



Meeting Notice

May 19, 2011

PHYSICIAN ASSISTANT COMMITTEE
2005 Evergreen Street – Hearing Room 1150
Sacramento, CA 95815
10:00 A.M. – 5:00 P.M.

AGENDA

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1. Call to Order by Chairman (Klompus)
2. Roll Call (Forsyth)
3. Approval of February 3, 2011 Meeting Minutes (Klompus)
4. Public Comment on Items not on the Agenda (Klompus)
5. Reports
 - a. Chair's Report (Klompus)
 - b. Executive Officer's Report (Portman)
 - c. Licensing Program Activity Report (Mitchell)
 - d. Diversion Program Activity Report (Mitchell)
 1. Update on Substance Abuse Coordination Committee Uniform Standards
 - e. Enforcement Program Activity Report (Tincher)
- 6a. **10:30 AM – Hearing**
Petition for reinstatement of physician assistant license – Ike Udengwu
- 6b. **11:30 AM - Hearing**
Petition for early termination of probation – Molly Kalejs

CLOSED SESSION: Pursuant to Section 11126(c) (3) of the Government Code, the Committee will move into closed session to deliberate the petition for reinstatement and the petition for early termination of probation.

CLOSED SESSION: Pursuant to Section 11126(c) (3) of the Government Code, the Committee will move into closed session to deliberate on disciplinary matters.

RETURN TO OPEN SESSION

Meeting Notice
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7. Discussion of Title 16 CCR §1399.541(i)(1) Personal Presence (Sachs)
8. Discussion of Physical Therapy Referrals by PAs Being Denied by Medi-Cal (Klompus)
9. Discussion of 2 year PA Programs in California and Potential New Programs (Sachs)
10. Report on the Physician Assistant Education and Training Subcommittee (Heppler); Consideration of Proposal to Amend Section 1399.536 of the California Code of Regulations
11. SB 541 Discussion and Potential Action of Expert Consultant Contract Request for Legislative Exemption (Portman)
12. Update and Consideration of Legislation of Interest to the Physician Assistant Committee (Klompus)
AB 30, AB 82, AB 92, AB 137, AB 138, SB 28, SB 69, SB 100, SB 161,
SB 233, SB 544, SB 943
13. Schedule of 2011 Meeting Dates and Locations (Portman)
14. Agenda Items for Next Meeting (Klompus)
15. Adjournment (Klompus)

Note: Agenda discussion and report items are subject to action being taken on them during the meeting by the Committee at its discretion. All times when stated are approximate and subject to change without prior notice at the discretion of the Committee. Agenda items may be taken out of order and total time allocated for public comment on particular issues may be limited.

Notice: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Lynn Forsyth at (916) 561-8785 or email Lynn.Forsyth@mbc.ca.gov or send a written request to the Physician Assistant Committee, 2005 Evergreen Street, Suite 1100, Sacramento, California 95815. Providing your request at least five (5) business days before the meeting will help to ensure availability of the request.



February 3, 2011

**Physician Assistant Committee
UC Davis Medical Campus
4610 "X" Street, Room 1204
Sacramento, CA 95817
9:15 A.M. – 5:00 P.M.
Meeting Minutes**

1. Call to Order by Chairman

Chairman Klompus called the meeting to order at 9:17 a.m.

2. Roll Call

Staff called the roll. A quorum was present.

Committee Members Present: Steve Klompus, PA
Rosslynn Byous, PA, Ph.D.
Cristina Gomez-Vidal Diaz
Reginald Low, M.D.
Robert Sachs, PA-C
Shaquawn D. Schasa
Steven Stumpf, Ph.D.
Shelia Young

Staff Present: Elberta Portman, Executive Officer
Kurt Heppler, Staff Counsel, Dept. of
Consumer Affairs (DCA)
Dianne Tincher, Enforcement Analyst
Lynn Forsyth, Staff Services Analyst

3. Approval of November 18, 2010 Meeting Minutes

The November 18, 2010 minutes were approved as written.
(m/Byous, s/Dr. Low, motion passes)

4. Public Comment on Items not on the Agenda

There were no comments received from the public on this agenda item.

5. Reports

a. Chair's Report

Chairman Klompus expressed his gratitude to Dr. Low and Wendy, of his staff, for hosting the PAC meeting at U.C. Davis, and he thanked them for all their work in preparing for the meeting.

Chairman Klompus welcomed Mr. Robert Sachs back as a PAC member. Mr. Sachs previously served on the PAC from 1993 to 2008. Chairman Klompus then congratulated Cristina Gomez-Vidal Diaz for her PAC re-appointment and Rosslyn Byous for her appointment to the California Healthcare Workforce Policy Commission.

b. Executive Officer's Report

Ms. Portman briefly discussed the current travel guidelines for the PAC.

Ms. Portman reported that staff submitted a budget change proposal to increase the enforcement reimbursement from \$25,000 to \$50,000 due an increase in the reimbursements received from probationers for the costs of probation monitoring. The number of probationers has grown from 20 to 35 so the PAC receives an average of \$35,000 per year from probationers for reimbursements for their probation monitoring in addition to cost recovery.

Ms. Portman reported that since July 2010 the PAC has issued several Interim Suspension Orders, which require extensive investigation and Attorney General hours. Due to these and other enforcement cases, the PAC enforcement budget for the Office of the Attorney General is almost depleted since \$200,000 has been spent.

Ms. Portman reported that a hiring freeze is still in effect so we are unable to fill the .5 position from the Consumer Protection Enforcement Initiative (CPEI).

Ms. Portman reported that the licensing scanning project was completed. All existing license files were scanned and indexed and new license files are scanned weekly.

Ms. Portman reported on the Executive Order from Governor Brown regarding the reduction of cell phones. The PAC has three cell phones, one for the Executive Officer and two for the probation monitors, which will not need to be relinquished.

Ms. Portman reported that since the last meeting staff presented at both Stanford and UC Davis, providing students with information regarding applications, enforcement and the laws and regulations.

Ms. Portman reported that the internet team will soon be placing information on the website regarding "inactive" licenses.

Ms. Portman reported that currently we have two regulations in process. One is for the notification to consumers per SB 139 and it is being prepared for submission to DCA. The other regulation will implement enhanced enforcement processes and includes several provisions from SB 1111.

Ms. Portman also reported that there are three legislative proposals submitted to the Department. The proposals involve reporting requirements, eliminating section 2 of Section 3519 of the Business and Professions Code, and the elimination of the international graduate program.

c. Licensing Program Activity Report

Between October 1, 2010 and December 1, 2010, 126 physician assistant licenses were issued. As of December 1, 2010, 7,988 physician assistant licenses are renewed and current. Currently there are a total of 157 California approved training programs.

d. Diversion Program Activity Report

As of February 1, 2011, the Diversion Program has 25 participants, 5 self-referred participants and 20 Committee referrals. There have been 98 participants since program implementation in 1990.

e. Enforcement Program Activity Report

Between July 1, 2010 and December 1, 2010, 142 complaints were received, 69 pending complaints, 31 pending investigations, 42 current probationers and 22 cases are pending at the Office of the Attorney General.

6. Department of Consumer Affairs' Report

Ms. Cindy Kanemoto provided a brief update from Department's Executive Office. Ms. Kanemoto stated that the hiring freeze is still in effect but noted that internal transfers are allowed. She also reported that the Department has almost met the goal of reducing cellular telephones by 50%, as directed by the Governor.

Ms. Kanemoto explained that there is a new process for expert consultants which requires boards and committees to contract for expert services. Discussion ensued. Staff was directed to investigate seeking an exemption from obtaining these contracts and to report back at the next meeting.

7. Report on the Physician Assistant Education and Training Subcommittee

Mr. Heppler reported that the Subcommittee held a meeting on January 19, 2011, and discussed many topics, including the right of the PAC to choose another program if necessary.

Mr. Heppler stated that a portion of the discussion focused on the fact that preceptors shall be licensed physicians engaged in the practice of medicine whose practice is sufficient to adequately expose preceptees to a full range of experience. Additionally, a preceptor shall not be assigned to supervise more than one preceptee at a time.

A motion was made to direct the Subcommittee to focus on the education aspect, the preceptor to preceptee ratio, and to define who can be a preceptor.
(m/Klompus, s/Young, motion passes)

8. Update on Health Care Reform

Ms. Portman reported that the California Healthcare Foundation was unable to provide a speaker for today's meeting. However, they did provide some written material for review.

Ms. Portman reported that under the reform, the primary and most direct impact on California government will be on health and insurance related agencies, such as the Department of Health Care Services, Department of Insurance and managed Health Care. Ms Portman also reported that it is anticipated that an increase in patients will result in an increase in the need for health providers.

9. Update on Enforcement Actions/Disciplinary Process

Mr. Heppler gave a presentation involving due process, consumer protection, statutes and regulations, including explaining the role of DCA legal counsel regarding conflict, communication and consumer protection.

10. Maximus Presentation regarding the Diversion Program

Linda Ryan, MFT, Maximus' Clinical Case Manager and Ginny Matthews, RN, Project Manager, provided an overview of the Physician Assistant Diversion Program.

Ms. Ryan stated that the primary purpose of the Diversion Program was to protect the health and safety of California's healthcare consumers. The program is designed to allow impaired professionals to be counseled, guided to appropriate treatment and returned to practice in a manner which will not endanger public health or safety.

11. Legislation of Interest to the Physician Assistant Committee

The current status of the following bills was discussed:

AB 30 - Hayashi

Under existing law, the State Department of Public Health licenses and regulates hospitals. Existing law requires hospitals to conduct a security and safety assessment and develop a security plan to protect hospital personnel (including physician assistants), patients, and visitors from aggressive or violent behavior.

AB 82 - Jeffries

Existing law regulates the operation of firefighting equipment, and permits a firefighter or volunteer firefighter to operate firefighting equipment only if the person holds a class A, B, or C license.

The examination for a class A or B driver's license shall also include a report of a medical examination of the applicant given by a health care professional. Health care professionals will include physician assistants.

AB 136 - Beall

Existing law requires the administration of the state's universal service programs, including the deaf and disabled programs. This bill would make technical, non-substantive changes to provisions of law relating to the deaf and disabled universal service program.

This bill would also allow a physician assistant to certify the needs of an individual diagnosed by a physician and surgeon as being deaf or hearing impaired to participate in the program after reviewing medical records or copies of the medical records containing that diagnosis.

AB 137 - Portantino

Health care coverage: mammograms.

The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care.

This bill would provide that health care service plan contracts and individual or group policies of health insurance issued, amended, delivered, or renewed on or after July 1, 2012, shall be deemed to provide coverage for mammograms for screening or diagnostic purposes upon referral of a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician.

SB 28 - Simitian

Existing law requires the Department of Motor Vehicles to examine applicants and includes a medical examination report given by a health care professional. Health care professionals will include physician assistants.

SB 100 - Price

This bill would require certain healing arts licensees to include in advertisements, as defined, certain words or designations following their names indicating the particular educational degree they hold or healing art they practice.

This bill would require the board to adopt regulations by January 1, 2013, regarding the appropriate level of physician availability needed within clinics or

other settings using certain laser or intense pulse light devices for elective cosmetic procedures.

AB 92 and SB 68

These bills are current budget bills.

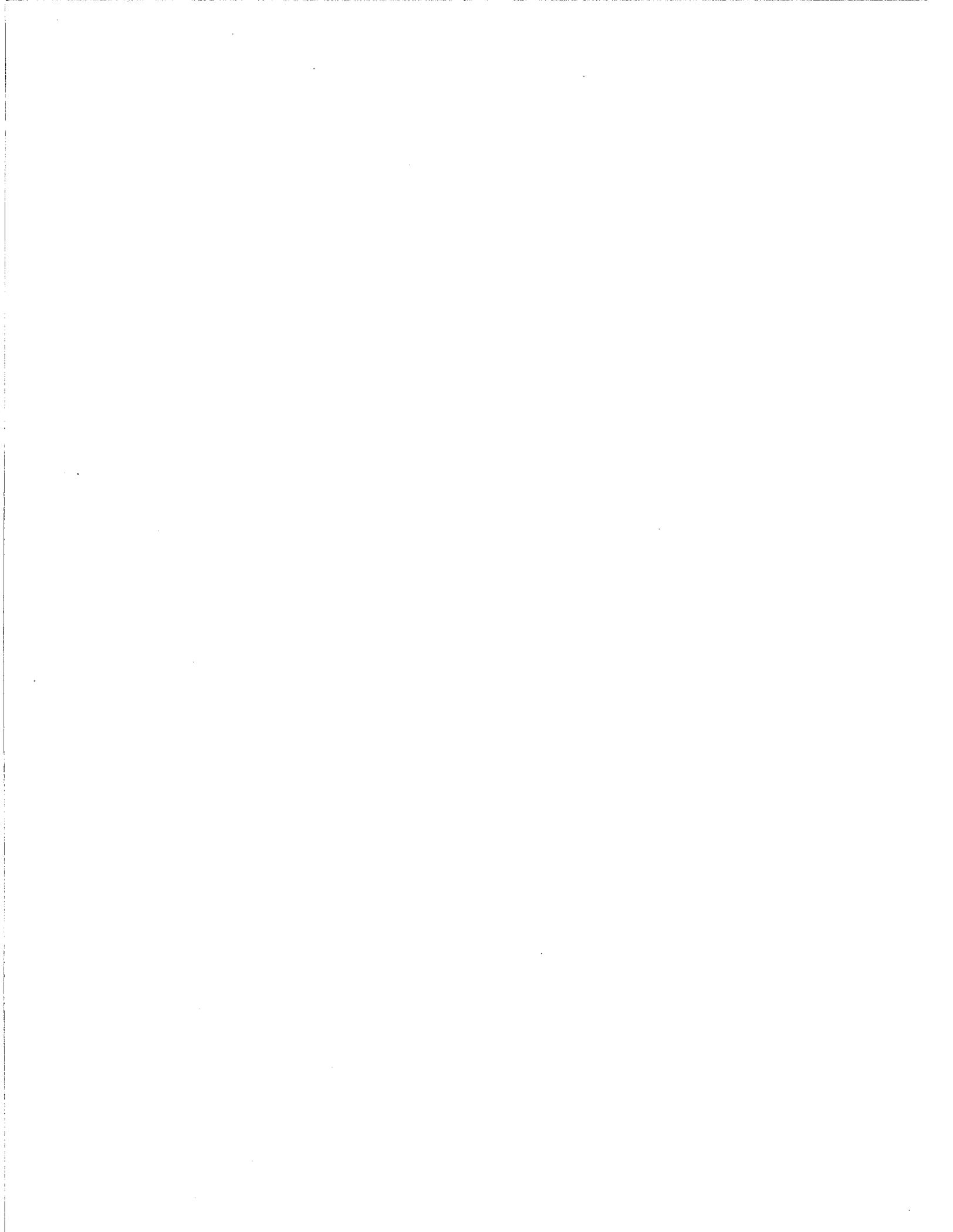
12. Agenda Items for Next Meeting

- a. Report on Maximus' participant success from 2003 to present
- b. Report on current fund condition
- c. Update on discussion on changing committee to board
- d. Update on obtaining a legislative exception for the Expert Consultant Contract issue

13. The Committee moved into closed session.

14. Adjournment

The meeting adjourned at 2:40 p.m.



0280 - Physician Assistant Committee Analysis of Fund Condition

Prepared 4/6/11

(Dollars in Thousands)

Proposed FY 2011-12 Governor's Budget
Includes \$1.5 M Loan
Includes \$220K Loan Repayment

	Actual 2009-10	CY 2010-11	Governor's Budget BY 2011-12	BY + 1 2012-13	2013-14	2014-15	2015-16
BEGINNING BALANCE	\$ 1,949	\$ 2,098	\$ 2,012	\$ 1,969	\$ 1,906	\$ 1,814	\$ 1,710
Prior Year Adjustment	\$ 3	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 1,952	\$ 2,098	\$ 2,012	\$ 1,969	\$ 1,906	\$ 1,814	\$ 1,710
REVENUES AND TRANSFERS							
Revenues:							
125600 Other regulatory fees	\$ 9	\$ 8	\$ 8	\$ 8	\$ 8	\$ 8	\$ 8
125700 Other regulatory licenses and permits	\$ 163	\$ 152	\$ 161	\$ 161	\$ 161	\$ 161	\$ 161
125800 Renewal fees	\$ 1,052	\$ 1,095	\$ 1,140	\$ 1,140	\$ 1,140	\$ 1,140	\$ 1,140
125900 Delinquent fees	\$ 3	\$ 4	\$ 4	\$ 4	\$ 4	\$ 4	\$ 4
141200 Sales of documents	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
142500 Miscellaneous services to the public	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
150300 Income from surplus money investments	\$ 14	\$ 20	\$ 19	\$ 19	\$ 18	\$ 34	\$ 31
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
161400 Miscellaneous revenues	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
164300 Penalty Assessments	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Totals, Revenues	\$ 1,241	\$ 1,279	\$ 1,332	\$ 1,332	\$ 1,331	\$ 1,347	\$ 1,344
Transfers from other Funds							
Proposed GF Loan Repay							
Transfers to other Funds							
Totals, Revenues and Transfers	\$ 1,241	\$ 1,279	\$ 1,332	\$ 1,332	\$ 1,331	\$ 1,347	\$ 1,344
Totals, Resources	\$ 3,193	\$ 3,377	\$ 3,344	\$ 3,301	\$ 3,237	\$ 3,161	\$ 3,054
EXPENDITURES							
Disbursements:							
0840 State Controllers	\$ 1	\$ 2	\$ 1	\$ -	\$ -	\$ -	\$ -
8880 FISCA (State Operations)		\$ 1	\$ 6				
1110 Program Expenditures (State Operations)	\$ 1,094	\$ 1,364	\$ 1,368	\$ 1,395	\$ 1,423	\$ 1,451	\$ 1,480
BreEZe Funding Realignment		\$ -2					
Total Disbursements	\$ 1,095	\$ 1,365	\$ 1,375	\$ 1,395	\$ 1,423	\$ 1,451	\$ 1,480
FUND BALANCE							
Reserve for economic uncertainties	\$ 2,098	\$ 2,012	\$ 1,969	\$ 1,906	\$ 1,814	\$ 1,710	\$ 1,574
Months in Reserve	18.4	17.6	16.9	16.1	15.0	13.9	12.5

NOTES:

- A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR 2009-10 AND ON-GOING.
- B. ASSUMES INTEREST RATE AT 1%
- C. ASSUMES APPROPRIATION GROWTH OF 2% PER YEAR

**DEPARTMENT OF CONSUMER AFFAIRS
BUDGET REPORT
AS OF 3/31/2011**

PHYSICIAN ASSISTANT COMMITTEE

RUN DATE 4/12/2011

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PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PERSONAL SERVICES							
SALARIES AND WAGES							
003 00 CIVIL SERVICE-PERM	202,263	14,442	139,164	0	139,164	63,099	
033 04 TEMP HELP (907)	0	2,144	17,592	0	17,592	(17,592)	
063 00 STATUTORY-EXEMPT	81,732	6,496	56,896	0	56,896	24,836	
063 03 COMM MEMBER (911)	16,000	0	1,700	0	1,700	14,300	
083 00 OVERTIME	0	0	10	0	10	(10)	
TOTAL SALARIES AND WAGES	299,995	23,083	215,362	0	215,362	84,633	28.21%
STAFF BENEFITS							
103 00 OASDI	20,340	1,261	11,727	0	11,727	8,613	
104 00 DENTAL INSURANCE	1,758	125	1,924	0	1,924	(166)	
105 00 HEALTH/WELFARE INS	36,657	1,744	23,439	0	23,439	13,218	
106 01 RETIREMENT	54,388	3,670	37,379	0	37,379	17,009	
125 00 WORKERS' COMPENSATIO	5,044	0	0	0	0	5,044	
125 15 SCIF ALLOCATION COST	0	10	1,158	2,806	3,964	(3,964)	
134 00 OTHER-STAFF BENEFITS	0	1,012	8,678	0	8,678	(8,678)	
134 01 TRANSIT DISCOUNT	0	0	56	0	56	(56)	
135 00 LIFE INSURANCE	0	8	75	0	75	(75)	
136 00 VISION CARE	445	26	313	0	313	132	
137 00 MEDICARE TAXATION	0	326	3,022	0	3,022	(3,022)	
TOTAL STAFF BENEFITS	118,632	8,182	87,772	2,806	90,578	28,054	23.65%
SALARY SAVINGS							
141 00 SALARY SAVINGS	(23,434)	0	0	0	0	(23,434)	
TOTAL SALARY SAVINGS	(23,434)	0	0	0	0	(23,434)	100.00%
TOTAL PERSONAL SERVICES	395,193	31,265	303,134	2,806	305,940	89,253	22.58%
OPERATING EXPENSES & EQUIPMENT							
FINGERPRINTS							
213 04 FINGERPRINT REPORTS	24,890	510	4,692	0	4,692	20,198	
TOTAL FINGERPRINTS	24,890	510	4,692	0	4,692	20,198	81.15%
GENERAL EXPENSE							
201 00 GENERAL EXPENSE	6,557	0	0	0	0	6,557	
206 00 MISC OFFICE SUPPLIES	0	184	768	0	768	(768)	
207 00 FREIGHT & DRAYAGE	0	20	278	0	278	(278)	

DEPARTMENT OF CONSUMER AFFAIRS

BUDGET REPORT

AS OF 3/31/2011

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PHYSICIAN ASSISTANT COMMITTEE

RUN DATE 4/12/2011

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PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
213 02 ADMIN OVERHEAD-OTHR	0	1,929	3,041	0	3,041	(3,041)	
217 00 MTG/CONF/EXHIBIT/SHO	0	879	2,903	4,899	7,801	(7,801)	
TOTAL GENERAL EXPENSE	6,557	3,012	6,991	4,899	11,889	(5,332)	-81.32%
PRINTING							
241 00 PRINTING	4,673	0	0	0	0	4,673	
242 02 REPRODUCTION SVS	0	11	52	0	52	(52)	
244 00 OFFICE COPIER EXP	0	0	618	702	1,320	(1,320)	
245 00 PRINTED FORM/STATNRY	0	0	10	0	10	(10)	
TOTAL PRINTING	4,673	11	680	702	1,382	3,292	70.44%
COMMUNICATIONS							
251 00 COMMUNICATIONS	8,339	0	0	0	0	8,339	
252 00 CELL PHONES,PDA,PAGE	0	0	1,363	0	1,363	(1,363)	
257 01 TELEPHONE EXCHANGE	0	731	1,254	0	1,254	(1,254)	
TOTAL COMMUNICATIONS	8,339	731	2,618	0	2,618	5,721	68.61%
POSTAGE							
261 00 POSTAGE	19,230	0	0	0	0	19,230	
262 00 STAMPS, STAMP ENVEL	0	7	63	0	63	(63)	
263 05 ALLOCATED POSTAGE-DC	0	392	2,250	0	2,250	(2,250)	
263 06 ALLOCATED POSTAGE-ED	0	0	1,195	0	1,195	(1,195)	
TOTAL POSTAGE	19,230	399	3,508	0	3,508	15,722	81.76%
TRAVEL: IN-STATE							
291 00 TRAVEL: IN-STATE	28,299	0	0	0	0	28,299	
292 00 PER DIEM-I/S	0	0	1,305	0	1,305	(1,305)	
294 00 COMMERCIAL AIR-I/S	0	0	2,249	0	2,249	(2,249)	
296 00 PRIVATE CAR-I/S	0	0	1,141	0	1,141	(1,141)	
297 00 RENTAL CAR-I/S	0	110	958	0	958	(958)	
301 00 TAXI & SHUTTLE SERV-	0	35	95	0	95	(95)	
TOTAL TRAVEL: IN-STATE	28,299	145	5,748	0	5,748	22,551	79.69%
TRAINING							
331 00 TRAINING	1,096	0	0	0	0	1,096	
TOTAL TRAINING	1,096	0	0	0	0	1,096	100.00%
FACILITIES OPERATIONS							
341 00 FACILITIES OPERATION	55,958	0	0	0	0	55,958	
343 00 RENT-BLDG/GRND(NON S	0	3,526	31,890	10,896	42,786	(42,786)	
347 00 FACILITY PLNG-DGS	0	64	509	0	509	(509)	

DEPARTMENT OF CONSUMER AFFAIRS

BUDGET REPORT

AS OF 3/31/2011

RUN DATE: 4/12/2011

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PHYSICIAN ASSISTANT COMMITTEE

PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
TOTAL FACILITIES OPERATIONS	55,958	3,589	32,399	10,896	43,295	12,663	22.63%
C/P SVS - INTERDEPARTMENTAL							
382 00 CONSULT/PROF-INTERDE	1,899	0	0	0	0	1,899	
TOTAL C/P SVS - INTERDEPARTMENTAL	1,899	0	0	0	0	1,899	100.00%
C/P SVS - EXTERNAL							
402 00 CONSULT/PROF SERV-EX	28,561	0	0	0	0	28,561	
418 02 CONS/PROF SVS-EXTRNL	0	5,004	41,705	33,342	75,046	(75,046)	
TOTAL C/P SVS - EXTERNAL	28,561	5,004	41,705	33,342	75,046	(46,485)	-162.76%
DEPARTMENTAL SERVICES							
424 03 OIS PRO RATA	55,877	4,481	40,332	0	40,332	15,545	
427 00 INDIRECT DISTRB COST	43,726	3,644	32,795	0	32,795	10,931	
427 01 INTERAGENCY SERVS	7,717	0	0	0	0	7,717	
427 02 SHARED SVS-MBC ONLY	98,682	24,670	74,012	24,670	98,682	0	
427 30 DOI - PRO RATA	1,479	123	1,109	0	1,109	370	
427 34 PUBLIC AFFAIRS PRO R	3,015	251	2,261	0	2,261	754	
427 35 CCED PRO RATA	1,835	153	1,376	0	1,376	459	
TOTAL DEPARTMENTAL SERVICES	212,331	33,322	151,885	24,670	176,555	35,776	16.85%
CONSOLIDATED DATA CENTERS							
428 00 CONSOLIDATED DATA CE	5,128	1,127	2,786	0	2,786	2,342	
TOTAL CONSOLIDATED DATA CENTERS	5,128	1,127	2,786	0	2,786	2,342	45.67%
DATA PROCESSING							
431 00 INFORMATION TECHNOLO	3,086	0	0	0	0	3,086	
TOTAL DATA PROCESSING	3,086	0	0	0	0	3,086	100.00%
CENTRAL ADMINISTRATIVE SERVICES							
438 00 PRO RATA	42,294	0	31,721	0	31,721	10,574	
TOTAL CENTRAL ADMINISTRATIVE SERVICES	42,294	0	31,721	0	31,721	10,574	25.00%
MAJOR EQUIPMENT							
452 00 REPLACEMENT-EQPT	13,000	0	0	0	0	13,000	
472 00 ADDITIONAL EQUIPMENT	6,000	0	0	0	0	6,000	
TOTAL MAJOR EQUIPMENT	19,000	0	0	0	0	19,000	100.00%
ENFORCEMENT							
396 00 ATTORNEY GENL-INTERD	246,418	13,898	211,847	0	211,847	34,571	
397 00 OFC ADMIN HEARNG-INT	75,251	1,780	43,575	0	43,575	31,676	
414 31 EVIDENCE/WITNESS FEE	492	1,433	8,825	0	8,825	(8,333)	

DEPARTMENT OF CONSUMER AFFAIRS

BUDGET REPORT

AS OF 3/31/2011

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PHYSICIAN ASSISTANT COMMITTEE

PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
418 97 COURT REPORTER SERVS	0	0	5,672	0	5,672	(5,672)	
427 32 INVEST SVS-MBC ONLY	205,870	5,009	77,807	0	77,807	128,063	
TOTAL ENFORCEMENT	528,031	22,119	347,726	0	347,726	180,305	34.15%
MINOR EQUIPMENT							
226 00 MINOR EQUIPMENT	4,000	0	0	0	0	4,000	
TOTAL MINOR EQUIPMENT	4,000	0	0	0	0	4,000	100.00%
TOTAL OPERATING EXPENSES & EQUIPMEN	993,372	69,970	632,458	74,508	706,965	286,407	28.83%
<hr/>							
PHYSICIAN ASSISTANT COMMITTEE	1,388,565	101,235	935,592	77,314	1,012,905	375,660	27.05%
<hr/>							
	1,388,565	101,235	935,592	77,314	1,012,905	375,660	27.05%

DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

BUDGET REPORT AS OF 2/28/2011

RUN DATE 3/10/2011

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PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
PERSONAL SERVICES							
SALARIES AND WAGES							
003 00 CIVIL SERVICE-PERM	202,263	16,076	124,722	0	124,722	77,541	
033 04 TEMP HELP (907)	0	2,815	15,448	0	15,448	(15,448)	
063 00 STATUTORY-EXEMPT	81,732	6,496	50,399	0	50,399	31,333	
063 03 COMM MEMBER (911)	16,000	0	1,700	0	1,700	14,300	
083 00 OVERTIME	0	0	10	0	10	(10)	
TOTAL SALARIES AND WAGES	299,995	25,388	192,279	0	192,279	107,716	35.91%
STAFF BENEFITS							
103 00 OASDI	20,340	1,347	10,466	0	10,466	9,874	
104 00 DENTAL INSURANCE	1,758	229	1,798	0	1,798	(40)	
105 00 HEALTH/WELFARE INS	36,657	2,878	21,696	0	21,696	14,961	
106 01 RETIREMENT	54,388	3,957	33,708	0	33,708	20,680	
125 00 WORKERS' COMPENSATIO	5,044	0	0	0	0	5,044	
125 15 SCIF ALLOCATION COST	0	116	1,148	0	1,148	(1,148)	
134 00 OTHER-STAFF BENEFITS	0	1,013	7,667	0	7,667	(7,667)	
134 01 TRANSIT DISCOUNT	0	0	56	0	56	(56)	
135 00 LIFE INSURANCE	0	8	67	0	67	(67)	
136 00 VISION CARE	445	35	287	0	287	158	
137 00 MEDICARE TAXATION	0	356	2,696	0	2,696	(2,696)	
TOTAL STAFF BENEFITS	118,632	9,938	79,590	0	79,590	39,042	32.91%
SALARY SAVINGS							
141 00 SALARY SAVINGS	(23,434)	0	0	0	0	(23,434)	
TOTAL SALARY SAVINGS	(23,434)	0	0	0	0	(23,434)	100.00%
TOTAL PERSONAL SERVICES	395,193	35,326	271,869	0	271,869	123,324	31.21%
OPERATING EXPENSES & EQUIPMENT							
FINGERPRINTS							
213 04 FINGERPRINT REPORTS	24,890	153	4,182	0	4,182	20,708	
TOTAL FINGERPRINTS	24,890	153	4,182	0	4,182	20,708	83.20%
GENERAL EXPENSE							
201 00 GENERAL EXPENSE	6,557	0	0	0	0	6,557	
206 00 MISC OFFICE SUPPLIES	0	26	584	0	584	(584)	
207 00 FREIGHT & DRAYAGE	0	146	258	0	258	(258)	

DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

BUDGET REPORT

AS OF 2/28/2011

RUN DATE 3/10/2011

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PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
213 02 ADMIN OVERHEAD-OTHR	0	0	1,113	0	1,113	(1,113)	
217 00 MTG/CONF/EXHIBIT/SHO	0	0	2,024	5,778	7,801	(7,801)	
TOTAL GENERAL EXPENSE	6,557	172	3,978	5,778	9,756	(3,199)	-48.79%
PRINTING							
241 00 PRINTING	4,673	0	0	0	0	4,673	
242 02 REPRODUCTION SVS	0	19	40	0	40	(40)	
244 00 OFFICE COPIER EXP	0	309	618	702	1,320	(1,320)	
245 00 PRINTED FORM/STATNRY	0	10	10	0	10	(10)	
TOTAL PRINTING	4,673	338	669	702	1,370	3,303	70.68%
COMMUNICATIONS							
251 00 COMMUNICATIONS	8,339	0	0	0	0	8,339	
252 00 CELL PHONES,PDA,PAGE	0	0	1,363	0	1,363	(1,363)	
257 01 TELEPHONE EXCHANGE	0	9	523	0	523	(523)	
TOTAL COMMUNICATIONS	8,339	9	1,887	0	1,887	6,452	77.38%
POSTAGE							
261 00 POSTAGE	19,230	0	0	0	0	19,230	
262 00 STAMPS, STAMP ENVEL	0	45	56	0	56	(56)	
263 05 ALLOCATED POSTAGE-DC	0	332	1,858	0	1,858	(1,858)	
263 06 ALLOCATED POSTAGE-ED	0	448	1,195	0	1,195	(1,195)	
TOTAL POSTAGE	19,230	825	3,109	0	3,109	16,121	83.83%
TRAVEL: IN-STATE							
291 00 TRAVEL: IN-STATE	28,299	0	0	0	0	28,299	
292 00 PER DIEM-I/S	0	74	1,305	0	1,305	(1,305)	
294 00 COMMERCIAL AIR-I/S	0	980	2,249	0	2,249	(2,249)	
296 00 PRIVATE CAR-I/S	0	360	1,141	0	1,141	(1,141)	
297 00 RENTAL CAR-I/S	0	402	848	0	848	(848)	
301 00 TAXI & SHUTTLE SERV-	0	0	60	0	60	(60)	
TOTAL TRAVEL: IN-STATE	28,299	1,816	5,604	0	5,604	22,695	80.20%
TRAINING							
331 00 TRAINING	1,096	0	0	0	0	1,096	
TOTAL TRAINING	1,096	0	0	0	0	1,096	100.00%
FACILITIES OPERATIONS							
341 00 FACILITIES OPERATION	55,958	0	0	0	0	55,958	
343 00 RENT-BLDG/GRND(NON S	0	3,526	28,365	14,421	42,786	(42,786)	
347 00 FACILITY PLNG-DGS	0	64	445	0	445	(445)	

DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

BUDGET REPORT
AS OF 2/28/2011

RUN DATE 3/10/2011

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PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
<u>TOTAL</u> FACILITIES OPERATIONS	55,958	3,589	28,810	14,421	43,231	12,727	22.74%
C/P SVS - INTERDEPARTMENTAL							
382 00 CONSULT/PROF-INTERDE	1,899	0	0	0	0	1,899	
<u>TOTAL</u> C/P SVS - INTERDEPARTMENTAL	1,899	0	0	0	0	1,899	100.00%
C/P SVS - EXTERNAL							
402 00 CONSULT/PROF SERV-EX	28,561	0	0	0	0	28,561	
418 02 CONS/PROF SVS-EXTRNL	0	11,708	36,701	38,346	75,046	(75,046)	
<u>TOTAL</u> C/P SVS - EXTERNAL	28,561	11,708	36,701	38,346	75,046	(46,485)	-162.76%
DEPARTMENTAL SERVICES							
424 03 OIS PRO RATA	55,877	4,481	35,851	0	35,851	20,026	
427 00 INDIRECT DISTRB COST	43,726	3,644	29,151	0	29,151	14,575	
427 01 INTERAGENCY SERVS	7,717	0	0	0	0	7,717	
427 02 SHARED SVS-MBC ONLY	98,682	0	49,342	49,340	98,682	0	
427 30 DOI - PRO RATA	1,479	123	986	0	986	493	
427 34 PUBLIC AFFAIRS PRO R	3,015	251	2,010	0	2,010	1,005	
427 35 CCED PRO RATA	1,835	153	1,223	0	1,223	612	
<u>TOTAL</u> DEPARTMENTAL SERVICES	212,331	8,652	118,563	49,340	167,903	44,428	20.92%
CONSOLIDATED DATA CENTERS							
428 00 CONSOLIDATED DATA CE	5,128	225	1,659	841	2,500	2,628	
<u>TOTAL</u> CONSOLIDATED DATA CENTERS	5,128	225	1,659	841	2,500	2,628	51.25%
DATA PROCESSING							
432 00 TITLE NOT FOUND	3,086	0	0	0	0	3,086	
<u>TOTAL</u> DATA PROCESSING	3,086	0	0	0	0	3,086	100.00%
CENTRAL ADMINISTRATIVE SERVICES							
438 00 PRO RATA	42,294	10,574	31,721	0	31,721	10,574	
<u>TOTAL</u> CENTRAL ADMINISTRATIVE SERVICES	42,294	10,574	31,721	0	31,721	10,574	25.00%
MAJOR EQUIPMENT							
452 00 REPLACEMENT-EQPT	13,000	0	0	0	0	13,000	
472 00 ADDITIONAL EQUIPMENT	6,000	0	0	0	0	6,000	
<u>TOTAL</u> MAJOR EQUIPMENT	19,000	0	0	0	0	19,000	100.00%
ENFORCEMENT							
396 00 ATTORNEY GENL-INTERD	246,418	21,035	197,950	0	197,950	48,468	
397 00 OFC ADMIN HEARNG-INT	75,251	5,715	41,795	0	41,795	33,456	
414 31 EVIDENCE/WITNESS FEE	492	312	7,392	0	7,392	(6,900)	

DEPARTMENT OF CONSUMER AFFAIRS

PHYSICIAN ASSISTANT COMMITTEE

BUDGET REPORT
AS OF 2/28/2011

RUN DATE 3/10/2011

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PHYSICIAN ASSISTANT COMMITTEE

DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
418 97 COURT REPORTER SERVS	0	4,043	5,672	0	5,672	(5,672)	
427 32 INVEST SVS-MBC ONLY	205,870	9,204	72,798	0	72,798	133,072	
<u>TOTAL</u> ENFORCEMENT	528,031	40,309	325,607	0	325,607	202,424	38.34%
MINOR EQUIPMENT							
226 00 MINOR EQUIPMENT	4,000	0	0	0	0	4,000	
<u>TOTAL</u> MINOR EQUIPMENT	4,000	0	0	0	0	4,000	100.00%
<u>TOTAL</u> OPERATING EXPENSES & EQUIPMEN	993,372	78,371	562,488	109,427	671,915	321,457	32.36%
PHYSICIAN ASSISTANT COMMITTEE	1,388,565	113,697	834,357	109,427	943,784	444,781	32.03%
	1,388,565	113,697	834,357	109,427	943,784	444,781	32.03%

Performance Measures

Q3 Report (January - March 2011)

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

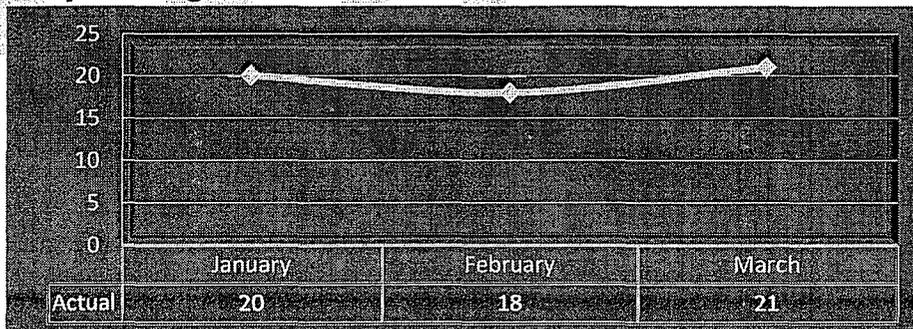
Volume

Number of complaints and convictions received.

Q3 Total: 59

Complaints: 55 Convictions: 4

Q3 Monthly Average: 20

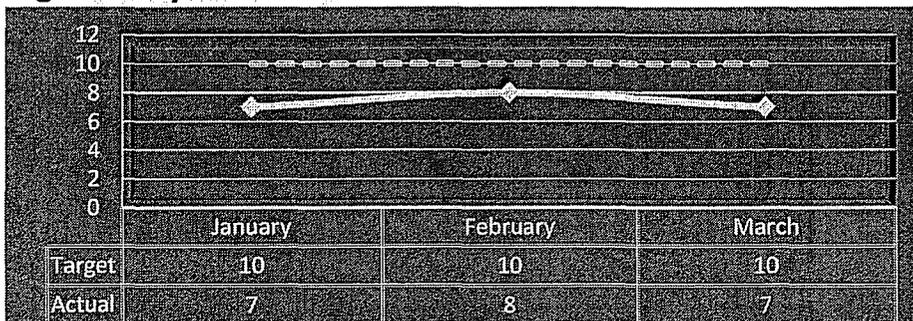


Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 10 Days

Q3 Average: 7 Days

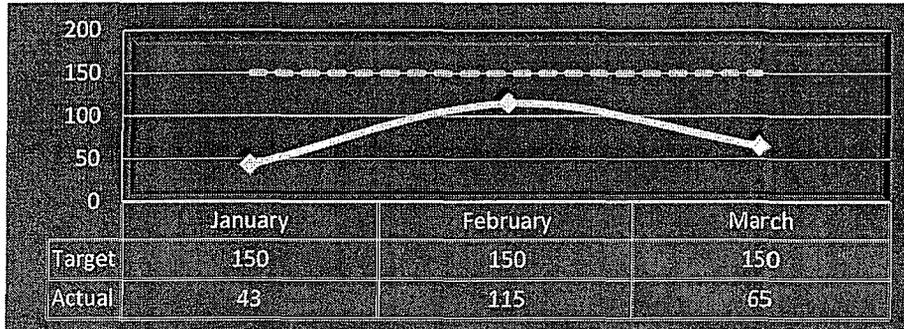


Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 150 Days

Q3 Average: 60 Days

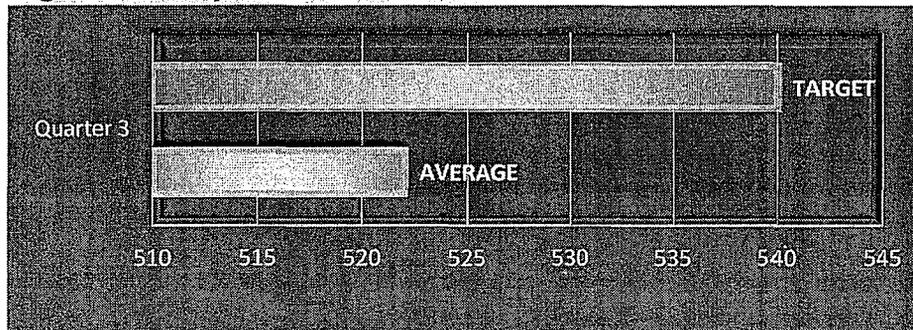


Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board, and prosecution by the AG)

Target: 540 Days

Q3 Average: 522 Days

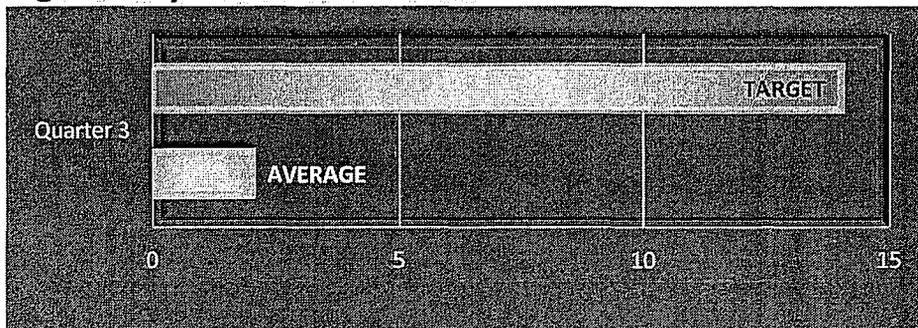


Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 14 Days

Q3 Average: 2 Days

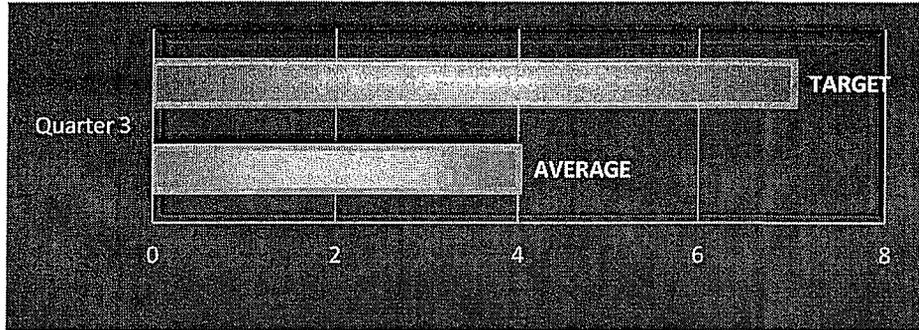


Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Target: 7 Days

Q3 Average: 4 Days



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PHYSICIAN ASSISTANT COMMITTEE
LICENSING PROGRAM ACTIVITY REPORT

INITIAL LICENSES ISSUED

	1 December 2010 1 April 2011	1 December 2009- 1 April 2010
Initial Licenses	196	202

SUMMARY OF RENEWED/CURRENT LICENSES

	As of 1 April 2011	As of 1 April 2010
Physician Assistant	8,062	7,558



**PHYSICIAN ASSISTANT COMMITTEE
DIVERSION PROGRAM**

ACTIVITY REPORT

California licensed physician assistants participating in the Physician Assistant Committee drug and alcohol diversion program:

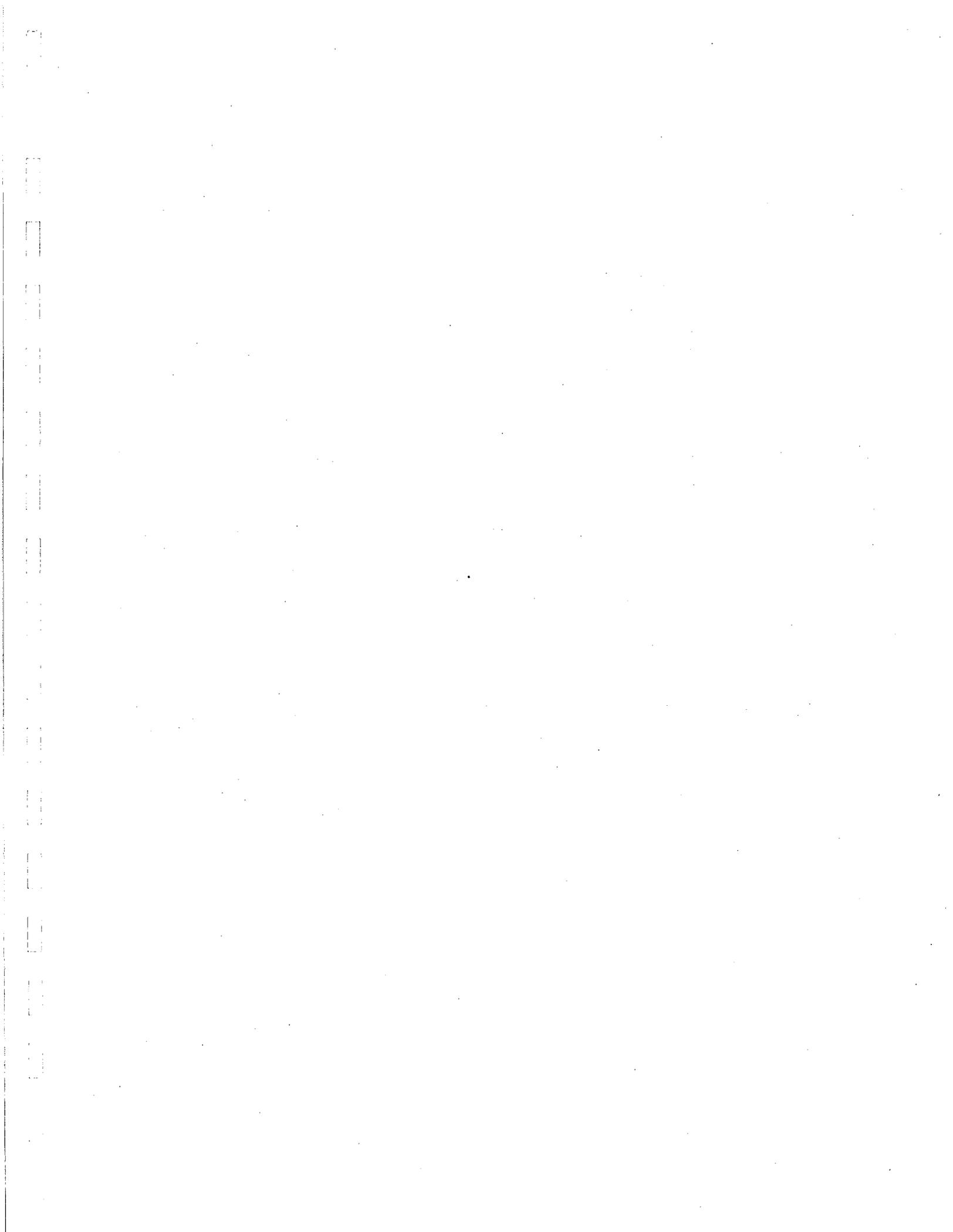
	As of 1 April 2011	As of 1 April 2010	As of 1 April 2009
Voluntary referrals	05	06	07
Committee referrals	20	17	12
Total number of participants	25	23	19

HISTORICAL STATISTICS
(Since program inception: 1990)

Total intakes into program as of 1 April 2011.....	98
Closed Cases as of 1 April 2011	
• Participant expired.....	1
• Successful completion.....	20
• Dismissed for failure to receive benefit.....	4
• Dismissed for non-compliance.....	23
• Voluntary withdrawal.....	18
• Not eligible.....	7
Total closed cases.....	73

OTHER DCA BOARD DIVERSION PROGRAM PARTICIPANTS
(As of 31 March 2011)

Dental Board of California.....	41
Osteopathic Medical Board of California.....	12
Board of Pharmacy.....	74
Physical Therapy Board of California.....	16
Board of Registered Nursing.....	491
Veterinary Board of California.....	3



**PHYSICIAN ASSISTANT COMMITTEE
DIVERSION PROGRAM**

**PARTICIPANT SUCCESSFUL COMPLETIONS
SINCE 2003**

2010	2009	2008	2007	2006	2005	2004	2003
0	0	1	0	1	4	1	2

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
April 2011

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

Substance Abuse Coordination Committee

Brian Stiger, Chair
Director, Department of Consumer Affairs

Elinore F. McCance-Katz, M.D., Ph. D.
CA Department of Alcohol & Drug Programs

Janelle Wedge
Acupuncture Board

Kim Madsen
California Board of Behavioral Sciences

Robert Puleo
Board of Chiropractic Examiners

Lori Hubble
Dental Hygiene Committee of California

Richard De Cuir
Dental Board of California

Linda Whitney
Medical Board of California

Heather Martin
California Board of Occupational Therapy

Mona Maggio
California State Board of Optometry

Teresa Bello-Jones
Board of Vocational Nursing and
Psychiatric Technicians

Donald Krpan, D.O.
Osteopathic Medical Board of California

Francine Davies
Naturopathic Medicine Committee

Virginia Herold
California State Board of Pharmacy

Steve Hartzell
Physical Therapy Board of California

Elberta Portman
Physician Assistant Committee

Jim Rathlesberger
Board of Podiatric Medicine

Robert Kahane
Board of Psychology

Louise Bailey
Board of Registered Nursing

Stephanie Nunez
Respiratory Care Board of California

Annemarie Del Mugnaio
Speech-Language Pathology & Audiology &
Hearing Aid Dispenser Board

Susan Geranen
Veterinary Medical Board

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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

If a healing arts board orders a licensee who is either in a diversion program or whose license is on probation due to a substance abuse problem to undergo a clinical diagnosis evaluation, the following applies:

1. The clinical diagnostic evaluation shall be conducted by a licensed practitioner who:
 - holds a valid, unrestricted license, which includes scope of practice 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. The Board shall order the licensee to cease practice 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 30 days 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, randomness, 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 standards shall govern all aspects of testing required to determine abstention from alcohol and drugs for any person whose license is placed on probation or in a diversion program due to substance use:

TESTING FREQUENCY SCHEDULE

A board may order a licensee to drug test at any time. Additionally, each licensee shall be tested RANDOMLY in accordance with the schedule below:

Level	Segments of Probation/Diversion	Minimum Range of Number of Random Tests
I	Year 1	52-104 per year
II*	Year 2+	36-104 per year

*The minimum range of 36-104 tests identified in level II, is for the second year of probation or diversion, and each year thereafter, up to five (5) years. Thereafter, administration of one (1) time per month if there have been no positive drug tests in the previous five (5) consecutive years of probation or diversion.

Nothing precludes a board from increasing the number of random tests for any reason. Any board who finds or has suspicion that a licensee has committed a violation of a board's testing program or who has committed a Major Violation, as identified in Uniform Standard 10, may reestablish the testing cycle by placing that licensee at the beginning of level I, in addition to any other disciplinary action that may be pursued.

EXCEPTIONS TO TESTING FREQUENCY SCHEDULE

I. PREVIOUS TESTING/SOBRIETY

In cases where a board has evidence that a licensee has participated in a treatment or monitoring program requiring random testing, prior to being subject to testing by the board, the board may give consideration to that testing in altering the testing

frequency schedule so that it is equivalent to this standard.

II. VIOLATION(S) OUTSIDE OF EMPLOYMENT

An individual whose license is placed on probation for a single conviction or incident or two convictions or incidents, spanning greater than seven years from each other, where those violations did not occur at work or while on the licensee's way to work, where alcohol or drugs were a contributing factor, may bypass level I and participate in level II of the testing frequency schedule.

III. NOT EMPLOYED IN HEALTH CARE FIELD

A board may reduce testing frequency to a minimum of 12 times per year for any person who is not practicing OR working in any health care field. If a reduced testing frequency schedule is established for this reason, and if a licensee wants to return to practice or work in a health care field, the licensee shall notify and secure the approval of the licensee's board. Prior to returning to any health care employment, the licensee shall be subject to level I testing frequency for at least 60 days. At such time the person returns to employment (in a health care field), if the licensee has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

IV. TOLLING

A board may postpone all testing for any person whose probation or diversion is placed in a tolling status if the overall length of the probationary or diversion period is also tolled. A licensee shall notify the board upon the licensee's return to California and shall be subject to testing as provided in this standard. If the licensee returns to employment in a health care field, and has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

V. SUBSTANCE USE DISORDER NOT DIAGNOSED

In cases where no current substance use disorder diagnosis is made, a lesser period of monitoring and toxicology screening may be adopted by the board, but not to be less than 24 times per year.

OTHER DRUG STANDARDS

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

The scheduling of drug tests shall be done on a random basis, preferably by a computer program, so that a licensee can make no reasonable assumption of when he/she will be tested again. Boards should be prepared to report data to support back-to-back testing as well as, numerous different intervals of testing.

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

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

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.

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

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.

Collection of specimens shall be observed.

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

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.

A board may use other testing methods in place of, or to supplement biological fluid testing, if the alternate testing method is appropriate.

PETITIONS FOR REINSTATEMENT

Nothing herein shall limit a board's authority to reduce or eliminate the standards specified herein pursuant to a petition for reinstatement or reduction of penalty filed pursuant to Government Code section 11522 or statutes applicable to the board that contains different provisions for reinstatement or reduction of penalty.

OUTCOMES AND AMENDMENTS

For purposes of measuring outcomes and effectiveness, each board shall collect and report historical and post implementation data as follows:

Historical Data - Two Years Prior to Implementation of Standard

Each board should collect the following historical data (as available), for a period of two years, prior to implementation of this standard, for each person subject to testing for banned substances, who has 1) tested positive for a banned substance, 2) failed to

appear or call in, for testing on more than three occasions, 3) failed to pay testing costs, or 4) a person who has given a dilute or invalid specimen.

Post Implementation Data- Three Years

Each board should collect the following data annually, for a period of three years, for every probationer and diversion participant subject to testing for banned substances, following the implementation of this standard.

Data Collection

The data to be collected shall be reported to the Department of Consumer Affairs and the Legislature, upon request, and shall include, but may not be limited to:

Probationer/Diversion Participant Unique Identifier

License Type

Probation/Diversion Effective Date

General Range of Testing Frequency by/for Each Probationer/Diversion Participant

Dates Testing Requested

Dates Tested

Identify the Entity that Performed Each Test

Dates Tested Positive

Dates Contractor (if applicable) was informed of Positive Test

Dates Board was informed of Positive Test

Dates of Questionable Tests (e.g. dilute, high levels)

Date Contractor Notified Board of Questionable Test

Identify Substances Detected or Questionably Detected

Dates Failed to Appear

Date Contractor Notified Board of Failed to Appear

Dates Failed to Call In for Testing

Date Contractor Notified Board of Failed to Call In for Testing

Dates Failed to Pay for Testing

Date(s) Removed/Suspended from Practice (identify which)

Final Outcome and Effective Date (if applicable)

#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 within the last year.
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, be another health care professional if no monitor with like practice is available, or, as approved by the board, be a person in a position of authority who is capable of monitoring the licensee at work.
3. If the worksite monitor is a licensed healthcare professional he or she 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:

1. The board shall order the licensee to cease practice;
2. The board shall contact the licensee and instruct the licensee to leave work; and
3. The board shall 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 shall immediately lift the cease practice order.

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. Licensee will be ordered to cease practice.
 - a) the licensee must undergo a new clinical diagnostic evaluation, and
 - b) the licensee must test negative for at least a month of continuous drug testing before being allowed to go back to work.
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) years.

#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:

(a) Specimen Collectors:

- (1) 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.
- (2) 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.
- (3) The provider or subcontractor must provide collection sites that are located in areas throughout California.
- (4) 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.
- (5) 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.
- (6) 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.

- (7) 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.
- (8) 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.
- (9) Must undergo training as specified in Uniform Standard #4 (6).

(b) Group Meeting Facilitators:

A group meeting facilitator for any support group meeting:

- (1) must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse;
- (2) must be licensed or certified by the state or other nationally certified organization;
- (3) must not have a financial relationship, personal relationship, or business relationship with the licensee within the last year;
- (4) shall report any unexcused absence within 24 hours to the board, and,
- (5) 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.

(c) Work Site Monitors:

The worksite monitor must meet the following qualifications:

- (1) 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 monitor's licensure scope of practice shall include the scope of practice of the licensee that is being monitored, be another health care professional if no

monitor with like practice is available, or, as approved by the board, be a person in a position of authority who is capable of monitoring the licensee at work.

- (3) Shall have an active unrestricted license, with no disciplinary action within the last five (5) years.
 - (4) 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.

(d) Treatment Providers

Treatment facility staff and services must have:

- (1) Licensure and/or accreditation by appropriate regulatory agencies;
- (2) Sufficient resources available to adequately evaluate the physical and mental needs of the client, provide for safe detoxification, and manage any medical emergency;
- (3) Professional staff who are competent and experienced members of the clinical staff;
- (4) Treatment planning involving a multidisciplinary approach and specific aftercare plans;
- (5) Means to provide treatment/progress documentation to the provider.

(e) General Vendor Requirements

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

- (1) 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.
- (2) 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.
- (3) 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 in recovering from substance abuse in the long term.

#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.

PHYSICIAN ASSISTANT COMMITTEE
ENFORCEMENT ACTIVITY REPORT

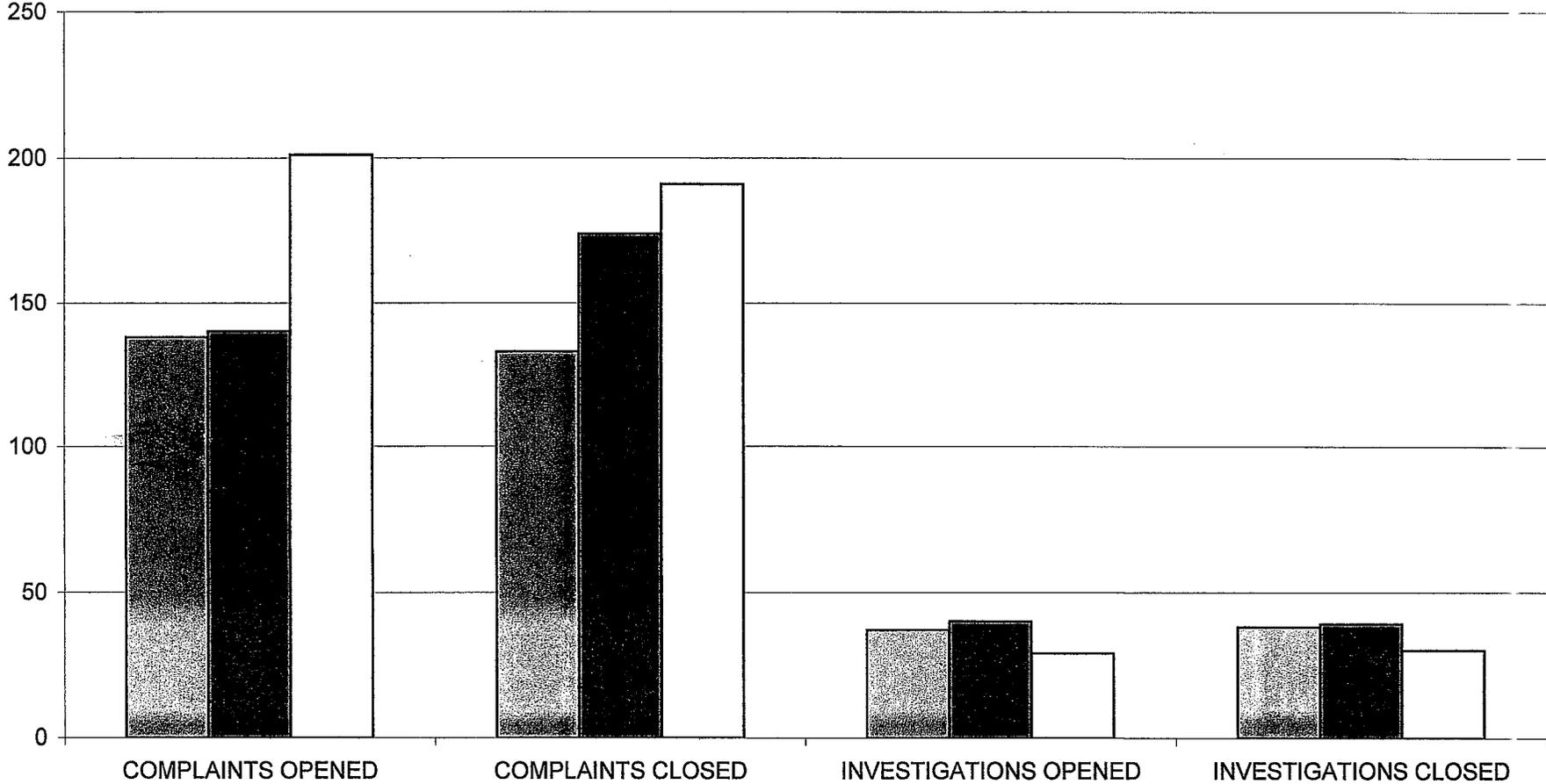
July 1 through March 31, 2011

Submitted by: Dianne Tincher

<u>Complaint Statistics</u>		<u>Disciplinary Decisions</u>	
Pending From Previous FY.....	69	License Denied	1
Received	201	Nonadopted.....	2
Closed.....	191	Probation	6
Pending.....	79	Public Reprimand/Reproval	1
At Expert Consultant.....	0	Revocation	3
		Voluntary Surrender	2
		Probationary Licenses Issued	3
		Petition for Reinstatement Denied	0
		Petition for Reinstatement Granted.....	0
		Petition for Termination of Probation Denied	0
		Petition for Termination of Probation Granted	0
		Other	0
		Out for Vote.....	0
<u>Violation Category of Complaints Received</u>		<u>Accusation/Statement of Issues</u>	
Substance Abuse.....	2	Accusation Filed.....	12
Drug Related.....	4	Accusation Withdrawn	0
Fraud.....	2	Statement of Issues Filed	2
Non Jurisdictional.....	54	Statement of Issues Withdrawn	0
Incompetence/Negligence	66	Petition to Revoke Probation Filed.....	2
Other.....	2	Petition to Compel Psychiatric Exam	0
Unprofessional Conduct	28	Interim Suspension Orders (ISO)/PC23.....	5
Sexual Misconduct.....	4		
Discipline by Another State.....	0		
Unlicensed	4		
Criminal.....	35		
		<u>Pending Cases</u>	
		Attorney General	26
		<u>Citation and Fines</u>	
		Pending from previous FY.....	3
		Issued	0
		Closed	3
		Withdrawn	0
		Sent to AG/noncompliance	0
		Pending	0
		Initial Fines Issued	\$0
		Modified Amount Due.....	\$0
		Fines Received	\$700
<u>Investigations</u>			
Pending from Previous FY	32		
Opened	28		
Closed.....	30		
Pending.....	30		
<u>Disposition of Closed Complaint</u>			
Closed with merit	80		
Closed/Insufficient Evidence.....	111		
<u>Criminal Complaint</u>			
Referred to District Attorney.....	0		
<u>Current Probationers</u>			
Active	39		
Tolled	10		
Cost Recovery Ordered	\$35,807		
Cost Recovery Received	\$23,108		

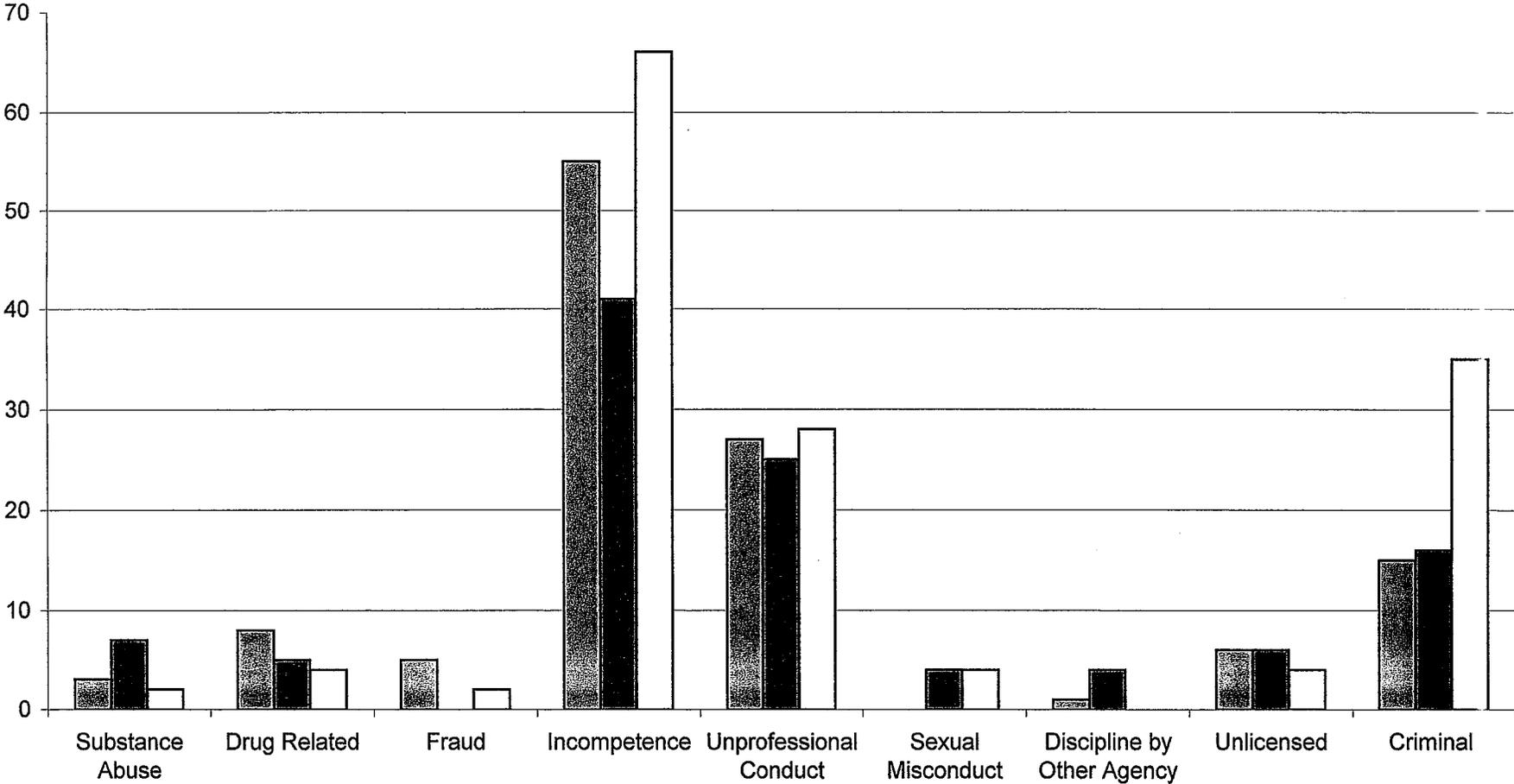
**PHYSICIAN ASSISTANT COMMITTEE
COMPLAINTS AND INVESTIGATION
JULY 1 THROUGH MARCH 31**

FY 08/09 FY 09/10 FY 10/11



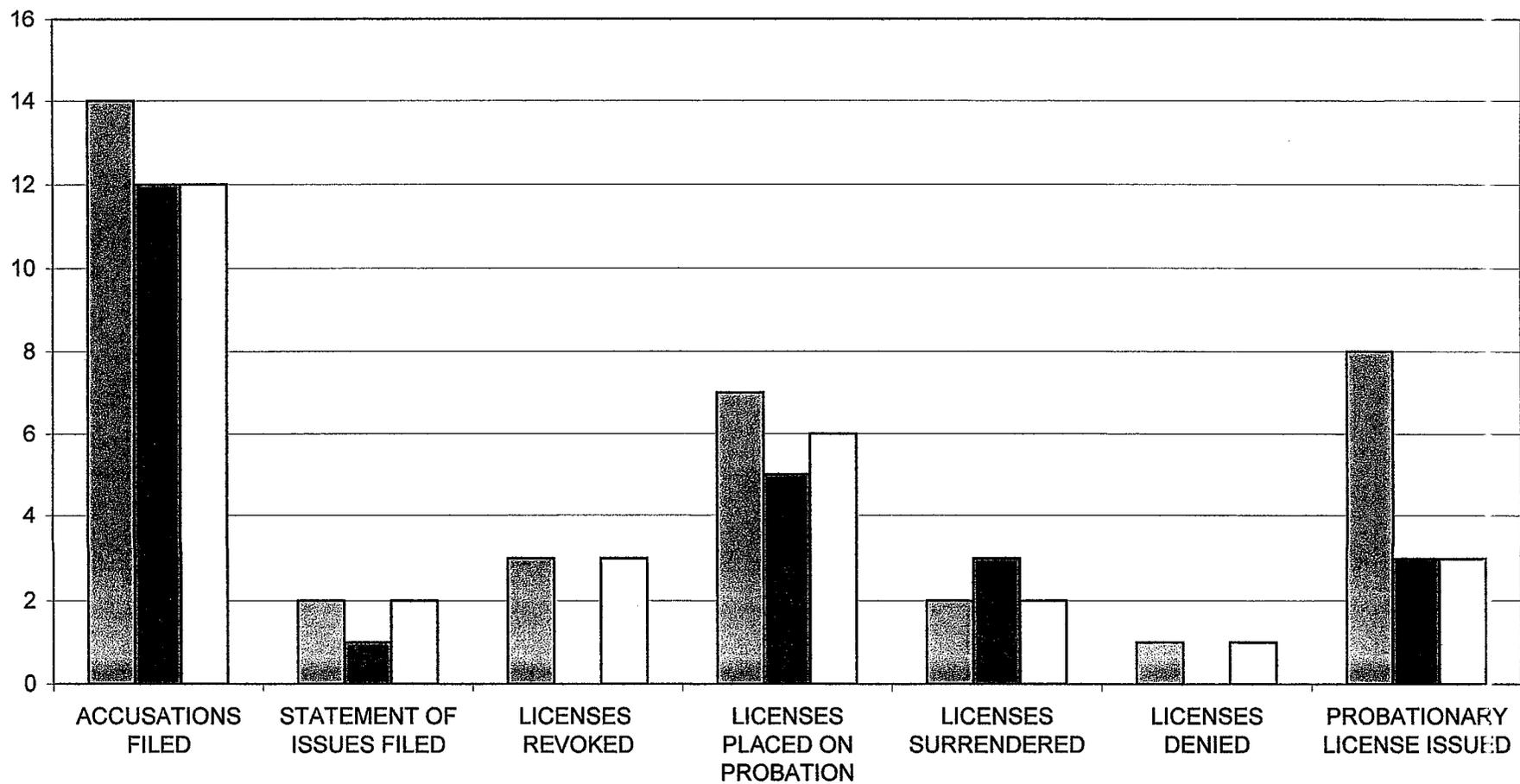
**PHYSICIAN ASSISTANT COMMITTEE
CATEGORY OF COMPLAINTS RECEIVED
JULY 1 THROUGH DECEMBER 31**

■ FY 08/09 ■ FY 09/10 □ FY 10/11



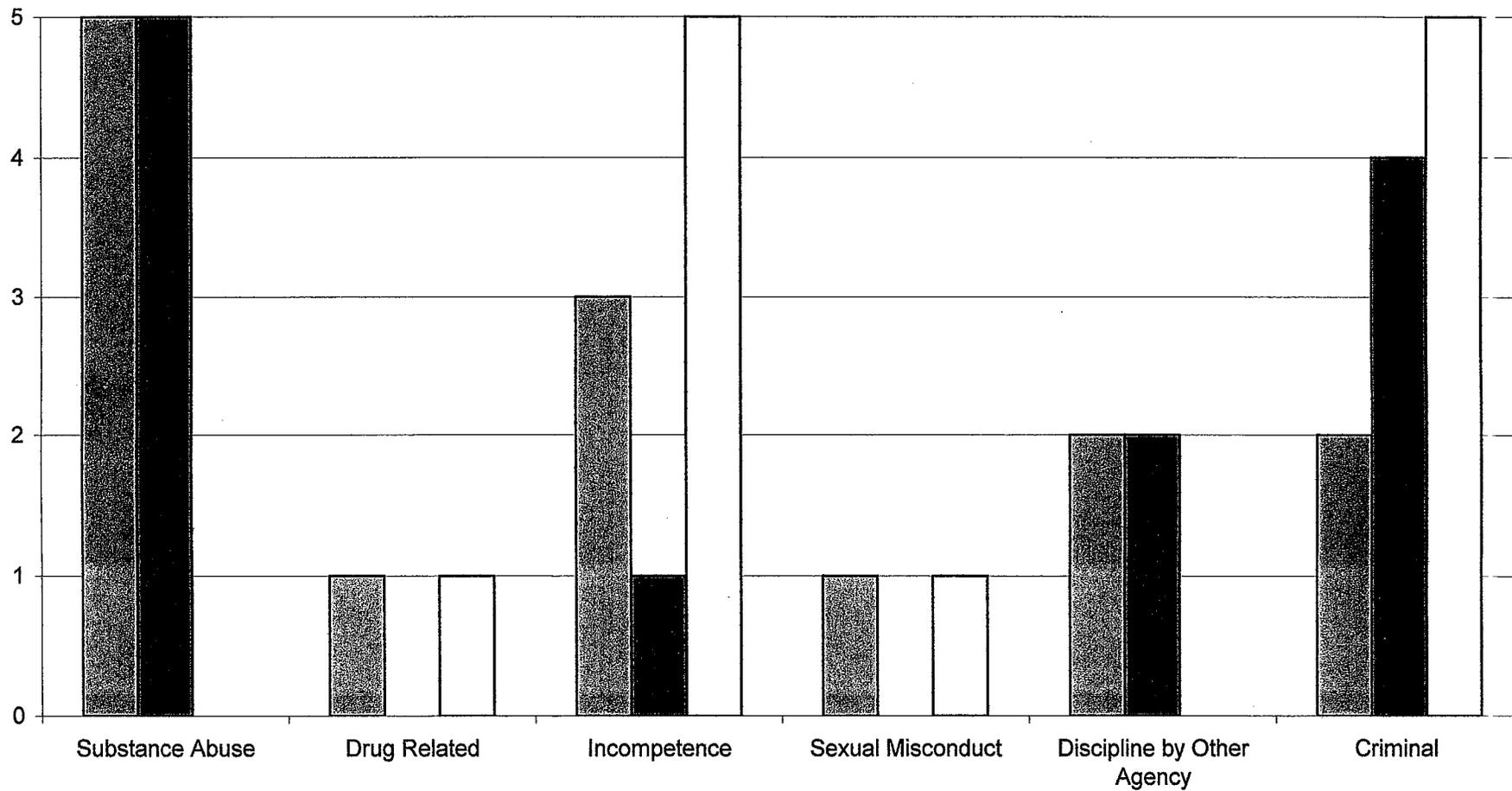
**PHYSICIAN ASSISTANT COMMITTEE
DISCIPLINARY ACTIONS
JULY 1 THROUGH MARCH 31**

■ FY 08/09 ■ FY 09/10 □ FY 10/11



**PHYSICIAN ASSISTANT COMMITTEE
CATEGORY OF ACCUSATIONS FILED
JULY 1 THROUGH MARCH 31**

FY 08/09 FY 09/10 FY 10/11



**Physician Assistant Committee
Cost Recovery
As of December 31, 2010**

<u>Cost Recovery</u>	<u>Amount</u>	<u># of Probationers</u>
Ordered over last 5 years	\$186,264	37
Received over last 5 years	\$101,988	45
Outstanding balance	\$ 101,120	17
Uncollectable amount*	\$ 92,997	14

*The uncollectable amount is from licenses that were surrendered, revoked, or sent to FTB over the last 5 years. The cost recovery would be required to be paid in full if they applied for a reinstatement of the license.

**Physician Assistant Committee
Cases Over 8 Months Old
As of March 31, 2011**

Investigations

Total Number of Investigations pending: 30

Number of Investigations over 8 months old: 15

Status of Cases over 8 months old:

<u># of cases</u>	<u>Status</u>
7	Scheduling/subpoena for Interview/records
2	At Medical consultant
1	Obtaining medical records
5	Working on final report

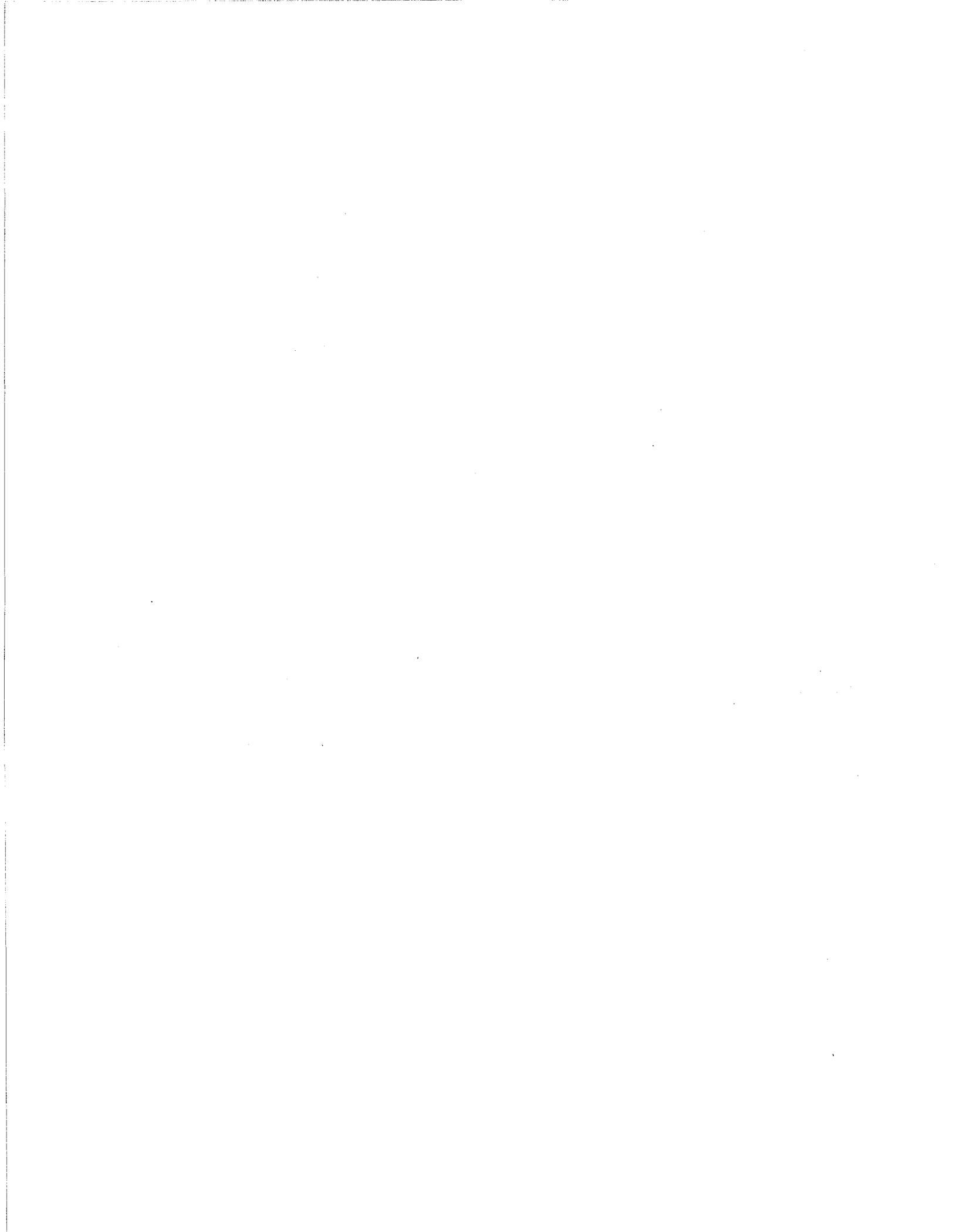
Disciplinary Actions

Total Number of Disciplinary Cases pending: 26

Number of Disciplinary Cases over 8 months old: 5

Status of Cases over 8 months old:

<u># of cases</u>	<u>Status</u>
5	Waiting for effective date of decision





AGENDA ITEM # 7

California Academy of Physician Assistants

March 15, 2011

RECEIVED
PHYSICIAN ASSISTANT

Elberta Portman, Executive Officer
Physician Assistant Committee
Medical Board of California
2005 Evergreen Street, Suite 1100
Sacramento, CA 95815

MAR 18 2011

COMMITTEE
LICENSING

Re: Request for Change in Interpretation of 16 C.C.R.
§ 1399.541(i)(1)

Dear Ms. Portman:

We are writing in support of the request by Kimberly Kreifeldt for a change in the interpretation by the Physician Assistant Committee (the "Committee") of § 1399.541 of Title 16 of the California Code of Regulations ("§ 1399.541"). That regulation addresses the performance of surgical procedures by physician assistants, and has been interpreted by the Committee's legal counsel as requiring "the personal presence of the supervising physician - in the same theater and within the line of sight or earshot - " when a patient is being closed under general anesthesia. This interpretation is found in the memorandum prepared by the Department of Consumer Affairs Legal Office dated April 25, 2005. The conclusion in that opinion states that "A physician assistant may not perform opening and closing surgical procedures on a patient under general anesthesia without the personal presence of the supervising physician and surgeon."

We respectfully submit, for the reasons raised by Ms. Kreifeldt in her correspondence to you, that this interpretation is incorrect. The provision in question, § 1399.541(i)(1), in pertinent part, states as follows:

A physician assistant may, pursuant to the delegation of services and protocols where present: . . .

(i)(1) perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. . . .

(2) A physician assistant may also act as first or second assistant in surgery under the supervision of an approved supervision physician.

We believe these two provisions should be read as separate, thereby permitting a physician assistant to either perform surgery without the personal presence of the supervising physician which is customarily performed under local anesthesia, *or* to “act as first or second assistant in surgery under the supervision of an approved supervising physician.” The second provision does not limit a PA to function as first or second assistant only when the patient is under local anesthesia. The role of a first assistant at surgery routinely includes closing patient wounds, regardless of whether the patient is under general or local anesthesia. The “job description” for surgical assistants as set forth on the website of the Commission on Accreditation of Allied Health Education Programs, includes “close all wound layers (facia, subcutaneous and skin) as per the surgeon’s directive.” Clearly, “first assisting” routinely includes “closing” patient wounds, regardless of the type of anesthesia the patient is under.

The DCA legal opinion also overlooks the fact that a patient under general anesthesia will generally have an anesthesiologist present during the closure portion of the procedure. The presence of the anesthesiologist addresses the public policy concern set forth in the DCA memorandum (“obviously, a patient under general anesthesia requires more vigilance and monitoring than a patient under local anesthesia”). The required vigilance and monitoring is performed by the anesthesiologist.

In addition to being consistent with patient safety and general practice elsewhere in the country, the interpretation we are suggesting is also consistent with the legislature’s intent in enacting the Physician Practice Act. Section 3500 of the Business and Professions Code (“Legislative Intent”) states, in pertinent part, that

The purpose of this chapter is to encourage the more effective utilization of the skills of physicians . . . by enabling them to delegate health care tasks to qualified physician assistants provided this delegation is consistent with the patient’s health and welfare and with the laws and regulations relating to physician assistants.

This chapter is established to encourage the utilization of physician assistants by physicians . . . and to provide that existing legal constraints should not be an unnecessary hindrance to the more effective provision of health care services.

Elberta Portman
March 15, 2011
Page three

Precluding PAs from performing the full range of surgical assist duties, as set forth in § 1399.541(i)(2), flies in the face of the Legislature's intent in enacting the Physician Assistant Practice Act. Consequently, we believe that the Committee should take a second look at this issue and reinterpret that section accordingly.

Finally, in the event the Committee decides not to correct the current interpretation of § 1399.541(i), we request that it recommend to the Medical Board that the regulation be revised accordingly. More specifically, we suggest that the Committee ask the Board to revise § 1399.541(i)(2) to read as follows:

A physician assistant may also act as first or second assistant in surgery, *including closing the wound for a patient under general or local anesthesia*, under the supervision of an approved supervision physician.

Thank you in advance for considering our views. Please let us know if you have any questions or would like to discuss this issue. Also, please let us know when this issue is on your agenda, as we would like to attend the meeting to address any concerns you may have regarding the foregoing.

Very truly yours,



Eric Glassman, PA-C
President

STATE OF CALIFORNIA

Memorandum

To: RICHARD WALLINDER
Executive Officer
Physicians Assistant Committee

Date: April 25, 2005

From: Department of Consumer Affairs
Legal Office

Telephone: (916) 322-5252
CalNet: 8-492-5252
FAX: (916) 323-0971

Subject: Title 16, Section 1399.541

INTRODUCTION

You have asked for an interpretation of section 1399.541 of Title 16 of the California Code of Regulations. Specifically, you have inquired as to the term "personal presence" as it is used in subsection (i) of section 1399.541. As we understand the matter, a physician assistant has inquired as to the meaning of the term in relation to performing the opening and closing portions of surgical procedure upon a patient under general anesthesia.

QUESTION PRESENTED

May a physician assistant perform opening and closing surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon?

OPINION

No. A physician assistant may not perform opening and closing surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon.

STATEMENT of FACTS

The Physician Assistant Committee (Committee) licenses physician assistants. (See Bus. & Prof. Code, §§ 3504, 3519.) In accordance with existing statute, the Committee has promulgated regulations that establish the scope of practice for physician assistants. (Cal. Code. Regs., tit. 16, §§ 1999.540, 1399.541.)

Section 1399.541 provides:

"(i) (1) Perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the physician assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the *personal presence* of an approved supervising physician.

RICHARD WALLINDER

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Page 2

(2) A physician assistant may also act as first or second assistant in surgery under the supervision of an approved supervising physician." (Emphasis added.)

ANALYSIS

The resolution of your inquiry requires an interpretation of section 1399.541. We first note that regulations are examined using the same standards that are used in cases of statutory construction and interpretation. (*Consumer Cause, Inc. v. Weider Nutrition* (2001) 111 Cal.Rptr. 823, 826, citing *Cal. Drive-In Restaurant Assn. v. Clark* (1943) 22 Cal.2d 287, 292.) The foremost concern is to ascertain the purpose of the agency issuing the regulation to effectuate the purpose of the law. (*Taxara v. Gutierrez* (2003) 8 Cal.Rptr.3d 172, 177.) In determining the intent, we must first turn to the words of the regulations themselves. (See *In re Marriage of Bonds* (2000) 99 Cal.Rptr.2d 252, 261.)

Courts often turn to dictionaries to determine the meaning of words. (*Bonds, supra*, at p. 261.) Personal means carried on between individuals directly. (Webster's Third International Dictionary (1993) at p. 1686.) Presence means the fact or condition of being present; the state of being in one place and not elsewhere. (Webster's Third International Dictionary (1993) at p. 1793.) Presence is also not mere physical proximity but also includes an awareness of the senses. (*Hamburg v. Wal-Mart Stores, Inc.* (2004) 10 Cal. Rptr.3d 568, 581.)

We think that the plain intent of the regulation is to require that when a physician assistant performs a delegated surgical procedure upon a patient under general anesthesia, his or her supervising physician must be within the same surgical area or theater and in close proximity such that the physician is able to assist the physician assistant immediately and without delay. From a pragmatic perspective, personal presence cannot mean available by telephone or pager or similar device or that the supervising physician is positioned on a different floor of the hospital or involved in another procedure that would render him or her unable to assist the physician assistant virtually instantaneously.

When the agency's intent cannot be discerned directly from the language of the regulation, we may look to a variety of extrinsic aids, including the purpose of the regulation, the legislative history, public policy, and the regulatory scheme. (*Taxara, supra*, at p. 177.) The purpose of the regulation is to clearly specify under what conditions a physician assistant may perform delegated surgical procedures. A physician assistant may perform delegated surgical procedures on a patient under local anesthesia without the personal presence of the supervising physician. (Cal. Code Regs., tit. 16, § 1399.541(i).) Logically, such authority is sound because the patient is alert, awake, and can easily alert the PA of unexpected distress.

General anesthesia, however, is defined as the loss of sensation in the entire body associated with a state of unconsciousness. (*Attorney's Dictionary of Medicine*, (2004), p. A-351.) General anesthesia also invokes a patient's loss of life-preserving protective reflexes. (See Bus. & Prof. Code, § 2216.) Obviously, a patient under general anesthesia requires more vigilance and monitoring than a patient under local anesthesia. In this situation where heightened awareness is necessary, prudent public policy both dictates and requires the personal presence of the

RICHARD WALLINDER

April 25, 2005

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supervising physician - in the same surgical theater or area and within line of sight or earshot - such that assistance to the physician assistant is immediately available.

CONCLUSION

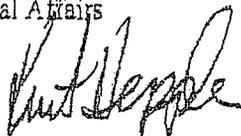
A physician assistant may not perform opening and closing surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon.

We trust the foregoing is of assistance.

DOREATHEA JOHNSON

Deputy Director

Legal Affairs



By KURT HEPPLER

Staff Counsel

KH:sib

STATE OF CALIFORNIA

Memorandum

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Executive Officer
Physicians Assistant Committee

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(2) A physician assistant may also act as first or second assistant in surgery under the supervision of an approved supervising physician.” (Emphasis added.)

ANALYSIS

The resolution of your inquiry requires an interpretation of section 1399.541. We first note that regulations are examined using the same standards that are used in cases of statutory construction and interpretation. (*Consumer Cause, Inc. v. Weider Nutrition* (2001) 111 Cal.Rptr. 823, 826, citing *Cal. Drive-In Restaurant Assn. v. Clark* (1943) 22 Cal.2d 287, 292.) The foremost concern is to ascertain the purpose of the agency issuing the regulation to effectuate the purpose of the law. (*Taxara v. Gutierrez* (2003) 8 Cal.Rptr.3d 172, 177.) In determining the intent, we must first turn to the words of the regulations themselves. (See *In re Marriage of Bonds* (2000) 99 Cal.Rptr.2d 252, 261.)

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February 23, 2011

Kimberly A. Kreifeldt
4561 Dickey Drive
La Mesa, CA 91941
(619) 804-7627 (cell) (619) 461-7278 (fax)

RECEIVED
PHYSICIAN ASSISTANT

MAR 16 2011

COMMITTEE
LICENSING

Physician Assistant Committee, Attention: Elberta Portman
2005 Evergreen Street
Suite 1100
Sacramento, CA 95815

Re: Reinterpretation of Title 16, Section 1399.541 of the California Code of Regulations

Dear Ms. Portman,

When looking into the issue of having the First assisting Physician Assistant (PA) close at the conclusion of a surgical procedure in which general anesthesia is used, I came across the Memorandum from the legal office of the Department of Consumer Affairs. I was surprised when I read the opinion, conclusion and arguments and respectfully disagree. Based on this opinion by Mr. Heppler, my role as a PA in the surgical arena is significantly limited and I kindly request that you readdress this issue and update and revise the opinion that was written almost six years ago.

In reviewing the April 2005 opinion I agree with Mr. Heppler that one must examine the intent of the drafters and review definitions of the language used by them when interpreting the original legislation. However, based on my knowledge of the operating arena, part of my conclusion is different from that of Mr. Heppler's. This lead me to hire an attorney to draft another Memorandum addressing CCR Title 16, Section 1399.541 i(1) and i(2). I've included that Memorandum, a brief synopsis of the "key points of disagreement" of the April 2005 opinion and a copy of the April 2005 opinion for your convenience.

It has also come to my attention that Mr. Heppler is currently functioning as legal council for the Department of Consumer Affairs and has been assigned to the Medical Board and Physician Assistant Committee. While I am certain that Mr. Heppler is both open minded and professional, I respectfully request that he be recused from readdressing this issue since it is his April 2005 opinion that is at the root of my request for a reinterpretation of section 1399.541.

I would like to thank you for taking the time to review my request and supporting documentation. This is an important issue for all practicing PAs in the state of California and this legal opinion, as it stands, significantly interferes with our ability to practice as I believe the drafters intended. I had a surgeon write me "why are there two highly paid professionals doing a one person job? I wonder how they'd feel if we were hospital employees and we insisted on being paid overtime or by the hour for sitting in the room while the PA closed."

Sincerely,



Kimberly A. Kreifeldt, MS, PA-C

**Key Points of Disagreement with the April 2005 Memorandum
addressing Title 16, Section 1399.541 i(1) and i(2)**

1. The issue of opening and closing should not be addressed together. Opening requires a different level of judgment and skill that is consistent with the training of a surgeon and not a physician assistant (PA). **Closing, however, is done after the completion of the surgical procedure and is routine, i.e. no longer requiring the skill and judgment of the surgeon.** Wound closure is consistent with the skill and training of a PA.
2. Looking at section 1399.541 the drafters clearly address i(1) the performing of surgical procedures from i(2) the PA may act in the role of First or Second assist separately by having two subsections of i.
PA's may:

“i(1) Perform surgical procures without the personal presence of the supervising physician which are **customarily** performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the PA is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a PA only in the personal presence of an approved supervising physician. **AND**

i(2) A PA may also act as **First or Second assistant** in surgery under the supervision of an approved supervising physician.”

- The **American College of Surgeons** define the duties of a surgical assist as providing aid in exposure, homeostasis, **closure** and other intraoperative technical functions that help the surgeon carry out a safe operation with optimal results for the patient. According to the **Commission on Accreditation of Allied Health Education Programs** first assistant duties include “**closing all wound layers (fascia, subcutaneous and skin) per the surgeon’s directive**”. The specific duties of an assistant are clearly defined by multiple authoritative sources.

3. The opinion cites case law and uses the dictionary for definitions to determine intent. Webster’s dictionary is used to define “personal” and “presence”, but “First assistant” is not defined nor is their role in the surgical arena. The opinion is based solely on i(1) and i(2) is ignored. Since the drafters specifically added i(2) after the original legislation, it seems clear that their intent was to include the duties of a “First assistant.” These duties of a First assistant (mentioned above) are “under the supervision of an approved supervising physician” and the “personal presence” of the surgeon is not required. **It is logical to assume the drafters had two sections of 1399.541, i(1&2) to insure that the “personal presence” of the surgeon was maintained during the procedural part of the**

surgery where the skill and judgment of a surgeon is critical, but allows for the PA to do the routine and customary wound closure after the procedure was completed.

4. The definition of “customarily” is also not included in the opinion. By itself, a wound closure is **customarily** done under local anesthesia in the emergency room and other clinical settings, and “customarily” is defined as “commonly practiced, used, or observed” according to Webster’s New Collegiate Dictionary. i(1) states “...perform surgical procedures without the personal presence of the supervising physician which are **customarily** performed under local anesthesia.” The drafters used the word “customarily” and not “solely” when defining what duties were able to be performed by a PA without the personal presence of the supervising physician. Once again, it seems logical by using the verbiage “...customarily performed...” and adding i(2) that the legislative intent is to allow PA’s to perform the routine and customary duty of closing a surgical wound without the personal presence of the physician.
5. The April 2005 memorandum continues that the drafters must have intended for a PA to only be able to perform procedures under local and not general anesthesia because the patient would be “alert, awake and can easily alert the PA of unexpected distress.” It seems more probable the two legal roles of the PA in a surgical setting is separated, as in i(1 & 2), to insure the personal presence of the surgeon is maintained during the actual surgical procedure when general anesthesia is used, but allows for the PA, functioning as the “First assistant” to do a “customary” wound closure which is consistent with the training and skills of a PA.
6. The opinion continues “Obviously, a patient under general anesthesia requires more vigilance and monitoring than a patient under local anesthesia. In this situation where heightened awareness is necessary...” This argument is flawed because the roles of surgical personnel are incorrect. It is the **duties of the anesthesiologist that are being described and not the surgeon or the PA.** According to Mosby’s Medical, Nursing & Allied Health Dictionary the definition of an anesthesiologist is a physician trained in the administration of anesthetics and in the provision of respiratory and cardiovascular support during anesthetic procedures. In the memorandum, there is clearly a lack of understanding of the roles of the anesthesiologist, surgeon, first assistant, second assistant, circulating nurse, scrub nurse and operating room technician in an operating room.

MEMORANDUM

Date: November 22, 2010

To: Kimberly Kreifeldt, President
Physician Assistant Surgical Services, Inc.

From: Carl A. Grubb
Grubb Law Office
(858) 699-0088

Re: California Code of Regulation Title 16, Section 1399.541(i)

INTRODUCTION

You have asked me to review the memorandum from the Department of Consumer Affairs Legal Office (DCALO) dated April 25, 2005 regarding Title 16, Section 1399.541 of the California Code of Regulations (Memorandum and/or DCALO Memorandum) and provide you with an opinion as to the efficacy of the opinion contained therein. I shall address the sections of the Memorandum as they appear in that document.

QUESTIONS PRESENTED

May a physician assistant perform opening and closing surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon?

How The Questions Should Have Been Presented

The memorandum identifies one compound question which I believe is at the root of the inaccuracy of the opinion authored by the DCALO. There are actually two questions presented:

1. May a physician assistant perform opening surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon?
2. May a physician assistant perform closing surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon?

OPINION

1. No. A physician assistant may not perform opening surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon.
2. Yes. A physician assistant may perform closing surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon.

STATEMENT OF FACTS

The section of the opinion entitled "STATEMENT OF FACTS" should have been entitled "STATEMENT OF THE LAW" since the memorandum clearly identifies existing statutes relevant to the opinion and sets forth the exact language of California Code of Regulations Title 16, Section 1399.541 (i.). I have no issue with the statutes identified or the recitation of California Code of Regulations Title 16, Section 1399.541 (i.). However, as discussed below, there is other law and analysis germane to this issue.

ANALYSIS

In 1970 a new category of health care professional called the "physician assistant" was created by the enactment of the Physician's Assistants Practice Act (the "Act") as Business and Professions Code, section 3500 et seq. which authorizes the regulations codified in Title 16 of the California Code of Regulations, including Section 1399.541 which is at the center of this issue. The purposes of the Act are set forth in section 3500. A portion of section 3500 states that:

"This chapter is established to encourage the utilization of physician assistants ... [and] to provide that existing legal constraints should not be an unnecessary hindrance to the more effective provision of health care services."

"It is a fundamental rule of law that a court should ascertain the intent of the Legislature so as to effectuate the purpose of the law. [Citation]" (See *In Re Marriage of Bonds* (2000) 24 Cal. 4th 1, 16) Therefore, the statutes and regulations implementing the Act's purpose concerning physician assistants should be interpreted so as not to unnecessarily hinder the more effective provisions of healthcare services. By treating opening surgical procedures the same as closing surgical procedures, the DCALO Memorandum is just such an unnecessary hindrance to the more effective provisions of healthcare services and is contrary to the intent of the drafters of the legislation.

Opening surgical procedures require a different and higher level of skills and judgment than does closing medical/surgical procedures. The opening procedure is generally performed under general anesthesia by a surgeon and not by a physician assistant because of the skill level, training and judgment involved. Prior to closing, the operation or procedure requiring the skill, training of the Surgeon is completed. Thereafter, all that is left to complete the operation or process is the routine act of closing the wound. Closing procedures are routinely done by physician assistants under local anesthesia as well as general anesthesia outside the scrutinizing presence of the supervising physician. The physician assistant is specifically trained to close wounds and routinely performs these procedures in emergency rooms and clinical settings. California Code of Regulations 1399.541 (i)(1) allows a physician assistant to "perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia ... [a]ll other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of an

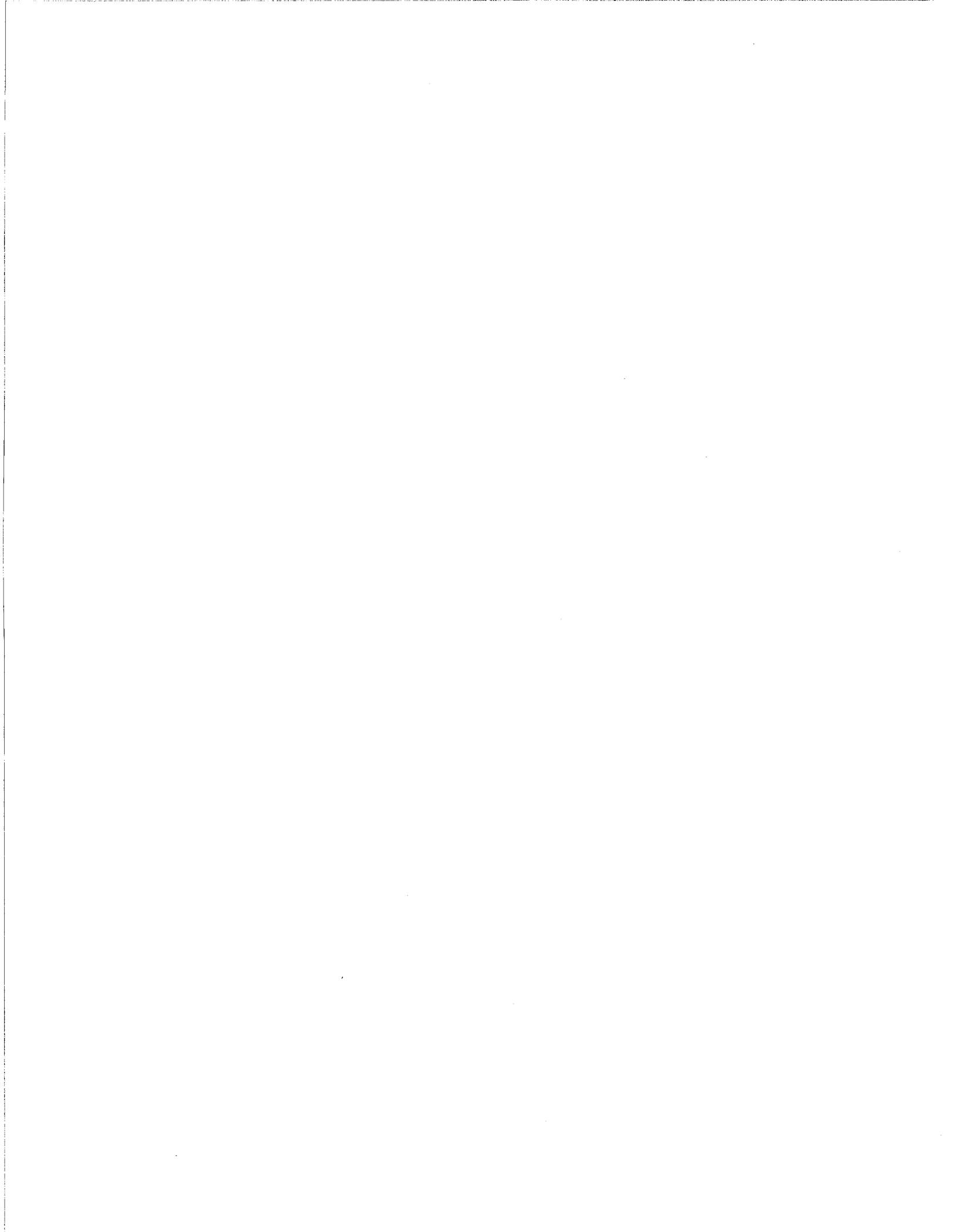
approved a supervising physician.” (California Code of Regulations 1399.541 (i)(1)). Operating under the DCALO Memorandum, a physician assistant could legally close a wound outside the personal presence of the supervising physician if a local anesthetic was used on the patient and not legally be allowed to close the same wound outside the personal presence of the supervising physician if other forms of anesthesia are used on the patient. I am sure the writer of the DCALO Memorandum is not suggesting that the physician assistant’s skill level to close the wound decreased because general anesthesia was used instead of local anesthesia.

The DCALO Memorandum defines general anesthesia and offers the opinion that “[i]n this situation [a patient under general anesthesia] where heightened awareness is necessary, prudent public policy both dictates and requires the personal presence of the supervising physician - in the same surgical theater or area and within line of sight or earshot - such that assistance to the physician assistant is immediately available.” Apparently the Memorandum writer believes the supervising physician is primarily responsible for monitoring and maintaining the vital life functions of the patient. However, this responsibility primary lies with the anesthesiologist who is personally present during the procedure, not with the supervising physician. The anesthesiologist is responsible for a patient's life functions as the surgeon and other members of the medical team operate. (See <http://careers.stateuniversity.com/pages/467/Anesthesiologist.html> and Mosby’s Medical, Nursing & Allied Health Dictionary for definition of “anesthesiologist”). If the patient is experiencing any distress, it is primarily the anesthesiologist’s responsibility to handle such a situation.

The DCALO memorandum fails to even mention California Code of Regulations 1399.541 (i)(2) which allows a physician assistant to act as a first or second assist in surgery. As defined by the American College of Surgeons, general surgical assistants have various responsibilities including closing all wound layers (facia, subcutaneous and skin). (See www.caahep.org/Content.aspx?ID=52). There is no personal presence of the supervising physician requirement for a first assist to perform his or her surgical duties relating to wound closings. In fact, wound closures are customarily and routinely performed by first assists outside the personal presence of the supervising physicians.

CONCLUSION

The opinion set forth in the DCALO memorandum is overly narrow and is not consistent with generally accepted standards of practice of physician assistants in the medical community. The DCALO memorandum inappropriately analyzes the question presented. Separate analysis should have been done with regard to the “questions” presented since opening procedures and closing procedures require substantially different skill levels, training and judgment. One of the major intents of the Legislature for enacting the Act was to address the growing shortage and geographic maldistribution of health care services in California. (See Business and Professions Code section 3500). To restrict physician assistants from performing routine, safe procedures for which they are properly trained and skilled without being tethered to the supervising physician, completely ignores the legislative intent of the Act and unnecessarily hinders the more effective provision of healthcare services.





Physical Therapy Board of California

STATE AND CONSUMER SERVICES AGENCY - GOVERNOR EDMUND G. BROWN JR.

Physical Therapy Board of California

2005 Evergreen St. Suite 1350, Sacramento, California 95815

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DIRECT ACCESS

Is a diagnosis nevertheless required by a diagnostician in order for a physical therapist to provide treatment under current law?

Physical therapists are not required to have a referral from a physician in order to provide treatment. The scope of practice of a licensed physical therapist in 1965 was set forth in then Section 2660 of the Business and Professions Code (All section references are to that Code). That section provided:

"2660. The term "physical therapy" shall mean the treatment of any bodily mental condition of any person by the use of the physical, chemical and other properties of heat, light, water, electricity, massage and active, passive, and resistive exercise. The use of roentgen rays and radioactive materials for diagnostic and therapeutic purposes, and the use of electricity for surgical purposes, including cauterization, are not authorized under the term "physical therapy" as used herein and a license issued hereunder shall not authorize the diagnosis of disease."

Section 2621 further provides:

"2621. Nothing in this chapter shall be construed as authorizing a physical therapist to practice medicine, surgery, or any other form of healing except as authorized by Section 2620."

The scope of practice of physical therapists (now section 2620 of the Code) was notably broadened by the authorization to perform physical therapy evaluations and treatment planning. May a physical therapy evaluation supplant a diagnosis when a diagnostician has not seen a patient initially? The Legislature reiterated in section 2621 that physical therapist may not practice medicine or diagnose (q.v. Section 2051).

It is clear from a reading of these statutes and authorities that recognizing disease or other physical condition is a result of the making of a diagnosis, and that logically a disease or other physical condition cannot be treated without a diagnosis. Therefore, if a physical therapist encounters a patient whose condition has not been diagnosed by a diagnostician, he or she should not treat the same without advice as to the diagnosis of the patient's condition by a physician.

To conclude, the Physical Therapy Board of California concurs with the opinions of the Attorney General and staff counsel, which support that a physical therapist may practice without a physician's referral, provided that a diagnosis is obtained from a diagnostician.

Note: This document is not a declaratory opinion of the Physical Therapy Board of California.

The Medi-Cal Provider Manual under Part 2: General Medicine

Non-Physician Medical Practitioners (NMP)

1

Services rendered by Non-Physician Medical Practitioners (NMPs) are covered by Medi-Cal. NMPs consist of Physician Assistants (PAs), Nurse Practitioners (NPs) and Certified Nurse Midwives (CNMs). The following information does not detract from the fact that CNMs and NPs (family and pediatric specialties) can enroll as free-standing individual providers and provider groups or as NMPs. For additional help, refer to the *Non-Physician Medical Practitioners (NMP) Billing Example* section of this manual.

PHYSICIAN ASSISTANTS

Physician Assistants (PAs) are Non-Physician Medical Practitioners (NMPs) that are approved by the Medical Board of California to perform direct patient care services under the supervision of a licensed physician. PAs are employed by a Medi-Cal provider, but are never an independent Medi-Cal provider.

EXCERPT from Manual

Covered Services Covered services for PAs include services performed by a PA within the scope of practice when the services would be a covered benefit if performed by a physician and surgeon.

CA Code of Regulations

1399.541. Medical Services Performable.

Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician. In any setting, including for example, any licensed health facility, out-patient settings, patients' residences, residential facilities, and hospices, as applicable, a physician assistant may, pursuant to a delegation and protocols where present:

- (a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician.
- (b) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services.
- (c) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.
- (d) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.
- (e) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.
- (f) Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.
- (g) Initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community.
- (h) Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive, of Section 3502.1 of the Code.
- (i) (1) Perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the physician assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of an approved supervising physician.
(2) A physician assistant may also act as first or second assistant in surgery under the supervision of an approved supervising physician.

NOTE: Authority cited: Sections 2018, 3502 and 3510, Business and Professions Code.
Reference: Sections 2058 and 3502, Business and Professions Code.

HISTORY:

1. Repealer of former section 1399.541 and renumbering and amendment of former section 1399.523 to section 1399.541 filed 9-20-83; effective thirtieth day thereafter (Register 83, No. 39). For prior history, see Registers 82, No. 10; 80, No. 6; and 79, No. 34.
2. Amendment of subsection (h) filed 7-12-85; effective thirtieth day thereafter (Register 85, No. 28).
3. Amendment of subsection (f) filed 8-24-89; operative 9-23-89 (Register 89, No. 36).
4. Amendment filed 1-28-92; operative 2-27-92 (Register 92, No. 12).
5. Editorial correction of printing error in first paragraph (Register 92, No. 27).
6. Change without regulatory effect amending subsection (h) and Note filed 8-3-2007 pursuant to section 100, title 1, California Code of Regulations (Register 2007, No. 31).

The law As of Jan 1, 2008

BILL NUMBER: AB 3 CHAPTERED
BILL TEXT

CHAPTER 376

FILED WITH SECRETARY OF STATE OCTOBER 10, 2007

APPROVED BY GOVERNOR OCTOBER 10, 2007

PASSED THE SENATE SEPTEMBER 7, 2007

PASSED THE ASSEMBLY SEPTEMBER 12, 2007

AMENDED IN SENATE JULY 17, 2007

AMENDED IN SENATE JULY 5, 2007

AMENDED IN SENATE JUNE 28, 2007

AMENDED IN ASSEMBLY JUNE 1, 2007

INTRODUCED BY Assembly Member Bass

BELOW EXCERPTED FROM AB 3

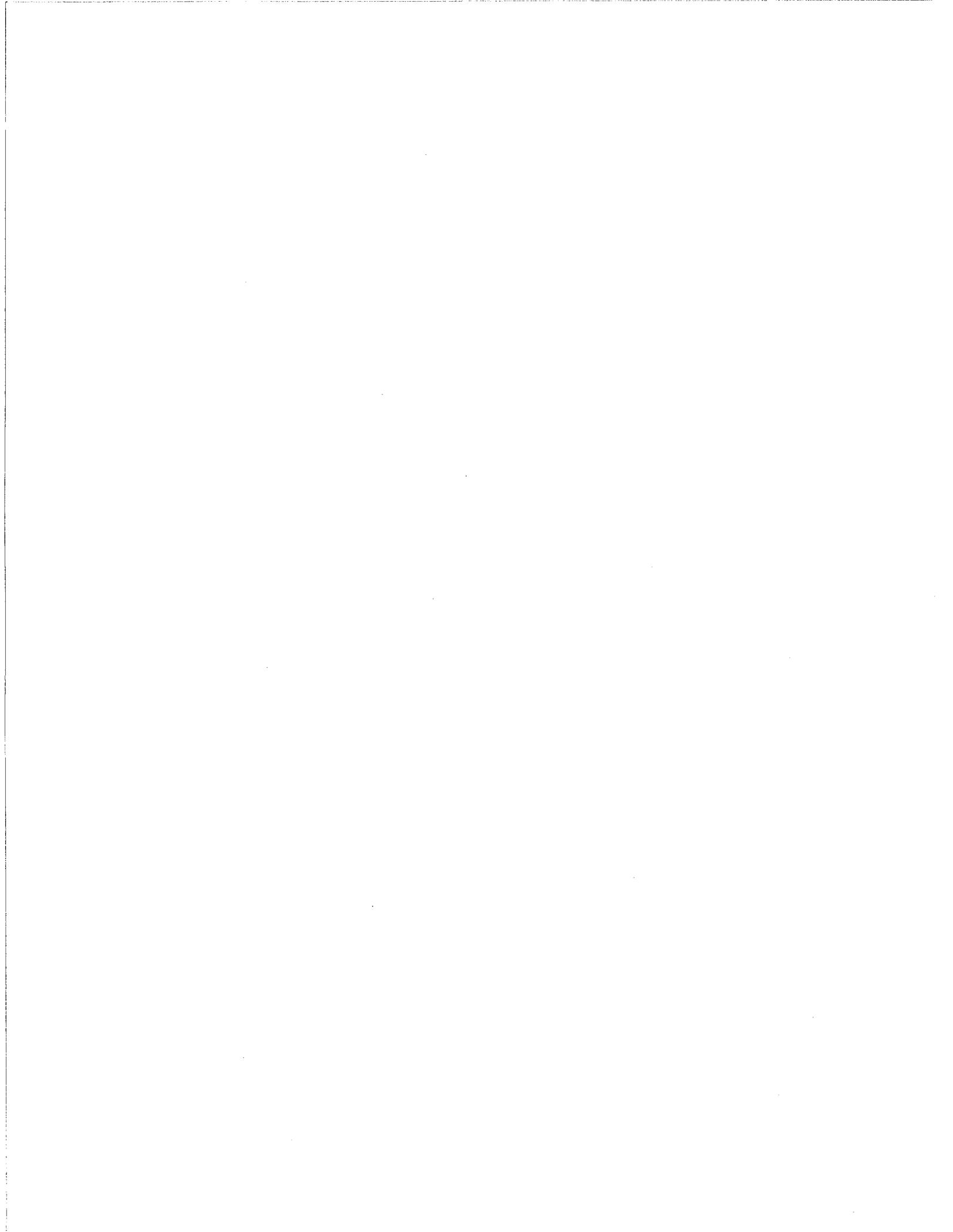
SEC 7 Section 14132.966 is added to the Welfare and Institutions Code, to read:

14132.966. (a) Services provided by a physician assistant are a covered benefit under this chapter to the extent authorized by federal law and subject to utilization controls.

(b) Subject to subdivision (a), all services performed by a physician assistant within his or her scope of practice that would be a covered benefit if performed by a physician and surgeon shall be a covered benefit under this chapter.

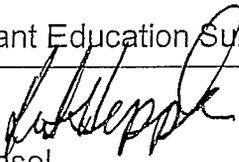
(c) The department shall not impose chart review, countersignature, or other conditions of coverage or payment on a physician and surgeon supervising physician assistants that are more

stringent than requirements imposed by Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code or regulations of the Medical Board of California promulgated under that chapter.





MEMORANDUM

DATE	February 22, 2011
TO	Members Physician Assistant Education Subcommittee
FROM	Kurt Heppler Senior Staff Counsel 
SUBJECT	Proposed Revisions to Section 1399.530 and Following of Title 16 of the California Code of Regulations

At the recent meeting of the Physician Assistant Committee (Committee), a motion was passed directing the Physician Assistant Education Subcommittee (Subcommittee) to convene and specifically consider amendments to section 1399.536 of title 16 of the California Code of Regulations (Section 1399.536), which relates to the qualifications of persons who may serve as preceptor in an approved physician assistant educational program and establishes a ratio of one preceptor to one preceptee. After consideration of any proposed revisions, the Subcommittee will then make its recommendations to the Committee.

Section 1399.536 provides:

- "(a) Preceptors participating in the preceptorship of an approved program shall:
- (1) Be licensed physicians who are engaged in the practice of medicine which practice is sufficient to adequately expose preceptees to a full range of experience. The practice need not be restricted to an office setting but may take place in licensed facilities, such as hospitals, clinics, etc.
 - (2) Not have had the privilege to practice medicine terminated, suspended, or otherwise restricted as a result of a final disciplinary action (excluding judicial review of that action) by any state medical board or any agency of the federal government, including the military, within 5 years immediately preceding his or her participation in a preceptorship.
 - (3) By reason of medical education, specialty and nature of practice be sufficiently qualified to teach and supervise preceptees.
 - (4) Not be assigned to supervise more than one preceptee at a time.
 - (5) Teach and supervise the preceptee in accordance with the provisions and limitations of sections 1399.540 and 1399.541.
 - (6) Shall in conjunction with his or her use of a preceptee, charge a fee for only those personal and identifiable services which he or she, the preceptor, renders. The services of the preceptee shall be considered as part of the global services provided and there shall be no separate billing for the services rendered by the

SUBCOMMITTEE MEMBERS

February 22, 2011

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preceptee.

(7) Obtain the necessary patient consent as required in section 1399.538.

(b) It shall be the responsibility of the approved program to assure that preceptors comply with the foregoing requirements.”

As the Subcommittee considers its task, please note that the purpose of regulations is to implement, make specific or interpret statutes. (See Gov. Code, §11342.2.) It is also important to consider that in the preparation of any rulemaking file, the PAC must articulate in writing why it is making the changes and why it chose this particular method to effectuate the change. As always, whenever the Committee exercises its regulatory functions, public protection is the paramount priority. (See Bus. & Prof. Code, § 3504.1.)

I look forward to upcoming Subcommittee meeting.

PHYSICIAN ASSISTANT COMMITTEE

Specific Language of Proposed Changed

§ 1399.536. Requirements for Preceptors.

(a) Preceptors participating in the preceptorship of an approved program shall:

(1) Be ~~a licensed health care provider~~ physicians who ~~is~~ are engaged in the practice of ~~the profession for which he or she is validly licensed and whose medicine which practice~~ is sufficient to adequately expose preceptees to a full range of experience. The practice need not be restricted to an office setting but may take place in licensed facilities, such as hospitals, clinics, etc.

(A) For the purposes of this section, a "licensed health care provider" means a physician and surgeon, a physician assistant, a registered nurse who has been certified in advance practices, a certified nurse midwife, a licensed clinical social worker, a marriage and family therapist, a licensed educational psychologist, a licensed psychologist.

(2) Not have had the privilege to practice ~~the profession for which he or she is licensed~~ medicine terminated, suspended, or otherwise restricted as a result of a final disciplinary action (excluding judicial review of that action) by any state healing arts licensing ~~medical~~ board or any agency of the federal government, including the military, within 5 years immediately preceding his or her participation in a preceptorship.

(3) By reason of his or her professional ~~medical~~ education, specialty and nature of practice be sufficiently qualified to teach and supervise preceptees within the scope of his or her license.

~~(4) Not be assigned to supervise more than one preceptee at a time.~~

~~(4) (5)~~ Teach and supervise the preceptee in accordance with the provisions and limitations of sections 1399.540 and 1399.541.

~~(6) Shall in conjunction with his or her use of a preceptee, charge a fee for only those personal and identifiable services which he or she, the preceptor, renders. The services of the preceptee shall be considered as part of the global services provided and there shall be no separate billing for the services rendered by the preceptee.~~

~~(5) (7)~~ Obtain the necessary patient consent as required in section 1399.538.

(b) It shall be the responsibility of the approved program to assure that preceptors comply with the foregoing requirements.

Note: Authority cited: Section 3510, Business and Professions Code. Reference: Sections 3509 and 3513, Business and Professions Code.

HISTORY

1. Renumbering and amendment of former section 1399.527 to section 1399.536 filed 9-20-83; effective thirtieth day thereafter (Register 83, No. 39).

2. Change without regulatory effect filed 2-5-91 pursuant to section 100, Title 1, California Code of Regulations (Register 91, No. 11).

3. Amendment of subsection (a)(2) filed 11-21-2000; operative 12-21-2000 (Register 2000, No. 47).



BILL NUMBER: SB 541 AMENDED
 BILL TEXT

AGENDA ITEM # 11

AMENDED IN SENATE APRIL 13, 2011

INTRODUCED BY Senator Price

FEBRUARY 17, 2011

An act to ~~amend Sections 7000.5 and 7011 of~~
 add Section 40 to the Business and Professions Code,
 relating to ~~contractors~~ profession and
 vocations, and declaring the urgency thereof, to take effect
 immediately .

LEGISLATIVE COUNSEL'S DIGEST

SB 541, as amended, Price. Contractors' State License
~~Board.~~ Regulatory boards: expert consultants.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law, the Chiropractic Act, enacted by initiative, provides for the licensure and regulation of chiropractors by the State Board of Chiropractic Examiners. Existing law, the Osteopathic Act, requires the Osteopathic Medical Board of California to regulate osteopathic physicians and surgeons. Existing law generally requires applicants for a license to pass an examination and authorizes boards to take disciplinary action against licensees for violations of law. Existing law establishes standards relating to personal service contracts in state employment.

This bill would authorize these boards to enter into an agreement with an expert consultant, subject to the standards regarding personal service contracts described above, to provide enforcement and examination assistance. The bill would require each board to establish policies and procedures for the selection and use of these consultants.

This bill would declare that it is to take effect immediately as an urgency statute.

~~Existing law establishes within the Department of Consumer Affairs, until January 1, 2012, the Contractors' State License Board and a registrar of contractors, for purposes of the licensure and regulation of contractors. Under existing law, boards scheduled for repeal are required to be evaluated by the Joint Sunset Review Committee.~~

~~This bill would extend the operation of those provisions until January 1, 2016, and would specify that the board would be subject to review by the appropriate policy committees of the Legislature.~~

Vote: ~~majority~~ 2/3 . Appropriation:
 no. Fiscal committee: yes. State-mandated local program: no.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 40 is added to the
 Business and Professions Code , to read:

40. (a) Subject to the standards described in Section 19130 of

the Government Code, any board, as defined in Section 22, the State Board of Chiropractic Examiners, or the Osteopathic Medical Board of California may enter into an agreement with an expert consultant to do any of the following:

- (1) Provide an expert opinion on enforcement-related matters, including providing testimony at an administrative hearing.
- (2) Assist the board as a subject matter expert in examination development, examination validation, or occupational analyses.
- (3) Evaluate the mental or physical health of a licensee or an applicant for a license as may be necessary to protect the public health and safety.

(b) An executed contract between a board and an expert consultant shall be exempt from the provisions of Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code.

(c) Each board shall establish policies and procedures for the selection and use of expert consultants.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

To ensure that licensees engaging in certain professions and vocations are adequately regulated at the earliest possible time in order to protect and safeguard consumers and the public in this state, it is necessary that this act take effect immediately.

~~SECTION 1. Section 7000.5 of the Business and Professions Code is amended to read:~~

~~7000.5. (a) There is in the Department of Consumer Affairs a Contractors' State License Board, which consists of 15 members.~~

~~(b) Notwithstanding any other provision of law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.~~

~~(c) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.~~

~~SEC. 2. Section 7011 of the Business and Professions Code is amended to read:~~

~~7011. (a) The board, by and with the approval of the director, shall appoint a registrar of contractors and fix his or her compensation.~~

~~(b) The registrar shall be the executive officer and secretary of the board and shall carry out all of the administrative duties as provided in this chapter and as delegated to him or her by the board.~~

~~(c) For the purpose of administration of this chapter, there may be appointed a deputy registrar, a chief reviewing and hearing officer, and, subject to Section 159.5, other assistants and subordinates as may be necessary.~~

~~(d) Appointments shall be made in accordance with the provisions of civil service laws.~~

~~(e) This section shall remain in effect only until January 1, 2016, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2016, deletes or extends that date.~~

The listed Legislative Bills are available upon request or you can go to the Legislative website at www.leginfo.ca.gov

PAC LEGISLATION FOR MAY 2011

AB 30 - Hayashi

Under existing law, the State Department of Public Health licenses and regulates hospitals. Existing law requires hospitals to conduct a security and safety assessment and develop a security plan to protect hospital personnel (including physician assistants), patients, and visitors from aggressive or violent behavior.

AB 82 - Jeffries

Existing law regulates the operation of firefighting equipment, and permits a firefighter or volunteer firefighter to operate firefighting equipment only if the person holds a class A, B, or C license.

The examination for a class A or B driver's license shall also include a report of a medical examination of the applicant given by a health care professional. Health care professionals will include physician assistants.

AB 136 - Beall

Existing law requires the administration of the state's universal service programs, including the deaf and disabled programs. This bill would make technical, non-substantive changes to provisions of law relating to the deaf and disabled universal service program.

This bill would allow a physician assistant to certify the needs of an individual diagnosed by a physician and surgeon as being deaf or hearing impaired to participate in the program after reviewing medical records or copies of the medical records containing that diagnosis.

AB 137 - Portantino

Health care coverage: mammograms.

The Knox-Keene Health Care Service Plan Act of 1975 provides for the licensure and regulation of health care service plans by the Department of Managed Health Care.

This bill would provide that health care service plan contracts and individual or group policies of health insurance issued, amended, delivered, or renewed on or after July 1, 2012, shall be deemed to provide coverage for mammograms for screening or diagnostic purposes upon referral of a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician.

SB 28 - Simitian

Existing law requires the Department of Motor Vehicles to examine applicants for specific driver's licenses. This bill would include a test of the applicant's understanding of cell use and text messaging while operating a vehicle.

SB 100 - Price

This bill would require certain healing arts licensees to include in advertisements, as defined, certain words or designations following their names indicating the particular educational degree they hold or healing art they practice.

Existing law requires the Medical Board of California, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, to review issues and problems relating to the use of laser or intense light pulse devices for elective cosmetic procedures by their respective licensees.

This bill would require the board to adopt regulations by January 1, 2013, regarding the appropriate level of physician availability needed within clinics or other settings using certain laser or intense pulse light devices for elective cosmetic procedures.

AB 92 and SB 69

Both bills are the budget bills and were not included in the packet due to their size; however, a copy can be provided if requested.

SB 161 - Huff

This bill would allow non-medical school personnel who undergo voluntary training to administer the drug Diastat to a pupil suffering an epileptic seizure.

SB 233 - Pavley

Expands the definition of a medical professional providing consultation, care, treatment and surgery in an emergency department (ED) setting to include a physician assistant (PA) practicing in compliance with prescribed provisions.

SB 544 - Price

Enacts the Consumer Health Protection Enforcement Act that includes various provisions affecting the investigation and enforcement of disciplinary actions against licensees of healing arts boards.

SB 943 – Business, Professions and Economic Development

Makes several non-controversial, minor, non-substantive or technical changes to miscellaneous provisions pertaining to regulatory boards of the Department of Consumer Affairs and professions regulated primarily under the Business and Professions Code.

CURRENT BILL STATUS

MEASURE : A.B. No. 82
AUTHOR(S) : Jeffries and Chesbro.
TOPIC : Vehicles: firefighting equipment.
HOUSE LOCATION : SEN
+LAST AMENDED DATE : 02/23/2011

TYPE OF BILL :

Active
Urgency
Non-Appropriations
2/3 Vote Required
Non-State-Mandated Local Program
Fiscal
Non-Tax Levy

LAST HIST. ACT. DATE: 04/14/2011
LAST HIST. ACTION : In Senate. Read first time. To Com. on RLS. for
assignment.
COMM. LOCATION : ASM APPROPRIATIONS
COMM. ACTION DATE : 04/06/2011
COMM. ACTION : Do pass, to Consent Calendar.
COMM. VOTE SUMMARY : Ayes: 16 Noes: 00 PASS

TITLE : An act to amend Sections 12804.9 and 12804.11 of the
Vehicle Code, relating to vehicles, and declaring the
urgency thereof, to take effect immediately.

CURRENT BILL STATUS

MEASURE : A.B. No. 92
AUTHOR(S) : Blumenfield.
TOPIC : 2011-12 Budget.
HOUSE LOCATION : ASM
+LAST AMENDED DATE : 02/28/2011

TYPE OF BILL :

- Active
- Non-Urgency
- Appropriations
- Majority Vote Required
- Non-State-Mandated Local Program
- Fiscal
- Non-Tax Levy

LAST HIST. ACT. DATE: 03/01/2011
LAST HIST. ACTION : Re-referred to Com. on BUDGET.

TITLE : An act making appropriations for the support of the government of the State of California and for several public purposes in accordance with the provisions of Section 12 of Article IV of the Constitution of the State of California, to take effect immediately, Budget Bill.

CURRENT BILL STATUS

MEASURE : A.B. No. 137
AUTHOR(S) : Portantino.
TOPIC : Health care coverage: mammographies.
HOUSE LOCATION : ASM

TYPE OF BILL :
Active
Non-Urgency
Non-Appropriations
Majority Vote Required
State-Mandated Local Program
Fiscal
Non-Tax Levy

LAST HIST. ACT. DATE: 05/04/2011

LAST HIST. ACTION : From committee: Do pass and re-refer to Com. on APPR.
(Ayes 18. Noes 0.) (May 3). Re-referred to Com. on
APPR.

COMM. LOCATION : ASM APPROPRIATIONS

HEARING DATE : 05/11/2011

TITLE : An act to amend Section 1367.65 of, and to add Section
1367.651 to, the Health and Safety Code, and to amend
Section 10123.81 of, and to add Section 10123.815 to,
the Insurance Code, relating to health care coverage.

CURRENT BILL STATUS

MEASURE : A.B. No. 138
AUTHOR(S) : Beall.
TOPIC : Elder Economic Planning Act of 2011.
HOUSE LOCATION : ASM

TYPE OF BILL :

- Active
- Non-Urgency
- Non-Appropriations
- Majority Vote Required
- Non-State-Mandated Local Program
- Fiscal
- Non-Tax Levy

LAST HIST. ACT. DATE: 04/13/2011

LAST HIST. ACTION : In committee: Set, first hearing. Referred to APPR.
suspense file.

COMM. LOCATION : ASM APPROPRIATIONS

TITLE : An act to amend Sections 9100 and 9400 of, and to add
Section 9009 to, the Welfare and Institutions Code,
relating to aging.

CURRENT BILL STATUS

MEASURE : S.B. No. 28
AUTHOR(S) : Simitian (Coauthor: Senator Alquist).
TOPIC : Vehicles: electronic wireless communications devices:
prohibitions.
HOUSE LOCATION : ASM
+LAST AMENDED DATE : 04/14/2011

TYPE OF BILL :

Active
Non-Urgency
Non-Appropriations
Majority Vote Required
State-Mandated Local Program
Fiscal
Non-Tax Levy

LAST HIST. ACT. DATE: 05/02/2011
LAST HIST. ACTION : Referred to Com. on TRANS.
COMM. LOCATION : ASM TRANSPORTATION

TITLE : An act to amend Sections 12804.9, 12810.3, 23123,
23123.5, and 23124 of, and to add Sections 21213,
21213.5, 21214, and 23124.5 to, the Vehicle Code,
relating to vehicles.

CURRENT BILL STATUS

MEASURE : S.B. No. 69
AUTHOR(S) : Leno.
TOPIC : 2011-12 Budget.
+LAST AMENDED DATE : 03/07/2011

TYPE OF BILL :

Active
Non-Urgency
Appropriations
Majority Vote Required
Non-State-Mandated Local Program
Fiscal
Non-Tax Levy

LAST HIST. ACT. DATE: 03/17/2011

LAST HIST. ACTION : Assembly adopted Conference Committee report. (Ayes 52.
Noes 26. Page 620.)

COMM. LOCATION : SEN BUDGET AND FISCAL REVIEW

TITLE : An act making appropriations for the support of the government of the State of California and for several public purposes in accordance with the provisions of Section 12 of Article IV of the Constitution of the State of California, to take effect immediately, Budget Bill.

CURRENT BILL STATUS

MEASURE : S.B. No. 100
AUTHOR(S) : Price.
TOPIC : Healing arts.
HOUSE LOCATION : SEN
+LAST AMENDED DATE : 05/03/2011

TYPE OF BILL :

Active
Non-Urgency
Non-Appropriations
Majority Vote Required
State-Mandated Local Program
Fiscal
Non-Tax Levy

LAST HIST. ACT. DATE: 05/06/2011
LAST HIST. ACTION : Set for hearing May 16.
COMM. LOCATION : SEN APPROPRIATIONS
HEARING DATE : 05/16/2011

TITLE : An act to amend Section 2023.5 of the Business and Professions Code, and to amend Sections 1248, 1248.15, 1248.2, 1248.25, 1248.35, 1248.5, 1248.7, and 1248.85 of the Health and Safety Code, relating to healing arts.

CURRENT BILL STATUS

MEASURE : S.B. No. 161
AUTHOR(S) : Huff (Coauthor: Senator Rubio) (Coauthor: Assembly
Member Halderman).
TOPIC : Schools: emergency medical assistance: administration of
epilepsy medication.
HOUSE LOCATION : SEN
+LAST AMENDED DATE : 04/25/2011

TYPE OF BILL :

Active
Non-Urgency
Non-Appropriations
Majority Vote Required
Non-State-Mandated Local Program
Fiscal
Non-Tax Levy

LAST HIST. ACT. DATE: 05/03/2011
LAST HIST. ACTION : Set, first hearing. Hearing canceled at the request of
author.
COMM. LOCATION : SEN APPROPRIATIONS
COMM. ACTION DATE : 05/03/2011
COMM. ACTION : Set, first hearing. Hearing cancelled at request of
author.

TITLE : An act to add and repeal Section 49414.7 of the
Education Code, relating to pupil health.

CURRENT BILL STATUS

MEASURE : S.B. No. 233
AUTHOR(S) : Pavley.
TOPIC : Emergency services and care.
HOUSE LOCATION : SEN
+LAST AMENDED DATE : 05/04/2011

TYPE OF BILL :

- Active
- Non-Urgency
- Non-Appropriations
- Majority Vote Required
- State-Mandated Local Program
- Fiscal
- Non-Tax Levy

LAST HIST. ACT. DATE: 05/06/2011
LAST HIST. ACTION : Set for hearing May 16.
COMM. LOCATION : SEN APPROPRIATIONS
HEARING DATE : 05/16/2011

TITLE : An act to amend Section 1317.1 of the Health and Safety Code, relating to emergency services.

BILL NUMBER: SB 233 AMENDED
BILL TEXT

AMENDED IN SENATE MAY 4, 2011
AMENDED IN SENATE MARCH 31, 2011

INTRODUCED BY Senator Pavley

FEBRUARY 9, 2011

An act to amend Section 1317.1 of the Health and Safety Code,
relating to emergency services.

LEGISLATIVE COUNSEL'S DIGEST

SB 233, as amended, Pavley. Emergency services and care.

Existing law provides for the licensure and regulation of health facilities. A violation of these provisions is a crime. Existing law requires emergency services and care to be provided to any person requesting the services or care for any condition in which the person is in danger of loss of life, or serious injury or illness , at any licensed health facility . For the purposes of these provisions, emergency services and care is defined to include medical screening, examination, and evaluation by a physician, or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine the care, treatment, and surgery by a physician necessary to relieve or eliminate the emergency medical condition or active labor, within the capability of the facility. Existing law ~~also~~ defines consultation as the rendering of an opinion, advice, or prescribing treatment by telephone and, when determined to be medically necessary jointly by the emergency and specialty physicians, includes review of the patient's record, examination, and treatment of the patient in person by a specialty physician who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient. Existing law also defines when stabilization of a patient has occurred.

~~This bill would expand the definition of emergency services and care to include care, treatment, and surgery by a physician assistant in compliance with prescribed provisions. This bill would also expand the definition of consultation to authorize physician assistants to provide a consultation.~~

This bill would, in regards to the definition of emergency services and care, require that the other appropriate personnel permitted by applicable law be acting pursuant to their scope of practice and licensure under the supervision of a physician and surgeon. This bill would expand the definition of consultation to also mean the rendering of a decision regarding hospitalization or transfer and would provide that consultation includes review of the patient's medical record, examination, and treatment of the patient in person by a specialty physician and surgeon when determined to be medically necessary jointly by the treating physician and surgeon and the consulting physician and surgeon, or by other appropriate personnel acting pursuant to their scope of practice and licensure under the supervision of a physician and surgeon. This bill would expand the definition of when stabilization of a patient has occurred to include the opinion of other personnel acting pursuant to their scope of practice and licensure under the supervision of a physician

and surgeon.

By expanding the definition of a crime, this bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1317.1 of the Health and Safety Code, as amended by Section 1 of Chapter 423 of the Statutes of 2009, is amended to read:

1317.1. Unless the context otherwise requires, the following definitions shall control the construction of this article and Section 1371.4:

(a) (1) "Emergency services and care" means medical screening, examination, and evaluation by a physician and surgeon, or, to the extent permitted by applicable law, by other appropriate personnel acting pursuant to their scope of practice and licensure under the supervision of a physician and surgeon, to determine if an emergency medical condition or active labor exists and, if it does, the care, ~~treatment,~~ and ~~surgery by a physician and surgeon, or physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code and who practices under the supervision of a qualified physician and surgeon, pursuant to Division 13.8 (commencing with Section 1399.502) of Title 16 of the California Code of Regulations, necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.~~ *treatment, and surgery necessary to relieve or eliminate the emergency medical condition, within the capability of the facility.*

(2) (A) "Emergency services and care" also means an additional screening, examination, and evaluation by a physician, or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the facility.

(B) The care and treatment necessary to relieve or eliminate a psychiatric emergency medical condition may include admission or transfer to a psychiatric unit within a general acute care hospital, as defined in subdivision (a) of Section 1250, or to an acute psychiatric hospital, as defined in subdivision (b) of Section 1250, pursuant to subdivision (k). Nothing in this subparagraph shall be construed to permit a transfer that is in conflict with the Lanterman-Petris-Short Act (Part 1 (commencing with Section 5000) of Division 5 of the Welfare and Institutions Code).

(C) For the purposes of Section 1371.4, emergency services and care as defined in subparagraph (A) shall not apply to Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000), Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590) of Part 3 of Division 9 of the

Welfare and Institutions Code, to the extent that those services are excluded from coverage under those contracts.

(D) This paragraph does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or other medical personnel.

(b) "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following:

(1) Placing the patient's health in serious jeopardy.

(2) Serious impairment to bodily functions.

(3) Serious dysfunction of any bodily organ or part.

(c) "Active labor" means a labor at a time at which either of the following would occur:

(1) There is inadequate time to effect safe transfer to another hospital prior to delivery.

(2) A transfer may pose a threat to the health and safety of the patient or the unborn child.

(d) "Hospital" means all hospitals with an emergency department licensed by the state department.

(e) "State department" means the State Department of Public Health.

(f) "Medical hazard" means a material deterioration in medical condition in, or jeopardy to, a patient's medical condition or expected chances for recovery.

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

(h) "Within the capability of the facility" means those capabilities that the hospital is required to have as a condition of its emergency medical services permit and services specified on Services Inventory Form 7041 filed by the hospital with the Office of Statewide Health Planning and Development.

~~(i) "Consultation" means the rendering of an opinion, advice, or prescribing treatment by telephone and, when determined to be medically necessary jointly by the emergency and specialty physicians and surgeons, or physician assistants practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code and who practices under the supervision of a qualified physician and surgeon, pursuant to Division 13.8 (commencing with Section 1399.502) of Title 16 of the California Code of Regulations, includes review of the patient's medical record, examination, and treatment of the patient in person by a specialty physician and surgeon, or physician assistant practicing in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code and who practices under the supervision of a qualified physician and surgeon, pursuant to Division 13.8 (commencing with Section 1399.502) of Title 16 of the California Code of Regulations, who is qualified to give an opinion or render the necessary treatment in order to stabilize the patient.~~

(i) "Consultation" means the rendering of an opinion, advice, prescribing treatment, or decision regarding hospitalization or transfer by telephone and, when determined to be medically necessary, jointly by the treating physician and surgeon and the consulting physician and surgeon, or by other appropriate personnel acting pursuant to their scope of practice and licensure under the supervision of a physician and surgeon, includes review of the patient's medical record, examination, and treatment of the patient in person by a specialty physician and surgeon who is qualified to give an opinion or render the necessary treatment in order to

SB 233 BILL AMENDED

stabilize the patient. A request for consultation shall be made by the treating physician and surgeon, or by other appropriate personnel acting pursuant to their scope of practice and licensure under the supervision of a physician and surgeon, provided the request is made with the contemporaneous approval of the treating physician and surgeon.

(j) A patient is "stabilized" or "stabilization" has occurred when, in the opinion of the treating ~~provider,~~ physician and surgeon, or other appropriate personnel acting pursuant to their scope of practice and licensure under the supervision of a physician and surgeon, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient as provided for in Section 1317.2, Section 1317.2a, or other pertinent statute.

(k) (1) "Psychiatric emergency medical condition" means a mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

(A) An immediate danger to himself or herself or to others.

(B) Immediately unable to provide for, or utilize, food, shelter, or clothing, due to the mental disorder.

(2) This subdivision does not expand, restrict, or otherwise affect the scope of licensure or clinical privileges for clinical psychologists or medical personnel.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

CURRENT BILL STATUS

AGENDA ITEM # 11

MEASURE : S.B. No. 541
AUTHOR(S) : Price.
TOPIC : Contractors' State License Regulatory boards: expert consultants.
HOUSE LOCATION : SEN
+LAST AMENDED DATE : 04/13/2011

TYPE OF BILL :

- Active
- Urgency
- Non-Appropriations
- 2/3 Vote Required
- Non-State-Mandated Local Program
- Fiscal
- Non-Tax Levy

LAST HIST. ACT. DATE: 05/06/2011
LAST HIST. ACTION : Set for hearing May 16.
COMM. LOCATION : SEN APPROPRIATIONS
HEARING DATE : 05/16/2011

TITLE : An act to add Section 40 to the Business and Professions Code, relating to profession and vocations, and declaring the urgency thereof, to take effect immediately.

CURRENT BILL STATUS

MEASURE : S.B. No. 544
AUTHOR(S) : Price.
TOPIC : Professions and vocations: regulatory boards.
HOUSE LOCATION : SEN
+LAST AMENDED DATE : 04/14/2011

TYPE OF BILL :

Active
Non-Urgency
Non-Appropriations
Majority Vote Required
State-Mandated Local Program
Fiscal
Non-Tax Levy

LAST HIST. ACT. DATE: 05/02/2011
LAST HIST. ACTION : Set, first hearing. Hearing canceled at the request of
author.
COMM. LOCATION : SEN BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT

TITLE : An act to amend Sections 116, 155, 159.5, 726, 802.1,
803, 803.5, 803.6, 822, 2246, 2960.1, 4982.26, and
4992.33 of, and to add Sections 40, 42, 44, 505, 734,
735, 736, 737, 803.7, 803.8, 857, 1688, 1688.1, 1688.2,
1688.3, 1688.4, 1688.5, 1688.6, 1947.1, 1947.2, 1947.3,
1947.4, 1947.5, 1947.6, 1947.7, 1947.8, 2533.5, 2533.6,
2533.7, 2533.8, 2533.9, 2533.10, 2533.11, 2533.12,
2533.13, 2533.14, 2570.38, 2570.39, 2570.40, 2570.41,
2570.42, 2570.43, 2570.44, 2570.45, 2570.46, 2570.47,
2661.8, 2661.9, 2661.10, 2661.11, 2661.12, 2661.13,
2661.14, 2661.15, 2661.16, 2661.17, 2766, 2766.1,
2766.2, 2766.3, 2766.4, 2766.5, 2766.6, 2766.7, 2766.8,
2879.1, 2879.2, 2879.3, 2879.4, 2879.5, 2879.6, 2879.7,
2879.8, 2879.10, 2969.1, 2969.2, 2969.3, 2969.4, 3112,
3112.1, 3112.2, 3112.3, 3112.4, 3112.5, 3112.6, 3112.7,
3112.8, 3112.9, 3405, 3405.1, 3405.2, 3405.3, 3405.4,
3405.5, 3405.6, 3405.7, 3405.8, 3405.9, 3531.1, 3531.2,
3531.3, 3531.4, 3531.5, 3531.6, 3531.7, 3531.8, 3531.9,
3531.10, 3665, 3665.1, 3665.2, 3665.3, 3665.4, 3665.5,
3665.6, 3665.7, 3665.8, 3665.9, 3769.4, 3769.5, 3769.6,
3769.7, 3769.8, 3769.9, 3769.10, 4316, 4316.1, 4316.2,
4316.3, 4316.4, 4316.5, 4316.6, 4375, 4526, 4526.1,
4526.2, 4526.3, 4526.4, 4526.5, 4526.6, 4526.8, 4526.9,
4888, 4888.1, 4888.2, 4888.3, 4888.4, 4888.5, 4888.6,
4888.7, 4964.1, 4964.2, 4964.3, 4964.4, 4964.55, 4964.6,
4964.7, 4964.8, 4964.9, 4964.10, 4990.44, 4990.45,
4990.46, 4990.47, 4990.48, 4990.49, 4990.50, 4990.51,
4990.52, and 4990.53 to, to add Article 16 (commencing
with Section 880) to Chapter 1 of Division 2 of, and to
repeal Sections 2608.5 and 2660.5 of, the Business and
Professions Code, and to add section 12529.8 to the
Government Code, relating to professions and vocations.

CURRENT BILL STATUS

MEASURE : S.B. No. 943
 AUTHOR(S) : Committee on Business, Professions and Economic
 Development (Senators Price (Chair), Corbett, Correa,
 Emmerson, Hernandez, Negrete McLeod, Vargas, Walters,
 and Wyland).
 TOPIC : Healing arts.
 HOUSE LOCATION : SEN

TYPE OF BILL :

- Active
- Non-Urgency
- Non-Appropriations
- Majority Vote Required
- State-Mandated Local Program
- Fiscal
- Non-Tax Levy

LAST HIST. ACT. DATE: 05/06/2011
 LAST HIST. ACTION : Set for hearing May 16.
 COMM. LOCATION : SEN APPROPRIATIONS
 HEARING DATE : 05/16/2011

TITLE : An act to amend Sections 1916, 1918, 1922, 1927, 1950,
 1952, 1955, 1957, 1959, 1961, 1962, 1963, 1966.1,
 2736.5, 2836.2, 2936, 4200, 4980.36, 4980.37, 4980.40.5,
 4980.42, 4980.43, 4980.45, 4982.25, 4989.54, 4990.38,
 4992.3, 4992.36, 4996.13, 4996.24, 4999.12, and 4999.90
 of, to add Sections 1902.1, 4999.91, and 4999.455 to,
 and to repeal Section 1945 of, the Business and
 Professions Code, relating to healing arts.



**PHYSICIAN ASSISTANT COMMITTEE
MEETING DATES FOR 2011**

<u>DATE</u>	<u>LOCATION</u>
August 25 th	Sacramento
November 10 th	Sacramento

MEDICAL BOARD MEETING DATES FOR 2011

<u>DATE</u>	<u>LOCATION</u>
July 28 th and 29 th	Sacramento
October 27 th and 28 th	San Diego

State Pay Period Calendar for 2011

JANUARY 2011

21 Days 168 Hours

SU	M	TU	W	TH	F	SA
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

FEBRUARY 2011

21 Days 168 Hours

SU	M	TU	W	TH	F	SA
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	1				

MARCH 2011

22 Days 176 Hours

SU	M	TU	W	TH	F	SA
			2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

APRIL 2011

21 Days 168 Hours

SU	M	TU	W	TH	F	SA
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30

MAY 2011

22 Days 176 Hours

SU	M	TU	W	TH	F	SA
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

JUNE 2011

22 Days 176 Hours

SU	M	TU	W	TH	F	SA
			1	2	3	4
5	6	7	8	9	10	11
12	13	14	15	16	17	18
19	20	21	22	23	24	25
26	27	28	29	30		

JULY 2011

22 Days 176 Hours

SU	M	TU	W	TH	F	SA
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31	1					

AUGUST 2011

22 Days 176 Hours

SU	M	TU	W	TH	F	SA
		2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

SEPTEMBER 2011

22 Days 176 Hours

SU	M	TU	W	TH	F	SA
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	

OCTOBER 2011

21 Days 168 Hours

SU	M	TU	W	TH	F	SA
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

NOVEMBER 2011

22 Days 176 Hours

SU	M	TU	W	TH	F	SA
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30			

DECEMBER 2011

22 Days 176 Hours

SU	M	TU	W	TH	F	SA
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29	30	31