter (see *Lee v Board of Registered Nursing*, 209 Cal. App. 4th 793; 147 Cal. Rptr. 3d 269; Sept. 26, 2012).

As noted during the prior MBC review and raised in MBC's 2016 report to the Legislature, to refuse or delay compliance with an examination order poses risks for consumers because of the possibility that a mentally or physically ill practitioner could continue to see patients until the MBC completes suspension or revocation proceedings. Public protection would be better served if MBC is authorized to issue a cease practice order in cases where compliance with an examination order under BPC Section 820 is delayed beyond a reasonable amount of time (the exact timeframe that constitutes "reasonable" could be determined through stakeholder discussions with MBC, interested parties and the Committees).

Staff Recommendation: ***The Act should be amended to provide MBC the authority to issue a cease practice order in cases where a licensee delays or all together does not comply with an order to undergo a physical or mental health examination.***

Board Response (March 2017):
The Board agrees with Committees' staff's recommendation. Public protection will be better served if the statue is amended to give the Board the authority to issue a cease practice order in cases where the licentiate delays or fails to comply with an order issued under Business and Professions Code section 820 within the specified time frame as set forth in the order. Language was submitted on March 10, 2017 to Senate BPC Committee staff to address this issue.

Board Response (2020):
The Board previously submitted statutory language to the Committee to amend BPC section 820. However, legislation has not been authored regarding this issue. SB 798 (Hill, Chapter 775, Statutes of 2017) included legislative intent to enact an amendment in 2017-2018. To date, no such legislation has been enacted. The Board looks forward to working with the Legislature toward such a legislative change.

ISSUE #25: (DISPARITY IN ENFORCEMENT ACTIONS.) MBC commissioned a third-party study to identify whether disparity in its enforcement actions were present. What is the status of MBC's efforts in the wake of the study's release?

Background: In response to concerns raised by members of the African American physician community and a formal request from the Golden State Medical Association (GSMA), MBC contracted with CRB to conduct a study aimed at determining if disparity exists in MBC's enforcement efforts. Anthony Jackson, M.D., an anesthesiologist from Southern California and GSMA raised the issue to MBC over the course of a number of meetings that African-American physicians were targeted and received discipline from MBC in higher numbers than other comparable ethnic groups.

MBC is required to collect certain demographic information from licensees on a voluntary basis. According to MBC, about 70 percent of licensees voluntarily provide this information.

CRB's study was released in January. Using archival data provided by MBC of complaints, investigations and discipline that occurred from July 2003 through June 2013, CRB determined that there is a correlation between physician race and the pattern of complaints, investigations and discipline. Latino and black physicians were both more likely to receive complaints and more likely to see those complaints escalate to investigations. According to the study, Latino physicians were also more likely to see those investigations result in disciplinary outcomes. CRB noted that the findings "should be taken with the caveat that this is an observational study, and many variables affecting the perception of physician performance (for instance, "bedside manner") could not be taken into account." CRB further determined that while there is evidence of disparate outcomes, there is no evidence that any actor has specifically applied racial bias to achieve these outcomes.

MBC discussed the study at its January meeting and formed a Demographic Study Task Force to further explore this issue and provide additional direction to MBC. MBC also noted that it would promptly begin training for members and all staff to ensure equity in its work.

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 (March 2017):
The California Research Bureau's report on Demographics of Disciplinary Action by the Medical Board of California 2003 – 2013 was requested by the Board in response to concerns about bias in the Board's disciplinary process. It is important to note that, due to limitations in the study's design and methodology, the CRB was not able to draw definitive conclusions regarding the drivers and scope of the disparities highlighted in its report. Despite the limitations, the Board takes the disparities highlighted in the CRB's report very seriously and is taking proactive steps to investigate and address them.

In response to the report, the Board established a Disciplinary Demographics Task Force made up of one physician and one public Board Member to review the report and deliver specific recommendations on how best to proceed. This Task Force had its first meeting on February 24, 2017. During this meeting, the Members began to identify available training and possible next steps.

The Board has been looking at available training on implicit bias that is already being provided to other entities. The training on implicit bias will be provided to all individuals in the enforcement process, from Board staff and Members to investigators, experts, prosecutors and judges, if not already required.

The Task Force will also review existing complaint, investigation, and disciplinary processes to better understand the institutional and procedural issues that may have contributed to the disparities outlined in the report. The Task Force's recommendations are going to be presented at the Board's next meeting.

The Board currently utilizes the DCA's Non-Discrimination Policy and Complaint Procedures, which must be reviewed and signed by all employees. This policy states that the DCA enforces a zero tolerance policy against discrimination, harassment, and retaliation. Every year, all employees must review this policy and indicate that they will comply with the policy. Due to this current policy that is already in place for all DCA boards and bureaus, the Board does not believe a separate policy is necessary. However, this will be discussed with the Disciplinary Demographics Task Force to determine if a separate policy should be developed.

Board Response (2020):
In September 2017, the Board held in-person implicit bias trainings for 298 employees of the Board, HQIU, Deputies Attorney General, and Board Members. The Board produced a webinar version of the training in 2019 and required the training be competed every two years. Board staff are encouraged to participate in other training on this topic, as well. For example, the Government Operations Agency offered training by Dr. Bryant T. Marks, Founding Director of the National Training Institute on Race & Equity, which was well-attended by Board executive staff. The invitation to attend this program was extended to Board staff by DCA, and the Board welcomes further training opportunities of this caliber.

Further, the Board implemented a policy to remove information from documents submitted to medical consultants, expert reviewers, and in the stipulation memos submitted to Board Members for review in licensing and disciplinary cases that is not essential to the evaluation of the matter, but that could trigger unconscious or implicit bias relating to race, ethnicity, or other factors, including where the person went to school, where they completed postgraduate training, and whether they are board certified by a specialty board. The Board recognizes that

addressing implicit bias requires steadfast commitment at every level, and will continue to look for and implement new approaches to training, as well as reviewing, investigating, and determining case outcomes in a manner that reduces the influence of unconscious bias.

ISSUE #26: (COMPLAINTS.) Complaints are the heart of MBC's enforcement program. Successfully processing complaints can ensure that patients and the public are protected. 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?

Background: Accepting, processing and acting on complaints from patients, the public, MBC staff, other agencies and other sources is a primary mechanism by which MBC can ensure that licensees are in compliance with the Act and that patients have options for action in the event that their physician violates the law. The timely processing of complaints provides MBC with critical information about their licensees and assists in prioritizing workloads.

The law establishes MBC's prioritization for complaints and outlines the following as the highest priority for MBC:

- Complaints related to 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 therefor

- 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

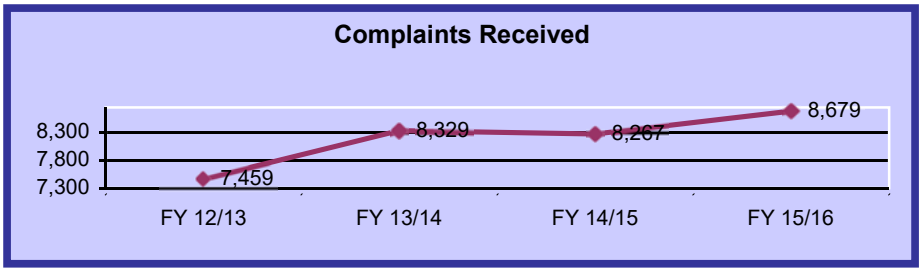
- Sexual misconduct with one or more patients during a course of treatment or an examination

- Practicing medicine while under the influence of drugs or alcohol

- Repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith examination of the patient and medical reason therefor.

Complaints are treated as confidential until such time as a complaint and investigation result in some type of formal, public action.

MBC reports there has been a continual increase in the number of complaints since the prior review. The average complaints received for the three fiscal years of the prior sunset report (FY 09/10 to FY 11/12) was 6,861 complaints received; whereas the average of the three fiscal years included in this report (FY 13/14 to FY 15/16) is 8,425, an increase of 1,564. Between FY 14/15 and FY 15/16 there was an increase of 412 complaints, which shows the numbers are continuing to increase.



It would be helpful for the Committees to better understand what MBC is doing to handle the influx of complaints. It would be helpful for the Committees to understand whether MBC treats complaints received by patients any differently than complaints generated by MBC staff in response to a report or news media article. It would be helpful for the Committees to better understand how MBC follows up on complaints, particularly how MBC contacts individuals who file complaints about their physicians to either gain additional information or to alert the individual of the status of a case.

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 whether they are ever proactively informed when a complaint leads to formal disciplinary action.***

Board Response (March 2017):
Complaints are brought to the Board's attention through a variety of sources, including patients, family members, licensees, other state agencies, media, mandated reporters, other state's disciplinary actions, and any other means of receiving information about a physician who may be violating the law. While the steps to process a complaint may be different based upon the type of complaint, all complaints go through the same process of triage and initial review by the Board's Central Complaint Unit (CCU), investigation, if warranted by either the Board's non-sworn investigators or the DCA's sworn investigators, and prosecution by the Attorney General's Office. As indicated in the Board's Sunset Review report and pointed out in this background paper, over the past four years the Board has seen an increase in the number of complaints received. Accordingly, the Board also saw an increase in the timeframe to process complaints within CCU. Due to this increase, in FY 15/16, the Board was able to obtain one additional staff member through the budget change proposal process to assist in the complaint triage. Further, the Board is seeking two more analysts this year, through the budget change proposal process, to review and process complaints within this unit. In addition to requesting additional staff, the Board has made business process improvements to assist in decreasing the timeframe. Such process improvements include performing quarterly case reviews on all complaints pending within the unit and reviewing pending reports to follow up on complaints that are not moving forward in a timely manner. These pending reports were just

recently able to be obtained and have greatly improved the follow up on complaints.

It is the Board's policy that individuals who file a complaint with the Board are notified at various stages within the enforcement process. Upon receipt and opening of a complaint, an acknowledgement letter is sent to the complainant. This letter informs the complainant that the Board received their complaint and that if they have additional information they may submit it to CCU for review. This letter provides examples of what type of additional information this may include.

In addition, the Board recently developed a letter that is sent to patients or plaintiffs in malpractice cases who may be unaware that the Board received a mandated report complaint. This letter informs them that the Board received this report, asks them to provide additional information they may have, and outlines the Board's statute of limitations.

When the Board sends a request to the complainant for their release of medical records the Board also informs the complainant that they can provide additional information to the Board regarding their complaint. During the complaint review process, if the complainant calls the Board, staff also informs them that additional information can be provided.

For quality of care cases, the complainant is notified that all the medical records have been received and that the complaint is going to be sent to an expert for review. For all cases, if it is determined that the complaint is moving to formal investigation then the complainant is sent a letter notifying them of this transition of the case. Once the complaint goes to formal investigation, the complainant will be contacted by the investigator. If the matter is referred to the Attorney General's Office, the complainant receives a letter notifying them the matter has been referred and also receives a letter and a copy of the accusation, if one is filed. Lastly, if disciplinary action is taken, the complainant also receives a copy of the final decision in the matter. Therefore, the complainant is made aware that the complaint they filed with the Board has led to disciplinary action.

For complaints that are closed at CCU, the Board sends the complainant a link to a consumer satisfaction survey. However, through this sunset review process and feedback from interested parties, the Board identified that not all complainants have received the survey link, including those whose complaints went to investigation and proceeded to disciplinary action. The Board is ensuring that this link will be added to all closing letters from the Board, including those sent after a formal investigation and after disciplinary action is taken.

Board Response (2020):

The number of complaints received by the Board continues to increase. The average number of complaints received in FY13/14 to FY15/16 was 8,425. In the past three year cycle, FY17/18 to FY19/20, the average was 11,054 complaints or an increase of approximately 31 percent over the prior reported average. Staffing has not increased significantly to reflect this increased workload change. CCU and CIO have placed a significant focus on addressing pending cases and those cases that are over one year in age. During the initial stages of the COVID-19 response, the Board encountered a reduction in the number of incoming complaints and it allowed staff to catch up on pending and aging matters.

In the past year, CCU has reduced the timeframe to initiate newly received complaints to less than ten days. For the first quarter of FY 20/21, it is seven days, down from last year's average

of 12 days.

In addition, CCU has addressed a significant amount of their pending files and resolved or forwarded those files for further investigation. In January 2020, CCU had 5,216 files pending, and by October 2020 the number of pending files was reduced to 2,980. CCU has reduced the number of pending cases over one year from 646 in January 2020 to 175 in October 2020.

ISSUE #27: (VERTICAL ENFORCEMENT.) Originally implemented as a tool to bring about efficiencies in MBC enforcement efforts, VE does not appear to have reduced timeframes for disciplinary action and appears saddled with administrative challenges that significantly impact the ability for effective prosecution of administrative cases against physicians. Given that the initial intent and structure of the VE model does not appear to be functioning the way it was intended and given that timeframes for disciplinary action have actually increased, should VE be continued?

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

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

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

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

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

The initial intent and structure of the VE model does not appear to be upheld, as cases are being conducted with the "handoff method". The entire purpose of the VE model was to

eliminate this handoff method by aligning investigators and legal staff to handle cases together, instead of the traditional route of investigator gathering information and "handing" the case off to legal staff. With high levels of staff turnover in HQIU and shifting assignments in HQE, cases are not handled by the same investigator and same DAG from start to finish.

There are still significant working relationship challenges between HQIU and HQE, despite completion of the protocol manual. HQE DAGs may direct investigators to seek out certain information that could prove beneficial in an administrative licensure case but that impacts the independence trained peace officer investigators need in order to effectively investigate cases. Government Code provisions related to VE (GC 12529.6(b)) specifically use the word "direction," stating that an investigator shall, "under the direction but not the supervision of the deputy attorney general," be responsible for obtaining evidence in a matter. This no doubt impacts the team approach and may result in the expertise of both the investigator and DAG not being effectively utilized. Not every case should result solely in administrative action as initiated by a DAG, as investigations may bring criminal violations to light as well. HQIU faces an almost 40 percent vacancy in investigators, numbers that are not the same for other DOI investigators whose cases are not required to be coordinated with a DAG from the outset, and who may have independence in how they put their investigative skills to use.

A March 2016 MBC report on VE showed that MBC has spent $18.6 million to implement the program and provided statistical data showing that the average investigation timeframe has increased. In FY 14/15 the timeframe was 382 days and during FY 15/16 the timeframe increased to 426 days. Data from the first half of FY 16/17 presented at a January MBC meeting indicate an average HQIU investigative case cycle time of 473 days.

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

Board Response (March 2017):
The Board agrees with Committees' staff recommendation that changes are necessary to the vertical enforcement (VE) model. In the Board's March 2016 report, the Board recommended that the Government Code authorizing this program be amended to more fully utilize the expertise of both the investigators and the prosecutors. In addition to that recommendation, Board staff agrees that there should be discretion in terms of determining which cases will be investigated under the VE model.

The Board has seen benefits to specific case types being placed in the VE model. If these specific case types were kept in the VE model, and all other cases were investigated through the normal investigation process, this would enable the prosecutors to focus on the highest priority matters from the perspective of consumer protection.

The Board looks forward to working with the Committees, the Attorney General's Office, and the DCA to identify the needed changes to this program in order to enhance consumer protection

and reduce the enforcement timeframes.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) addressed this issue and there is no further action needed. VE was eliminated as of January 1, 2019. As of this writing, the Board has not identified a significant savings in expenses or a reduction in the investigative timeframes as a result of eliminating the VE model. Costs increased after an AGO rate increase became effective on July 1, 2020. The Board currently utilizes a VE type model, now called joint investigations, when it believes the case would benefit from the input of the Attorney General's Office during the investigation phase.

ISSUE #28: (PUBLIC NOTIFICATION OF DISCIPLINARY ACTION.) Access to timely, accurate information about MBC licensees is a fundamental means by which patients and the public are informed about medical services provided to them. MBC posts information on its website and has improved these efforts yet significant gaps remain in the ability for patients to have full awareness of disciplinary action taken against their physician. For the small number of physicians ordered on probation by MBC, requiring that patients are proactively notified of their probationary status can serve as a useful tool in patients' efforts to know their physician and know when their physician has violated the Act. What steps should be taken to ensure patients and the public are properly informed about MBC disciplinary action and about physician probationary status for the rare cases that result in MBC having to take such action to protect patients from harm?

Background: SB 231 referenced above in Issue #14 required the Little Hoover Commission to conduct a study and make recommendations on the role of public disclosure in the public protection mandate of the MBC. Those responsibilities were then transferred through SB 1438 (Figueroa, Chapter 223, Statutes of 2006) to the CRB of the California State Library. The study, *Physician Misconduct and Public Disclosure Practices at the Medical Board of California*, was completed in November 2008 and offered 11 policy options aimed at improving public disclosure access to information about physician misconduct, many of which were implemented by MBC and frame MBC's current requirements and practices for public disclosure of disciplinary action. As a follow up to the study, MBC sponsored legislation in 2014 (AB1886, Eggman, Chapter 285, Statutes of 2014) to update the length of time information is made available to the public on the MBC's website, allowing MBC to post the most serious disciplinary information on MBC's website for as long as it remains public, rather than just 10 years.

MBC reports that it exceeds the DCA recommended minimum standards for public information and is consistent with the requirement that boards post accusations and disciplinary actions. MBC states that in the event that the section of MBC's website which enables consumers to access information about a physician is not operational at any given time, MBC provides a phone number consumers can call to receive enforcement updates from MBC staff.

MBC's website provides the following information about physicians:

- Discipline taken by MBC (public reprimands and public letters of reprimand are only available for ten years on the website).
- Formal accusations by MBC of wrongdoing.

- Practice restrictions or practice suspensions pursuant to a court order.
- Discipline taken by a medical board of another state or federal government agency.
- Felony convictions MBC has reports of (for convictions after January 3, 1991).
- Misdemeanor convictions (for convictions after January 1, 2007) that resulted in a disciplinary action or an accusation being filed by MBC if the accusation is not subsequently withdrawn or dismissed.
- Citations received for a minor violation of the Act within the last three years (for citations that have not been withdrawn or dismissed).
- Public letter of reprimand issued at time of licensure within the last three years.
- Any hospital disciplinary actions that resulted in the termination or revocation of the physician's privileges to provide health care services at a healthcare facility for a medical disciplinary cause or reason reported to MBC after January 1, 1995.
- All malpractice judgments and arbitration awards reported to MBC 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 MBC).
- All malpractice settlements over $30,000 reported to MBC after January 1, 2003 that meet certain criteria.

MBC also provides the following documents on its website for each licensee, as relevant, and unless specifically prohibited by law, allowing the public to see:

- The accusation or petition to revoke a license or amended accusation as filed by a DAG.
- The public letter of reprimand received by a licensee.
- The actual citation and fine received by a licensee.
- The suspension or restriction order issued by MBC.
- The administrative or disciplinary decision adopted by MBC.

While it is true that important information is available on MBC's website, a key issue for the Committees remains how easily available it is for California patients to access easily understandable information about physicians who have been the subject of disciplinary action, placed on probation and are practicing. When the MBC places physicians on probation, generally they continue to practice medicine and see patients under restricted conditions. Terms of probation may include certain practice limitations and requirements, but most commonly physicians on probation are not required to provide any information to their patients regarding discipline taken by MBC.

A determination of probation is a step in a lengthy disciplinary process, conducted in accordance with the Administrative Procedures Act, and offering due process for accused licensees. Once an individual is placed on probation, they have already had an accusation filed against them which is publicly available on MBC's website. The filing of an accusation alone requires significant justification that a violation of the Act has occurred. In reviewing MBC data for current physicians on probation, proven violations that result in probation include gross negligence or incompetence, substance abuse, inappropriate prescribing, sexual misconduct or conviction of a felony. Probationary status is not secret. MBC only orders probation for a licensee once multiple steps in the life of a case have been taken. Probation is not loosely issued for suspicions or complaints or facts gained during an investigation that lead to the filing of an accusation for which clear and convincing evidence is present.

According to MBC data, there are currently 635 physicians on probation (this includes those issued a probationary license at application and those with an out of state address of record, for a total of 497 on probation with an address in California, 83 on probation with an address in another state, 38 with a probationary license with an address in California and 17 with a probationary license with an address in another state.) These individuals represent only a fraction of overall MBC licensees. (…)

The MBC posts information regarding probation on its website and distributes the information to its email list, which includes media and interested persons who have signed up to receive it, relying on members of the public to take the steps to access important information. According to a recent Pew Research Center U.S. analysis, seniors, the most likely group to seek healthcare, are also the group most likely to say they never go online. About four-in-ten adults ages 65 and older (39 percent) do not use the internet, compared with only 3 percent of 18- to 29-year-olds. One-in-five African Americans, 18 percent of Hispanics and 5 percent of English-speaking Asian Americans do not use the internet, compared with 14 percent of whites.

Patients may be especially deserving of greater access to information about a physician on probation given the potential for future disciplinary action. The 2008 CRB study reported that physicians who have received serious sanctions in the past are far more likely to receive additional sanctions in the future. According to the CRB report, “These findings strongly imply that disciplinary histories provide patients with important information about the likely qualities of different physicians.” The CRB cited research that examined physician discipline data provided by FSMB. The researchers split their sample into two periods, Period A 1994 - 98 and Period B 1999 - 2002. They classified physicians by whether they had no sanctions in the period, or had been assessed with one or more mild, medium or severe sanctions. Severe sanctions encompassed disciplinary actions that resulted in the revocation, suspension, surrender, or mandatory retirement of a license or the loss of privileges afforded by that license. The medium sanctions included actions that resulted in probation, limitation, or conditions on the medical license or a restriction of license privileges. The study found that less than 1 percent of physicians who were unsanctioned during Period A were assessed a disciplinary action during Period B. However, physicians sanctioned during the earlier period were much more likely to be assessed additional sanctions in the second period; for example, 15.7% of those who received a medium sanction in Period A went on to receive either a medium or a severe sanction in Period B; physicians who received a medium sanction in Period A were 28 percent more likely to receive a severe sanction in Period B than someone who received no sanction in period A; and, physicians who received a medium sanction in Period A were 32 percent more likely to receive another medium sanction in Period B than someone who received no sanction in Period A.

In October, 2012 MBC staff made a proposal to the MBC to require physicians to inform their patients when the physician is on probation and required to have a monitor. In its recommendation staff said, “This would insure the public has the ability to make informed decisions regarding their healthcare provider.” MBC did not approve the staff proposal.

In 2015, a petition filed before the MBC by Consumers’ Union Safe Patient Project called on MBC to amend its Manual of Model Disciplinary Orders and Disciplinary Guidelines by requiring physicians on probation to notify patients about their status as a probationer. Specifically, the petition asked MBC to require physicians who continue to see patients to inform their patients of their probationary status and take steps accordingly, including; (1)

notifying patients of probationary status when the patient contacts a physician's office to make an appointment; (2) disclosing probationary status in writing; (3) having patients sign an acknowledgment that they received information from their physician about his or her probation; (4) posted a disclosure about probation in a physician's office in a place readily apparent to patients; (5) ensuring that disclosures include at least a one-paragraph description of the offenses that led the MBC to place the physician on probation as well any practice restrictions placed on the physician; (6) referring a patient to MBC's website to access the actual documents related to a physician's probation; and (7) maintaining a log of all patients who were provided notification.

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

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

Board Response (March 2017):
After the Board denied the petition for rulemaking from the Consumer's Union, the Board established a Patient Notification Task Force. After a meeting of the Task Force, the Board determined that the issues raised during the Patient Notification Task Force meeting would be pursued within other standing Board committees. The improvements recommended for outreach and changes to the website were pursued within the Board's Public Outreach, Education, and Wellness Committee. The signage and changes in legislation to allow the Board to require more information on the sign a physician must post are being addressed in this sunset report. The issue of a possible change to the disciplinary guidelines to have an optional condition that would require a physician to notify their patients they are on probation is being discussed and an interested parties meeting was held on January 11, 2017, to obtain public input.

The Board took a neutral if amended position on the bill proposed last year, SB 1033, regarding patient notification. The Board looks forward to working with Committee staff and interested parties on this issue.

Board Response (2020):
SB 1448 (Hill, Chapter 570, Statutes of 2018) required physicians who are placed on probation for specified acts of serious misconduct to notify their patients. Further, SB 1448 required the Board to provide specified information for licensees on probation and licensees granted probationary licenses in plain view on the licensee's profile page on the Board's website.

ISSUE #29: (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.

Background: There are instances in the Medical Practice Act where technical clarifications may improve MBC operations and application of the statutes governing the MBC's work.

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

Board Response (March 2017):
The Board submitted language to Senate BPC Committee staff on March 10, 2017 to make some technical changes to laws pertaining to the Board's licensing program as identified in the Board's Sunset Review Report.

Board Response (2020):
SB 798 (Hill, Chapter 775, Statutes of 2017) addressed these issues and there is no further action needed.

ISSUE #30: (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?

Background: Patients and the public are best protected by a strong regulatory board with oversight for physicians and surgeons and associated allied professions. MBC needs to take swift enforcement action and needs to improve timelines for case processing, particularly for complaints and cases with a high risk of patient and public harm. The MBC should be continued with a 4-year extension of its sunset date so that the Legislature may once again review whether the issues and recommendations in this Background Paper have been addressed.

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

Board Response (March 2017):
The Board appreciates the opportunity of the sunset review process and looks forward to working with both the Senate and the Assembly BPC Committees and their staff on issues that have been identified for future consideration. The Board is pleased that Committee staff has recommended that the licensing and regulation of physicians and surgeons and allied health

professions continue to be regulated by the Medical Board of California in order to protect the interests of the public and be reviewed once again in four years.

Board Response (2020):
The Board serves a critical consumer protection role and believes that its sunset date should be extended again. The Board believes it should continue to regulate polysomnography trainees, technicians, and technologists. As discussed in Section 12 of this report, the Board believes it is more appropriate for LMs to be regulated by a separate entity and for RPs to be regulated by the BOP.

Section 12

New Issues

- **Financial Needs**
  - #1 - Increases to Board Fees and Maximum Reserve Amount
  - #2 - Restoring Cost Recovery

- **Enforcement Enhancements**
  - #3 - Improved Communication and Collaboration with Investigators
  - #4 - Statute of Limitations Tolling for Subpoena Enforcement
  - #5 - Enhancement of Authorized Inspection Powers
  - #6 - Non-Adversarial Enforcement
  - #7 - Obtaining Pharmacy Records in a Timely Manner

- **Licensing Updates**
  - #8 - Midwifery Sunrise
  - #9 - Research Psychoanalyst Program
  - #10 - Licensing Enhancements (clean-up)

New Issues

The Board has identified the following issues that it believes the Legislature should consider during its review of the Board. The Board believes that legislative changes to address these issues will assist the Board in its role of consumer protection and/or assist the Board in fulfilling its regulatory obligations.

The following ten issues are grouped into three categories: Financial Needs, Enforcement Enhancements, and Licensing Updates. These three categories also represent the order of the Board's priorities for the Legislature's consideration during Sunset Review.

Financial Needs

#1 - 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 entirely 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.

Based upon its current trajectory, staff project the Board will become insolvent around the end of FY 2021-22. Exacerbating its financial challenges, the Board is limited by current law (see BPC Section 2435 (g)) to a reserve of no more than four months' operating expenditures.

Fee Study Indicates Need for Increases to Fees
In 2019, the Board contracted with CPS HR Consulting to conduct a study of the Board's expenditures and revenue. Their report, Medical Board of California: Fee Study, published January 2020, made certain key findings and recommendations, including:

Key Finding 1:

> [The Board's] revenue has remained relatively static in the past 13 fiscal years, growing from $49.7 million in FY 06/07 to $59.6 million in FY 18/19, representing an increase of 19.9 percent. This calculates to an annual growth of 1.5%.
>
> During the same period, [the Board's] expenditures have outpaced revenues. [The Board's] total expenditures have grown from $44 million in FY 06/07 to $65.9 million in FY 18/19 for an overall increase of 49.8% and an annual growth of 3.8%.
>
> The [Board's] fund is structurally imbalanced and is estimated to have a fund balance of $0.6 million (0.08 months-in-reserve) by the end of FY 20/21 and will be insolvent by the beginning of FY 21/22. If [the Board] incurs any additional unbudgeted cost increases or seeks any additional resources beyond what is currently authorized, the fund reserve will drop even further.

Recommendation 1:

> To prevent insolvency and to achieve a mandatory reserve as required by statute, it is recommended that the Board seek statutory fee increases in each of their fee

categories to accommodate the expenditures and increase the reserve to four months utilizing the fee options outlined by this study.

The Board agrees with setting in statute the minimum amount for its various fees at the levels recommended by CPS HR Consulting. Although these fee increases were included in budget trailer language for the Fiscal Year 2020-21 State Budget proposed by the Department of Finance, the Legislature did not approve them at the time.

The chart below illustrates the proposed fee increases:

Fee Type	Current Fee	Adjusted Fee	Percent Increase	Increase amount
Physician/Surgeon Application	$442	$625	+41%	$183
Physician/Surgeon Initial Licensure	$783	$1150	+47%	$367
Physician/Surgeon Renewal	$783	$1150	+47%	$367
Research Psychoanalyst Initial App + License	$100	$150	+50%	$50
Research Psychoanalyst Renewal	$50	$75	+50%	$25
Polysomnography Application (Trainee, Technician, Technologist)	$100	$120	+20%	$20
Polysomnography Initial Registration (Trainee, Technician, Technologist)	$100	$120	+20%	$20
Polysomnography Renewal (Trainee, Technician, Technologist)	$150	$220	+47%	$70
Midwife Initial	$300	$450	+50%	$150
Midwife Renewal	$200	$300	+50%	$100
Special Faculty Permit Application	$442	$442	0%	0
Special Faculty Permit Initial Licensure	$783	$783	0%	0
Special Faculty Permit Renewal	$783	$1150	+47%	$367
Fictitious Name Permit Initial	$50	$70	+40%	$20
Fictitious Name Permit Renewal	$40	$50	+25%	$10
Fictitious Name Duplicate Certificate	$30	$40	+33%	$10

Further, the Board requests authority to increase those amounts by up to an additional 10 percent, and decrease them if the Board reaches its maximum reserve amount, through the rulemaking process.

Granting the Board authority to modestly increase (if necessary) and decrease its fees as requested has multiple benefits including:

1. The Board will be better positioned to actively manage its revenue if unforeseen circumstances negatively impact the Board's budget.
2. The Board will have clear authority to lower its fees when it has a sufficient reserve amount.

3. Authorizing a possible future fee increase of no more than 10 percent (which is substantially smaller than the currently requested fee increase) may mitigate the concerns that may arise when applicants and licensees are faced with large fee increases.

Fee and Workload History

The Board's fee structure has been unchanged since 2009, when the initial licensure and renewal licensure fees for physicians and surgeons were reduced from $805 to $783. This reduction was due to the discontinuation of the Board's Diversion Program. The Board's fees for its other regulated professions (LMs, polysomnography technicians, and RPs) have not changed since their inception.

The Board has continued to see a significant increase in the workload for its licensing and enforcement programs. Specifically, the Board has seen the following workload increases from FY 06/07 to FY 18/19:

28% in Physician and Surgeon applications,
57% in Physician and Surgeon complaints,
31% in Physician and Surgeon investigations opened, and
54% of Physician and Surgeon investigations referred to the AGO.

In particular, expenditures related to the AGO have been a significant cost driver for the Board, having increased 35.3 percent ($4M) from FY 06/07 to FY 18/19 ($15.2M). For example, between FY 16/17 through FY 18/19 the AGO exceeded their budget allocation by $1.7M, resulting in the Board having to absorb these costs.

The Board also projects certain future increases to its expenditures, including:

- In FY 19/20 the Board's AGO's budget allocation increased 41.0 percent ($4.9M) from $12M to $16.9M in FY 20/21 due to the increased AGO's hourly rate. From FY 20/21 to FY 24/25 the projected budget is expected to increase an additional 23.1 percent from $16.9M to $20.8M.

- The HQIU provides investigative services to Board. HQIU staff salary and benefits expenditures are expected to increase by 44.3 percent from $19.6M in FY 18/19 to $28.3M in FY 24/25. This is based on an annual average increase of approximately 6.3 percent.

- Between FY 18/19 and FY 24/25 the Board's Personnel Services costs including salary and benefits are projected to increase by 59 percent from $15.0M to $23.8M. This is based on an annual average increase of approximately 9.8 percent.

- OAH costs are projected to increase 69 percent from FY 18/19 ($1.6M) to $2.7M in FY 24/25. This is based on an annual average increase of approximately 11.5 percent.

- Departmental Services (DCA Pro Rata) is projected to increase from $5.1M in FY 18/19 to $6.7M in FY 24/25, which equates to an average of 4.5 percent each year.

- Evidence/witness costs are projected to increase from $2.3M in FY 18/19 to $2.8M in FY 24/25 which equates to an average of 3.1 percent each year.

Four Month Reserve Limit Inhibits the Board's Ability to Manage Revenue Shortfalls

Current law (see BPC section 2435 (g)) requires the Board to maintain a reserve fund balance of between two and four months. Other DCA boards have either no cap specific to their reserve funds or one that is higher than the Board's. Those boards without a cap specific to their respective practice act are bound by BPC section 128.5, which generally requires all DCA boards and bureaus to lower its fees whenever it has an unencumbered balance equal to or greater than the board's operating budget for the following two years.

To address future revenue shortfalls and unanticipated expenses, the Board believes the two-to-four month reserve requirement should be repealed, therefore authorizing it to maintain a reserve balance of up to two years of unencumbered expenses.

#2 - Restoring Cost Recovery

BPC section 125.3 generally authorizes each board within DCA to direct its licensees through a disciplinary order to pay an amount not to exceed the reasonable costs of the investigation and enforcement of the case. However, BPC section 125.3(k) prohibits the Board from exercising this authority for its physician licensees.

Background on Removal of Cost Recovery Authority

SB 231 Figueroa (Chapter 674, Statutes 2005), effective January 1, 2006, eliminated the Board's authority to request or obtain investigation and prosecution costs for a disciplinary proceeding. The bill also added language that authorized the Board, as specified, to increase its fees to offset the loss of this revenue. The loss of revenue at the time was calculated to be approximately $850,000, annually. Accordingly, beginning January 1, 2007, the Board's initial licensure and renewal fees increased by $15.

Enabling the Board to seek cost recovery may help offset the costs of investigations through either recouping a portion of those costs or by providing incentive for an accused physician to settle their case, thereby avoiding the costs associated with an ALJ hearing.

A Tool to Reduce Enforcement Timelines

The settlement process is the most expeditious way for the Board to resolve cases in a manner that provides an adequate level of consumer protection and avoids the additional costs and risks associated with taking a case to an administrative hearing.

Over the prior four fiscal years, the Board has settled an average of 79.5 percent of its disciplinary proceedings. The Board expects that restoring the authority to order recovery of its investigatory costs could provide further opportunity to settle more cases at an earlier point, possibly leading to lower costs and enhanced consumer protection by imposing discipline more quickly.

Enforcement Enhancements

#3 - Improved Communication and Collaboration with Investigators

A core function of the Board resides in its enforcement of the Medical Practice Act on behalf of Californians. The Board's investigations are paramount to its enforcement efforts and are currently conducted on behalf of the Board by HQIU.

Once the Board transmits a case to HQIU, it no longer has direct oversight of the investigation, yet the Board is held accountable for the results. In most cases, it is not until the investigation is complete, and an expert reviewer has opined on the investigation, that the case is returned to the Board for review. Sometimes, for a variety of reasons, the investigations must be sent back to the field for additional investigatory work, which further delays the cases.

The Board is hopeful that through improved communication and collaboration between the Board and HQIU, and updated HQIU procedures, will help decrease enforcement timelines and costs associated with investigations.

Background
The issue of the quality of investigations, and enforcement timelines, is a problem that the Legislature attempted to solve with the passing of SB 304 on October 2, 2013, which transferred the Board's investigators to the newly-created HQIU.

At the time, the VE paired a DAG from the AGO and an investigator to conduct a joint investigation into Board cases from their onset. The intent of VE was to conduct joint investigations from a central agency with the goal of resolving cases efficiently. The legislation in 2005 that birthed VE sought to move the Board's investigators to the AGO, however, SB 304 moved the investigators to DCA's newly created HQIU.

Created July 1, 2014, in compliance with SB 304, HQIU started to investigate cases for the Medical Board, Physician Assistants Board, the BOP, the Osteopathic Medical Board, and the Board of Podiatric Medicine.

Enforcement timelines
Following the move of the Board's investigators to HQIU, the Board has experienced a significant increase in enforcement timeframes. The Board transfers most complaints that require additional investigation to HQIU. The Board is responsible for reviewing the outcome of the investigation for approval, but day-to-day management and direction of the investigation process is handled by DCA and is outside the Board's oversight. Prior to transferring the Board's investigative staff to the HQIU, the Board's median days to investigate a physician and surgeon complaint was 205 days in FY 13/14.

Just one year later, the median days for the HQIU to investigate a physician and surgeon complaint increased to 352 days in FY 14-15, an increase of 72 percent (147 days). The median number of days for the HQIU to investigation a complaint have increased by 43 percent from 352 days in FY 14/15 to 502 days in FY 18/19. Since moving the Board investigators to HQIU, this increase to 502 days has more than doubled the timeframes from 205 days in FY 13/14.

Costs
The costs associated with the investigations have also increased significantly. In recent years, the Board has seen substantial cost increase for HQIU and expects these cost increases to continue during the next few years. HQIU expenses have increased by 20 percent from $16.5 million in FY 14/15 to $19.6 million in FY 18/19. The Board expects the HQIU staff salary and benefit expenses to increase by an additional 44 percent from $19.6 million in FY 18/19 to $28.3 million in FY 24/25.

The Board seeks to update its Memorandum of Understanding (MOU) between HQIU and the Board with the goal of providing a better foundation to efficiently collaborate on investigations that includes a shared understanding of timeframes and priorities. The MOU should address various topics, including, but not limited to the following items:

- Establish standardized investigative approaches based upon templates and guidelines developed with the assistance of the AGO.
- Expected timeframes for completion of an investigation.
- Establish clearly defined tasks, expectations, and milestones for each case. Milestones should provide defined targets and help ensure the field investigator is making consistent progress towards the goals and timelines.
- Include a process to manage investigations to do not progress based upon expectations and appropriate communication with HQIU commanders and Board staff.
- Set up monthly/weekly task update meetings with HQIU commanders and Board staff.
- Establish a program to include more non-sworn staff at HQIU and a possible hiring pathway for qualified Board staff who seek to further their investigative experience.
- Establish priority programs and processes for investigating complaints in the areas of physician sexual misconduct and substance abuse.

#4 – Statute of Limitations Tolling for Subpoena Enforcement

Under current law, when a licensee refuses to produce medical records pursuant to a lawfully-issued and patient-noticed investigative subpoena, the Board is required to litigate a petition for subpoena enforcement in superior court. 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.)

During this often lengthy process, the statute of limitations continues to run on the stalled underlying investigation of the subject. The statute does not begin to toll unless and until the licensee fails to produce the subpoenaed records by the deadline set by the court, after granting the Board's enforcement petition. Moreover, the delay to the process is compounded because the Board's subpoena enforcement matters are not entitled to be given priority by the courts. As a result, licensees and their counsel have every incentive to draw out the subpoena

enforcement litigation, thereby delaying the production of needed evidence in the underlying investigation. Case law allows physicians to argue on behalf of the patient's privacy interests even though there is misalignment, and outright conflict, with the Board's public protection interests. Even where the Board proceeds at the quickest pace possible to obtain a superior court order compelling production, investigations are often severely delayed while the Board litigates subpoena enforcement matters, sometimes leaving very little time to fully develop an investigation, obtain expert review of the subpoenaed records, and draft and file an Accusation. As an example, in the past four fiscal years, the DOJ, Civil Division, Health Quality Enforcement Section has filed 24 subpoena matters in superior court on behalf of the Board, and eight of those matters have gone up on appeal. While the number of subpoena enforcement cases relative to the total number of accusations filed in a fiscal year is small, the time and expense is great.

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. The Board would still have a strong incentive to promptly bring its subpoena enforcement actions, but having brought such an action, any delays in the litigation would not benefit either party, and the respondent licensee will not be able to use the subpoena enforcement action to their advantage to try to run out the statute of limitations. Accordingly, the Board proposes amending BPC section 2225.5(b)(1) to read as follows (changes 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.

#5 – Enhancement of Authorized Inspection Powers

Under current law, the Board is authorized to conduct inspections and review medical records in the office of a licensee, but subject to such severe limitations that such inspections and records review are virtually meaningless and ineffective. (See BPC sections 2225 and 2226.)

The Board proposes legislation that would enable qualified and properly trained investigators with the CIO and with the HQIU, along with medical consultants when desired, to conduct inspections and review patient medical records of licensed medical professionals in their professional office. This legislation would enable CIO and HQIU investigators and medical consultants to view the records of specific patients to assist in targeting with greater precision the information sought in an investigative subpoena. Such a review would greatly strengthen the Board's position in subpoena enforcement actions, wherein the Board is required to establish good cause to believe that misconduct has occurred, sufficient to overcome the patient's right to privacy. In actions where good cause is based on a review of the very records

under subpoena, the Board has been very successful. (See *Fett v. Medical Board* (2016) 245 Cal.App.4th 211.)

This enhanced inspection authority would also assist in determining whether necessary in-house procedures were capable of being performed safely in the questioned patient treatment. For example, investigators will be able to observe whether crash carts and other equipment expected to be found in an outpatient surgery setting or medical office are present and in good working order. Such early on-premise investigation will also help investigators to quickly determine whether further investigation is warranted. In certain cases, a draft investigation report could be provided to an in-house medical consultant for further assessment, and could result in earlier closure of meritless complaints or cases where there is insufficient evidence to prove a case by clear and convincing evidence.

The proposed legislation below is similar to 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.

This proposal would 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.

Under current law, 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 the records pursuant to a release signed by the patient, rather than inspecting the records in the office of the licensee. To make the Board's inspection authority meaningful, and, in particular, to assist investigators in developing good cause to support a subpoena for the records of uncooperative patients, the Board seeks the following amendment to section 2225:

> (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.

#6 - Non-Adversarial Enforcement

A steady increase in enforcement costs and a relatively stagnant income stream has resulted in a worsening fiscal position of the Board that threatens its financial independence and sustainability. In addition, increasing timelines to complete enforcement actions require a fresh look at the regulatory toolkit available to the Board. The net point to consider is what additional regulatory approaches need to be available to the Board to enhance the effectiveness and efficiency of the Board's enforcement actions and more align the Board with best international practice.

The Board has a limited number of regulatory tools at its disposal to directly resolve enforcements matters at an early stage without the requirement of a formal regulatory process.

The Board is empowered to issue public letters of reprimand (pre-accusation) and letters of reprimand (post-accusation). The Board issues these letters in circumstances where multiple simple departures or a single, extreme departure from the standard of care is established. Such letters are published on the Board's website and may place certain education requirements on a licensee. A public letter of reprimand issued pursuant to BPC section 2233 for minor violations is available to the public indefinitely but posted on the Board's website for 10 years from the effective date of the decision.

A public letter of reprimand issued pursuant to BPC section 2221.05, is a non-disciplinary administrative action issued at the time of licensure, and purged three years from the date of issuance. These letters are imposed directly by the Board and do not require any further legal process. The Board uses these letters to educate an applicant who has committed minor violations that the Board deems do not merit the denial of a license or require probationary status, as well as to alert the public about the issue.

The Board is also empowered to issue "warning" or "educational" letters to licensees. Such letters identify a potential shortcoming in the licensee's practice that does not rise to the level

of multiple simple departures or a single extreme departure from the standard of care, along with a recommended remedial action. The Board does not publish these letters and they are not legally binding. These letters have been issued in the past but the practice of issuing the letters by the Board has fallen into disuse in recent times.

The Board proposes renewed consideration be given to an increase in use of both types of letters. The letters of reprimand may often achieve the same ultimate objective currently achieved in enforcement actions only after cases go through the complete enforcement process, but at considerably less time and cost. In addition, the use of warning and educational letters may be a useful instrument in raising standards of practice in cases for which no other regulatory instruments are available.

Proposed Enhancements to Regulatory Toolkit

1. *Physician and Surgeon Health and Wellness Program*
   BPC section 2340 et seq. (enacted in 2017) establishes the Board's authority to create a PHWP. The requirements of this program are designed to address the major deficiencies found in the Board's former diversion program by the June 2007 State Auditor's Report, which identified the following problems:

   - Inadequate monitoring of compliance of participants
   - Failure to restrict the practice of noncompliant participants in a manner consistent with protection of the public
   - Lack of effective oversight of the program by the Board.

   After reviewing the auditor's report, the Board voted to terminate the diversion program, and it was discontinued on July 1, 2008.

   In contrast to the diversion program, the framework for the PWHP provides for the institutional independence of the administering body, an important consideration in establishing the integrity and confidentiality of the program. The PHWP will have to comply with the Uniform Standards. Any major or minor violation of the program will have to be reported to the Board which will initiate enforcement action. In addition, any restriction placed on a participant's ability to practice will be reported to the Board and posted to the participant's online profile for public notification.

   The establishment of the program awaits the adoption of necessary enabling regulations. The drafting and enacting of the regulations and getting the PHWP fully implemented is a priority of the Board.

   The Board considers the addition of the PHWP a necessary and welcome improvement in its regulatory toolkit. International practice has demonstrated that substance abuse and impairment issues disproportionately affect medical professionals and confidential and non-adversarial approaches have the greatest chance of achieving positive outcomes for patients. Traditional enforcement approaches can frequently have the unintended effects of denial and concealment, resulting in licensees being less willing to come forward to seek treatment. The PHWP will be a resource for physicians seeking professional assistance to overcome a substance abuse problem before it becomes an enforcement matter.

2. *Letter of Advice*
   Consideration should be given to an additional method of resolving enforcement actions in a non-adversarial manner – the letter of advice (sometimes referred to as “stipulation to informal disposition”). The Board proposes this regulatory instrument should be available in matters where the threshold for a public letter of reprimand has not been met. For example, in circumstances where there is only a single simple departure from the standard of care or a view is taken that there may not be clear and convincing evidence available to support a case against the licensee.

   The letter proposed would be a letter of advice, not reprimand or warning, and may include simple conditions, such as the taking of an educational course or other straightforward method of remediation. A letter of advice would be a confidential communication from the Board to 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.

   These letters would be issued with the agreement of the licensee, thereby ending the investigation. If the licensee fails to meet the conditions of the letter, the Board may reopen the investigation. The investigation may also be reopened in the event of a repeated similar offense.

#7 - Obtaining Pharmacy Records in a Timely Manner

HQIU and Board staff may experience months-long delays obtaining pharmacy records, as the law does not provide a clear and definite timeframe for pharmacies to turn over their records to investigators.

BPC section 4081 requires a pharmacy to maintain various records for a period of at least three years and make them available for inspection to authorized officers of the law within business hours. BPC section 4332 states that any person who fails, upon request by an authorized person, to produce or provide pharmacy records within “a reasonable time” is guilty of a misdemeanor. Investigators indicate that a reasonable time standard is vague and difficult to enforce, sometimes leading to a lengthy delay to receive necessary records.

The Board believes that BPC section 4081 should be amended to include a time-bound deadline so that its investigators may obtain pharmacy records without needless delays.

Licensing Updates

#8 - Midwifery Sunrise

The Board currently licenses and regulates California midwives. LMs do not have member representation on the Board, rather, BPC section 2509 authorizes the Board to create a MAC and appoint its members consisting of LMs and members of the public. The MAC makes recommendations on matters specified by the Board and the Board holds all authority to take action regarding the licensure and regulation of midwives in California.

When the Licensed Midwifery Practice Act of 1993 (BPC sections 2505-2523) was first enacted, LMs were required to practice under the supervision of physicians. Since AB 1308 Bonilla (Chapter 665, Statutes 2013) went into effect on January 1, 2014, LMs now practice autonomously without any supervision requirements.

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.

#9 - Research Psychoanalyst Program

According to the American Psychological Association (APA), 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. The APA states that psychoanalytic training typically requires four to eight years of advanced study after completion of a doctoral degree in psychology acceptable to the American Board of Professional Psychology and further requires specialized training at free-standing psychoanalytic institutes, postdoctoral university programs, or an equivalent training secured independently that is acceptable to the American Board and Academy of Psychoanalysis.

In California, the BOP licenses psychologists and registers psychologists and psychological assistants. Licensed psychologists may practice independently in any private or public setting. Psychological assistants are those individuals who have an advanced degree in psychology and provide limited psychological services under direct supervision. Registered psychologists are authorized to engage in psychological activities under direct supervision only at a nonprofit community agency that receives a minimum of 25 percent of their funding from a governmental source.

The BOP previously had a member who served as president of the Northern California Society for the Psychoanalytic Psychology Board of Directors and was an assistant editor for a psychoanalytic publication.

In 1977, when the RPs 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 BOP came into existence, the RPs remained under the Board's oversight while all other psychology professions moved under the BOP.

Currently, graduates of specified psychoanalytic institutes who have completed clinical training in psychoanalysis and wish to engage in psychoanalysis as an adjunct to teaching or research in California must register with the Board as a RP. Students in the specified psychoanalysis institutes who wish to engage in psychoanalysis under supervision must also register with the

Board as a SRP. The Board has authority to suspend or revoke these registrations under BPC section 2529.

The Board recommends transfer of the Research Psychoanalysis program to the BOP. The BOP currently licenses and regulates psychologists in California, and therefore maintains the resources and expertise to regulate a specialty of psychology, such as psychoanalysis. The BOP will more effectively and efficiently regulate research psychoanalysis and the Board does not believe there would be any adverse effect to transfer this program to the BOP.

#10 - Licensing Enhancements (clean-up)

BPC section 2096
Approved postgraduate training programs may include portions of non-clinical experience conducting research that the accrediting agency does not consider part of the approved postgraduate training program. When a program verifies the years of postgraduate training completed by the resident, the program may include the resident's time spent conducting research, up to one year, in the total number of years of accredited training. As a result, the total time of approved postgraduate training reported to the Board may exceed the training years identified by the accrediting agency. When the Board receives the Certificate of Completion of Postgraduate Training (Forms PTA/B) from the training program, the Board's current review process requires verifying the accredited years of training for that particular specialty with the accrediting agency. If the postgraduate training program includes the time spent conducting research in the total years of postgraduate training reported on the PTA/B form, the application review process may be delayed and cause confusion for the program verifying the total years of postgraduate training. The Board must ensure the additional time reported in the training program was not due to training deficiencies, leave of absence, or any other issues the Board must review to determine eligibility for licensure.

The Board recommends making the following changes to BPC section 2096:

> (a) In addition to other requirements of this chapter, before a physician's and surgeon's license may be issued, each applicant, including an applicant applying pursuant to Article 5 (commencing with Section 2100), shall show by evidence satisfactory to the board that the applicant has successfully completed at least 36 months of board-approved postgraduate training, with at least 24 continuous months in the same program.
> (b) The postgraduate training required by this section shall include at least four months of general medicine and shall be obtained in a postgraduate training program approved by the ACGME, the Royal College of Physicians and Surgeons of Canada (RCPSC), or the CFPC. Training that does not fall within the parameters of the ACGME, RCPSC, or CFPC- approved postgraduate training program does not qualify toward the training requirement in subsections (a) and (c), including, but not limited to, time spent conducting research that is not part of the approved postgraduate training program.
> (c) An applicant who has completed at least 36 months of board-approved postgraduate training, not less than 24 months of which was completed as 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 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).

(d) This section shall become operative on January 1, 2020.

These proposed changes to BPC section 2096 will define the type of training accepted towards the 36 months required under subsection (a) by specifying that research is not considered board-approved training and the time spent conducting research outside of the accredited training program will not meet the requirements for licensure. This will also help reduce unnecessary delays in the application review process.

BPC sections 2111, 2112, and 2113

The Board does not have the authority to cancel special permits granted under BPC sections 2111, 2112, and 2113 when the exemption is no longer renewable or upon request by the sponsoring medical school or the registrant.

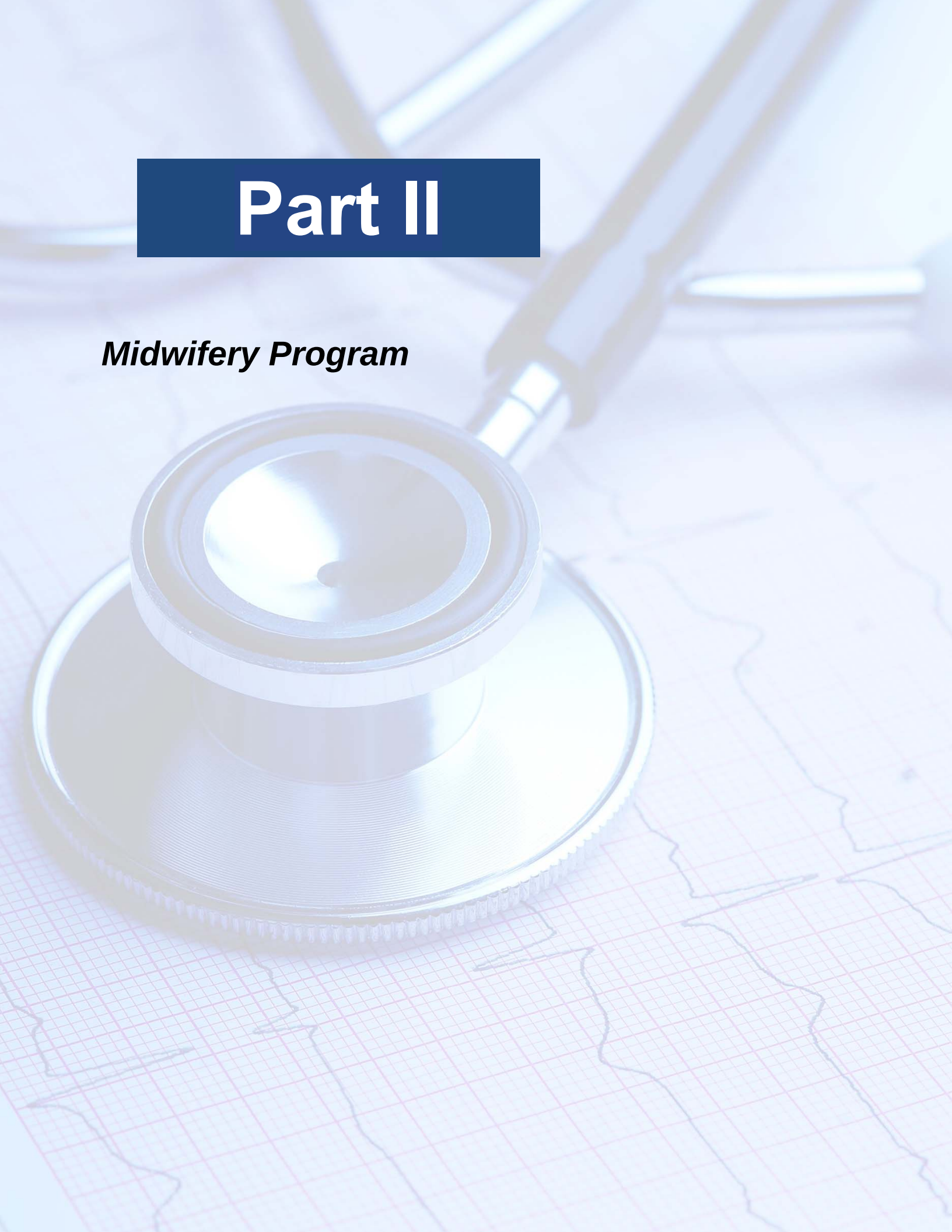
Section 2111 allows the Board to grant the license exemption approval for a maximum of three years. Sections 2112 and 2113 allow the Board to grant the license exemption approval for a maximum of five years.

Currently, the Board requests the sponsoring medical school to submit a Notice of Separation form signed by the dean and the registrant's supervisor within 30 days of the last day of practice. Upon receipt of the signed form, the Board will cancel the license exemption. However, under existing law, the sponsoring medical school is not required to submit the Notice of Separation form. This results in many sponsoring medical schools failing to report to the Board in a timely manner when a registrant is no longer practicing at their institution.

Without the authority to cancel these license exemptions, the registrations may continue to appear as renewed and current on the Board's website, leading consumers to believe that the registered physician is eligible to practice at the sponsoring medical school. In addition, license exemptions may appear as delinquent and expired at the end of the maximum allowed timeframe, leading formerly registered physicians to believe they can or must renew with the Board when the registration is no longer renewable.

The Board recommends amending BPC sections 2111, 2112, and 2113 to authorize the Board to cancel license exemptions in instances when the license exemption is no longer renewable, the sponsoring medical school requests the cancellation, or the registrant requests the cancellation.

By authorizing the Board to cancel license exemptions, this will provide registrants and the public accurate information on the status of the registration in order to determine which registrants are currently practicing under a license exemption in California. Additionally, this will decrease Board staff workload by reducing the time spent requesting the Notice of Separation form from sponsoring medical schools or AMCs.



Part II

Midwifery Program

Midwifery Program

Section 1 – Background and Description of Midwifery Program

History and Functions of the Midwifery Program

An LM is an individual who has been issued a license to practice midwifery by the Board. The Midwifery Practice Act was chaptered in 1993 and implemented in 1994 with the first direct entry midwives licensed in September 1995. The practice of midwifery authorizes the licensee to attend cases of normal childbirth, in a home, birthing clinic, or hospital environment.

Pathways to licensure for midwives include completion of a three-year postsecondary education program in an accredited school approved by the Board or through a Challenge Mechanism. The Challenge Mechanism pathway is pursuant to BPC section 2513, which allows a midwifery student and prospective applicant the opportunity to obtain credit by examination for previous midwifery education and clinical experience. Prior to licensure, all midwives must take and pass the North American Registry of Midwives (NARM) examination, adopted by the Board in 1996, which satisfies the written examination requirements set forth in law.

In order to provide the guidance necessary to the Board on midwifery issues, effective January 1, 2007, the Board was mandated to have a MAC. The MAC is made up of LM (pursuant to BPC section 2509, at least half of the Council shall be LMs), one licensed physician, and two members of the public who have an interest in midwifery practice, including, but not limited to, home births. The Board specifies issues for the MAC to discuss/resolve and the MAC also identifies issues and requests approval from the Board to develop solutions to the various matters. Some items that have been discussed include regulations impacting midwifery practice, difficulties providing collaborative care with physicians, and the Licensed Midwife Annual Report. The MAC chair attends the Board meetings and provides an update on the issues and outcomes of the MAC meetings, and requests Board approval for future agenda items.

Major Legislation/Regulations Since the Last Sunset Review

Legislation

2016

AB 2745 (Holden, Chapter 303) – Healing Arts: Licensing and Certification
In pertinent part, this Board-sponsored bill clarifies the Board's authority for the allied health licensees/registrants overseen by the Board. It allows the Board to revoke or deny a license/registration for registered sex offenders, allows the Board to take disciplinary action for excessive use of drugs or alcohol, allows allied health licensees/registrants to petition the Board for license/registration reinstatement, and allows the Board to use probation as a disciplinary option for allied health licensees/registrants.

2017

SB 798 (Hill, Chapter 775) – Healing Arts: Boards [All Board Programs]
This is the Board's sunset bill, which includes language on a portion of the new issues from the Board's 2016 Sunset Review Report, and will extend the Board's sunset date for four years, until January 1, 2022. Specifically, this bill includes LMs in the peer review reporting requirements and provisions in existing law and adds LMs to the listing of medical corporations.

2018

AB 2138 (Chiu and Low, Chapter 995) – Licensing Boards: Denial of Application: Revocation or Suspension of Licensure: Criminal Conviction
This bill, which became effective July 1, 2020, limits discretion for boards, bureaus and committees within the DCA to apply criminal conviction history for a license denial. This bill amends the definition of a conviction in existing law to mean a judgment following a plea or verdict of guilty or a plea of nolo contendere or finding of guilt. This bill no longer allows a conviction that has been dismissed under Penal Code section 1203.4 to fall under the definition of a conviction. This bill 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. This bill does not allow prior disciplinary action by a board within the preceding seven years to be the basis for denial of a license if the basis for that disciplinary action was a conviction that has been dismissed pursuant to the Penal Code, or a comparable dismissal or expungement. Among other provisions, this bill also prohibits regulatory boards from requiring an applicant to self-disclose criminal history information and requires boards to collect and publish demographic data regarding applicants who are denied licensure or who have licenses revoked or suspended.

2019

SB 425 (Hill, Chapter 849) – Health Care Practitioners: Licensee's File: Probationary Physician's and Surgeon's Certificate: Unprofessional Conduct
This bill, in pertinent part, requires health facilities and entities that allow a licensed health care professional to provide care for patients, to report allegations of sexual abuse and sexual misconduct made by a patient in writing against a licensed health care practitioner to that practitioner's licensing board within 15 days, and imposes a fine for failure to report. This bill also amends existing law that requires the Board to provide a "comprehensive" summary to a licensee upon request, and now just requires the Board to provide a summary. This bill requires probationary license information to stay on the Board's website for a period of 10 years.

2020

N/A

Regulations

Midwife Assistants - Implementation of SB 408 (Morrell, Chapter 280) (effective September 21, 2017)
SB 408 required midwife assistants to meet minimum training requirements and set forth the duties that a midwife assistant could perform, which are technical support services only. This bill allowed the Board to adopt regulations and standards for any additional midwife technical support services.

Cite and Fine of Allied Health Professionals (effective January 1, 2018)
The Board authorized this rulemaking to allow a Board official to issue citations containing orders of abatement and fines to individuals, partnerships, corporations or associations, who are performing or who have performed services for which licensure as a LM or registration as a polysomnographic technologist, technician or trainee is required.

Substantial Relationship and Rehabilitation – Implementation of AB 2138 (Chiu, Chapter 995, Statutes of 2018) (pending)
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.

Notice to Patients (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. With this change, the need for the list of statutes and regulations subject to citation under 16 CCR section 1364.11(a) will be eliminated. 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.

Medical and Midwife Assistant Certifying Organizations and Administration of Training for Medical Assistants (pending)
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.

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.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2020 Medical Board Sunset Report.

Section 3 – Fiscal and Staff Issues

The fees collected for the Midwifery Program go into the Licensed Midwifery Fund. When this Program began in 1994, it received a $70,000 loan from the General Fund. In order to ensure solvency, this loan was paid off over the course of the next ten years and paid in full in 2004. Beginning in FY 14/15, an appropriation was established to fund the personnel needed to administer the Midwifery Program. Starting in FY 17/18, the Board began requesting payment from the Midwifery Program for the staff resources to perform the licensing and enforcement functions of the Program. There have been no General Fund loans from the Licensed Midwifery Fund.

LMs submit an application and initial license fee of $300 and have a biennial renewal fee of $200. The renewal fee comprises about 78 percent of the fees received in the Licensed Midwifery Fund.

Table 2- Fund Condition Midwifery

(Dollars in Thousands)	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Beginning Balance	327	362	398	451
Total Revenue	49	46	60	58
Total Resources	362	393	451	509
Budget Authority	13	13	120	120
Expenditures	14	15	7	109*
Loans to General Fund	0	0	0	0
Accrued Interest, Loans to General Fund	0	0	0	0
Loans Repaid From General Fund	0	0	0	0
Fund Balance	362	393	451	400
*FM12 expenditures				

Table 4 - Fee Schedule and Revenue							
Fee	Current Fee Amount	Statutory Limit	FY 2016/2017 Revenue	FY 2017/2018 Revenue	FY 2018/2019 Revenue	FY 2019/2020 Revenue	% of Total Revenue*
LICENSED MIDWIFERY FUND							
Licensed Midwife Duplicate Cert Fee	25.00	25.00	0	0	0	0	N/A
Licensed Midwife Application and Initial License Fee (BPC 2520) (16 CCR 1379.5)	300.00	300.00	10,000	9,000	13,000	10,000	20%
Licensed Midwife Biennial Renewal Fee (BPC 2520) (16 CCR 1379.5)	200.00	200.00	35,000	35,000	38,000	40,000	78%
Licensed Midwife Delinquency Fee (BPC 2520) (16 CCR 1379.5)	50.00	50.00	1,000	1,000	0	1,000	2%
*Not including revenue from Investment Income - Surplus Money Investments							

Section 4 – Licensing Program

Application Review

16 CCR section 1379.11 requires the Board to inform an applicant for licensure as a midwife in writing within 30 days of receipt of an application as to whether the application is complete and accepted for filing or is deficient and what specific information is required. The Midwifery Program's goals have been to review all applications received within 30 days. The Board is currently in compliance with the mandated timeframes and is reaching the internal goals that have been set by the program.

Due to the small number of new applications received, processing times have remained consistent during the last four years. The number of applications received each year has mostly remained the same as well over the last four fiscal years.

The tables below show the Midwifery Program licensee population, licenses issued and licenses renewed.

Table 6 - Licensee Population					
		FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Licensed Midwife	Active	390	418	429	461
	Delinquent	41	45	70	68
	Out-of-State	Unknown	Unknown	Unknown	36
	Out-of-Country	Unknown	Unknown	Unknown	1

Table 7a. Licensing Data by Type – 8001 – Licensed Midwife											
Licensed Midwife		Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2016/2017	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	26	30	2	30	unk[a]	-	-	13	39	37
	(Renewal)	170	n/a	n/a	170	0	-	-	-	-	-
FY 2017/2018	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	30	36	0	36	unk[a]	-	-	19	60	55
	(Renewal)	193	193	n/a	193	0	-	-	-	-	-
FY 2018/2019	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	43	40	0	40	unk[a]	-	-	11	50	41
	(Renewal)	190	190	n/a	190	0	-	-	-	-	-
FY 2019/2020	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	32	35	0	35	1	-	-	11	26	18
	(Renewal)	201	201	n/a	201	0	-	-	-	-	-

* Optional. List if tracked by the board.
[a] Data not captured in previous years.

Table 7b. Total Licensing Data – 8001 – Licensed Midwife				
	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Initial Licensing Data:				
Initial License/Initial Exam Applications Received	26	30	43	32
Initial License/Initial Exam Applications Approved	30	36	40	35
Initial License/Initial Exam Applications Closed	2	0	0	0
License Issued	30	36	40	35
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	N/A	N/A	N/A	1
Pending Applications (outside of board control)*	N/A	N/A	N/A	N/A
Pending Applications (within the board control)*	N/A	N/A	N/A	N/A

Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	37	55	41	18
Average Days to Application Approval (incomplete applications)*	39	60	50	26
Average Days to Application Approval (complete applications)*	13	19	11	11
License Renewal Data:				
License Renewed	170	193	190	201
Note: The values in Table 7b are the aggregates of values contained in Table 7a. * Optional. List if tracked by the board.				

Exams

The LM examination is a national examination offered by the NARM. This is a computer based exam with a required passing score of 75.

Verification of Application Information

Applicants are required by law to disclose truthfully all questions asked on the application for licensure. Out-of-state and out-of-country applicants must meet the same requirements as California applicants.

The application forms and LV are valid for one year. After one year, the applicant must submit updated forms to ensure that the Board's current information accurately reflects any change in an applicant's credentials. The Board requires primary source verification for certification of midwifery education, examination scores, LV, diplomas, certificates, and challenge documentation.

The application asks about discipline by any other licensing jurisdiction for the practice of midwifery or any other healing arts license type. If an affirmative response to either of these questions is provided, the applicant and the involved institution or agency must provide a detailed narrative of the events and circumstances leading to the action(s).

License applications used to request information about convictions, including those that may have been deferred, set aside, dismissed, expunged or issued a stay of execution, however, these questions were removed from the application pursuant to AB 2138 (Chiu, Chapter 995, Statutes of 2018). 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.

All reports of criminal history, prior disciplinary actions, or other unlawful acts of the applicant are reviewed on a case-by-case basis to determine if the applicant is eligible for licensure.

Individuals applying for a midwifery license must obtain fingerprint clearances through the DOJ and FBI in order to establish the identity of the applicant and in order to determine whether the applicant has a record of any criminal convictions in this state or in any other jurisdiction. Criminal record history reports are obtained from both the DOJ and the FBI prior to issuing a license.

All LMs with a current license have been fingerprinted. As fingerprinting is a requirement for licensure, a midwife's license will not be issued prior to completion of this requirement. The Board receives supplemental reports from the DOJ and FBI following the initial submittal of fingerprints should future criminal convictions occur post licensure. Supplemental reports will be reviewed by the Enforcement Program to determine if any action should be taken against the licensee.

A midwifery applicant must disclose all current and/or previous licenses held and provide a LV from each state or province to be sent directly to the Board verifying the applicant's licensure information and whether any action has been taken against the license. If the LV indicates action has been taken, certified documents from the state or province must be provided detailing the circumstances related to the action and the outcome.

The comprehensive licensing examination developed by the NARM was adopted by the Board in May 1996, and satisfies the written examination requirements as outlined in law.

School Approvals

The Board approves midwifery schools by independently conducting a thorough and comprehensive assessment to evaluate the school's educational program curriculum and the program's academic and clinical preparation equivalent. Schools wishing to obtain approval by the Board must submit supporting documentation to verify that they meet the requirements of BPC section 2512.5(a). Currently, the BPPE does not provide any role in approval of midwifery schools.

Currently, there are 11 approved midwifery schools. The three-year program at each approved school has been accepted as meeting the requirements listed in BPC section 2512.5(a) and 16 CCR section 1379.15. The re-assessment of approved schools is not currently mandated by law or regulation as it pertains to the midwifery program.

If an international midwifery school were to apply for approval by the Board, it would be required to submit the same documentation and requirements as a U.S. school. As of this date, the Board has yet to receive an application for approval of an international midwifery school.

Continuing Education/Competency Requirements

Under Article 10 of the Medical Practice Act commencing with BPC section 2518, the Board has adopted and administers standards for the CE of midwives. The Board requires each LM to document the completion of 36 hours of CE in areas that fall within the scope of the practice of midwifery, as specified by the Board.

Each LM is required to certify under penalty of perjury, upon renewal, that they have met the CE requirements. 16 CCR section 1379.28 requires the Board to audit a random sample of LMs who have reported compliance with the CE requirements. The Board requires that each LM retain records for a minimum of four years of all CE programs attended which may be needed in the event of an audit by the Board. The CE audit is performed on a monthly basis and is designed to randomly audit approximately 10 percent of the total number of renewing LMs per year. The CE audit selection process is completed automatically through the BreEZe system. Licensees must provide proof of attendance at CE courses or programs if selected for the audit. Upon receipt of documents, staff conduct a review to determine compliance with the

law. Due to the coronavirus pandemic and the waiving of CE requirements for a six month period upon renewal, the Board has temporarily suspended its CE Audit program.

If an LM fails the audit by either not responding or failing to meet the requirements as set forth by 16 CCR section 1379.28, the LM will be allowed to renew their license one time following the audit to permit them to make up any deficient CE hours. However, the Board will not renew the license a second time until all of the required hours have been documented by the Board. It is considered unprofessional conduct for any LM to misrepresent their compliance with 16 CCR section 1379.28.

In addition to CE programs approved pursuant to 16 CCR section 1379.26, the Board approves CE programs based on the criteria defined under 16 CCR section 1379.27. The Board has not received any recent applications for CE providers or courses, but has approved several programs in the past.

16 CCR section 1379.27(b) authorizes the Board to 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 providers will be asked to submit to the Board documentation concerning each of the items described in 16 CCR section 1379.27(a).

Section 5 – Enforcement Program

The Board utilizes its Disciplinary Guidelines as a model for disciplinary action imposed on midwives. Over the past three fiscal years, there were three accusations filed against LMs.

The majority of the complaints received regarding LMs relate to the care provided during labor and delivery. These complaints are considered to be the highest priority. The Board also receives complaints regarding the unlicensed practice of midwifery which are also considered urgent complaints. The Program's complaint prioritization policy is consistent with DCA's guidelines.

The midwifery program does not have a statute of limitation requirement in statute but recognizes public protection as its highest authority and strives to investigate each complaint as quickly as possible.

Table 9a, b, and c. Enforcement Statistics Licensed Midwife

	FY 2017/2018	FY 2018/2019	FY 2019/2020
COMPLAINT			
Intake			
Received	29	31	39
Closed	0	0	0
Referred to INV	32	31	44
Average Time to Close	0 days	0 days	0 days
Pending (close of FY)	1	1	1
Source of Complaint			
Public	15	12	14

Table 9a, b, and c. Enforcement Statistics Licensed Midwife			
	FY 2017/2018	FY 2018/2019	FY 2019/2020
Licensee/Professional Groups	6	2	9
Governmental Agencies	0	7	3
Other	8	10	13
Conviction / Arrest			
CONV Received	0	1	1
CONV Closed	0	0	0
Referred to INV	0	1	1
Average Time to Close	0 Days	0 days	0 days
CONV Pending (close of FY)	0	0	0
LICENSE DENIAL			
License Applications Denied	0	0	0
Statements of Issues (SOI) Filed	0	0	0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	0 days	0 days	0 days
ACCUSATION			
Accusations Filed	0	2	1
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations	0 days	738 days	1091 days
Pending (close of FY)	2	0	0
DISCIPLINE			
Disciplinary Actions	0	0	0
Proposed(PD)/Default (DD) Decisions	PD - 0 DD - 0 Total - 0	PD - 0 DD - 0 Total - 0	PD - 0 DD - 0 Total - 0
Stipulations	0	0	0
Average Days to Complete	0 days	0 days	0 days
AG Cases Initiated	2	0	4
AG Cases Pending (close of FY)	2	2	3
Disciplinary Outcomes			
Revocation	0	0	0
Surrender	0	0	0
Suspension	0	0	0
Probation with Suspension	0	0	0
Probation	0	0	0
Probationary License Issued	0	0	0
Public Reprimands	0	0	0
Other	0	0	0
PROBATION			
New Probationers	0	0	0
Probations Successfully Completed	0	0	0

Table 9a, b, and c. Enforcement Statistics Licensed Midwife			
	FY 2017/2018	FY 2018/2019	FY 2019/2020
Probationers (close of FY) – 19/20 probationers	In State - 0 Out of State - 0 Total - 0	In State - 0 Out of State - 0 Total - 0	In State - 0 Out of State - 0 Total - 0
Petitions to Revoke Probation Filed	0	0	0
Probations Revoked	0	0	0
Probations Surrendered	0	0	0
Probation Extended with Suspension	0	0	0
Probation Extended	0	0	0
Public Reprimands	0	0	0
Petitions to Revoke Probation Withdrawn	0	0	0
Petitions to Revoke Probation Dismissed	0	0	0
Probations Modified	0	0	0
Probations Terminated	0	0	0
Probationers Subject to Drug Testing	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0
Petition for Reinstatement Granted	0	0	0
DIVERSION – Not Applicable			
INVESTIGATION			
All Investigations			
First Assigned	32	32	32
Closed	28	26	48
Average days to close	166 days	265 days	202 Days
Pending (close of FY)	15	26	19
Desk Investigations			
Closed	22	13	36
Average days to close	56 days	107 days	100 Days
Pending (close of FY)	7	11	5
Non-Sworn Investigation			
Closed	0	0	0
Average days to close	0 Days	0 Days	0 Days
Pending (close of FY)	0	0	0
Sworn Investigation			
Closed	4	7	3
Average days to close	493 days	698 days	764 days
Pending (close of FY)	8	15	14
COMPLIANCE ACTION			
ISO & TRO Issued	ISO=0 TRO=0 Total=0	ISO=0 TRO=0 Total =0	ISO=0 TRO=0 TOTAL=0
PC 23 Orders Granted/Issued	0	0	0
Court Orders	0	0	0
Other Suspension Orders	0	0	0
Public Letter of Reprimand	n/a	n/a	n/a
Cease & Desist/Warning	0	0	0

Table 9a, b, and c. Enforcement Statistics Licensed Midwife	FY 2017/2018	FY 2018/2019	FY 2019/2020
Referred for Diversion	n/a	n/a	n/a
Compel Examination (Filed)	0	0	0
CITATION AND FINE			
Citations Issued	0	1	0
Average Days to Complete	0 days	127 days	0 days
Amount of Fines Assessed	$0	$500	$0
Reduced, Withdrawn, Dismissed	$0	$0	$0
Amount Collected	$0	$500	$0
CRIMINAL ACTION			
Referred for Criminal Prosecution	2	0	0

Table 10. Enforcement Aging Licensed Midwife	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
0 - 1 Year	0	0	0	0	0	0 %
1 - 2 Years	0	0	0	0	0	0 %
2 - 3 Years	1	0	0	0	1	100 %
3 - 4 Years	0	0	0	0	0	0 %
Over 4 Years	0	0	0	0	0	0 %
Total Attorney General Cases Closed	1	0	0	0	1	100 %
Investigations (Average %)						
Closed Within:						
90 Days	21	18	13	24	76	56 %
91 - 180 Days	2	4	4	6	16	12 %
181 - 1 Year	9	0	4	10	23	17 %
1 - 2 Years	0	7	2	3	12	9 %
2 - 3 Years	0	0	2	4	6	5 %
Over 3 Years	0	0	1	1	2	1 %
Total Investigation Cases Closed	32	29	26	48	135	100%

Mandatory Reporting

BPC section 2510 requires hospitals to report to the Board each transfer to a hospital by a LM of a planned out-of-hospital birth. The chart below indicates the number of these reports sent to the Board between FY 17/18 and FY 19/20. These specific reports are not a complaint of inappropriate treatment, but a mandated report received by the Board. This mandated report is reviewed by the Board's Enforcement Program to determine if a complaint needs to be opened and action pursued.

Fiscal Year	FY 2017/2018	FY 2018/2019	FY 2019/2020
Transfer of Planned Out-of-Hospital Delivery to Hospital Reporting Form Received	153	172	179

Cite and Fine
As of January 1, 2018, the Board has cite and fine authority to issue citations with fines or orders of abatement to LMs.

Fiscal Year	Pre-Appeal Average	Post-Appeal Average
16/17	$0	$0
17/18	$0	$0
18/19	$500	$0
19/20	$0	$0

Cost Recovery and Restitution
BPC section 125.3 provides the Board with authority to collect investigation and prosecution costs of midwifery cases.

There is no set cost recovery amount. Cost recovery is calculated based on the number of hours to complete an investigation multiplied by a set hourly rate determined by the DCA.

For cases that do not rise to the level of being transmitted to the AGO for formal disciplinary action, the Board will not seek cost recovery.

The Board has not used the FTB's intercept program to collect cost recovery from LMs.

The Board does not seek restitution for consumers. Restitution may be ordered by criminal courts.

Table 11. Cost Recovery

	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Total Enforcement Expenditures	$0	$0	$0	$0
Potential Cases for Recovery *	n/a	n/a	n/a	n/a
Cases Recovery Ordered	0	0	0	0
Amount of Cost Recovery Ordered	$0	$0	$0	$0
Amount Collected	$22,790	$38,745	$0	$0

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

Table 12. Restitution

	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Amount Ordered	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

Section 6 – Public Information Policies

Refer to Full 2020 Medical Board Sunset Report.

Section 7 – Online Practice Issues

Refer to Full 2020 Medical Board Sunset Report.

Section 8 – Workforce Development and Job Creation

Refer to Full 2020 Medical Board Sunset Report.

Section 9 – Current Issues

Refer to Full 2020 Medical Board Sunset Report.

Section 10 – Board Actions and Responses to COVID-19

Refer to Full 2020 Medical Board Sunset Report.

Section 11 – Board Action and Response to Prior Sunset Issues

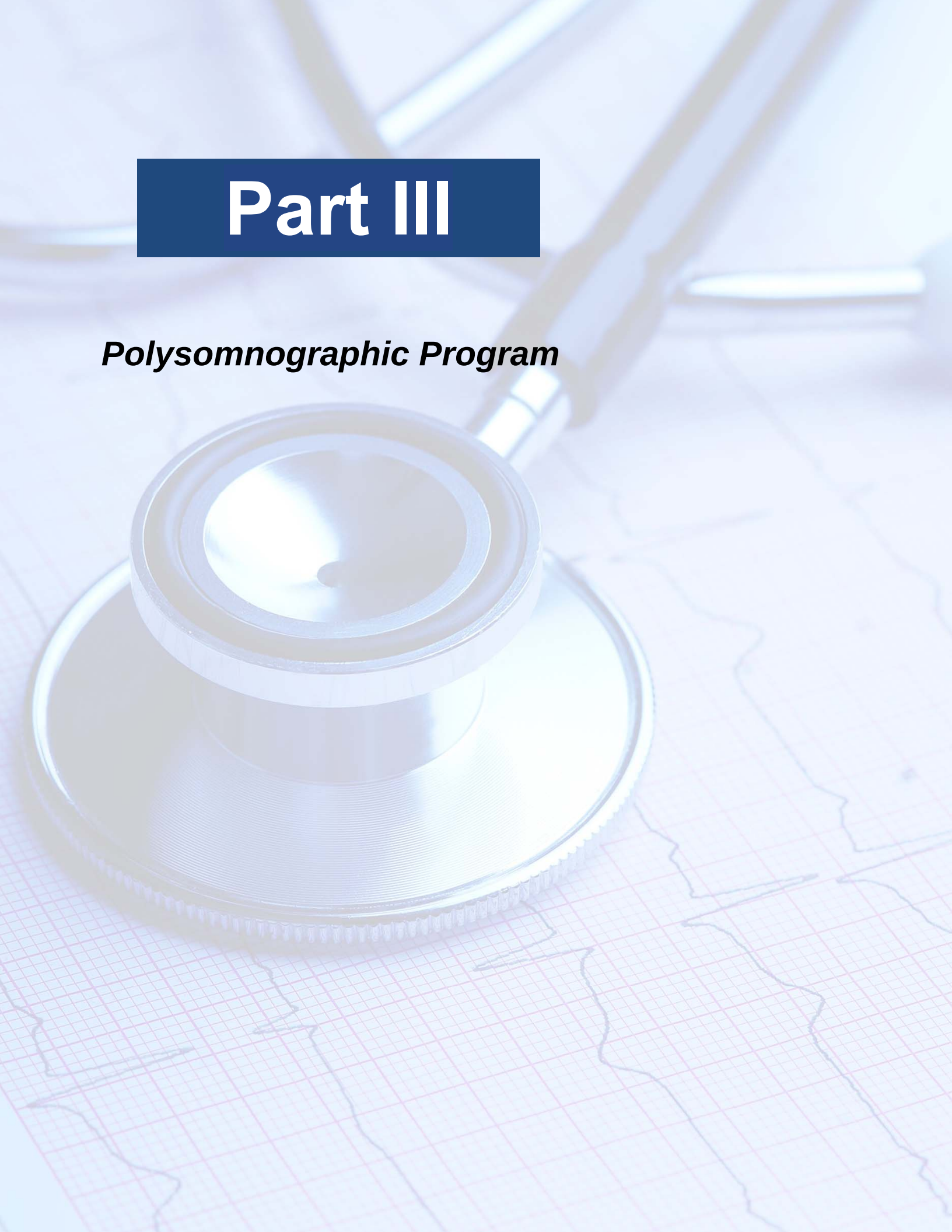
Please see Issue #4, Section 11 in Part I – Physicians.

Section 12 – New Issues

Please see Issue #8, Section 12 in Part I – Physicians.

Part III

Polysomnographic Program



Polysomnographic Program

Section 1 – Background and Description of Polysomnographic Program

History and Functions of the Polysomnographic Program

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

The Legislature enacted the regulation of the Polysomnographic Program under the jurisdiction of the Board in 2009. This Program registers individuals that are involved in the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. The Polysomnographic Program registers individuals as polysomnographic trainees, technicians or technologists.

Polysomnographic trainee registration is required for individuals under the direct supervision of a supervising physician, polysomnographic technologist or other licensed health care professionals who provide basic supportive services as part of their education program, including, but not limited to, gathering and verifying of patient information, testing preparation and monitoring, documenting routine observations, data acquisition and scoring, and assisting with appropriate interventions for patient safety in California. In order to qualify as a polysomnographic trainee, one must have either a high school diploma or GED and have completed at least six months of supervised direct polysomnographic patient care experience, or be enrolled in a polysomnographic education program approved by the Board. Applicants must also possess at the time of application a current certificate in basic life support issued by the American Heart Association.

The polysomnographic technician registration is required for individuals who may perform the services equivalent to that of a polysomnographic trainee under general supervision *and* may implement appropriate interventions necessary for patient safety in California. In order to qualify for a polysomnographic technician registration, an individual must meet the initial requirements for a polysomnographic trainee *and* have at least six months experience at a level of polysomnographic trainee.

Polysomnographic technologist registration is required for individuals who, under the supervision of a physician, are responsible for the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders in California. Registrants are required to have a valid, current credential as a polysomnographic technologist issued by the Board of Registered Polysomnographic Technologists (BRPT); graduated from a polysomnographic educational program that has been approved by the Board; and taken and passed the BRPT examination.

Over the past four years, the number of applications received has maintained a consistent volume with a slight decrease in FY 19/20.

Major Legislation/Regulations Since the Last Sunset Review

Legislation

2016

AB 2745 (Holden, Chapter 303) – Healing Arts: Licensing and Certification
In pertinent part, this Board-sponsored bill clarifies the Board's authority for the allied health licensees/registrants overseen by the Board. It allows the Board to revoke or deny a license/registration for registered sex offenders, allows the Board to take disciplinary action for excessive use of drugs or alcohol, allows allied health licensees/registrants to petition the Board for license/registration reinstatement, and allows the Board to use probation as a disciplinary option for allied health licensees/registrants.

2017

N/A

2018

AB 2138 (Chiu and Low, Chapter 995) – Licensing Boards: Denial of Application: Revocation or Suspension of Licensure: Criminal Conviction
This bill, which became effective July 1, 2020, limits discretion for boards, bureaus and committees within the DCA to apply criminal conviction history for a license denial. This bill amends the definition of a conviction in existing law to mean a judgment following a plea or verdict of guilty or a plea of nolo contendere or finding of guilt. This bill no longer allows a conviction that has been dismissed under Penal Code section 1203.4 to fall under the definition of a conviction. This bill 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. This bill does not allow prior disciplinary action by a board within the preceding seven years to be the basis for denial of a license if the basis for that disciplinary action was a conviction that has been dismissed pursuant to the Penal Code, or a comparable dismissal or expungement. Among other provisions, this bill also prohibits regulatory boards from requiring an applicant to self-disclose criminal history information and requires boards to collect and publish demographic data regarding applicants who are denied licensure or who have licenses revoked or suspended.

2019

SB 425 (Hill, Chapter 849) – Health Care Practitioners: Licensee's File: Probationary Physician's and Surgeon's Certificate: Unprofessional Conduct
This bill, in pertinent part, requires health facilities and entities that allow a licensed health care

professional to provide care for patients, to report allegations of sexual abuse and sexual misconduct made by a patient in writing against a licensed health care practitioner to that practitioner's licensing board within 15 days, and imposes a fine for failure to report. This bill also amends existing law that requires the Board to provide a "comprehensive" summary to a licensee upon request, and now just requires the Board to provide a summary. This bill requires probationary license information to stay on the Board's website for a period of 10 years.

2020

N/A

Regulations

Cite and Fine of Allied Health Professionals (effective January 1, 2018)
The Board authorized this rulemaking to allow a Board official to issue citations containing orders of abatement and fines to individuals, partnerships, corporations or associations, who are performing or who have performed services for which licensure as a LM or registration as a polysomnographic technologist, technician or trainee is required.

Substantial Relationship and Rehabilitation – Implementation of AB 2138 (Chiu, Chapter 995, Statutes of 2018) (pending)
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/registrant when considering denying or disciplining a license based on a conviction or professional discipline.

Notice to Patients (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. With this change, the need for the list of statutes and regulations subject to citation under 16 CCR section 1364.11(a) will be eliminated. 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.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2020 Medical Board Sunset Report.

Section 3 – Fiscal and Staff

Refer to Full 2020 Medical Board Sunset Report.

Section 4 – Licensing Program

Application Review

Current law does not define the required time to review an initial application for the Polysomnography Program; however, the Board has set an internal expectation that all new applicants will be notified in writing within 30 days of receipt of an application as to whether the application is complete and accepted for filing or is deficient and what specific information is required. This applies to all registration types under the Polysomnography Program. The Board is currently meeting this expectation and is reviewing applications within 30 days.

The polysomnography application volume remains consistent with previous years. The average time to process a polysomnography application has remained constant, and occurs within 30 days. Pending applications for the program are very small and those in a pending status are outside of the Board's control.

The tables below show the Polysomnographic Program data.

Table 6. Registration Population

		FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
8012 – Polysomnography Trainee	Active	64	58	61	57
	Delinquent	14	27	32	37
	Out of State	Unknown	Unknown	Unknown	1
	Out of Country	Unknown	Unknown	Unknown	0
8012 – Polysomnography Technician	Active	106	123	131	144
	Delinquent	24	35	49	52
	Out of State	Unknown	Unknown	Unknown	1
	Out of Country	Unknown	Unknown	Unknown	0
8012 – Polysomnography Technologist	Active	580	663	637	668
	Delinquent	135	133	199	154
	Out of State	Unknown	Unknown	Unknown	50
	Out of Country	Unknown	Unknown	Unknown	0

Table 7a. Registration Data by Type – 8012 – Polysomnography - Trainee

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2016/2017	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	27	29	0	29	unk[a]	-	-	19	118	115
	(Renewal)	10	n/a	n/a	10	0	-	-	-	-	-
FY 2017/2018	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	23	19	0	19	unk[a]	-	-	0	95	95
	(Renewal)	13	13	n/a	13	0	-	-	-	-	-
FY 2018/2019	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	21	20	0	20	unk[a]	-	-	12	68	59
	(Renewal)	22	22	n/a	22	0	-	-	-	-	-
FY 2019/2020	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	14	14	0	14	10	-	-	11	207	123
	(Renewal)	14	14	n/a	14	0	-	-	-	-	-

* Optional. List if tracked by the board.
[a] Data not captured in previous years

Table 7a. Registration Data by Type – 8012 – Polysomnography – Technician

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2016/2017	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	17	29	0	29	unk[a]	-	-	n/a	102	102
	(Renewal)	28	n/a	n/a	28	0	-	-	-	-	-
FY 2017/2018	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	35	34	0	34	unk[a]	-	-	12	82	74
	(Renewal)	39	39	n/a	39	0	-	-	-	-	-
FY 2018/2019	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	39	31	0	31	unk[a]	-	-	8	89	79
	(Renewal)	47	47	n/a	47	0	-	-	-	-	-
FY 2019/2020	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	35	30	0	30	9	-	-	14	36	24
	(Renewal)	37	37	n/a	37	0	-	-	-	-	-

* Optional. List if tracked by the board.
[a] Data not captured in previous years

Table 7a. Registration Data by Type – 8012 – Polysomnography - Technologist

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2016/2017	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	58	63	2	63	unk[a]	-	-	26	69	64
	(Renewal)	110	n/a	n/a	110	0	-	-	-	-	-
FY 2017/2018	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	67	63	0	63	unk[a]	-	-	11	200	185
	(Renewal)	165	165	n/a	165	0	-	-	-	-	-
FY 2018/2019	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	39	42	0	42	unk[a]	-	-	16	126	111
	(Renewal)	438	438	n/a	438	0	-	-	-	-	-
FY 2019/2020	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	39	35	0	35	21	-	-	14	73	53
	(Renewal)	169	169	n/a	169	0	-	-	-	-	-

* Optional. List if tracked by the board.
[a] Data not captured in previous years

Table 7b. Total Licensing Data – 8012 – Polysomnography - Trainee

	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Initial Licensing Data:				
Initial License/Initial Exam Applications Received	27	23	21	14
Initial License/Initial Exam Applications Approved	29	19	20	14
Initial License/Initial Exam Applications Closed	0	5	3	0
License Issued	29	19	20	14
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	N/A	N/A	N/A	10
Pending Applications (outside of board control)*	N/A	N/A	N/A	N/A
Pending Applications (within the board control)*	N/A	N/A	N/A	N/A
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	115	95	59	123
Average Days to Application Approval (incomplete applications)*	118	95	68	207
Average Days to Application Approval (complete applications)*	19	N/A	12	11
License Renewal Data:				
License Renewed	10	13	22	14

Note: The values in Table 7b are the aggregates of values contained in Table 7a.
* Optional. List if tracked by the board.

Table 7b. Total Licensing Data – 8012 – Polysomnography - Technician	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Initial Licensing Data:				
Initial License/Initial Exam Applications Received	17	35	39	35
Initial License/Initial Exam Applications Approved	29	34	31	30
Initial License/Initial Exam Applications Closed	0	5	3	10
License Issued	29	34	31	30
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	N/A	N/A	N/A	9
Pending Applications (outside of board control)	N/A	N/A	N/A	N/A
Pending Applications (within the board control)	N/A	N/A	N/A	N/A
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	102	74	79	24
Average Days to Application Approval (incomplete applications)	102	82	89	36
Average Days to Application Approval (complete applications)	N/A	12	8	14
License Renewal Data:				
License Renewed	28	39	47	37
Note: The values in Table 7b are the aggregates of values contained in Table 7a.				

Table 7b. Total Licensing Data – 8012 – Polysomnography - Technologist	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Initial Licensing Data:				
Initial License/Initial Exam Applications Received	58	67	39	39
Initial License/Initial Exam Applications Approved	63	63	42	35
Initial License/Initial Exam Applications Closed	2	5	2	42
License Issued	63	63	42	35
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	N/A	N/A	N/A	21
Pending Applications (outside of board control)	N/A	N/A	N/A	N/A
Pending Applications (within the board control)	N/A	N/A	N/A	N/A
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	64	185	111	53
Average Days to Application Approval (incomplete applications)	69	200	126	73
Average Days to Application Approval (complete applications)	26	11	16	14
License Renewal Data:				
License Renewed	110	165	438	169
Note: The values in Table 7b are the aggregates of values contained in Table 7a.				

Verification of Application Information

Polysomnographic applicants are required by law to disclose truthfully all questions asked on the application for registration. Out-of-state and out-of-country applicants must meet the same requirements as California applicants. The application forms and LV are valid for one year. After one year, they must be updated to ensure that correct and current information accurately reflects any change in an applicant's qualifications. The Board requires primary source verification for proof of enrollment, diploma and transcripts from Board approved polysomnographic education programs, examination scores, LV, certification of Basic Life Support, and the Verification of Experience form.

The applicant must disclose all current and/or previous licenses/registrations held and provide an LV from each state or province to be sent directly to the Board verifying the applicant's licensure information and whether any action has been taken against the license.

The application asks about discipline by any other licensing/registering jurisdiction for the practice of polysomnography or any other healing arts license type. If an affirmative response to either of these questions is provided, the applicant and the involved institution must provide a detailed narrative of the events and circumstances leading to the action(s).

Registration applications previously requested information about convictions, including those that may have been deferred, set aside, dismissed, expunged or issued a stay of execution, however, these questions were removed from the application pursuant to AB 2138 (Chiu, Chapter 995, Statutes of 2018). 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.

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

All applicants must obtain fingerprint criminal record checks from both the DOJ and the FBI prior to the issuance of a registration. 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.

The Board receives subsequent arrest reports from the DOJ following the initial submittal of fingerprints. These supplemental reports are reviewed by the Board's Enforcement Program to determine if any action should be taken against the registrant.

An examination is not required for the trainee or technician registration types; however, the polysomnographic technologist registration requires an applicant to have taken and passed a national examination (Registered Polysomnographic Technologist Exam) administered by the BRPT. This is the only examination accepted by the Board for purposes of qualifying for registration pursuant to Chapter 7.8 of Division 2 of the BPC. This is a computer-based test that requires a minimum passing score of 350.

Section 5 – Enforcement Program

Since the Board's last Sunset Report of 2016, the Board has received 14 complaints against a polysomnographic trainee, technician, or technologist during the last three fiscal years and only five complaint investigations led to the Board filing an accusation for formal disciplinary action.

The Board has not seen a significant increase in the number of complaints received during the last three fiscal years and the average number of complaints from FY 17/18 through FY 19/20 is five, down from eight for the previous three-year period.

Below are several tables that provide enforcement statistics regarding polysomnographic complaints.

Table 9a, b, and c. Enforcement Statistics Polysomnographic Registrants

	FY 2017/2018	FY 2018/2019	FY 2019/2020
COMPLAINT			
Intake			
Received	0	5	9
Closed	0	0	0
Referred to INV	0	5	9
Average Time to Close	0 days	0 days	0 days
Pending (close of FY)	0	0	0
Source of Complaint			
Public	0	3	4
Licensee/Professional Groups	0	0	0
Governmental Agencies	0	2	5
Other	0	0	0
Conviction / Arrest			
CONV Received	7	13	11
CONV Closed	0	0	0
Referred to INV	7	10	14
Average Time to Close	0 days	0 days	0 days
CONV Pending (close of FY)	0	3	0
LICENSE DENIAL			
License Applications Denied	0	0	0
Statements of Issues (SOI) Filed	0	0	0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	0 days	days	0 days
ACCUSATION			
Accusations Filed	0	3	2
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations	0 Days	369 Days	827 days

Table 9a, b, and c. Enforcement Statistics Polysomnographic Registrants			
Pending (close of FY)	0	0	1
DISCIPLINE			
Disciplinary Actions			
Proposed(PD)/Default (DD) Decisions	PD - 0 DD - 0 Total - 0	PD - 0 DD - 1 Total - 1	PD - 0 DD - 0 Total - 0
Stipulations	0	1	1
Average Days to Complete	0 days	465 days	695 days
AG Cases Initiated	0	3	4
AG Cases Pending (close of FY)	0	1	3
Disciplinary Outcomes			
Revocation	0	1	0
Surrender	0	1	0
Suspension	0	0	0
Probation with Suspension	0	0	0
Probation	0	0	1
Probationary License Issued	0	0	0
Public Reprimands	0	0	0
Other	0	0	0
PROBATION			
New Probationers	0	0	1
Probations Successfully Completed	0	0	0
Probationers (close of FY)	In State 0 Out of State 0 Total 0	In State 0 Out of State 0 Total 0	In State 1 Out of State 0 Total 1
Petitions to Revoke Probation Filed	0	0	0
Probations Revoked	0	0	0
Probations Surrendered	0	0	0
Probation Extended with Suspension	0	0	0
Probation Extended	0	0	0
Public Reprimands	0	0	0
Petitions to Revoke Probation Withdrawn	0	0	0
Petitions to Revoke Probation Dismissed	0	0	0
Probations Modified	0	0	0
Probations Terminated	0	0	0
Probationers Subject to Drug Testing	0	0	1
Drug Tests Ordered	0	0	57
Positive Drug Tests	0	0	0
Petition for Reinstatement Granted	0	0	0
DIVERSION – Not Applicable			
INVESTIGATION			
All Investigations			
First Assigned	7	15	15
Closed	5	14	21
Average days to close	307 days[3]	162 days	230 days
Pending (close of FY)	8	10	16
Desk Investigations			

Table 9a, b, and c. Enforcement Statistics Polysomnographic Registrants			
Closed	1	0	6
Average days to close	368 days	0 days	81 days
Pending (close of FY)	8	3	5
Non-Sworn Investigation			
Closed	2	9	8
Average days to close	143 Days	144 days	135 days
Pending (close of FY)	0	6	11
Sworn Investigation			
Closed	1	0	1
Average days to close	729 days	0 Days	950 days
Pending (close of FY)	0	1	0
COMPLIANCE ACTION			
ISO & TRO Issued	ISO=0 TRO=0 Total=0	ISO=1 TRO=0 Total =1	ISO=0 TRO=0 TOTAL=0
PC 23 Orders Granted/Issued	0	0	0
Court Orders	0	0	0
Other Suspension Orders	0	0	0
Public Letter of Reprimand	0	0	0
Cease & Desist/Warning	0	0	0
Referred for Diversion	n/a	n/a	n/a
Compel Examination (Filed)	0	0	0
CITATION AND FINE			
Citations Issued	0	0	0
Average Days to Complete	0 Days	0 days	0 days
Amount of Fines Assessed	$0	$0	$0
Reduced, Withdrawn, Dismissed	$0	$0	$0
Amount Collected	$0	$0	$0
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	0	1

Table 10. Enforcement Aging Polysomnographic Registrants	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
0 - 1 Year	0	0	0	0	0	0 %
1 - 2 Years	0	0	2	1	3	100 %
2 - 3 Years	0	0	0	0	0	0 %
3 - 4 Years	0	0	0	0	0	0 %
Over 4 Years	0	0	0	0	0	0 %
Total Attorney General Cases Closed	0	0	2	1	3	100%
Investigations (Average %)						
Closed Within:						
90 Days	3	1	5	10	19	43 %
91 - 180 Days	0	1	1	3	5	11 %
181 - 1 Year	0	1	8	3	12	27 %
1 - 2 Years	1	1	0	3	5	12 %
2 - 3 Years	0	1	0	2	3	7 %
Over 3 Years	0	0	0	0	0	0 %
Total Investigation Cases Closed	4	5	14	21	44	100%

As of January 1, 2018, the Board has cite and fine authority to issue citations with fines or orders of abatement to polysomnographic registrants.

The Polysomnographic Program has the ability to order cost recovery and restitution, however no cases have resulted in discipline and therefore no cost recovery or restitution have been ordered.

Table 11. Cost Recovery	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Total Enforcement Expenditures [1]	$	$	$	$
Potential Cases for Recovery [2]	n/a	n/a	n/a	n/a
Cases Recovery Ordered	0	0	0	0
Amount of Cost Recovery Ordered	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

[1] "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act. Since the Board cannot order investigative cost recovery this is not applicable.

Table 12. Restitution (list dollars) in thousands)	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Amount Ordered	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

Section 6 – Public Information Policies

Refer to Full 2020 Medical Board Sunset Report.

Section 7 – Online Practice Issues

Refer to Full 2020 Medical Board Sunset Report.

Section 8 – Workforce Development and Job Creation

Refer to Full 2020 Medical Board Sunset Report.

Section 9 – Current Issues

Refer to Full 2020 Medical Board Sunset Report.

Section 10 – Board Actions and Responses to COVID-19

Refer to Full 2020 Medical Board Sunset Report.

Section 11 – Board Action and Response to Prior Sunset Issues

None.

Section 12 – New Issues

None.

Part IV

Research Psychoanalysts

Research Psychoanalysts

Section 1 – Background and Description of Research Psychoanalysts

History and Functions of the Research Psychoanalyst Program

The Legislature enacted the regulation of RPs under the jurisdiction of the Board in 1977. A registered RP is an individual who has graduated from an approved psychoanalytic institution and is registered with the Board. Additionally, students, who are currently enrolled in an approved psychoanalytic institution and are registered with the Board as a SRP, may engage in psychoanalysis under supervision.

Sections 2529 and 2529.5 of the BPC requires RPs to register with the Board, and authorizes individuals who have graduated from an approved psychoanalytic institute to engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts. "Adjunct" means that the RP may not render psychoanalytic services on a fee-for-service basis for more than an average of one-third of their total professional time, including time spent in practice, teaching, training or research. Such teaching, training or research shall be the primary activity of the RP.

Students who are enrolled in an approved institute may engage in psychoanalysis under supervision and must also register with the Board.

Major Legislation/Regulations Since the Last Sunset Review

2016

AB 2745 (Holden, Chapter 303) – Healing Arts: Licensing and Certification
In pertinent part, this Board-sponsored bill clarifies the Board's authority for the allied health licensees/registrants overseen by the Board. It allows the Board to revoke or deny a license/registration for registered sex offenders, allows the Board to take disciplinary action for excessive use of drugs or alcohol, allows allied health licensees/registrants to petition the Board for license/registration reinstatement, and allows the Board to use probation as a disciplinary option for allied health licensees/registrants.

2017

N/A

2018

AB 2138 (Chiu and Low, Chapter 995) – Licensing Boards: Denial of Application: Revocation or Suspension of Licensure: Criminal Conviction
This bill, which became effective July 1, 2020, limits discretion for boards, bureaus and committees within the DCA to apply criminal conviction history for a license denial. This bill amends the definition of a conviction in existing law to mean a judgment following a plea or verdict of guilty or a plea of nolo contendere or finding of guilt. This bill no longer allows a conviction that has been dismissed under Penal Code section 1203.4 to fall under the definition of a conviction. This bill 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. This bill does not allow prior disciplinary action by a board within the preceding seven years to be the basis for denial of a license if the basis for that disciplinary action was a conviction that has been dismissed pursuant to the Penal Code, or a comparable dismissal or expungement. Among other provisions, this bill also prohibits regulatory boards from requiring an applicant to self-disclose criminal history information and requires boards to collect and publish demographic data regarding applicants who are denied licensure or who have licenses revoked or suspended.

2019

SB 425 (Hill, Chapter 849) – Health Care Practitioners: Licensee's File: Probationary Physician's and Surgeon's Certificate: Unprofessional Conduct
This bill requires, in pertinent part, health facilities and entities that allow a licensed health care professional to provide care for patients, to report allegations of sexual abuse and sexual misconduct made by a patient in writing against a licensed health care practitioner to that practitioner's licensing board within 15 days, and imposes a fine for failure to report. This bill also amends existing law that requires the Board to provide a "comprehensive" summary to a licensee upon request, and now just requires the Board to provide a summary. This bill requires probationary license information to stay on the Board's website for a period of 10 years.

2020

N/A

Regulations

Substantial Relationship and Rehabilitation – Implementation of AB 2138 (Chiu, Chapter 995, Statutes of 2018) (pending)
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/registrant when considering denying or disciplining a license based on a conviction or professional discipline.

Notice to Patients (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.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2020 Medical Board Sunset Report.

Section 3 – Fiscal and Staff

Refer to Full 2020 Medical Board Sunset Report.

Section 4 – Licensing Program

Application Review

16 CCR section 1367.4 requires the Board to inform an applicant for registration as an RP in writing within 11 days of receipt of the initial application form whether the application is complete and accepted for filing or is deficient and what specific information is required. The Board is in compliance with this mandated timeframe.

Due to the small number of new applications received, processing times have neither decreased nor increased significantly during the last four years. The number of pending applications for the program are also very low and are outside of the Board's control because they are incomplete.

The tables below show the RP registration population, registration applications received, registrations issued, and registrations renewed.

Table 6. Registration Population

		FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
8003 – Research Psychoanalyst	Active	94	86	90	82
	Delinquent	14	24	15	25
	Out of State	Unknown	Unknown	Unknown	1
	Out of Country	Unknown	Unknown	Unknown	0

Table 7a. Registration Data by Type – 8003 – Research Psychoanalyst

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control	Within Board control	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2016/2017	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	4	6	1	6	unk[a]	-	-	10	54	46
	(Renewal)	78	n/a	n/a	78	-	-	-	-	-	-
FY 2017/2018	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	7	5	0	5	unk[a]	-	-	20	62	48
	(Renewal)	80	80	n/a	80	0	-	-	-	-	-
FY 2018/2019	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	6	6	0	6	unk[a]	-	-	0	39	39
	(Renewal)	6	6	n/a	6	0	-	-	-	-	-

FY 2019/2020	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	5	4	0	4	1	-	-	19	74	32
	(Renewal)	69	69	n/a	69	0	-	-	-	-	-
[a] Data not captured in previous years											

Table 7b. Total Licensing Data – 8003 – Research Psychoanalyst

	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Initial Licensing Data:				
Initial License/Initial Exam Applications Received	4	7	6	5
Initial License/Initial Exam Applications Approved	6	5	6	4
Initial License/Initial Exam Applications Closed	1	0	0	1
License Issued	6	5	6	4
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)	N/A	N/A	N/A	1
Pending Applications (outside of board control)*	N/A	N/A	N/A	N/A
Pending Applications (within the board control)*	N/A	N/A	N/A	N/A
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)	46	48	39	32
Average Days to Application Approval (incomplete applications)*	54	62	39	74
Average Days to Application Approval (complete applications)*	10	20	N/A	19
License Renewal Data:				
License Renewed	78	80	6	69

Note: The values in Table 7b are the aggregates of values contained in Table 7a.
* Optional. List if tracked by the board.

Verification of Application Information

RP applicants are required by law to truthfully disclose all questions asked on the application for licensure. The application is valid for one year. After one year, an application must be updated to ensure that correct and current information accurately reflects any change in an applicant's qualifications. Out-of-state and out-of-country applicants must meet the same requirements as California applicants.

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

The RP application previously requested information about convictions, including those that may have been deferred, set aside, dismissed, expunged or issued a stay of execution,

however, these questions were removed from the application pursuant to AB 2138 (Chiu, Chapter 995,Statutes of 2018). 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.

The application asks about discipline by any other licensing jurisdiction or governmental agency for any professional license/registration. If an affirmative response to any of these questions is provided, the applicant and the involved institution must provide a detailed summary of the events and circumstances leading to the action(s).

All reports of criminal history, prior disciplinary actions, or other unlawful acts of the applicant are reviewed on a case-by-case basis to determine whether a registration should be issued.

All applicants must obtain fingerprint criminal record checks from both the DOJ and the FBI prior to the issuance of a registration. 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.

All RPs with a current registration have been fingerprinted. As fingerprinting is a requirement for registration, an RP registration will not be issued prior to completion of this requirement. The Board receives subsequent arrest reports from the DOJ following the initial submittal of fingerprints. These supplemental reports are reviewed by the Board's Enforcement Program to determine if any action should be taken against the registrant.

School Approvals

16 CCR section 1374 defines the requirements for a psychoanalytic institute to be deemed acceptable. The Board is tasked with determining, based on documentation submitted by the institute, whether or not it meets the mandated requirements. The BPPE does not play a role in determining the qualifications of a psychoanalytic institute for approval.

The Board has approved 19 research psychoanalytic institutions. These institutions have met the requirements for psychoanalytical training as defined in BPC section 2529. BPC section 2529 also states that education received at an institute deemed equivalent to one of the approved institutions would be acceptable. In order to be deemed an equivalent psychoanalytic institute, such an institute, department or program would have to meet the requirements outlined in 16 CCR section 1374. Current law does not define the timeframe required for reviewing psychoanalytical institutes. International psychoanalytical institutes are required to submit the same documentation and meet the same requirements as a U.S. institute.

Section 5 – Enforcement Program

Since the Board's last Sunset Report of 2016, the Board has received 12 complaints against RPs, however only one disciplinary action has been filed or taken against registered RPs.

Many of the complaints received by the Board do not relate to the care and treatment being provided and instead relate to billing practices or other issues outside the jurisdiction of the Board. The RP Program utilizes the Disciplinary Guidelines as a model for any disciplinary actions that would be imposed on registrants.

The complaint prioritization policy for handling complaints filed against RPs is consistent with DCA's guidelines. Currently, there are no mandatory reporting requirements for registered RPs.

The RP Program does not have a statute of limitations established in law. The Board recognizes public protection as its highest priority and therefore strives to investigate each complaint as quickly as possible.

This registration category is extremely limited and only applies to registrants engaging in psychoanalysis services under specific circumstances. There are not any known cases of unlicensed practice. However, should such a complaint be received, the Board would use its investigative resources to pursue and prosecute, if appropriate, individuals providing psychoanalysis services without the proper registration.

Below are several tables that provide enforcement statistics regarding RPs.

Table 9a, b, and c. Enforcement Statistics Research Psychoanalysts

	FY 2017/2018	FY 2018/2019	FY 2019/2020
COMPLAINT			
Intake			
Received	3	2	7
Closed	0	0	0
Referred to INV	1	4	7
Average Time to Close	0 days	0 days	0 days
Pending (close of FY)	2	0	0
Source of Complaint			
Public	2	2	6
Licensee/Professional Groups	0	0	0
Governmental Agencies	0	0	0
Other	1	0	1
Conviction / Arrest			
CONV Received	0	0	0
CONV Closed	0	0	0
Referred to INV	0	0	0
Average Time to Close	0 days	0 days	0 days
CONV Pending (close of FY)	0	0	0
LICENSE DENIAL			
License Applications Denied	0	0	0
Statements of Issues (SOI) Filed	0		0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	0 days	0 days	0 days

Table 9a, b, and c. Enforcement Statistics Research Psychoanalysts			
ACCUSATION			
Accusations Filed	1	0	0
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations	1000 days	0 days	0 days
Pending (close of FY)	0	0	0
DISCIPLINE			
Disciplinary Actions			
Proposed(PD)/Default (DD) Decisions	PD - 0 DD - 0 Total - 0	PD - 0 DD - 1 Total - 1	PD - 0 DD - 0 Total - 0
Stipulations	0	0	0
Average Days to Complete	0 days	1129 days	0 days
AG Cases Initiated	1	0	0
AG Cases Pending (close of FY)	1	0	0
Disciplinary Outcomes			
Revocation	0	1	0
Surrender	0	0	0
Suspension	0	0	0
Probation with Suspension	0	0	0
Probation	0	0	0
Probationary License Issued	0	0	0
Public Reprimands	0	0	0
Other	0	0	0
PROBATION			
New Probationers	0	0	0
Probations Successfully Completed	0	0	0
Probationers (close of FY)	In State 0 Out of State 0 Total 0	In State 0 Out of State 0 Total 0	In State 0 Out of State 0 Total 0
Petitions to Revoke Probation Filed	0	0	0
Probations Revoked	0	0	0
Probations Surrendered	0	0	0
Probation Extended with Suspension	0	0	0
Probation Extended	0	0	0
Public Reprimands	0	0	0
Petitions to Revoke Probation Withdrawn	0	0	0
Petitions to Revoke Probation Dismissed	0	0	0
Probations Modified	0	0	0
Probations Terminated	0	0	0
Probationers Subject to Drug Testing	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0
Petition for Reinstatement Granted	0	0	0
DIVERSION – Not Applicable			

Table 9a, b, and c. Enforcement Statistics Research Psychoanalysts			
INVESTIGATION			
All Investigations			
First Assigned	1	4	4
Closed	2	5	8
Average days to close	507 Days	129 days	165 days
Pending (close of FY)	0	2	1
Desk Investigations			
Closed	1	5	8
Average days to close	74 Days	142 days	177 days
Pending (close of FY)	0	2	1
Non-Sworn Investigation			
Closed	0	0	0
Average days to close	0 Days	0 days	0 Days
Pending (close of FY)	0	0	0
Sworn Investigation			
Closed	0	0	0
Average days to close	0 Days	0 days	0 days
Pending (close of FY)	0	0	0
COMPLIANCE ACTION			
ISO & TRO Issued	ISO=0 TRO=0 Total=0	ISO=0 TRO=0 Total =0	ISO=0 TRO=0 TOTAL=0
PC 23 Orders Granted/Issued	0	0	0
Court Orders	0	0	0
Other Suspension Orders	0	0	0
Public Letter of Reprimand	n/a	n/a	n/a
Cease & Desist/Warning	0	0	0
Referred for Diversion	n/a	n/a	n/a
Compel Examination (Filed)	0	0	0
CITATION AND FINE			
Citations Issued	0	0	0
Average Days to Complete	0 Days	0 days	0 Days
Amount of Fines Assessed	$0	$0	$0
Reduced, Withdrawn, Dismissed	$0	$0	$0
Amount Collected	$0	$0	$0
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	0	0

Table 10. Enforcement Aging Research Psychoanalysts						
	FY 2016/2017	**FY 2017/2018**	**FY 2018/2019**	**FY 2019/2020**	**Cases Closed**	**Average %**
Attorney General Cases (Average %)						
Closed Within:						
0 - 1 Year	0	0	0	0	0	0 %
1 - 2 Years	2	0	0	0	2	50 %
2 - 3 Years	1	0	0	0	1	25 %

3 - 4 Years	0	0	1	0	1	25 %
Over 4 Years	0	0	0	0	0	0 %
Total Attorney General Cases Closed	3	0	1	0	4	100%
Investigations (Average %)						
Closed Within:						
90 Days	2	1	1	4	8	33 %
91 - 180 Days	2	0	3	1	6	25 %
181 - 1 Year	4	0	1	1	6	25 %
1 - 2 Years	1	0	0	2	3	13 %
2 - 3 Years	0	1	0	0	1	4 %
Over 3 Years	0	0	0	0	0	0 %
Total Investigation Cases Closed	9	2	5	8	24	100%

Citation and Fine

The RP Program has not utilized its citation and fine authority primarily because there are no technical violations that would be appropriate to resolve through this administrative remedy.

Cost Recovery and Restitution

The RP Program has the ability to order cost recovery and restitution, however no cases have resulted in discipline and therefore no cost recovery or restitution have been ordered.

Table 11. Cost Recovery

	FY 2016/20217	FY 2017/2018	FY 2018/2019	FY 2019/2020
Total Enforcement Expenditures	$	$	$	$
Potential Cases for Recovery [1]	n/a	n/a	n/a	n/a
Cases Recovery Ordered	0	0	0	0
Amount of Cost Recovery Ordered	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

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

Table 12. Restitution

	FY 2016/2017	FY 2017/2018	FY 2018/2019	FY 2019/2020
Amount Ordered	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

Section 6 – Public Information Policies

Refer to Full 2020 Medical Board Sunset Report.

Section 7 – Online Practice Issues

Refer to Full 2020 Medical Board Sunset Report.

Section 8 – Workforce Development and Job Creation

Refer to Full 2020 Medical Board Sunset Report.

Section 9 – Current Issues

Refer to Full 2020 Medical Board Sunset Report.

Section 10 – Board Actions and Responses to COVID-19

Refer to Full 2020 Medical Board Sunset Report.

Section 11 – Board Action and Response to Prior Sunset Issues

Please see Issue # 3, Section 11 in Part I – Physicians.

Section 12 – New Issues

Please see Issue #9, Section 12 in Part I – Physicians.

Section 13

Attachments

- Attachment A – Board Member Administrative Procedure Manual
- Attachment B – Current Organizational Chart Showing Relationship of Committees to the Board and Membership of Each Committee
- Attachment C – Major Studies and Publications
- Attachment D – Year-End Organizational Charts
- Attachment E – Board Member Attendance
- Attachment F – Revenue and Fee Schedule
- Attachment G – Performance Measures
- Attachment H – List of Acronyms

Attachments

Attachment A – Board Member Administrative Procedure Manual

State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

Board Member Administrative Procedure Manual

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Sacramento, CA 95815
(916) 263-2389
www.mbc.ca.gov

Board Member Administrative Procedure Manual

Updates to Manual – August 2020

Table of Contents

Chapter 1. Introduction

Overview The Medical Board of California (MBC) was created by the California Legislature in 1876. Today the MBC is one of the boards, bureaus, commissions, and committees within the Department of Consumer Affairs (DCA), part of the State and Consumer Services Agency under the aegis of the Governor. The Department is responsible for consumer protection and representation through the regulation of certain licensed professions and the provision of consumer services. While the DCA provides oversight in various areas including, but not limited to, budget change proposals, regulations, and contracts, and also provides support services, MBC has policy autonomy and sets its own policies procedures, and initiates its own regulations. (See Business and Professions Code sections 108, 109(a), and 2018.)

The MBC is presently comprised of 15 Members. By law, seven are public Members, and eight are physicians. The Senate Rules Committee and the Speaker of the Assembly each appoint one public member. Board Members may serve two full four-year terms. Board Members fill non-salaried positions, and are paid $100 per day for each day worked and are reimbursed travel expenses.

This procedure manual is provided to Board Members as a ready reference of important laws, regulations, and Board policies, to guide the actions of Board Members and ensure Board effectiveness and efficiency.

Due notice of each meeting and the time and place thereof shall be given each member in the manner provided by law.

Definitions

B&P	Business and Professions Code
SAM	State Administrative Manual
President	Where the term “President” is used in this manual, it includes “his or her designee”

General Rules of Conduct

Board Members shall not speak to interested parties (such as vendors, lobbyists, legislators, or other governmental entities) on behalf of the Board or act for the Board without proper authorization.

Board Members shall maintain the confidentiality of confidential documents and information.

Board Members shall commit time, actively participate in Board activities, and prepare for Board meetings, which includes reading Board packets and all required legal documents.

Board Members shall respect and recognize the equal role and responsibilities of all Board Members, whether public or licensee.

Board Members shall act fairly and in a nonpartisan, impartial, and unbiased manner.

Board Members shall treat all applicants and licensees in a fair and impartial manner.

Board Members' actions shall uphold the Board's primary mission – protection of the public.

Board Members shall not use their positions on the Board for political, personal, familial, or financial gain.

Chapter 2. Board Meeting Procedures

Frequency of Meetings
(B&P Code sections 2013, 2014)

The Board shall meet at least once each calendar quarter in various parts of the state for the purpose of transacting such business as may properly come before it.

Special meetings of the Board may be held at such times the Board deems necessary.

Four Members of a panel of the Board shall constitute a quorum for the transaction of business at any meeting of the panel.

Eight Members shall constitute a quorum for the transaction of business at any Board meeting.

Due notice of each meeting and the time and place thereof shall be given each member in the manner provided by the law.

Board Member Attendance at Board Meetings
(B&P Code sections 106, 2011)

Board Members shall attend each meeting of the Board. If a member is unable to attend, he or she must contact the Board President and ask to be excused from the meeting for a specific reason. The Governor has the power to remove from office any member appointed by him for continued neglect of duties, which may include unexcused absences from meetings.

Board Members shall attend the entire meeting and allow sufficient time to conduct all Board business at each meeting.

Public Attendance at Board Meetings
(Government Code section 11120 et. seq.)

Meetings are subject to all provisions of the Bagley-Keene Open Meetings Act. This act governs meetings of state regulatory boards and meetings of committees of those boards where the committee consists of more than two Members. It specifies meeting notice and agenda requirements and prohibits discussing or taking action on matters not included on the agenda.

If the agenda contains matters that are appropriate for closed session, the agenda must cite the particular statutory section and subdivision authorizing the closed session.

Quorum
(B&P Code section 2013)

Eight of the Members of the Board constitute a quorum of the Board for the transaction of business. The concurrence of a majority of those Members of the Board present and voting at a duly noticed meeting at which a quorum is present shall be necessary to constitute an act or decision of the Board.

Agenda Items
(Board Policy)

Any Board Member may submit items for a meeting agenda to the Executive Director not fewer than 30 days prior to the meeting with the approval of the Board President or Chair of the Committee.

Notice of Meetings
(Government Code section 11120 et seq.)

In accordance with the Open Meetings Act, meeting notices (including agendas for Board, Committee, or Panel meetings) shall be sent to persons on the Board's mailing list at least 10 calendar days in advance. The notice shall include the name, work address, and work telephone number of a staff person who can provide further information prior to the meeting.

Notice of Meetings to be Posted on the Internet
(Government Code section 11125 et seq.)

Notice shall be given and made available on the Internet at least 10 days in advance of the meeting and shall include the name, address, and telephone number of any person who can provide further information prior to the meeting, but need not include a list of witnesses expected to appear at the meeting. The written notice shall additionally include the address of the Internet site where notices required by this article are made available.

Record of Meetings
(B&P Code section 2017)

The Board and each Committee or Panel shall keep an official record of all his or her proceedings. The minutes are a summary, not a transcript, of each Board or Committee meeting. They shall be prepared by staff and submitted to Members for review before the next meeting. Minutes shall be approved at the next scheduled meeting of the Board, Committee, or Panel. When approved, the minutes shall serve as the official record of the meeting.

Tape Recording/Web Casting
(Board Policy)

The meeting may be tape-recorded if determined necessary for staff purposes. Tape recordings will be disposed of upon approval of the minutes in accordance with record retention schedules. The meeting will be Web cast, as DCA staff is available, including the Committees of the Board. The Web cast will be posted on the Board's Web site within two weeks and kept for 10 years or more.

Meeting Rules
(Board Policy)

The Board will use Robert's Rules of Order, to the extent that it does not conflict with state law (e.g. Bagley-Keene Open Meeting Act), as a guide when conducting its meetings.

Public Comment
(Board Policy)

Due to the need for the Board to maintain fairness and neutrality when performing their adjudicative function, the Board shall not receive any substantive information from a member of the public regarding any matter that is currently under or subject to investigation or involves a pending criminal or administrative action.

1. If, during a Board meeting, a person attempts to provide the Board with substantive information regarding matters that are currently under or subject to investigation or involve a pending administrative or criminal action, the person shall be advised that the Board cannot properly consider or hear such substantive information, and the person shall be instructed to refrain from making such comments.

2. If, during a Board meeting, a person wishes to address the Board concerning alleged errors of procedure or protocol or staff misconduct, involving matters that are currently under or subject to investigation or involve a pending administrative or criminal action, the Board will address the matter as follows:

   a. Where the allegation involves errors of procedure or protocol, the Board may designate either its Executive Director or a Board employee to review whether the proper procedure or protocol was followed and to report back to the Board.
   b. Where the allegation involves significant staff misconduct, the Board may designate one of its Members to review the allegation and to report back to the Board.

3. The Board may deny a person the right to address the Board and have the person removed if such person becomes disruptive at the Board meeting.

(Government Code section 11120 et seq.)

4. Persons wishing to address the Board or a Committee of the Board shall be requested to complete a speaker request slip in order to have an appropriate record of the speaker for the minutes. At the discretion of the Board President or Chair of the Committee, speakers may be limited in the amount of time to present to give adequate time to everyone who wants to speak. In the event the number of people wishing to address the Board exceeds the allotted time, the Board President or Chair of the Committee may limit each speaker to a statement of his/her name, organization, and whether they support or do not support the proposed action

Written Comment
(Board Policy)

Prior to a Board meeting, an individual or group may submit materials related to a meeting agenda item to the Executive Director and request that the material be provided to the Board or Committee Members. Upon receipt of such a request, the Executive Director will verify that the materials are related to an open session agenda item (no materials will be distributed regarding complaints, investigations, contested cases, litigation, or other matters that may be properly discussed in closed session) and then forward the materials to the Board or

Committee Members. When forwarding the applicable materials to the Board members, the Executive Director may include information regarding existing law, regulation, or past Board action relevant to the issue presented. The written communication must be provided at least four business days prior to the meeting in order to ensure delivery to the Board Members.
NOTE: This section is not applicable to a formal regulatory hearing.

Chapter 3. Travel & Salary Policies & Procedures

Travel Approval
(DCA Memorandum 96-01)

The Board President's approval is required for all Board Members for travel, except for travel to regularly scheduled Board and Committee meetings to which the Board Member is assigned.

Travel Arrangements
(Board Policy)

Board Members may make their own travel arrangements but are encouraged to coordinate with the Executive Director's Administrative Assistant on lodging accommodations.

Out-of-State Travel
(SAM section 700 et seq.)

For out-of-state travel, Board Members will be reimbursed for actual lodging expenses, supported by vouchers, and will be reimbursed for meal and supplemental expenses. Out-of-state travel for all persons representing the State of California is controlled by and approved by the Governor's Office.

Travel Claims
(SAM section 700 et seq. and DCA Memorandum 96-01)

Rules governing reimbursement of travel expenses for Board Members are the same as for management-level state staff. All expenses shall be claimed on the appropriate travel expense claim forms. The Executive Director's Administrative Assistant maintains these forms and completes them as needed. Board Members should submit their travel expense forms immediately after returning from a trip and no later than two weeks following the trip.

For the expenses to be reimbursed, Board Members shall follow the procedures contained in DCA Departmental Memoranda, which are periodically disseminated by the Executive Director and are provided to Board Members.

Salary Per Diem
(B&P Code section 103)

Compensation in the form of salary per diem and reimbursement of travel and other related expenses for Board Members is regulated by B&P Code Section 103.

In relevant part, this section provides for the payment of salary per diem for Board Members "for each day actually spent in the discharge of official duties," and provides that the Board Member "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

(Board Policy)

Accordingly, the following general guidelines shall be adhered to in the payment of salary per diem or reimbursement for travel:

1. No salary per diem or reimbursement for travel-related expenses shall be paid to Board Members, except for attendance at an official Board, Committee, or Panel meeting, unless a substantial official service is performed by the Board Member. Attendance at gatherings, events, hearings, conferences, or meetings other than official Board, Committee, or Panel meetings, in which a substantial official service is performed, shall be approved in advance by the Board President. The Executive Director shall be notified of the event and approval shall be obtained from the Board President prior to Board Member's attendance.
2. The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a Board, Committee, or Panel meeting to the conclusion of that meeting.

For Board-specified work, Board Members will be compensated for actual time spent performing work authorized by the Board President. That work includes, but is not limited to, authorized attendance at other gatherings, events, meetings, hearings, or conferences. It includes preparation time for Board, Committee, or Panel meetings.

Chapter 4. Selection of Officers & Committees

Officers of the Board
(B&P Code Section 2012)

The Board shall select a President, Vice President, and Secretary from its Members.

Election of Officers
(Board Policy)

The Board shall elect the officers at the first meeting of the fiscal year. Officers shall serve a term of one year beginning the next meeting day. All officers may be elected on one motion or ballot as a slate of officers unless more than one Board Member is running per office. An officer may be re-elected and serve for more than one term.

Panel Members
(B&P Code section 2008)

A Panel of the Board shall at no time be composed of less than four Members and the number of public Members assigned shall not exceed the number of licensed physician and surgeon Members assigned to the Panel. The Board usually is comprised of two panels, however, if there is an insufficient number of Members, there may only be one Panel.

Election of Panel Members
(B&P Code section 2008)

Each Panel shall annually, at the last meeting of the calendar year, elect a Chair and a Vice Chair.

Officer Vacancies
(Board Policy)

If an office becomes vacant during the year, an election shall be held at the next meeting. If the office of the President becomes vacant, the Vice President shall assume the office of the President. Elected officers then shall serve the remainder of the term.

Committee Appointments
(Board Policy)

The Board President shall establish Committees, whether standing or special, as he or she deems necessary. The composition of the Committees and the appointment of the Members shall be determined by the Board President in consultation with the Vice President, Secretary, and the Executive Director. Committees may include the appointment of non-Board Members.

Attendance at Committee Meetings
(Government Code section 11120 et seq.)

Board Members are encouraged to attend a meeting of a Committee of which he or she is not a member. Board Members who are not Members of the Committee that is meeting cannot vote during the Committee meeting and may participate only as observers if a majority of the Board is present at a Committee meeting.

Duties of the Officers

The following matrix delineates the duties of the Board officers, Committee Chairs, and Panel officers.

Roles of Board Officers/Committee Chairs/Panel Officers

President

- Spokesperson for the Medical Board (including but not limited to) – may attend legislative hearings and testify on behalf of the Board, may attend meetings with stakeholders and Legislators on behalf of Board, may talk to the media on behalf of the Board, and signs letters on behalf of the Board
- Meets and communicates with the Executive Director on a regular basis
- Communicates with other Board Members for Board business
- Authors a president's message in every quarterly newsletter
- Approves Board Meeting agendas
- Chairs and facilitates Board Meetings
- Chairs the Executive Committee
- Signs specified full board enforcement approval orders
- Signs the minutes for each of the Board's quarterly Board Meetings
- Represents the Board at Federation of State Medical Boards' meetings and other such meetings

Vice President

- Is the back-up for the duties above in the President's absence.
- Is a member of Executive Committee

Secretary

- Signs the minutes for each of the Board's quarterly Board Meetings
- Is a member of Executive Committee

Past President

- Is responsible for mentoring and imparting knowledge to the new Board President
- May attend meetings and legislative hearings to provide historical background information, as needed
- Is a member of Executive Committee

Committee Chair

- Approves the Committee Agendas
- Chairs and facilitates Committee Meetings

Panel Officers

- Chair – Chairs and facilitates Panel Meetings
- Chair – Signs orders for Panel decisions
- Vice Chair – Acts as Chair when Chair is absent

Chapter 5. Board Administration & Staff

Board Administration *(DCA Reference Manual)*	Board Members should be concerned primarily with formulating decisions on Board policies rather than decisions concerning the means for carrying out a specific course of action. It is inappropriate for Board Members to become involved in the details of program delivery. Strategies for the day-to-day management of programs and staff shall be the responsibility of the Executive Director. Board Members should not interfere with day-to-day operations, which are under the authority of the Executive Director.
Strategic Planning	The Board will conduct periodic strategic planning sessions.
Executive Director Evaluation *(Board Policy)*	Board Members shall evaluate the performance of the Executive Director on an annual basis.
Board Staff *(DCA Reference Manual)*	Employees of the Board, with the exception of the Executive Director, are civil service employees. Their employment, pay, benefits, discipline, termination, and conditions of employment are governed by a myriad of civil service laws and regulations and often by collective bargaining labor agreements. Because of this complexity, it is most appropriate that the Board delegate all authority and responsibility for management of the civil service staff to the Executive Director. Board Members shall not intervene or become involved in specific day-to-day personnel transactions.
Business Cards	Business cards will be provided to each Board Member with the Board's name, address, telephone and fax number, and Web site address.

Chapter 6. Other Policies & Procedures

Board Member Disciplinary Actions
(Board Policy)

A member may be censured by the Board if, after a hearing before the Board, the Board determines that the member has acted in an inappropriate manner.

The President of the Board shall sit as chair of the hearing unless the censure involves the President's own actions, in which case the Vice President of the Board shall sit as President. In accordance with the Open Meeting Act, the censure hearing shall be conducted in open session.

Removal of Board Members
(B&P Code sections 106 & 2011)

The Governor has the power to remove from office, at any time, any member of any Board appointed by him or her for continued neglect of duties required by law or for incompetence or unprofessional or dishonorable conduct.

Resignation of Board Members
(Government Code section 1750)

In the event that it becomes necessary for a Board Member to resign, a letter shall be sent to the appropriate appointing authority (Governor, Senate Rules Committee, or Speaker of the Assembly) with the effective date of the resignation. Written notification is required by state law. A copy of this letter also shall be sent to the director of the Department, the Board President, and the Executive Director.

Conflict of Interest
(Government Code section 87100)

No Board Member may make, participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest. Any Board Member who has a financial interest shall disqualify himself or herself from making or attempting to use his or her official position to influence the decision. Any Board Member who feels he or she is entering into a situation where there is a potential for a conflict of interest should immediately consult the Executive Director or the Board's legal counsel.

Board Members should refrain from attempting to influence staff regarding applications for licensure or potential disciplinary matters.

Gifts from Candidates
(Board Policy)

Gifts of any kind to Board Members from candidates for licensure with the Board shall not be permitted.

Request for Records Access
(Board Policy)

No Board Member may access the file of a licensee or candidate without the Executive Director's knowledge and approval of the conditions of access. Records or copies of records shall not be removed from the MBC's office.

Meetings with the Public and Interested Parties
(Board Policy)

Interested parties may request to meet with a Board Member on a matter or matters under the Board's jurisdiction. Members must remember that the power of the Board is vested in the Board itself and not with any individual Board Member. For that reason, Board Members are cautioned to not express their personal opinions as a Board policy or position or represent that the Board has taken a position on a particular issue when it has not. It is strongly suggested that Board Members disclose their attendance at any meeting of this type at the next scheduled Board meeting as identified in the next section, "Communication with Interested Parties".

Communication with Interested Parties

Board Members are required to disclose at Board Meetings all discussions and communications with interested parties regarding any item pending or likely to be pending before the Board. The Board minutes shall reflect the items disclosed by the Board Members. All agendas will include, as a regular item, a disclosure agenda item where each Member relays any relevant conversations with interested parties.

Media Inquiries
(Board Policy)

If a Board Member receives a media call, the Member should promptly refer the caller to the Board's Public Information Officer who is employed to interface with all types of media on any type of inquiry. Members are recommended to make this referral as the power of the Board is vested in the Board itself and not with any individual Board Member. Expressing a personal opinion can be seen as a Board policy or position and may be represented as the Board has taken a position on a particular issue when it has not.

A Board Member who receives a call should politely thank the caller for the call, but state that it is the Board's policy to refer all callers to the Public Information Officer. The Board Member should then send an email to the Executive Director indicating they received a media call and relay any information supplied by the caller.

Service of Lawsuits

The Board Members may receive service of a lawsuit against themselves and the Board pertaining to a certain issue (e.g. a disciplinary matter, a complaint, a legislative matter, etc.). To prevent a confrontation, the Board Member should accept service. Upon receipt, the Board Member should notify the Executive Director of the service and indicate the name of the matter that was served and any other pertinent information. The Board Member should then mail the entire package that was served to the Executive Director as soon as possible. The Board's legal counsel will provide instructions to the Board

Members on what is required of them once service has been made. The Board Members may be required to submit a request for representation to the Board to provide to the Attorney General's Office.

Ex Parte Communications
(*Government Code section 11430.10 et seq.)*

The Government Code contains provisions prohibiting *ex parte* communications. An "*ex parte*" communication is a communication to the decision-maker made by one party to an enforcement action without participation by the other party. While there are specified exceptions to the general prohibition, the key provision is found in subdivision (a) of section 11430.10, which states:

"*While the proceeding is pending, there shall be no communication, direct or indirect, regarding any issue in the proceeding to the presiding officer from an employee or representative or if an agency that is a party or from an interested person outside the agency, without notice and an opportunity for all parties to participate in the communication.*"

An applicant who is being formally denied licensure, or a licensee against whom a disciplinary action is being taken, may attempt to directly contact Board Members.

If the communication is written, the member should read only enough to determine the nature of the communication. Once he or she realizes it is from a person against whom an action is pending, he or she should reseal the documents and send them to the Executive Director, or forward the email.

If a Board Member receives a telephone call from an applicant or licensee against whom an action is pending, he or she should immediately tell the person he or she cannot speak to him or her about the matter. If the person insists on discussing the case, he or she should be told that the Board Member will be required to recuse himself or herself from any participation in the matter. Therefore, continued discussion is of no benefit to the applicant or licensee.

If a Board Member believes that he or she has received an unlawful *ex parte* communication, he or she should contact the Board's assigned attorney or Executive Director.

Board Member Training Requirements

Upon initial appointment, Board Members will be given an overview of Board operations, policies, and procedures by Board Executive Staff.

(B&P Code section 453)

Every appointed Board Member shall, within one year of assuming office, complete a training and orientation program offered by the Department of Consumer Affairs. This is in addition to the Board orientation given by Board staff.

(Government Code section 11146)

All Board Members are required to file an annual Form 700 statement of economic interest. Members must also complete an orientation course on the relevant ethics statutes and regulations that govern the official conduct of state officials. The Government Code requires completion of this ethics orientation within the first six months of appointment and completion of a refresher every two years thereafter.

(Government Code section 12950.1)

SB 530 (Chapter 722, Statutes of 2019, Galgiani) requires supervisors, including Board Members, to complete two hours of sexual harassment prevention training by January 1, 2021, and every two years thereafter.

Appendix 1
Board Member Responsibilities

Board members represent the State of California and although he/she is an individual member, Members have an obligation to represent the Board as a body. Each member should carefully consider each responsibility and time commitment prior to agreeing to become a Board Member.

Attending meetings (12-20 days per year)

- Attend all meetings; be prepared for all meetings by reviewing and analyzing all Board materials; actively participate in meeting discussions; serve on committees of the Board to provide expertise in matters related to the Board

Disciplinary Matters (12-40 days per year)

- Review and analyze all materials pertaining to disciplinary matters and provide a fair, unbiased decision; timely respond to every request for a decision on any disciplinary matter; review and understand the Board's disciplinary guidelines; review and amend the Board's disciplinary guidelines on a regular basis to align with the policies set by the Board

Policy Decision Making (included above)

- Make educated policy decisions based upon both qualitative and quantitative data; obtain sufficient background information on issues upon which decisions are being made; seek information from Board staff regarding the functions/duties/requirements for the licensees being overseen; allow public participation and comment regarding matters prior to making decisions; ensure public protection is the highest priority in all decision making

Governance (2-4 days per year)

- Monitor key and summary data from the Board's programs to evaluate whether business processes are efficient and effective; obtain training on issues pertaining to the Board (e.g. budget process, legislative process, enforcement/licensing process, etc.); make recommendations regarding improvements to the Board's mandated functions

- Participate in the drafting and approval of a Strategic Plan; oversee the Strategic Plan on a quarterly basis to ensure activities are being implemented and performed; monitor any new tasks/projects to ensure they are in-line with the Strategic Plan

- Provide guidance and direction to the Executive Officer on the policies of the Board; annually evaluate the Executive Officer; assist the Executive Officer in reaching the goals for the Board

Outreach (1-4 days per year)

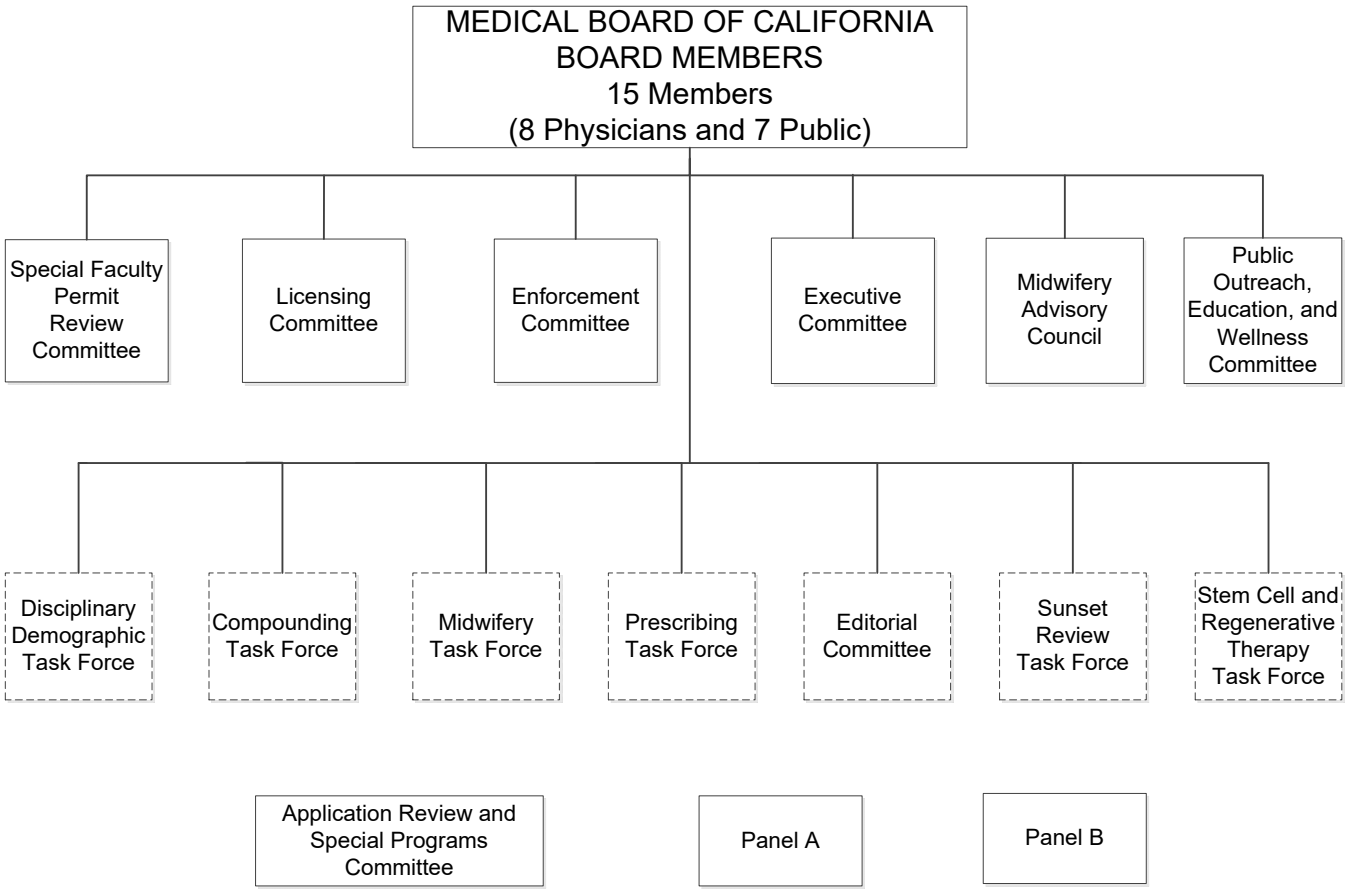
- When approved by the Board, represent the Board in its interaction with interested parties, the legislature, and the Department of Consumer Affairs

Training (2 day per year)

- Obtain the required Board Member training, i.e. Board Member Orientation Training, Sexual Harassment Prevention Training, and Ethics Training

Total Time: 29 – 70 days per year

Attachment B – Current Organizational Chart Showing Relationship of Committees to the Board and Membership of Each Committee



Standing Committees, Task Forces and Councils of the Medical Board of California

Committee	Members
Executive Committee	Kristina D. Lawson, J.D., President Howard R. Krauss, M.D., Vice President Randy W. Hawkins, M.D., Secretary Dev GnanaDev, M.D., Past President Felix C. Yip, M.D.
Licensing Committee	Howard R. Krauss, M.D., Chair Dev GnanaDev, M.D. Randy W. Hawkins, M.D. Cinthia Tirado, M.D.
Enforcement Committee	Felix C. Yip, M.D., Chair Ronald H. Lewis, M.D. Laurie Rose Lubiano, J.D. Richard Thorpe, M.D.
Application Review and Special Programs Committee	Kristina D. Lawson, J.D., Chair Randy W. Hawkins, M.D. Felix C. Yip, M.D.
Special Faculty Permit Review Committee	Dev GnanaDev, M.D., Chair Laurie Rose Lubiano, J.D., Vice Chair Neal Cohen, M.D. (UCSF) Daniel Giang, M.D. (LLU) Mohammad Helmy, M.D. (UCI) Jonathan Hiatt, M.D. (UCLA) Laurence Katznelson, M.D. (Stanford) For-Shing Lui, M.D. (CNUCOM) RaM.D.as Pai, M.D. (UCR) Andrew Ries, M.D. (UCSD) Javed Siddiqi, M.D. (CUSM) Frank Sinatra, M.D. (USC)
Public Outreach, Education, and Wellness Committee	Randy W. Hawkins, M.D., Chair Howard R. Krauss, M.D. Ronald H. Lewis, M.D. Laurie Rose Lubiano, J.D.
Midwifery Advisory Council	Diane Holzer, L.M., Chair Claudia Breglia, L.M., Vice Chair Donyale Abe Anne Marie Adams, M.D. Jocelyn Dugan Chemin Perez, L.M.

Committee	Members
Panel A	Ronald H. Lewis, M.D., Chair Randy W. Hawkins, M.D. Laurie Rose Lubiano, J.D. Cinthia Tirado, M.D. Eserick “TJ” Watkins Felix C. Yip, M.D.
Panel B	Kristina D. Lawson, J.D., Chair Richard E. Thorp, M.D. Vice Chair Dev GnanaDev, M.D. Howard R. Krauss, M.D. Asif Mahmood, M.D.
Prescribing Task Force	Kristina D. Lawson, J.D.
Editorial Committee	Howard R. Krauss, M.D.
Sunset Review Task Force	Kristina D. Lawson, J.D., President Howard R. Krauss, M.D., Vice President
Midwifery Task Force	
Disciplinary Demographic Task Force	Howard R. Krauss, M.D.
Compounding Task Force	Dev GnanaDev, M.D. Felix C. Yip, M.D.
Stem Cell and Regenerative Therapy Task Force	Randy W. Hawkins, M.D. Howard R. Krauss, M.D.

Attachment C – Major Studies and Publications

Major Studies Conducted by the Board
and
Major Publications Prepared by the Board

- **Medical Board of California Fee Study**
  https://www.mbc.ca.gov/About_Us/Meetings/Materials/1990/brd-AgendaItem7-20200130.pdf

- **Leadership Accountability Report**
  https://www.mbc.ca.gov/Download/Reports/2019-Leadership-Accountability-Report.pdf

- **Board Newsletter**
  http://www.mbc.ca.gov/Publications/Newsletters/

- **Demographics Study**
  https://www.mbc.ca.gov/Download/Reports/Notice-CRB-Demographics-Report.pdf

- **Cannabis Guidelines**
  https://www.mbc.ca.gov/Download/Publications/guidelines-cannabis-recommendation.pdf

- **Strategic Plan**
  https://www.mbc.ca.gov/Download/Reports/strategic-plan-2018.pdf

- **Annual Report**
  http://www.mbc.ca.gov/Publications/Annual_Reports/

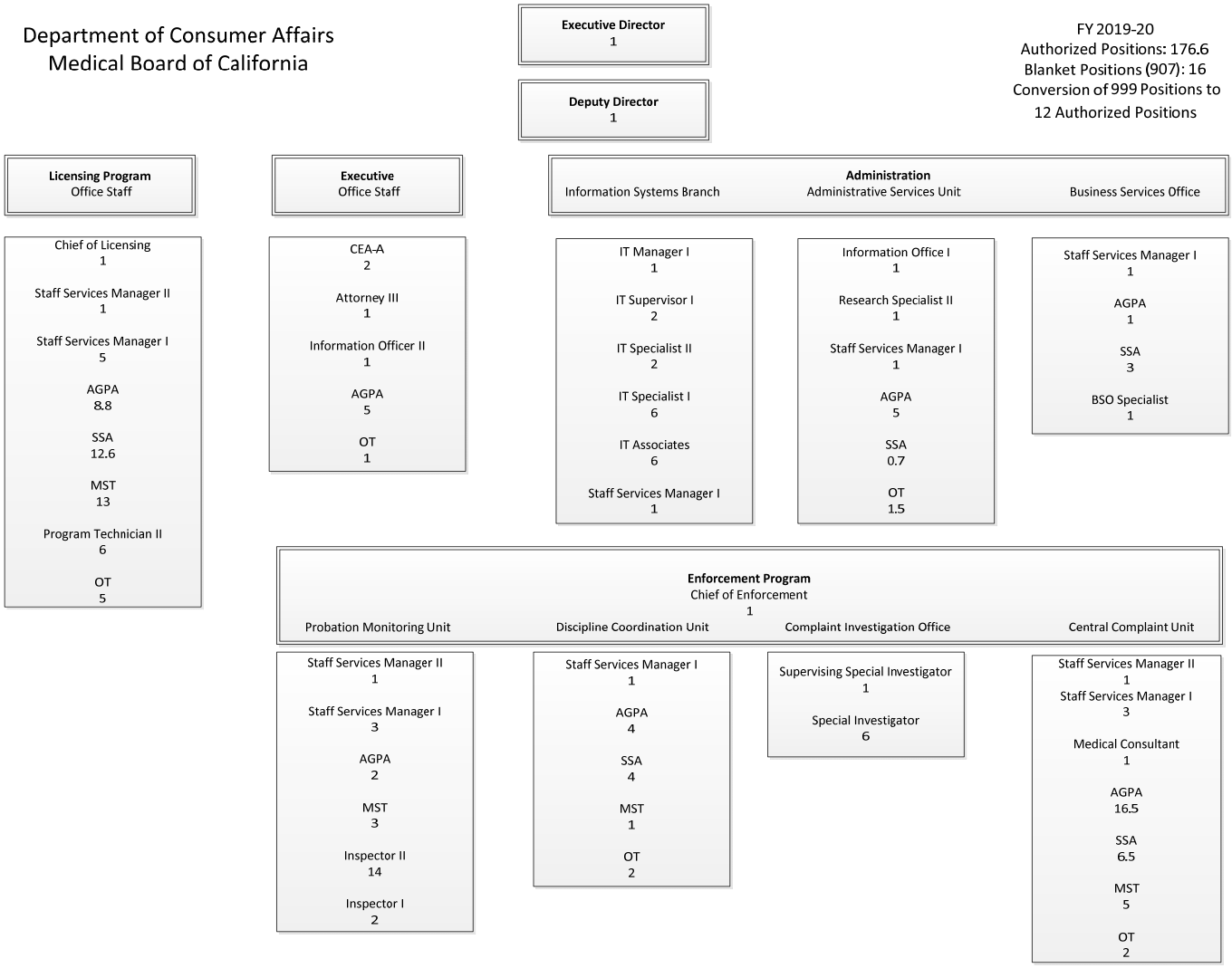
- **A Consumer's Guide to the Complaint Process**
  https://www.mbc.ca.gov/Publications/Brochures/Complaints.aspx

- **Medical Board Chat Podcast**
  https://www.mbc.ca.gov/About_Us/Media_Room/PSAs/

- **Expert Reviewer Program Brochure**
  https://www.mbc.ca.gov/Publications/Brochures/Expert_Reviewer_Program.aspx

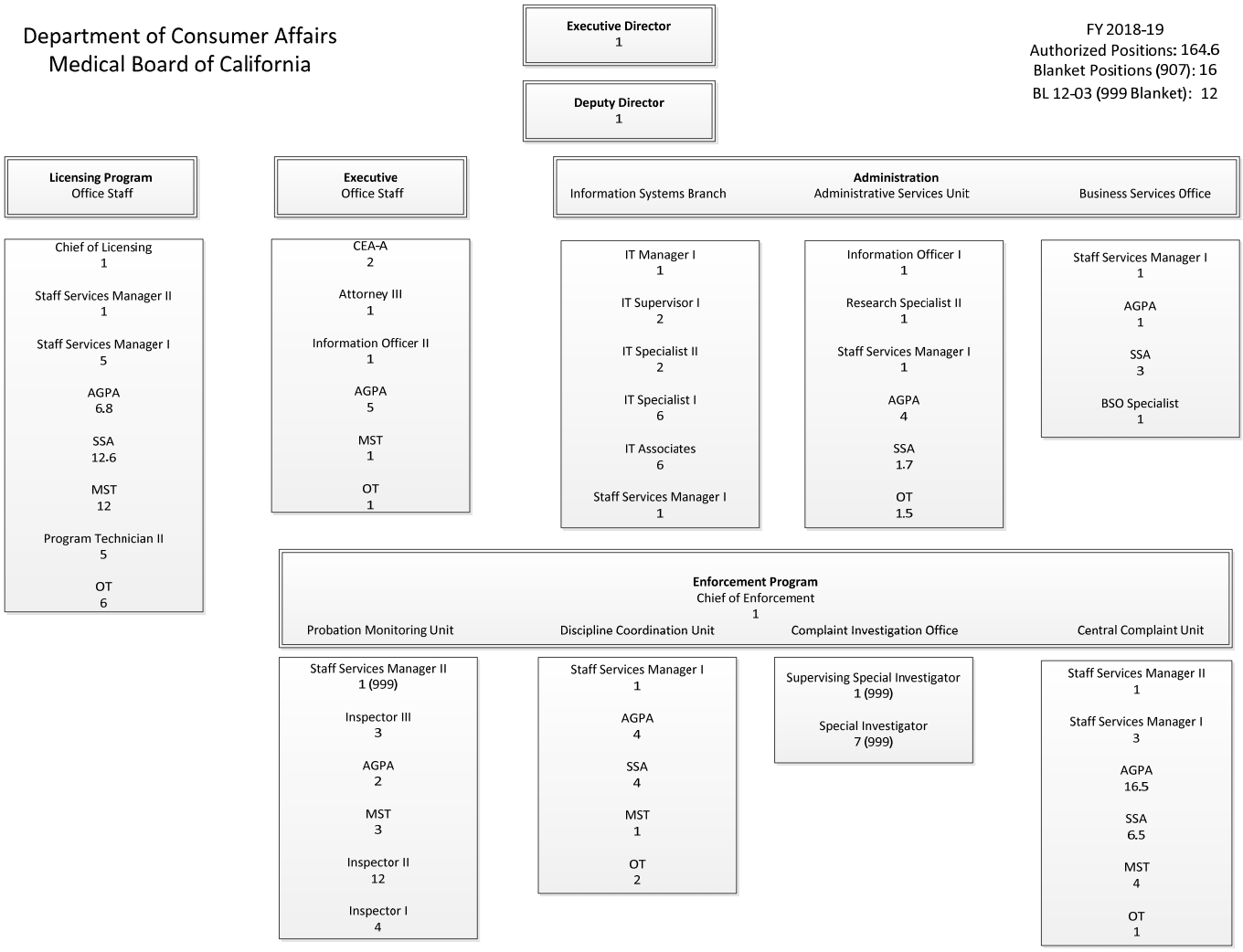
- **License Alert Mobile App Marketing Materials**
  https://www.mbc.ca.gov/About_Us/iOS/

Attachment D – Year-End Organizational Charts



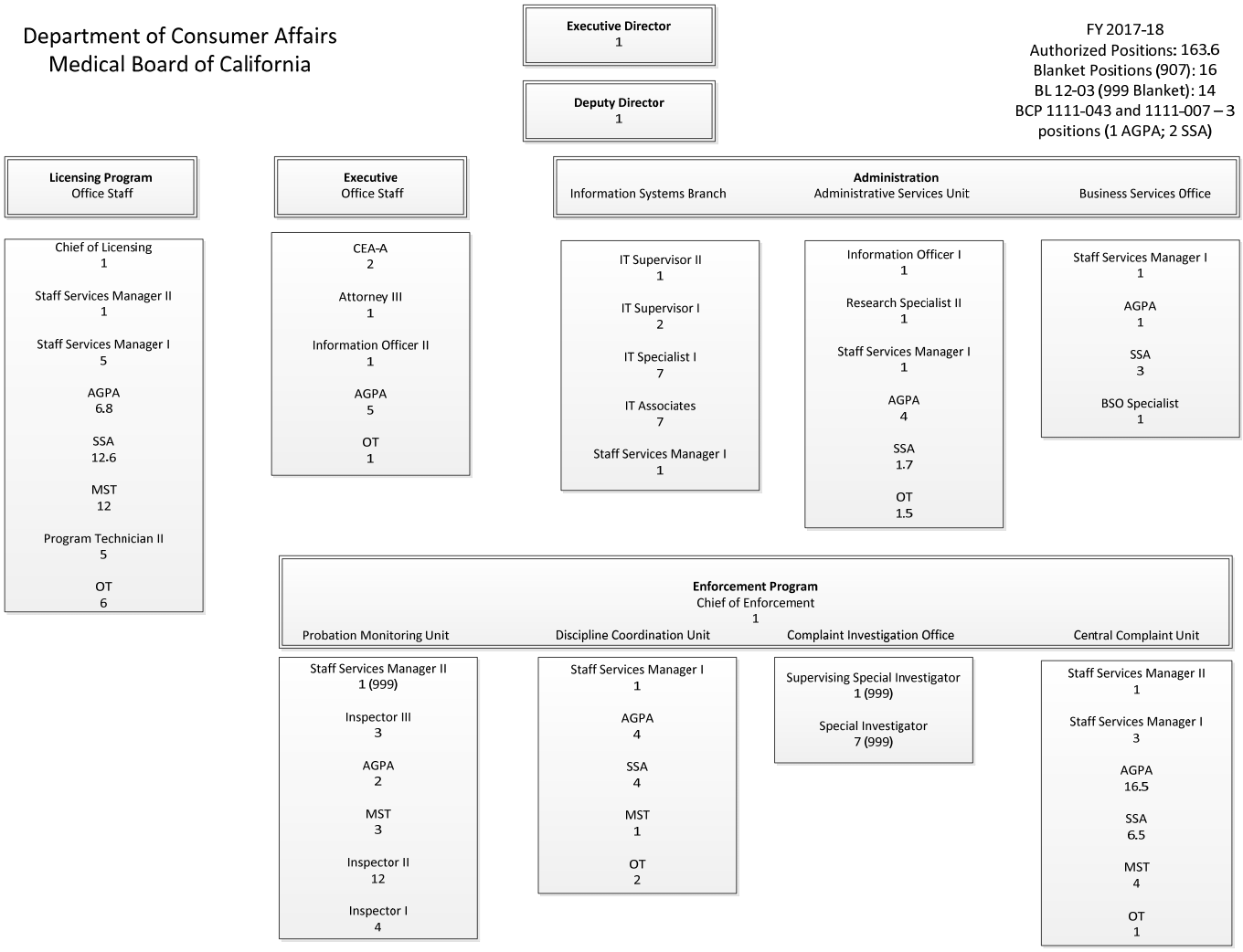
Department of Consumer Affairs
Medical Board of California

FY 2018-19
Authorized Positions: 164.6
Blanket Positions (907): 16
BL 12-03 (999 Blanket): 12



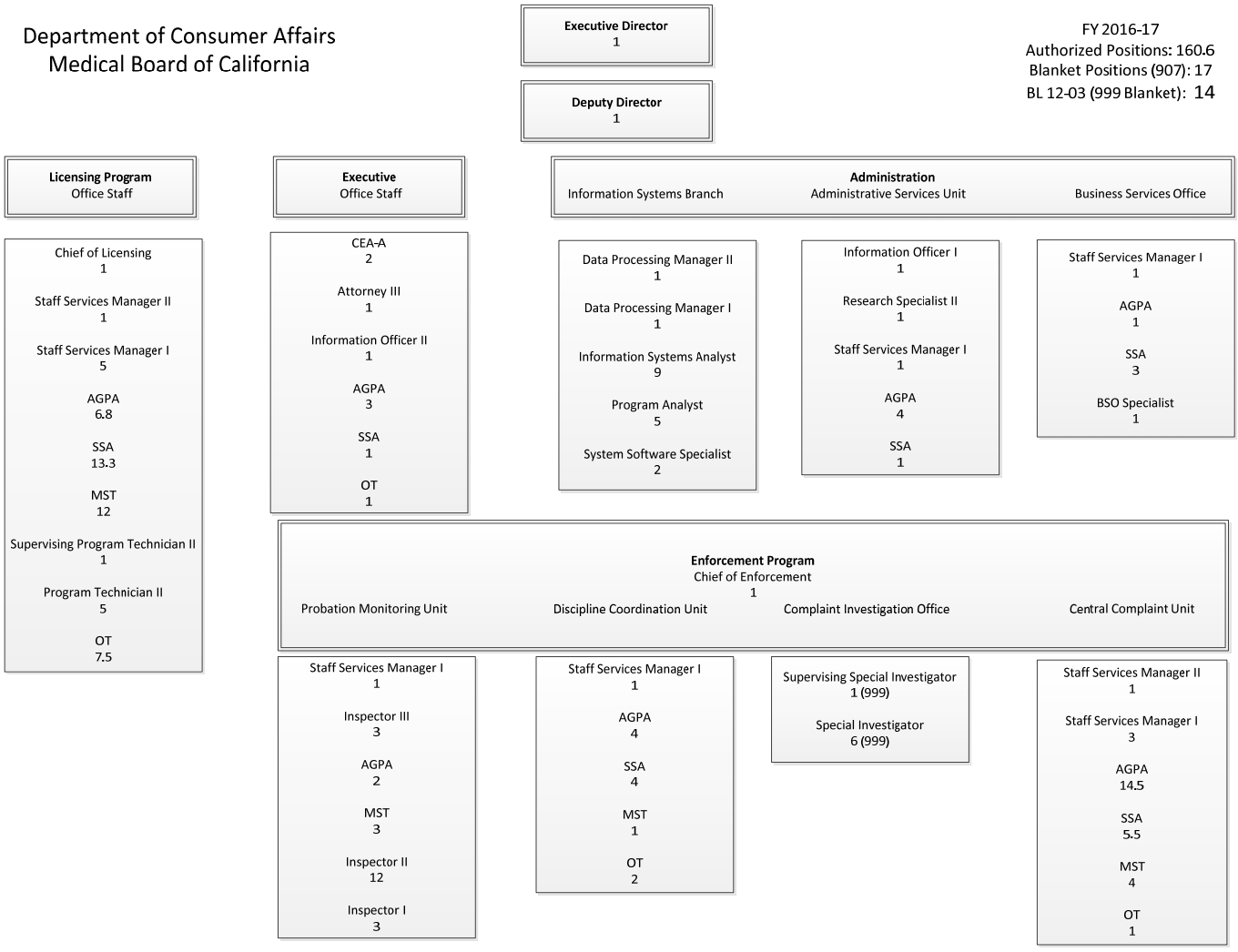
Department of Consumer Affairs
Medical Board of California

FY 2017-18
Authorized Positions: 163.6
Blanket Positions (907): 16
BL 12-03 (999 Blanket): 14
BCP 1111-043 and 1111-007 – 3 positions (1 AGPA; 2 SSA)



Department of Consumer Affairs
Medical Board of California

FY 2016-17
Authorized Positions: 160.6
Blanket Positions (907): 17
BL 12-03 (999 Blanket): 14



Attachment E – Board Member Attendance

Table 1a. Attendance			
Michelle Bholat, M.D.			
Date Appointed: February 25, 2015			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Special Faculty Permit Review Committee	September 29, 2016	Sacramento	Yes
Panel B Meeting	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel B Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Enforcement Committee	January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Panel B Meeting	April 26, 2017 April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes
Panel B Meeting	July 26, 2017 July 27, 2017	San Francisco	No Yes
Enforcement Committee	July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes No
Special Faculty Permit Review Committee	October 11, 2017	Teleconference	Yes
Panel B Meeting	October 25, 2017	San Diego	No
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Special Faculty Permit Review Committee	January 2, 2018	Teleconference	Yes
Panel B Meeting	January 18, 2018	Milpitas	Yes
Enforcement Committee	January 18, 2018	Milpitas	Yes
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	Yes
Special Faculty Permit Review Committee	March 8, 2018	Teleconference	Yes
Panel B Meeting	April 19, 2018	Los Angeles	Yes
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes
Special Faculty Permit Review Committee	June 14, 2018	Teleconference	Yes

Table 1a. Attendance			
Panel B Meeting	July 25, 2018 July 26, 2018	South San Francisco	Yes
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel B Meeting	October 18, 2018	San Diego	Yes
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	Yes
Special Faculty Permit Review Committee	December 6, 2018	Teleconference	Yes
Board Meeting	December 18, 2018	Los Angeles	Yes
Panel B Meeting	January 31, 2019	Milpitas	Yes
Enforcement Committee	January 31, 2019	Milpitas	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Special Faculty Permit Review Committee	March 14, 2019	Teleconference	Yes
Panel B Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	Yes
Michael Bishop, M.D.			
Date Appointed: December 21, 2011			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel A Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Panel A Meeting	April 27, 2017	Santa Ana	Yes
Licensing Committee	April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes
Campoverdi, Alejandra			
Date Appointed: October 12, 2020			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Katherine Feinstein, J.D.			
Date Appointed: January 13, 2016			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**

Table 1a.	Attendance		
Panel A Meeting	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel A Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Panel A Meeting	April 27, 2017	Santa Ana	No
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	No
Panel A Meeting	July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Panel A Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Friedman, Susan			
Date Appointed: December 15, 2018			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	January 31, 2019	Milpitas	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Panel B Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	Yes
Panel B Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Panel B Meeting	November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Dev GnanaDev, M.D.			
Date Appointed: December 21, 2011			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel B Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes

Table 1a.	Attendance		
Panel B Meeting	April 26, 2017 April 27, 2017	Santa Ana	Yes
Licensing Committee	April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes
Panel B Meeting	July 26, 2017 July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Panel B Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Panel B Meeting	January 18, 2018	Milpitas	Yes
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	Yes
Panel B Meeting	April 19, 2018	Los Angeles	Yes
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes
Panel B Meeting	July 25, 2018 July 26, 2018	South San Francisco	Yes
Licensing Committee	July 26, 2018	South San Francisco	No
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel B Meeting	October 18, 2018	San Diego	Yes
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	Yes
Board Meeting	December 18, 2018	Los Angeles	Yes
Panel B Meeting	January 31, 2019	Milpitas	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Panel B Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	Yes
Panel B Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Special Faculty Permit Review Committee	August 22, 2019	Teleconference	Yes
Panel B Meeting	November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes

Table 1a.	Attendance		
Panel B Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes
Special Faculty Permit Review Committee	March 25, 2020	Teleconference	Yes
Panel B Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Special Faculty Permit Review Committee	June 11, 2020	Teleconference	Yes
Panel B Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel B Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Randy Hawkins, M.D.			
Date Appointed: March 4, 2015			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel A Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Panel A Meeting	April 27, 2017	Santa Ana	Yes
Licensing Committee	April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes
Panel A Meeting	July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Panel A Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Application Review and Special Programs Committee	October 27, 2017	San Diego	Yes
Panel A Meeting	January 18, 2018	Milpitas	Yes

Table 1a.	Attendance		
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	Yes
Panel A Meeting	April 19, 2018	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	April 19, 2018	Los Angeles	Yes
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes
Application Review and Special Programs Committee	April 20, 2018	Los Angeles	Yes
Panel A Meeting	July 26, 2018	South San Francisco	Yes
Licensing Committee	July 26, 2018	South San Francisco	Yes
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel A Meeting	October 17, 2018 October 18, 2018	San Diego	Yes
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	Yes
Board Meeting	December 18, 2018	Los Angeles	Yes
Panel A Meeting	January 31, 2019	Milpitas	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Panel A Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	Yes
Panel A Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Stem Cell and Regenerative Therapy Interested Parties Meeting	September 18, 2019	Sacramento	Yes
Panel A Meeting	November 6, 2019 November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Panel A Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes
Panel A Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes

Table 1a.	Attendance		
Application Review and Special Programs Committee	August 12, 2020	WebEx	Yes
Panel A Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel A Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Howard Krauss, M.D.			
Date Appointed: August 20, 2013			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel B Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Marijuana Task Force Meeting	February 8, 2017	Sacramento	Yes
Panel B Meeting	April 26, 2017 April 27, 2017	Santa Ana	Yes
Licensing Committee	April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes
Panel B Meeting	July 26, 2017 July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Marijuana Task Force Meeting	August 30, 2017	Sacramento	Yes
Panel B Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Panel B Meeting	January 18, 2018	Milpitas	Yes
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	Yes
Panel B Meeting	April 19, 2018	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	April 19, 2018	Los Angeles	Yes

Table 1a.	Attendance		
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes
Panel B Meeting	July 25, 2018 July 26, 2018	South San Francisco	Yes
Licensing Committee	July 26, 2018	South San Francisco	Yes
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel B Meeting	October 18, 2018	San Diego	Yes
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	Yes
Board Meeting	December 18, 2018	Los Angeles	No
Panel B Meeting	January 31, 2019	Milpitas	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Panel B Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	No
Panel B Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Stem Cell and Regenerative Therapy Interested Parties Meeting	September 18, 2019	Sacramento	Yes
Panel B Meeting	November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Panel B Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes
Panel B Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Panel B Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel B Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Kristina Lawson, J.D.			
Date Appointed: October 28, 2015			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**

Table 1a. Attendance			
Panel B Meeting	October 27, 2016	Sacramento	Yes
Application Review and Special Programs Committee	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel B Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Marijuana Task Force Meeting	February 8, 2017	Sacramento	Yes
Panel B Meeting	April 26, 2017 April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes
Panel B Meeting	July 26, 2017 July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes No
Marijuana Task Force Meeting	August 30, 2017	Sacramento	Yes
Panel B Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Application Review and Special Programs Committee	October 27, 2017	San Diego	Yes
Panel B Meeting	January 18, 2018	Milpitas	Yes
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	No
Panel B Meeting	April 19, 2018	Los Angeles	No
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes
Application Review and Special Programs Committee	April 20, 2018	Los Angeles	Yes
Panel B Meeting	July 25, 2018 July 26, 2018	South San Francisco	Yes
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel B Meeting	October 18, 2018	San Diego	No
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	No
Board Meeting	December 18, 2018	Los Angeles	Yes
Panel B Meeting	January 31, 2019	Milpitas	Yes

Table 1a.	**Attendance**		
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	No Yes
Panel B Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	Yes
Panel B Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Panel B Meeting	November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Panel B Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes
Panel B Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Application Review and Special Programs Committee	August 12, 2020	WebEx	Yes
Panel B Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel B Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Sharon Levine, M.D.			
Date Appointed: February 11, 2009			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel B Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 26, 2017	Sacramento	Yes
Enforcement Committee	January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Panel B Meeting	April 26, 2017 April 27, 2017	Santa Ana	No

Table 1a.	Attendance		
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	No
Panel B Meeting	July 26, 2017 July 27, 2017	San Francisco	Yes
Enforcement Committee	July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Panel B Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Panel B Meeting	January 18, 2018	Milpitas	No
Enforcement Committee	January 18, 2018	Milpitas	No
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	No
Panel B Meeting	April 19, 2018	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	April 19, 2018	Los Angeles	Yes
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes
Panel B Meeting	July 25, 2018 July 26, 2018	South San Francisco	No
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	No
Panel B Meeting	October 18, 2018	San Diego	Yes
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	Yes
Board Meeting	December 18, 2018	Los Angeles	Yes
Ronald Lewis, M.D.			
Date Appointed: August 14, 2013			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	October 27, 2016	Sacramento	Yes
Application Review and Special Programs Committee	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel A Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 26, 2017	Sacramento	Yes
Enforcement Committee	January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes

Table 1a.	Attendance		
Panel A Meeting	April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes
Panel A Meeting	July 27, 2017	San Francisco	Yes
Enforcement Committee	July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Panel A Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Application Review and Special Programs Committee	October 27, 2017	San Diego	Yes
Panel A Meeting	January 18, 2018	Milpitas	Yes
Enforcement Committee	January 18, 2018	Milpitas	Yes
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	Yes
Panel A Meeting	April 19, 2018	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	April 19, 2018	Los Angeles	Yes
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes
Panel A Meeting	July 26, 2018	South San Francisco	Yes
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel A Meeting	October 17, 2018 October 18, 2018	San Diego	Yes
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	Yes
Board Meeting	December 18, 2018	Los Angeles	Yes
Panel A Meeting	January 31, 2019	Milpitas	Yes
Enforcement Committee	January 31, 2019	Milpitas	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Panel A Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	No
Panel A Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Panel A Meeting	November 6, 2019 November 7, 2019	San Diego	Yes

Table 1a.	Attendance		
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Panel A Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes
Panel A Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Panel A Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel A Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Laurie Rose Lubiano, J.D.			
Date Appointed: December 17, 2018			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Panel A Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	Yes
Panel A Meeting	August 8, 2019	Burlingame	No
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	No
Special Faculty Permit Review Committee	August 22, 2019	Teleconference	Yes
Panel A Meeting	November 6, 2019 November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes No
Panel A Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes
Special Faculty Permit Review Committee	March 25, 2020	Teleconference	Yes
Panel A Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Special Faculty Permit Review Committee	June 11, 2020	Teleconference	Yes
Panel A Meeting	August 13, 2020	WebEx	Yes

Table 1a.	Attendance		
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel A Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Asif Mahmood, M.D.			
Date Appointed: June 3, 2019			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Panel B Meeting	November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Panel B Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes
Interested Parties Meeting	January 31, 2020	Sacramento	
Panel B Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Panel B Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel B Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Denise Pines			
Date Appointed: August 29, 2012			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel B Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Panel B Meeting	April 26, 2017 April 27, 2017	Santa Ana	Yes

Table 1a.	Attendance		
Licensing Committee	April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes
Panel B Meeting	July 26, 2017 July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Panel B Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Panel B Meeting	January 18, 2018	Milpitas	Yes
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	Yes
Panel B Meeting	April 19, 2018	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	April 19, 2018	Los Angeles	Yes
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes
Panel B Meeting	July 25, 2018 July 26, 2018	South San Francisco	Yes
Licensing Committee	July 26, 2018	South San Francisco	Yes
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel B Meeting	October 18, 2018	San Diego	Yes
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	Yes
Board Meeting	December 18, 2018	Los Angeles	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	Yes
Panel B Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Panel B Meeting	November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Panel B Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes
Panel B Meeting	May 7, 2020	WebEx	Yes

Table 1a.	Attendance		
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Panel B Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel B Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Brenda Sutton-Wills, J.D.			
Date Appointed: April 4, 2016			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Special Faculty Permit Review Committee	September 29, 2016	Sacramento	Yes
Panel B Meeting	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel B Meeting	January 25, 2017 January 26, 2017	Sacramento	No Yes
Public Outreach, Education and Wellness Committee	January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Panel B Meeting	April 26, 2017 April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	No Yes
Panel B Meeting	July 26, 2017 July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Special Faculty Permit Review Committee	October 11, 2017	Teleconference	Yes
Panel B Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Special Faculty Permit Review Committee	January 2, 2018	Teleconference	Yes
Panel A Meeting	January 18, 2018	Milpitas	No
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	No
Special Faculty Permit Review Committee	March 8, 2018	Teleconference	Yes

Table 1a.	**Attendance**		
Panel A Meeting	April 19, 2018	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	April 19, 2018	Los Angeles	Yes
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes
Special Faculty Permit Review Committee	June 14, 2018	Teleconference	Yes
Panel A Meeting	July 26, 2018	South San Francisco	Yes
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel A Meeting	October 17, 2018 October 18, 2018	San Diego	No
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	No
Special Faculty Permit Review Committee	December 6, 2018	Teleconference	Yes
Board Meeting	December 18, 2018	Los Angeles	Yes
Panel B Meeting	January 31, 2019	Milpitas	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes No
Special Faculty Permit Review Committee	March 14, 2019	Teleconference	Yes
Panel B Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	No
Richard Thorp, M.D.			
Date Appointed: July 26, 2019			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Panel B Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes
Panel B Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Panel B Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes

Table 1a.	Attendance		
Panel B Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Cinthia Tirado, M.D.			
Date Appointed: June 15, 2020			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel A Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
David Warmoth			
Date Appointed: February 29, 2016			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	Yes
Panel A Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Panel A Meeting	April 27, 2017	Santa Ana	Yes
Licensing Committee	April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes
Panel A Meeting	July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Panel A Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	Yes
Panel A Meeting	January 18, 2018	Milpitas	Yes
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	Yes
Panel A Meeting	April 19, 2018	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	April 19, 2018	Los Angeles	Yes
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes

Table 1a.	Attendance		
Panel A Meeting	July 26, 2018	South San Francisco	Yes
Licensing Committee	July 26, 2018	South San Francisco	Yes
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel A Meeting	October 17, 2018 October 18, 2018	San Diego	Yes
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	Yes
Board Meeting	December 18, 2018	Los Angeles	Yes
Panel A Meeting	January 31, 2019	Milpitas	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Panel A Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	Yes
Panel A Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Panel A Meeting	November 6, 2019 November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Panel A Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes
Panel A Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Eserick "TJ" Watkins			
Date Appointed: June 1, 2019			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Panel A Meeting	November 6, 2019 November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Panel A Meeting	January 30, 2020	Sacramento	Yes
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	Yes

Table 1a.	Attendance		
Panel A Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Panel A Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel A Meeting	November 12, 2020	WebEx	Yes
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes
Jamie Wright			
Date Appointed: August 20, 2013			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	October 27, 2016	Sacramento	No
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	No Yes
Panel A Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Enforcement Committee	January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes No
Panel A Meeting	April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes No
Panel A Meeting	July 27, 2017	San Francisco	Yes
Enforcement Committee	July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Panel A Meeting	October 25, 2017	San Diego	No
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	No
Panel A Meeting	January 18, 2018	Milpitas	Yes
Enforcement Committee	January 18, 2018	Milpitas	Yes
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	Yes
Panel A Meeting	April 19, 2018	Los Angeles	Yes
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	No
Panel A Meeting	July 26, 2018	South San Francisco	Yes
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel A Meeting	October 17, 2018 October 18, 2018	San Diego	Yes

Table 1a.	Attendance		
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	Yes
Board Meeting	December 18, 2018	Los Angeles	Yes
Panel A Meeting	January 31, 2019	Milpitas	Yes
Enforcement Committee	January 31, 2019	Milpitas	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Panel A Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes No
Interim Board Meeting	May 28, 2019	Teleconference	No
Felix Yip, M.D.			
Date Appointed: January 30, 2013			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	October 27, 2016	Sacramento	No
Application Review and Special Programs Committee	October 27, 2016	Sacramento	Yes
Quarterly Board Meeting	October 27, 2016 October 28, 2016	San Diego	No
Panel A Meeting	January 25, 2017 January 26, 2017	Sacramento	Yes
Enforcement Committee	January 26, 2017	Sacramento	Yes
Quarterly Board Meeting	January 26, 2017 January 27, 2017	Sacramento	Yes
Panel A Meeting	April 27, 2017	Santa Ana	Yes
Quarterly Board Meeting	April 27, 2017 April 28, 2017	Santa Ana	Yes
Panel A Meeting	July 27, 2017	San Francisco	Yes
Enforcement Committee	July 27, 2017	San Francisco	Yes
Quarterly Board Meeting	July 27, 2017 July 28, 2017	San Francisco	Yes
Panel A Meeting	October 25, 2017	San Diego	Yes
Quarterly Board Meeting	October 26, 2017 October 27, 2017	San Diego	No
Application Review and Special Programs Committee	October 27, 2017	San Diego	No
Panel A Meeting	January 18, 2018	Milpitas	Yes
Enforcement Committee	January 18, 2018	Milpitas	Yes
Quarterly Board Meeting	January 18, 2018 January 19, 2018	Milpitas	Yes
Panel A Meeting	April 19, 2018	Los Angeles	Yes

Table 1a.	**Attendance**		
Quarterly Board Meeting	April 19, 2018 April 20, 2018	Los Angeles	Yes
Application Review and Special Programs Committee	April 20, 2018	Los Angeles	Yes
Panel A Meeting	July 26, 2018	South San Francisco	Yes
Quarterly Board Meeting	July 26, 2018 July 27, 2018	South San Francisco	Yes
Panel A Meeting	October 17, 2018 October 18, 2018	San Diego	Yes
Quarterly Board Meeting	October 18, 2018 October 19, 2018	San Diego	Yes
Board Meeting	December 18, 2018	Los Angeles	Yes
Panel A Meeting	January 31, 2019	Milpitas	Yes
Enforcement Committee	January 31, 2019	Milpitas	Yes
Quarterly Board Meeting	January 31, 2019 February 1, 2019	Milpitas	Yes
Panel A Meeting	May 9, 2019	Los Angeles	Yes
Quarterly Board Meeting	May 9, 2019 May 10, 2019	Los Angeles	Yes
Interim Board Meeting	May 28, 2019	Teleconference	Yes
Panel A Meeting	August 8, 2019	Burlingame	Yes
Quarterly Board Meeting	August 8, 2019 August 9, 2019	Burlingame	Yes
Panel A Meeting	November 6, 2019 November 7, 2019	San Diego	Yes
Quarterly Board Meeting	November 7, 2019 November 8, 2019	San Diego	Yes
Panel A Meeting	January 30, 2020	Sacramento	No
Quarterly Board Meeting	January 30, 2020 January 31, 2020	Sacramento	No
Panel A Meeting	May 7, 2020	WebEx	Yes
Quarterly Board Meeting	May 7, 2020	WebEx	Yes
Application Review and Special Programs Committee	August 12, 2020	WebEx	Yes
Panel A Meeting	August 13, 2020	WebEx	Yes
Quarterly Board Meeting	August 13, 2020 August 14, 2020	WebEx	Yes
Panel A Meeting	November 12, 2020	WebEx	Yes

Table 1a.	**Attendance**		
Quarterly Board Meeting	November 12, 2020 November 13, 2020	WebEx	Yes

Attachment F – Revenue and Fee Schedule

Table 4. Fee Schedule and Revenue (revenue dollars in thousands)

Fee	Current Fee Amount	Statutory Limit	FY 16/17 Revenue	FY 17/18 Revenue	FY 18/19 Revenue	FY 19/20 Revenue	% of Total Rev.
Application Fee (BPC 2435)	$ 442	$ 442	$ 3,514	$ 3,543	$ 3,342	$ 2,481	5.52%
Initial License Fee (BPC 2435) (16 CCR 1351.5)	$ 790	$ 790	$ 2,046	$ 1,956	$ 2,000	$ 2,159	3.50%
Initial License Fee (Reduced) (BPC 2435)	$ 395	$ 395	$ 1,672	$ 1,716	$ 1,680	$ 1,255	2.71%
Biennial Renewal Fee (BPC 2435) (16 CCR 1352)	$ 790	$ 790	$ 48,537	$ 50,278	$ 50,602	$ 50,612	85.76%
PTL Application Fee			$ -	$ -	$ -	$ 1,421	0.61%
Out-of-State Volunteer Physician	$ 25		$ -	$ -	$ -	$ -	0.00%
Physician Oral Re-exam Fee	$ 100		$ -	$ -	$ -	$ -	0.00%
Physician Biennial Renewal Fee One-Time Reduction	$ 761		$ -	$ -	$ -	$ -	0.00%
Physician Delinquency Fee: Renewal Fee (BPC 2435) 10% of Biennial	various	various	$ -	$ -	$ -	$ -	0.00%
Physician Duplicate License/Certification Fee (BPC 2435)	$ 10	$ 50	$ -	$ -	$ -	$ -	0.00%
Reinstatement Fee - A physician may various various 88,166 17,600 - - 0.00% "reinstate" by paying an amount equivalent to the total of renewal fees & delinquent fees which have accrued (BPC 125.3)	various	various	$ -	$ -	$ -	$ -	0.00%
Specialty Board Application Fee (BPC 651, 16 CCR 1354)	$ 4,030	$ 4,030	$ -	$ -	$ -	$ -	0.00%
Refunded - OSHP			$ -	$ -	$ -	$ -	0.00%
Suspended Revenue	various	various	$ 175	$ 137	$ 105	$ 120	0.23%
SB 2036 Application Fee	$ 4,030		$ 4	$ -	$ -	$ -	0.00%
Physician Penalty Fee (BPC 2424, 16 CCR 1352.2)	$ 391.50	$ 391.50	$ 285	$ 266	$ 260	$ 257	0.46%

Table 4. Fee Schedule and Revenue (revenue dollars in thousands)							
Physician Delinquency Fee (BPC 2435)	$ 79	$ 79	$ 122	$ 108	$ 110	$ 100	0.19%
Physician Duplicate Certificate Fee (BPC 2435)	$ 50	$ 50	$ 29	$ 33	$ 28	$ 33	0.05%
Physician Letter of Good Standing (BPC 2435)	$ 10	$ 10	$ 99	$ 100	$ 114	$ 113	0.18%
Citations and Fines (BPC 125.9)	various	$ 5,000	$ 74	$ 63	$ 79	$ 35	0.11%
Citation/Fine FTB Collection (BPC 125.9)	various	various	$ -	$ 3	$ 1	$ 3	0.00%
Special Faculty Permit Application Fee (BPC 2168.4 & 2435)	$ 442	$ 442	$ -	$ 1	$ 1	$ 2	0.00%
Special Faculty Permit Initial License Fee (BPC 2435, 16 CCR 1351.5)	$ 790	$ 790	$ 2	$ 2	$ 2	$ 3	0.00%
Special Faculty Permit Biennial Renewal Fee (BPC 2168.4 & 2435, 16 CCR 1352.1)	$ 790	$ 790	$ 9	$ 9	$ 7	$ 5	0.01%
Special Faculty Permit Delinquency Fee (BPC 2168.4 & 2435)	$ 79	$ 79	$ -	$ -	$ -	$ -	0.00%
Fictitious Name Permit Application and Initial Permit Fee (BPC 2443)	$ 50	$ 50	$ 72	$ 74	$ 73	$ 67	0.12%
Fictitious Name Permit Biennial Renewal Fee (BPC 2443)	$ 40	$ 40	$ 190	$ 222	$ 217	$ 229	0.37%
Fictitious Name Permit Delinquency Fee (BPC 2443)	$ 20	$ 20	$ 13	$ 14	$ 12	$ 14	0.02%
Fictitious Name Permit Duplicate Cert (BPC 2443)	$ 30	$ 50	$ 1	$ 1	$ 2	$ 2	0.00%
Research Psychoanalyst Registration Fee (BPC 2529.5, 16 CCR 1377)	$ 75	$ 75	$ 1	$ 1	$ -	$ -	0.00%
Research Psychoanalyst Biennial Renewal Fee (BPC 2529.5, 16 CCR 1377)	$ 50	$ 50	$ -	$ 4	$ -	$ 3	0.00%
Research Psychoanalyst Delinquency Fee (BPC 2529.5)	$ 25	$ 25	$ -	$ -	$ -	$ -	0.00%
Dishonored Check Fee (BPC 206)	$ 25	$ 25	$ 1	$ 1	$ 1	$ 1	0.00%

Table 4. Fee Schedule and Revenue (revenue dollars in thousands)							
Special Programs Initial Application Fee (BPC 2111 & 2113, 16 CCR 1351.5)	$ 86	$ 86	$ -	$ 1	$ 4	$ 5	0.00%
Special Programs Annual Renewal Fee (BPC 2111 & 2113, 16 CCR 1351.1)	$ 43	$ 43	$ 1	$ 1	$ 1	$ 2	0.00%
Special Programs Delinquency Fee (BPC 163.5)	$ 25	$ 25	$ -	$ -	$ -	$ -	0.00%
Polysomnography Trainee Application Fee (BPC 3577, 16 CCR 1379.78)	$ 100	$ 100	$ 4	$ 2	$ 2	$ 1	0.00%
Polysomnography Trainee Registration Fee (BPC 3577, 16 CCR 1379.78)	$ 100	$ 100	$ 3	$ 2	$ 2	$ 1	0.00%
Polysomnography Trainee Biennial Renewal Fee (BPC 3577, 16 CCR 1379.78)	$ 150	$ 150	$ 3	$ 2	$ 3	$ 2	0.00%
Polysomnography Trainee Delinquency Fee (BPC 163.5, 16 CCR 1379.78)	$ 75	$ 75	$ -	$ -	$ -	$ -	0.00%
Polysomnography Technician Application Fee (BPC 3577, 16 CCR 1379.78)	$ 100	$ 100	$ 3	$ 3	$ 3	$ 3	0.01%
Polysomnography Technician Registration Fee (BPC 3577, 16 CCR 1379.78)	$ 100	$ 100	$ 3	$ 3	$ 3	$ 3	0.01%
Polysomnography Technician Biennial Renewal Fee (BPC 3577, 16 CCR 1379.78)	$ 150	$ 150	$ 6	$ 5	$ 7	$ 6	0.01%
Polysomnography Technician Delinquency Fee (BPC 163.5, 16 CCR 1379.78)	$ 75	$ 75	$ 1	$ -	$ -	$ -	0.00%
Polysomnography Technologist Application Fee (BPC 3577, 16 CCR 1379.78)	$ 100	$ 100	$ 7	$ 6	$ 4	$ 3	0.01%
Polysomnography Technologist Registration Fee (BPC 3577, 16 CCR 1379.78)	$ 100	$ 100	$ 7	$ 7	$ 4	$ 3	0.01%

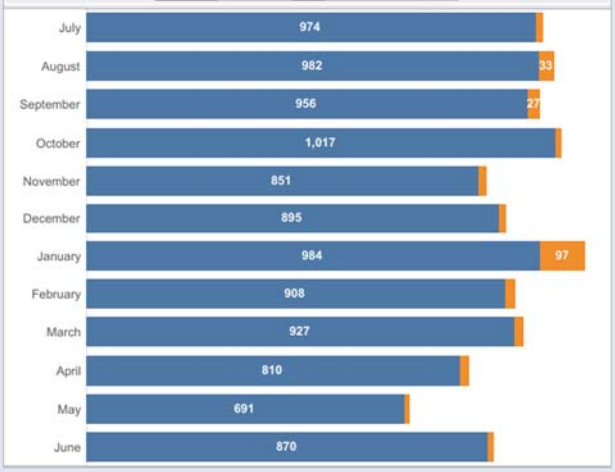
Table 4. Fee Schedule and Revenue (revenue dollars in thousands)							
Polysomnography Technologist Biennial Renewal Fee (BPC 3577, 16 CCR 1379.78)	$ 150	$ 150	$ 53	$ 26	$ 60	$ 29	0.07%
Polysomnography Technologist Delinquency Fee (BPC 163.5, 16 CCR 1379.78)	$ 75	$ 75	$ 3	$ 2	$ 2	$ 2	0.00%

Attachment G – Performance Measures

Enforcement Performance Measures
Annual Report (July 2019 – June 2020)

Board Name: Medical Board of California
State Fiscal Year: SFY 2020
Enforcement Case Type: Complaints, Conviction/Arrest

Medical Board of California
SFY 2020: 12-Month | **PM1:** Case Volume by Type



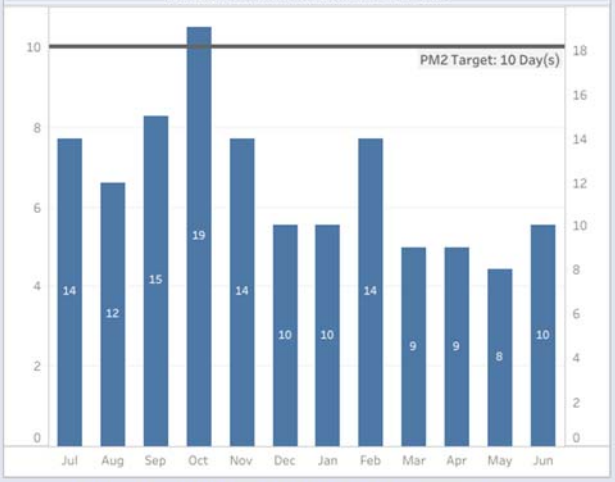
Medical Board of California
SFY 2020: 12-Month | **PM1:** Summary

	Complaints	Conviction/Arrest	Total Volume
Grand Total	10,865	304	11,169
July	974	16	990
August	982	33	1,015
September	956	27	983
October	1,017	13	1,030
November	851	16	867
December	895	15	910
January	984	97	1,081
February	908	23	931
March	927	20	947
April	810	20	830
May	691	11	702
June	870	13	883

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 2020
Processing Time: Actual, Target
Performance v Target: Above Target, At Target, Below Target

Medical Board of California
SFY 2020: 12-Month | **PM2:** Intake Cycle Time



Medical Board of California
SFY 2020: 12-Month | **PM2:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	11,389	10 Days	12 Days	▲2 Days
July	988	10 Days	14 Days	▲4 Days
August	1,025	10 Days	12 Days	▲2 Days
September	937	10 Days	15 Days	▲5 Days
October	906	10 Days	19 Days	▲9 Days
November	1,123	10 Days	14 Days	▲4 Days
December	1,075	10 Days	10 Days	0
January	899	10 Days	10 Days	0
February	1,009	10 Days	14 Days	▲4 Days
March	993	10 Days	9 Days	▼-1 Days
April	931	10 Days	9 Days	▼-1 Days
May	667	10 Days	8 Days	▼-2 Days
June	836	10 Days	10 Days	0

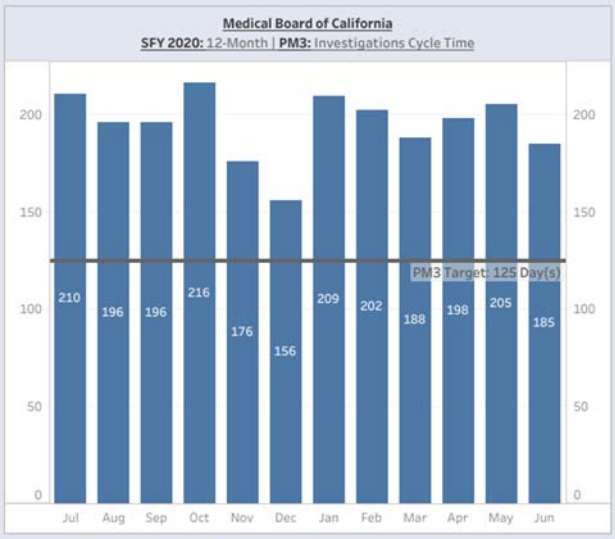
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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 2020

Processing Time
Actual Target

Performance versus Target
Above Target



Medical Board of California
SFY 2020: 12-Month | **PM3:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	12,699	125 Days	196 Days	▲71 Days
July	869	125 Days	210 Days	▲85 Days
August	1,122	125 Days	196 Days	▲71 Days
September	1,189	125 Days	196 Days	▲71 Days
October	1,084	125 Days	216 Days	▲91 Days
November	844	125 Days	176 Days	▲51 Days
December	822	125 Days	156 Days	▲31 Days
January	932	125 Days	209 Days	▲84 Days
February	1,112	125 Days	202 Days	▲77 Days
March	972	125 Days	188 Days	▲63 Days
April	1,439	125 Days	198 Days	▲73 Days
May	1,245	125 Days	205 Days	▲80 Days
June	1,069	125 Days	185 Days	▲60 Days

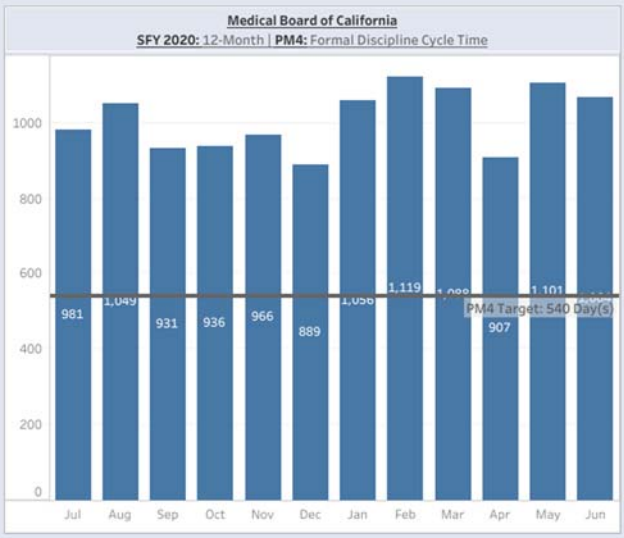
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

Select a DCA Entity
Medical Board of California

State Fiscal Year
SFY 2020

Processing Time
Actual Target

Performance versus Target
Above Target



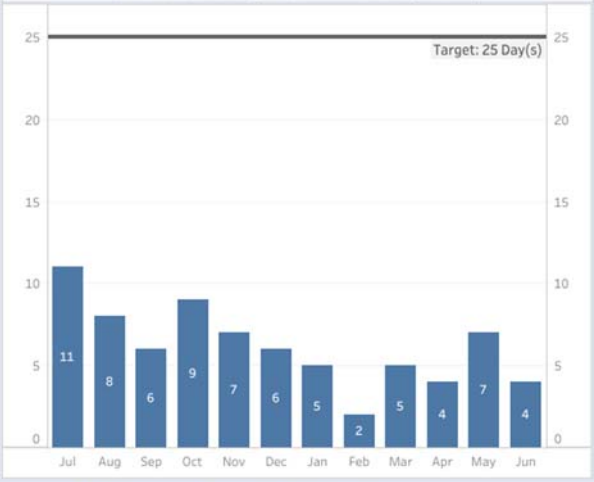
Medical Board of California
SFY 2020: 12-Month | **PM4:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	555	540 Days	1,010 Days	▲470 Days
July	54	540 Days	981 Days	▲441 Days
August	57	540 Days	1,049 Days	▲509 Days
September	47	540 Days	931 Days	▲391 Days
October	46	540 Days	936 Days	▲396 Days
November	55	540 Days	966 Days	▲426 Days
December	46	540 Days	889 Days	▲349 Days
January	40	540 Days	1,056 Days	▲516 Days
February	41	540 Days	1,119 Days	▲579 Days
March	61	540 Days	1,088 Days	▲548 Days
April	26	540 Days	907 Days	▲367 Days
May	48	540 Days	1,101 Days	▲561 Days
June	34	540 Days	1,064 Days	▲524 Days

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 2020 | Performance Measure: PM7 | Processing Time: Actual, Target | Performance versus Target: Below Target

Medical Board of California
SFY 2020: 12-Month | **PM7:** Probation Intake Cycle Time



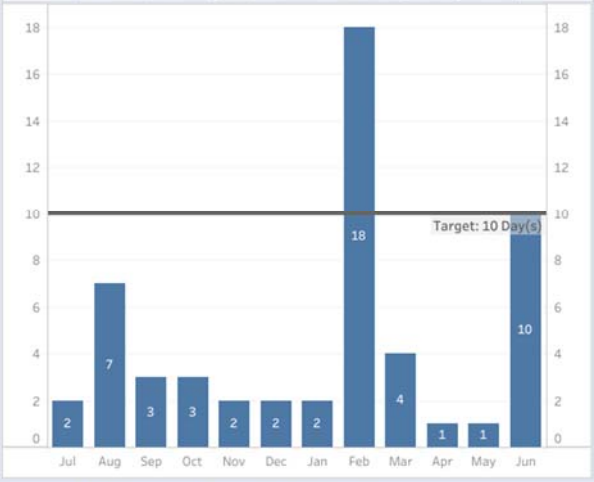
Medical Board of California
SFY 2020: 12-Month | **PM7:** Summary

	Case Volume	Target	Actual	Variance
Grand To..	175	25 Days	6 Days	▼ -19 Days
July	18	25 Days	11 Days	▼ -14 Days
August	16	25 Days	8 Days	▼ -17 Days
September	10	25 Days	6 Days	▼ -19 Days
October	13	25 Days	9 Days	▼ -16 Days
November	10	25 Days	7 Days	▼ -18 Days
December	20	25 Days	6 Days	▼ -19 Days
January	16	25 Days	5 Days	▼ -20 Days
February	10	25 Days	2 Days	▼ -23 Days
March	21	25 Days	5 Days	▼ -20 Days
April	8	25 Days	4 Days	▼ -21 Days
May	14	25 Days	7 Days	▼ -18 Days
June	19	25 Days	4 Days	▼ -21 Days

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 2020 | Performance Measure: PM8 | Processing Time: Actual, Target | Performance versus Target: Above Target, At Target, Below Target

Medical Board of California
SFY 2020: 12-Month | **PM8:** Probation Violation Response Cycle Time



Medical Board of California
SFY 2020: 12-Month | **PM8:** Summary

	Case Volume	Target	Actual	Variance
Grand To..	120	10 Days	4 Days	▼ -6 Days
July	10	10 Days	2 Days	▼ -8 Days
August	7	10 Days	7 Days	▼ -3 Days
September	10	10 Days	3 Days	▼ -7 Days
October	24	10 Days	3 Days	▼ -7 Days
November	11	10 Days	2 Days	▼ -8 Days
December	4	10 Days	2 Days	▼ -8 Days
January	15	10 Days	2 Days	▼ -8 Days
February	9	10 Days	18 Days	▲ 8 Days
March	10	10 Days	4 Days	▼ -6 Days
April	7	10 Days	1 Days	▼ -9 Days
May	8	10 Days	1 Days	▼ -9 Days
June	5	10 Days	10 Days	0 Days

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.

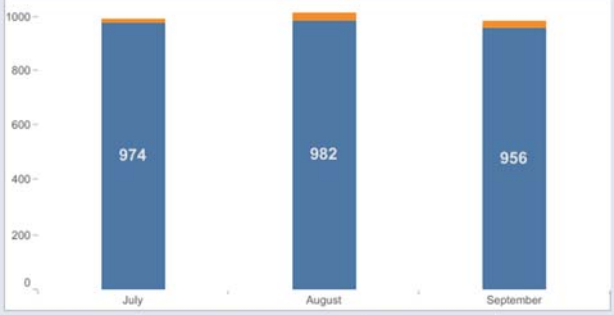
Enforcement Performance Measures
Q1 Report (July – September 2019)

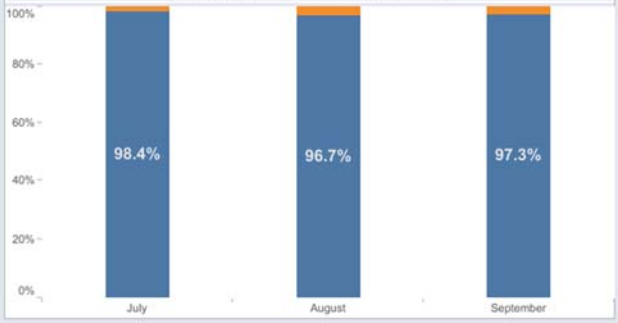
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q1 | Case Type: Conviction/Arrest, Complaints

Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Data last refreshed on 10/16/2020

Complaints	Conviction/Arrest	Total Volume
2,912	76	2,988





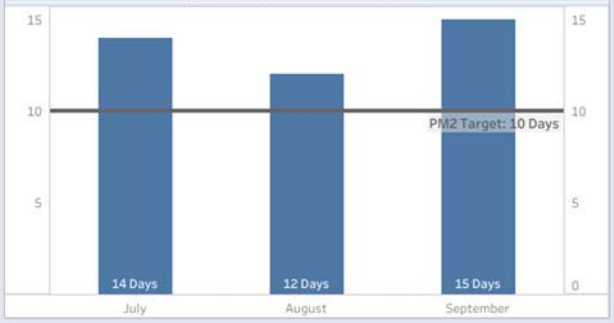
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

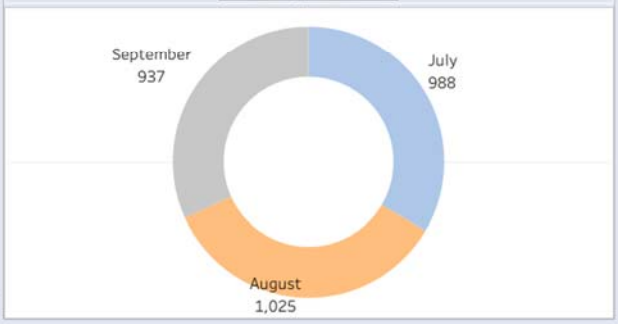
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q1 | Processing Time: Actual, Target | Case Volume by Month: July, August, September

Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
2,950	10 Days	14 Days	▲ 4 Days





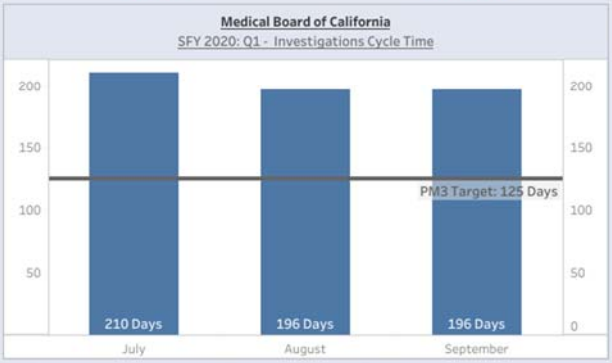
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

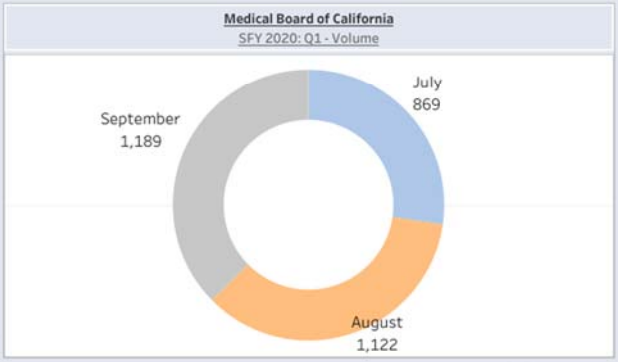
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q1 | Processing Time: Actual, Target | Case Volume by Month: July, August, Septemb..

Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
3,180	125 Days	200 Days	▲ 75 Days





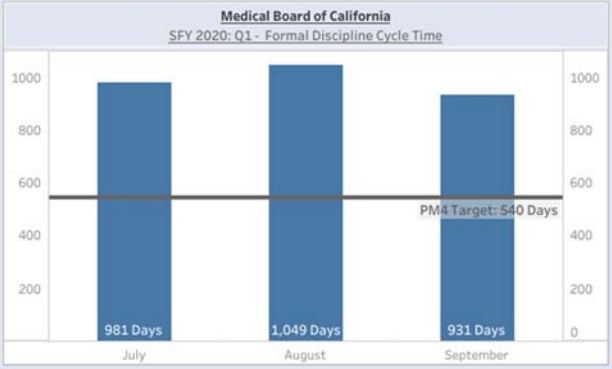
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

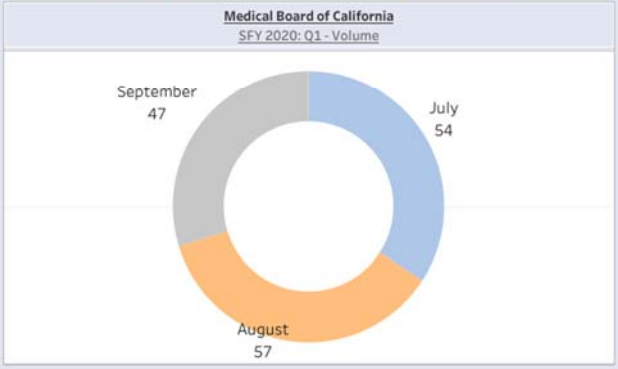
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q1 | Processing Time: Actual, Target | Case Volume by Month: July, Augu.., Sept..

Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
158	540 Days	991 Days	▲ 451 Days





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 inst..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Performance Measure: PM7 | Select a Quarter: Q1 | Processing Time: Actual, Target | Case Volume by Month: July, August, Septemb..

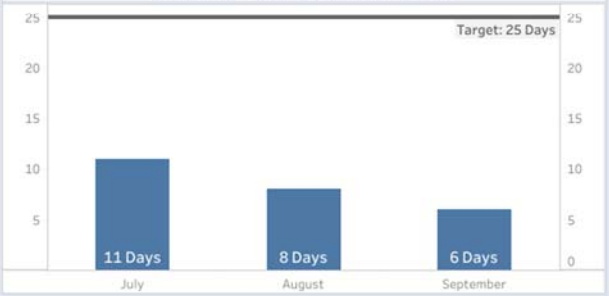
Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

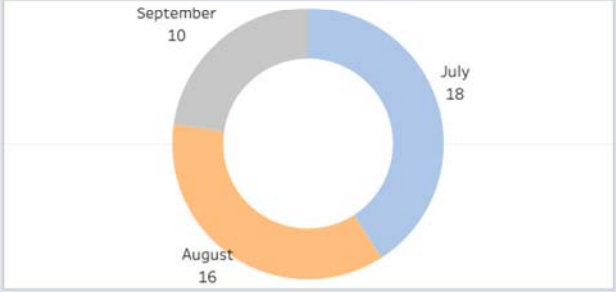
Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
44	25 Days	9 Days	▼ -16 Days

Medical Board of California
SFY 2020: Q1 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2020: Q1 -PM7: Probation Cases



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 inst..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Performance Measure: PM8 | Select a Quarter: Q1 | Processing Time: Actual, Target | Case Volume by Month: July, August, Septemb..

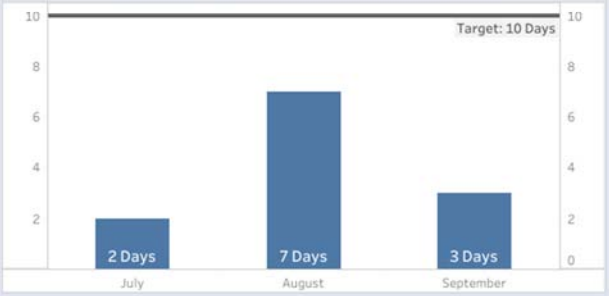
Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

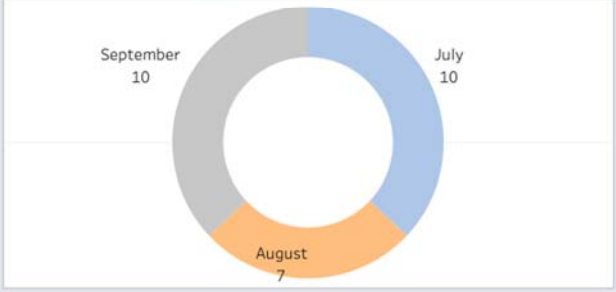
Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
27	10 Days	4 Days	▼ -6 Days

Medical Board of California
SFY 2020: Q1 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2020: Q1 -PM8: Probation Violation Cases



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 inst..

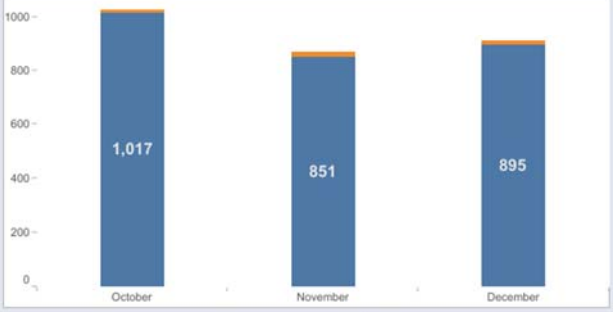
Enforcement Performance Measures
Q2 Report (October – December 2019)

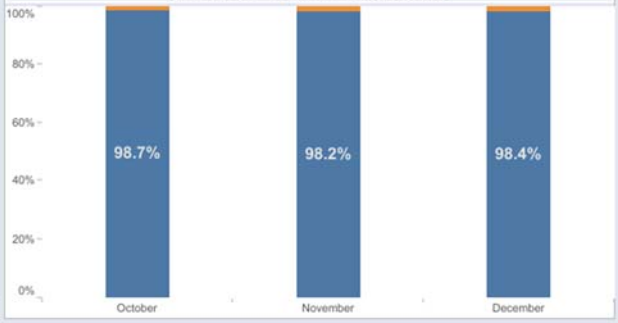
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q2 | Case Type: Conviction/Arrest, Complaints

Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Data last refreshed on 10/16/2020

Complaints	Conviction/Arrest	Total Volume
2,763	44	2,807





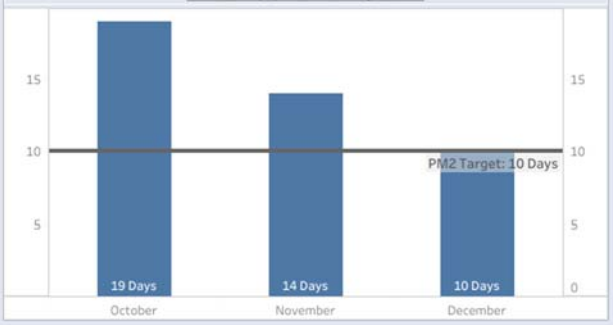
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

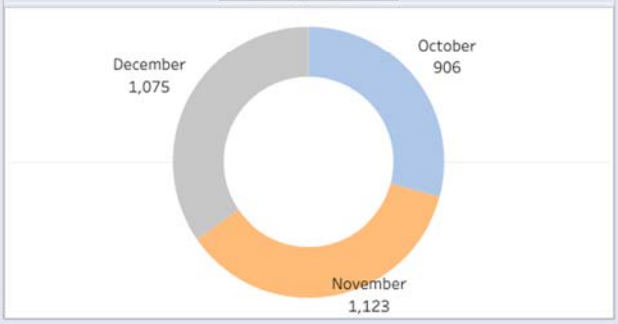
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q2 | Processing Time: Actual, Target | Case Volume by Month: October, November, December

Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
3,104	10 Days	14 Days	▲ 4 Days





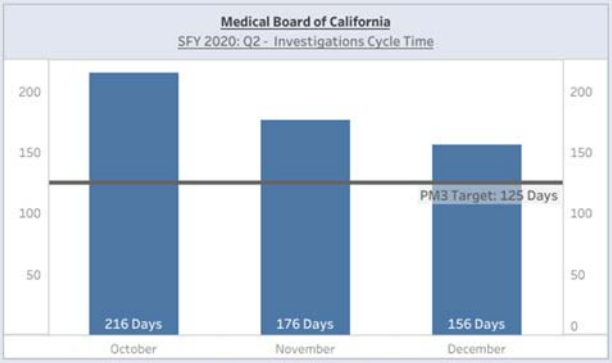
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

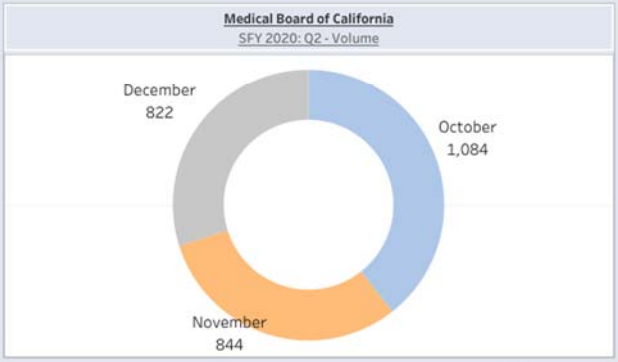
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q2 | Processing Time: Actual, Target | Case Volume by Month: October, Novemb.., December

Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
2,750	125 Days	186 Days	▲ 61 Days





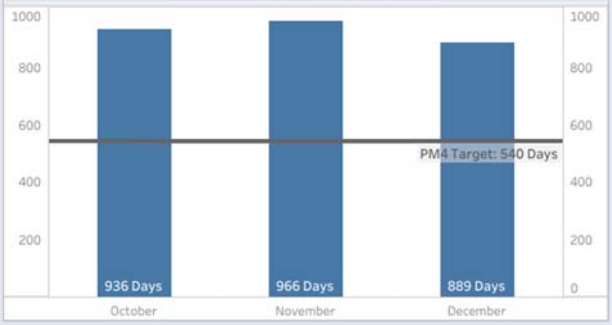
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

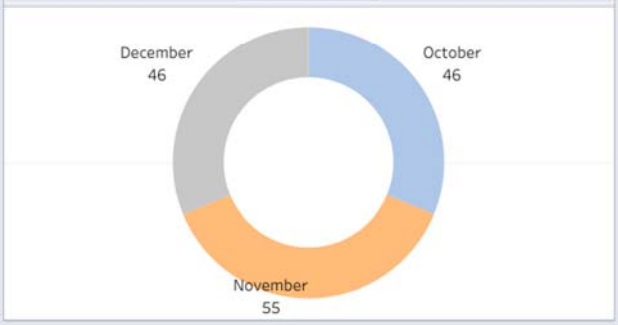
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q2 | Processing Time: Actual, Target | Case Volume by Month: Octo.., Nove.., Dece..

Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
147	540 Days	933 Days	▲ 393 Days





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 inst..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Performance Measure: PM7 | Select a Quarter: Q2 | Processing Time: Actual, Target | Case Volume by Month: October, Novemb.., December

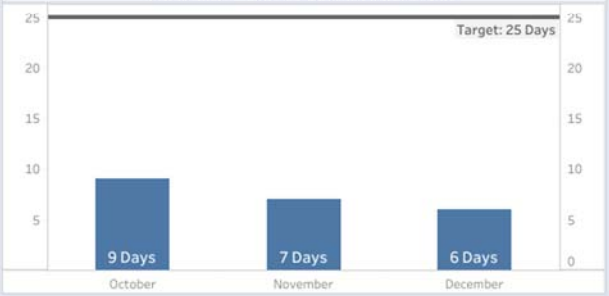
Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

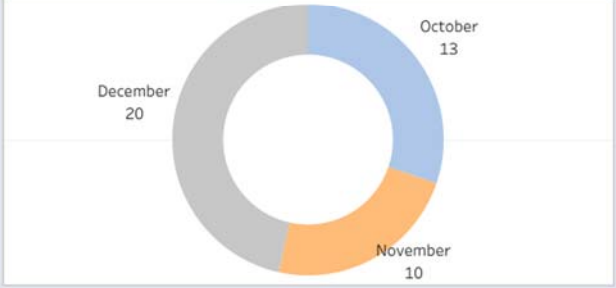
Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
43	25 Days	7 Days	▼ -18 Days

Medical Board of California
SFY 2020: Q2 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2020: Q2 -PM7: Probation Cases



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 inst..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Performance Measure: PM8 | Select a Quarter: Q2 | Processing Time: Actual, Target | Case Volume by Month: October, Novemb.., December

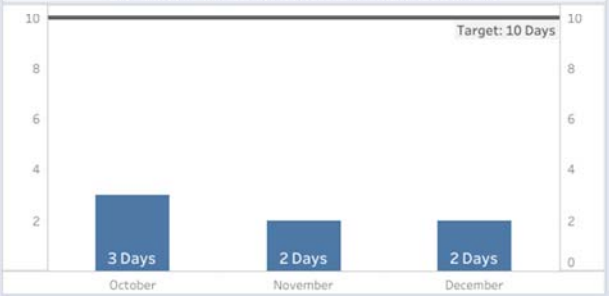
Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

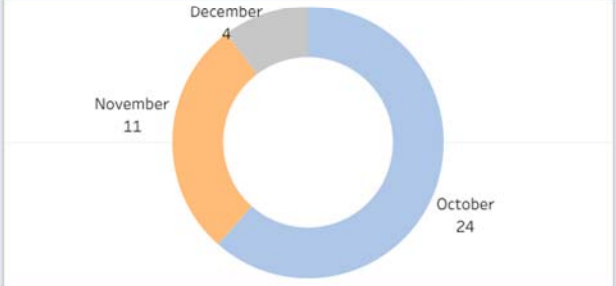
Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
39	10 Days	3 Days	▼ -7 Days

Medical Board of California
SFY 2020: Q2 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2020: Q2 -PM8: Probation Violation Cases



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 inst..

Enforcement Performance Measures
Q3 Report (January – March 2020)

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q3 | Case Type: Conviction/Arrest, Complaints

Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Data last refreshed on 10/16/2020

Complaints	Conviction/Arrest	Total Volume
2,819	140	2,959

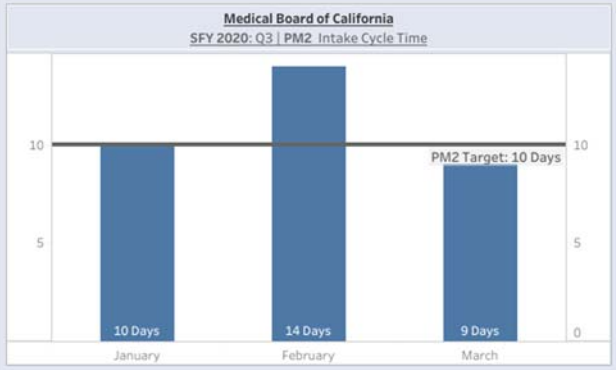
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

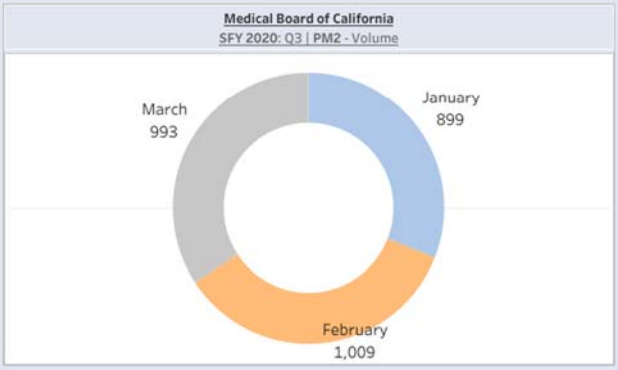
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q3 | Processing Time: Actual, Target | Case Volume by Month: January, February, March

Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
2,901	10 Days	11 Days	▲ 1 Days





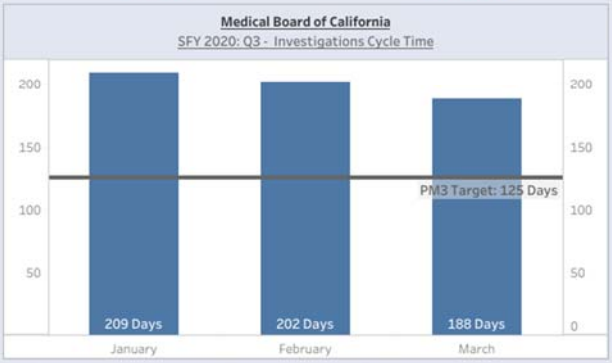
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

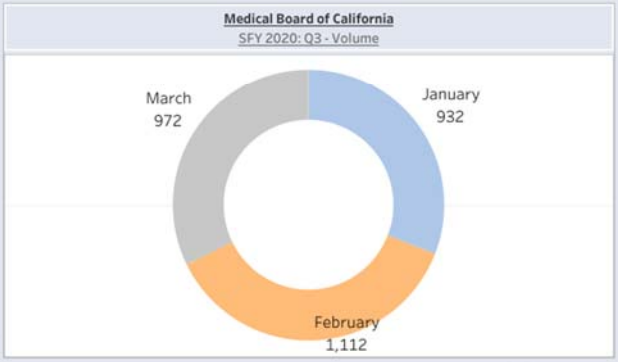
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q3 | Processing Time: Actual, Target | Case Volume by Month: January, February, March

Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
3,016	125 Days	200 Days	▲ 75 Days





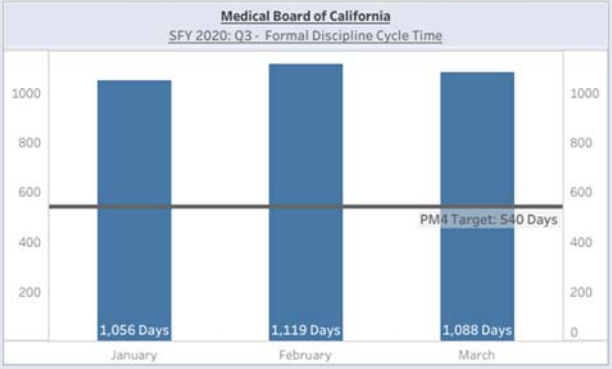
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

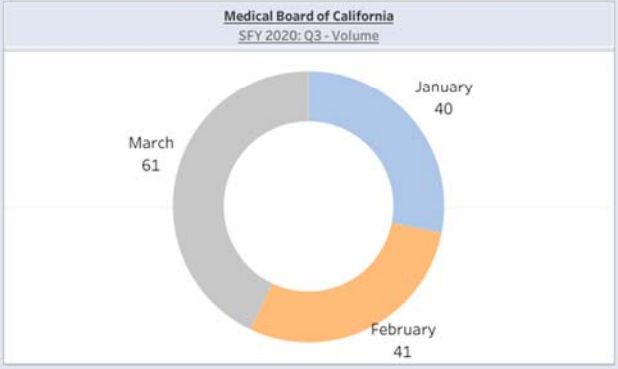
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q3 | Processing Time: Actual, Target | Case Volume by Month: Janu.., Febr.., March

Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

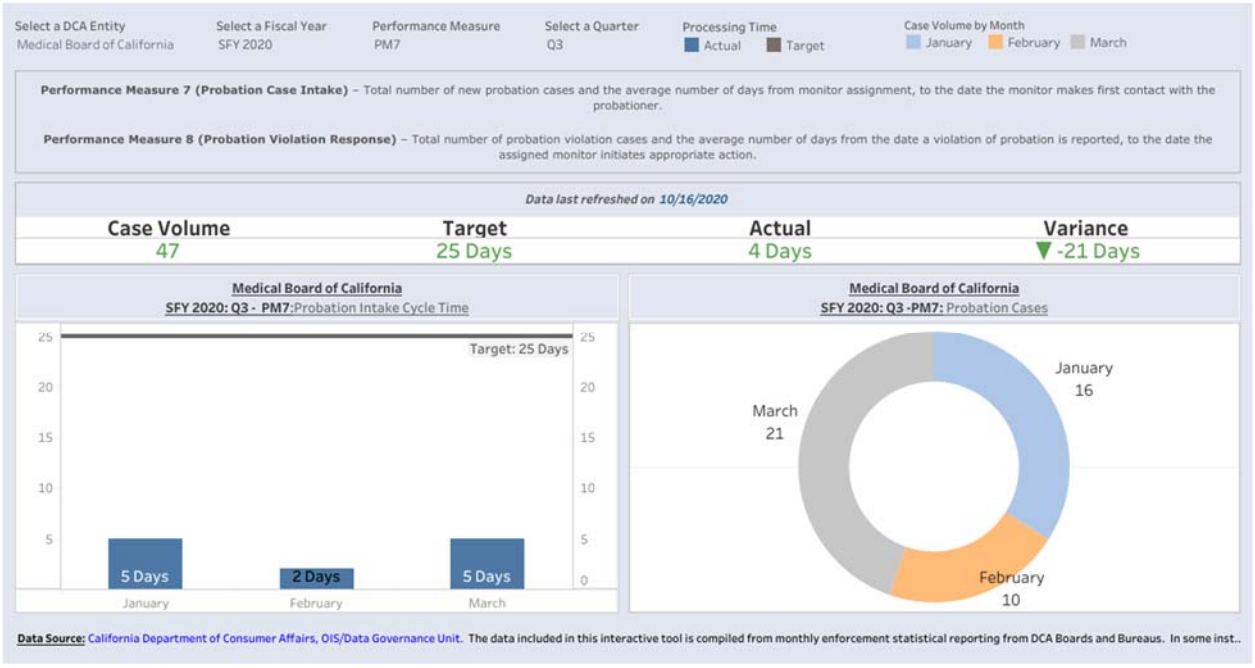
Data last refreshed on 10/16/2020

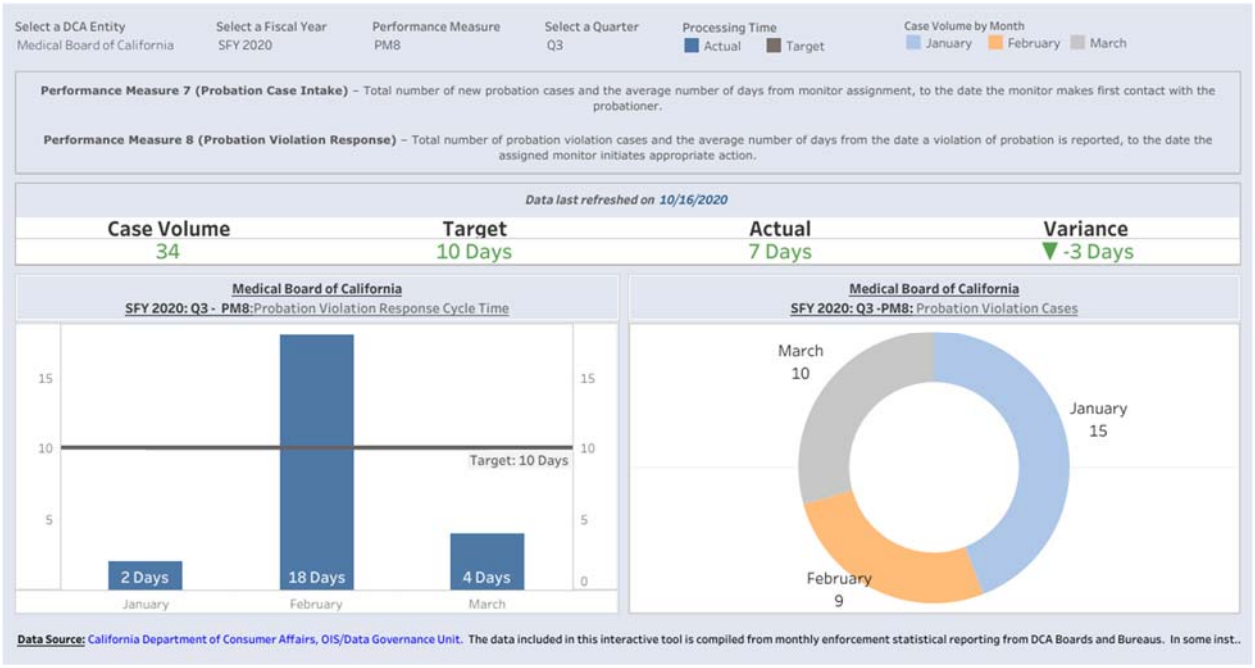
Case Volume	Target	Actual	Variance
142	540 Days	1,088 Days	▲ 548 Days





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 inst..


Select a DCA Entity
Medical Board of California
Select a Fiscal Year
SFY 2020
Performance Measure
PM7
Select a Quarter
Q3
Processing Time
Actual
Target
Case Volume by Month
January
February
March
Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.
Data last refreshed on 10/16/2020
Case Volume
47
Target
25 Days
Actual
4 Days
Variance
-21 Days
Medical Board of California
SFY 2020: Q3 - PM7:Probation Intake Cycle Time
Target: 25 Days
5 Days
2 Days
5 Days
January
February
March
Medical Board of California
SFY 2020: Q3 -PM7: Probation Cases
January
16
March
21
February
10
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 inst..


Select a DCA Entity
Medical Board of California
Select a Fiscal Year
SFY 2020
Performance Measure
PM8
Select a Quarter
Q3
Processing Time
Actual
Target
Case Volume by Month
January
February
March
Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.
Data last refreshed on 10/16/2020
Case Volume
34
Target
10 Days
Actual
7 Days
Variance
-3 Days
Medical Board of California
SFY 2020: Q3 - PM8:Probation Violation Response Cycle Time
Target: 10 Days
2 Days
18 Days
4 Days
January
February
March
Medical Board of California
SFY 2020: Q3 -PM8: Probation Violation Cases
March
10
January
15
February
9
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 inst..

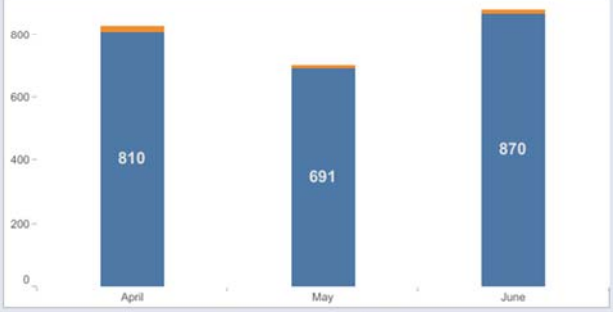
Enforcement Performance Measures
Q4 Report (April – June 2020)

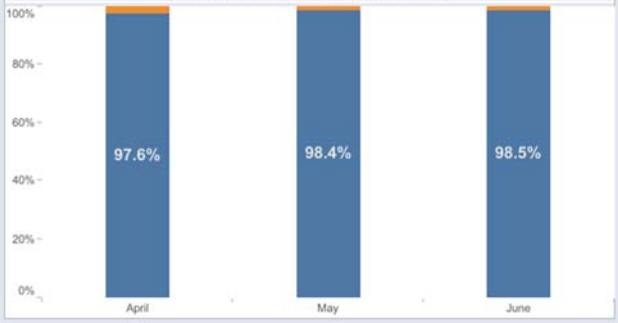
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q4 | Case Type: Conviction/Arrest, Complaints

Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Data last refreshed on 10/16/2020

Complaints	Conviction/Arrest	Total Volume
2,371	44	2,415





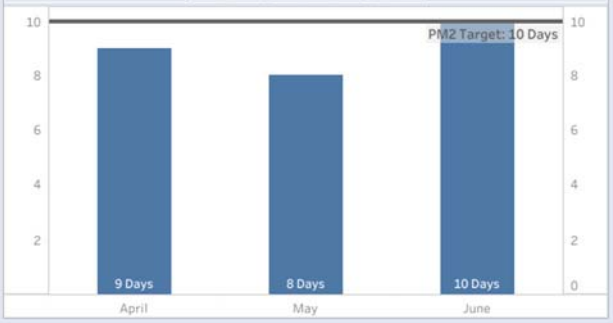
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

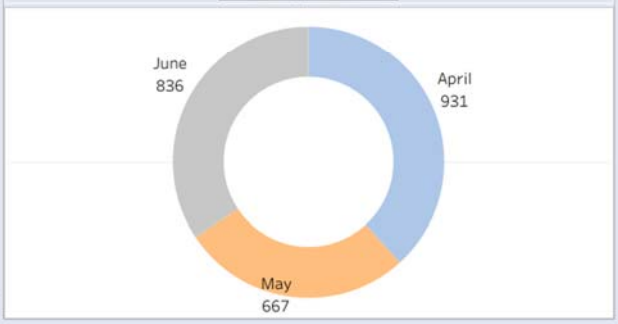
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q4 | Processing Time: Actual, Target | Case Volume by Month: April, May, June

Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
2,434	10 Days	9 Days	▼ -1 Days





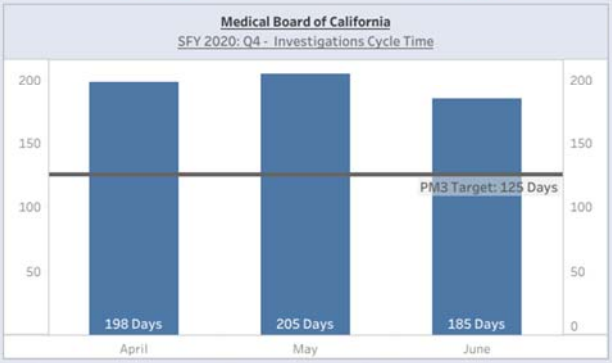
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

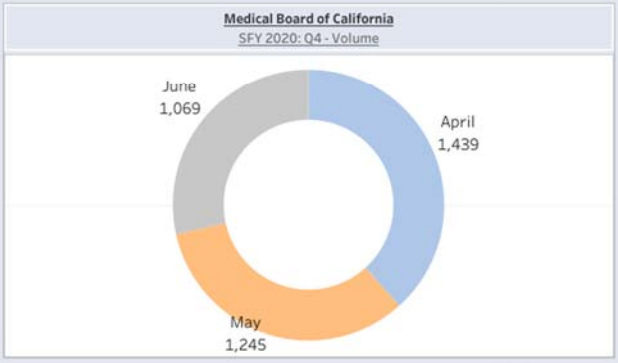
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q4 | Processing Time: Actual, Target | Case Volume by Month: April, May, June

Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Data last refreshed on 10/16/2020

Case Volume	Target	Actual	Variance
3,753	125 Days	197 Days	▲ 72 Days





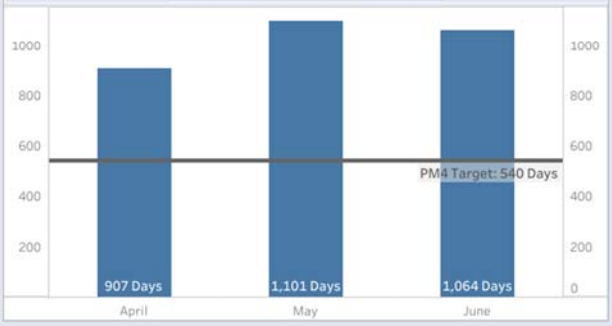
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data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

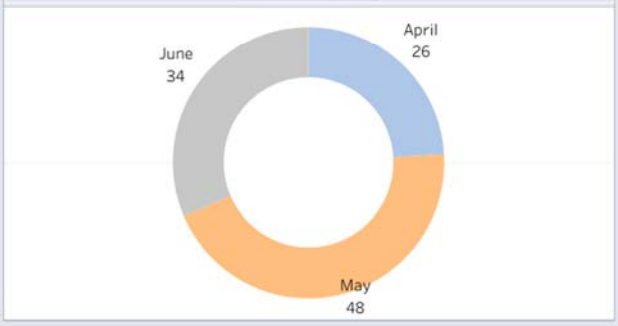
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2020 | Select a Quarter: Q4 | Processing Time: Actual, Target | Case Volume by Month: April, May, June

Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

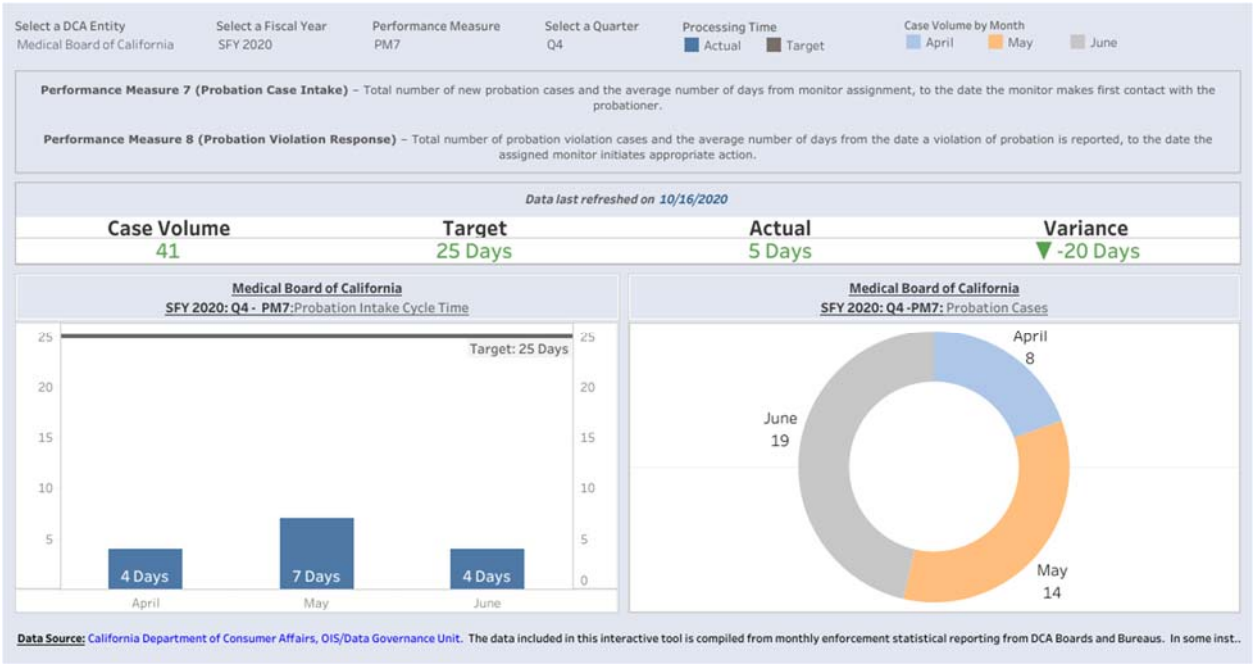
Data last refreshed on 10/16/2020

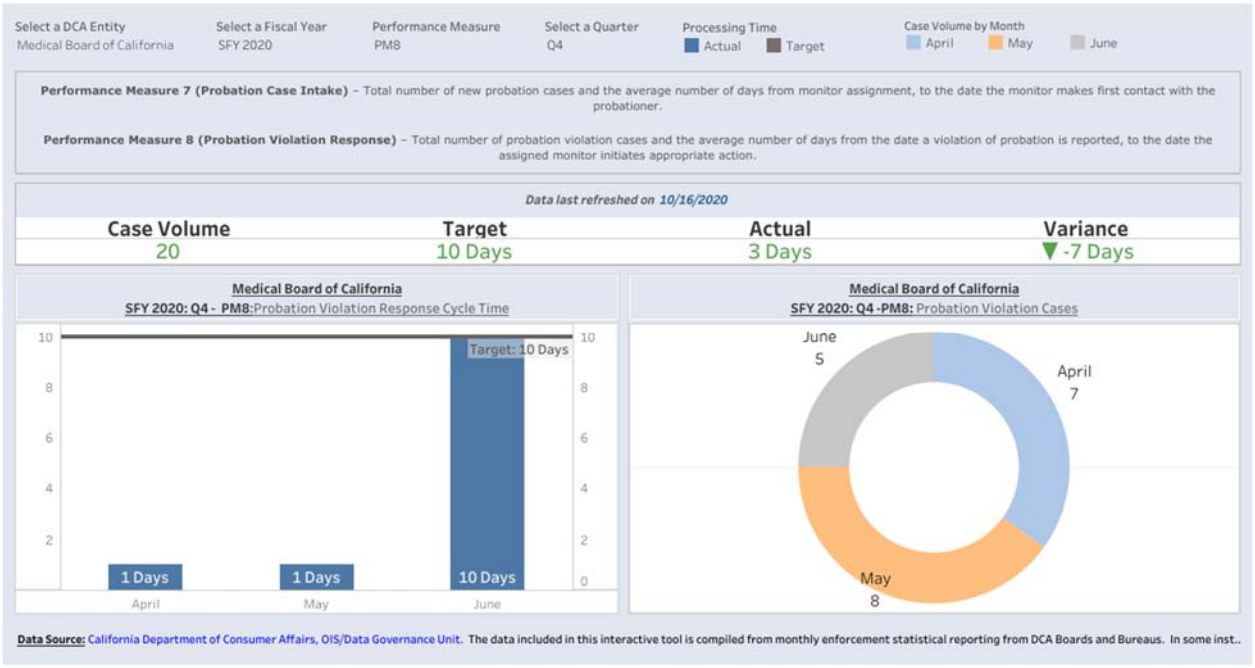
Case Volume	Target	Actual	Variance
108	540 Days	1,043 Days	▲ 503 Days





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 inst..


Select a DCA Entity
Medical Board of California
Select a Fiscal Year
SFY 2020
Performance Measure
PM7
Select a Quarter
Q4
Processing Time
Actual
Target
Case Volume by Month
April
May
June
Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.
Data last refreshed on 10/16/2020
Case Volume
41
Target
25 Days
Actual
5 Days
Variance
▼ -20 Days
Medical Board of California
SFY 2020: Q4 - PM7:Probation Intake Cycle Time
Target: 25 Days
4 Days
7 Days
4 Days
April
May
June
Medical Board of California
SFY 2020: Q4 -PM7: Probation Cases
April
8
June
19
May
14
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 inst..

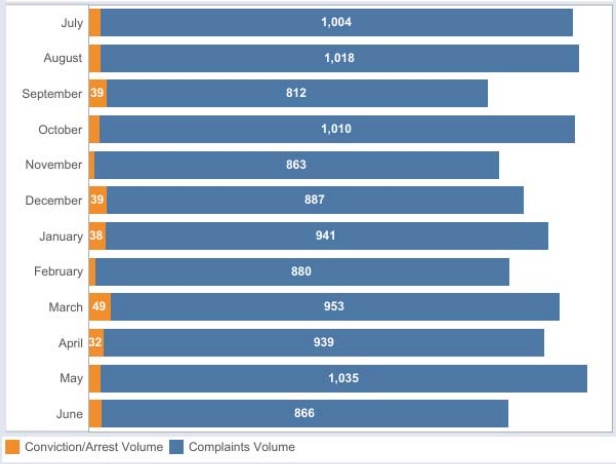

Select a DCA Entity
Medical Board of California
Select a Fiscal Year
SFY 2020
Performance Measure
PM8
Select a Quarter
Q4
Processing Time
Actual
Target
Case Volume by Month
April
May
June
Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.
Data last refreshed on 10/16/2020
Case Volume
20
Target
10 Days
Actual
3 Days
Variance
▼ -7 Days
Medical Board of California
SFY 2020: Q4 - PM8:Probation Violation Response Cycle Time
Target: 10 Days
1 Days
1 Days
10 Days
April
May
June
Medical Board of California
SFY 2020: Q4 -PM8: Probation Violation Cases
June
5
April
7
May
8
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 inst..

Enforcement Performance Measures
Annual Report (July 2018 – June 2019)

Board Name
Medical Board of California

State Fiscal Year
SFY18/19

Medical Board of California
SFY18/19: 12-Month | **PM1:** Case Volume by Type



Medical Board of California
SFY18/19: 12-Month | **PM1:** Summary

	Complaints Volume	Conviction/Arrest Volume	Total Volume
Grand Total	**11,208**	**357**	**11,565**
July	1,004	27	1,031
August	1,018	27	1,045
September	812	39	851
October	1,010	25	1,035
November	863	12	875
December	887	39	926
January	941	38	979
February	880	15	895
March	953	49	1,002
April	939	32	971
May	1,035	26	1,061
June	866	28	894

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.

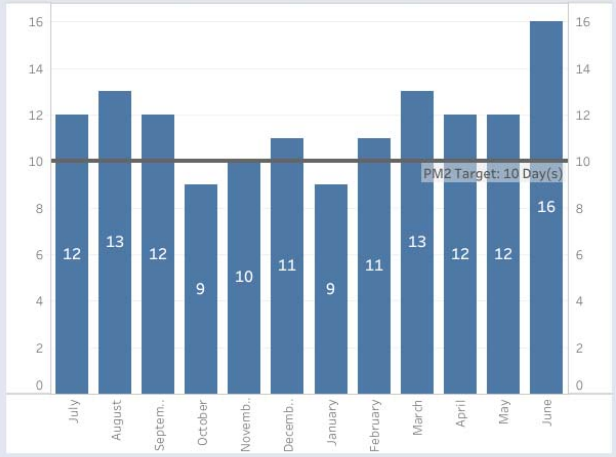
Select a DCA Entity
Medical Board of California

Select a Fiscal Year
SFY18/19

Intake Cycle Time
Actual Target

Cycle Time Performance versus Target
Above Target Below Target
At Target

Medical Board of California
SFY18/19: 12-Month | **PM2:** Intake Cycle Time



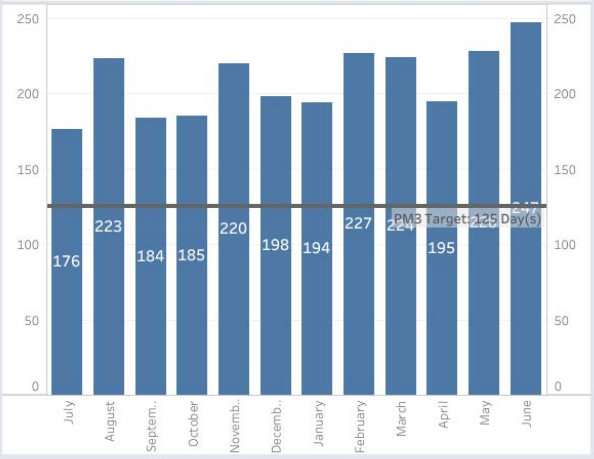
Medical Board of California
SFY18/19: 12-Month | **PM2:** Summary

	Case Volume	Target	Actual	Variance
Grand Tot..	11,494	10 Days	12 Days	▲2 Days
July	988	10 Days	12 Days	▲2 Days
August	979	10 Days	13 Days	▲3 Days
September	984	10 Days	12 Days	▲2 Days
October	1,096	10 Days	9 Days	▼-1 Days
November	848	10 Days	10 Days	0 Days
December	1,009	10 Days	11 Days	▲1 Days
January	907	10 Days	9 Days	▼-1 Days
February	858	10 Days	11 Days	▲1 Days
March	881	10 Days	13 Days	▲3 Days
April	1,074	10 Days	12 Days	▲2 Days
May	1,021	10 Days	12 Days	▲2 Days
June	849	10 Days	16 Days	▲6 Days

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: SFY18/19 | Intake Cycle Time: Actual, Target | Cycle Time Performance versus Target: Above Target

Medical Board of California
SFY18/19: 12-Month | **PM3:** Intake Cycle Time



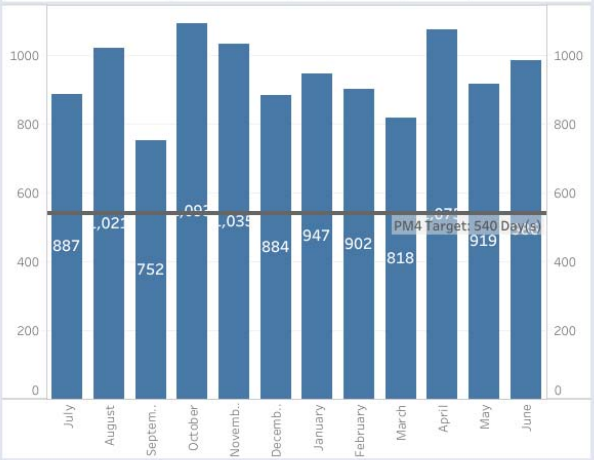
Medical Board of California
SFY18/19: 12-Month | **PM3:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	9,403	125 Days	208 Days	▲ 83 Days
July	708	125 Days	176 Days	▲ 51 Days
August	565	125 Days	223 Days	▲ 98 Days
September	621	125 Days	184 Days	▲ 59 Days
October	750	125 Days	185 Days	▲ 60 Days
November	711	125 Days	220 Days	▲ 95 Days
December	715	125 Days	198 Days	▲ 73 Days
January	771	125 Days	194 Days	▲ 69 Days
February	630	125 Days	227 Days	▲ 102 Days
March	1,127	125 Days	224 Days	▲ 99 Days
April	1,222	125 Days	195 Days	▲ 70 Days
May	942	125 Days	228 Days	▲ 103 Days
June	641	125 Days	247 Days	▲ 122 Days

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 | State Fiscal Year: SFY18/19 | Intake Cycle Time: Actual, Target | Cycle Time Performance versus Target: Above Target

Medical Board of California
SFY18/19: 12-Month | **PM4:** Intake Cycle Time



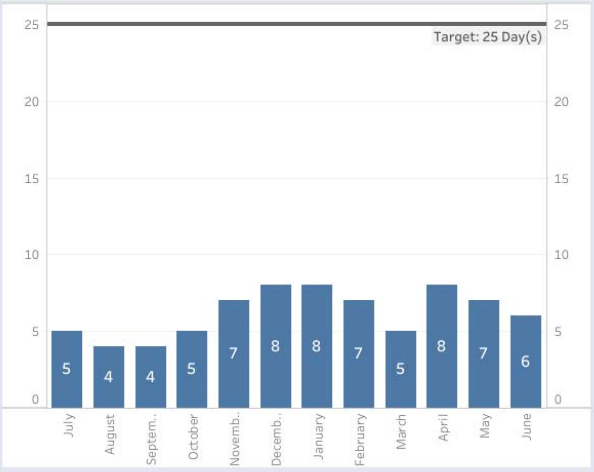
Medical Board of California
SFY18/19: 12-Month | **PM4:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	502	540 Days	949 Days	▲ 409 Days
July	31	540 Days	887 Days	▲ 347 Days
August	40	540 Days	1,021 Days	▲ 481 Days
September	36	540 Days	752 Days	▲ 212 Days
October	39	540 Days	1,093 Days	▲ 553 Days
November	64	540 Days	1,035 Days	▲ 495 Days
December	27	540 Days	884 Days	▲ 344 Days
January	34	540 Days	947 Days	▲ 407 Days
February	54	540 Days	902 Days	▲ 362 Days
March	38	540 Days	818 Days	▲ 278 Days
April	33	540 Days	1,075 Days	▲ 535 Days
May	57	540 Days	919 Days	▲ 379 Days
June	49	540 Days	986 Days	▲ 446 Days

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 2019 | Performance Measure: PM7 | Intake Cycle Time: Actual, Target | Cycle Time Performance versus Target: Below Target

Medical Board of California
SFY 2019: 12-Month | **PM7:** Probation Intake Cycle Time



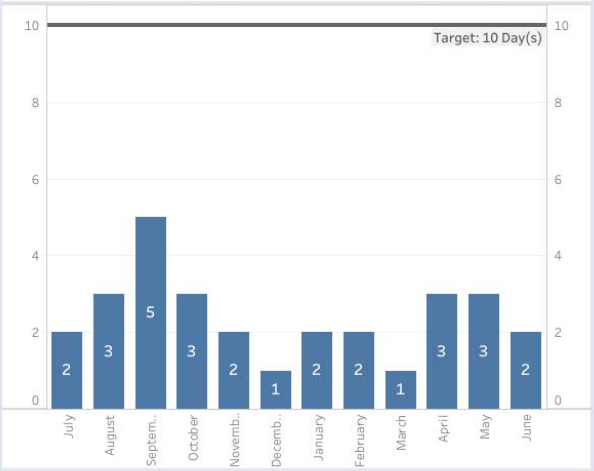
Medical Board of California
SFY 2019: 12-Month | **PM7:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	182	25 Days	6 Days	▼ -19 Days
July	16	25 Days	5 Days	▼ -20 Days
August	16	25 Days	4 Days	▼ -21 Days
September	14	25 Days	4 Days	▼ -21 Days
October	22	25 Days	5 Days	▼ -20 Days
November	12	25 Days	7 Days	▼ -18 Days
December	8	25 Days	8 Days	▼ -17 Days
January	15	25 Days	8 Days	▼ -17 Days
February	17	25 Days	7 Days	▼ -18 Days
March	10	25 Days	5 Days	▼ -20 Days
April	14	25 Days	8 Days	▼ -17 Days
May	19	25 Days	7 Days	▼ -18 Days
June	19	25 Days	6 Days	▼ -19 Days

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 2019 | Performance Measure: PM8 | Intake Cycle Time: Actual, Target | Cycle Time Performance versus Target: Below Target

Medical Board of California
SFY 2019: 12-Month | **PM8:** Probation Violation Response Cycle Time

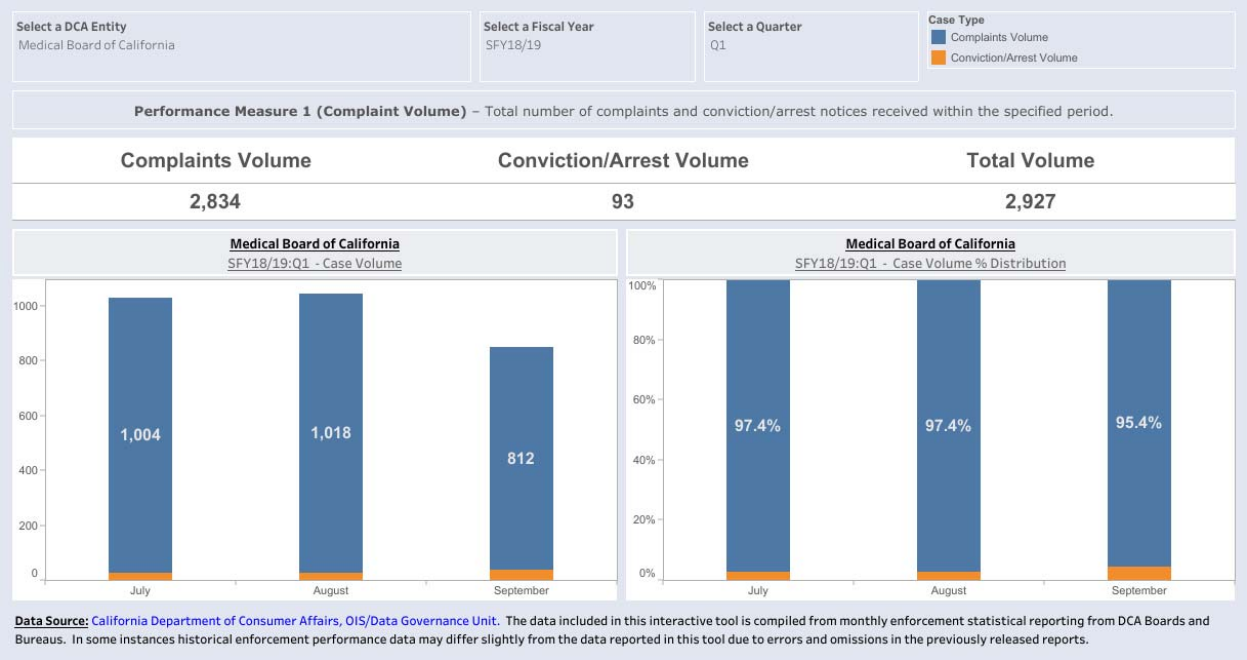


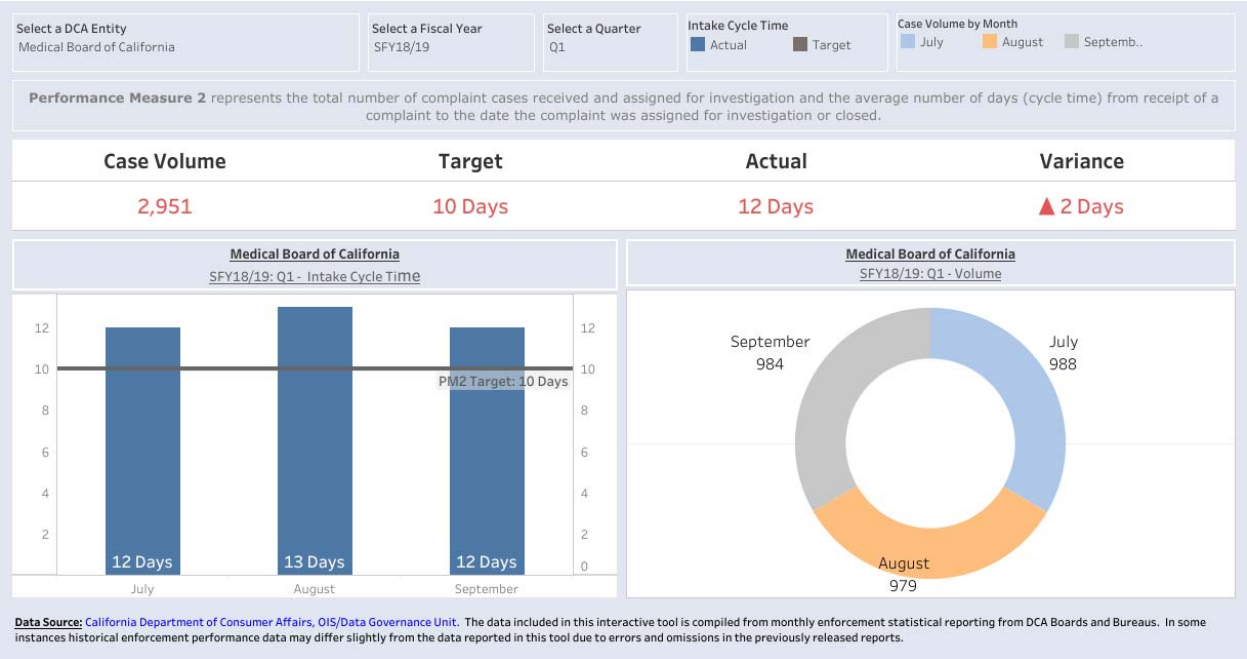
Medical Board of California
SFY 2019: 12-Month | **PM8:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	152	10 Days	2 Days	▼ -8 Days
July	28	10 Days	2 Days	▼ -8 Days
August	14	10 Days	3 Days	▼ -7 Days
September	9	10 Days	5 Days	▼ -5 Days
October	20	10 Days	3 Days	▼ -7 Days
November	13	10 Days	2 Days	▼ -8 Days
December	11	10 Days	1 Days	▼ -9 Days
January	10	10 Days	2 Days	▼ -8 Days
February	3	10 Days	2 Days	▼ -8 Days
March	8	10 Days	1 Days	▼ -9 Days
April	16	10 Days	3 Days	▼ -7 Days
May	15	10 Days	3 Days	▼ -7 Days
June	5	10 Days	2 Days	▼ -8 Days

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.

Enforcement Performance Measures
Q1 Report (July – September 2018)





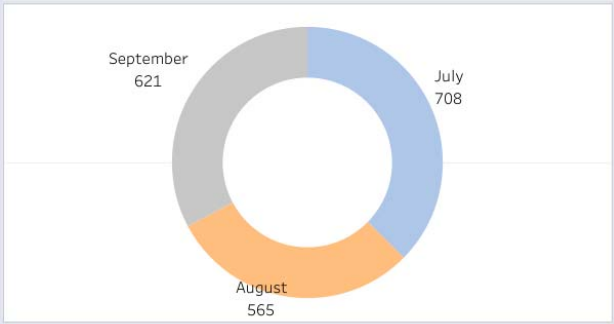
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY18/19 | Select a Quarter: Q1 | Intake Cycle Time: Actual, Target | Case Volume by Month: July, August, Septemb..

Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
1,894	125 Days	193 Days	▲ 68 Days

Medical Board of California
SFY18/19: Q1 - Investigations Cycle Time

Medical Board of California
SFY18/19: Q1 - Volume



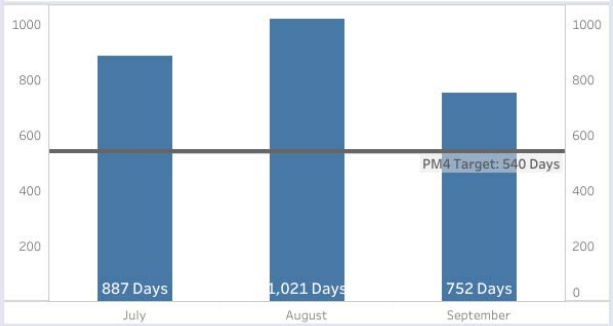
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bu..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY18/19 | Select a Quarter: Q1 | Intake Cycle Time: Actual, Target | Case Volume by Month: July, Augu.., Sept..

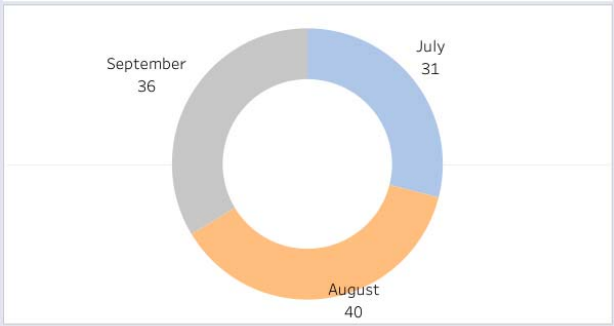
Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
107	540 Days	892 Days	▲ 352 Days

Medical Board of California
SFY18/19: Q1 - Investigations Cycle Time



Medical Board of California
SFY18/19: Q1 - Volume



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 Bu..

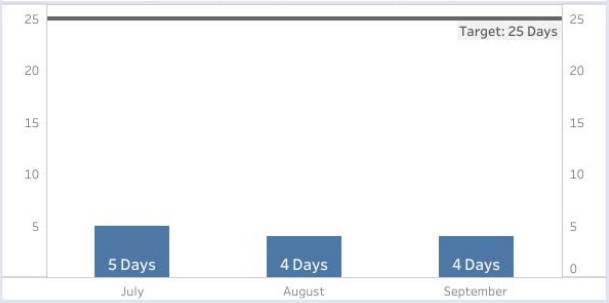
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2019	PM7	Q1	Actual Target	July August Septemb..

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

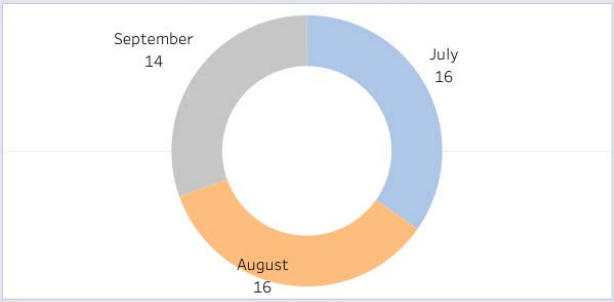
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
46	25 Days	4 Days	▼ -21 Days

Medical Board of California
SFY 2019: Q1 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2019: Q1 -PM7: Probation Cases



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 inst..

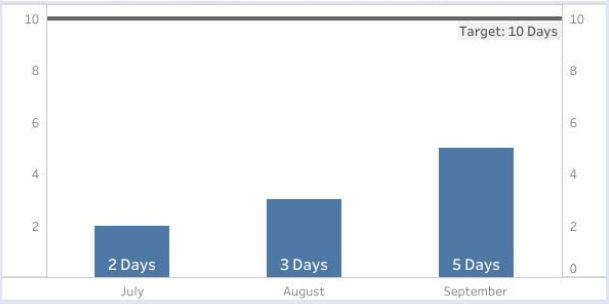
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2019	PM8	Q1	Actual Target	July August Septemb..

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

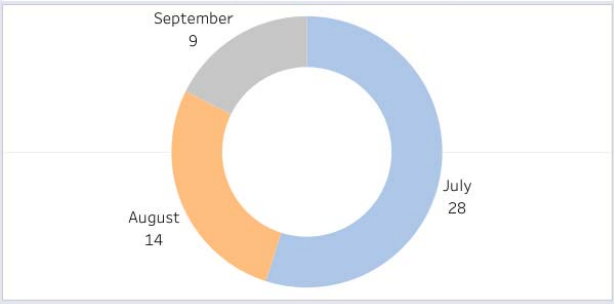
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
51	10 Days	3 Days	▼ -7 Days

Medical Board of California
SFY 2019: Q1 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2019: Q1 -PM8: Probation Violation Cases



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 inst..

Enforcement Performance Measures
Q2 Report (October – December 2018)

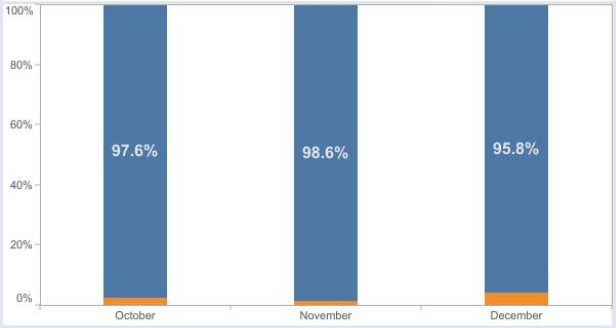
Select a DCA Entity: Medical Board of California
Select a Fiscal Year: SFY18/19
Select a Quarter: Q2
Case Type: Complaints Volume; Conviction/Arrest Volume

Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Complaints Volume	Conviction/Arrest Volume	Total Volume
2,760	76	2,836

Medical Board of California
SFY18/19:Q2 - Case Volume

Medical Board of California
SFY18/19:Q2 - Case Volume % Distribution



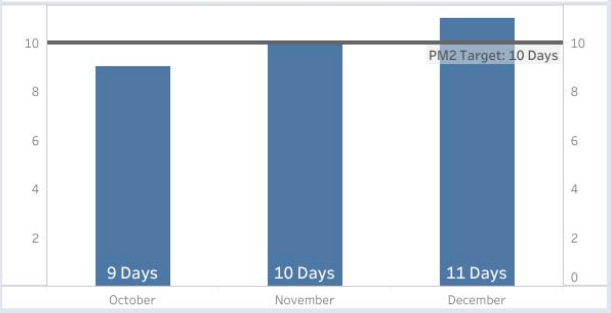
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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: SFY18/19
Select a Quarter: Q2
Intake Cycle Time: Actual; Target
Case Volume by Month: October; Novemb..; December

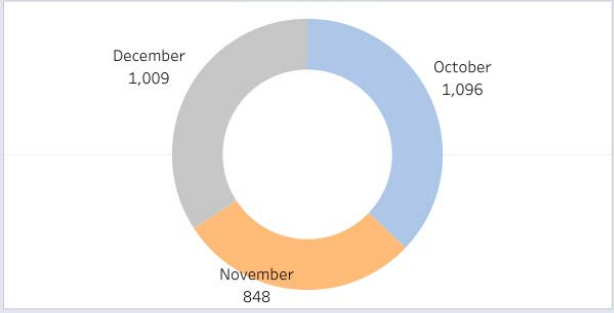
Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Case Volume	Target	Actual	Variance
2,953	10 Days	10 Days	0 Days

Medical Board of California
SFY18/19: Q2 - Intake Cycle Time



Medical Board of California
SFY18/19: Q2 - Volume



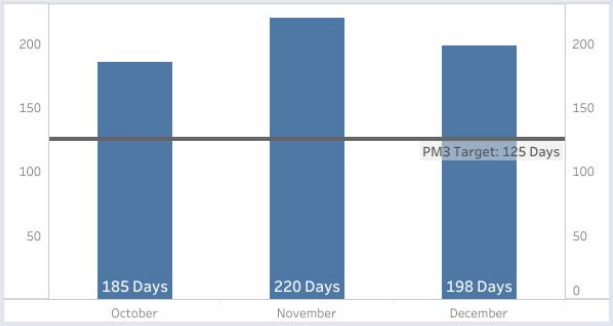
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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: SFY18/19 | Select a Quarter: Q2 | Intake Cycle Time: Actual, Target | Case Volume by Month: October, Novemb.., December

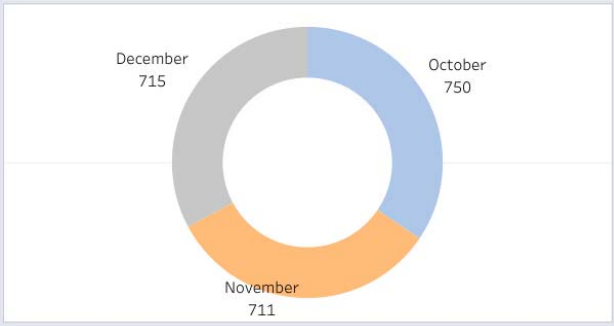
Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
2,176	125 Days	201 Days	▲ 76 Days

Medical Board of California
SFY18/19: Q2 - Investigations Cycle Time



Medical Board of California
SFY18/19: Q2 - Volume



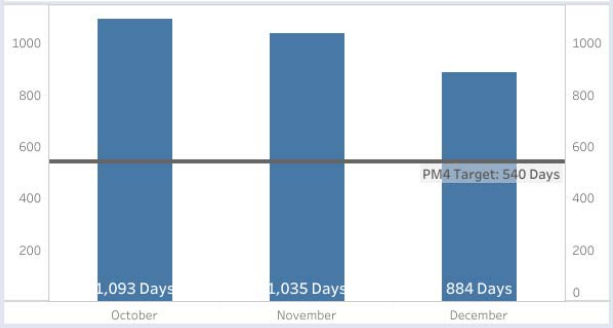
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bu..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY18/19 | Select a Quarter: Q2 | Intake Cycle Time: Actual, Target | Case Volume by Month: Octo.., Nove.., Dece..

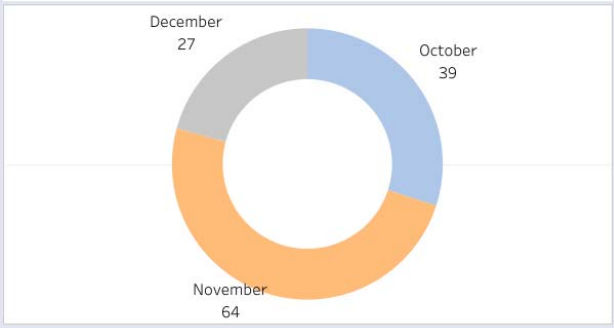
Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
130	540 Days	1,021 Days	▲ 481 Days

Medical Board of California
SFY18/19: Q2 - Investigations Cycle Time



Medical Board of California
SFY18/19: Q2 - Volume



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 Bu..

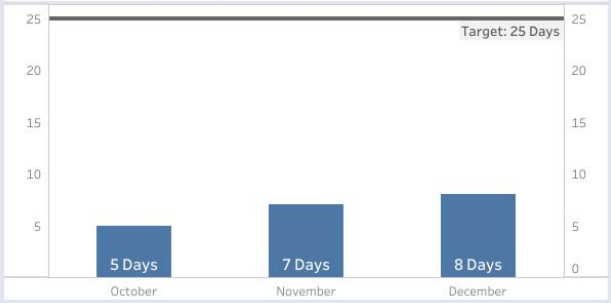
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2019 | Performance Measure: PM7 | Select a Quarter: Q2 | Intake Cycle Time: Actual, Target | Case Volume by Month: October, Novemb.., December

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

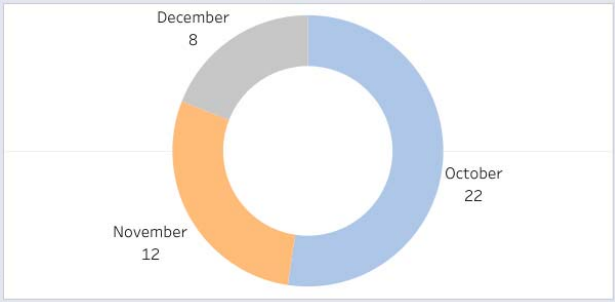
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
42	25 Days	6 Days	▼ -19 Days

Medical Board of California
SFY 2019: Q2 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2019: Q2 -PM7: Probation Cases



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 inst..

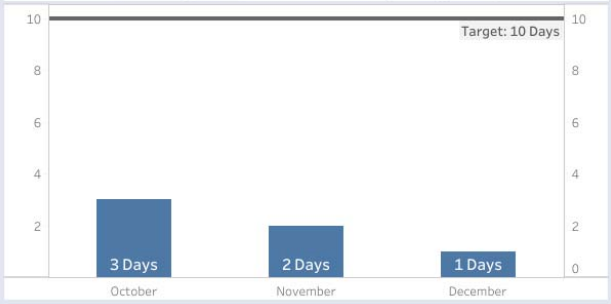
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2019 | Performance Measure: PM8 | Select a Quarter: Q2 | Intake Cycle Time: Actual, Target | Case Volume by Month: October, Novemb.., December

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

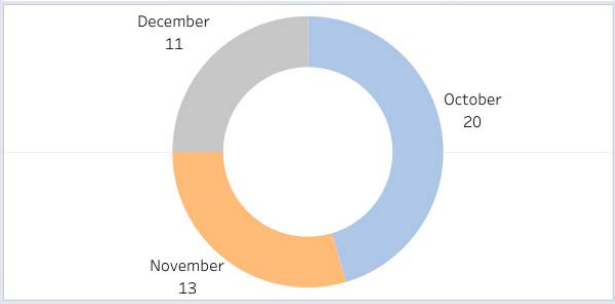
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
44	10 Days	2 Days	▼ -8 Days

Medical Board of California
SFY 2019: Q2 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2019: Q2 -PM8: Probation Violation Cases



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 inst..

Enforcement Performance Measures
Q3 Report (January – March 2019)

Select a DCA Entity
Medical Board of California

Select a Fiscal Year
SFY18/19

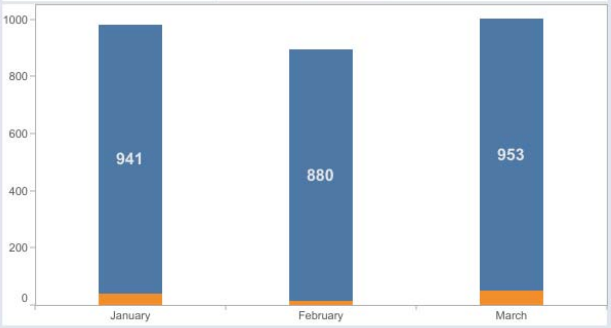
Select a Quarter
Q3

Case Type
Complaints Volume
Conviction/Arrest Volume

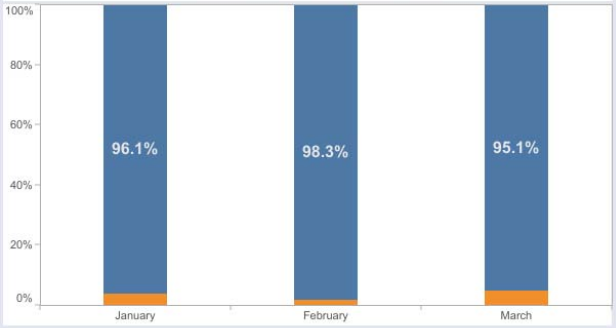
Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Complaints Volume	Conviction/Arrest Volume	Total Volume
2,774	102	2,876

Medical Board of California
SFY18/19:Q3 - Case Volume



Medical Board of California
SFY18/19:Q3 - Case Volume % Distribution



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
SFY18/19

Select a Quarter
Q3

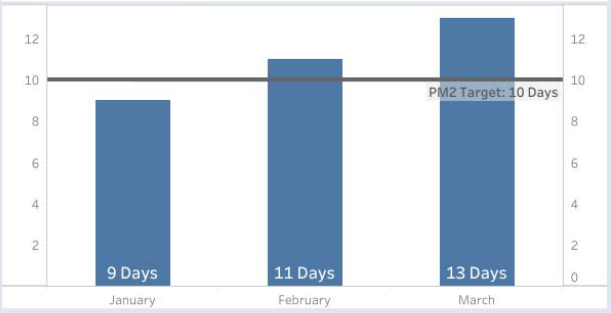
Intake Cycle Time
Actual
Target

Case Volume by Month
January
February
March

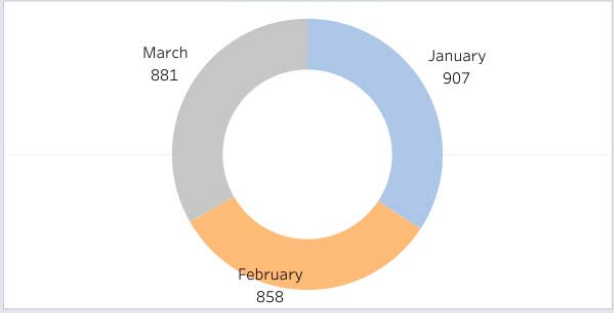
Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Case Volume	Target	Actual	Variance
2,646	10 Days	11 Days	▲ 1 Days

Medical Board of California
SFY18/19: Q3 - Intake Cycle Time



Medical Board of California
SFY18/19: Q3 - Volume



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.

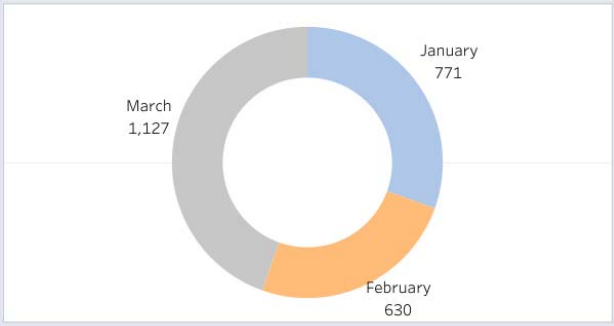
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY18/19 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: January, February, March

Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
2,528	125 Days	216 Days	▲ 91 Days

Medical Board of California
SFY18/19: Q3 - Investigations Cycle Time

Medical Board of California
SFY18/19: Q3 - Volume



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 Bu..

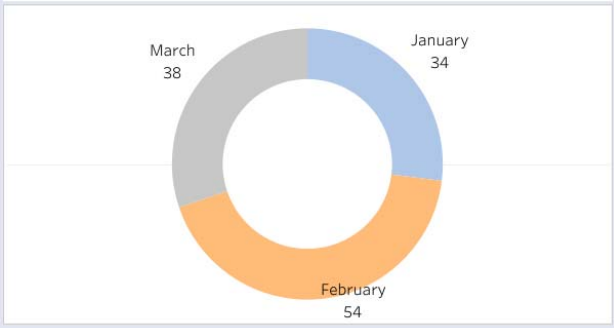
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY18/19 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: Janu.., Febr.., March

Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
126	540 Days	889 Days	▲ 349 Days

Medical Board of California
SFY18/19: Q3 - Investigations Cycle Time

Medical Board of California
SFY18/19: Q3 - Volume



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 Bu..

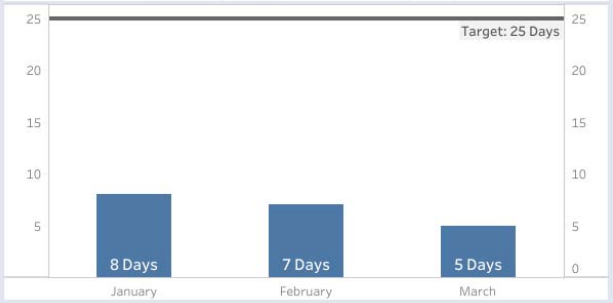
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2019 | Performance Measure: PM7 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: January, February, March

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

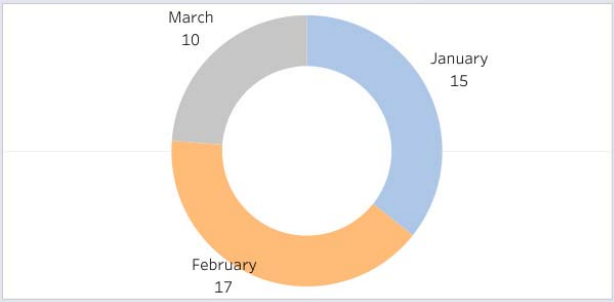
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
42	25 Days	7 Days	▼ -18 Days

Medical Board of California
SFY 2019: Q3 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2019: Q3 -PM7: Probation Cases



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 inst..

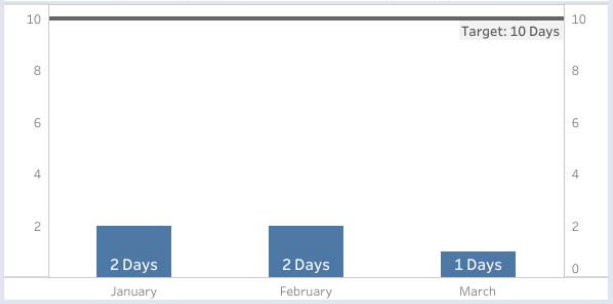
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2019 | Performance Measure: PM8 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: January, February, March

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

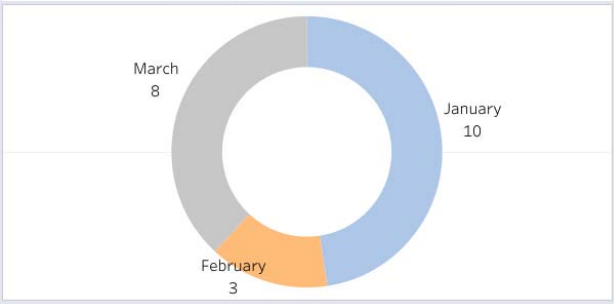
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
21	10 Days	2 Days	▼ -8 Days

Medical Board of California
SFY 2019: Q3 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2019: Q3 -PM8: Probation Violation Cases



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 inst..

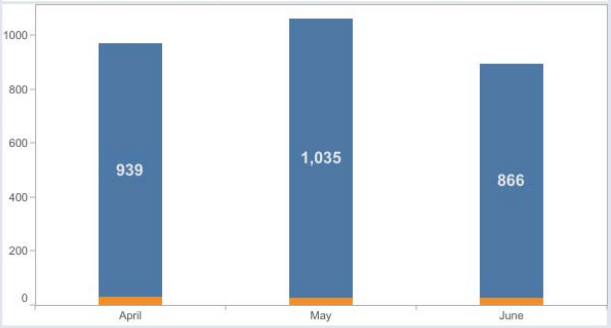
Enforcement Performance Measures
Q4 Report (April – June 2019)

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY18/19 | Select a Quarter: Q4 | Case Type: Complaints Volume, Conviction/Arrest Volume

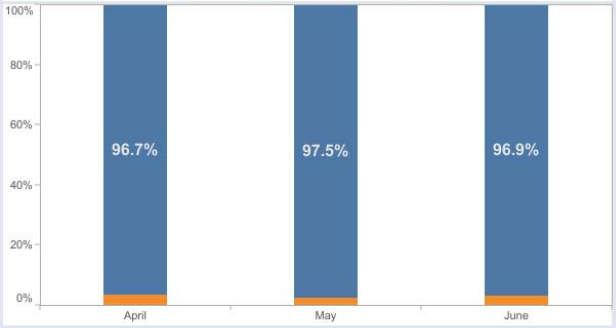
Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Complaints Volume	Conviction/Arrest Volume	Total Volume
2,840	86	2,926

Medical Board of California
SFY18/19:Q4 - Case Volume



Medical Board of California
SFY18/19:Q4 - Case Volume % Distribution



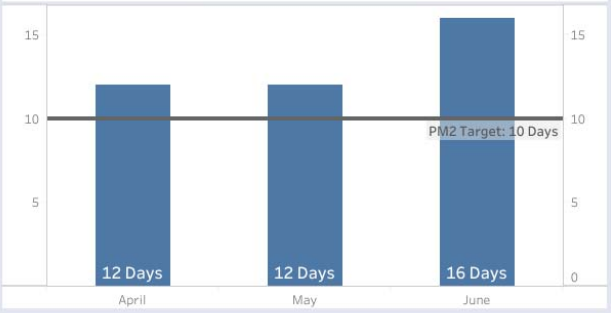
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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: SFY18/19 | Select a Quarter: Q4 | Intake Cycle Time: Actual, Target | Case Volume by Month: April, May, June

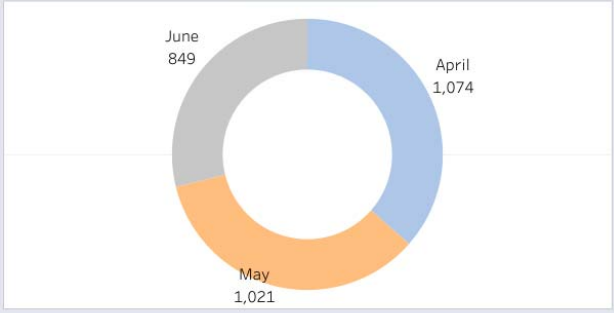
Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Case Volume	Target	Actual	Variance
2,944	10 Days	13 Days	▲ 3 Days

Medical Board of California
SFY18/19: Q4 - Intake Cycle Time



Medical Board of California
SFY18/19: Q4 - Volume



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.

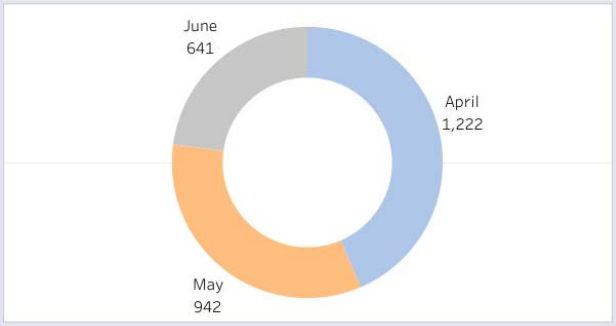
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY18/19 | Select a Quarter: Q4 | Intake Cycle Time: Actual, Target | Case Volume by Month: April, May, June

Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
2,805	125 Days	218 Days	▲ 93 Days

Medical Board of California
SFY18/19: Q4 - Investigations Cycle Time

Medical Board of California
SFY18/19: Q4 - Volume



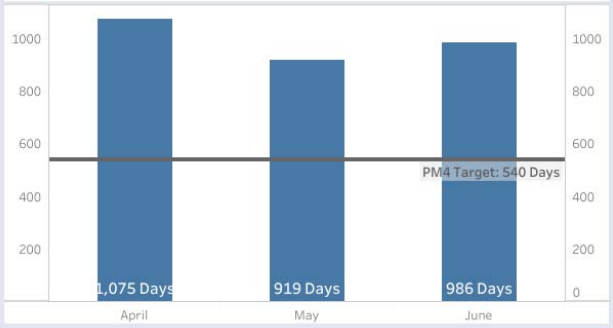
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bu..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY18/19 | Select a Quarter: Q4 | Intake Cycle Time: Actual, Target | Case Volume by Month: April, May, June

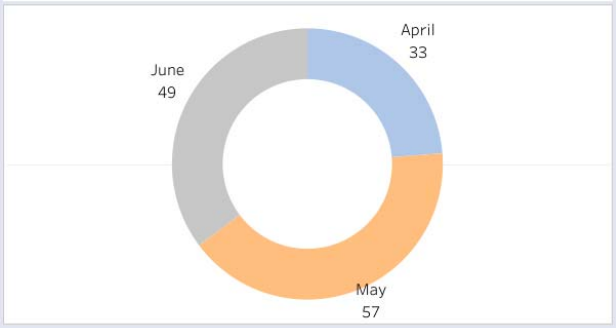
Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
139	540 Days	980 Days	▲ 440 Days

Medical Board of California
SFY18/19: Q4 - Investigations Cycle Time



Medical Board of California
SFY18/19: Q4 - Volume



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 Bu..

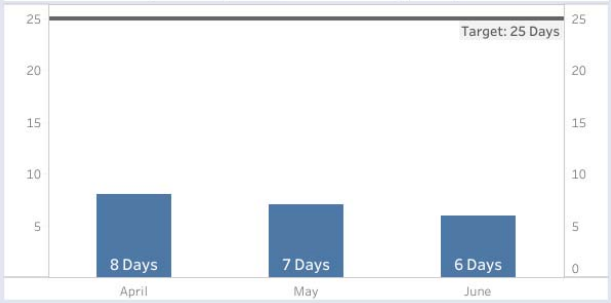
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2019	PM7	Q4	Actual Target	April May June

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

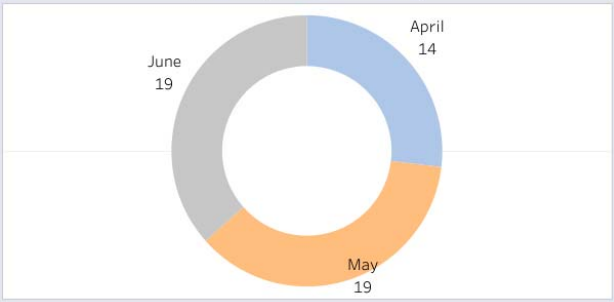
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
52	25 Days	7 Days	▼ -18 Days

Medical Board of California
SFY 2019: Q4 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2019: Q4 -PM7: Probation Cases



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 inst..

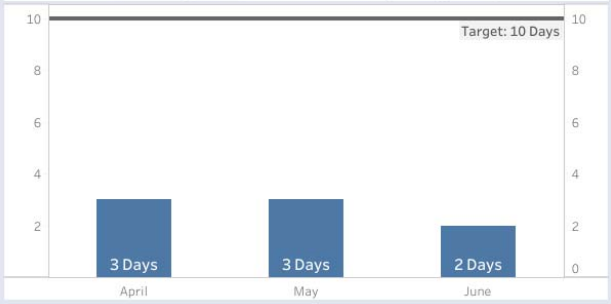
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2019	PM8	Q4	Actual Target	April May June

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

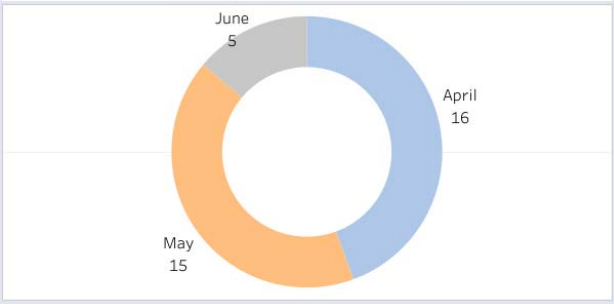
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
36	10 Days	3 Days	▼ -7 Days

Medical Board of California
SFY 2019: Q4 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2019: Q4 -PM8: Probation Violation Cases



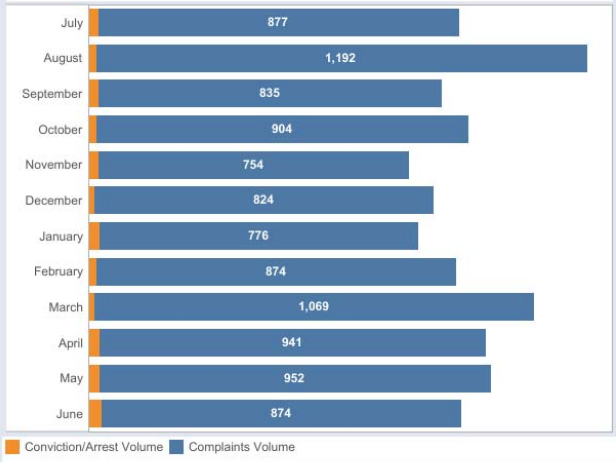
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some inst..

Enforcement Performance Measures
Annual Report (July 2017 – June 2018)

Board Name
Medical Board of California

State Fiscal Year
SFY17/18

Medical Board of California
SFY17/18: 12-Month | **PM1:** Case Volume by Type



Medical Board of California
SFY17/18: 12-Month | **PM1:** Summary

	Complaints Volume	Conviction/Arrest Volume	Total Volume
Grand Total	**10,872**	**283**	**11,155**
July	877	26	903
August	1,192	21	1,213
September	835	25	860
October	904	21	925
November	754	26	780
December	824	15	839
January	776	27	803
February	874	20	894
March	1,069	14	1,083
April	941	27	968
May	952	28	980
June	874	33	907

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.

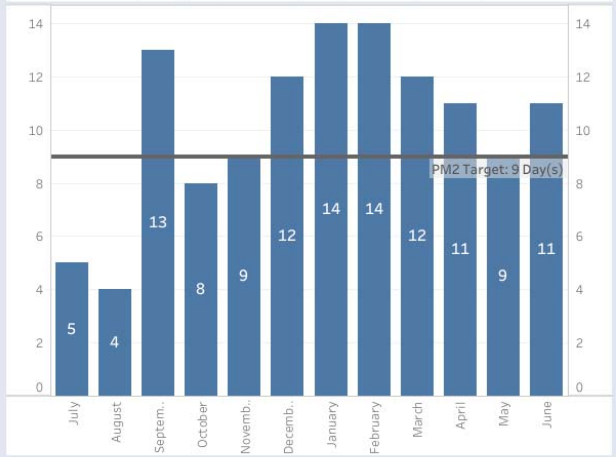
Select a DCA Entity
Medical Board of California

Select a Fiscal Year
SFY17/18

Intake Cycle Time
Actual Target

Cycle Time Performance versus Target
Above Target Below Target
At Target

Medical Board of California
SFY17/18: 12-Month | **PM2:** Intake Cycle Time



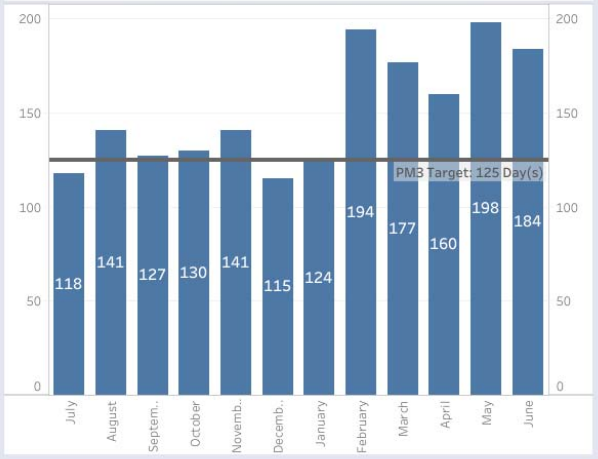
Medical Board of California
SFY17/18: 12-Month | **PM2:** Summary

	Case Volume	Target	Actual	Variance
Grand Tot..	10,846	9 Days	10 Days	▲ 1 Days
July	795	9 Days	5 Days	▼ -4 Days
August	1,133	9 Days	4 Days	▼ -5 Days
September	818	9 Days	13 Days	▲ 4 Days
October	1,027	9 Days	8 Days	▼ -1 Days
November	679	9 Days	9 Days	0 Days
December	839	9 Days	12 Days	▲ 3 Days
January	704	9 Days	14 Days	▲ 5 Days
February	885	9 Days	14 Days	▲ 5 Days
March	1,126	9 Days	12 Days	▲ 3 Days
April	1,000	9 Days	11 Days	▲ 2 Days
May	992	9 Days	9 Days	0 Days
June	848	9 Days	11 Days	▲ 2 Days

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: SFY17/18 | Intake Cycle Time: Actual, Target | Cycle Time Performance versus Target: Above Target, Below Target

Medical Board of California
SFY17/18: 12-Month | **PM3:** Intake Cycle Time



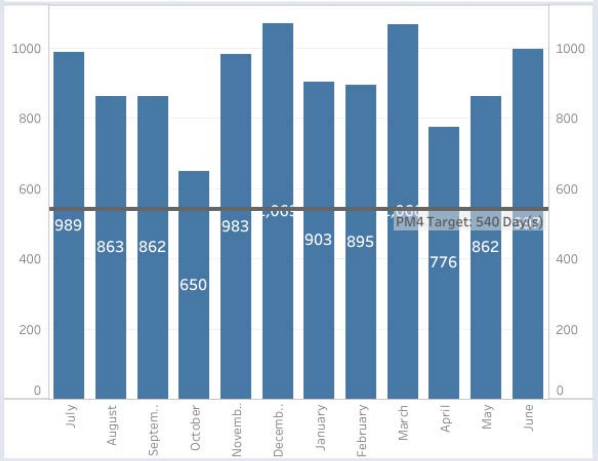
Medical Board of California
SFY17/18: 12-Month | **PM3:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	8,940	125 Days	148 Days	▲ 23 Days
July	728	125 Days	118 Days	▼ -7 Days
August	1,042	125 Days	141 Days	▲ 16 Days
September	717	125 Days	127 Days	▲ 2 Days
October	936	125 Days	130 Days	▲ 5 Days
November	874	125 Days	141 Days	▲ 16 Days
December	657	125 Days	115 Days	▼ -10 Days
January	763	125 Days	124 Days	▼ -1 Days
February	595	125 Days	194 Days	▲ 69 Days
March	803	125 Days	177 Days	▲ 52 Days
April	573	125 Days	160 Days	▲ 35 Days
May	632	125 Days	198 Days	▲ 73 Days
June	620	125 Days	184 Days	▲ 59 Days

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 | State Fiscal Year: SFY17/18 | Intake Cycle Time: Actual, Target | Cycle Time Performance versus Target: Above Target

Medical Board of California
SFY17/18: 12-Month | **PM4:** Intake Cycle Time



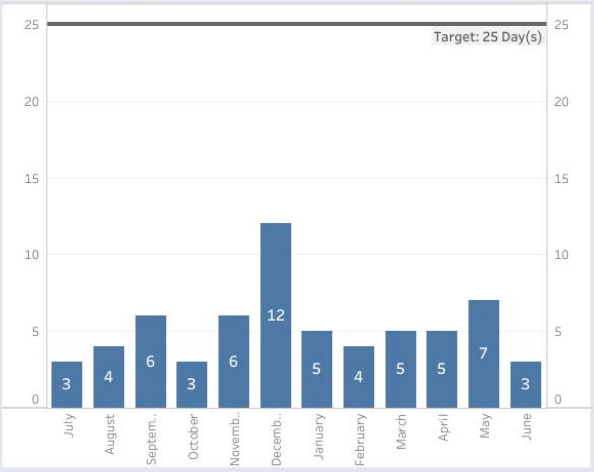
Medical Board of California
SFY17/18: 12-Month | **PM4:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	452	540 Days	921 Days	▲ 381 Days
July	38	540 Days	989 Days	▲ 449 Days
August	44	540 Days	863 Days	▲ 323 Days
September	45	540 Days	862 Days	▲ 322 Days
October	17	540 Days	650 Days	▲ 110 Days
November	31	540 Days	983 Days	▲ 443 Days
December	33	540 Days	1,069 Days	▲ 529 Days
January	34	540 Days	903 Days	▲ 363 Days
February	46	540 Days	895 Days	▲ 355 Days
March	54	540 Days	1,066 Days	▲ 526 Days
April	29	540 Days	776 Days	▲ 236 Days
May	56	540 Days	862 Days	▲ 322 Days
June	25	540 Days	997 Days	▲ 457 Days

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 2018 | Performance Measure: PM7 | Intake Cycle Time: Actual, Target | Cycle Time Performance versus Target: Below Target

Medical Board of California
SFY 2018: 12-Month | **PM7:** Probation Intake Cycle Time



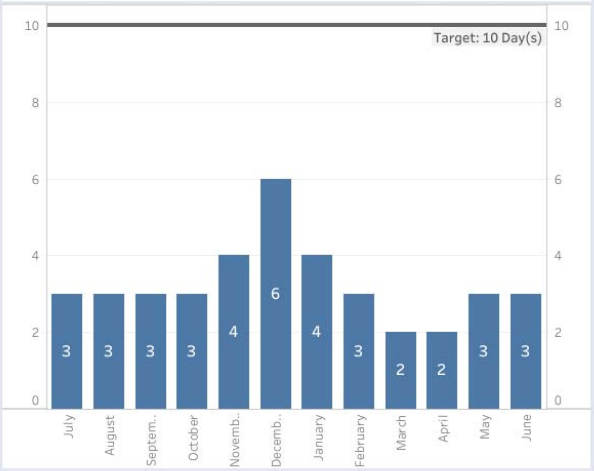
Medical Board of California
SFY 2018: 12-Month | **PM7:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	140	25 Days	5 Days	▼ -20 Days
July	13	25 Days	3 Days	▼ -22 Days
August	19	25 Days	4 Days	▼ -21 Days
September	8	25 Days	6 Days	▼ -19 Days
October	11	25 Days	3 Days	▼ -22 Days
November	12	25 Days	6 Days	▼ -19 Days
December	12	25 Days	12 Days	▼ -13 Days
January	12	25 Days	5 Days	▼ -20 Days
February	10	25 Days	4 Days	▼ -21 Days
March	10	25 Days	5 Days	▼ -20 Days
April	7	25 Days	5 Days	▼ -20 Days
May	16	25 Days	7 Days	▼ -18 Days
June	10	25 Days	3 Days	▼ -22 Days

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 2018 | Performance Measure: PM8 | Intake Cycle Time: Actual, Target | Cycle Time Performance versus Target: Below Target

Medical Board of California
SFY 2018: 12-Month | **PM8:** Probation Violation Response Cycle Time



Medical Board of California
SFY 2018: 12-Month | **PM8:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	398	10 Days	3 Days	▼ -7 Days
July	60	10 Days	3 Days	▼ -7 Days
August	22	10 Days	3 Days	▼ -7 Days
September	19	10 Days	3 Days	▼ -7 Days
October	60	10 Days	3 Days	▼ -7 Days
November	23	10 Days	4 Days	▼ -6 Days
December	23	10 Days	6 Days	▼ -4 Days
January	68	10 Days	4 Days	▼ -6 Days
February	30	10 Days	3 Days	▼ -7 Days
March	19	10 Days	2 Days	▼ -8 Days
April	38	10 Days	2 Days	▼ -8 Days
May	20	10 Days	3 Days	▼ -7 Days
June	16	10 Days	3 Days	▼ -7 Days

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.

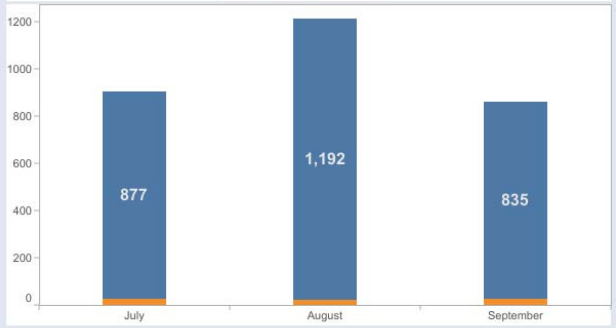
Enforcement Performance Measures
Q1 Report (July – September 2017)

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY17/18 | Select a Quarter: Q1 | Case Type: Complaints Volume, Conviction/Arrest Volume

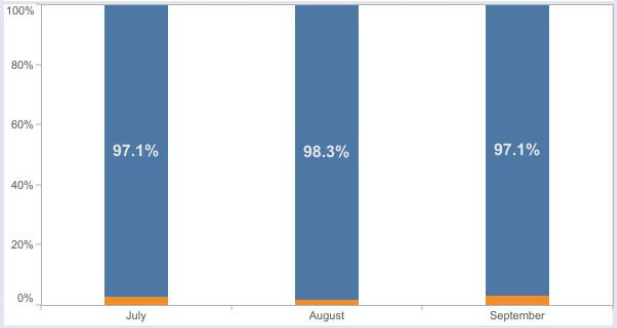
Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Complaints Volume	Conviction/Arrest Volume	Total Volume
2,904	72	2,976

Medical Board of California
SFY17/18:Q1 - Case Volume



Medical Board of California
SFY17/18:Q1 - Case Volume % Distribution



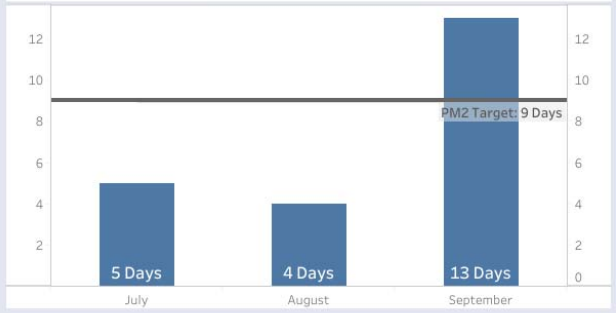
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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: SFY17/18 | Select a Quarter: Q1 | Intake Cycle Time: Actual, Target | Case Volume by Month: July, August, Septemb..

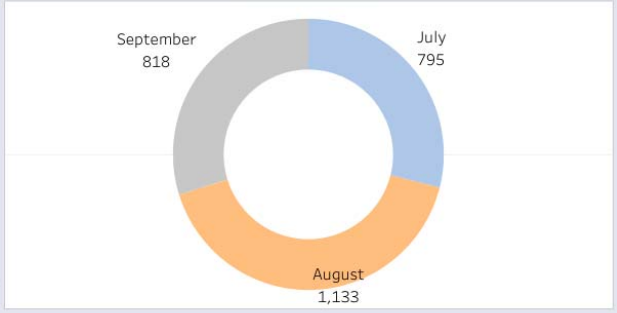
Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Case Volume	Target	Actual	Variance
2,746	9 Days	7 Days	▼ -2 Days

Medical Board of California
SFY17/18: Q1 - Intake Cycle Time



Medical Board of California
SFY17/18: Q1 - Volume



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.

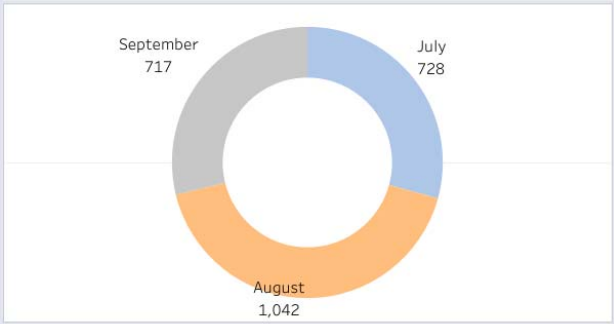
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY17/18 | Select a Quarter: Q1 | Intake Cycle Time: Actual, Target | Case Volume by Month: July, August, Septemb..

Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
2,487	125 Days	130 Days	▲ 5 Days

Medical Board of California
SFY17/18: Q1 - Investigations Cycle Time

Medical Board of California
SFY17/18: Q1 - Volume



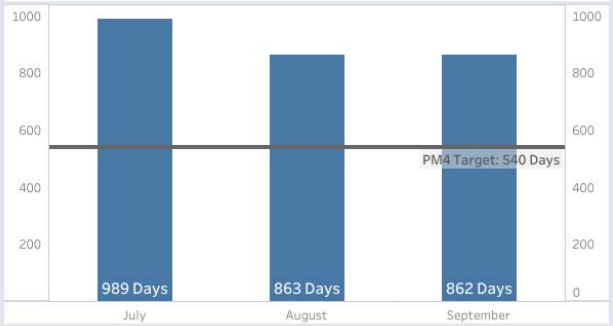
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bu..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY17/18 | Select a Quarter: Q1 | Intake Cycle Time: Actual, Target | Case Volume by Month: July, Augu.., Sept..

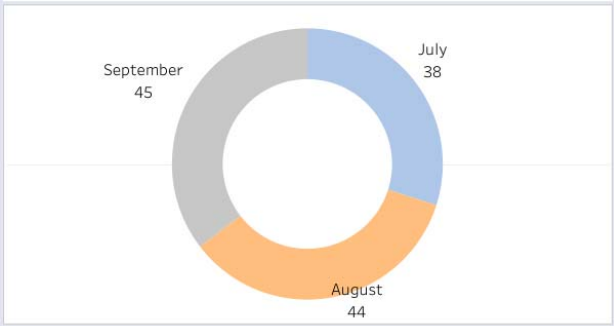
Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
127	540 Days	900 Days	▲ 360 Days

Medical Board of California
SFY17/18: Q1 - Investigations Cycle Time



Medical Board of California
SFY17/18: Q1 - Volume



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 Bu..

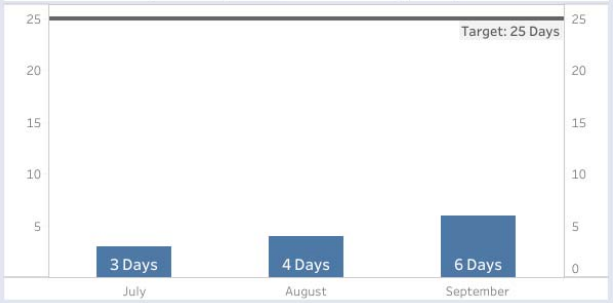
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2018 | Performance Measure: PM7 | Select a Quarter: Q1 | Intake Cycle Time: Actual, Target | Case Volume by Month: July, August, Septemb..

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

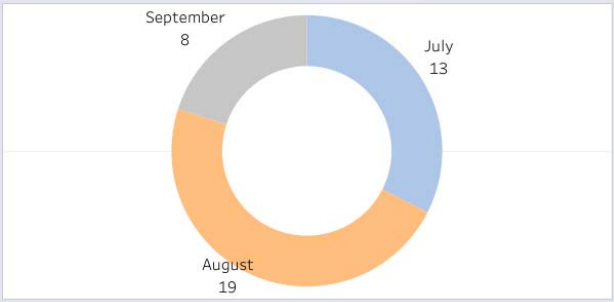
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
40	25 Days	4 Days	▼ -21 Days

Medical Board of California
SFY 2018: Q1 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2018: Q1 -PM7: Probation Cases



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 inst..

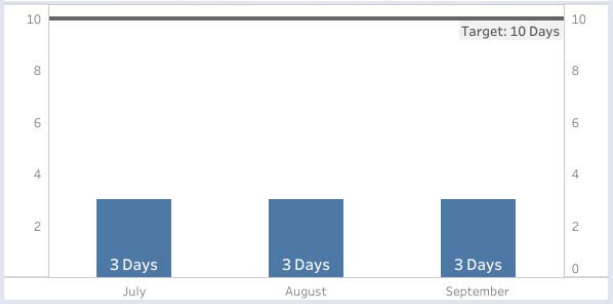
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2018 | Performance Measure: PM8 | Select a Quarter: Q1 | Intake Cycle Time: Actual, Target | Case Volume by Month: July, August, Septemb..

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

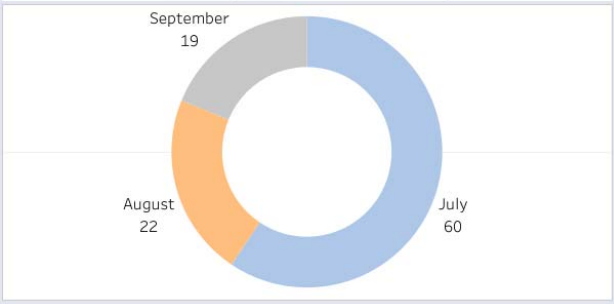
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
101	10 Days	3 Days	▼ -7 Days

Medical Board of California
SFY 2018: Q1 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2018: Q1 -PM8: Probation Violation Cases



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 inst..

Enforcement Performance Measures
Q2 Report (October – December 2017)

Select a DCA Entity
Medical Board of California

Select a Fiscal Year
SFY17/18

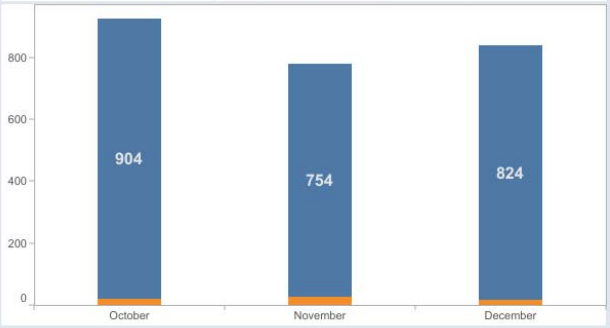
Select a Quarter
Q2

Case Type
Complaints Volume
Conviction/Arrest Volume

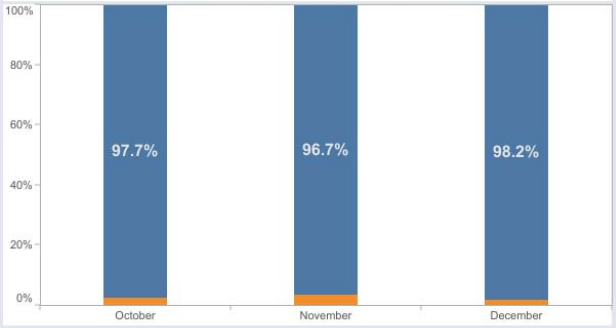
Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Complaints Volume	Conviction/Arrest Volume	Total Volume
2,482	62	2,544

Medical Board of California
SFY17/18:Q2 - Case Volume



Medical Board of California
SFY17/18:Q2 - Case Volume % Distribution



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
SFY17/18

Select a Quarter
Q2

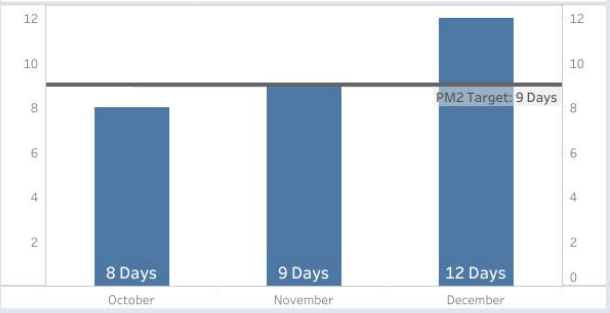
Intake Cycle Time
Actual
Target

Case Volume by Month
October
Novemb..
December

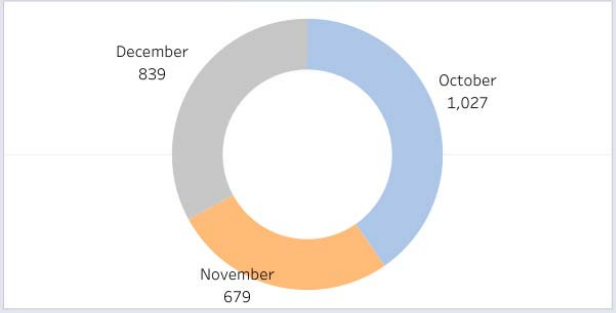
Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Case Volume	Target	Actual	Variance
2,545	9 Days	10 Days	▲ 1 Days

Medical Board of California
SFY17/18: Q2 - Intake Cycle Time



Medical Board of California
SFY17/18: Q2 - Volume



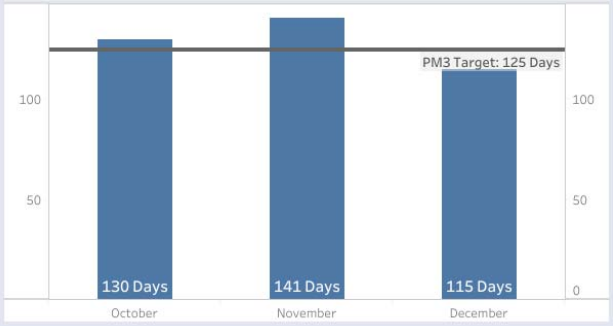
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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: SFY17/18 | Select a Quarter: Q2 | Intake Cycle Time: Actual, Target | Case Volume by Month: October, Novemb.., December

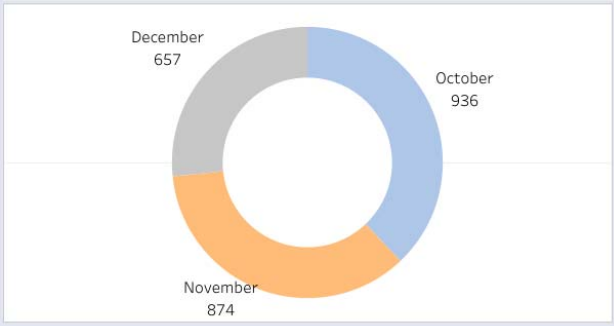
Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
2,467	125 Days	130 Days	▲ 5 Days

Medical Board of California
SFY17/18: Q2 - Investigations Cycle Time



Medical Board of California
SFY17/18: Q2 - Volume



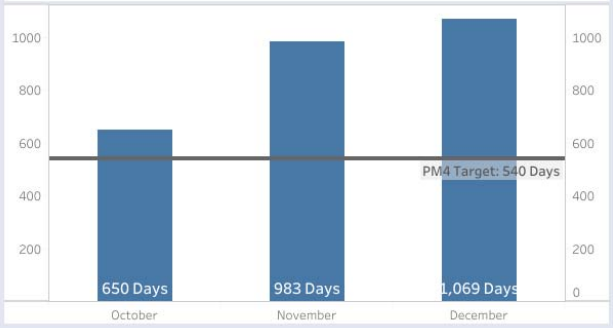
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bu..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY17/18 | Select a Quarter: Q2 | Intake Cycle Time: Actual, Target | Case Volume by Month: Octo.., Nove.., Dece..

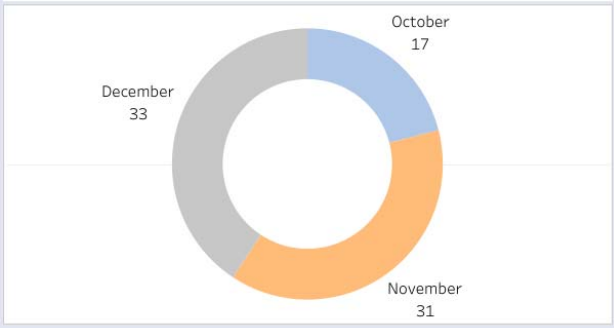
Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
81	540 Days	948 Days	▲ 408 Days

Medical Board of California
SFY17/18: Q2 - Investigations Cycle Time



Medical Board of California
SFY17/18: Q2 - Volume



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 Bu..

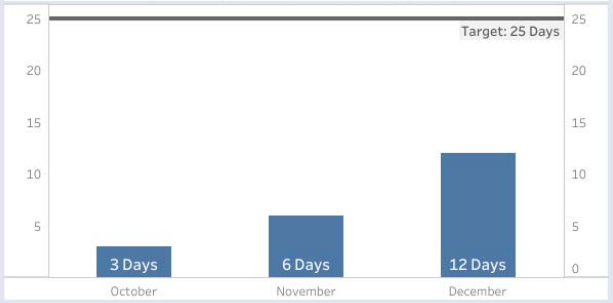
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2018	PM7	Q2	Actual Target	October Novemb.. December

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

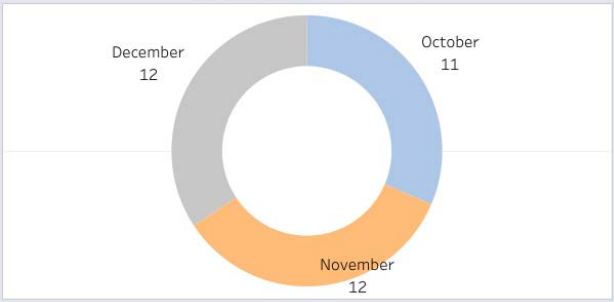
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
35	25 Days	7 Days	▼ -18 Days

Medical Board of California
SFY 2018: Q2 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2018: Q2 -PM7: Probation Cases



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 inst..

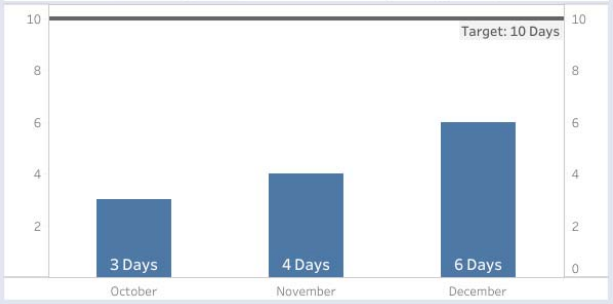
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2018	PM8	Q2	Actual Target	October Novemb.. December

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

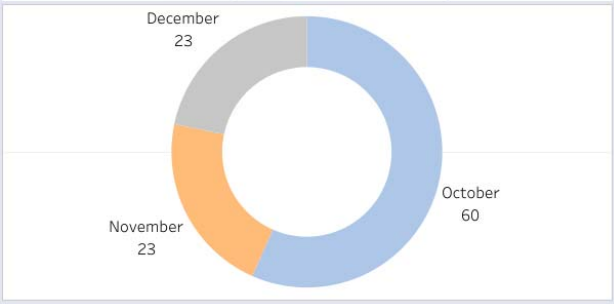
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
106	10 Days	4 Days	▼ -6 Days

Medical Board of California
SFY 2018: Q2 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2018: Q2 -PM8: Probation Violation Cases



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 inst..

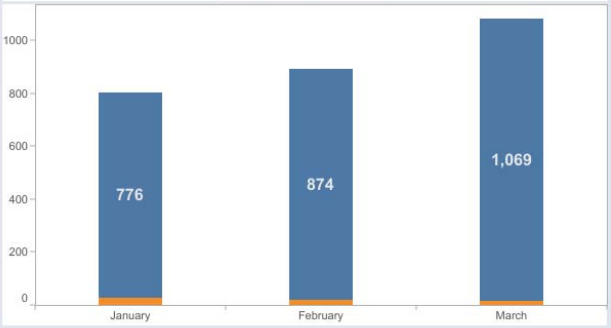
Enforcement Performance Measures
Q3 Report (January – March 2018)

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY17/18 | Select a Quarter: Q3 | Case Type: Complaints Volume, Conviction/Arrest Volume

Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Complaints Volume	Conviction/Arrest Volume	Total Volume
2,719	61	2,780

Medical Board of California
SFY17/18:Q3 - Case Volume



Medical Board of California
SFY17/18:Q3 - Case Volume % Distribution

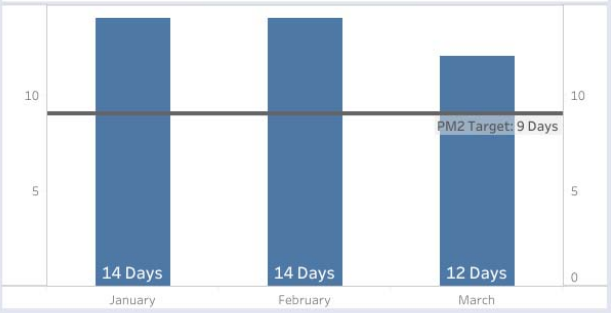
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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: SFY17/18 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: January, February, March

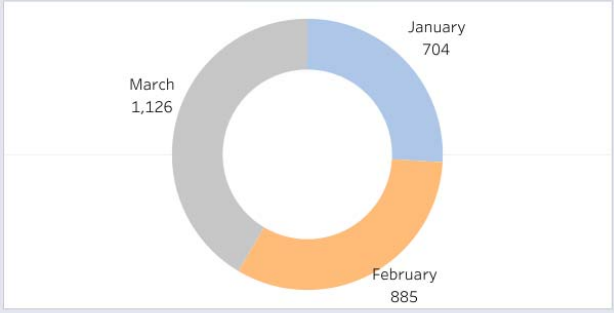
Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Case Volume	Target	Actual	Variance
2,715	9 Days	13 Days	▲ 4 Days

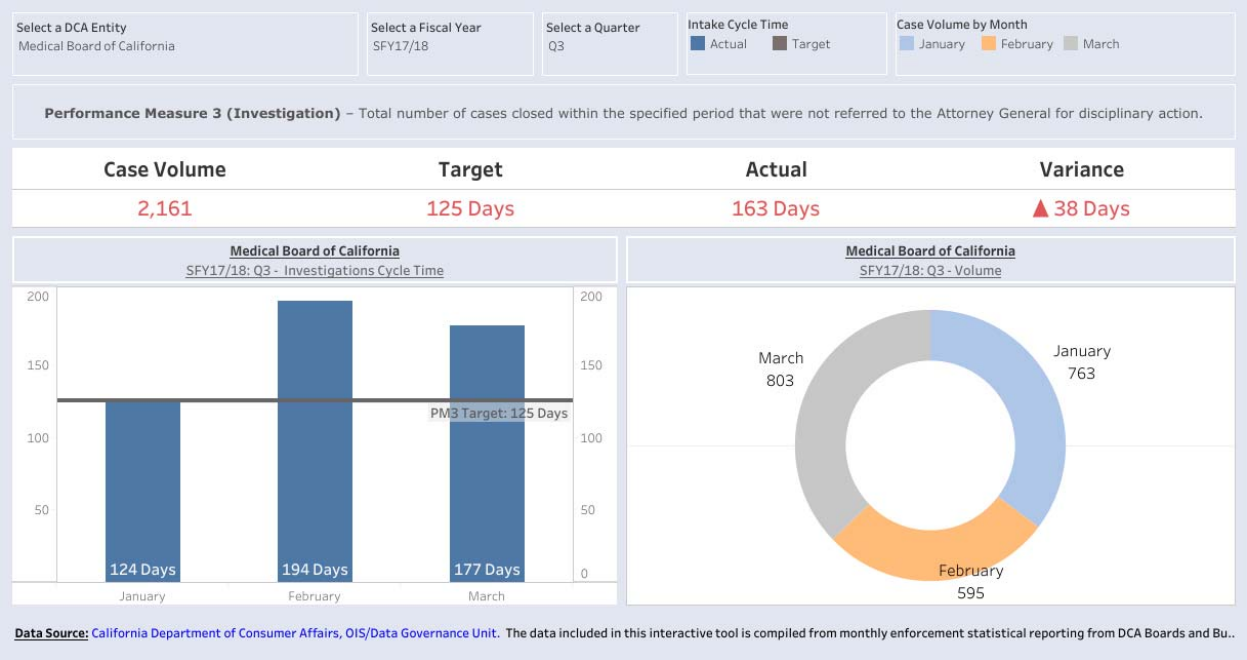
Medical Board of California
SFY17/18: Q3 - Intake Cycle Time

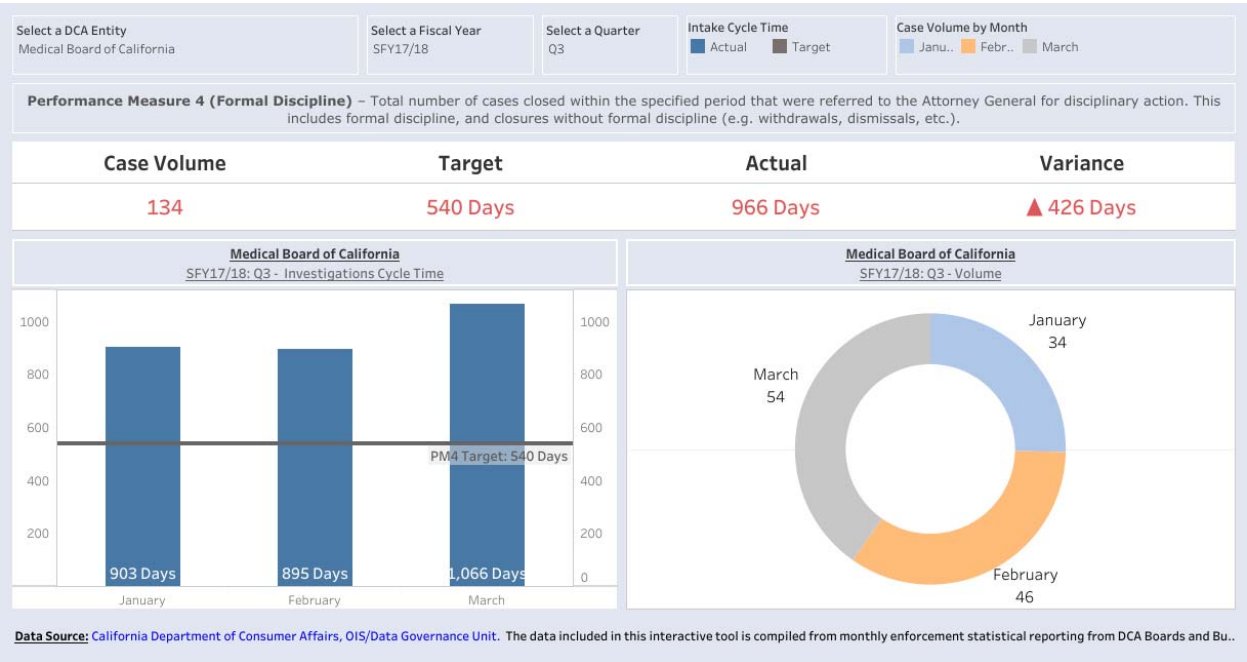


Medical Board of California
SFY17/18: Q3 - Volume



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
SFY17/18
Select a Quarter
Q3
Intake Cycle Time
Actual
Target
Case Volume by Month
January
February
March
Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.
Case Volume
Target
Actual
Variance
2,161
125 Days
163 Days
▲ 38 Days
Medical Board of California
SFY17/18: Q3 - Investigations Cycle Time
200
150
100
50
0
PM3 Target: 125 Days
124 Days
194 Days
177 Days
January
February
March
Medical Board of California
SFY17/18: Q3 - Volume
March
803
January
763
February
595
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 Bu..


Select a DCA Entity
Medical Board of California
Select a Fiscal Year
SFY17/18
Select a Quarter
Q3
Intake Cycle Time
Actual
Target
Case Volume by Month
Janu..
Febr..
March
Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).
Case Volume
Target
Actual
Variance
134
540 Days
966 Days
▲ 426 Days
Medical Board of California
SFY17/18: Q3 - Investigations Cycle Time
1000
800
600
400
200
0
PM4 Target: 540 Days
903 Days
895 Days
1,066 Days
January
February
March
Medical Board of California
SFY17/18: Q3 - Volume
January
34
March
54
February
46
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 Bu..

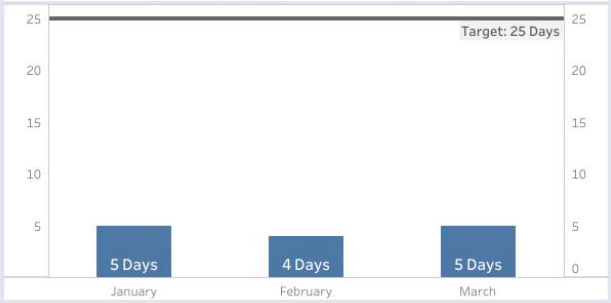
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2018 | Performance Measure: PM7 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: January, February, March

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

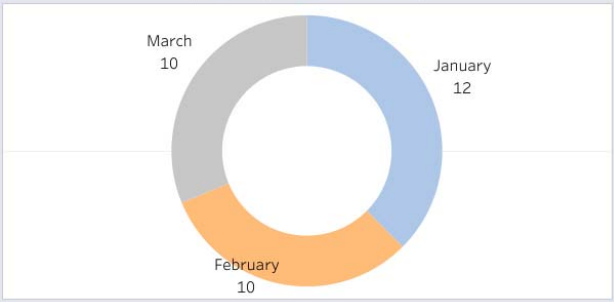
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
32	25 Days	5 Days	▼ -20 Days

Medical Board of California
SFY 2018: Q3 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2018: Q3 -PM7: Probation Cases



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 inst..

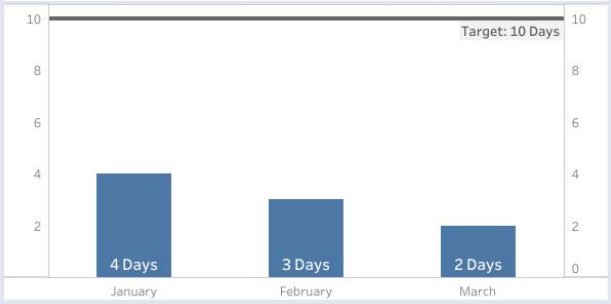
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2018 | Performance Measure: PM8 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: January, February, March

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

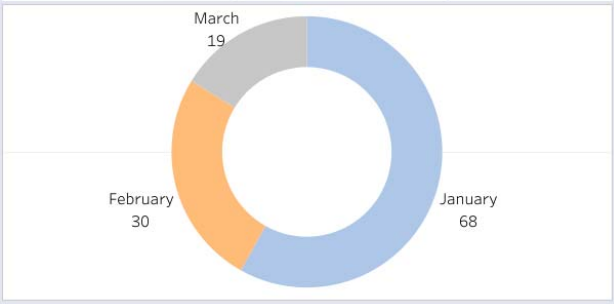
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
117	10 Days	3 Days	▼ -7 Days

Medical Board of California
SFY 2018: Q3 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2018: Q3 -PM8: Probation Violation Cases



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 inst..

Enforcement Performance Measures
Q4 Report (April – June 2018)

Select a DCA Entity
Medical Board of California

Select a Fiscal Year
SFY17/18

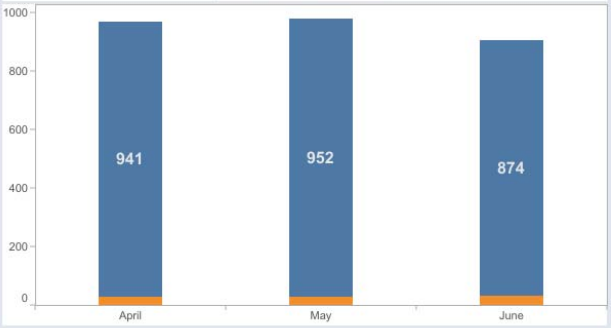
Select a Quarter
Q4

Case Type
Complaints Volume
Conviction/Arrest Volume

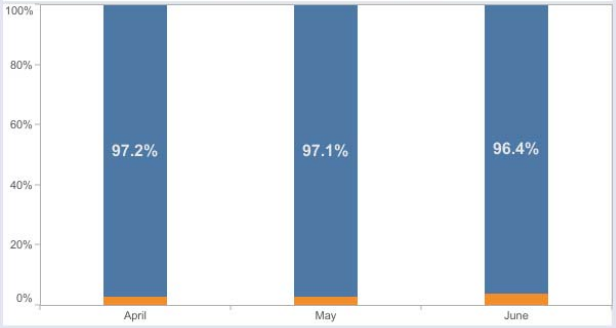
Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Complaints Volume	Conviction/Arrest Volume	Total Volume
2,767	88	2,855

Medical Board of California
SFY17/18:Q4 - Case Volume



Medical Board of California
SFY17/18:Q4 - Case Volume % Distribution



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
SFY17/18

Select a Quarter
Q4

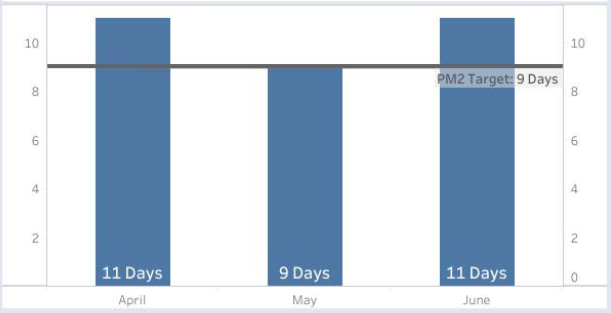
Intake Cycle Time
Actual
Target

Case Volume by Month
April
May
June

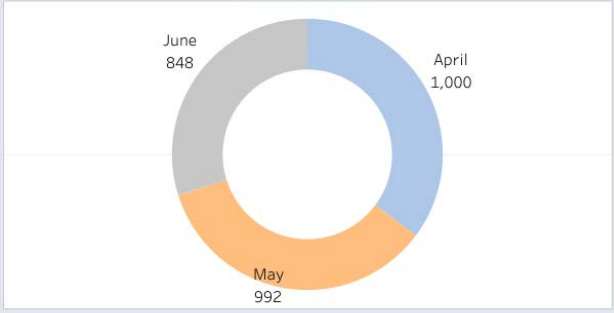
Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Case Volume	Target	Actual	Variance
2,840	9 Days	10 Days	▲ 1 Days

Medical Board of California
SFY17/18: Q4 - Intake Cycle Time



Medical Board of California
SFY17/18: Q4 - Volume



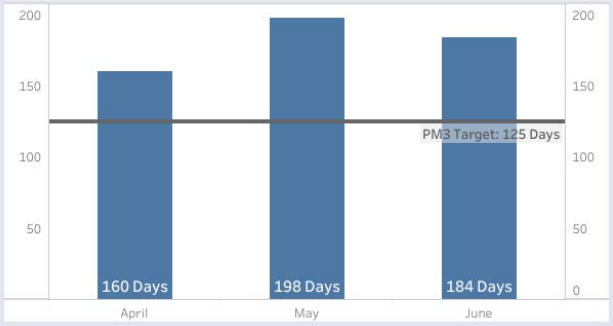
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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: SFY17/18 | Select a Quarter: Q4 | Intake Cycle Time: Actual, Target | Case Volume by Month: April, May, June

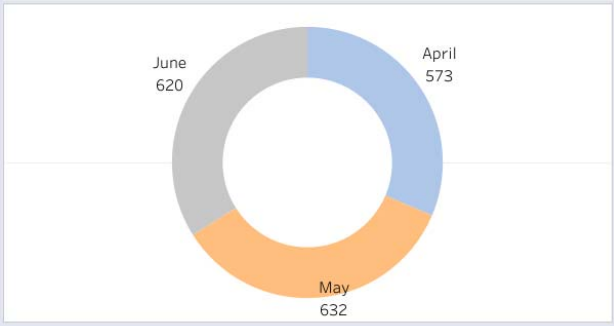
Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
1,825	125 Days	181 Days	▲ 56 Days

Medical Board of California
SFY17/18: Q4 - Investigations Cycle Time



Medical Board of California
SFY17/18: Q4 - Volume



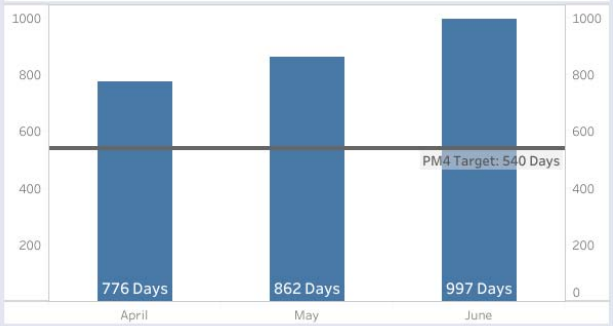
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bu..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY17/18 | Select a Quarter: Q4 | Intake Cycle Time: Actual, Target | Case Volume by Month: April, May, June

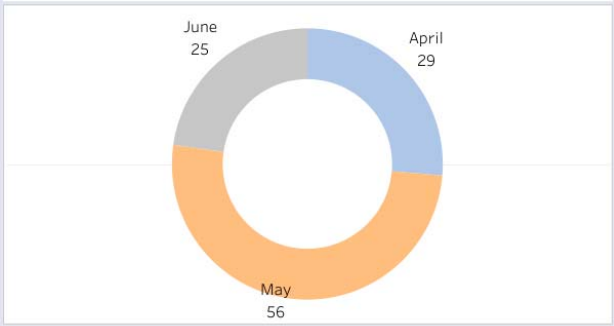
Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
110	540 Days	870 Days	▲ 330 Days

Medical Board of California
SFY17/18: Q4 - Investigations Cycle Time



Medical Board of California
SFY17/18: Q4 - Volume



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 Bu..

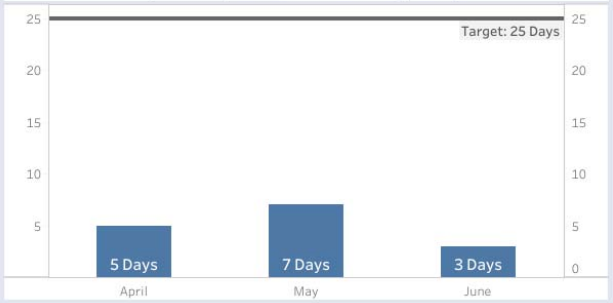
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2018	PM7	Q4	Actual Target	April May June

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

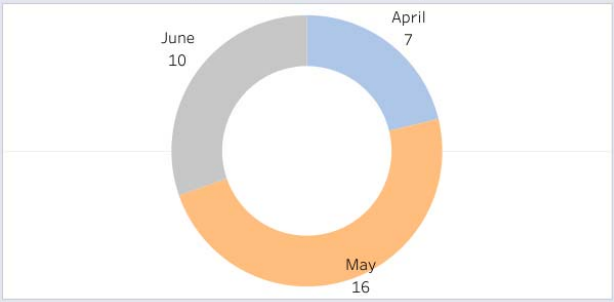
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
33	25 Days	5 Days	▼ -20 Days

Medical Board of California
SFY 2018: Q4 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2018: Q4 -PM7: Probation Cases



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 inst..

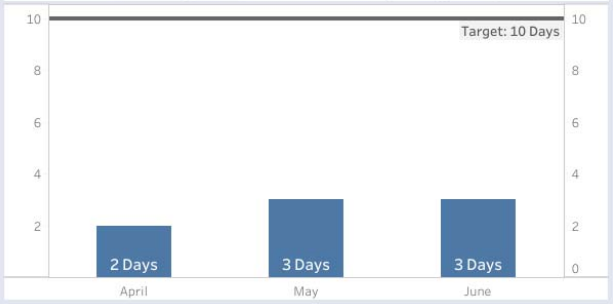
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2018	PM8	Q4	Actual Target	April May June

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

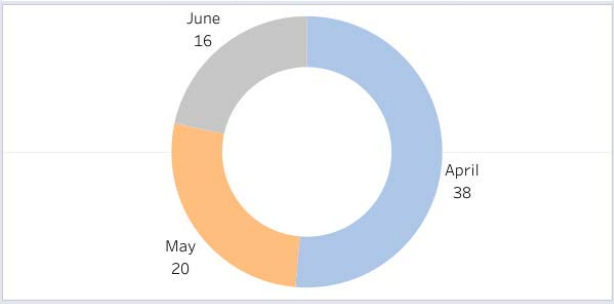
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
74	10 Days	2 Days	▼ -8 Days

Medical Board of California
SFY 2018: Q4 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2018: Q4 -PM8: Probation Violation Cases



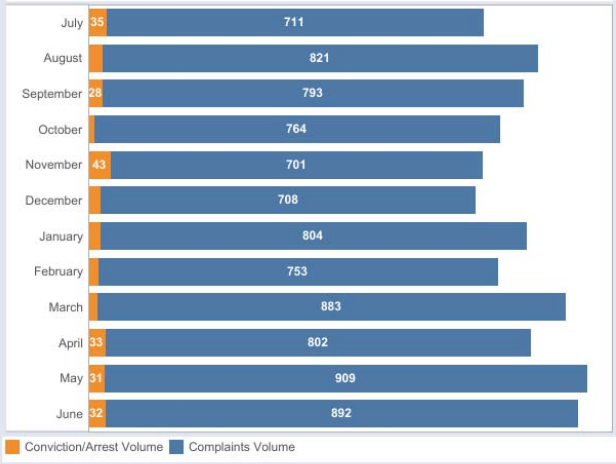
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some inst..

Enforcement Performance Measures
Annual Report (July 2016 – June 2017)

Board Name
Medical Board of California

State Fiscal Year
SFY16/17

Medical Board of California
SFY16/17: 12-Month | **PM1:** Case Volume by Type



Medical Board of California
SFY16/17: 12-Month | **PM1:** Summary

	Complaints Volume	Conviction/Arrest Volume	Total Volume
Grand Total	**9,541**	**325**	**9,866**
July	711	35	746
August	821	27	848
September	793	28	821
October	764	12	776
November	701	43	744
December	708	23	731
January	804	23	827
February	753	20	773
March	883	18	901
April	802	33	835
May	909	31	940
June	892	32	924

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.

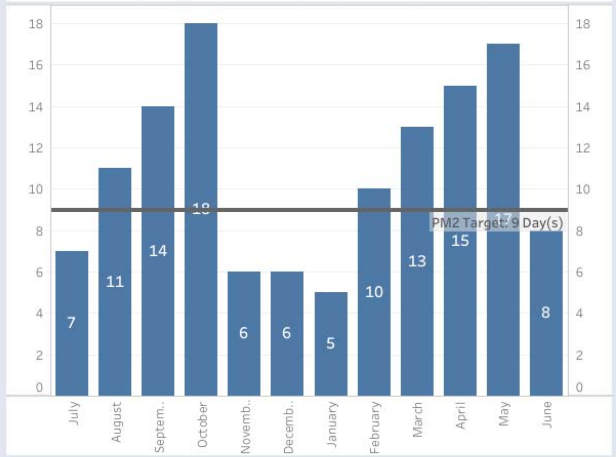
Select a DCA Entity
Medical Board of California

Select a Fiscal Year
SFY16/17

Intake Cycle Time
Actual Target

Cycle Time Performance versus Target
Above Target
Below Target

Medical Board of California
SFY16/17: 12-Month | **PM2:** Intake Cycle Time



Medical Board of California
SFY16/17: 12-Month | **PM2:** Summary

	Case Volume	Target	Actual	Variance
Grand Tot..	9,986	9 Days	11 Days	▲ 2 Days
July	605	9 Days	7 Days	▼ -2 Days
August	790	9 Days	11 Days	▲ 2 Days
September	673	9 Days	14 Days	▲ 5 Days
October	1,131	9 Days	18 Days	▲ 9 Days
November	763	9 Days	6 Days	▼ -3 Days
December	790	9 Days	6 Days	▼ -3 Days
January	691	9 Days	5 Days	▼ -4 Days
February	646	9 Days	10 Days	▲ 1 Days
March	755	9 Days	13 Days	▲ 4 Days
April	789	9 Days	15 Days	▲ 6 Days
May	1,135	9 Days	17 Days	▲ 8 Days
June	1,218	9 Days	8 Days	▼ -1 Days

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.

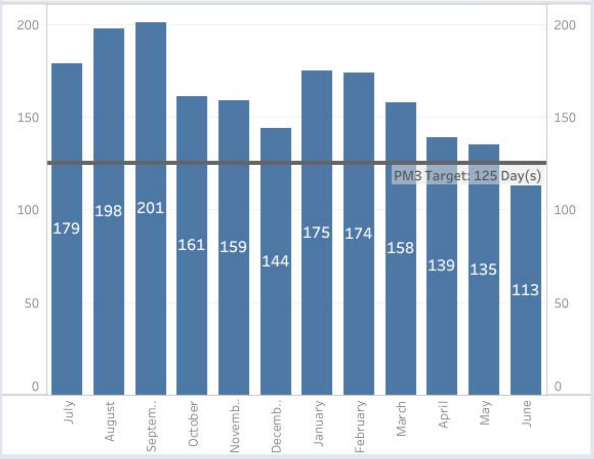
Select a DCA Entity: Medical Board of California

Select a Fiscal Year: SFY16/17

Intake Cycle Time: Actual, Target

Cycle Time Performance versus Target: Above Target, Below Target

Medical Board of California
SFY16/17: 12-Month | **PM3:** Intake Cycle Time



Medical Board of California
SFY16/17: 12-Month | **PM3:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	9,955	125 Days	159 Days	▲ 34 Days
July	747	125 Days	179 Days	▲ 54 Days
August	679	125 Days	198 Days	▲ 73 Days
September	680	125 Days	201 Days	▲ 76 Days
October	904	125 Days	161 Days	▲ 36 Days
November	803	125 Days	159 Days	▲ 34 Days
December	882	125 Days	144 Days	▲ 19 Days
January	809	125 Days	175 Days	▲ 50 Days
February	882	125 Days	174 Days	▲ 49 Days
March	958	125 Days	158 Days	▲ 33 Days
April	741	125 Days	139 Days	▲ 14 Days
May	840	125 Days	135 Days	▲ 10 Days
June	1,030	125 Days	113 Days	▼ -12 Days

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.

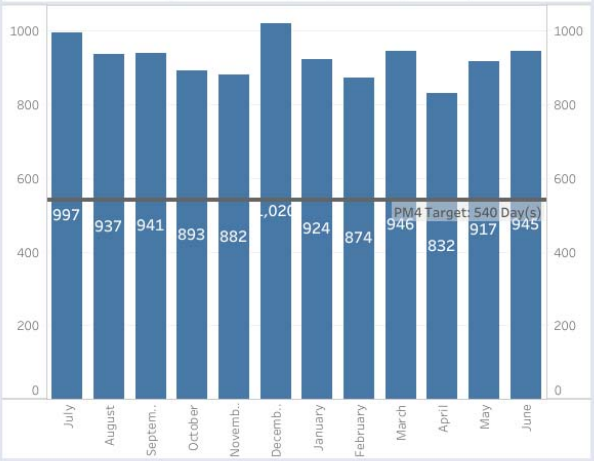
Select a DCA Entity: Medical Board of California

State Fiscal Year: SFY16/17

Intake Cycle Time: Actual, Target

Cycle Time Performance versus Target: Above Target

Medical Board of California
SFY16/17: 12-Month | **PM4:** Intake Cycle Time



Medical Board of California
SFY16/17: 12-Month | **PM4:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	519	540 Days	936 Days	▲ 396 Days
July	34	540 Days	997 Days	▲ 457 Days
August	42	540 Days	937 Days	▲ 397 Days
September	64	540 Days	941 Days	▲ 401 Days
October	22	540 Days	893 Days	▲ 353 Days
November	27	540 Days	882 Days	▲ 342 Days
December	68	540 Days	1,020 Days	▲ 480 Days
January	37	540 Days	924 Days	▲ 384 Days
February	31	540 Days	874 Days	▲ 334 Days
March	60	540 Days	946 Days	▲ 406 Days
April	35	540 Days	832 Days	▲ 292 Days
May	50	540 Days	917 Days	▲ 377 Days
June	49	540 Days	945 Days	▲ 405 Days

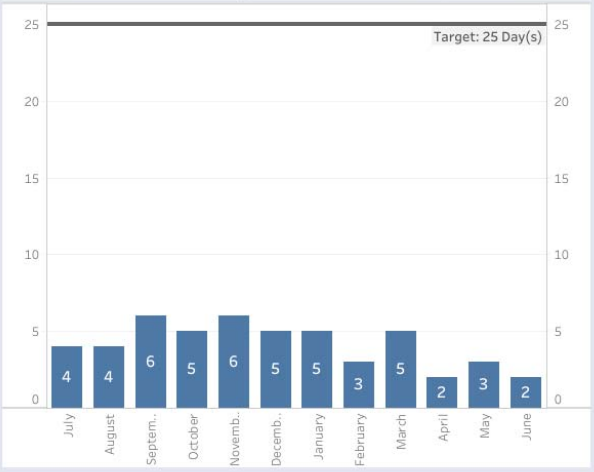
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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 2017 | Performance Measure: PM7

Intake Cycle Time: Actual, Target

Cycle Time Performance versus Target: Below Target

Medical Board of California
SFY 2017: 12-Month | **PM7:** Probation Intake Cycle Time



Medical Board of California
SFY 2017: 12-Month | **PM7:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	191	25 Days	4 Days	▼ -21 Days
July	16	25 Days	4 Days	▼ -21 Days
August	13	25 Days	4 Days	▼ -21 Days
September	11	25 Days	6 Days	▼ -19 Days
October	15	25 Days	5 Days	▼ -20 Days
November	26	25 Days	6 Days	▼ -19 Days
December	18	25 Days	5 Days	▼ -20 Days
January	22	25 Days	5 Days	▼ -20 Days
February	20	25 Days	3 Days	▼ -22 Days
March	9	25 Days	5 Days	▼ -20 Days
April	11	25 Days	2 Days	▼ -23 Days
May	20	25 Days	3 Days	▼ -22 Days
June	10	25 Days	2 Days	▼ -23 Days

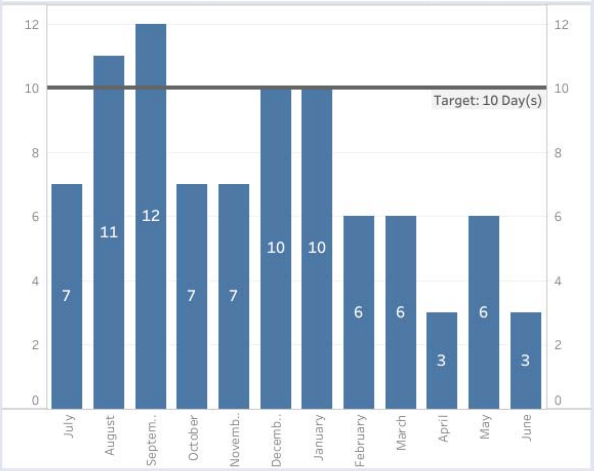
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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 2017 | Performance Measure: PM8

Intake Cycle Time: Actual, Target

Cycle Time Performance versus Target: Above Target, At Target, Below Target

Medical Board of California
SFY 2017: 12-Month | **PM8:** Probation Violation Response Cycle Time

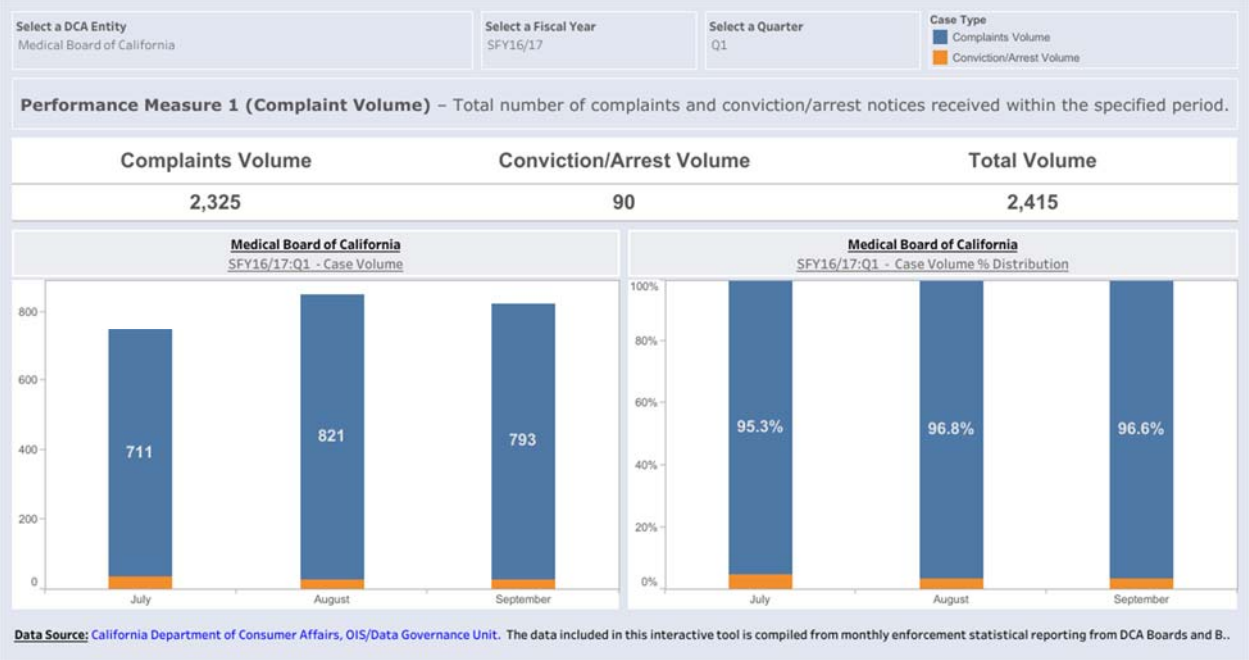


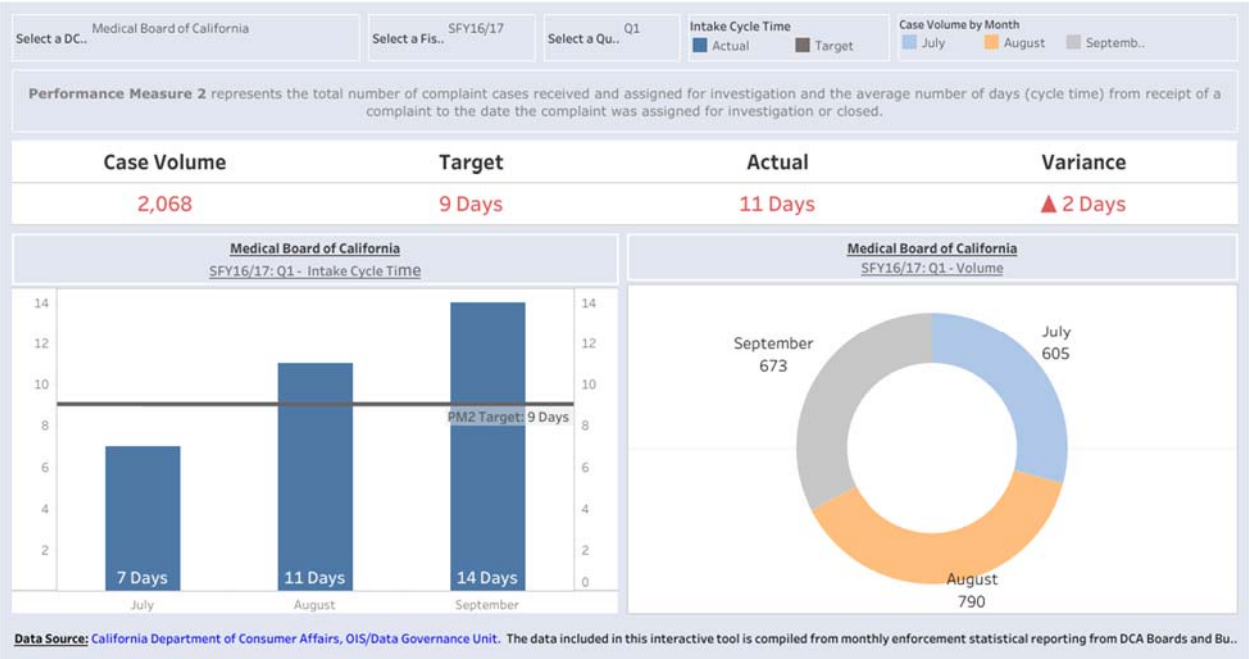
Medical Board of California
SFY 2017: 12-Month | **PM8:** Summary

	Case Volume	Target	Actual	Variance
Grand Total	295	10 Days	6 Days	▼ -4 Days
July	8	10 Days	7 Days	▼ -3 Days
August	22	10 Days	11 Days	▲ 1 Days
September	17	10 Days	12 Days	▲ 2 Days
October	8	10 Days	7 Days	▼ -3 Days
November	9	10 Days	7 Days	▼ -3 Days
December	18	10 Days	10 Days	0 Days
January	10	10 Days	10 Days	0 Days
February	24	10 Days	6 Days	▼ -4 Days
March	45	10 Days	6 Days	▼ -4 Days
April	52	10 Days	3 Days	▼ -7 Days
May	44	10 Days	6 Days	▼ -4 Days
June	38	10 Days	3 Days	▼ -7 Days

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.

Enforcement Performance Measures
Q1 Report (July – September 2016)

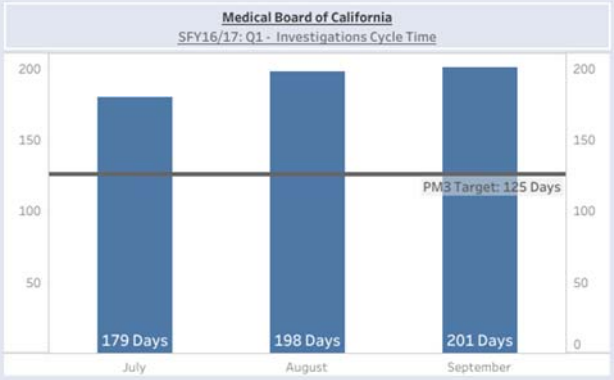


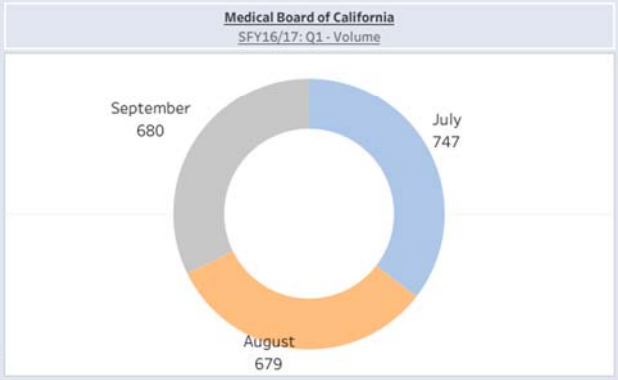


Select a DC.. Medical Board of California | Select a Fis.. SFY16/17 | Select a Qu.. Q1 | Intake Cycle Time: Actual, Target | Case Volume by Month: July, August, Septemb..

Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
2,106	125 Days	192 Days	▲ 67 Days



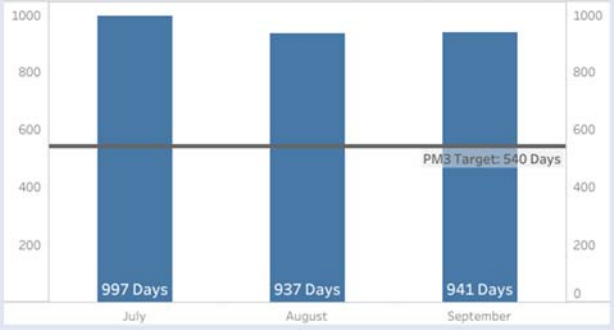


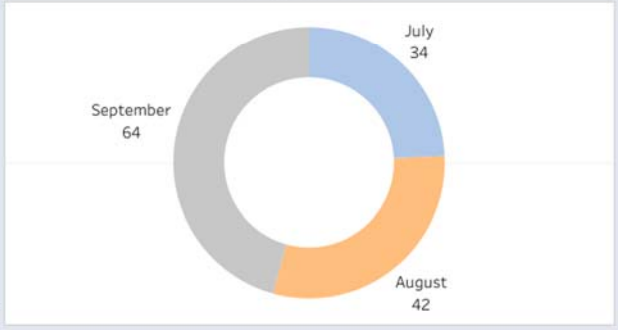
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bu..

Select a DC.. Medical Board of California | Select a Fis.. SFY16/17 | Select a Qu.. Q1 | Intake Cycle Time: Actual, Target | Case Volume by Month: July, Augu.., Sept..

Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
140	540 Days	953 Days	▲ 413 Days





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 Bu..

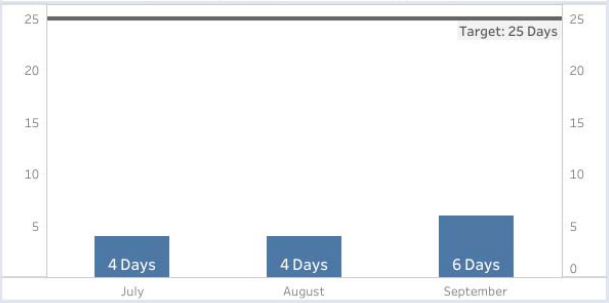
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2017	PM7	Q1	Actual Target	July August Septemb..

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

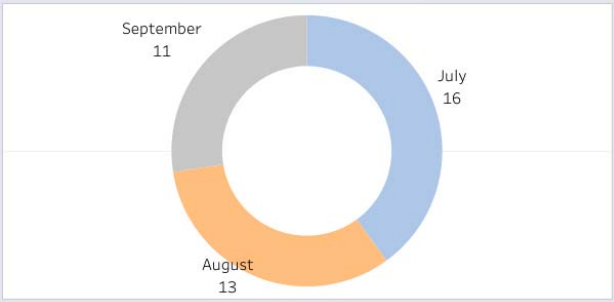
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
40	25 Days	5 Days	▼ -20 Days

Medical Board of California
SFY 2017: Q1 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2017: Q1 -PM7: Probation Cases



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 inst..

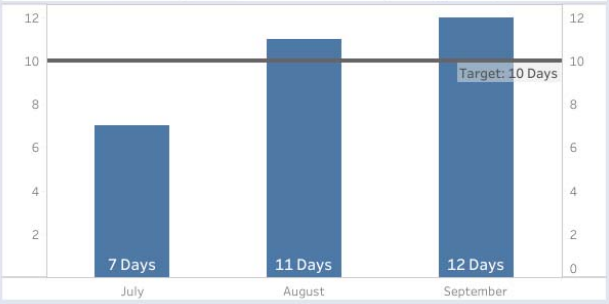
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2017	PM8	Q1	Actual Target	July August Septemb..

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

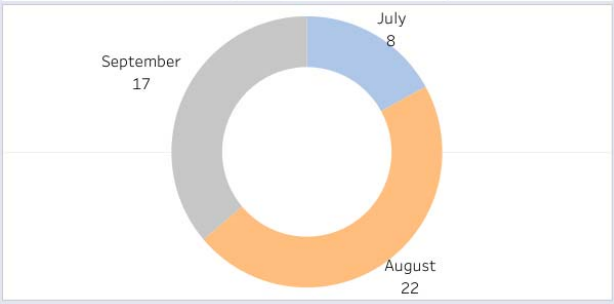
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
47	10 Days	11 Days	▲ 1 Days

Medical Board of California
SFY 2017: Q1 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2017: Q1 -PM8: Probation Violation Cases



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 inst..

Enforcement Performance Measures
Q2 Report (October – December 2016)

Select a DCA Entity
Medical Board of California

Select a Fiscal Year
SFY16/17

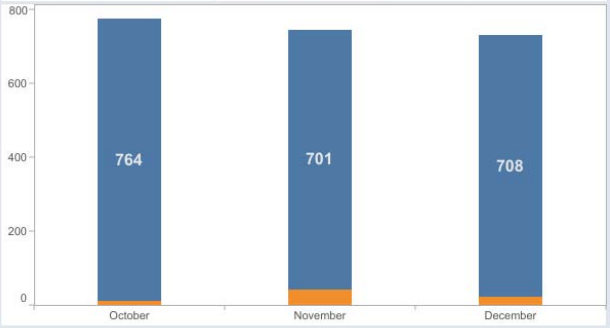
Select a Quarter
Q2

Case Type
Complaints Volume
Conviction/Arrest Volume

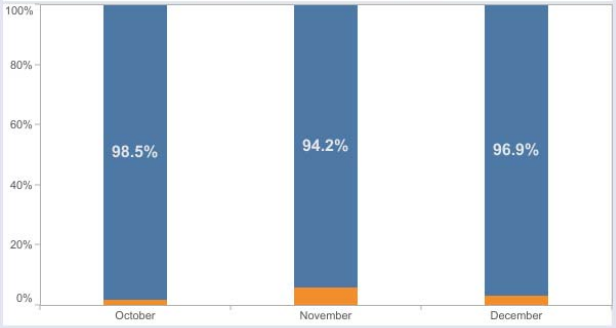
Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Complaints Volume	Conviction/Arrest Volume	Total Volume
2,173	78	2,251

Medical Board of California
SFY16/17:Q2 - Case Volume



Medical Board of California
SFY16/17:Q2 - Case Volume % Distribution



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
SFY16/17

Select a Quarter
Q2

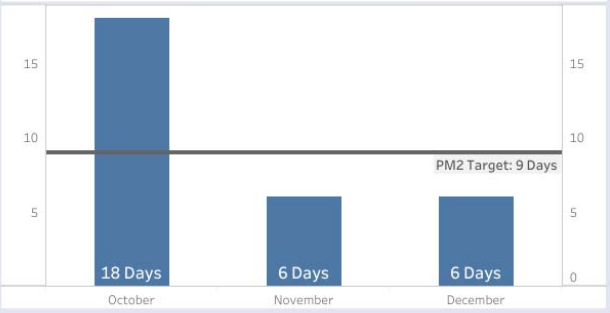
Intake Cycle Time
Actual
Target

Case Volume by Month
October
Novemb..
December

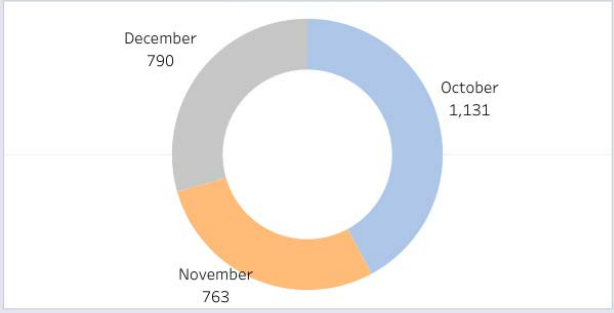
Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Case Volume	Target	Actual	Variance
2,684	9 Days	11 Days	▲ 2 Days

Medical Board of California
SFY16/17: Q2 - Intake Cycle Time



Medical Board of California
SFY16/17: Q2 - Volume



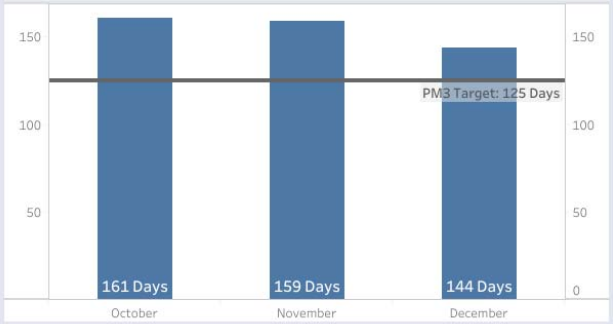
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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: SFY16/17 | Select a Quarter: Q2 | Intake Cycle Time: Actual, Target | Case Volume by Month: October, Novemb.., December

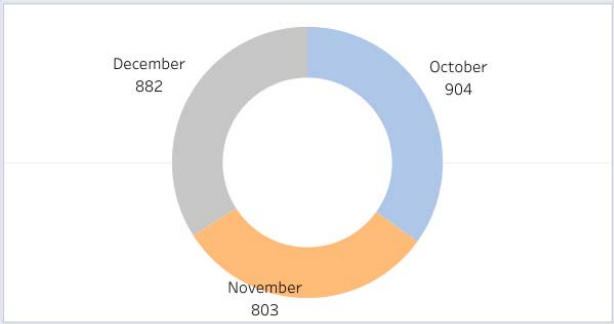
Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
2,589	125 Days	155 Days	▲ 30 Days

Medical Board of California
SFY16/17: Q2 - Investigations Cycle Time



Medical Board of California
SFY16/17: Q2 - Volume



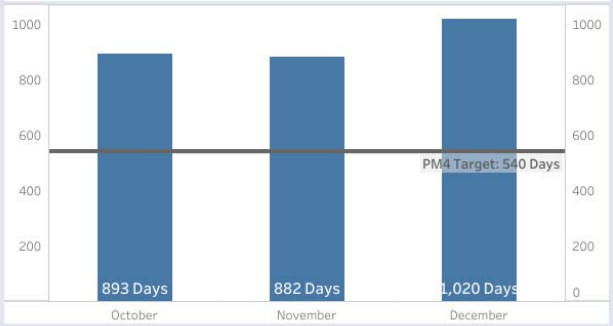
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bu..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY16/17 | Select a Quarter: Q2 | Intake Cycle Time: Actual, Target | Case Volume by Month: Octo.., Nove.., Dece..

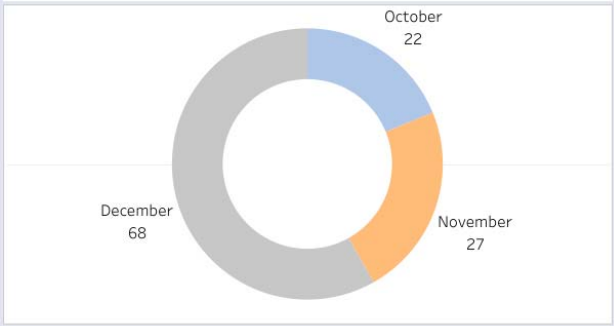
Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
117	540 Days	964 Days	▲ 424 Days

Medical Board of California
SFY16/17: Q2 - Investigations Cycle Time



Medical Board of California
SFY16/17: Q2 - Volume



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 Bu..

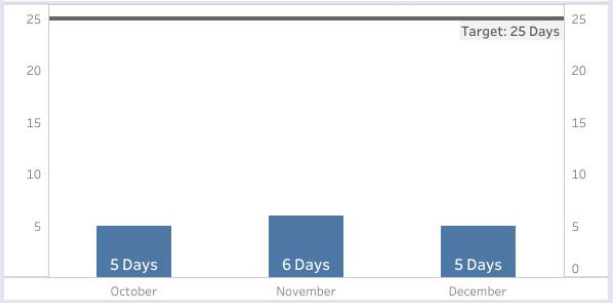
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2017	PM7	Q2	Actual Target	October Novemb.. December

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

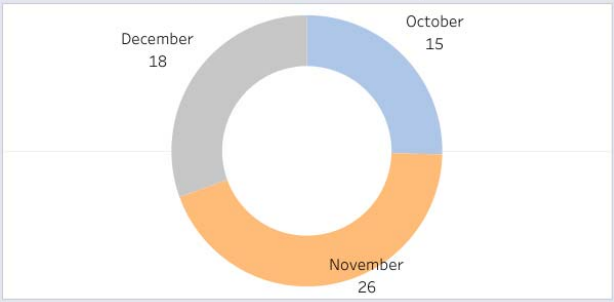
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
59	25 Days	5 Days	▼ -20 Days

Medical Board of California
SFY 2017: Q2 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2017: Q2 -PM7: Probation Cases



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 inst..

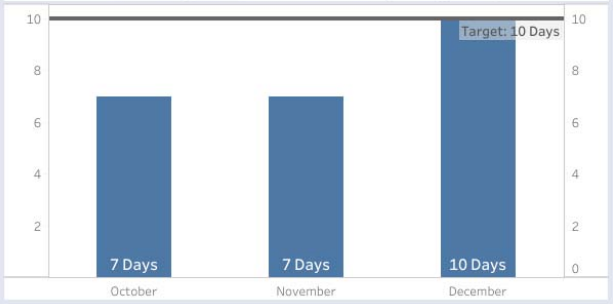
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2017	PM8	Q2	Actual Target	October Novemb.. December

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

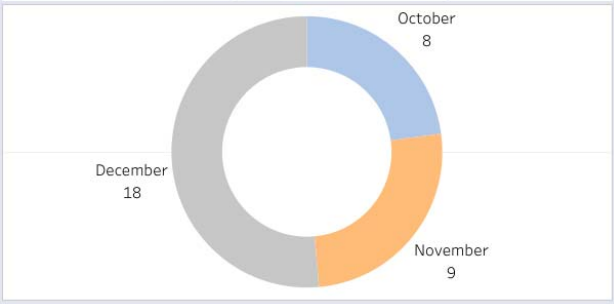
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
35	10 Days	9 Days	▼ -1 Days

Medical Board of California
SFY 2017: Q2 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2017: Q2 -PM8: Probation Violation Cases



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 inst..

Enforcement Performance Measures
Q3 Report (January – March 2017)

Select a DCA Entity
Medical Board of California

Select a Fiscal Year
SFY16/17

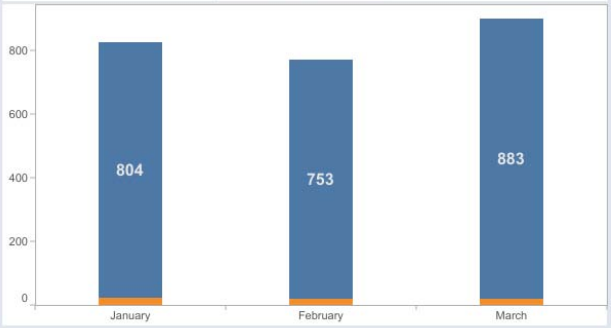
Select a Quarter
Q3

Case Type
Complaints Volume
Conviction/Arrest Volume

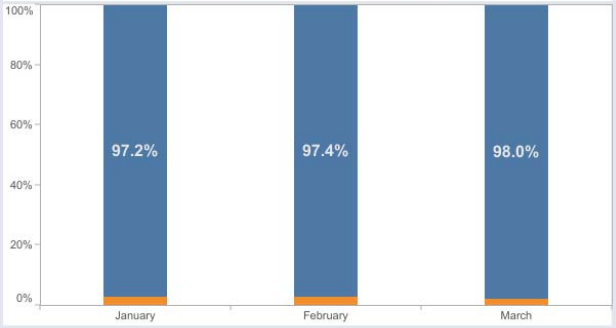
Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Complaints Volume	Conviction/Arrest Volume	Total Volume
2,440	61	2,501

Medical Board of California
SFY16/17:Q3 - Case Volume



Medical Board of California
SFY16/17:Q3 - Case Volume % Distribution



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
SFY16/17

Select a Quarter
Q3

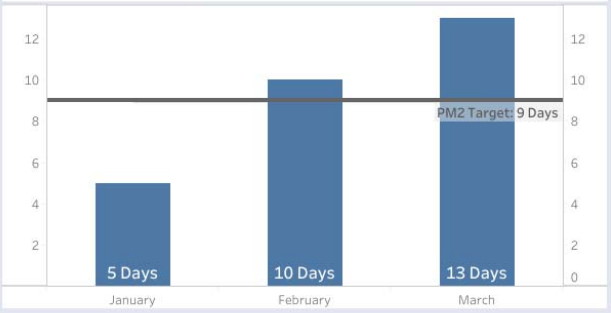
Intake Cycle Time
Actual
Target

Case Volume by Month
January
February
March

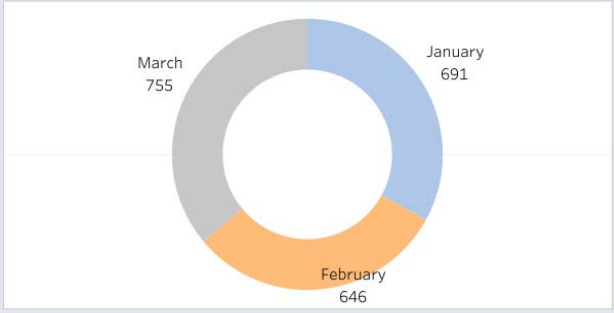
Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Case Volume	Target	Actual	Variance
2,092	9 Days	9 Days	0 Days

Medical Board of California
SFY16/17: Q3 - Intake Cycle Time



Medical Board of California
SFY16/17: Q3 - Volume



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.

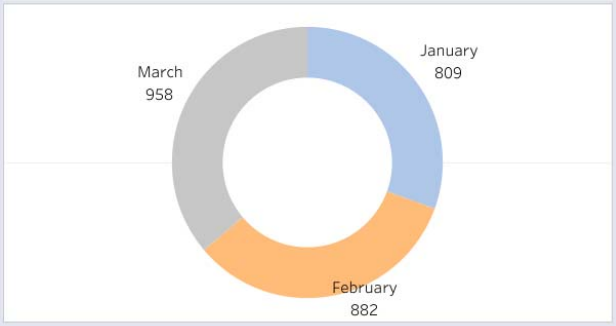
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY16/17 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: January, February, March

Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
2,649	125 Days	169 Days	▲ 44 Days

Medical Board of California
SFY16/17: Q3 - Investigations Cycle Time

Medical Board of California
SFY16/17: Q3 - Volume



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 Bu..

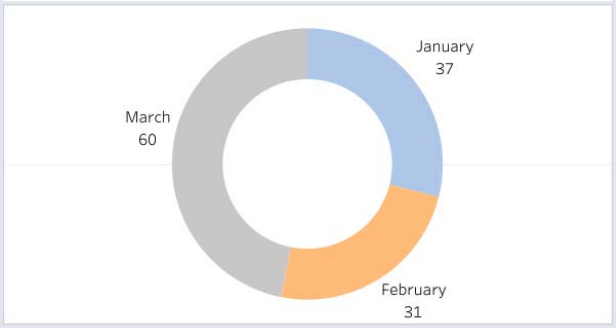
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY16/17 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: Janu.., Febr.., March

Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
128	540 Days	922 Days	▲ 382 Days

Medical Board of California
SFY16/17: Q3 - Investigations Cycle Time

Medical Board of California
SFY16/17: Q3 - Volume



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 Bu..

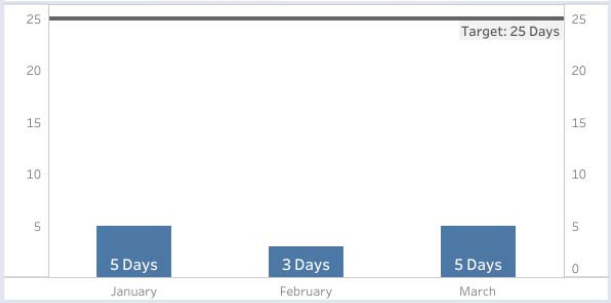
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2017 | Performance Measure: PM7 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: January, February, March

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

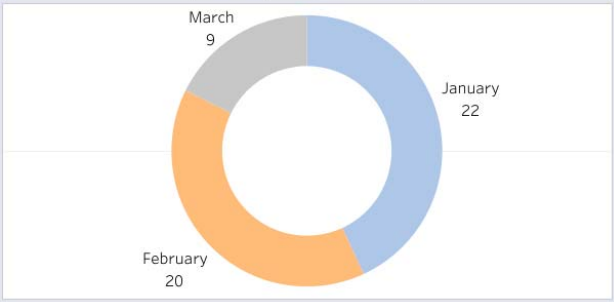
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
51	25 Days	4 Days	▼ -21 Days

Medical Board of California
SFY 2017: Q3 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2017: Q3 -PM7: Probation Cases



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 inst..

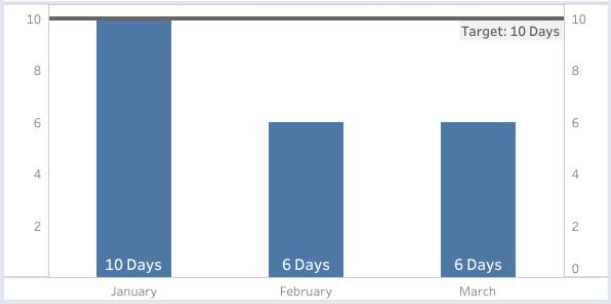
Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY 2017 | Performance Measure: PM8 | Select a Quarter: Q3 | Intake Cycle Time: Actual, Target | Case Volume by Month: January, February, March

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

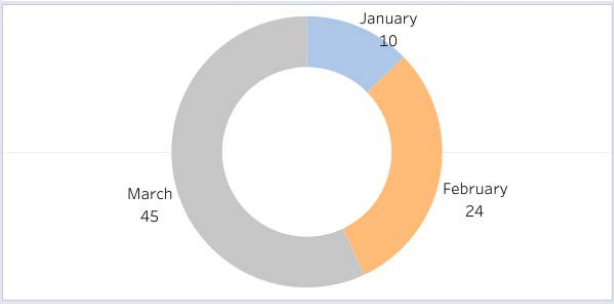
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
79	10 Days	7 Days	▼ -3 Days

Medical Board of California
SFY 2017: Q3 - PM8: Probation Violation Response Cycle Time



Medical Board of California
SFY 2017: Q3 -PM8: Probation Violation Cases



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 inst..

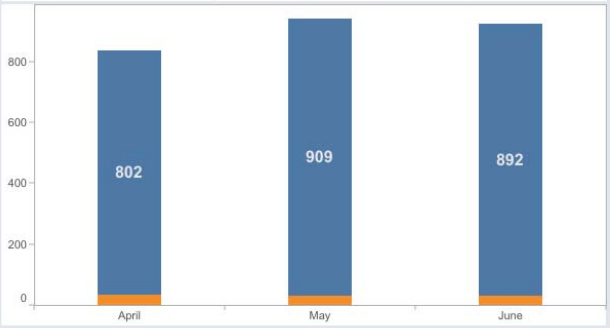
Enforcement Performance Measures
Q4 Report (April – June 2017)

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY16/17 | Select a Quarter: Q4 | Case Type: Complaints Volume, Conviction/Arrest Volume

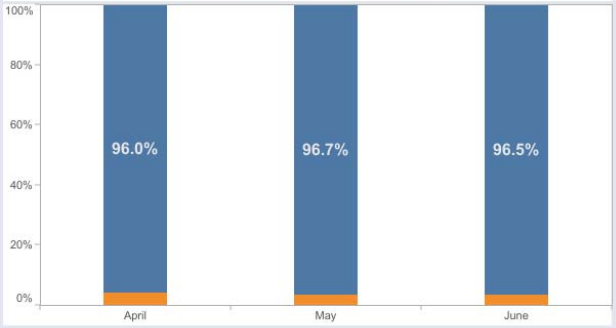
Performance Measure 1 (Complaint Volume) – Total number of complaints and conviction/arrest notices received within the specified period.

Complaints Volume	Conviction/Arrest Volume	Total Volume
2,603	96	2,699

Medical Board of California
SFY16/17:Q4 - Case Volume



Medical Board of California
SFY16/17:Q4 - Case Volume % Distribution



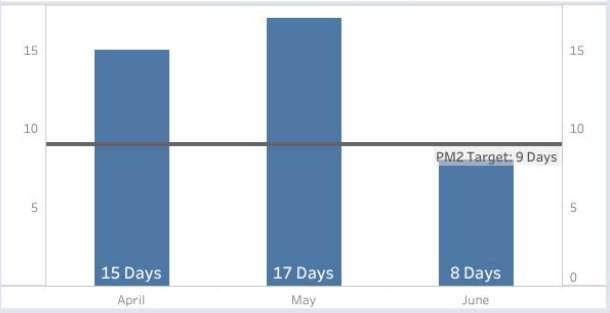
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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: SFY16/17 | Select a Quarter: Q4 | Intake Cycle Time: Actual, Target | Case Volume by Month: April, May, June

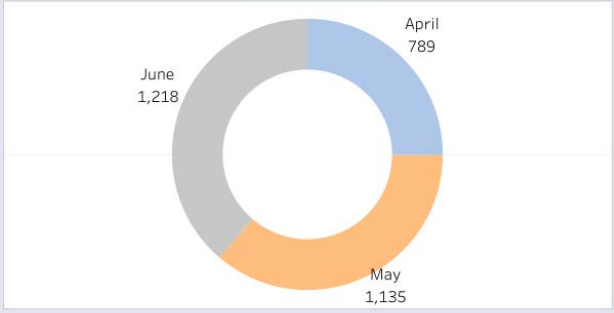
Performance Measure 2 represents the total number of complaint cases received and assigned for investigation and the average number of days (cycle time) from receipt of a complaint to the date the complaint was assigned for investigation or closed.

Case Volume	Target	Actual	Variance
3,142	9 Days	13 Days	▲ 4 Days

Medical Board of California
SFY16/17: Q4 - Intake Cycle Time



Medical Board of California
SFY16/17: Q4 - Volume



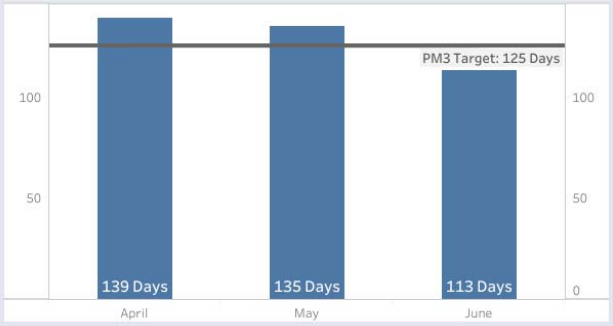
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some instances historical enforcement performance data may differ slightly from the data 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: SFY16/17 | Select a Quarter: Q4 | Intake Cycle Time: Actual, Target | Case Volume by Month: April, May, June

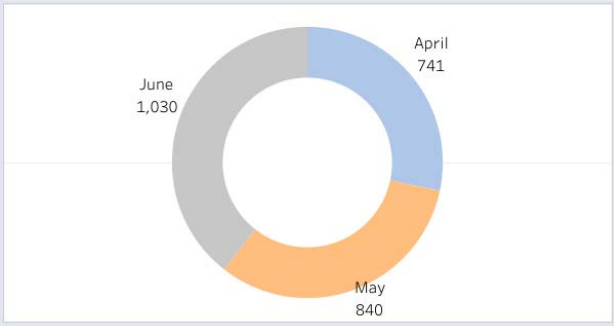
Performance Measure 3 (Investigation) – Total number of cases closed within the specified period that were not referred to the Attorney General for disciplinary action.

Case Volume	Target	Actual	Variance
2,611	125 Days	127 Days	▲ 2 Days

Medical Board of California
SFY16/17: Q4 - Investigations Cycle Time



Medical Board of California
SFY16/17: Q4 - Volume



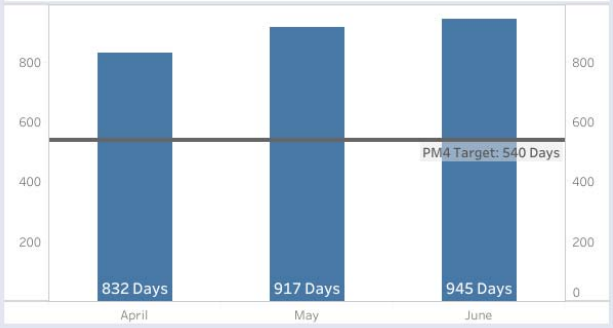
Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bu..

Select a DCA Entity: Medical Board of California | Select a Fiscal Year: SFY16/17 | Select a Quarter: Q4 | Intake Cycle Time: Actual, Target | Case Volume by Month: April, May, June

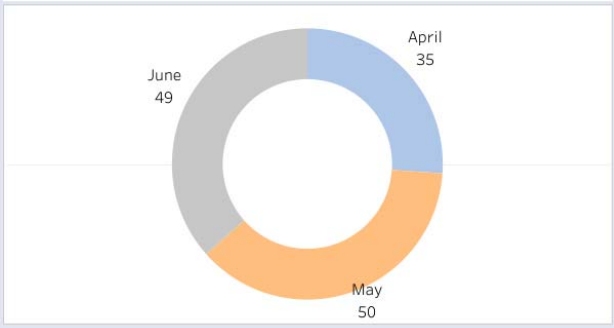
Performance Measure 4 (Formal Discipline) – Total number of cases closed within the specified period that were referred to the Attorney General for disciplinary action. This includes formal discipline, and closures without formal discipline (e.g. withdrawals, dismissals, etc.).

Case Volume	Target	Actual	Variance
134	540 Days	905 Days	▲ 365 Days

Medical Board of California
SFY16/17: Q4 - Investigations Cycle Time



Medical Board of California
SFY16/17: Q4 - Volume



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 Bu..

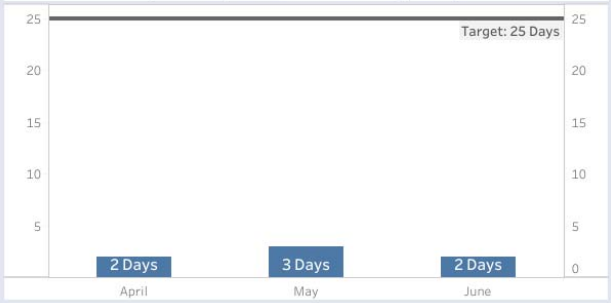
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2017	PM7	Q4	Actual Target	April May June

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

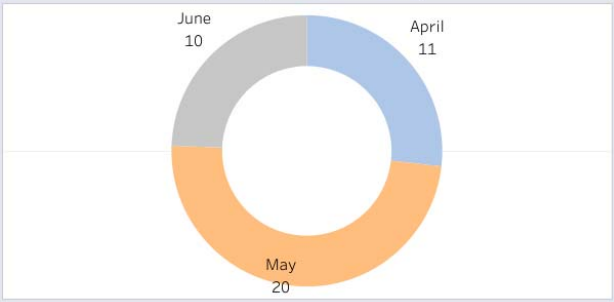
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
41	25 Days	2 Days	▼ -23 Days

Medical Board of California
SFY 2017: Q4 - PM7: Probation Intake Cycle Time



Medical Board of California
SFY 2017: Q4 -PM7: Probation Cases



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 inst..

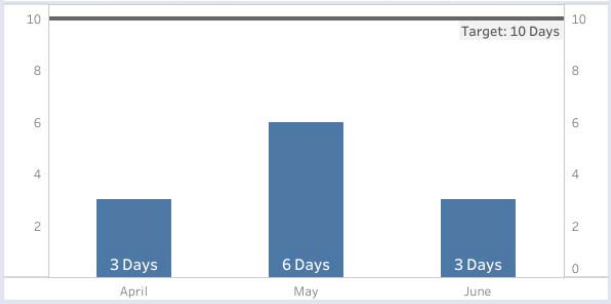
Select a DCA Entity	Select a Fiscal Year	Performance Measure	Select a Quarter	Intake Cycle Time	Case Volume by Month
Medical Board of California	SFY 2017	PM8	Q4	Actual Target	April May June

Performance Measure 7 (Probation Case Intake) – Total number of new probation cases and the average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

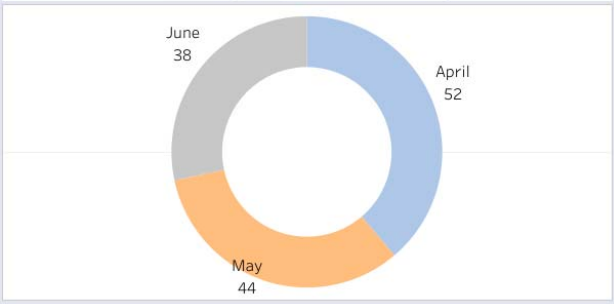
Performance Measure 8 (Probation Violation Response) – Total number of probation violation cases and the average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Case Volume	Target	Actual	Variance
134	10 Days	4 Days	▼ -6 Days

Medical Board of California
SFY 2017: Q4 - PM8: Probation Violation Response Cycle Time

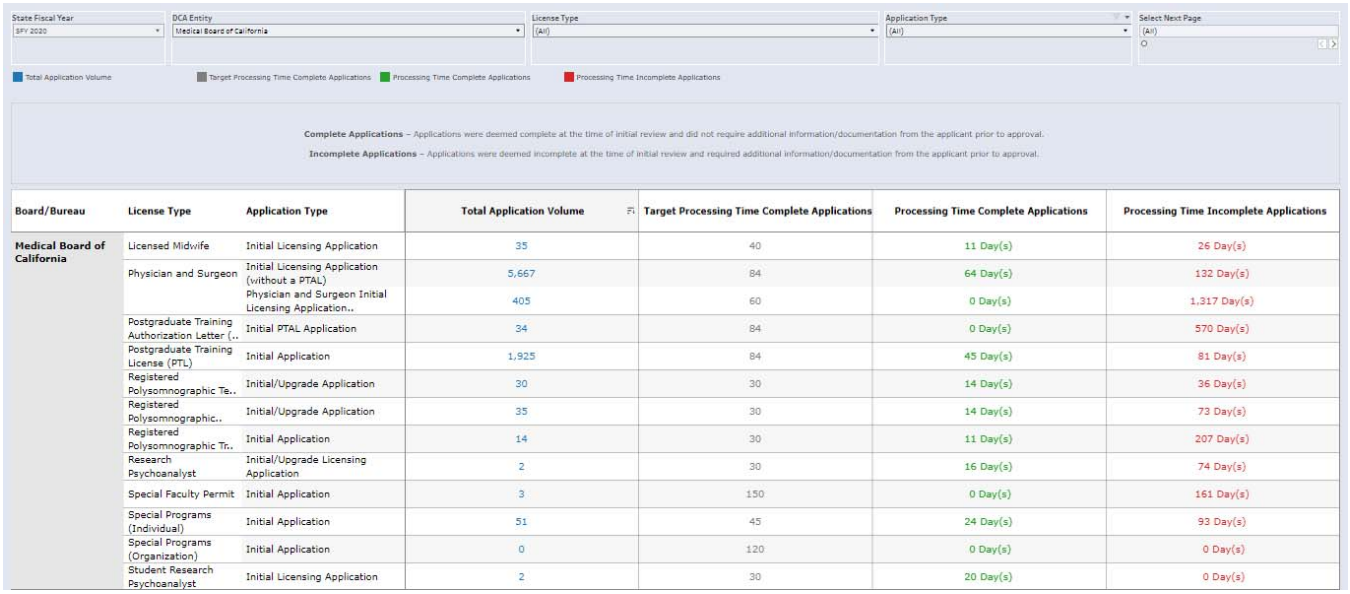


Medical Board of California
SFY 2017: Q4 -PM8: Probation Violation Cases

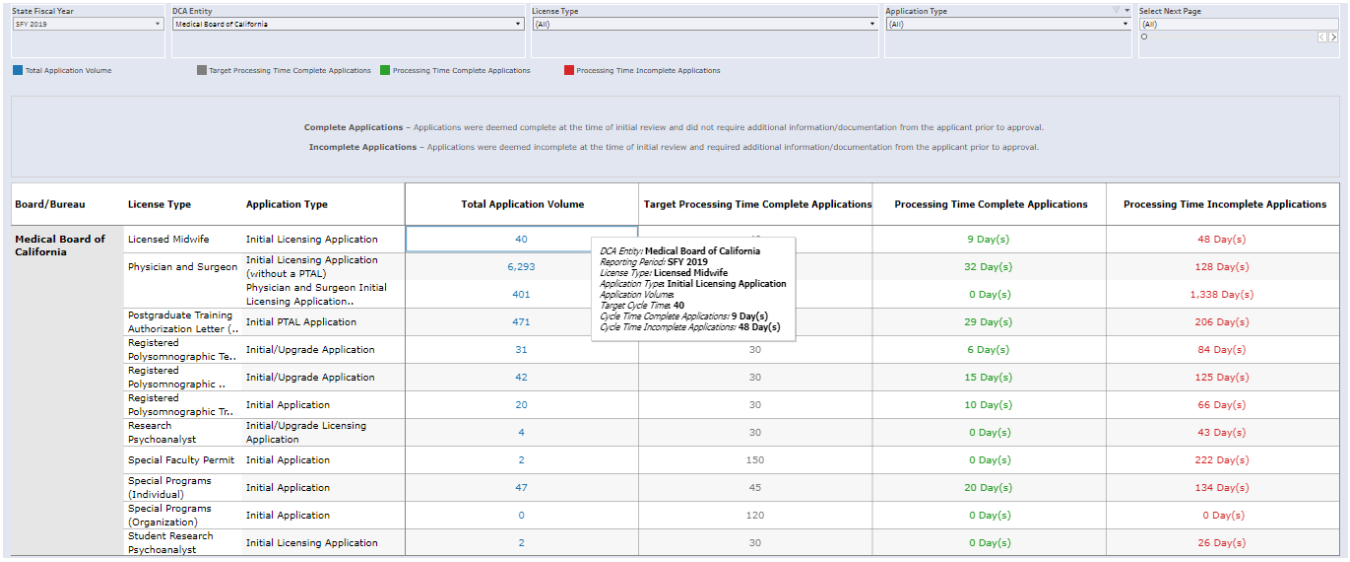


Data Source: California Department of Consumer Affairs, OIS/Data Governance Unit. The data included in this interactive tool is compiled from monthly enforcement statistical reporting from DCA Boards and Bureaus. In some inst..

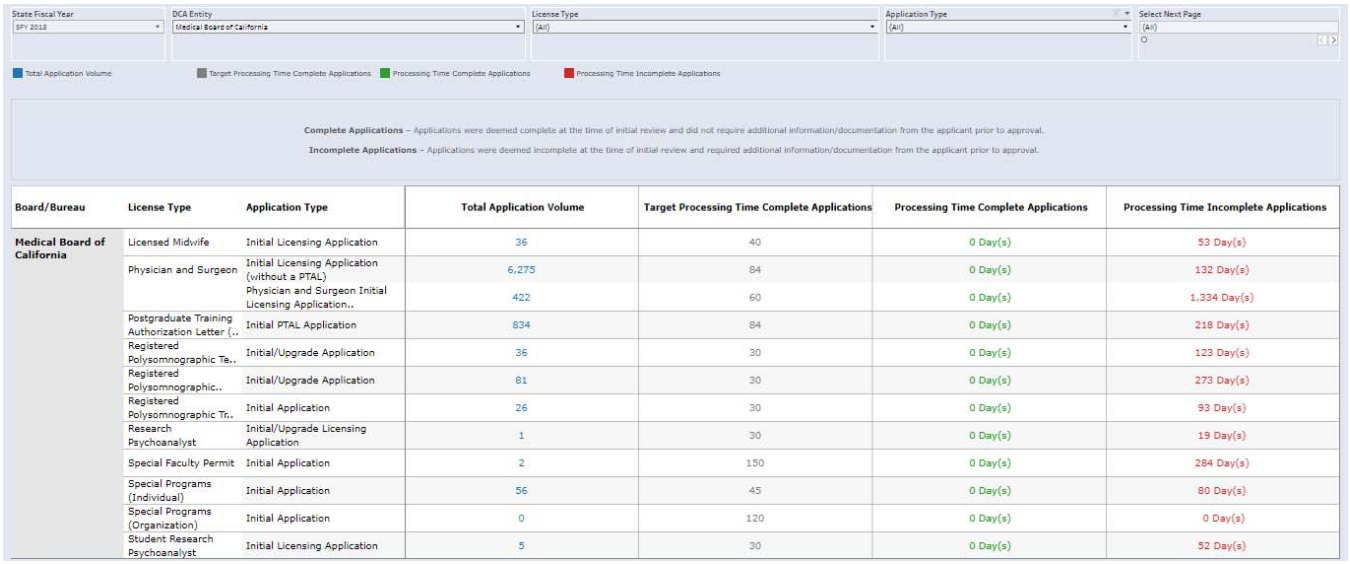
Licensing Performance Measures
Annual Reports



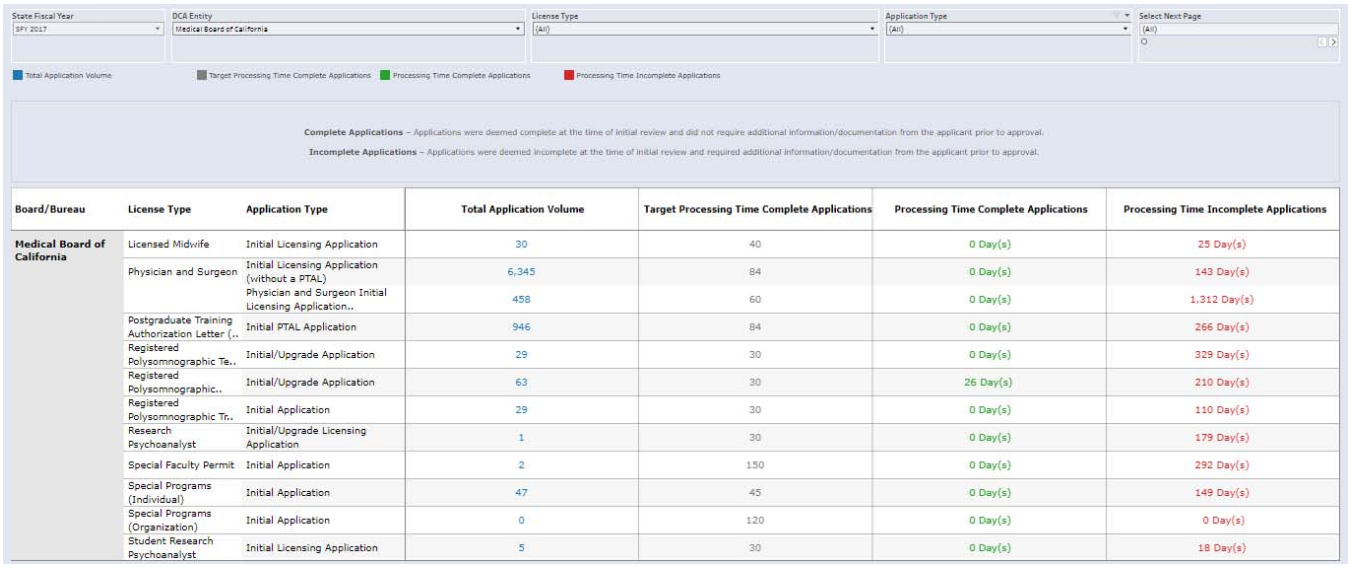
Board/Bureau	License Type	Application Type	Total Application Volume	Target Processing Time Complete Applications	Processing Time Complete Applications	Processing Time Incomplete Applications
Medical Board of California	Licensed Midwife	Initial Licensing Application	35	40	11 Day(s)	26 Day(s)
	Physician and Surgeon	Initial Licensing Application (without a PTAL)	5,667	84	64 Day(s)	132 Day(s)
		Physician and Surgeon Initial Licensing Application..	405	60	0 Day(s)	1,317 Day(s)
	Postgraduate Training Authorization Letter (..	Initial PTAL Application	34	84	0 Day(s)	570 Day(s)
	Postgraduate Training License (PTL)	Initial Application	1,925	84	45 Day(s)	81 Day(s)
	Registered Polysomnographic Te..	Initial/Upgrade Application	30	30	14 Day(s)	36 Day(s)
	Registered Polysomnographic..	Initial/Upgrade Application	35	30	14 Day(s)	73 Day(s)
	Registered Polysomnographic Tr..	Initial Application	14	30	11 Day(s)	207 Day(s)
	Research Psychoanalyst	Initial/Upgrade Licensing Application	2	30	16 Day(s)	74 Day(s)
	Special Faculty Permit	Initial Application	3	150	0 Day(s)	161 Day(s)
	Special Programs (Individual)	Initial Application	51	45	24 Day(s)	93 Day(s)
	Special Programs (Organization)	Initial Application	0	120	0 Day(s)	0 Day(s)
	Student Research Psychoanalyst	Initial Licensing Application	2	30	20 Day(s)	0 Day(s)



Board/Bureau	License Type	Application Type	Total Application Volume	Target Processing Time Complete Applications	Processing Time Complete Applications	Processing Time Incomplete Applications
Medical Board of California	Licensed Midwife	Initial Licensing Application	40		9 Day(s)	48 Day(s)
	Physician and Surgeon	Initial Licensing Application (without a PTAL)	6,293		32 Day(s)	128 Day(s)
		Physician and Surgeon Initial Licensing Application..	401		0 Day(s)	1,338 Day(s)
	Postgraduate Training Authorization Letter (..	Initial PTAL Application	471		29 Day(s)	206 Day(s)
	Registered Polysomnographic Te..	Initial/Upgrade Application	31	30	6 Day(s)	84 Day(s)
	Registered Polysomnographic ..	Initial/Upgrade Application	42	30	15 Day(s)	125 Day(s)
	Registered Polysomnographic Tr..	Initial Application	20	30	10 Day(s)	66 Day(s)
	Research Psychoanalyst	Initial/Upgrade Licensing Application	4	30	0 Day(s)	43 Day(s)
	Special Faculty Permit	Initial Application	2	150	0 Day(s)	222 Day(s)
	Special Programs (Individual)	Initial Application	47	45	20 Day(s)	134 Day(s)
	Special Programs (Organization)	Initial Application	0	120	0 Day(s)	0 Day(s)
	Student Research Psychoanalyst	Initial Licensing Application	2	30	0 Day(s)	26 Day(s)



Board/Bureau	License Type	Application Type	Total Application Volume	Target Processing Time Complete Applications	Processing Time Complete Applications	Processing Time Incomplete Applications
Medical Board of California	Licensed Midwife	Initial Licensing Application	36	40	0 Day(s)	53 Day(s)
	Physician and Surgeon	Initial Licensing Application (without a PTAL)	6,275	84	0 Day(s)	132 Day(s)
		Physician and Surgeon Initial Licensing Application..	422	60	0 Day(s)	1,334 Day(s)
	Postgraduate Training Authorization Letter (..	Initial PTAL Application	834	84	0 Day(s)	218 Day(s)
	Registered Polysomnographic Te..	Initial/Upgrade Application	36	30	0 Day(s)	123 Day(s)
	Registered Polysomnographic..	Initial/Upgrade Application	81	30	0 Day(s)	273 Day(s)
	Registered Polysomnographic Tr..	Initial Application	26	30	0 Day(s)	93 Day(s)
	Research Psychoanalyst	Initial/Upgrade Licensing Application	1	30	0 Day(s)	19 Day(s)
	Special Faculty Permit	Initial Application	2	150	0 Day(s)	284 Day(s)
	Special Programs (Individual)	Initial Application	56	45	0 Day(s)	80 Day(s)
	Special Programs (Organization)	Initial Application	0	120	0 Day(s)	0 Day(s)
	Student Research Psychoanalyst	Initial Licensing Application	5	30	0 Day(s)	52 Day(s)



Board/Bureau	License Type	Application Type	Total Application Volume	Target Processing Time Complete Applications	Processing Time Complete Applications	Processing Time Incomplete Applications
Medical Board of California	Licensed Midwife	Initial Licensing Application	30	40	0 Day(s)	25 Day(s)
	Physician and Surgeon	Initial Licensing Application (without a PTAL)	6,345	84	0 Day(s)	143 Day(s)
		Physician and Surgeon Initial Licensing Application..	458	60	0 Day(s)	1,312 Day(s)
	Postgraduate Training Authorization Letter (..	Initial PTAL Application	946	84	0 Day(s)	266 Day(s)
	Registered Polysomnographic Te..	Initial/Upgrade Application	29	30	0 Day(s)	329 Day(s)
	Registered Polysomnographic..	Initial/Upgrade Application	63	30	26 Day(s)	210 Day(s)
	Registered Polysomnographic Tr..	Initial Application	29	30	0 Day(s)	110 Day(s)
	Research Psychoanalyst	Initial/Upgrade Licensing Application	1	30	0 Day(s)	179 Day(s)
	Special Faculty Permit	Initial Application	2	150	0 Day(s)	292 Day(s)
	Special Programs (Individual)	Initial Application	47	45	0 Day(s)	149 Day(s)
	Special Programs (Organization)	Initial Application	0	120	0 Day(s)	0 Day(s)
	Student Research Psychoanalyst	Initial Licensing Application	5	30	0 Day(s)	18 Day(s)

Attachment H – List of Acronyms

List of Acronyms

16 CCR = Title 16, California Code of Regulations
AAAHC = Accreditation Association for Ambulatory Health Care
AAASF = American Association for Accreditation of Ambulatory Surgery Facilities Inc.
AAFP = American Academy of Family Physicians
AB = Assembly Bill
ABMS = American Board of Medical Specialties
ACCME = Accreditation Council for Continuing Medical Education
ACGME = Accreditation Council for Graduate Medical Education
AGO = Attorney General's Office
AIM = Administrators in Medicine
ALJ = Administrative Law Judge
AMA = American Medical Association
AMC = Academic Medical Center
APA = American Psychological Association
BCP = Budget Change Proposal
BOP = Board of Psychology
BMFEA = Bureau of Medi-Cal Fraud and Elder Abuse
Board = Medical Board of California
BPC = Business and Professions Code
BPPE = Bureau for Private Postsecondary Education
BRPT = Board of Registered Polysomnographic Technologists
CAC = Citizen Advocacy Center
CCU = Central Complaint Unit
CDPH = California Department of Public Health
CE = Continuing Education
CFPC = College of Family Physicians of Canada
CHCF = California Health Care Foundation
CIO = Board's Complaint Investigation Office
CK = Clinical Knowledge
CMA = California Medical Association
CMC = Chief Medical Consultant
CME = Continuing Medical Education
CODA = Commission on Dental Accreditation
CPEI = Consumer Protection Enforcement Initiative
CS = Clinical Skills
CURES = Controlled Substance Utilization Review and Evaluation System
DAG = Deputy Attorney General

DCA = Department of Consumer Affairs
DHCS = California Department of Health Care Services
Disciplinary Guidelines = Manual of Model Disciplinary Orders and Disciplinary
DOCS = Direct Online Certification Submission
DOJ = California Department of Justice
DSA = Delegation of Services Agreement
DSS = Department of Social Services
DUI = Driving Under the Influence
ECFMG = Educational Commission for Foreign Medical Graduates
e-prescriptions = Electronic Data Transmission Prescriptions
FAIMER = Foundation for Advancement of International Medical Education and Research
FAQ = Frequently Asked Question
FBI = Federal Bureau of Investigation
FDA = U.S. Food and Drug Administration
FI$Cal = Financial Information System for California
FLEX = Federation Licensing Examination
FNP = Fictitious Name Permits
FSMB = Federation of State Medical Boards
FTB = Franchise Tax Board
GME = Graduate Medical Education
HFAP = American Osteopathic Association/Healthcare Facilities Accreditation Program
HPEF = Health Professions Education Foundation
HQIU = DCA's Division of Investigation, Health Quality Investigation Unit
HSC = Health and Safety Code
IAMRA = International Association of Medical Regulatory Authorities
IDP = Individual Development Plans
IMQ = Institute for Medical Quality
ISB = Information Systems Branch
ISO = Interim Suspension Order
JC = Joint Commission
LCME = Liaison Committee on Medical Education
LM = Licensed Midwife
LV = License Verification
MAC = Midwifery Advisory Council
M.D. = Medical Doctor
MOU = Memorandum of Understanding
NARM = North American Registry of Midwives
NBME = National Board of Medical Examiners

ND = Naturopathic doctor
NLI = No Longer Interested
NMC = Naturopathic Medicine Committee
NPDB = National Practitioner Data Bank
OAH = Office of Administrative Hearings
OAL = Office of Administrative Law
OIS = DCA's Office of Information Services
OMB = Osteopathic Medical Board of California
ORI = Originating Agency Identifier
OSHPD = Office of Statewide Health Planning and Development
OSM = Operation Safe Medicine
OSS = Outpatient Surgery Settings
PA = Physician Assistant
PDMP = California's Prescription Drug Monitoring Program
PHWP = Physician and Surgeon Health and Wellness Program
PTAL = Postgraduate Training Authorization Letter
PTL = Postgraduate Training License
QBIRT = DCA's Quality Business Interactive Reporting Tool
RCPSC = Royal College of Physicians and Surgeons of Canada
RDO = Registered Dispensing Optician
RP = Research Psychoanalysts
SACC = Substance Abuse Coordination Committee
SB = Senate Bill
SFP = Special Faculty Permit
SFPRC = Special Faculty Permit Review Committee
SOLID = DCA's Strategic Organizational Leadership and Individual Development Training and Planning Solutions
SRP = Student Research Psychoanalyst
TMAS = Telephone Medical Advice Services
Uniform Standards = Uniform Standards for Substance-Abusing Licensees
UR = Utilization Review
USMLE = United States Medical Licensure Examination
VE = Vertical Enforcement
VPR = Volunteer Physician Registry
WFME = World Federation for Medical Education