FAQs – Consumer Protection Enforcement Initiative (CPEI)

What is the Consumer Protection Enforcement Initiative (CPEI)?
The CPEI is a *comprehensive initiative* the Department of Consumer Affairs (DCA) has launched to overhaul the enforcement process at the healing arts boards it oversees.

Why is the CPEI needed?
The program is needed to enable healings arts boards to more efficiently investigate and prosecute consumer complaints against licensees under their regulation. The *systemic* problems embedded in the enforcement process at some of these boards have pushed the timeline for investigation and prosecution of licensee violation cases to an average of three years.

How will the CPEI streamline the enforcement process?
The CPEI will target three critical ways to reform the enforcement process and ultimately reduce the average timeline from 36 months to between 12 and 18 months. The CPEI will address:

- **Administrative improvements,** such as focusing on cases one year or older, employing better methods for complaint intake, and developing enhanced training for enforcement staff;
- **Increased enforcement resources** that include authorizing boards to hire non-sworn investigators for more effective workload distribution;
- **Pursuit of legislation** to help boards better protect consumers in areas where their enforcement authorities have not kept up with legal trends.

What will the CPEI cost and how will it be funded?
DCA is requesting an additional $27 million over the next two years in a Budget Change Proposal to the Governor. Because DCA is specially funded through professional licensing fees, the project will not drain the General Fund. Additional funds will come from existing board resources or license fee increases.

Who will benefit from the CPEI and how?
The initiative will benefit California consumers as well as the healing arts boards under DCA that serve them.

- DCA ensures consumer protection as its first priority and as the first priority of its health-related boards. Consumers will have increased confidence in their health professionals when boards can more speedily resolve complaints or exercise the authority to suspend or limit the practice of violators who may pose a potential threat.
    - Consumers can see efforts DCA has already made toward accountability in enforcement. DCA is issuing a regular Enforcement Progress Report through its Web site. The report provides practical information for consumers, including links to enforcement actions taken against licensees and updates on evolving enforcement reform.
- Healing arts boards will be able to use their staff and resources more effectively in enforcement matters.

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Updated: 1/21/10

CONSUMER PROTECTION ENFORCEMENT INITIATIVE

"A Systematic Solution to a Systemic Problem"

The Department of Consumer Affairs (DCA) is the umbrella agency that oversees 19 healing arts boards that protect and serve California consumers. The healing arts boards regulate a variety of professions from doctors and nurses to physical therapists and optometrists. These licensees are some of the best in the country and provide excellent care to Californians on a daily basis. However, when a licensee violates the laws that govern his or her profession, enforcement action must be taken to protect the public.

In recent years some of DCA's healing arts boards have been unable to investigate and prosecute consumer complaints in a timely manner. In fact, some boards take an average of three years to investigate and prosecute these cases; this is an unacceptable timeframe that could put consumers' safety at risk.

DCA reviewed the existing enforcement process and found systemic problems that limit the boards' abilities to investigate and act on these cases in a timely manner. These problems range from legal and procedural challenges to inadequate resources. In response, DCA launched the Consumer Protection Enforcement Initiative (CPEI) to overhaul the enforcement process at the healing arts boards. The CPEI is a systematic approach designed to address three specific areas:

- Administrative Improvements
- Staffing and IT Resources
- Legislative Changes

Once fully implemented, DCA expects the healing arts boards to reduce the average enforcement completion timeline from 36 months to between 12 and 18 months.

I. Administrative Improvements

During the review of the enforcement process, DCA worked with the boards to identify areas that could be improved administratively to better coordinate broad enforcement objectives, improve the services provided to the healing arts boards, and establish streamlined enforcement processes and procedures that can be used by all boards. The following are some of the efforts that emerged from those discussions:

"365 Project"
DCA's Division of Investigation (DOI) embarked on a project in 2009 to strategically focus on cases that were one year or older. DOI worked closely with boards to identify the cases upon which they should focus their resources. This project has produced impressive results, and in 2009 the DOI closed 50% more cases than the comparable period in 2008.

Delegation of Subpoena Authority
One of the initial administrative changes implemented by DCA was delegating subpoena authority to each executive officer as a tool to gather evidence and interview witnesses. DCA's Legal Office conducted subpoena training for board staff, and this authority has started being exercised by boards. We expect to see increased use of subpoenas as a result of this change, and boards will be able to pursue cases that they otherwise would not have pursued.

Process Improvement
DCA and the boards are working to identify best practices for a number of enforcement processes and procedures, such as complaint intake, handling of anonymous complaints, vote by email protocols, and adjudication procedures. This effort will take advantage of the most effective practices utilized by the various boards, and entities in other states, and will ultimately shave time off all aspects of the enforcement process.

Enforcement Academy
DCA's Strategic Organization, Leadership, & Individual Development Division is developing enhanced training programs for enforcement staff. The enforcement academy will teach investigators and other enforcement staff key skills used in complaint intake, investigation procedures, case management, database use, and other areas. Never before has DCA offered such a comprehensive enforcement training program. An initial training was offered in November 2009, and the full enforcement academy will begin its regular cycle in April 2010.

Deputy Director for Enforcement and Compliance
DCA established an executive level position that reports to the Director and is responsible for regularly examining each board's enforcement program to monitor enforcement performance and compliance with all applicable requirements. This position monitors performance measures so that boards' enforcement programs can be continuously assessed for improvement.

Performance Expectations with Other Agencies
DCA has been working with the Attorney General's Office and the Office of Administrative Hearings (OAH) to establish performance agreements that will expedite the prosecution of cases. DCA and the AG's Office are developing expectations for filing accusations, setting settlement conferences, and filing continuance requests. Further, DCA is working with OAH to establish timelines for setting cases for hearings, which, once implemented, could reduce a case timeline by months.

II. Enhancing Enforcement Resources

There are 36 licensing entities under the DCA (of which are 19 healing arts boards) and, with a few exceptions, all of these programs share the resources of the Department, from Division of Investigations (DOI), to Personnel to IT Support. While the healing arts boards fall under the umbrella of DCA they are separate semi-autonomous groups overseen by board members appointed by the Governor and the Legislature. Additionally, all of the licensing entities under DCA are special fund agencies funded exclusively through fees collected through licensees with no general fund support.

Enforcement Staff
DCA's review of the enforcement process identified a need for more focused staff resources in the areas of investigations and complaint intake. The majority of DCA's licensing entities share the resources of DCA's overburdened DOI. Annually, DOI's 48 investigative staff members receive over 1,300 cases, in topics ranging from nurses to repossessors to smog check stations. Having so many investigations performed by DOI has resulted in a number of problems, including loss of control over the investigation by the boards, a lack of investigators with expertise in specific licensing areas, and excessive caseloads. These problems have led to excessive turn-around times and growing backlogs. Through the 365 Project, the DOI has worked with boards to reduce the case backlog, but the current structure has revealed a need for more significant changes.

In order to increase accountability in the investigative process, DCA is working to provide boards with the authority to hire non-sworn investigators to be housed within each board. This will enhance boards' control over investigations, allow for more appropriate workload distribution, and enable investigators to develop expertise. Additionally, to coincide with process improvement efforts, some boards will increase complaint intake staff. DCA is seeking a total of approximately 140 new enforcement positions (full year equivalent) across all healing arts boards. The vast majority of these positions are investigators and investigative supervisors, and the remainder is mostly complaint intake staff. In addition to increasing staffing, DCA will ensure that staff are properly trained, monitored, and assessed so that cases are expedited as quickly as possible.

Because DCA's boards are special fund agencies, new positions will not place a drain on the General Fund and boards will pay for new staff with existing resources or with fee increases where necessary. The number of positions requested is a result of an individual assessment of each board, and assumes workload savings associated with DCA's current process improvement efforts. The Governor's Budget includes the initial phase-in of these positions beginning July 2010.

Create a New Licensing and Enforcement Database
DCA's current licensing and enforcement database systems are antiquated and impede the boards' ability to meet their program goals and objectives. Over the past 25 years, these systems have been updated and expanded, but system design and documentation have deteriorated to such an extent that it has left the systems unstable and difficult to maintain. These systems have inadequate performance measurement, data quality errors, an inability to quickly adapt to changing laws and regulations, and a lack of available public self-service options. The CPEI relies on advanced workflow capabilities and cross-entity external system communications that the aging system's technology cannot provide.

The implementation of a replacement system is needed to support enforcement monitoring, automate manual processes, streamline processes, and integrate information about licensees. DCA intends to procure a Modifiable Commercial Off-The-Shelf (or "MOTS") enterprise licensing and enforcement case management system. DCA's research has shown various MOTS licensing and enforcement systems exist that can provide intelligent case management to reduce enforcement and licensing turnaround times, detailed performance measurements, increased data quality, advanced configurability, and robust web presences for public self-service.

The Governor's Budget authorizes DCA to redirect existing funds to begin implementation of this system in FY 2010-11.

III. Statutory Changes: Putting Consumers First

Each board within DCA has a statutory mandate to hold consumer protection as its paramount objective. Over the years, boards' enforcement authorities have been slow to keep up with legal trends and changes in the professions regulated, and due process protections have grown to protect licensees above consumers. DCA believes that now is the time to re-align consumer protection laws so that they place public protection first. In 2010, the DCA will pursue legislation to help boards carry out their critical missions of protecting consumers.

Increased Suspension Authority
One of the most important roles that professional licensing boards do to protect consumers is preventing potentially dangerous individuals from practicing. The CPEI would strengthen the boards' ability to do this in a number of ways, including authorizing the DCA Director to issue an order for a licensee to cease practice or restrict practice, upon the request of a board executive officer. This authority is necessary in the most egregious cases because the standard enforcement process can take a year to complete, at best, and even the expedited process in existing law (interim suspension order) can take months to complete. This proposal would also seek the statutory authority to revoke or deny a license to an individual for acts of sexual misconduct with a patient or conviction as a felony sex offender. Additionally, the CPEI would provide for the automatic suspension of convicted felons for the duration of their sentence.

Increased Access to Critical Information
The CPEI would make improvements to the information that boards receive, so they can investigate possible violations of law. Specifically, it would prohibit the use of a gag clause in a civil settlement that would prohibit consumers or their legal counsel from filing a complaint with the appropriate board. Regulatory gag clauses are explicitly prohibited in legal malpractice settlements and there have been numerous court decisions that describe a compelling public interest in voiding regulatory gag clauses in other professions. The Center for Public Interest Law notes that the inclusion of gag clauses is an alarmingly pervasive practice that thwarts the ability of boards to carry out their consumer protection mission. The CPEI would also require court officials to report to the healing arts boards convictions and felony charges filed against the boards' licensees, and expand reporting by employers and supervisors regarding individuals who were suspended or terminated for cause.

Adequate access to medical records can shave months off the process to investigate a licensee. Medical records are used by healing arts boards' to determine whether a licensee caused harmed to a patient. Any delay in an investigation of a licensee may result in a potentially dangerous licensee continuing to practice. Thus, it is essential that healing arts boards have quick access to medical records. The CPEI gives all of the healing arts boards the authority to inspect and copy, as applicable, any documents and records relevant to an investigation. In cases where a licensee fails to cooperate with an investigation, the CPEI provides boards with additional authorities to ensure compliance.

Enforcement Process Efficiencies
DCA proposes to remove unnecessary workload and costs from the enforcement process. This can be done by streamlining the appeal process for citations, permitting boards to contract with collection agencies to retrieve unpaid fines and fees, authorizing executive officers to sign default decisions and certain stipulated settlements, and allowing licensees to agree to stipulated settlements before a formal accusation is filed. These are relatively small changes that could result in significant workload savings.

Efficiency and accountability will also be improved by establishing a deadline for the Department of Justice (DOJ) to notify healing arts boards of arrests and convictions of licensees, which would greatly improve the board's ability to pursue cases in a timely manner. Additionally, it requires DOJ to serve accusations, default decisions and set hearing dates within a specified period of time.

Licensing Fees

Lastly, DCA is seeking to tie the maximum licensing fee amounts to the Consumer Price Index to keep up with inflation and ensure the boards have the resources to adequately run their enforcement programs.

Department of Consumer Affairs
Consumer Protection Enforcement Initiative
Resource Request Included in FY 2010 Governor's Budget

FY 2010-11	Complaint Intake /Processing Analyst	Special Investigators (non-sworn)	Investigators (sworn)	Pharmacy Inspectors	Supervisors /Managers	Expert Consultants	DCA Admin Support (incl. Enforce. Compliance Support)	CPEI TOTAL Auth. Pos.	Salary Savings	TOTAL PYs (Pers Yrs)	TOTAL 10-11 Auth. Pos. excluding CPEI	% Growth
Acupuncture		0.8						**0.8**	0	**0.8**	8.0	10%
Behavioral Science		1.1						**1.1**	-0.1	**1.0**	45.8	2%
Dental Board/Assistants	1.1	4.9	1.3		1.0	0.5		**8.8**	-0.4	**8.4**	60.3	15%
Dental Hygiene		0.4	0.5					**0.9**	0	**0.9**	6.0	15%
Hearing Aid Dispensers		0.8						**0.8**	-0.1	**0.7**	3.0	27%
Medical Board [1]		15.4			2.0			**17.4**	-0.9	**16.5**	272.6	6%
Occupational Therapy	1.9							**1.9**	-0.1	**1.8**	9.4	20%
Optometry	0.4							**0.4**	0	**0.4**	11.5	3%
Osteopathic Med	0.4					0.5		**0.9**	0	**0.9**	11.0	8%
Pharmacy	0.4			14.3	3.0			**17.7**	-1.0	**16.7**	61.5	29%
Physical Therapy	2.6	0.4			1.0			**4.0**	-0.2	**3.8**	12.5	32%
Physician Assistants	0.4							**0.4**	0	**0.4**	4.5	9%
Podiatric Med								**0.0**	0	**0.0**	5.0	0%
Psychology	0.8					1.0		**1.8**	-0.1	**1.7**	14.5	12%
Registered Nursing	3.8	18.0			4.0	4.0		**29.8**	-1.5	**28.3**	108.2	28%
Respiratory Care						0.3		**0.3**	0	**0.3**	17.5	2%
Veterinary Med		0.8						**0.8**	0	**0.8**	12.4	6%
Vocational Nurse	2.3	6.0			2.0			**10.3**	-0.5	**9.8**	59.0	17%
Psychiatric Techs	0.4	1.5						**1.9**	-0.1	**1.8**	11.5	17%
Administrative Support							7.0	**7.0**	-0.4	**6.6**	426.0	2%
TOTAL	**14.5**	**50.1**	**1.8**	**14.3**	**13.0**	**6.3**	**7.0**	**107.0**	**-5.4**	**101.6**	1160.2	9%

* Positions have staggered start dates in this initial year.

[1] MBC conducts investigations for four Allied Health Programs. Of the 15.4 MBC Investigators (non-sworn), includes 0.4 for Osteo, 0.8 for Phys Asst, 0.4 for Podiatry and 1.5 for Psychology

Department of Consumer Affairs
Consumer Protection Enforcement Initiative
Resource Request Included in FY 2010 Governor's Budget

FY 2011-12	Complaint Intake /Processing Analyst	Special Investigators (non-sworn)	Investigators (sworn)	Pharmacy Inspectors	Supervisors /Managers	Expert Consultants	DCA Admin Support (incl. Enforce. Compliance Support)	CPEI TOTAL Auth. Pos	Salary Savings	TOTAL PYs (Pers Yrs)	TOTAL 10-11 Auth. Pos. excluding CPEI	% Growth
Acupuncture		1.0						**1.0**	-0.1	**0.9**	8.0	13%
Behavioral Science		1.5						**1.5**	-0.1	**1.4**	45.8	3%
Dental Board/Assistants	1.5	6.5	2.5		1.0	1.0		**12.5**	-0.6	**11.9**	60.3	21%
Dental Hygiene		0.5	1.0					**1.5**	-0.1	**1.4**	6.0	25%
Hearing Aid Dispensers		1.0						**1.0**	-0.1	**0.9**	3.0	33%
Medical Board [1]		20.5			2.0			**22.5**	-1.1	**21.4**	272.6	8%
Occupational Therapy	2.5							**2.5**	-0.1	**2.4**	9.4	27%
Optometry	0.5							**0.5**	0	**0.5**	11.5	4%
Osteopathic Med	0.5					1.0		**1.5**	-0.1	**1.4**	11.0	14%
Pharmacy	0.5			19.0	3.0			**22.5**	-1.1	**21.4**	61.5	37%
Physical Therapy	3.5	0.5			1.0			**5.0**	-0.3	**4.7**	12.5	40%
Physician Assistants	0.5							**0.5**	0	**0.5**	4.5	11%
Podiatric Med								**0.0**	0	**0.0**	5.0	0%
Psychology	1.0					2.0		**3.0**	-0.2	**2.8**	14.5	21%
Registered Nursing	5.0	24.0			4.0	4.0		**37.0**	-1.9	**35.1**	108.2	34%
Respiratory Care						0.5		**0.5**	0	**0.5**	17.5	3%
Veterinary Med		1.0						**1.0**	-0.1	**0.9**	12.4	8%
Vocational Nurse	3.0	8.0			2.0			**13.0**	-0.7	**12.3**	59.0	22%
Psychiatric Techs	0.5	2.0						**2.5**	-0.1	**2.4**	11.5	22%
Administrative Support							9.0	**9.0**	-0.5	**8.5**	426.0	2%
TOTAL	**19.0**	**66.5**	**3.5**	**19.0**	**13.0**	**8.5**	**9.0**	**138.5**	**-7.2**	**131.3**	1160.2	12%

[1] MBC conducts investigations for four Allied Health Programs. Of the 20.5 MBC Investigators (non-sworn), includes 0.5 for Osteo, 1.0 for Phys Asst, 0.5 for Podiatry and 2.0 for Psychology

Uniform Standards Regarding Substance-Abusing Healing Arts Licensees

Senate Bill 1441 (Ridley-Thomas)

Implementation by
Department of Consumer Affairs,
Substance Abuse Coordination Committee

Brian J. Stiger, Director
December 2009 (Corrected Version)
Corrections shown in red

STATE OF CALIFORNIA
dca
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#1 SENATE BILL 1441 REQUIREMENT

Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

#1 Uniform Standard

Any licensee in a board diversion program or whose license is on probation, who the board has reasonable suspicion has a substance abuse problem shall be required to undergo a clinical diagnostic evaluation at the licensee's expense. The following standards apply to the clinical diagnostic evaluation.

1. The clinical diagnostic evaluation shall be conducted by a licensed practitioner who:
    - holds a valid, unrestricted license to conduct a clinical diagnostic evaluation;
    - has three (3) years experience in providing evaluations of health professionals with substance abuse disorders; and,
    - is approved by the board.
2. The clinical diagnostic evaluation shall be conducted in accordance with acceptable professional standards for conducting substance abuse clinical diagnostic evaluations.
3. The clinical diagnostic evaluation report shall:
    - set forth, in the evaluator's opinion, whether the licensee has a substance abuse problem;
    - set forth, in the evaluator's opinion, whether the licensee is a threat to himself/herself or others; and,
    - set forth, in the evaluator's opinion, recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee's rehabilitation and safe practice.

The evaluator shall not have a financial relationship, personal relationship, or business relationship with the licensee within the last five years. The evaluator shall provide an objective, unbiased, and independent evaluation.

If the evaluator determines during the evaluation process that a licensee is a threat to himself/herself or others, the evaluator shall notify the board within 24 hours of such a determination.

For all evaluations, a final written report shall be provided to the board no later than ten (10) days from the date the evaluator is assigned the matter unless the evaluator requests additional information to complete the evaluation, not to exceed 30 days.

#2 SENATE BILL 1441 REQUIREMENT

Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation described in subdivision (a) and any treatment recommended by the evaluator described in subdivision (a) and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

#2 Uniform Standard

The following practice restrictions apply to each licensee who undergoes a clinical diagnostic evaluation:

1. His or her license shall be placed on inactive status during the clinical diagnostic evaluation pending the results of the clinical diagnostic evaluation and review by the diversion program/board staff.

2. While awaiting the results of the clinical diagnostic evaluation required in Uniform Standard #1, the licensee shall be randomly drug tested at least two (2) times per week.

   After reviewing the results of the clinical diagnostic evaluation, and the criteria below, a diversion or probation manager shall determine, whether or not the licensee is safe to return to either part-time or fulltime practice. However, no licensee shall be returned to practice until he or she has at least one (1) month of negative drug tests.

   - the license type;
   - the licensee's history;
   - the documented length of sobriety/time that has elapsed since substance use;
   - the scope and pattern of use;
   - the treatment history;
   - the licensee's medical history and current medical condition;
   - the nature, duration and severity of substance abuse, and
   - whether the licensee is a threat to himself/herself or the public.

#3 SENATE BILL 1441 REQUIREMENT

Specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status or condition.

#3 Uniform Standard

If the licensee who is either in a board diversion program or whose license is on probation has an employer, the licensee shall provide to the board the names, physical addresses, mailing addresses, and telephone numbers of all employers and supervisors and shall give specific, written consent that the licensee authorizes the board and the employers and supervisors to communicate regarding the licensee's work status, performance, and monitoring.

#4 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomnicity, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

#4 Uniform Standard

The following drug testing standards shall apply to each licensee subject to drug testing:

1. Licensees shall be randomly drug tested at least 104 times per year for the first year and at any time as directed by the board. After the first year, licensees, who are practicing, shall be randomly drug tested at least 50 times per year, and at any time as directed by the board.

2. Drug testing may be required on any day, including weekends and holidays.

3. The scheduling of drug tests shall be done on a random basis, preferably by a computer program.

4. Licensees shall be required to make daily contact to determine if drug testing is required.

5. Licensees shall be drug tested on the date of notification as directed by the board.

6. Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S. Department of Transportation.

7. Specimen collectors shall adhere to the current U.S. Department of Transportation Specimen Collection Guidelines.

8. Testing locations shall comply with the Urine Specimen Collection Guidelines published by the U.S. Department of Transportation, regardless of the type of test administered.

9. Collection of specimens shall be observed.

10. Prior to vacation or absence, alternative drug testing location(s) must be approved by the board.

11. Laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.

A collection site must submit a specimen to the laboratory within one (1) business day of receipt. A chain of custody shall be used on all specimens. The laboratory shall process results and provide legally defensible test results within seven (7) days of receipt of the specimen. The appropriate board will be notified of non-negative test results within one (1) business day and will be notified of negative test results within seven (7) business days.

#5 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

#5 Uniform Standard

If a board requires a licensee to participate in group support meetings, the following shall apply:

When determining the frequency of required group meeting attendance, the board shall give consideration to the following:

- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use;
- the recommendation of the clinical evaluator;
- the scope and pattern of use;
- the licensee's treatment history; and,
- the nature, duration, and severity of substance abuse.

Group Meeting Facilitator Qualifications and Requirements:

1. The meeting facilitator must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or other nationally certified organizations.

2. The meeting facilitator must not have a financial relationship, personal relationship, or business relationship with the licensee in the last five (5) years.

3. The group meeting facilitator shall provide to the board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.

4. The facilitator shall report any unexcused absence within 24 hours.

#6 SENATE BILL 1441 REQUIREMENT

Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

#6 Uniform Standard

In determining whether inpatient, outpatient, or other type of treatment is necessary, the board shall consider the following criteria:

- recommendation of the clinical diagnostic evaluation pursuant to Uniform Standard #1;
- license type;
- licensee's history;
- documented length of sobriety/time that has elapsed since substance abuse;
- scope and pattern of substance use;
- licensee's treatment history;
- licensee's medical history and current medical condition;
- nature, duration, and severity of substance abuse, and
- threat to himself/herself or the public.

#7 SENATE BILL 1441 REQUIREMENT

Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

#7 Uniform Standard

A board may require the use of worksite monitors. If a board determines that a worksite monitor is necessary for a particular licensee, the worksite monitor shall meet the following requirements to be considered for approval by the board.

1. The worksite monitor shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the board; however, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.

2. The worksite monitor's license scope of practice shall include the scope of practice of the licensee that is being monitored or be another health care professional if no monitor with like practice is available.

3. The worksite monitor shall have an active unrestricted license, with no disciplinary action within the last five (5) years.

4. The worksite monitor shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and/or contract and agrees to monitor the licensee as set forth by the board.

5. The worksite monitor must adhere to the following required methods of monitoring the licensee:

    a) Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the board, at least once per week.

    b) Interview other staff in the office regarding the licensee's behavior, if applicable.

    c) Review the licensee's work attendance.

Reporting by the worksite monitor to the board shall be as follows:

1. Any suspected substance abuse must be verbally reported to the board and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the board's normal business hours the verbal report must be within one (1) hour of the next business day. A written report shall be submitted to the board within 48 hours of occurrence.

2. The worksite monitor shall complete and submit a written report monthly or as directed by the board. The report shall include:

    - the licensee's name;
    - license number;
    - worksite monitor's name and signature;
    - worksite monitor's license number;
    - worksite location(s);
    - dates licensee had face-to-face contact with monitor;
    - staff interviewed, if applicable;
    - attendance report;
    - any change in behavior and/or personal habits;
    - any indicators that can lead to suspected substance abuse.

The licensee shall complete the required consent forms and sign an agreement with the worksite monitor and the board to allow the board to communicate with the worksite monitor.

#8 SENATE BILL 1441 REQUIREMENT

Procedures to be followed when a licensee tests positive for a banned substance.

#8 Uniform Standard

When a licensee tests positive for a banned substance, the board shall:

1. Place the licensee's license on inactive status; and
2. Immediately contact the licensee and instruct the licensee to leave work; and
3. Notify the licensee's employer, if any, and worksite monitor, if any, that the licensee may not work.

Thereafter, the board should determine whether the positive drug test is in fact evidence of prohibited use. If so, proceed to Standard #9. If not, the board should reactivate the license.

In determining whether the positive test is evidence of prohibited use, the board should, as applicable:

1. Consult the specimen collector and the laboratory;
2. Communicate with the licensee and/or any physician who is treating the licensee; and
3. Communicate with any treatment provider, including group facilitator/s.

#9 SENATE BILL 1441 REQUIREMENT

Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

#9 Uniform Standard

When a board confirms that a positive drug test is evidence of use of a prohibited substance, the licensee has committed a major violation, as defined in Uniform Standard #10 and the board shall impose the consequences set forth in Uniform Standard #10.

#10 SENATE BILL 1441 REQUIREMENT

Specific consequences for major and minor violations. In particular, the committee shall consider the use of a "deferred prosecution" stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency until or unless licensee commits a major violation, in which case it is revived and license is surrendered.

#10 Uniform Standard

Major Violations include, but are not limited to:

1. Failure to complete a board-ordered program;
2. Failure to undergo a required clinical diagnostic evaluation;
3. Multiple minor violations;
4. Treating patients while under the influence of drugs/alcohol;
5. Any drug/alcohol related act which would constitute a violation of the practice act or state/federal laws;
6. Failure to obtain biological testing for substance abuse;
7. Testing positive and confirmation for substance abuse pursuant to Uniform Standard #9;
8. Knowingly using, making, altering or possessing any object or product in such a way as to defraud a drug test designed to detect the presence of alcohol or a controlled substance.

Consequences for a major violation include, but are not limited to:

1. Inactivation of the license.
   a) the license is put on inactive status, and
   b) the licensee must undergo a new clinical diagnostic evaluation, and
   c) the licensee must test clean for at least a month of continuous drug testing before being allowed to go back to work. ~~(, and)~~

2. Termination of a contract/agreement.

3. Referral for disciplinary action, such as suspension, revocation, or other action as determined by the board.

Minor Violations include, but are not limited to:

1. Untimely receipt of required documentation;
2. Unexcused non-attendance at group meetings;
3. Failure to contact a monitor when required;
4. Any other violations that do not present an immediate threat to the violator or to the public.

Consequences for minor violations include, but are not limited to:

1. Removal from practice;
2. Practice limitations;
3. Required supervision;
4. Increased documentation;
5. Issuance of citation and fine or a warning notice;
6. Required re-evaluation/testing;
7. Other action as determined by the board.

#11 SENATE BILL 1441 REQUIREMENT

Criteria that a licensee must meet in order to petition for return to practice on a full time basis.

#11 Uniform Standard

"Petition" as used in this standard is an informal request as opposed to a "Petition for Modification" under the Administrative Procedure Act.

The licensee shall meet the following criteria before submitting a request (petition) to return to full time practice:

1. Demonstrated sustained compliance with current recovery program.
2. Demonstrated the ability to practice safely as evidenced by current work site reports, evaluations, and any other information relating to the licensee's substance abuse.
3. Negative drug screening reports for at least six (6) months, two (2) positive worksite monitor reports, and complete compliance with other terms and conditions of the program.

#12 SENATE BILL 1441 REQUIREMENT

Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

#12 Uniform Standard

"Petition for Reinstatement" as used in this standard is an informal request (petition) as opposed to a "Petition for Reinstatement" under the Administrative Procedure Act.

The licensee must meet the following criteria to request (petition) for a full and unrestricted license.

1. Demonstrated sustained compliance with the terms of the disciplinary order, if applicable.

2. Demonstrated successful completion of recovery program, if required.

3. Demonstrated a consistent and sustained participation in activities that promote and support their recovery including, but not limited to, ongoing support meetings, therapy, counseling, relapse prevention plan, and community activities.

4. Demonstrated that he or she is able to practice safely.

5. Continuous sobriety for three (3) to five (5) year.

#13 SENATE BILL 1441 REQUIREMENT

If a board uses a private-sector vendor that provides diversion services, (1) standards for immediate reporting by the vendor to the board of any and all noncompliance with process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors; (3) standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and (4) standards for a licensee's termination from the program and referral to enforcement.

#13 Uniform Standard

1. A vendor must report to the board any major violation, as defined in Uniform Standard #10, within one (1) business day. A vendor must report to the board any minor violation, as defined in Uniform Standard #10, within five (5) business days.

2. A vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors is as follows:

   Specimen Collectors:

   a) The provider or subcontractor shall possess all the materials, equipment, and technical expertise necessary in order to test every licensee for which he or she is responsible on any day of the week.

   b) The provider or subcontractor shall be able to scientifically test for urine, blood, and hair specimens for the detection of alcohol, illegal, and controlled substances.

   c) The provider or subcontractor must provide collection sites that are located in areas throughout California.

   d) The provider or subcontractor must have an automated 24-hour toll-free telephone system and/or a secure on-line computer database that allows the participant to check in daily for drug testing.

   e) The provider or subcontractor must have or be subcontracted with operating collection sites that are engaged in the business of collecting urine, blood, and hair follicle specimens for the testing of drugs and alcohol within the State of California.

   f) The provider or subcontractor must have a secure, HIPAA compliant, website or computer system to allow staff access to drug test results and compliance reporting information that is available 24 hours a day.

g) The provider or subcontractor shall employ or contract with toxicologists that are licensed physicians and have knowledge of substance abuse disorders and the appropriate medical training to interpret and evaluate laboratory drug test results, medical histories, and any other information relevant to biomedical information.

h) A toxicology screen will not be considered negative if a positive result is obtained while practicing, even if the practitioner holds a valid prescription for the substance.

i) Must undergo training as specified in Uniform Standard #4 (6).

Group Meeting Facilitators:

A group meeting facilitator for any support group meeting:

a) must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse;

b) must be licensed or certified by the state or other nationally certified organization;

c) must not have a financial relationship, personal relationship, or business relationship with the licensee in the last five (5) years;

d) shall report any unexcused absence within 24 hours to the board, and,

e) shall provide to the board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.

Work Site Monitors:

1. The worksite monitor must meet the following qualifications:

   a) Shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the board; however, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.

   b) The monitor's licensure scope of practice shall include the scope of practice of the licensee that is being monitored or be another health care professional, if no monitor with like practice is available.

   c) Shall have an active unrestricted license, with no disciplinary action within the last five (5) years.

d) Shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and/or contract and agrees to monitor the licensee as set forth by the board.

2. The worksite monitor must adhere to the following required methods of monitoring the licensee:

   a) Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the board, at least once per week.

   b) Interview other staff in the office regarding the licensee's behavior, if applicable.

   c) Review the licensee's work attendance.

3. Any suspected substance abuse must be verbally reported to the contractor, the board, and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the board's normal business hours the verbal report must be within one (1) hour of the next business day. A written report shall be submitted to the board within 48 hours of occurrence.

4. The worksite monitor shall complete and submit a written report monthly or as directed by the board. The report shall include:

   - the licensee's name;
   - license number;
   - worksite monitor's name and signature;
   - worksite monitor's license number;
   - worksite location(s);
   - dates licensee had face-to-face contact with monitor;
   - staff interviewed, if applicable;
   - attendance report;
   - any change in behavior and/or personal habits;
   - any indicators that can lead to suspected substance abuse.

<u>Treatment Providers</u>

1. Treatment facility staff and services must have:

   a) Licensure and/or accreditation by appropriate regulatory agencies;

   b) Sufficient resources available to adequately evaluate the physical and mental needs of the client, provide for safe detoxification, and manage any medical emergency;

   c) Professional staff who are competent and experienced members of the clinical staff;

d) Treatment planning involving a multidisciplinary approach and specific aftercare plans;

e) Means to provide treatment/progress documentation to the provider.

2. The vendor shall disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services as follows:

   a) The vendor is fully responsible for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by any of them. No subcontract shall relieve the vendor of its responsibilities and obligations All state policies, guidelines, and requirements apply to all subcontractors.

   b) If a subcontractor fails to provide effective or timely services as listed above, but not limited to any other subcontracted services, the vendor will terminate services of said contractor within 30 business days of notification of failure to provide adequate services.

   c) The vendor shall notify the appropriate board within five (5) business days of termination of said subcontractor.

#14 SENATE BILL 1441 REQUIREMENT

If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

#14 Uniform Standard

The board shall disclose the following information to the public for licensees who are participating in a board monitoring/diversion program regardless of whether the licensee is a self-referral or a board referral. However, the disclosure shall not contain information that the restrictions are a result of the licensee's participation in a diversion program.

- Licensee's name;
- Whether the licensee's practice is restricted, or the license is on inactive status;
- A detailed description of any restriction imposed.

#15 SENATE BILL 1441 REQUIREMENT

If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor's performance in adhering to the standards adopted by the committee.

#15 Uniform Standard

1. If a board uses a private-sector vendor to provide monitoring services for its licensees, an external independent audit must be conducted at least once every three (3) years by a qualified, independent reviewer or review team from outside the department with no real or apparent conflict of interest with the vendor providing the monitoring services. In addition, the reviewer shall not be a part of or under the control of the board. The independent reviewer or review team must consist of individuals who are competent in the professional practice of internal auditing and assessment processes and qualified to perform audits of monitoring programs.

2. The audit must assess the vendor's performance in adhering to the uniform standards established by the board. The reviewer must provide a report of their findings to the board by June 30 of each three (3) year cycle. The report shall identify any material inadequacies, deficiencies, irregularities, or other non-compliance with the terms of the vendor's monitoring services that would interfere with the board's mandate of public protection.

3. The board and the department shall respond to the findings in the audit report.

#16 SENATE BILL 1441 Requirement

Measurable criteria and standards to determine whether each board's method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees

#16 Uniform Standard

Each board shall report the following information on a yearly basis to the Department of Consumer Affairs and the Legislature as it relates to licensees with substance abuse problems who are either in a board probation and/or diversion program.

- Number of intakes into a diversion program
- Number of probationers whose conduct was related to a substance abuse problem
- Number of referrals for treatment programs
- Number of relapses (break in sobriety)
- Number of cease practice orders/license in-activations
- Number of suspensions
- Number terminated from program for noncompliance
- Number of successful completions based on uniform standards
- Number of major violations; nature of violation and action taken
- Number of licensees who successfully returned to practice
- Number of patients harmed while in diversion

The above information shall be further broken down for each licensing category, specific substance abuse problem (i.e. cocaine, alcohol, Demerol etc.), whether the licensee is in a diversion program and/or probation program.

If the data indicates that licensees in specific licensing categories or with specific substance abuse problems have either a higher or lower probability of success, that information shall be taken into account when determining the success of a program. It may also be used to determine the risk factor when a board is determining whether a license should be revoked or placed on probation.

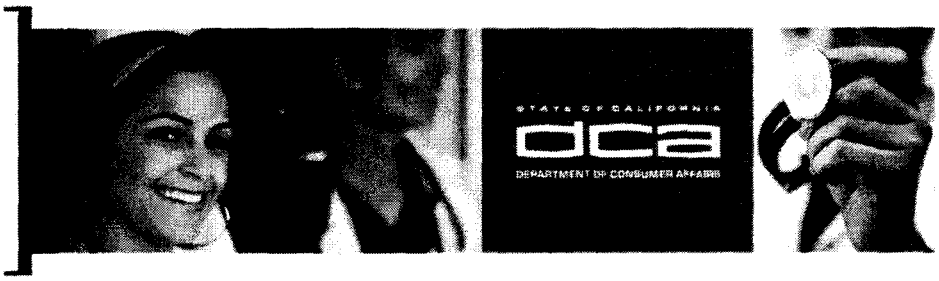
The board shall use the following criteria to determine if its program protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

- At least 100 percent of licensees who either entered a diversion program or whose license was placed on probation as a result of a substance abuse problem successfully completed either the program or the probation, or had their license to practice revoked or surrendered on a timely basis based on noncompliance of those programs.

- At least 75 percent of licensees who successfully completed a diversion program or probation did not have any substantiated complaints related to substance abuse for at least five (5) years after completion.

ENFORCEMENT

Progress REPORT



February 2010, vol. 5

The *Enforcement Progress Report* represents the Department of Consumer Affairs (DCA)'s commitment to consumer protection; it is also an effort to increase transparency and awareness of all enforcement actions currently underway at DCA. The department will issue the *Enforcement Progress Report* on a monthly basis to document progress on enforcement reform.

The report will now highlight significant events in the life of the Consumer Protection Enforcement Initiative (CPEI). In some instances, you will be able to click on the links to access more detailed information, press releases, reports and/or video content.

Governor Schwarzenegger has mandated that all healing arts boards at the DCA are to overhaul the enforcement and disciplinary processes and the department is heeding this call. DCA will continue to make changes to ensure consumer protection is the number one priority for all of its health-related boards.

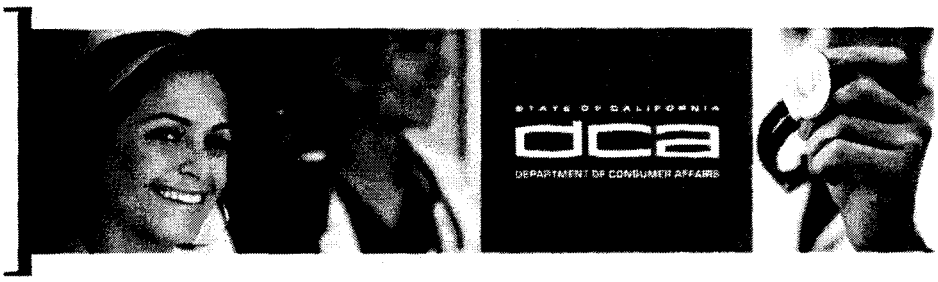
Although DCA will continue to issue this monthly report, enforcement progress from BRN and the other healing arts boards will now be highlighted on a quarterly basis, beginning with the April 2010 volume.

This volume includes a brief biography of the new Chief for DCA's Division of Investigation and an overview of the division.

This volume provides links to the Web cast of the last public meeting held by the Board of Registered Nursing; to the logo and latest legislative update on DCA's Consumer Protection Enforcement Initiative; and an update from healing arts boards on their efforts to achieve enforcement compliance.

Division of Investigation

- Emory J. "Jack" Hagan has been appointed Chief of DCA's Division of Investigation. Hagan was most recently a Special Agent with the California Department of Justice, a position to which he returned after three years as Commanding General of the California State Military



Reserve, part of the California Military Department. He has also been Deputy Director of the Governor's Office of Homeland Security and for more than 27 years was an officer in the United State Marine Corps.

- The Division of Investigation (DOI) provides investigative services for the department and its consumers and is DCA's law enforcement arm. DOI undertakes numerous functions that DCA's boards and bureaus are unequipped or not authorized to perform because they are not backed by law enforcement power.

  Among other functions, DOI staff:

  - Conduct sting operations and make arrests;
  - Engage in undercover investigations;
  - Carry out search warrants;
  - Refer criminal cases to the District Attorney's Office;
  - Execute special operations, such as personal security details, comprehensive background checks, and sensitive internal affairs maneuvers;
  - Obtain legal evidence using computer forensics and electronic surveillance; and
  - Monitor suspicious activity with GPS tracking.

  DOI also supports the boards and bureaus with enforcement training, which will gain increasing importance starting in April 2010, when DCA's Enforcement Academy begins its first regular cycle.

Board of Registered Nursing Public Meeting

Watch the video of the January 13 – 14, 2010 public meeting of the Board of Registered Nursing:
http://www.dca.ca.gov/publications/multimedia/index.shtml

The Board of Registered Nursing also conducted a public meeting on February 25, 2010.

ENFORCEMENT
Progress REPORT

Consumer Protection Enforcement Initiative — Logo and Legislative Update

- The Consumer Protection Enforcement Initiative (CPEI) now has a distinctive logo to identify it. The logo, soon to be posted on the Web sites of DCA's healing arts boards, will direct viewers to more detailed information on the initiative and to updates as they become available.

  Access this link for the logo and related information:
  http://www.dca.ca.gov/about_dca/cpei/index.shtml

- Some of the enforcement challenges facing DCA's healing arts boards involve legislative change. The department has been working closely with the Legislature to initiate such change.

  On February 17, 2010, Senator Negrete McLeod introduced DCA's proposal as Senate Bill 1111, which has now made its way into the legislative process.

  Beginning in February, DCA also began meeting with external stakeholders who have a vested interest in the outcome of SB 1111.

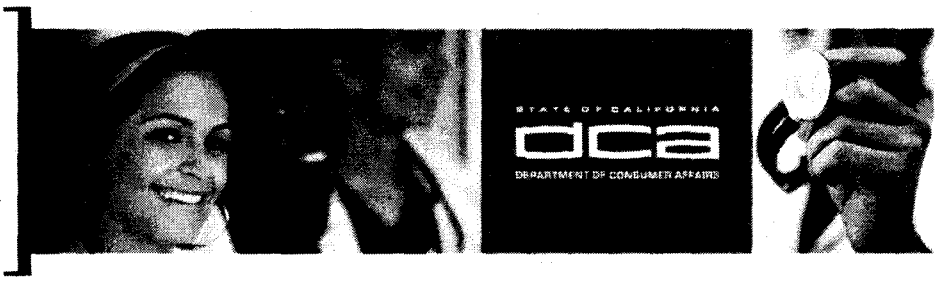
  These meetings will continue as SB 1111 moves through the legislative process and as the department works with stakeholders, consumer groups, and representatives of the healing arts boards to ensure protection both to consumers and to licensees in good standing.

  Among other significant improvements resulting from the bill's passage would be reduction of the average enforcement completion timeline, from 36 months to between 12 and 18 months.

  This link gives specifics of SB 1111:
  SB 1111

Compliance Update from Healing Arts Boards

- The Occupational Therapy, Optometry, and Acupuncture Boards have submitted their fingerprint regulations to the Office of Administrative



Law (OAL). The Acupuncture Board has scheduled a public hearing for April 14, 2010.

- The Board of Pharmacy and the Dental Board have launched their live fingerprint automation process.

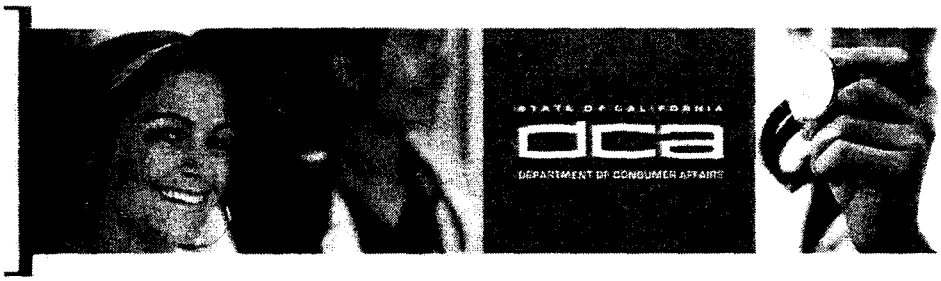
Future Actions

Meaningful enforcement reform will be instituted when changes are made to the structural procedures of the investigation and disciplinary processes and streamlined efficiencies are implemented. Many of the structural changes can occur only through legislative action. The Department of Consumer Affairs continues to mandate that all healing arts boards are operating their enforcement programs as efficiently and effectively as possible. As the department executes its enforcement reform, this document will be updated to reflect its progress.

Your Suggestions for Further Improvements

The Department of Consumer Affairs is committed to implementing changes that will make it a model for enforcement across the nation. We welcome any input you may have to help us reach that goal. Please email your suggestions to enforcementsuggestions@dca.ca.gov.

ENFORCEMENT
Progress REPORT



January 2010, vol. 4

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The report includes a list of all current and future enforcement actions. In some instances, you will be able to click on the links to access more detailed information, press releases, reports and/or video content.

Governor Arnold Schwarzenegger has mandated that all healing arts boards at the DCA are to overhaul the enforcement and disciplinary processes and the department is heeding this call. DCA will continue to make changes to ensure consumer protection is the number one priority for the Board of Registered Nursing (BRN) and all of its health-related boards and bureaus.

To help us further accelerate our progress, Governor Schwarzenegger has proposed investing up to $27 million in a new Consumer Protection Enforcement Initiative (CPEI) over the next two years.

This volume includes an overview of DCA's new Consumer Protection Enforcement Initiative which represents a multimillion dollar investment in the protection of California health care consumers.

Consumer Protection Enforcement Initiative (CPEI)

DCA has launched the Consumer Protection Enforcement Initiative (CPEI) to improve the enforcement process at its healing arts boards. The initiative overhauls a decades-old enforcement infrastructure that has not served the public well in recent years. Read DCA Director Brian Stiger's op-ed, published in the Capitol Weekly, on how the CPEI better protects the safety of health care consumers:
www.capitolweekly.net/article.php?_c=ykob2lbomuh99e&xid=ykobxd04hfpk63&done=.ykoccucc8r3pug

You can also watch DCA Director Stiger's monthly video message to find out more about this critical and long overdue enforcement initiative.

The CPEI focuses on:

- Administrative improvements that include targeting older, backlogged cases and developing enhanced training for enforcement staff;
- Increased resources that include authorizing healing arts boards to hire non-sworn investigators to expedite enforcement and replacing DCA's antiquated licensing database with a system that supports current needs; and
- Continuing pursuit of legislation to help boards better protect consumer safety.

The CPEI:

- Cuts completion of the enforcement process from an average 36 months to between 12 and 18 months;
- Enables healing arts boards to more efficiently screen, monitor, and, if necessary, investigate, prosecute, or remove from practice violators of their professional standards; and
- Increases public confidence in the professionalism of California's health care practitioners when complaints against violators are more swiftly resolved.

Budget Change Proposal (BCP)

The Governor's Budget Proposal includes a reinvestment of $27 million in funds over the next two years to increase the department's consumer protection mission and make a significant investment in the Consumer Enforcement Protection Initiative, which has been specifically designed to help boards under DCA reduce the average enforcement completion timeline.

Additional funds requested will come, in some cases, from existing board resources and, in other cases, from license fee increases. The proposal does not borrow any money from the General Fund.

The Governor's budget proposes the following changes:

- Additional staff resources.
- Procurement of a new licensing and enforcement database to replace the present antiquated system and meet current needs. The Governor's Budget authorizes DCA to redirect existing funds for a new system in FY 2010-11.

Enforcement Actions Timeline: October 2009 – January 2010

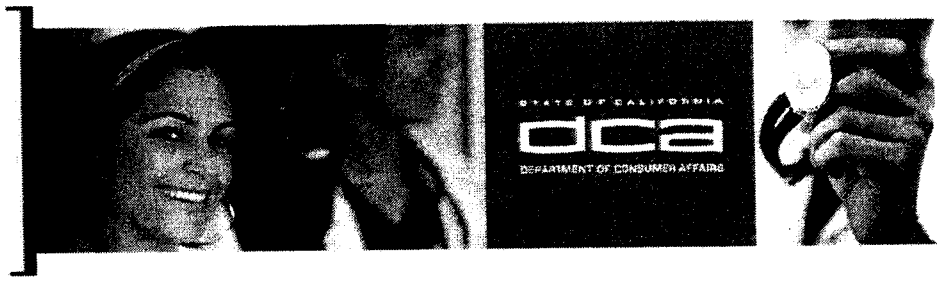
- BRN Retroactive Fingerprinting
  - From October 1, 2009 through December 31, 2009, BRN has received 45,784 fingerprint results, with 4,706 fingerprints rejected.
  - As of January 29, 2010, 74,676 individuals have submitted their fingerprints.
  - As of January 29, 2010, 973 licenses have been put on hold due to refusal to submit fingerprints. Refusal to submit fingerprints results in a hold on one's license and the licensee is not eligible to practice.
  - BRN opened 2,148 complaints with convictions (please note: multiple complaints can be associated with one individual).
    - 1,582 complaints have been closed.
    - 566 complaints are pending.
    - 12 accusations have been filed.
- Update on Healing Arts Boards Retroactive Fingerprinting Regulations
  - Four boards have put into place regulations that require fingerprinting of licensees who were issued a license before mandatory fingerprinting regulations took effect. Nine boards are in the process of adopting such regulations. See chart on page **5** for details.

Enforcement Actions: October 2009 – January 2010

- Between October 1, 2009 and December 31, 2009, BRN filed 140 accusations against licensees. In comparison, during the same time period in 2008, the number of accusations filed was 85.
- Between October 1, 2009 and December 31, 2009, BRN took 122 disciplinary actions against licensees. In comparison, during the same time period in 2008, the number of disciplinary actions taken was 122.
    - This includes the following actions: revocation, probation, suspension/probation, license surrendered, public reprimand/reprovals, and others.
- Between October 1, 2009 and December 31, 2009, BRN referred 163 cases to the Attorney General's Office. During the same time period in 2008, the number of cases referred to the AG's office was 93.
    - Follow this link to find individual cases by month and links to public documents for each case for the last twelve months.

- Diversion
    - Under SB 1441, DCA created the Substance Abuse Coordination Committee to monitor and regulate licensees with substance abuse problems.
    - The audit of the diversion program mandated by SB 1441 – originally anticipated for completion by December 30, 2009 – is still underway and will be sent to the Legislature by June 30, 2010. Implementation of the new diversion program contract for all health care-related boards began January 1, 2010.

- Division of Investigation (DOI) Intake Task Force Addresses Current Backlog of Cases
    - To date, the Intake Task Force has reviewed all cases that have been designated for internal investigation and is preparing to request patient authorizations and various documents from health care agencies. DOI closed 37 percent more cases in 2009 than in 2008.



- Staff
  - To view a breakdown of the CPEI position resources that have been requested in the Governor's FY 2010-11 Budget, please click on the following link: http://www.dca.ca.gov/about_dca/cpei/position_detail.pdf

Status on Retroactive Fingerprinting Requirement by Healing Arts Boards

January 2010

Boards with Retroactive Fingerprinting Regulations in Place	Regulation Start Date
Registered Nursing	March 2009
Behavioral Sciences	June 2009
Vocational Nursing and Psychiatric Technicians	August 2009
Podiatric Medicine	October 2009
Boards with Proposed Regulations	**Regulations in Process**
Acupuncture	Nov 2009 - Board approved language to begin rulemaking process
Dental	Regulations hearing Feb. 4, 2010
Dental Hygiene Committee	Dec 2009 – Board approved regulatory language for retroactive fingerprint collection
Occupational Therapy	Awaiting approval by OAL
Optometry	Aug 2009 – Board adopted regulations
Pharmacy	In 45 days, comment pending
Psychology	Nov 2009 – Approved by Board
Speech-Language Pathology and Audiology	Postponed to allow work on merger with Hearing Aid Dispenser Bureau
Veterinary	Board has approved regulation language
Boards that Do Not Require Retroactive Fingerprinting	**Status**
Medical	Board has fingerprints on all current licensees
Osteopathic	Board has fingerprints on all current licensees
Physical Therapy	Board has fingerprints on all current licensees
Physician Assistant Committee	Board has fingerprints on all current licensees
Respiratory Care Board	Board has fingerprints on all current licensees

Future Actions

Meaningful enforcement reform will be instituted when changes are made to the structural procedures of the investigation and disciplinary processes and

streamlined efficiencies are implemented. Many of the structural changes can occur only through legislative action. Currently, the Department of Consumer

Affairs is exploring legislative authority to complete these structural changes and continues to mandate that all healing arts boards and bureaus are operating their enforcement programs as efficiently and effectively as possible. As the Department executes its enforcement reform, this document will be updated to reflect its progress.

Your Suggestions for Further Improvements

The Department of Consumer Affairs is committed to implementing changes that will make it a model for enforcement across the nation. We welcome any input you may have to help us reach that goal. Please email your suggestions to enforcementsuggestions@dca.ca.gov.

ENFORCEMENT

Progress REPORT

December 2009, vol. 3

The *Enforcement Progress Report* represents the Department of Consumer Affairs (DCA)'s commitment to consumer protection; it is also an effort to increase transparency and awareness of all enforcement actions currently underway at DCA. The department will issue the *Enforcement Progress Report* on a monthly basis to document progress on enforcement reform.

The report includes a list of all current and future enforcement actions. In some instances, you will be able to click on the links to access more detailed information, press releases, reports and/or video content.

Governor Schwarzenegger has mandated that all healing arts boards at the DCA are to overhaul the enforcement and disciplinary processes and the department is heeding this call. DCA will continue to make changes to ensure consumer protection is the number one priority for the Board of Registered Nursing (BRN) and all of its health-related boards and bureaus.

Volumes 1 and 2 of this report include a timeline of actions taken to date. Volume 3 includes an overview of the retroactive fingerprinting process underway at BRN and other healing arts boards.

Enforcement Actions Timeline: November– December 2009

- BRN Retroactive Fingerprinting
  - Retroactive fingerprinting efforts, which began in March 2009, have provided BRN the ability to gather fingerprinting results and take action against licensees who represent a potential threat to public safety.
  - As of December 9, 2009, BRN has received 128,314 fingerprint results (about one-third of total number of its collection efforts), with 14,786 fingerprints rejected.
  - As of November 11, 2009, 404 licenses have been put on hold due to refusal to submit fingerprints. Refusal to submit fingerprints results in a hold on one's license and the licensee is not eligible to practice.

- BRN opened 1,904 complaints with convictions (Please note: multiple complaints can be associated with one individual).
  - 1,292 complaints have been closed.
  - 581 complaints are pending.
  - 1 accusation has been filed.
- Efficiencies gained with BRN's fingerprint collection process will be shared and implemented with other boards to ensure a systemic, global enhancement of processes of collection, processing of fingerprints and criminal records.

➢ Update on Healing Arts Boards Retroactive Fingerprinting Regulations.

- Four boards have put into place regulations that require licensees who were issued a license before mandatory fingerprinting regulations took effect to be fingerprinted. Nine boards are in the process of adopting such regulations. See chart for details. See chart on page 4.

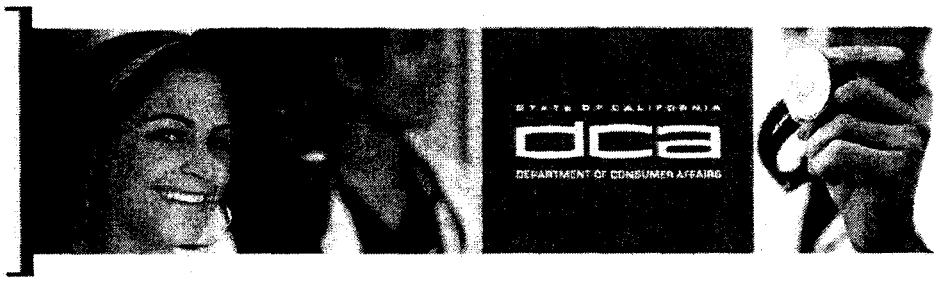
Enforcement Actions

➢ Between July 1, 2009 and December 9, 2009 the BRN filed 259 accusations against licensees. In comparison, during the same time period in 2008, the number of accusations filed was 126.

- This includes the following actions: revocation, probation, suspension/probation, license surrendered, public reprimand/reproval and other.

➢ Between July 1, 2009 and December 9, 2009 the BRN referred 272 cases to the Attorney General's office. During the same time period in 2008, the number of cases referred to the AG's office was 206.

- Chart listing individual cases and links to public documents for each case will be updated on a quarterly basis. Volume 4 of the Enforcement Progress Report, to be published January 2010, will include an updated chart.



- Diversion
  - November 19, 2009 – Established by SB 1441, DCA created Substance Abuse Coordination Committee charged with developing consistent, uniform standards to monitor and regulate licensees with substance abuse problems to ensure the highest standards of consumer protection.
  - SB1441 requires all healing arts boards to adopt the new standards.
    - The new standards:
      - Allow quick removal from practice of licensees who pose a danger to consumers;
      - Require that any substance abuse treatment vendor report licensee noncompliance within one day;
      - Institute worksite monitoring for licensees who are in a diversion program but who are deemed safe to practice;
      - Allow employers and the public to know if a diversion program participant's license is inactive or possesses restrictions; and
      - Grant boards the ability to communicate with a licensee's employer regarding their diversion program participation.

  See DCA press release on formation of Substance Abuse Coordination Committee.

  - Implementation of the new diversion program contract for all health care related boards will begin January 1, 2010.

- Division of Investigation (DOI) Intake Task Force Addresses Current Backlog of Cases
  - To date, the Intake Task Force has reviewed all cases which have been designated for internal investigation and is preparing to request patient authorizations and various documents from health care agencies. DOI closed 500 more cases in 2009 than in 2008.

- Performance Measures
  - DCA is developing a set of common performance measures for all the board and bureau enforcement programs. These measures establish clear performance expectations against which each program will be measured on an annual basis. The measures have been developed by DCA to ensure that resources employed to reduce investigation timelines are being used wisely and efficiently across all department boards and bureaus. This will establish a common standard for every entity under the department.

- Staff
  - DCA has named Paul Riches as Deputy Director of Enforcement and Compliance, a newly created position. Riches most recently served as Executive Officer of the Board of Behavioral Sciences, where he used innovative strategies to cut the amount of time Board staff required to complete an investigation by more than fifty percent. The Deputy Director will partner with DCA Director Brian Stiger to oversee all enforcement programs for all boards and bureaus within DCA, with a focus on reducing enforcement timeframes for all healing arts boards.

Status on Retroactive Fingerprinting Requirement by Healing Arts Boards

December 2009

Boards with Retroactive Fingerprinting Regulations in Place	Regulation Start Date
Registered Nursing	March 2009
Behavioral Sciences	June 2009
Vocational Nursing and Psychiatric Technicians	August 2009
Podiatric Medicine	October 2009
Boards with Proposed Regulations	**Regulations in Process**
Acupuncture	Nov 2009 - Board approved language to begin rulemaking process
Dental	Spring 2009 - Board approved regulation language
Dental Hygiene Committee	Dec 2009 - Board anticipates approving regulations at Dec. mtg

Occupational Therapy	Board approved regulations, DCA approval is pending
Optometry	Aug 2009 - Board adopted regulations
Pharmacy	Oct 2009 - Board approved regulation language
Psychology	Nov 2009 - Board considered regulations
Speech-Language Pathology and Audiology	Postponed to allow work on merger with Hearing Aid Dispenser Bureau
Veterinary	Board has approved regulation language
Boards that Do Not Require Retroactive Fingerprinting	**Status**
Medical	Board has fingerprints on all current licensees
Osteopathic	Board has fingerprints on all current licensees
Physical Therapy	Board has fingerprints on all current licensees
Physician Assistant Committee	Board has fingerprints on all current licensees

Consumer Safety and Protection

To help consumers avoid errors when buying and taking prescription drugs, the California State Board of Pharmacy and DCA released a video in December 2009 on the importance of consulting with a pharmacist when purchasing prescription medications. The 2.5 minute video, titled "Right Drug, Right Dose, Right Patient," will be posted on the Pharmacy Board's and DCA's websites, Facebook page and YouTube channel. In the coming months, DCA will release a series of user-friendly consumer videos that aim to educate and protect consumers.

Future Actions

Meaningful enforcement reform will be instituted when changes are made to the structural procedures of the investigation and disciplinary processes and streamlined efficiencies are implemented. Many of the structural changes can occur only through legislative action. Currently, the Department of Consumer Affairs is exploring legislative authority to complete these structural changes and continues to mandate that all healing arts boards and bureaus are operating their enforcement programs as efficiently and effectively as possible. As the Department executes its enforcement reform, this document will be updated to reflect its progress.

Your Suggestions for Further Improvements

ENFORCEMENT

Progress REPORT

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DRAFT

MEMORANDUM

DATE: January 29, 2010

TO: Executive Officers & Bureau Chiefs

FROM: Brian Stiger, Director
Department of Consumer Affairs

SUBJECT: Anonymous Complaint Guidelines

DRAFT

Purpose:

The following guidelines were developed to assist the boards, bureaus and commissions (hereafter referred to as "boards") within the Department of Consumer Affairs in their ongoing efforts to enhance all aspects of their enforcement programs.

Goal:

Anonymous complaints may involve serious violations of the laws protecting consumers and should be processed and investigated to the best of our abilities, taking into consideration the problems facing a board when a complaint is anonymous.

Background:

In the past, some consumers have been told that anonymous complaints are either not accepted or if accepted, will most likely not be investigated due to confidentiality issues or evidentiary issues. While this may be the case if certain medical information must be disclosed in order to investigate the complaint, it should not be the case if sufficient information is obtained from the anonymous complainant. Where sufficient information is obtained from the anonymous complaintant, the matter should be investigated consistent with the DCA Complaint Priority Guidelines.

Definition:

For the purpose of these guidelines an "anonymous complaint" is defined as:

"Any written or verbal complaint received by a board alleging a licensee violated state or federal laws that does not include the name of the complainant."

Confidentiality:

Complainants who identify themselves in their complaint to a board are not anonymous even if the complainant asked that his or her name be kept confidential. A board should never promise a complainant that his or her name will remain confidential. Aside from the need to oftentimes disclose a complainant's name to the subject of the complaint in order to investigate the allegations, the complainant's identity is often disclosed in the discovery phase of the administrative adjudication process.

Anonymous Complaint Review Process:

Anonymous complaints, like all complaints, should be reviewed in accordance with the board's complaint prioritization policy.

Record Retention:

Complaints that do not meet the threshold for investigation should be closed. In addition, where a complaint is investigated and deemed without merit, it too should be closed. Once closed, anonymous complaints, like other complaints, should be purged in accordance with each board's record retention schedule.

DRAFT

Draft Guideline for Electronic Mail Balloting

Existing mail ballot processes used by boards for disciplinary votes have proven effective in allowing disciplinary decisions to proceed on a continuous basis. Some boards have implemented electronic mail balloting or are in the process of doing so. The DCA encourages boards to implement electronic mail ballots for disciplinary actions.

Electronic mail (e-mail) ballots offer a number of benefits including:

- Reduced time for disciplinary actions to be completed
- Increased Security
- Increased Accessibility and ease of use for board members
- Elimination of paper documents

As with mail ballot processes, any board implementing electronic mail ballots should have documented procedures for use by staff and board members to ensure the accuracy and integrity of the ballot process.

The Medical Board and the Physician Assistant Committee have existing electronic mail ballot systems. The Board of Pharmacy is in the process of procuring a system that will be maintained by the Office of Information Services (OIS) that can accommodate additional boards who purchase the needed software. Boards seeking to implement electronic mail balloting should contact the Office of Information Services or the Medical Board as appropriate.

CALIFORNIA BOARD OF OCCUPATIONAL THERAPY
2010 Enforcement Improvement Plan

DRAFT

The California Board of Occupational Therapy (Board), was recently established - Senate Bill (SB) 1046, [Stats 2000, ch 697]. The focus of the first few years have been spent establishing and bolstering key operations: issuing licenses to qualified individuals, denying the applications of unqualified individuals, and taking disciplinary action against practitioners who violate the laws and regulations relating to the practice of occupational therapy. As one of the state's newest health regulatory boards, much time has been spent educating the occupational therapists (OTs) and occupational therapy assistants (OTAs); consumer's contacting the Board with complaints did not occur during its initial years of operations. However, now that the Board is not so "new," the Board receives complaints from a variety of sources, including: consumers, employers, OTs and OTAs (reporting other practitioners), and other licensing boards and governmental agencies.

Thus, the number of complaints received by the Board has increased over the years, which has lead to an increase in the number of enforcement cases, as illustrated below:

HISTORICAL COMPLAINT DATA

	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09
Complaints Received	115	138	220	442	427	485
Complaints Closed	89	109	164	303	398	417
Complaints Pending	44	73	129	268	297	365
Referred to DOI	6	8	12	11	6	13
SOIs filed	5	4	1	2	4	4
Accusations filed	2	4	1	8	4	12
Disciplinary Action	6	13	3	7	11	16

The Board's enforcement staffing levels have not kept pace with the annual increase in complaints. Thus, a backlog of complaints needing investigation and/or prosecution has developed. (*See Complaints Pending data.)* In order for the Board to pursue and implement many of the objectives outlined in the new Consumer Protection Enforcement Initiative (CPEI), and carry out its mandate, with consumer protection being its highest priority, it is necessary to shift priorities and resources.

For example, goals and objectives outlined in the Board's 2007 Strategic Plan that do not support or meet the highest standard for consumer protection must be modified or delayed, in order to provide sufficient resources to the CPEI and the Board's enforcement program. Bolstering the Board's enforcement program will allow us to address the existing backlog as well as strive to meet DCA's target cycle time of 12 -18 months for the completion of investigation and prosecution of cases.

Enforcement Backlog

We must first address the backlog by using the Complaint Prioritization Guidelines, adopted in December 2009, to identify the higher priority enforcement cases. This will help us focus our efforts on the higher level complaints and consumer's "patient care" complaints; higher priority will also be given to applicants with serious convictions and licensees with arrests and/or convictions for serious crimes.

This shift in prioritization will prompt a delay in lower enforcement priorities, reduce or eliminate the number of continuing competency audits completed, and reduce the issuance of citations and fines (for less serious violations).

We must also evaluate the strengths of existing staff and reassign duties accordingly. It is imperative those staff members with enforcement expertise begin working on the backlog of the most difficult complaints. If fiscally possible, we will also recruit additional temporary staff to assist us with the backlog and work toward meeting the new target cycle times.

SB 1441 (Substance Abusing Licensees Standards) Implementation

In December 2009, Uniform Standards were established as required by SB 1441 (2008 statutes), to provide some consistency among Healing Arts Boards' and their methods for addressing substance using/abusing licensees. Once the proposed legislative language prepared by DCA is provided to the boards, the Board will move forward, in consult with its legal counsel, to determine if it needs additional legislative amendments and which regulatory amendments it will need. The Board hopes to have its regulatory proposal prepared by its July 2010 meeting.

One of the most significant and changes made in the Uniform Standards, was to require each probationer, subject to drug testing, to be tested a minimum of 104 times per year for the first year, and 50 times a year, for each subsequent year (while on probation).

The Board does not need any additional authority to implement this standard. Thus, Board staff is working with the Office of the Attorney General (AGO) to incorporate the new testing standards when considering stipulated settlements. The Board also increased random testing for current probationers in December 2009, from once per month to twice per month, and will continue to increase the number of tests, as appropriate.

Also, until the Uniform Standards are incorporated into the Board's Disciplinary Guidelines, when considering stipulated settlements, staff will work with the AGO to incorporate the other Uniform Standards, e.g., requiring substance using/abusing licensees undergo a Clinical Diagnostic Evaluation, to the extent possible.

DRAFT

Non Sworn Investigator Class
The DCA, in concert with the Department of Personnel Administration, has recently put in place a process allowing boards to use the Non-Sworn Special Investigator series classifications. The Board is in the process of reclassing an existing vacancy to a Non-Sworn Special Investigator. This position has been requested on a limited term basis; we are cautiously optimistic that this position will be ready to fill by July 1, 2010. (The Board will continue the use of investigative services provided by the Division of Investigation, as appropriate.)

Subpoena Authority
The Board recently completed the training process to receive subpoena authority from DCA. Once approval is provided by the Legal Office, we will receive subpoena authorization from DCA. Over the next several months, the Board will reevaluate high priority cases to determine if these cases may be expedited using this new authority.

Enforcement Program Training
Enforcement staff will complete the new Enforcement Academy provided by DCA. Managers are slated to attend in the Spring and other staff in the Fall.

National Database Search
The Board is currently recruiting additional enforcement staff; once hired, the Board will begin submitting reports of past and disciplinary actions to the Healthcare Integrity and Protection Data Bank (HIPDB). (Anticipated compliance of past actions is June 30, 2010.) In the future all, disciplinary actions will be reported on an on-going basis. The Board will explore the authority and resources needed to access the HIPDB to determine if disciplinary action has been taken by another state for new and existing licensees. The Board will need to evaluate the cost to access both federal data banks, the HIPDB and the National Practitioner Data Bank (NPDB), which receives adverse action reports from hospitals and insurers, the benefits, and the authority and resources needed to include this as part of the application review process.

Expert Witness Guidelines/Recruitment
The Board has begun recruitment for Expert Witnesses to have a larger pool of licenses that can assist Board staff with case review. This includes sending information to those on the Interested Parties lists, providing information on the Board's website, and advertising the recruitment several times in 2009 in the monthly newsletter published by the Occupational Therapy Association of California.

Reevaluate Enforcement Program/Resources
The Board is currently in the process of recruiting additional enforcement staff. This includes recruitment of a manager, to assist with oversight of the Board's enforcement program; one additional analyst, to implement a new Complaint Intake/Analysis/Assignment ("triage") process, and two additional clerical staff. The additional resources will be used to implement the new "triage" process, address the enforcement backlog, report actions to the HIPDB, and meet new enforcement timeframe goals.

We will reevaluate the Board's Enforcement Program as a whole, to determine if there are any additional areas where processes can be streamlined or alternate paths established. With the assistance of DCA (SOLID) staff, we will also establish baseline performance standards and identify target goals for improvement.

At the same time we will implement many of the new standards, policies and tools listed in this "Improvement Plan." In the latter part of the year, Board staff will examine the Enforcement Program and perform a detailed work analysis to determine if the program is sufficiently staffed in order to meet the new goal of completing cases in less than 18 months. Also, this data will assist us in determining whether the limited term resources provided by the CPEI should be requested to remain on a permanent basis.

Board Meetings
The Board will increase its transparency by making all of its agenda materials available on-line, in addition to the agenda notice and minutes that are currently posted. Future agendas will also include a "Director's Report" to encourage DCA Executives to provide regular updates to the board members themselves, on the activities and direction of the DCA, and increase communication between the DCA and the Board.

CLOSING REMARKS
In recent years, the State of California has undergone many challenges that will mark this as one of the most difficult economic times in history. However, there are many opportunities for all of the healing arts boards under the DCA umbrella, to make historical milestones in improving consumer protection.

The Board will move forward with increasing its consumer protection and remains committed to:

1) Protect the public from the unauthorized and unqualified practice of occupational therapy and from unprofessional conduct by persons licensed to practice occupational therapy,
2) Ensure protection of the public is its highest priority in exercising its licensing, regulatory, and disciplinary functions, and
3) Implementing the new standards in SB 1441 and objectives in the CPEI, as well as evaluating and re-engineering its Enforcement Program, and expanding the resources available to its staff.

While these efforts will be challenging with existing resources, we welcome the opportunities that are before us, as well as the challenges that lie ahead, in order to achieve better consumer protection.

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MEMORANDUM

DATE: **January 5, 2010**

TO: **Executive Officers**
Executive Directors
Registrars
Bureau Chiefs
Interested Parties

Doreathea Johnson

FROM: **DOREATHEA JOHNSON**
Deputy Director
Legal Affairs

Subject: **Public Meetings (Bagley-Keene Open Meeting Act)**

This memorandum is to update you on the provisions of the public meetings law, officially called the Bagley-Keene Open Meeting Act (Article 9 (commencing with section 11120), Chapter 1, Part 1, Division 3, Title 2 of the Government Code). The attached guide includes all statutory amendments through January 1, 2010. Please disregard all of our previous memoranda on the subject, and our Guide to the Bagley-Keene Open Meeting Act, issued January 9, 2009.

The following changes are important:

1. Page 2: The definition of a "meeting" has been expanded to preclude serial communication between a majority of members of a board or committee (directly or through intermediaries) to discuss, deliberate or take action on any item of business that is within the subject matter of the board or committee. Discussion alone is sufficient to trigger a violation of the law.

2. Page 5: We have modified the disability accommodation language required to be included on the agenda.

We hope you find this document helpful in answering questions you may have about the requirements of the Open Meeting Act. If you have any suggestions for ways to improve the guide in the future, please let us know.

BAGLEY-KEENE OPEN MEETING ACT 2010 AMENDMENT UPDATE

A recent change to the Bagley-Keene Open Meeting Act amended Government Code Section 11122.5 to expand the definition of a "meeting." Whereas prior law prohibited any communication or technology to be "employed by a majority of the members of the state body to develop a **collective concurrence** as to action to be taken," the amendment now prohibits the use of a "series of communications of any kind, directly or through intermediaries, to **discuss**, deliberate, or take action on any item of business that is within the subject matter of the state body. (Emphasis added.) Discussion alone is sufficient to trigger a violation of the law.

To obtain Bagley-Keene Open Meeting Act publications please visit the following websites:

http://www.dca.ca.gov/publications/bagleykeene_meetingact.pdf

http://ag.ca.gov/publications/bagleykeene2004_ada.pdf

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DATE: **February 25, 2010**

TO: **EXECUTIVE OFFICERS, EXECUTIVE DIRECTORS, BUREAU CHIEFS, REGISTRAR**

FROM: **BRIAN J. STIGER**
Director

SUBJECT: **Cite and Fine Policies**

Business and Professions Code section 125.9 authorizes agencies within the Department of Consumer Affairs ("Department") to issue citations for violations of their respective licensing laws or regulations. These citations may include an administrative fine up to $5,000. In 2004 when the maximum amount of the fine was increased from $2,500 to $5,000, the State and Consumer Services Agency ("Agency') directed the Department that its boards and bureaus could issue fines between $2,501 and $5,000 if one or more of the following circumstances apply:

1. The citation involves a violation that has an immediate relationship to the health and safety of another person.
2. The cited person has a history of two or more prior citations of the same or similar violations.
3. The citation involves multiple violations that demonstrate a willful disregard of the law.
4. The citation involves a violation or violations perpetrated against a senior citizen or disabled person.

Recent discussions with Agency to maximize the use of existing enforcement tools have resulted in Agency agreeing that the 2004 policy regarding citations should no longer apply. Accordingly, those agencies within the Department that wish to impose fines up to $5,000 using criteria other than those specified in 2004, may now do so. Such a change may require an agency to amend their citation regulations concerning the criteria and the appropriate level of fines to be imposed.

If you have any questions regarding the above, please consult with your assigned legal counsel to determine the best method for implementing such changes to your cite and fine regulations.

I hope that the foregoing is of assistance.

cc: DCA Attorneys

OCCUPATIONAL THERAPY OPPORTUNITIES IN TELEMEDICINE

Tammy Richmond MS OTRL

March 11th 2010

Presentation to Board of Occupational Therapy

Today's Discussion

- Introduction
- Review of the opportunity and objectives
- Understanding telemedicine, telehealth, telerehabilitation
- Overview of OT Telemedicine opportunities
- Discuss need for inclusion in Business and Professions Code 2290.5 (2)(b)
- Strategic positioning

IMAGINE:

- A man living in Oroville, CA, a small remote town north of Sacramento, in the hospital after a Total Hip Replacement. An Occupational Therapist from UCLA Medical Center meets with him via interactive video telemedicine monitor to demonstrate proper dressing techniques and discuss other ADL adaptations and precautions.
- A child upper arm amputee in Haiti at a triage, makeshift hospital. An Occupational Therapist from UC Davis Medical Center consults with the volunteer Occupational Therapist from Dominican Republic on a treatment plan to exercise, strengthen and care for the upper extremity to prepare for a future prosthetic and to train the other arm to perform ADLs.

IMAGINE:

- A soldier returning from IRAQ with mild traumatic brain injury and post traumatic stress disorder now living with his family over 50 miles away from the nearest VA. An Occupational Therapist has sent a downloadable application to his cell phone to assist him with selective attention and mental processing skills.
- A 84 yr old woman living alone at home unable to drive to her doctors or therapists' appointments for follow up on her right sightedness weakness and balance problems after suffering a mild stroke. An Occupational Therapist sets up a live, video conference call through her INTEL Health Guide monitoring device to guide her through modifying her home for safety and to train her caregiver in transfers, ADL assistance and home exercises.

IMAGINE:

- Being able to provide Occupational Therapy services through the new safety network of the Center of Connected Health Policy foundation funded with federal stimulus money; $5.5 million dollars

*Show Media http://www.chcf.org/topics/view.cfm?itemID=133805

- Being able to provide Occupational Therapy services through the CISCO HealthPresence Telemedicine Pilot Project in San Diego county through Molina Health Care Inc, servicing 1.4 million members and funded with $10 million dollars

Opportunity Overview

- Country facing a potential shortage of health care professionals due to population growth, aging, and chronic diseases
- 8 million people a day go online to research health care topics and products
- California is 9% rural and has identified 481 Health clinics that would benefit from accessibility to specialists, case managers, nurses, etc through telemedicine
- California Dept of Corrections reports they saved the state $13 million dollars last year utilizing telemedicine (2.18.10)
- On an average, billable hours of therapy equals 6.5 hrs/8 hr day. Telemedicine could allow more patients to be seen whenever, wherever. Therefore, increase *accessibility, quality of care, improved outcomes and provide OT job opportunities and sustainability.*

Objectives

- Describe telemedicine, telehealth and telerehabilitation
- Discuss the history, the present and the future of telemedicine
- Identify OT opportunities in telehealth
- Discuss legislative inclusion for OT in telehealth
- Look at overall strategic positioning

Definitions

- Telemedicine: means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Does not include a telephone conversation nor an electronic mail message between a health care practitioner and patient . *"store and forward" and "interactive video"* (http://www.mbc.ca.gov/licensee/telemedicine.html)

- Telehealth: Broader term for providing health care, health information, and health education across a distance, using telecommunications technology, and specially adapted equipment. (http://www.telehealthlawcenter.org/)*Telehealth and telemedicine are legally defined as meaning the same thing.*

- Telerehabilitation: rehabilitation services through the use of telehealth technologies; computer-based technologies and telecommunications to improve access to rehabilitation services and support independent living *Does include non-medical professionals.* (http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3328)

History of Telemedicine

- 1900's: Radio communications providing medical services.
- 1910: First trans-telephonic "electrical stethoscope."
- 1924: Remote radio doctor.
- 1950: Radiological images transmitted for first time.
- 1950's: First interactive videocommunication in health care, Nebraska Psychiatric Institute (1959)
- 1959: Canadian Radiologist, Albert Jutras, using coaxial cable for diagnostic consult
- 1960's: Teledermatology project from Logan International Airport to Mass. General Hospital
- 1960's and 1970's: NASA flight program
- 1980's and 1990's: NASA Space Bridge, NASA Antarctic, Dept of Defense healthcare services
- 2000's: Highlighted by DoD, VA and non-profit global outreach (i.e.The Swinfen Charitable Trust servicing 36 countries) and 25 States.

(Reference: Cooper, R., et al. 2001, Richmond, T. 2009)

Present Overview of Telemedicine

- Two main healthcare application models:
  - Clinical: scope of services (practice), consultation, case management, clinical supervision
  - Non-clinical: distance learning, research, administration
- Technology: "store and forward", and "live, video, interactive"
  - Web-based; internet, videoconferencing, streaming media, software solutions
  - Mobile: wireless cellular, PDAs (i.e. download apps, Twitter)
  - Mobile Health Vans: mobile healthcare on wheels
  - Enhanced Interactive: Gaming, Virtual Reality, Robotics
- Information capture or Health Informatics
  - EMRs, EHRs, PHRs (electronic medical records) and other documents
  - Still images
  - Audio and Video

Overview of Telemedicine

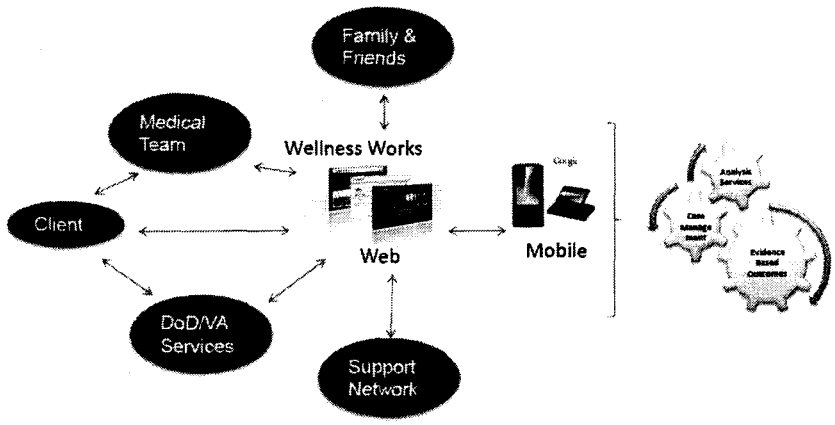
- Approved providers
  - Physicians, Surgeons and Physician assistants
  - Nurse practitioners and Clinical nurse specialists
  - Certified registered nurse anesthetist
  - Certified nurse-midwife
  - Clinical social worker
  - Registered dietitian or nutrition professional
  - Clinical psychologist
  - Clinical social worker
  - *Optometrist
  - *Dentist
  - *Marriage and family therapist
  - *Persons authorized to practice medicine (i.e. dermatology and podiatry)

*CA Business and Professions Code 805 (2) and 2290.5 (2)(b)

Legislation and Funding

- Senate Bill 1665 enacted the "Telemedicine Development Act of 1996"
- HR 5661 Appropriations bill revising Medicare rules for reimbursement (2000)
- 2001, JCAHO issued standards for Telemedicine credentialing and privileging of providers (rev 2004)
- 2005, California Legislation passed AB 354, broadening the definition of telemedicine to include, "store and forward" and expanded Medi-Cal reimbursement
- HR 2068 Medicare Telehealth Enhancement Act of 2009; inclusion of OT as provider, improve provisions and grants
- ARRA (American Recovery and Reinvestment Act) 2009 giving $7 billion dollars to expand broadband, promote adoption of telehealth and fund related projects (fed stimulus money)
- CA Business and Professions Code 2290.5; Telemedicine

Future: What does it look like?



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OT Opportunities

- AOTA Telerehabilitation Position Paper 2005 (being revised presently)
- AOTA Reimbursement and Regulatory policy staff are tracking HR 2068, EHR certification and "meaningful use"
- ATA (American Telemedicine Association) has a Telerehabilitation SIG (OT/PT/SP/others); drafting standards and expanding bibliography of evidence
- APTA Health Policy and Administration Section, Technology SIG and Legislation staff involved
- ASHA(American Speech-Language Hearing Association) have policy documents, bibliography and resources on "telespeech". Have been providing telespeech in North Dakota and Hawaii

OT Opportunities

- Alaska OT/PT Practice Act

12 AAC 54.530. STANDARDS FOR PRACTICE OF TELEREHABILITATION BY PHYSICAL THERAPIST. (a) The purpose of this section is to establish standards for the practice of telerehabilitation by means of an interactive telecommunication system by a physical therapist licensed under AS 08.84 and this chapter in order to provide physical therapy to patients who are located at distant sites in the state which are not in close proximity of a physical therapist.

(b) A physical therapist licensed under AS 08.84 and this chapter conducting telerehabilitation by means of an interactive telecommunication system

(1) must be physically present in the state while performing telerehabilitation under this section;

(2) must interact with the patient maintaining the same ethical conduct and integrity required under 12 AAC 54.500(c) and (d);

(3) must comply with the requirements of 12 AAC 54.510 for any licensed physical therapist assistant providing services under this section;

(4) may conduct one-on-one consultations, including initial evaluation, under this section; and

(5) must provide and ensure appropriate client confidentiality and HIPAA compliance, establish secure connections, activate firewalls, and encrypt confidential information.

Authority: AS 08.84.010

OT Opportunities

- Current Telehealth applications:
  - Clinical:
    - OT working with OEF, OIF Vets
    - OT working with engineers at University of Pittsburgh; Ergonomics
    - OT working on Virtual Reality software; USC
    - OT in Alaska performing OT services
    - Telehealth Survey of 50 states, Alan Chong W. Lee, PT, DPT, CWS, GCS, Assistant Professor, Mount St. Mary's College (member of HPA Section of APTA and Secretary of ATA SIG: Telerehab)
  - Non-Clinical
    - Distance learning; common use
    - Research; collaborative between USC Occupational Science and Denmark

Potential OT services

- Leveraging present OT markets across a new delivery system:
  - Stroke, Parkinson's, and other Neurology
  - Brain Injury
  - Pediatrics
  - Mental Health
  - Ergonomics/Hand
  - Orthopedic
  - Community based Health Services
  - Public Health
  - Prisons
  - Global foundations
  - Distance teaching and training to therapists, students and patients
  - Supervision of students

GOAL: Consumer Protection

- Telehealth Benefits
  - Accessibility of services
    - Services to remote, global, incapacitated, aging in place
    - Services of providers and specialists otherwise unavailable
    - Prevention of unnecessary delays in receiving care
    - Distance learning, teaching, consultation, and research
  - Improve outcome measurements
    - Empower the patient; management, educate, record keeping
    - Monitoring devices, alert systems, data collection
  - Increase quality of care
    - Distance learning, sharing, teaching, supervising
    - Improve standards of care through electronic data exchange, tracking, and measuring
    - Advocate for patient; online users

Business and Professions Codes

- Code 2290.5
  - *(a) (1) For the purposes of this section, "telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes "telemedicine" for purposes of this section.*
  - *(2) For purposes of this section, "interactive" means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.*
  - *(b) For the purposes of this section, "health care practitioner" has the same meaning as "licentiate" as defined in paragraph (2) of subdivision (a) of Section 805 and also includes a person licensed as an optometrist pursuant to Chapter 7 (commencing with Section 3000).*

Business and Professions Code

- Code 805
  - *(2) "Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, or dentist. "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113 or 2168.*

Business and Professions Code

- Code 2570-2571
  - Add in: "Standards of Practice for Telehealth by Occupational Therapist".
  - Example: Alaska State Practice Act
- Suggestion:
  - If approved as a provider under HR 2068; Medicare, commercial insurers will follow, will need to be on State provider list. Code 2290.5
  - Need for Standards?? Alaska example. American Telemedicine Association SIG: Telerehab guidelines are being drafted

Strategic Positioning

- 25 States now have telemedicine legislation
- ARRA Stimulus money is being used in CA right now for major telehealth projects. OT should position self for opportunity now for expansion of "specialists"
- HR 2068 passes; on Medicare provider list and opportunity to provide services and gain reimbursement
- Practice, evidence and bibliography need to be developed therefore, we need a task force in OTAC and AOTA
- Speech and PT are already providing services in state VA and other states and one pilot here in LA
- OT beginning to be involved in Telehealth projects
- NOW is the time to take action!!!

Future Direction???

- Questions
- Where do we go from here?

BUSINESS AND PROFESSIONS CODE SECTION 4999-4999.7

4999. (a) Any business entity that employs, or contracts or subcontracts, directly or indirectly, with, the full-time equivalent of five or more persons functioning as health care professionals, whose primary function is to provide telephone medical advice, that provides telephone medical advice services to a patient at a California address shall be registered with the Telephone Medical Advice Services Bureau.

(b) A medical group that operates in multiple locations in California shall not be required to register pursuant to this section if no more than five full-time equivalent persons at any one location perform telephone medical advice services and those persons limit the telephone medical advice services to patients being treated at that location.

(c) Protection of the public shall be the highest priority for the bureau in exercising its registration, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

4999.1. Application for registration as an in-state or out-of-state telephone medical advice service shall be made on a form prescribed by the department, accompanied by the fee prescribed pursuant to Section 4999.5. The department shall make application forms available. Applications shall contain all of the following:

(a) The signature of the individual owner of the in-state or out-of-state telephone medical advice service, or of all of the partners if the service is a partnership, or of the president or secretary if the service is a corporation. The signature shall be accompanied by a resolution or other written communication identifying the individual whose signature is on the form as owner, partner, president, or secretary.

(b) The name under which the person applying for the in-state or out-of-state telephone medical advice service proposes to do business.

(c) The physical address, mailing address, and telephone number of the business entity.

(d) The designation, including the name and physical address, of an agent for service of process in California.

(e) A list of all in-state or out-of-state staff providing telephone medical advice services that are required to be licensed, registered, or certified pursuant to this chapter. This list shall be submitted to the department on a quarterly basis on a form to be prescribed by the department and shall include, but not be limited to, the name, address, state of licensure, category of license, and license number.

(f) The department shall be notified within 30 days of any change of name, physical location, mailing address, or telephone number of any business, owner, partner, corporate officer, or agent for service of process in California, together with copies of all resolutions or other written communications that substantiate these changes.

4999.2. (a) In order to obtain and maintain a registration, in-state or out-of-state telephone medical advice services shall comply with the requirements established by the department. Those requirements shall include, but shall not be limited to, all of the following:

(1) (A) Ensuring that all staff who provide medical advice services are appropriately licensed, certified, or registered as a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) or the Osteopathic Initiative Act, as a dentist, dental hygienist, dental hygienist in alternative practice, or dental hygienist in extended functions pursuant to Chapter 4 (commencing with Section 1600), as an occupational therapist pursuant to Chapter 5.6 (commencing with Section 2570), as a registered nurse pursuant to Chapter 6 (commencing with Section 2700), as a psychologist pursuant to Chapter 6.6 (commencing with Section 2900), as a marriage and family therapist pursuant to Chapter 13 (commencing with Section 4980), as a licensed clinical social worker pursuant to Chapter 14 (commencing with Section 4990.1), as an optometrist pursuant to Chapter 7 (commencing with Section 3000), or as a chiropractor pursuant to the Chiropractic Initiative Act, and operating consistent with the laws governing their respective scopes of practice in the state within which they provide telephone medical advice services, except as provided in paragraph (2).

(B) Ensuring that all staff who provide telephone medical advice services from an out-of-state location are health care professionals, as identified in subparagraph (A), who are licensed, registered, or certified in the state within which they are providing the telephone medical advice services and are operating consistent with the laws governing their respective scopes of practice.

(2) Ensuring that the telephone medical advice provided is consistent with good professional practice.

(3) Maintaining records of telephone medical advice services, including records of complaints, provided to patients in California for a period of at least five years.

(4) Ensuring that no staff member uses a title or designation when speaking to an enrollee or subscriber that may cause a reasonable person to believe that the staff member is a licensed, certified, or registered professional described in subparagraph (A) of paragraph (1), unless the staff member is a licensed, certified, or registered professional.

(5) Complying with all directions and requests for information made by the department.

(b) To the extent permitted by Article VII of the California Constitution, the department may contract with a private nonprofit accrediting agency to evaluate the qualifications of applicants for registration pursuant to this chapter and to make recommendations to the department.

4999.3. (a) The department may suspend, revoke, or otherwise discipline a registrant or deny an application for registration as an in-state or out-of-state telephone medical advice service based on any of the following:

(1) Incompetence, gross negligence, or repeated similar negligent acts performed by the registrant or any employee of the registrant.

(2) An act of dishonesty or fraud by the registrant or any employee of the registrant.

(3) The commission of any act, or being convicted of a crime, that constitutes grounds for denial or revocation of licensure pursuant to any provision of this division.

(b) The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2

of the Government Code, and the department shall have all powers granted therein.

(c) Copies of any complaint against an in-state or out-of-state telephone medical advice service shall be forwarded to the Department of Managed Care.

(d) The department shall forward a copy of any complaint submitted to the department pursuant to this chapter to the entity that issued the license to the licensee involved in the advice provided to the patient.

4999.4. (a) Every registration issued to a telephone medical advice service shall expire 24 months after the initial date of issuance.

(b) To renew an unexpired registration, the registrant shall, before the time at which the license registration would otherwise expire, apply for renewal on a form prescribed by the bureau, and pay the renewal fee authorized by Section 4999.5.

(c) A registration that is not renewed within three years following its expiration shall not be renewed, restored, or reinstated thereafter, and the delinquent registration shall be canceled immediately upon expiration of the three-year period. An expired registration may be renewed at any time within three years after its expiration upon the filing of an application for renewal on a form prescribed by the bureau and the payment of all fees authorized by Section 4999.5.

4999.5. The department may set fees for registration, as an in-state or out-of-state telephone medical advice service sufficient to pay the costs of administration of this chapter.

4999.6. The department may adopt, amend, or repeal any rules and regulations that are reasonably necessary to carry out this chapter. A telephone medical advice services provider who provides telephone medical advice to a significant total number of charity or medically indigent patients may, at the discretion of the director, be exempt from the fee requirements imposed by this chapter. However, those providers shall comply with all other provisions of this chapter.

4999.7. (a) Nothing in this section shall limit, preclude, or otherwise interfere with the practices of other persons licensed or otherwise authorized to practice, under any other provision of this division, telephone medical advice services consistent with the laws governing their respective scopes of practice, or licensed under the Osteopathic Initiative Act or the Chiropractic Initiative Act and operating consistent with the laws governing their respective scopes of practice.

(b) For the purposes of this chapter, "telephone medical advice" means a telephonic communication between a patient and a health care professional in which the health care professional's primary function is to provide to the patient a telephonic response to the patient's questions regarding his or her or a family member's medical care or treatment. "Telephone medical advice" includes assessment, evaluation, or advice provided to patients or their family members.

(c) For the purposes of this chapter, "health care professional" is a staff person described in Section 4999.2 who provides medical advice services and is appropriately licensed, certified, or registered as a registered nurse pursuant to Chapter 6 (commencing

with Section 2700), as a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) or the Osteopathic Initiative Act, as a dentist, dental hygienist, dental hygienist in alternative practice, or dental hygienist in extended functions pursuant to Chapter 4 (commencing with Section 1600), as a psychologist pursuant to Chapter 6.6 (commencing with Section 2900), as a marriage and family therapist pursuant to Chapter 13 (commencing with Section 4980), as a licensed clinical social worker pursuant to Chapter 14 (commencing with Section 4990.1), as an optometrist pursuant to Chapter 7 (commencing with Section 3000), or as a chiropractor pursuant to the Chiropractic Initiative Act, and who is operating consistent with the laws governing his or her respective scopes of practice in the state in which he or she provides telephone medical advice services.

Business and Professions Codes

- Code 2290.5
  - *(a) (1) For the purposes of this section, "telemedicine" means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications. Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes "telemedicine" for purposes of this section.*
  - *(2) For purposes of this section, "interactive" means an audio, video, or data communication involving a real time (synchronous) or near real time (asynchronous) two-way transfer of medical data and information.*
  - *(b) For the purposes of this section, "health care practitioner" has the same meaning as "licentiate" as defined in paragraph (2) of subdivision (a) of Section 805 and also includes a person licensed as an optometrist pursuant to Chapter 7 (commencing with Section 3000).*

Business and Professions Code

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