STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
Medical Board of California

Board of Podiatric Medicine

Sunset Review Report

2011

"State medical boards are the hidden, unactivated levers to reform."

Thomas H. Meikle, Jr., MD, *President*
Josiah Macy, Jr. Foundation
Address to Federation of State Medical Boards' Annual Meeting, 1992

"Throughout the western world, medical licensure and discipline authorities are . . . are being compelled to face a paradigm shift of major significance -- from a system grounded in self-regulation by the medical profession itself to one based on protecting the public in accord with its expressed interests. . . . In the public protection paradigm, medical licensure authorities are public, not professional, bodies focused on public protection."

Mark R. Yessian, PhD
"From Self-Regulation to Protection"
Federation Bulletin, Vol 81, No 3 1994
Federation of State Medical Boards

CONTENTS

CALIFORNIA BOARD OF PODIATRIC MEDICINE
BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM
As of November 1, 2011

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

Provide a short explanation of the history and function of the board.[1] Describe the occupations/profession that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).

The California Board of Podiatric Medicine (BPM) licenses and regulates Doctors of Podiatric Medicine (DPMs). Though functioning semi-independently as other boards within the Department of Consumer Affairs (DCA), BPM is part of the Medical Board of California (B&P Code §2460) and it is MBC that officially issues licenses to this small specialty group of about 2,000 independent practitioners upon the "recommendation" of BPM (B&P §2486).

DPMs have been licensed by MBC since the 1920s, and the Legislature created the separate podiatric medical entity within MBC in 1957.

The Podiatric Medicine Practice Act is Article 22 of Chapter 5 (Medical Practice Act) of Division 2 (Healing Arts) of the Business and Professions Code (B&P Code). In brief, DPMs are independent practitioners of medicine diagnosing and treating conditions affecting the lower extremity (foot, ankle, and muscles and tendons of the leg governing their functions). In addition, DPMs are authorized by Section 2472 to perform as *assistant* surgeons in any surgical procedure, and they commonly are called upon to do so.

While it is unprofessional conduct for all doctors to practice outside their area of competence, the scope of practice itself in Section 2472 is defined as indicated above. Also noteworthy is that BPM is the only doctor-licensing board in the nation to have implemented a Continuing Competence program over and above continuing education. Since proposed by BPM and enacted in our first Sunset Review in 1998, consumer complaints have decreased by more than 50 percent.

The Continuing Competence program (B&P §2496) succeeded due to the profession's embracing it as a higher standard of its own, i.e., a mark of professionalism. It is the cornerstone for BPM's goal of *preventing* patient harm.

Article 12 (Enforcement) is another important and applicable portion of the Medical Practice Act. BPM was the first State agency to support the "Presley bills" sponsored by the Center for Public Interest Law (CPIL). Beginning with SB 2375 of 1990, these moved physician discipline into closer step with public expectations.

Upon leaving the Legislature, Senator Presley accepted an appointment to BPM and transmitted our 1997 *Sunset Review Report* as BPM President. The recommendations in that report led to enactment of the Continuing Competence program, the sunset of BPM's diversion program, and other reforms.

Mark Yessian argued against the grain in "Medical Licensure Authorities in an Age of Rising Consumerism," [*Federation Bulletin*, Vol 81, No 3 1994, Federation of State Medical Boards], "In the public protection paradigm, medical licensure authorities are public, not professional bodies."

The State Medical Board and BPM *are not physicians' organizations* but government agencies that license MDs and DPMs and are primarily accountable to the public, functioning properly within a public administration framework.

BPM's Board Members--licensee and lay--are all professional and all represent the public. Under law, their responsibilities are identical, and fully equal. This is reflected in BPM's organizational culture.

BPM's *Strategic Plan* emphasizes:

2.3 Represent the public

- ❑ Maintain BPM culture that licensee and lay Board Members are equal
- ❑ Maintain BPM culture that licensee and lay Board Members have same statutory role
- ❑ Maintain BPM culture that licensee and lay Board Members all represent the public at large

http://www.bpm.ca.gov/about_us/spweb.shtml

The mission of the Board is public protection. For two decades, BPM's letterhead has carried the statement from B&P §101.6 that "Boards are established to protect the people of California." BPM strives to avoid diversions of its challenged, limited resources from this statutory licensing and enforcement regulatory responsibility that no one else performs.

Beginning in the early 1990s, BPM cut every other area of its budget to emphasize public safety through careful licensing and rigorous enforcement. This has paid off. Higher licensing standards, primary source verification, continuing competence, and enforcement actions gained attention of providers and contributed to better medical care for Californians. And in the past four fiscal years, almost 70 percent of BPM expenditures were for enforcement (Table 5).

BPM's Board Members have worked to raise expectations. The question is not whether MBC or BPM are the best boards in the country--a low bar--but whether we meet the standards Californians deserve.

BPM's *Strategic Plans* over the past two decades sought to elevate competency levels, reduce medical error, and cut costly enforcement expenditures through responsible licensing and prevention of patient harm rather than just responding to it after the fact.

"Boards have broad powers to shape the medical profession. For the most part, they do not fully exercise these powers. . . . of . . . enhancing the licensing process as a means of preventing unfit, incompetent physicians from practicing in the first place," said Thomas H. Meikle, Jr., MD, in his President's Statement, *1991 Annual Report*, Josiah Macy, Jr. Foundation.

With the emphasis given enforcement since the 1990s, California might focus more on licensing as well. BPM was in the enforcement forefront in the 1990s. It initiated the much resisted, still-instrumental Medical Board Enforcement Matrix report to enhance accountability and the quality of data for management and reporting purposes. BPM was the first state agency to support the Presley bills to reform physician discipline, and the first of the MBC "affiliated" health board to hire a full-time Enforcement Coordinator.

But for licensing boards, good licensing is essential as well. Shortchanging licensing, relying on catching up with dangerous doctors through enforcement -- eventually -- after much harm has been done, raises public policy questions.

BPM's licensing initiatives, unique in California, include annual review and approval of all California-based podiatric graduate medical education (GME) residency programs. The Board requires a Resident's License for all GME participants, and requires two-years of GME rather than just one as required for other doctors. BPM wrote primary source verification of licensing credentials--the unwritten gold standard everywhere--into the law, Article 22 (Podiatric Medicine). And BPM is the only doctor-licensing board in the country to implement a Continuing Competence program, long recommended in the medical licensing literature. Each licensee must meet at least one peer-reviewed indicator of continuing competence at each two-year renewal.

In sum, BPM fought for stronger enforcement in the 1990s. The lasting reputation contributed to higher standards among practitioners.

With the first decade of the 21st Century, aided by the 1997-98 and 2001-02 Sunset Reviews, BPM advanced licensing reforms. The Continuing Competence program in particular has contributed to the long-term longitudinal decline in complaints. Since it became law in 1999, complaints on DPMs filed with MBC Central Complaints have now fallen by two-thirds.

BPM Revocations & Surrenders During Prosecution

1950s.....2
1960s.....2
1970s.....7
1980s.....19
1990s.....43
2000s (thru June 2010 26

BPM's signature reforms include:

- **Primary Source Verification**--no waivers, no exceptions
- **Continuing Competence**--implemented pursuant to first Sunset Review
- **Diversion**--sunsetted pursuant to first Sunset Review
- **Information Disclosure**--overrode former Director's veto to implement DCA *Recommended Minimum Standards for Consumer Complaint Disclosure* (i.e., when "complaint will be referred for legal action")

In this new decade, one focus might be the "rare collaboration" reported on the June 27, 2011 *American Medical News* -- the California Podiatric Medical Association-California Medical Association-California Orthopaedic Association task force on podiatric medical training:

http://www.ama-assn.org/amednews/2011/06/27/prl20627.htm

"The CMA is excited to be part of "this unprecedented partnership," said Dustin Corcoran, CEO of the medical association."The licensure requirements of podiatrists have increased in California in recent years, and the time has come to evaluate their training programs in this context."

BPM has been part of this, co-sponsoring the 1993 "Medio-Nelson Report," *Report on the General Medical and Surgical Components of Podiatric Residency Training in California: A Report to the Medical Board of*

California and the Board of Podiatric Medicine in California, by distinguished medical educators Franklin J. Medio, Ph.D. and Thomas L. Nelson, M.D.:

http://www.bpm.ca.gov/forms_pubs/nelson.pdf

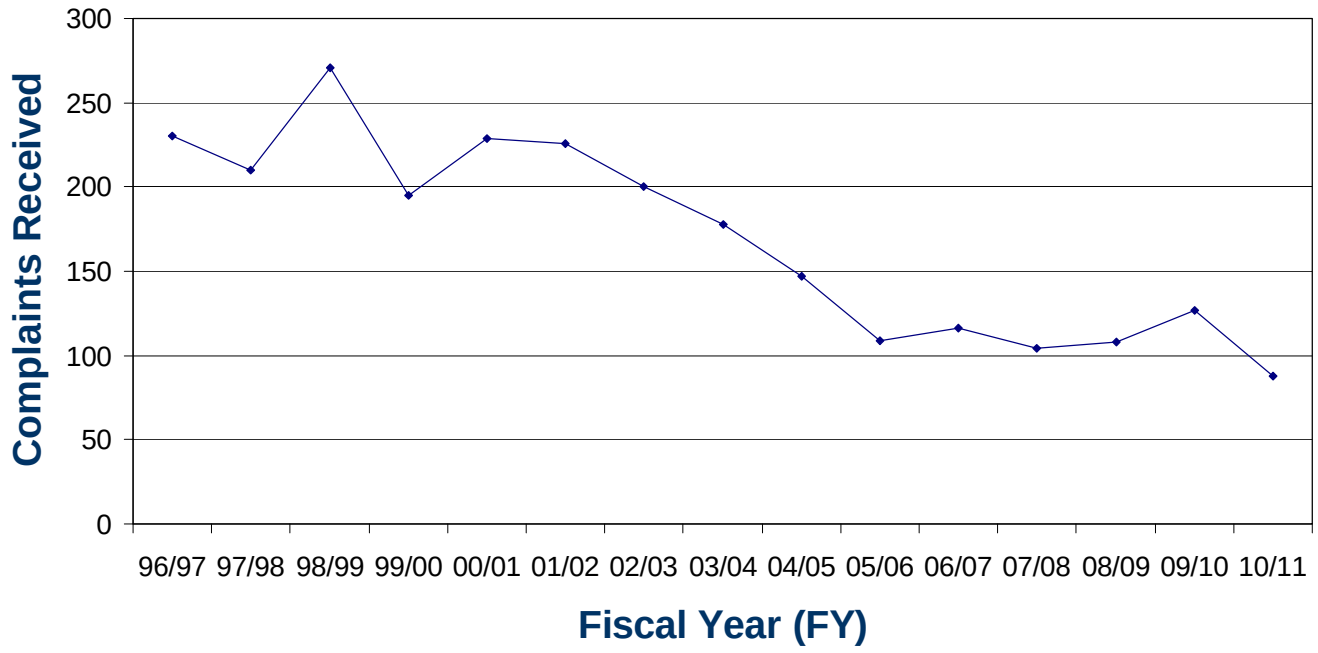
BPM helped create the California Liaison Committee and its UC-Access Committees in efforts to implement the Medio-Nelson recommendations. BPM sponsored specific amendments of the B&P Code as discussed herein, and contributed a substantial advisory and technical role in enactment of AB 932, which passed without a single *nay* vote in either House or any committee in 2004, and increased the postgraduate training requirement from one year to two.

BPM and other licensing boards are mandated to establish entry-level standards. BPM, MBC and other State boards are not certification agencies setting higher standards under the authority of professional bodies like the American Board of Medical Specialties or Council on Podiatric Medical Education. But licensing boards should consider how the professions themselves define what constitutes entry-level education and training. The American Podiatric Medical Association (APMA), has indicated since 1995 that two-years of residency training is the minimum required to achieve entry-level competence.

Medical education is also continually evolving as medical educators update and improve curriculum and training methods. BPM's work over the past two decades has been in the interests of the profession but designed to improve patient outcomes.

BPM will aid and assist again in the current studies.

Complaints Received Since Implementation of BPM's Continuing Competence Program (January 1, 1999)



Fiscal Year	96/97	97/98	98/99	99/00	00/01	01/02	02/03	03/04	04/05	05/06	06/07	07/08	08/09	09/10	10/11
Complaints Received	230	210	271	195	229	226	200	178	147	109	116	104	108	127	90

"I have given a *lot* of thought to this and brought my staff, faculty (including the former CEO of the American Board of Medical Specialties), our faculty in podiatric medicine, and our colleagues at the National Board of Medical Examiners into the discussion. . . .

"First, you will never know how much we respect the California Board of Podiatric Medicine for being the first Board of any discipline, to our knowledge, to have made a true Maintenance of Competence requirement a legal requirement of licensure. The medical profession is many years away from attaining this enlightenment, if it ever happens at all. We are not aware of any State or country, anywhere in the world, where this is the law. Your Board has done the right thing, and we congratulate you. Your Board will be recounted as heroes in the history books, and I mean this honestly and literally."

--William A. Norcross, M.D., Clinical Professor of Family Medicine, and Director of the Physician Assessment and Clinical Education (PACE) Program, University of California at San Diego, April 2, 2010

http://www.bpm.ca.gov/education/wtsacc.pdf

1. Describe the make-up and functions of each of the board's committees.

BPM currently has five committees, which are appointed by the President. BPM's committees serve principally as a means for Board Members (the committee chair and vice chair) to oversee preparation of and present agenda items at Board Meetings. They may also bring items of concern in their area to the attention of the Board and executive officer.

The Board considers it optimum to keep all seven Board Members involved in all governance areas. In particular, the Board has not created an "Executive Committee" as doing so could tend to limit the input of some Board Members.

BPM structured its governance model after John Carver's *Boards that Make a Difference* in the early 1990s, and that remains an influence: ". . . an executive committee tends to become the real board within the board, with debilitating effects on holism." [Third Edition, page 233]

The Board functions as a Board, and the Executive Officer serves and reports to the entire Board, not to one or two officers. The Board's Position Descriptions for President, Vice President and Executive Officer underscore this:

http://www.bpm.ca.gov/about_us/policies.shtml

There have been no separate committee meetings since the Licensing and Medical Education Committee met October 7, 2004 to prepare the final "Section 2499.5(k)" exams for doctors licensed prior to 1984, in order to provide them opportunity to obtain the modern scope of practice pursuant to the amendment of Section 2472 made by AB 932 of 2004.

Dr. Wrubel, who was re-elected President for 2011, appointed the current committees February 24, 2010:

Public Outreach	--external communication & public liaison
Ms. Dixon, *chair*	staff: Jim Rathlesberger (916-834-2445)
Enforcement	--enforcement procedures
Dr. Mansdorf, *chair*	staff: Bethany DeAngelis (916-263-4324)
Legislative	--legislative liaison
Ms. Dixon, *chair*	staff: Mischa Matsunami (916-263-0315)
Dr. Longobardi, *vice chair*	
Licensing & Medical Education	--licensing, exams, approval of schools & residencies
Dr. Longobardi, *chair*	staff: Christine Raymond (916-263-2649)
Professional Practice	--guides & advises staff on practice matters
Dr. Wrubel, *chair*	staff: Jim Rathlesberger (916-834-2445)

The committees are two-Member bodies, but since February 24, 2010 the terms/grace years of two former Board Members expired so that only the Legislative Committee retains two Members. Following the election of new officers September 23, the President-elect for 2012 will appoint new committees with the Board's current membership. Mr. Barnes was appointed by Senate Rules effective June 15, 2011 and there are two vacant Gubernatorial positions (one licensee, one lay) that could be filled by that time.

Table 1a. Attendance (Last Sunset Review 2001)

Jon H. Williams, DPM			
Date Appointed:	Original Appointment 5/7/1993 Re-Appointed 9/18/1996 – 6/1/2001		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2001	1/25/2001	Sacramento, CA	N
	5/4/2001	Millbrae, CA	Y
	Grace Year Term expired 6/1/2001		

Elaine S. Davis, DPM			
Date Appointed:	Original Appointment 4/4/1994 Re-Appointed 12/15/1997 – 6/1/2002		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2001	1/25/2001	Sacramento, CA	Y
	5/4/2001	Millbrae, CA	Y
	11/2/2001	Los Angeles, CA	Y
Board Meeting 2002	2/13/2002	Sacramento, CA	Y
	5/3/2002	Millbrae, CA	Y
	Grace Year Term expired 6/1/2002		

Iva P. Greene, MA			
Date Appointed:	Original Appointment 11/21/1994 Re-Appointed 11/2/1999 – 6/1/2002		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2001	1/25/2001	Sacramento, CA	N
	5/4/2001	Millbrae, CA	Y
	11/2/2001	Los Angeles, CA	Y
Board Meeting 2002	2/13/2002	Sacramento, CA	N
	5/3/2002	Millbrae, CA	Y
	11/8/2002	San Diego, CA	Y
	Term expired 6/1/2002		

Kenneth K. Phillips, Jr., DPM			
Date Appointed:	12/15/1997 – 6/1/2001		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2001	1/25/2001	Sacramento, CA	N

	5/4/2001	Millbrae, CA	Y
	Grace Year Term expired 6/1/2001		

Paul J. Califano, DPM

Date Appointed:	1/1/1999 – 6/1/2002		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2001	1/25/2001	Sacramento, CA	Y
	5/4/2001	Millbrae, CA	Y
	11/2/2001	Los Angeles, CA	Y
Board Meeting 2002	2/13/2002	Sacramento, CA	Y
	5/3/2002	Millbrae, CA	Y
	Term expired 6/1/2002		

Joseph M. Girard, MBA, JD

Date Appointed:	1/1/1999 – 6/1/2002		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2001	1/25/2001	Sacramento, CA	Y
	5/4/2001	Millbrae, CA	Y
	11/2/2001	Los Angeles, CA	Y
Board Meeting 2002	2/13/2002	Sacramento, CA	Y
	5/3/2002	Millbrae, CA	N
	Term expired 6/1/2002		

Anne M. Kronenberg, MPA

Date Appointed:	8/18/1999 – 6/1/2003		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2001	1/25/2001	Sacramento, CA	Y
	5/4/2001	Millbrae, CA	Y
	11/2/2001	Los Angeles, CA	Y
Board Meeting 2002	2/13/2002	Sacramento, CA	Y
	5/3/2002	Millbrae, CA	Y
	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
	Term expired 6/1/2003		

Brad Naylor, DPM

Date Appointed:	5/23/2002 – 6/1/2005		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2002	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	Y
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	Grace Year Term expired 6/1/2005		

Phyllis Weinstein, DPM

Date Appointed:	5/23/2002 – 6/1/2005		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2002	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	N
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	Grace Year Term expired 6/1/2005		

Raymond Cheng, AIA

Date Appointed:	Original Appointment 10/31/2002 – 6/1/2006 Re-Appointed 5/16/2007 – 6/1/2011		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2002	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	N
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	9/30/2005	Millbrae, CA	Y
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y

	11/3/2006	Sacramento, CA	Y
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y
	6/5/2009	San Francisco, CA	Y
	10/16/2009	Hawthorne, CA	Y
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	Y
	10/15/2010	Los Angeles, CA	N
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	Grace Year Term expires 6/1/2011		

James LaRose, DPM

Date Appointed:	Original Appointment 10/31/2002 – 6/1/2005 Grace Year Term expired 6/1/2006 Re-Appointed 7/31/2006 – 6/1/2010		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2002	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	Y
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	9/30/2005	Millbrae, CA	N
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	Y
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y
	6/5/2009	San Francisco, CA	Y

	10/16/2009	Hawthorne, CA	Y
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	Term expired 6/1/2010		

Robert Mohr, DPM

Date Appointed:	10/31/2002 – 6/1/2007		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2002	11/8/2002	San Diego, CA	Y
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	Y
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	9/30/2005	Millbrae, CA	Y
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	Y
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	Grace Year Term expired 6/1/2007		

Elizabeth Graddy, PhD

Date Appointed:	2/4/2003 -6/1/2007		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2003	2/6/2003	Sacramento, CA	Y
	6/6/2003	San Francisco, CA	Y
	10/3/2003	Teleconference	Y
Board Meeting 2004	1/26/2004	Oakland, CA	Y
	5/21/2004	Irvine, CA	Y
	10/8/2004	San Diego, CA	Y
Board Meeting 2005	1/28/2005	Sacramento, CA	N
	9/30/2005	Millbrae, CA	N
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	Y
	Grace Year Term expired 6/1/2007		

Aleida Gerena-Rios, MBA			
Date Appointed:	Original Appointment 8/25/2004 – 6/1/2007 Re-Appointed 6/1/2007 – 6/1/2011		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2004	10/8/2004	San Diego, CA	N
Board Meeting 2005	1/28/2005	Sacramento, CA	Y
	9/30/2005	Millbrae, CA	Y
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	N
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y
	6/5/2009	San Francisco, CA	Y
	10/16/2009	Hawthorne, CA	Y
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	N
	10/15/2010	Los Angeles, CA	N
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	Grace Year Term exp 6/1/2011		

Hienvu Nguyen, DPM			
Date Appointed:	8/16/2005 – 6/1/2009		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2005	9/30/2005	Millbrae, CA	Y
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	Y
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y

	Term expired 6/1/2009

Michael Levi, DPM

Date Appointed:	9/28/2005 – 6/1/2009		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2005	9/30/2005	Millbrae, CA	Y
	12/2/2005	Sacramento, CA	Y
Board Meeting 2006	3/3/2006	San Diego, CA	Y
	8/25/2006	Sacramento, CA	Y
	11/3/2006	Sacramento, CA	Y
Board Meeting 2007	2/2/2007	Irvine, CA	Y
	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y
	Term expired 6/1/2009		

Karen Wrubel, DPM

Date Appointed:	Original Appointment 5/16/2007 – 6/1/2010 Re-Appointed 12/21/2010 - 6/1/2014		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2007	6/1/2007	Sacramento, CA	Y
	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	Y
	6/5/2009	San Francisco, CA	Y
	10/16/2009	Hawthorne, CA	Y
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	Y
	10/15/2010	Los Angeles, CA	Y
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	7/26/2011	Sacramento, CA	Cancelled
	9/23/2011	Los Angeles, CA	TBD

Paul Koretz

Date Appointed:	6/15/2007 – 6/1/2010*		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2007	10/19/2007	Sherman Oaks, CA	Y
Board Meeting 2008	2/29/2008	Ontario, CA	Y
	6/6/2008	Sacramento, CA	Y
	11/18/2008	Los Angeles, CA	Y
Board Meeting 2009	2/6/2009	San Diego, CA	N
	6/5/2009	San Francisco, CA	N
*8/22/2009 resigned position on Board due to time & other conflicts			

Neil Mansdorf, DPM

Date Appointed:	1/26/2010 – 6/1/2012		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	Y
	10/15/2010	Los Angeles, CA	Y
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	7/26/2011	Sacramento, CA	Cancelled
	9/23/2011	Los Angeles, CA	TBD

James Longobardi, DPM

Date Appointed:	1/26/2010 – 6/1/2012		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	Y
	10/15/2010	Los Angeles, CA	Y
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	7/26/2011	Sacramento, CA	Cancelled
	9/23/2011	Los Angeles, CA	TBD

Kristina Dixon, MBA

Date Appointed:	Original Appointment 2/2/2010 – 6/1/2010 Re-Appointed 11/15/2010 – 6/1/2014		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2010	2/18/2010	Hawthorne, CA	Y
	7/26/2010	Sacramento, CA	Y
	10/15/2010	Los Angeles, CA	Y
Board Meeting 2011	2/11/2011	Sacramento, CA	Y
	7/26/2011	Sacramento, CA	Cancelled

	9/23/2011	Los Angeles, CA	TBD
Edward E. Barnes			
Date Appointed:	6/15/2011 – 6/1/2015		
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended?**
Board Meeting 2011	2/11/2011	Sacramento, CA	Not on Board
	7/26/2011	Sacramento, CA	Cancelled
	9/23/2011	Los Angeles, CA	TBD

The Board currently has two vacancies. One four-term term began in 2009 and the other in 2010:

Member Name (Include Vacancies)	Date First Appointed	Date Re-appointed	Date Term Expires	Appointing Authority	Type (public or professional)
Karen Wrubel	5/16/2007	12/21/2010	6/1/2014	Governor	Licensee
Neil Mansdorf	1/26/2010		6/1/2012	Governor	Licensee
James Longobardi	1/26/2010		6/1/2012	Governor	Licensee
Kristina Dixon	2/2/2010	11/15/2010	6/1/2014	Speaker of Assembly	Lay
Edward E. Barnes	6/15/2011		6/1/2015	Senate Rules	Lay
- **Vacant** -			**6/1/2014**	Governor	Lay
- **Vacant** -			**6/1/2013**	Governor	Licensee
			6/1/2006 Grace term exp 6/1/2007	Governor	Licensee

* Paul Koretz resigned his position as Board Member on 8/22/2009 to pursue elected office.

2. In the past four years, was the board unable to hold any meetings due to lack of quorum?

No.

3. Describe any major changes to the board since the last Sunset Review, including:

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

Along with the Medical and other boards, BPM moved from the 1420 Howe Avenue complex to 2005 Evergreen Street in 2008.

Since the 2002 Sunset Review, Paul Califano, DPM was succeeded as Board President sequentially by Anne Kronenberg, MPA, Brad Naylor, DPM, Raymond Cheng, AIA, James LaRose, DPM, Hienvu Nguyen, DPM, Aleida Gerena-Rios, MBA, Michael Levi, DPM and Karen Wrubel, DPM.

During her presidency, Anne Kronenberg, MPA hosted a two-day Strategic Planning session at the San Francisco Health Commission October 3 and 4, 2003 facilitated by Travis McCann, chief of DCA Training and Development Services. This Strategic Plan, not strikingly different than previous strategic plans in essential substance, has been updated annually by the Board.

- All legislation sponsored by the board and affecting the board

SB 1955 [Joint Committee, Statutes of 2002, Chapter 1150] extended BPM sunset date to July 1, 2007. It in effect sunsetted the Board's oral clinical State licensing exam and required Part III of the national written exam instead. It extended the $900 renewal fee from January 1, 2004 to January 1, 2006. In addition, it refined BPM's Continuing Competence program, initiated at the Board's recommendation in the 1997-98 sunset review. This landmark initiative, recommended in the medical licensing literature for decades, remains the first and still the only such program implemented by any doctor-licensing board in the U.S. It has led to a steady longitudinal 50 percent decline in patient complaints, helping to reduce medical error and patient harm. One of several signature BPM programs, it is at the core of BPM's Strategic Plan to *prevent* patient harm rather than just respond to it after the fact.

AB 1777 [Assembly B&P, Statutes of 2003, Chapter 586] included BPM's recommendation for *statutory* primary source verification of DPM licensing requirements. Another unique BPM reform contributing to professional excellence and quality care, writing the unwritten national "Gold Standard" of all professional licensing into BPM's licensing law created a firewall against any pressures for waivers and exceptions.

SB 1077 [Senate B&P, Statutes of 2003, Chapter 607], a committee bill with Medical Board provisions and conforming language for BPM regarding fictitious name permits and retired licenses.

AB 932 [Koretz, Statutes of 2004, Chapter 88] updated antiquated, discriminatory practice act language, and authorized DPMs to be assistant surgeons in any surgical procedure--not limited to foot and ankle. It also upped the graduate medical education licensing requirement from one to two years, the highest for any doctor profession in the State, in conformity with the medical education literature. Sponsored by the California Podiatric Medical Association (CPMA), and passing without a single nay vote in either House or any committee, AB 932 was influenced by BPM's development of the Federation of Podiatric Medical Boards' (FPMB) *Model Law*.

SB 1549 [Figueroa, Statutes of 2004, Chapter 691] removed the sunset clause on BPM's $900 biennial renewal fee. This, together with proposals herein to modernize the remainder of the fee schedule (Section 11), was designed to stabilize the Board's fund condition. The renewal fee, previously $800, had been increased to $900 temporarily by AB 1252 [Wildman, Statutes of 1999, Chapter 977].

SB 1913 [Senate B&P, Statutes of 2004, Chapter 695] added B&P Code §2475.1 as recommended by the Board to require passage of the National Board of Podiatric Medical Examiners exam Parts I and II prior to BPM's issuance of a Resident's license, for a candidate to participate in a California-based graduate medical education residency program.

SB 231 [Figueroa, Statutes of 2005, Chapter 674] fine-tuned MBC-BPM enforcement procedures including initiation of "vertical enforcement," providing for co-assignment of investigations to MBC investigators and Deputy Attorneys General (DAGs) from the outset so that investigations benefit from AG input.

SB 232 [Figueroa, Statutes of 2005, Chapter 675] extended sunset date for BPM and several other boards from July 1, 2007 to July 1, 2008.

SB 1111 [Senate B,P&ED, Statutes of 2005, Chapter 621] enacted BPM-sponsored housekeeping provisions recommended in BPM's 2005 Sunset Review Report (submitted prior to the extension of the 2007 sunset date).

SB 1438 [Figueroa, Statutes of 2006, Chapter 223] updated and clarified language in Article 11 (Professional Reporting) of the B&P Code regarding reporting requirements to the Medical Board about MD or DPM misconduct. Recommendations from BPM's Strategic Plan and BPM Counsel George Ritter were included.

SB 1476 [Figueroa, Statutes of 2006, Chapter 658]. Following submission of BPM's 2006 Sunset Review Report, this bill extended the sunset date to July 1, 2010.

SB 1048 [Senate B,P&ED, Statutes of 2007, Chapter 588] included a BPM-sponsored provision restoring its hiring authority, which had been inadvertently sunsetted..

SB 1779 [Senate B,P&ED], extending statutory primary source verification to B&P Sections 2486 and 2488, vetoed by Governor Schwarzenegger September 27, 2008.

AB 1071 [Emmerson, Statutes of 2009, Chapter 270], extended BPM sunset date to current January 1, 2013.

SB 819 [Yee, Statutes of 2009, Chapter 308], extended statutory primary source verification to B&P Sections 2486 and 2488.

SB 953 [Walters, Statutes of 2010, Chapter 105] sunsetted Section 2397(d), which excluded DPMs from the Article 17 Good Samaritan exemptions from liability provisions in Chapter 5 (Medicine), Division 2 (Healing Arts) of the B&P Code.

SB 1111 [Negrete McLeod], the Schwarzenegger Administration's "Consumer Health Care Enforcement Act," attempted to extend to other health licensing boards measures first enacted for the Medical Board and BPM by the "Presley Bills" sponsored by the Center for Public Interest Law. BPM was the first State agency to support those measures, beginning with SB 2375 of 1990. BPM voted unanimously February 18, 2010 to endorse SB 1111, but was the only board listed in support in the committee's bill analysis.

- All proposed regulations initiated since the board's last sunset review.

  http://www.bpm.ca.gov/lawsregs/index.shtml

  Public Disclosure; Public Retention [1399.698]
  Amendment Filed w/Secretary of State: January 31, 2002
  Effective: March 2, 2002

  Applications, Certificates [1399.660]
  Amendment Filed w/Secretary of State January 7, 2003
  Effective: February 6, 2003

  Continuing Competence
  Filed w/Secretary of State: July 24, 2003
  Effective: August 23, 2003

Licensing Education and Certification
Filed w/Secretary of State: November 12, 2003
Effective: December 12, 2003

Information Disclosure
Filed w/Secretary of State: April 15, 2004
Effective: May 15, 2004
Board voted unanimously to override DCA Director's Veto (see Section 6, question 47)

Advertising [Fictitious Name Permits]
Filed w/Secretary of State: March 28, 2005
Effective: April 27, 2005

Disciplinary Guidelines
Filed w/Secretary of State: January 5, 2005
Effective: February 4, 2006
Board of Podiatric Medicine Manual of Disciplinary Guidelines With Model Disciplinary Orders

Waiver of Requirement
Filed w/Secretary of State: October 4, 2007
Effective: November 3, 2007

Applications, Certificates
Filed w/Secretary of State: April 18, 2008
Effective: May 17, 2008

Citations and Fines - Contest of Citations
Filed w/Secretary of State: May 16, 2008
Effective: June 15, 2008

Review of National Board Applications; Processing Time [1399.664 Repealed]
Change without regulatory effect filed 6-11-08

Retroactive Fingerprinting
Filed w/Secretary of State: September 16, 2009
Effective: October 16, 2009

Notice to Consumers,
http://www.bpm.ca.gov/lawsregs/prop_regs.shtml
http://www.bpm.ca.gov/lawsregs/fsr_1399_730.pdf
Vetoed by DCA Director July 30, 2010

4. Describe any major studies conducted by the board.

None.

BPM has not conducted formal studies itself since the last review. It continues to review the literature and recommend a centralized, departmental Policy Analysis Office supported by special fund pro rata. A multi-disciplined, professional office, with a small team of MPAs, MBAs, economists, *et cet*, could form collaborative linkages with graduate public administration university programs in Sacramento.

The Board did sponsor a focus group in 2008 as recommending by the Department in conjunction with adopting its Section 1399.660(c) regulation shown below on equivalent exams. The focus group unanimously supported the Board's regulation, now in effect:

http://www.bpm.ca.gov/forms_pubs/focus_group_rprt.shtml
http://www.bpm.ca.gov/forms_pubs/focus_group_rprt.pdf

http://www.bpm.ca.gov/lawsregs/bpmregs.shtml

1399.660. Applications, Certificates.

(a) Applications for certificates to practice podiatric medicine and the form and endorsement of such certificates are subject to and administered according to the provisions of Article 2 (Sections 1307, 1308, 1309), Article 9 (Sections 1331-1332) and Article 10 (Section 1335), of the Medical Practice Regulations (Division 13, Chapter 1).

(b) The parts of the examination administered by the National Board of Podiatric Medical Examiners required by the board pursuant to Section 2486(b) of the Code are Parts I, II and III.

(c) Pursuant to Sections 2475.1, 2486 and 2488 of the Code, the board recognizes the respective, corresponding sections of examinations of the United States Medical Licensing Examination and the National Board of Osteopathic Medical Examiners as equivalent in content to those administered by the National Board of Podiatric Medical Examiners.

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

The Federation of Podiatric Medical Boards (FPMB) is the only organization in which BPM holds membership.

- Does the board's membership include voting privileges?

  Yes, at the Annual Meeting (prevented from attending by travel restrictions).

- List committees, workshops, working groups, task forces, etc., on which board participates.

  None.

- How many meetings did board representative(s) attend? When and where?

  Last FPMB meeting attended was August 22, 2004 in Boston. One attendee (BPM executive officer).

- If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?

BPM has a DCA contract with the National Board of Podiatric Medicine Examiners (NBPME), which develops, scores, analyzes and administers the national licensing exam, the American Podiatric Medical Licensing Examination (APMLE) Parts I, II and III. The Board monitors and communicates with NBPME and others but is not directly involved in NBPME procedures. NBPME changed the name of the exam to APMLE this year. It was previously known as NBPME Parts I, II, and III.

Even prior to enactment of AB 932 of 2004, BPM was a leader nationally in urging NBPME to upgrade the Part III licensing exam to reflect postgraduate training. NBPME has now informed BPM this year that, "The June 2011 examination and all subsequent forms will include a board-adopted passing score that reflects entry-level competence by a podiatric physician with one year of post-graduate training."

And the Fall 2011 *NBPME Reports* (Vol. 21 No.1) states: "The culmination of an effort begun in 2008 with an updated practice analysis survey followed by revised test specifications was the administration of a revised Part III examination in June 2011. The examination is now directed toward the competencies expected of a candidate with at least one year post graduate training."

With that, BPM is now recommending deletion of B&P 2493(b) added by AB 932, as discussed in Section 4--Licensing Program, Question 24 and in Section 11--New Issues, 2f.

Section 2 –
Performance Measures and Customer Satisfaction Surveys

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

Please see Attachment G.

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

The Medical Board performs customer satisfaction surveys of consumers who have filed complaints against doctors. BPM inquired about this in 2009 and was informed by a Central Complaint Unit Manager that "Podiatry is not included, just P&S," i.e., it only surveys complainants against MDs and not those who file DPM complaints.

However, as MBC Central Complaint and Investigation staffs handle MD and DPM cases identically, it is reasonable to expect consumer satisfaction is approximately the same regardless of the doctor's degree.

As these surveys measure satisfaction with Medical Board staff, BPM defers to MBC to conduct them.

BPM has a *Share Comments* tab in its Home Page:
https://app.dca.ca.gov/bpm/comments.asp

as well as a *File a Complaint about the BPM* in its Consumer tab:

http://www.dca.ca.gov/online_services/complaints/citizen_complaint.shtml

Only a couple comments have been received from these links over the past several years.

Since the 1990s, MBC has significantly improved Central Complaint Unit communication with patients throughout the process. BPM is also fortunate that MBC Enforcement managers have assigned BPM cases to Consumer Service Representatives who are among the very best. Ian McGlone, BPM's current CSR, is a hidden asset not appearing on BPM's organizational chart.

Very few complainants initiate contact with BPM HQs staff, and those who do are connected directly with MBC Central Complaints. BPM's executive officer has always advised staff to let him speak directly with callers dissatisfied with the resolution of their complaints, however. As MBC has reported, complaints are not always the result of unprofessional conduct as defined in the B&P Code, there is not always clear and convincing evidence, and sometimes the matter is not even within MBC jurisdiction, but taking time to listen and discuss often goes a long way towards satisfying a person that they are being respected and heard.

Section 3 – Fiscal and Staff

Fiscal Issues

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

Following standard financial planning practices, DCA projects full budget expenditure. With that assumption, BPM's reserve is shown to decline. However, BPM tightly manages its budget every year so as to stay under budget and return money to its fund for long-term solvency and avoidance of fee increases.

A statutory reserve level does not exist, but the Board seeks to maintain a healthy fund balance. BPM considers this prudent given the small size of the budget and the potential for unpredictable, volatile and somewhat uncontrollable spikes in enforcement costs. It is crucial that BPM maintains a healthy reserve in order to be prepared, for such events as the 25 lawsuits filed against the Board by one attorney 10 years ago. All were dismissed, but the AG defense cost BPM $374,282. Even then, however, BPM managed to stay just under budget, and withstood the strategic effort to force the Board's public policy and enforcement hand.

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

The Board has not submitted any BCPs in the past four fiscal years.

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

BPM and the DCA Budget Office have historically recommended updating the BPM schedule of service fees as indicated in this report to match costs that have increased over the past couple decades. These were proposed in conjunction with the $900 biennial renewal fee already enacted, to complement that fee in order to recover full costs of service and fully stabilize the fund condition. Please see Section 11, Question 2 item h (re B&P Section 2499.5).

Table 2. Budget Change Proposals (BCPs) -- NONE

BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	$ Requested	$ Approved	$ Requested	$ Approved
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

Table 3. Fee Schedule and Revenue

Fee	Current Fee Amount	Statutory Limit	FY 2007/08 Revenue	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	% of Total Revenue
Resident's License	60	60	2,100	3,180	2,460	2,400	0.27%
Duplicate License	40	40	0	0	0	0	0.00%
Duplicate Renewal Receipt	40	40	1,000	880	1,080	1,200	0.14%
Letter of Good Standing	30	30	1,080	1,350	1,440	1,470	0.17%
CME Course Approval	100	100	200	100	500	200	0.02%
Exam Appeal	25	25	0	0	25	0	0.00%
Citation Fee	VAR						0.00%
Application Fee	20	20	1,300	1,360	1,400	1,340	0.15%
Fictitious Name Permit	50	50	1,650	1,450	900	1,500	0.17%
Wall Certificate	100	100	5,100	4,800	5,900	5,600	0.64%
Ankle Certification	50	50	0	0	0	0	0.00%
Oral Exam	700	700	0	0	0	0	0.00%
Ankle Exam	700	700	0	0	2	0	0.00%
Initial License	800	800	39,200	38,400	47,200	44,800	5.11%
Fictitious Name Renewal	40	40	6,720	6,640	6,840	6,960	0.79%
Biennial Renewal	900	900	808,200	808,200	825,300	808,100	92.17%
DPM Delinquent Fee	150	150	900	1800	750	1,650	0.19%
FNP – Delinquent Renewal Fee	20	20	180	260	200	200	0.02%
Penalty Fee	450	450	1,350	1,800	1,350	1,350	0.15%

Table 4. Fund Condition

(Dollars in Thousands)	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Beginning Balance	1,195	1,093	1,037	1,011	859	817
Revenues and Transfers	922	896	905	883	918 (proj)	918 (proj)
Total Revenue	$2,117	$1,989	$1,942	$1,894	$1,777	$1,745
Budget Authority	1,355	1,303	1,272	1,359	1,381	1,408 (est.)
Expenditures	1,038	966	931	1,035	960 (proj)	979 (proj)
Fund Balance	$1,079	$1,023	$1,011	$859	$817	$756
Months in Reserve	13.4	13.2	11.7	10.7	10.0	9.3

11. Describe license renewal cycles and history of fee changes in the last 10 years.

B&P Section 2499.5(c) specifies a biennial renewal cycle, with the initial license expiring "the second year after its issuance on the last day of the month of birth." There have been no fee changes in the last 10 years. AB 1252 [Wildman, Statutes of 1999, Chapter 977] temporarily increased the renewal fee from $800 to $900, and the $900 renewal fee was subsequently extended and then made permanent in Section 2499.5(d).

12. Describe history of general fund loans. When were the loans made? When were payments made? What is the remaining balance?

Loan:	Repayments:	Balance:
FY 1991/92: $625,000	FY 96/97: $140,000	$0
	FY 98/99: $438,550	
	FY 00/01: $140,115	

13. Describe the amounts and percentages of expenditures by program components. Use the attached Table 5a: Expenditures by Program Component Worksheet as the basis for calculating expenditures by program component. Expenditures by each component should be broken out by personnel expenditures and other expenditures.

During the past four years, almost 70 percent of the Board's total expenditures were for enforcement-related functions. This is consistent with the Board's mission. Nearly half of the Board's enforcement-related expenditures were for investigation and discipline action by the Department of Justice and the Medical Board of California's investigation units. Other expenditure categories were allocated to the Personnel Services and Operating Expenses & Equipment components based on time and resource estimates.

Table 5. Expenditures by Program Component

	FY 2007/08		FY 2008/09		FY 2009/10		FY 2010/11	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	244,730	496,640	242,243	449,170	231,382	466,611	240,968	545,716
Examination	0	11,978	0	0	0	751	0	0
Licensing	133,489	91,047	132,133	76,005	126,209	67,680	131,437	72,277
Diversion (if applicable)								
Administration	66,745	45,487	66,066	37,962	63,104	33,802	65,718	36,095
TOTALS	$444,694	$645,152	$440,442	$563,137	$420,695	$ 568,844	$438,123	$654,088

Staffing Issues

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

BPM has a staff of five (5) with no vacancies. In addition to the exempt executive officer, BPM has an office assistant, two AGPA associate government program analysts (one Administrative Analyst, one Enforcement Coordinator) and one SSA staff services analyst (Licensing Coordinator). There has been limited turnover. BPM's previous enforcement coordinator served 17 years, and the administrative analyst is currently in his second round of service with BPM in that position.

All executive officers wear many hats, and this is especially so at a small board such as BPM, which has no assistant executive officer, and no supervisor or manager other than the executive officer. The incumbent executive officer has emphasized staff development and training, and job expansion as possible, in order to empower the Board and its public services.

BPM attempted unsuccessfully to upgrade the previous enforcement coordinator position to an SSM staff services manager. Upon the incumbent's subsequent leaving for a career opportunity elsewhere after 17 years, BPM moved its licensing coordinator into the enforcement job after an open recruitment, and hired an experienced licensing professional from a larger board for the licensing coordinator role.

Following the last sunset review, BPM's office technician left for a promotion just before a hiring freeze. Vacant for more than six months, the position was abolished automatically by law. BPM struggled for a couple years to win support for a freeze exemption before being able to reestablish and fill this position. During this difficult time, analyst staff stepped up to perform BPM's clerical and administrative tasks in addition to their own program duties. Customer service was maintained but some programs, such as the annual continuing competence audit, were temporarily interrupted.

With utilization, financed through BPM's budget, of shared services from the Department, Medical Board, Attorney General and Office of Administrative Hearings, BPM functions efficiently with a small HQs staff. Dedicated, assigned staff in the Medical Board's Central Complaints, Discipline Coordination, and investigating field units flesh out the staffing, as do the two corps of BPM medical consultants and expert witnesses. All of the DPM consultants and experts are active practitioners who work for BPM on an hourly basis as cases are assigned.

15. Describe the board's staff development efforts and how much is spent annually on staff development. Provide year-end organizational charts for the last four fiscal years.

Please see Attachment D for the year-end organizational charts.

BPM has maximized use of training opportunities provided by DCA's Strategic Organization, Leadership and Individual Develop (SOLID) program, offered at no cost to the Board:

FY	Cost	Staff	Course Title	Course Description
10/11	$375	Enforcement	National Certified Investigator/Inspector Training	Review of interviewing techniques, report writing, administrative proceedings, and principles of administrative law
	N/C	Licensing	Procedures Manual Writing	Tips and tools related to the development of administrative procedures
	N/C	Enforcement	DCA Enforcement Academy	5-day comprehensive overview of the enforcement process.
	N/C	Enforcement/ Administration	Delegated Contracts	Requirements for Expert Consultant contracts
	N/C	Executive	Improving Enforcement and Board Governance	DCA Board Member and Advisory Committee Member Training
	N/C	Executive	DCA Board Member Orientation Training	Roles and responsibilities of Board Members
	N/C	Enforcement/ Executive	BPM Podiatric Medical Consultant Training	Enforcement training
	N/C	Enforcement/ Executive	BPM Expert Review Training	Enforcement training
	N/C	All	DCA Sexual Harassment Prevention Training	Sexual harassment prevention policies
	N/C	Licensing	Completed Staff Work	Analytical processes used to identify and present solutions
	N/C	Administrative	Records Retention Training	Retention guidelines and State Records Center transfer procedures
	N/C	Enforcement	Understanding the Drug Testing Process	Policies and procedures related to the drug testing of licensees as a condition of probation
09/10	N/C	Executive	DCA Investigational Subpoena Training	Subpoena process
	N/C	All	Ethics Orientation for State Officials – Department of Justice	Laws governing acceptable practices as a state official
08/09	$23	All	DCA Sexual Harassment Prevention Training	Sexual harassment prevention policies
07/08	$23	All	DCA Sexual Harassment	Sexual harassment prevention

			Prevention Training	policies
	$100	Enforcement	Sacramento Safety Training	Regulatory investigative techniques
	N/C	Executive	DCA Board Member Orientation Training	Roles and responsibilities of Board Members
	N/C	Executive	DCA Labor Relations Training	Overview of DCA policies and procedures concerning matters related to the Labor Relations program
	N/C	Executive	Understanding the Reasonable Accommodation Process and Effectively Managing Leaves of Absence	Policy overview

Section 4 – Licensing Program

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

The Board issues licenses the same day that all licensing requirements are met. License numbers are given out at that time by phone and appear after midnight on the BPM website verifications page. There has been no change or variation in this since the last sunset review. The Licensing Coordinator provides a "personal shopper level of service" to applicants, who meet higher requirements than other doctors (e.g., two years of graduate medical education), pay larger fees, and must comply with statutory primary source verifications. The Licensing Coordinator troubleshoots, expedites and walks the new doctors through the system.

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

BPM has not had licensing delays or backlogs in over 20 years, and will do what it takes to prevent any in the future.

BPM has a single application for resident's licenses (for postgraduate training) and regular DPM licensure. The average time taken to process a permanent license from application to issuance varies only due to each applicant's fulfilling of the requirements. License numbers are issued the day all requirements are met and will appear online the following day. Applicants may hold off paying the $900 initial license/certification fee until they are ready to begin practicing.

Most podiatric residents take the Part III exam after completing one or two years of post-graduate training, and then continue in training or seek regular licensure. Since January 1, 2005 [AB 932, Statutes of 2004, Chapter 88], two years of graduate medical education (GME) has been required instead of just one. Some Resident's License holders do not seek the permanent license, as they intend to practice in another state. GME residency programs are either two or three years in duration. The Council on Podiatric Medical Education (CPME) is transitioning all of them into three-year programs.

BPM experienced an increase in processing time in FY 2002-03 due to the conversion to the National Boards Part III exam, pursuant to the last Sunset Review. NBPME requires applicants to register for the exam 60 days prior to the exam date. Since application to the appropriate state licensing agency is a prerequisite for exam registration, BPM now requires applicants to apply/register for the permanent license 60 days prior to the exam date. Additionally, score reporting is at times delayed slightly as opposed to prior BPM oral exam results, which were available immediately following the examination (mailed Monday following Saturday exam).

BPM's Licensing Coordinator has streamlined the application process. Application forms were simplified. Notarization is no longer required, and the need for multiple photographs was reduced to just one. Application instructions and forms are now available on BPM's website.

Primary source verification has been strengthened, not compromised.

BPM is proposing sunsetting of B&P Section 2493(b) under Question 24 below in the Examinations section.

Table 6. Licensee Population

		FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11
License Type: DPM (E, EFE – Military[1])	Active (In-State)	1719	1729	1736	1764
	Out-of-State	151	143	151	145
	Out-of-Country	3	3	3	4
	Delinquent[2]	138	139	124	128
License Type: Resident (EL)	Active (In-State)	121	141	137	128
	Out-of-State[3]	3	2	9	20
	Out-of-Country[4]	0	0	0	1
	Delinquent	N/A	N/A	N/A	N/A

[1] Active (In-State) count includes military status EFE licenses.
[2] Delinquent licenses cancel after three years. B&P Code 2427(b).
[3] Podiatric Medical Residents, with out-of-state addresses of record, holding California Resident's Licenses for participation in California-based graduate medical education programs.
[4] Podiatric Medical Residents, with out-of-country addresses of record, holding California Resident's Licenses for participation in California-based graduate medical education programs.

The Table 7a and 7b data is for the regular DPM license (not including the residency training EL licenses):

Table 7a. Licensing Data by Type

	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2008/09	(Exam)	-	-	-	-	-	-	-	-	-	-
	(License)	23	23	0	47	-	-	-	-	-	-
FY 2009/10	(Exam)	-	-	-	-	-	-	-	-	-	-
	(License)	61	61	0	59	-	-	-	-	-	-
FY 2010/11	(Exam)	-	-	-	-		-	-	-	-	-
	(License)	61	61	0	58	3	3	0	-	43	-

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data

	FY 2008/09	FY 2009/10	FY 2010/11
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	23	61	61
Initial License/Initial Exam Applications Approved	23	61	61
Initial License/Initial Exam Applications Closed	0	0	0
License Issued	47	59	58
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	-	-	3
Pending Applications (outside of board control)*	-	-	3
Pending Applications (within the board control)*	-	-	0
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE)			
Average Days to Application Approval (All - Complete/Incomplete)	-	-	2
Average Days to Application Approval (incomplete applications)*	-	-	43
Average Days to Application Approval (complete applications)*	-	-	0

* Optional. List if tracked by the board.

18. How does the board verify information provided by the applicant?

The Board has always required "primary source verification." This is intended to prevent falsification of documents or any possibility of hurried licensing without proper credentialing. Under this policy, all licensure documents certifying applicants' education, training, out-of-state licensure, testing and criminal record clearance must be sent directly to the Board from the certifying organizations rather than from the applicants.

At BPM's recommendation, AB 1777 [Assembly B&P Committee, Statutes of 2003, Chapter 586] initiated *statutory* primary source verification. Being a national "Gold Standard" in all professional licensing, it seemed appropriate for BPM to take the lead in having this good business practice introduced into the law itself.

Applicants are required to obtain a state and federal criminal record clearance from the state Department of Justice (DOJ) (including those applying for a Resident's License) and the Federal Bureau of Investigation (for permanent licensure). Applicants must submit fingerprint cards or utilize DOJ's "Live Scan" fingerprinting method. The Live Scan technology allows the applicants to have their fingerprints electronically scanned at numerous locations in California and obtain results in a fraction of the time required for the traditional fingerprint cards. Effective in FY 05/06, all applicants residing in California were required to utilize the Live Scan fingerprinting method for background clearance purposes.

Eight separate questions on the licensing application require the applicant to disclose under penalty of perjury any disciplinary actions (past or pending), denials, or convictions related to licensing in other states or health care facilities. Applicants are also required to disclose any addictions to controlled substances and any convictions of misdemeanors or felonies.

Applicants who have been licensed in other states must arrange for their respective licensing agencies to directly submit verification of license status and any disciplinary actions or active investigations to the Board. In addition, applicants must request a disciplinary databank report be submitted directly from the Federation of Podiatric Medical Boards to the BPM.

When the Board is notified of any adverse information or criminal record, applicants must provide full and complete explanations and certified copies of arrest reports, all applicable court documents, and documentation of rehabilitation, if any. After careful consideration, Board staff may deny the license or endorse a stipulated agreement for a probationary license. Applicants may appeal this decision and request a hearing before an administrative law judge. Stipulations and ALJ proposed decisions go to the Board Members for final review and approval.

a. What process is used to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?

   Fingerprint reports from California Department of Justice and FBI, report from Federation of Podiatric Medical Boards data bank, self-disclosure under penalty of perjury.

b. Does the board fingerprint all applicants?

   Yes.

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

   All applicants since 1964 were fingerprinted. Those licensed prior to 1964 are being fingerprinted upon renewal pursuant to the Board's regulations (Article 12).

d. Does the board check a national databank?

   Yes.

e. Does the board require primary source documentation?

   Yes. And BPM sponsored legislation writing statutory primary source verification into all DPM licensure requirements. The gold standard is tarnished if subject to waiver.

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

Since the last Sunset Review, BPM sponsored SB 363 [Figueroa, Statutes of 2003, Chapter 874], which created B&P Code §2488 providing for "licensure by credentialing." Section 2488 provides for that for doctors licensed in another State, only one year of graduate medical education is required, rather than two, and only part III rather than parts I, II and III of the National Board exams is required if it has not been taken and passed within 10 years.

Out-of-country applicants have not been an issue to date because all schools approved by the national Council on Podiatric Medical Education (CPME) are in the U.S. To date there has not been any four-year school in another country, and the podiatric professions abroad have not been on par with that in the U.S As chiropody and podiatry schools in the United Kingdom continue advancing, this could become a matter for legislative proposals in the future. Podiatric medicine in the UK is approaching U.S. standards in some cases. There has been preliminary, exploratory discussion at the Federation of Podiatric Medical Boards (FPMB) and other professional bodies with U.K. podiatric medical representatives.

In 2005, California Podiatric Medical Association President T. L. Basso, DPM, FACFAS and other association representatives met with DCA Director Charlene Zettel. In an August 9, 2005 follow-up letter, Dr. Basso wrote:

> Also during our conversation you made a very interesting point regarding boards having the potential for limiting licensees from coming into the state. Having been in practice for over 15 years, and having been on the board of the California Podiatric Medical Association for going on eight years now, I have never once come across a single complaint to our Association regarding restriction of trade imposed by the Board of Podiatric Medicine. In my view they have had a consistently very fair and balanced approach to licensing.

Continuing Education/Competency Requirements

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

Pursuant to B&P §2496, BPM's regulations [CCR Title 16, Division 13.9, Section 1399.669] require 50 hours of continuing medical education (CME) at each two-year renewal. In addition, Section 2496 requires compliance at each renewal with at least one of several peer-reviewed pathways for the Continuing Competence requirement. This was enacted in 1998 through SB 1981 [Greene, Statutes of 1998, Chapter 736] at BPM's recommendation during the Board's first Sunset Review.

CME remains important, but it is the Continuing Competence requirement that defines the professional culture, of which CME is now a part. BPM proposed the first -- and still only -- Continuing Competency program of any doctor-licensing board in the Nation in its first Sunset Review.

As BPM recommended in its second Sunset Review, the Continuing Competence program was refined and tightened up by SB 1955 [Joint Committee, Statutes of 2002, Chapter 1150] and follow up Board regulations, as discussed below under Issue #8.

Section 2496 provides *several* ***peer-reviewed*** *pathways* indicating maintenance of competence, as was recommended in the medical licensing literature on which BPM based its legislation. Since implementation of

the program in 1999, there has been a ***steady longitudinal decline in complaints of more than 50 percent***. The 90 complaints in FY 2010-11 is an all-time low.

For DPMs not receiving peer review through specialty board certification or health facility privileging, B&P Code §2496 offers the pathway of taking and passing Part III of the National Boards. Some have taken this route, while the law serves as an incentive for many others to maintain hospital privileges and board certifications. Maintenance of skills through life-long learning was exactly the intent of the legislation, which was drafted based on the medical licensing literature, including that of the Federation of State Medical Boards, Pew Health Professions Commission and the American Board of Medical Specialties. Most importantly, the Continuing Competence statute created a new, higher standard that the podiatric medical profession has internalized and made its own.

It seems clear that Continuing Competence maintains physician competence and prevents patient harm, and could help offset the epidemic of medical error harming patients and the healthcare delivery system.

CME alone is insufficient. The Pew Health Professions Commission commented in 1995: "States should require each board to develop, implement and evaluate continuing competency requirements to assure the continuing competence of regulated health care professionals. . . . The evidence that continuing education cannot guarantee continuing competence is sobering." (*Reforming Health Care Workforce Regulation: Policy Considerations for the 21st Century*, Report of the Taskforce on Health Care Workforce Regulation, December 1995).

The Federation of State Medical Boards (FSMB) reported in its January 2005 *News Line* that a Gallup Poll of patients found that "Ninety percent of respondents ranked physicians being periodically re-evaluated on their qualifications as "very important" or "important."

a. How does the board verify CE or other competency requirements?

Self-certification under penalty of perjury at each two-year renewal.

b. Does the board conduct CE audits on its licensees? Describe the board's policy on CE audits.

BPM verifies the continuing competence and education requirements through audits. Audits are conducted on all licensees subject to investigator interviews (due to complaints), as well as through an annual random audit of one percent of licensees.

The Board's Regulations, §1399.676(b), Audit and Sanctions for Noncompliance, authorize an annual random audit, and BPM considers it an excellent good practice.

As indicated below in Issue #5 from the 2002 Sunset Review, BPM's annual audit was temporarily interrupted when the Board discontinued its audit contract with the Medical Board due to fiscal challenges. BPM resumed the annual audit in 2004. It had been delayed when BPM lost its only clerical position. The Office Technician (OT) position was abolished after being vacant for six months during a hiring freeze. After three years of concentrated effort, during which time BPM's professional staff was performing the OT duties as well as their own, the Board was finally able to reestablish this position January 1, 2005. The Licensing Coordinator actually resumed performing an annual audit in 2004.

BPM recruited a new Licensing Coordinator in 2009 when the incumbent transferred elsewhere for promotion potential. When the Enforcement Coordinator of 17 years did the same in 2011, BPM concluded

the recruitment for that position by moving the Licensing Coordinator into enforcement and hiring from another board to fill the licensing position. These staff changes and the impact of furloughs beginning in February 2009 led to another break in the audits. The new Licensing Coordinator has initiated an audit for 2011.

The annual random audit verifies the self-certification under penalty of perjury in the current renewal period with the Continuing Competence and 50-hour CME requirements. The Licensing Coordinator processes the renewal as indicated by the audit.

c. What are consequences for failing a CE audit?

The doctor cannot be renewed without a waiver granted by the Board (BPM's Regulations: §1399.669(d)), and only one two-year waiver is permitted. If not brought current in next two-year cycle, the license will not be renewed until the deficiency is corrected pursuant to §1399.676(c)--Audit and Sanctions for Noncompliance), and §1399.678(e)--Waiver of Requirement.

d. How many CE audits were conducted in the past four fiscal years? How many fails?

After the hiatus caused by losing its only clerical employee, BPM's Licensing Coordinator resumed the CME/Continuing Competence Audit in 2004:

In FY 2004-05, 20 licenses were audited without any failures indicated in the records.

In FY 2005-06, 20 were audited. All passed except for two receiving waivers (one converting to Retired status and one to Disabled).

In FY 2006-07, 20 were selected. One waiver was granted, and two cancelled.

For FY 2007-08, 23 were selected. 21 passed. One cancelled. One converted to Retired.

In FY 2008-09, a random selection was requested from DCA Information Services, but the audit was not completed due to turnover in the Licensing Coordinator position.

The interruption continued as furloughs strained the ability of BPM's five-person staff to maintain daily licensing and enforcement operations.

BPM's new Licensing Coordinator has initiated a FY 2011-12 Audit.

e. What is the board's course approval policy?

Under BPM's regulations (1399.670--Approved Continuing Education Programs), medically-related courses sponsored by medical and podiatric medical associations and schools are automatically approved. This covers almost all CME taken by DPMs in health facilities and medical conferences such as the Western Foot and Ankle Conference, the pre-eminent podiatric medical CME conference in the country.

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

BPM's regulations (1399.671--Criteria for Approval of Courses) provide guidance for Board approval of additional programs but this is rarely employed. The Board's Licensing and Medical Education Committee reviews and approves such applications, staffed by the Licensing Coordinator.

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

Since the last review in 2002, there have been 15 CE applications received. All 15 of the providers and courses were approved.

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

BPM's regulations (1399.674--Withdrawal of Approval) authorize BPM to withdraw approval from providers if indicated. Given the small number of providers approved by the Board, BPM does not audit but does monitor feedback for any action that might be appropriate.

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

Done. In 1998, BPM became the first and still only doctor-licensing Board in the country to implement Continuing Competence. CME remains important but Continuing Competence is more so, and is BPM's focal point rather than CME.

Flashback--April 21, 1992--Senate Business & Professions Chairman Dan Boatwright commented in "an impromptu appearance" before another board:

He reminded the committee members that the only function that the boards have is to serve the consumer. He reiterated the fact that the only function of the committee is to license people to make sure they are competent. When they put that certificate on the wall, the state is vouching that they're competent.

--official Minutes

"Boards typically open cases on the basis of complaints or referrals made to them. If they are to become major players in the quality assurance field, this reactive mode is insufficient. They must find ways of preventing or minimizing harm, not just responding once harm is done."

--Mark R. Yessian, PhD, "State Medical Boards and Quality Assurance," *Federation Bulletin*, September 1992, Federation of State Medical Boards

Table 8. Examination Data				
California Examination (include multiple language) if any: NONE				
	License Type	N/A	N/A	N/A
	Exam Title			
FY 2007/08	# of 1st Time Candidates			
	Pass %			
FY 2008/09	# of 1st Time Candidates			
	Pass %			
FY 2009/10	# of 1st Time Candidates			
	Pass %			
FY 2010/11	# of 1st time Candidates			
	Pass %			
	Date of Last OA			
	Name of OA Developer			
	Target OA Date			
National Examination (include multiple language) if any: American Podiatric Medical Licensing Exam				
	License Type	DPM		
	Exam Title	Part III		
FY 2007/08	# of 1st Time Candidates	43		
	Pass %	96%		
FY 2008/09	# of 1st Time Candidates	52		
	Pass %	93%		
FY 2009/10	# of 1st Time Candidates	45		
	Pass %	96%		
FY 2010/11	# of 1st time Candidates	49		
	Pass %	94%		
	Date of Last OA	2008		
	Name of OA Developer	NBPME		
	Target OA Date	2013		

Examinations

21. Describe the examinations required for licensure. Is a national exam used? Is there a California specific exam required?

The examinations required for licensure, pursuant to B&P Section 2486, are Parts I, II and III of the American Podiatric Medical Licensing Examination (APMLE) of the National Board of Podiatric Medical Examiners (NBPME). This is a national exam. As recommended by the Department and the Joint Committee during BPM's last sunset review, the Board sunsetted its state oral clinical exam and began requiring Part III in

addition to the first two parts of APMLE. This was codified by SB 1955 of 2002. APMLE Parts I and II are taken during podiatric medical school, and must be passed prior to BPM's issuance of a Resident's License for postgraduate training [B&P Code §2475.1]. Part III is the clinical competence portion, i.e., the national licensure exam, taken during postgraduate training, and must be passed prior to BPM's issuance of the DPM license.

22. What are pass rates for first time vs. retakes in the past 4 fiscal years? *(Refer to Table 8: Exam Data)*

Pass rates for first time examinees range from 93-96 percent, as indicated in Table 8. There were two candidates retaking the Part III exam in FY 2007/08 and four in FY 2008/09. All six of these candidates passed. There were no retakes in FYs 2009/10 or 2010/11.

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

APMLE Parts I, II and III are all computer based. Testing for Parts I and II are given three times a year while Part III is offered twice a year.

Part I is taken upon completion of the second year of podiatric medical school. It focuses on basic sciences.
Part II is taken near the completion of the candidate's final, fourth year of study. This portion of the testing covers General Medicine.

Part III is a licensing exam that is designed to determine whether a candidate's knowledge and clinical skills are adequate for safe practice. NBPME has updated Part III as of the June 2011 exam, as discussed in the next question.

NBPME selects computerized testing centers for each exam based on the number and location of candidates who register.

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

Yes. B&P Section 2493(b).

AB 932 [Koretz, Statutes of 2004, Chapter 88], sponsored by the California Podiatric Medical Association, amended B&P Code §2493 to reflect the change it made in §2484 upping the graduate medical education requirement for DPMs from one to two years.

Section 2493 (see full text attached to this report) was amended to require "a passing score one standard error of measurement higher than the national passing scale score" on APMLE Part III.

This technical language was added by AB 932 pursuant to association negotiations with input from the Board, the National Board of Podiatric Medical Examiners, and the Department's Office of Examination Resources (OER), which raised concern about such technical language being included in the statute.

NBPME utilizes a national passing scale score of 75, after converting actual raw scores on individual exams to scaled scores allowing comparison with the scores of applicants taking previous administrations of the exam. The scale passing score corresponds to a level of achievement judged by NBPME to represent entry-level competence.

Nationally, passing rates on Part III have ranged between 80-90 percent. During its history from November 1984 to May 2002, BPM's oral clinical licensing exam had a 76 percent pass rate (1,269 of 1,667).
In BPM's experience, the California score, one standard error of measurement higher than the national scale passing score, raises the passing score from 75 one or two points, e.g., to 77, and slightly lowers the overall pass rate percentage. Numerically, this means that for each biannual Part III exam, one or two California candidates might achieve the national scale passing score of 75 but fall just below California's one standard error of measurement higher, and must retake the examination.

BPM's requirement by law for a higher score than the national passing score confuses and disappoints applicants, and delays or blocks their entering practice, sometimes losing job offers in the process. In the judgment of BPM's professional staff it has a marginal if any effect on the quality of licensees and patient care.

In June 2011, the Executive Director of the NBPME informed BPM that it was revising the Part III exam to reflect the level of competence expected following one year of graduate medical education (residency training), an upgrade from the previous competency level reflecting graduation from podiatric medical school.

In August 2011 he reported: "The June 2011 examination and all subsequent forms will include a board-adopted passing score that reflects entry-level competence by a podiatric physician with one year of post-graduate training."

And the Fall 2011 *NBPME Reports* (Vol. 21 No.1) states: "The culmination of an effort begun in 2008 with an updated practice analysis survey followed by revised test specifications was the administration of a revised Part III examination in June 2011. The examination is now directed toward the competencies expected of a candidate with at least one year post graduate training."

With this step, BPM recommends deleting B&P Section 2493(b) as indicated in Attachment F.

Section 2493(b) requires a passing score consistent with Section 2484. Section 2484 requires two-years of postgraduate training for California licensure. However, California is the only one of the 50 States to require more than one year, and the Medical Board of California requires only one year for MDs. For licensure, the one-year NBPME standard is a satisfactory advance and reasonably consistent with Section 2484.

Part III already examines for the full scope of podiatric medical practice in California established in Section 2472 and referenced in Section 2493(b). BPM's concern has always been that it does so at a competency level expected following postgraduate training.

While some negotiating AB 932 wanted a more rigorous exam, comparable to BPM's sunsetted oral clinical exam or the American Board of Podiatric Surgery's specialty certification exam, B&P Code Sections 2492 and 2493, and the Department of Consumer Affairs' *Examination Validation Policy* developed under B&P §139, require a *licensing* exam testing for "entry-level competence." Part III is equivalent to the USMLE Step 3 licensing exam taken by first-year MD residents, which is itself distinct from medical specialty exams administered by boards recognized by the American Board of Medical Specialties (ABMS).

BPM recommends sunsetting Section 2493(b).

School approvals

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

BPM has authority to approve schools of podiatric medicine pursuant to B&P Code Sections 2475, 2476, 2483, 2486, and 2488. BPM's regulations (1399.662 -- Approved Schools) require that schools be accredited by the national Council on Podiatric Medical Education (CPME), which is designated for this purpose by the U.S. Department of Education. BPPE does not approve medical and podiatric medical schools.

26. How many schools are approved by the board? How often are schools reviewed?

CPME has accredited eight schools and in addition has granted candidate status to the College of Podiatric Medicine at Western University of Health Sciences in Pomona, CA. An institution that has achieved candidate status is viewed by the Council to have satisfied the eligibility requirements and to have the potential for meeting CPME accreditation standards and requirements once the DPM program is fully activated with students enrolled in all four years.

CPME re-evaluates accredited podiatric medical schools on a regular basis. According to its publication *CPME 130*: "In order for accreditation to be reaffirmed, the Council conducts re-evaluation of the institution on a periodic basis." This involves a comprehensive on-site evaluation.

27. What are the board's legal requirements regarding approval of international schools?

BPM's regulations require that schools be accredited by the CPME, which to date has only approved schools within the U.S. To date, there are no comparable four-year podiatric medical schools in other countries offering the DPM degree.

Section 5 – Enforcement Program

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

In January 1990, BPM staff instituted new complaint tracking goals. The new staff goals were 24-hours for Executive Officer review, 30 days for DPM medical consultant review, and six months for MBC investigators.

SB 2375 of 1990, which BPM was the first State agency to support, enacted Business & Professions Code Section 2319, which mandated that the Medical Board "set as a goal … so that an average of no more than six months will elapse from the receipt of complaint to the completion of an investigation…. The goal…for cases which … involve complex … issues … should be no more than one year to investigate."

The BPM Board Members at that time requested initiation of a Medical Board Enforcement Matrix Report that would show, for MBC, BPM, and all other health boards affiliated at that time with MBC, the number of cases in the system at each step and how long they had been there. This proved controversial. While other affiliated health boards dropped out, the report was continued for MDs and DPMs despite ongoing resistance for several years and has been a valuable management tool. MBC career managers used it to clean up the data base, so that MBC would have reliable data. BPM exhibits it in each quarterly Board Member meeting agenda book.

BPM strives to keep its timelines within the B&P Code Section 2319 statutory goals for Medical Board investigations (180 days on average, 360 for complex cases). BPM is also seeking to meet the new Department of Consumer Affairs target cycle time. DCA's goal is 12-18 months from receipt of complaint to completion of investigation and final decision. Please see Tables 9-10 and Attachment G.

BPM Investigation Aging in Table 10 shows improvement from prior Sunset Reports. As indicated on pages 19-20 of the Board's 2001 *Sunset Review Report* available from our website [http://www.bpm.ca.gov/forms_pubs/sunset_final.pdf], seven investigations or three percent took longer than three years in the four fiscal years beginning with FY 1997-98. And that had been an improvement from the prior 1997 report, when 11 percent took more than three years.

BPM will continue improvements. Twenty years ago, BPM became the first of the health boards affiliated with the Medical Board to hire a full-time Enforcement Coordinator.

As noted above, BPM is part of the Medical Board and it is in fact the MBC that issues DPM licenses. The Medical Board also handles BPM complaint and enforcement cases under an annual Shared Services agreement, funded by BPM's budget, which is efficient given BPM's less than 2,000 licensees and five (5) staff.

Under Shared Services, MBC:

- Receives, processes, coordinates and tracks DPM complaints in its Central Complaint Unit
- Sends cases to DPM consultants, in coordination with BPM's Enforcement Coordinator, in quality/standard of care cases

- Sends cases to Medical Board investigators, as appropriate
- Sends cases to BPM's DPM expert reviewers/witnesses when DPM consultants determine indepth review indicated
- Refers cases to the Attorney General, as appropriate
- Processes and manages proposed decisions, stipulated agreements, mail ballots to BPM Board Members, and final decisions, and coordinates petitions and court appeal documents
- Reports data to BPM in the Enforcement Matrix Report referenced above
- Reports BPM Accusations, Statements of Issue, and final decisions in its MBC Action Report

BPM's Enforcement Coordinator assists, facilitates and expedites this entire process. Central to BPM's mission is an emphasis on the quality and appropriateness of case handling, in addition to moving cases expeditiously. Justice delayed is justice denied, but inadequate plea bargaining could negate justice altogether and undermine BPM's consumer protection law enforcement.

The Enforcement Coordinator monitors each case to ensure adherance to at least the minimum disciplinary standards in the Board's adopted Regulations (*Manual of Disciplinary Guidelines*).

Strong enforcement and weak enforcement each send a message. Strong enforcement (and high licensing standards) reinforce high professional standards, which lead to higher-quality care, less patient harm, fewer complaints, and fewer costly enforcement cases (after the patient harm has already been suffered).

With DCA's Consumer Protection Enforcement Initiative (CPEI), the Medical Board was to receive authority to hire non-sworn investigators to help expedite investigations. One-half of one of these positions was to be dedicated to DPM cases and funded by BPM's budget. This .5 non-sworn addition to the boots on the ground beginning after July 1, 2010, was to assist the Medical Board's ability to move BPM cases. The BPM Enforcement Coordinator will monitor this and add assistance to any non-sworn investigators to her daily program.

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

The most significant trend in BPM data is the nationally-unique decline in complaints, more than a 50-percent steady longitudinal decline over the last decade.

What is BPM doing different? It is part of the Medical Board, its enforcement is handled by the same Medical Board and Attorney General staff. It utilizes the same enforcement laws.

BPM continues to prosecute a vigorous enforcement program. In part because it has fewer cases and has a full-time enforcement coordinator dedicated to expediting and overseeing the system, BPM is able to micromanage cases and has not infrequently been told for years that it tends to seek and obtain stronger results in final orders.

This sent a message decades ago and no doubt has an effect. The Board is viewed as strong, tough, and public-minded. However, good results for licensing boards depend as much--or more--on licensing. Licensing must not be shortchanged. It may not be wise to rationalize that boards can catch up to questionable providers in their enforcement programs (at great expense, and after much harm to Californians has been done--irreparably, to people).

BPM remains the only health licensing board in the country to have implemented a Continuing Competence program.

BPM may be the only health licensing board in California to have sponsored legislation writing Primary Source Verification (PSV) of licensing standards written into its law.

BPM is the only doctor-licensing board in the State to require two-years of postgraduate training, long recognized as a minimum standard for licensing.

BPM devised the MBC Enforcement Matrix Report in the early 1990s, which was bitterly opposed over several years but helped bring accountability to this area of State government. Career MBC staff used it to clean up the data base so that MBC and BPM had reasonably accurate management and public reporting data. BPM has monitored this data in part to evaluate whether MBC and the AG service DPM cases equally to MD cases. They consistently have. The Matrix Report is designed to show timelines, i.e., where cases are in the system and how long they have been there.

The strength of DCA is the career civil-service. BPM supports strong good-government stewardship to aid board and bureau consumer protection law enforcement. Strengthening the Department could be much to the purpose of associations and the State economy as well as to our citizens as individual consumers.

Increased special fund assessments could support:

- Establishing a Policy Analysis unit arming the DCA Director with rigorously developed options, pros and cons. With inter-disciplinary career staff (MPA, MBA, economists *et cet*), it could vet public policy issues professionally with input from constituents and stakeholders, clarifying issues in the face of conflicting claims.

.

- Public-service advertizing of a single DCA toll-free help & complaint line with multi-lingual staff connecting callers with appropriate board and bureau personnel. Given the numbers of boards for Californians to keep track of, Departmental coordination seems preferable to Balkanization of effort.

- Upgrading the internal audit unit into a semi-independent Inspector General with multi-disciplinary professional staffing.

- Upgrading office of exam resources with professionally-credentialed staff and management.

- Reduction of paper work, bureaucratic meetings, red tape, duplicative reporting, and unnecessary rulemaking to free staff for customer service and consumer protection.

Table 9a. Enforcement Statistics			
	FY 2008-09	FY 2009-10	FY 2010-11
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received	108	127	90
Closed	0	0	0
Referred to INV	108	126	86
Average Time to Close	10	20	10
Pending (close of FY)	3	4	0
Source of Complaint (Use CAS Report 091)			
Public	69	87	56
Licensee/Professional Groups	2	10	5
Governmental Agencies	1	2	3
Other	36	28	26
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received	1	12	5
CONV Closed	1	12	5
Average Time to Close	15	9	22
CONV Pending (close of FY)	0	0	0
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
License Applications Denied	0	0	1
SOIs Filed	0	2	0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	0	0	555
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed	4	6	8
Accusations Withdrawn	0	0	2
Accusations Dismissed	0	0	0
Accusations Declined	0	1	0
Average Days Accusations	1060	808	660
Pending (close of FY)	10	9	13

Table 9b. Enforcement Statistics (continued)			
	FY 2008-09	FY 2009-10	FY 2010-11
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions	2	2	1
Stipulations	8	5	2
Average Days to Complete	1060	808	660
AG Cases Initiated	6	9	11
AG Cases Pending (close of FY)	10	9	13
Disciplinary Outcomes (Use CAS Report 096)			
Revocation	2	1	0
Voluntary Surrender	0	1	1
Suspension	0	0	0
Probation with Suspension	1	1	0
Probation	5	4	2
Probationary License Issued	0	0	0
Other	1	0	0
PROBATION			
New Probationers	7	5	1
Probations Successfully Completed	4	5	9
Probationers (close of FY)	19	19	15
Petitions to Revoke Probation	0	0	0
Probations Revoked	0	0	0
Probations Modified	1	1	1
Probations Extended	0	0	1
Probationers Subject to Drug Testing	0	0	4
Drug Tests Ordered	0	0	86
Positive Drug Tests	0	0	0
Petition for Reinstatement Granted	0	1	1
DIVERSION N/A			
New Participants	0	0	0
Successful Completions	0	0	0
Participants (close of FY)	0	0	0
Terminations	0	0	0
Terminations for Public Threat	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0

Table 9c. Enforcement Statistics (continued)			
	FY 2008-09	FY 2009-10	FY 2010-11
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned	109	127	91
Closed	112	115	111
Average days to close	207	168	191
Pending (close of FY)	53	65	45
Desk Investigations (Use CAS Report EM 10)			
Closed	109	96	77
Average days to close	135	116	103
Pending (close of FY)	36	31	23
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed	0	0	0
Average days to close	0	0	0
Pending (close of FY)	0	0	0
Sworn Investigation			
Closed (Use CAS Report EM 10)	22	19	34
Average days to close	502	431	393
Pending (close of FY)	17	34	22
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued	0	1	0
PC 23 Orders Requested	1	0	0
Other Suspension Orders	1	0	0
Public Letter of Reprimand	0	0	0
Cease & Desist/Warning	5	2	0
Referred for Diversion	N/A	N/A	N/A
Compel Examination	0	0	0
CITATION AND FINE* (Use CAS Report EM 10 and 095)			
Citations Issued	4	4	0
Average Days to Complete	485	586	0
Amount of Fines Assessed	1,000	2,500	0
Reduced, Withdrawn, Dismissed	2	3	0
Amount Collected	500	900	1,600
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	0	0

**Citation and Fines:*

- *Citations Issued – All issued including those reduced, withdrawn or dismissed.*
- *Amount of Fines Assessed – Executive Officer's final assessment (after any informal conference).*
- *Reduced, Withdrawn, Dismissed – Withdrawn is by Executive Officer following informal conference and compliance obtained. Reduced or Dismissed would be by the Board's adoption of an Administrative Law Judge's Proposed Decision dismissing the citation or reducing the fine, following an Administrative Procedure Act appeal. There were no such appeals in these three FYs.*
- *Amount Collected – Fine amounts collected in this FY on all fines past and present.*
- *A $500 citation payment was received in October 2011 (FY 2011-12). With that payment, all final amounts assessed in the three FYs covered in Table 9c have been collected in full.*

Table 10. Enforcement Aging

	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11	Cases Closed	Average* %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	7	3	2	0	12	38.5
2 Years	2	7	1	2	12	38.5
3 Years	1	1	3	1	6	19.5
4 Years	0	0	1	0	1	3.5
Over 4 Years	0	0	0	0	0	0%
Total Cases Closed	10	11	7	3	31	
Investigations (Average %)**						
Closed Within:						
90 Days	2	0	2	3	7	7.5
180 Days	0	3	4	4	11	11.5
1 Year	9	6	5	8	28	29.5
2 Years	6	9	3	17	35	37
3 Years	2	5	5	2	14	14.5
Over 3 Years	0	0	0	0	0	0
Total Cases Closed	19	23	19	34	95	

**Percentages have been rounded up or down.*

***These numbers only represent the investigations that were sent to the field, not complaints classified as desk investigations in the Consumer Affairs System (CAS) prior to being closed.*

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

Overall, statistics indicate that BPM has stayed the course in maintaining a strong, meaningful enforcement program since 2001. The gradual longitudinal declines in complaints, referrals to the Attorney General and revocations/surrenders of license all reflect the impact of strong enforcement during the 1990s and good licensing practices, particularly the Continuing Competence program.

31. How are cases prioritized? What is the board's compliant prioritization policy? Is it different from DCA's model? If so, explain why.

BPM complaints are managed by the Medical Board Central Complaints Unit identically to MD cases, following the same MBC and DCA prioritization policies. BPM's Enforcement Coordinator works to expedite appropriate handling of each and every complaint. To BPM, there is no low-priority complaint.

32. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report any actions taken against the licensee. Are there problems with receiving the required reports? If so, what could be done to correct the problems?

SB 1438 [Figueroa, Statutes of 2006, Chapter 223] updated and clarified language in Article 11 (Professional Reporting) of the B&P Code, beginning with Section 800. This included BPM recommendations to ensure complete coverage of DPMs. These sections of Article 11 require insurers, doctors, prosecuting attorneys, courts, coroners, peer review bodies and health facilities to report to the Medical Board on MDs or DPMs in

regard to malpractice (settlements, arbitrations and judgments), felony charges, criminal convictions, patient deaths resulting from gross negligence or incompetence, and negative staff-privileging actions.

The MBC Central Complaint Unit receives these reports. BPM will defer to the Medical Board regarding compliance. Included in the Table 9a Source of Complaint "Other" line, based on CAS Report 091, are Section 800 reports: 18 for FY 2008-09, 11 in 2009-10 and 16 in 2010-11.

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

No cases were lost due to the applicable statute of limitations found in B&P Code:

> 2230.5. (a) Except as provided in subdivisions (b), (c), and (e), any accusation filed against a licensee pursuant to Section 11503 of the Government Code shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action, or within seven years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first.
>
> (b) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging the procurement of a license by fraud or misrepresentation is not subject to the limitation provided for by subdivision (a).
>
> (c) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging unprofessional conduct based on incompetence, gross negligence, or repeated negligent acts of the licensee is not subject to the limitation provided for by subdivision (a) upon proof that the licensee intentionally concealed from discovery his or her incompetence, gross negligence, or repeated negligent acts.
>
> (d) If an alleged act or omission involves a minor, the seven-year limitations period provided for by subdivision (a) and the 10-year limitations period provided for by subdivision (e) shall be tolled until the minor reaches the age of majority.
>
> (e) An accusation filed against a licensee pursuant to Section 11503 of the Government Code alleging sexual misconduct shall be filed within three years after the board, or a division thereof, discovers the act or omission alleged as the ground for disciplinary action, or within 10 years after the act or omission alleged as the ground for disciplinary action occurs, whichever occurs first. This subdivision shall apply to a complaint alleging sexual misconduct received by the board on and after January 1, 2002.
>
> (f) The limitations period provided by subdivision (a) shall be tolled during any period if material evidence necessary for prosecuting or determining whether a disciplinary action would be appropriate is unavailable to the board due to an ongoing criminal investigation.

Cite and Fine

34. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes from last review and last time regulations were updated. Has the board increased its maximum fines to the $5,000 statutory limit? **and**
35. How is cite and fine used? What types of violations are the basis for citation and fine?

BPM's cite and fine regulations are in California Code of Regulations, Title 16, Division 13.9, Article 8, §1399.696.

Citation and fine remains an effective tool for BPM to obtain compliance in advertizing, record keeping and other such cases when they do not seem to rise to the level of an Accusation. There is no significant change from the last review.

BPM was among the first to implement non-disciplinary citation and fine authority, filing regulations in 1988 that became operative that same year [Register 88, No. 37]. Beginning in the early 1990s, BPM used this authority to respond, some felt zealously, to advertising violations and occasional lax compliance with requirements such as postgraduate residents beginning graduate medical education programs prior to fulfilling all the requirements and obtaining a Resident's License (something not required for MD residents).

With greater awareness and compliance, there are now fewer violations at the cite and fine level. As stated in BPM's 2001 *Sunset Report*: "BPM uses the cite and fine program to obtain compliance with the law and will frequently withdraw citations or reduce fines based on compliance obtained and demonstrated good faith of the licensee. As the program has succeeded in helping the Board demonstrate an ability to enforce the law, the number of violations in areas such as advertising has diminished."

BPM last updated its cite and fine regulations in 2008 (Register 2008, No. 20) to add new Division 13.9, Section 1399.696 subsections (c)(61), (d) and (e). These added authority to cite for failure to produce medical records, increased the maximum fine to $5,000 with qualifying language mandated to all boards at the time by the Schwarzenegger Administration (which in BPM's practice would tend to elevate cases above the citation level, i.e., to the filing of an Accusation), and authority to cite for a failure to comply with a term and condition of probation.

BPM does not employ citation and fine against simple technical violations such as forgetting to notify the Board promptly of address changes. The executive officer routinely issues the preliminary citation at the $2,500 amount, which typically obtains the licensee's attention. All eight of the citations issued in the three FYs covered in Table 9c were initially $2,500 prior to the informal conference, which provides the licensee an opportunity to tell their side of the story and agree to any compliance indicated.

BPM will withdraw the citation or significantly reduce the fine following the informal conference based on compliance obtained, if the doctor evidences good faith as is often the case. Thus it becomes an educational process winning the licensee's understanding and higher standard in the future. Of the eight citations in Table 9c, five were withdrawn based on compliance and evidence obtained at the informal conference. Of the three not withdrawn, two of the fines were reduced to $500. In the third, the licensee paid the $2,500 without requesting an informal conference. Including one $500 payment received in October 2011, all citations have been paid in full.

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

In the past four fiscal years there were seven (7) informal office conferences and no Administrative Procedure Act appeals. The Board does not utilize Disciplinary Review Committees.

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

In the past four fiscal years, the most frequently cited violations in BPM's three final citations, post-informal conference, have been B&P Code Sections 2266 (Failure to Maintain Adequate Records and 2234 (Unprofessional Conduct). Each of these violations was cited twice, in total.

38. What is average fine pre and post appeal?

The average fine was $1,167 (one at $2,500 and two at $500). There were no appeals to an Administrative Procedure Act hearing before an Administrative Law Judge, so the post appeal amount remained the same.

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

None to date. As part of the Medical Board, BPM utilizes MBC discipline coordination and enforcement staff offices, and the Attorney General's Health Quality Enforcement Unit, as necessary. As indicated, all final fine amounts were paid in full.

Cost Recovery and Restitution

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

While part of the Medical Board, and though utilizing MBC staff for enforcement, BPM has cost recovery authority (B&P §2497.5) while MBC does not (B&P §125.3(k)).

BPM's precedent-setting cost recovery program was established by SB 1503 [Statutes of 1984, Chapter 695] and amended by SB 1879 [Statutes of 1986, Chapter 655].

BPM's *Manual of Disciplinary Guidelines and Model Disciplinary Orders* provides that cost recovery is a standard condition for all cases:

http://bpm.ca.gov/lawsregs/dgl.pdf

Administrative Law Judges (ALJs) are uneven in the amount of cost recovery they propose from one case to another. In stipulated agreements, the Board's staff and Attorney General always seek cost recovery as part of the negotiation, second only to negotiating provisions aimed at enhancing public protection, which is the Board's mission, and without which the Board will go to hearing rather stipulating to a settlement. The Board has also made payment of probation monitoring costs a standard condition in the *Manual* pursuant to B&P §2222 and §2227(a)(3) of Article 12 (Enforcement) of the Medical Practice Act.

BPM recommends amending B& P §2497.5(b):

> 2497.5. (a) The board may request the administrative law judge, under his or her proposed decision in resolution of a disciplinary proceeding before the board, to direct any licensee found

guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

(b) The costs to be assessed shall be fixed by the administrative law judge and shall not **~~in any event~~ be increased by the board unless the board does not adopt a proposed decision and in making its own decision finds grounds for increasing the costs to be assessed, not to exceed the actual and reasonable costs of the investigation and prosecution of the case. ~~When the board does not adopt a proposed decision and remands the case to an administrative law judge, the administrative law judge shall not increase the amount of any costs assessed in the proposed decision.~~**

41. How many and how much is ordered for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.

In the past four fiscal years, the Board has ordered $112,806 in cost recovery for a total of 15 disciplinary cases it adopted from Proposed Decisions or Stipulated Agreements. It has collected $110,560 over the same period of time. While the amount collected in a given fiscal year is not directly related to the cases for which cost recovery was ordered during the same year, this remains indicative of BPM's effort to ensure full compliance with the terms and conditions of each disciplinary order.

BPM believes all current outstanding costs are collectable. All cases in which there is an outstanding cost recovery balance pertain to active licensees.

42. Are there cases for which the board does not seek cost recovery? No. Why? N/A

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

None to date. As part of the Medical Board, BPM utilizes MBC discipline coordination and enforcement staff offices, and the Attorney General's Health Quality Enforcement Unit, of which the MBC is the chief client. Under B&P Section 125.3(k) the MBC "shall not request nor obtain from a physician and surgeon, investigation and prosecution costs for a disciplinary proceeding against the licentiate."

44. Does the board have legal authority to order restitution? If so, describe the board's efforts to obtain restitution for individual complainants, the board's formal restitution program, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Discuss any changes since last review.

Outside of insurance fraud (B&P Section 810), MBC-BPM have limited authority for seeking restitution (see B&P §125.5). Many physician complaints do come to MBC Central Complaints as a result of malpractice filings, and it is the civil malpractice system in which restitution is generally addressed. Administrative discipline under the Medical Practice Act is oriented principally towards protection of future patients through licensee discipline, while the civil malpractice system is extensively used for restitution to former patients. MBC and BPM have no jurisdiction over billing issues outside of insurance fraud.

	MALPRACTICE	DISCIPLINE
Venue	Civil court	Administrative law
Trier	Judge	Administrative Law Judge
Jury	Lay	Licensee majority
Required evidence	Preponderance	Clear and convincing
Primary purpose	Compensate former patient	Protect future patients
Primary result	Monetary award or settlement	Revocation, suspension, probation of license

Malpractice attorneys may advise clients to accept monetary settlement in lieu of going to civil trial given a case's strength relative to the *preponderance of the evidence* test. With the even higher standard in administrative law, some patients may consider monetary settlement in the civil arena a good result. A monetary settlement may bring better closure to some patients than would a closure letter from the Medical Board in cases where the Attorney General is unlikely to see *clear and convincing* arguments that the doctor acted below the range of the community standard of care.

While restitution is usually addressed prior to the administrative hearing before an ALJ, BPM's *Manual of Disciplinary Guidelines*, promulgated as guidance to the Attorney General and Administrative Law Judges (ALJs), provides the following language for "restitution to consumers or other injured partners":

> Within 90 days of the effective date of this Decision, respondent shall provide proof to the BPM or its designee of restitution in the amount $_____ paid to _____. Failure to pay restitution shall be considered a violation of probation.
>
> NOTE: In offenses involving economic exploitation, restitution is a necessary term of probation. For example, restitution would be a standard term in any case involving Medi-Cal or other insurance fraud. The amount of restitution shall be no less than the amount of money that was fraudulently obtained by the licensee. Evidence relating to the amount of restitution would have to be introduced at the administrative hearing.

With regard to this issue, the MBC and Joint Legislative Sunset Review Committee have previously reported:

http://www.senate.ca.gov/ftp/SEN/COMMITTEE/JOINT/SUNSET_REVIEW/_home/MED_BOARD_2002_SUNSET_REVIEW_REPORT.DOC

RESTITUTION PROVIDED TO CONSUMERS

Public Protection Versus Damages

Only rarely does the Board seek restitution for damages done to individual consumers. Historically, restitution for damages caused by substandard or reckless medical practice is handled in superior court, through civil malpractice cases.

The primary responsibility of the Board is to protect consumers from substandard or dishonest practitioners, whether or not damage has occurred. Civil malpractice cases are for the purpose of seeking recompense for damages to an individual, whether or not the conduct poses a danger to the public. Conversely, while substandard care may cause no damage to an individual patient, the conduct may be potentially dangerous and pose a threat to future patients. (As an example, a simple error or act that is neither legally negligent or incompetent may cause great damage and therefore is legal cause for a large malpractice award or settlement. Conversely, a terribly negligent or incompetent act may not cause any harm in a single instance, and therefore may be subject for discipline, but will not yield any civil award or settlement as no damage was done.)

While the Medical Boards complaint staff often mediates between patients and their physicians on minor, technical issues such as obtaining medical records, they cannot act as mediators to obtain sufficient financial redress for serious damages caused by medical malpractice, such as wrongful death or loss of bodily function.

Table 11. Cost Recovery

	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11
Total Enforcement Expenditures	299,750	276,418	311,345	377,876
Potential Cases for Recovery *	5	8	6	3
Cases Recovery Ordered	4	6	3	2
Amount of Cost Recovery Ordered	27,050	32,084	34,872	18,800
Amount Collected**	36,937	11,867	32,966	28,790

** "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on a violation(s) of the license practice act. B&P Code §2497.5 (a) states "The board may request the administrative law judge, under his or her proposed decision in resolution of a disciplinary proceeding before the board, to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case."*

***Amount collected in a given fiscal year is not directly related to the cases for which cost recovery was ordered during that same year. Amounts ordered are not necessarily due within the same fiscal year, and are often paid over a number of years (e.g., a three-year payment plan).*

Table 12. Restitution

	FY 2007/08	FY 2008/09	FY 2009/10	FY 2010/11
Amount Ordered	0	0	0	0
Amount Collected	0	0	0	0

Section 6 –
Public Information Policies

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

The Board posts agenda and meeting materials online at least 10 days prior to public meetings. They remain on the website continuously. Draft meeting minutes are posted as soon as drafted. Final minutes are posted immediately following their approval by the Board at a public meeting. They remain on the website continuously.

46. Does the board webcast its meetings? How far in advance does the board post future meeting dates?

BPM initiated webcasting in 2010 with the February 18 meeting in Los Angeles. Meeting dates for each year are usually established by the Board at the last meeting of the previous year, and those dates are immediately posted online. BPM is awaiting the Sunset hearing schedule before setting its 2012 meeting dates.

47. Are the board's complaint disclosure policies consistent with DCA's complaint disclosure and public disclosure policies?

BPM was the first board to implement the Departments' *Recommended Minimum Standards for Consumer Complaint Disclosure*, which "were adopted following a series of public hearings throughout the state. Those hearings drew extensive interest from consumer groups, professional associations, the press, law enforcement and regulatory agencies. The input received was enormously insightful and helped shape the final standards.The Department's regulatory Bureaus have been directed to implement these procedures and the Department's regulatory Boards have been asked to consider adopting policies consistent with that of the Department."

http://www.dca.ca.gov/about_dca/disclosure.shtml
http://www.dca.ca.gov/about_dca/disclosure_standards.shtml

BPM's regulations were drafted by the DCA Legal Office to implement this and are contained in Article 9 of its regulations. Disclosure of complaints pursuant to the Minimum Standards ("the complaint will be referred for legal action") is specifically addressed in Section 1399.704.

Under these BPM regulations approved by the Office of Administrative Law (OAL) in 2004, BPM discloses referrals to the Attorney General without waiting for preparation of a formal Accusation. BPM believes this information should be disclosed to prospective, inquiring patients.

BPM's regulations in effect disclose complaints when they are referred to the Attorney General, which the former Director had made the departmental standard, at the recommendation of BPM and others. In the event, BPM's Board had to vote unanimously to override her veto of the proposed regulations. The Office of Administrative Law (OAL) examined the legality of disclosing referrals to the AG and upheld BPM's position, which has been adopted by at least one other health board. In approving BPM's regulations, OAL considered the contention that disclosure of AG referrals is prohibited and rejected it.

The BPM Board Members decided they could not justify telling trusting Californians scheduled for surgery, and calling BPM for information, that there is no adverse public information to disclose if the Board has already fully investigated complaints and referred their surgeon to the Attorney General for prosecution due to incompetence, gross negligence or other unprofessional conduct.

The Medical Board handles DPM verifications through budgeted Shared Services, but does not include AG Referrals information. Nor is such information included in official online verifications. Referrals are only disclosed on BPM's web site or by BPM staff over the telephone, and only for DPMs.

BPM does not concur in statements made at DCA Board Member Orientation and Training sessions that there are "a lot of problems" with disclosing referrals to the AG and that boards should not consider it. BPM has not experienced any problems.

TYPE OF INFORMATION PROVIDED	YES	NO
Complaint Filed		**X**
Citation	X	
Fine	X	
Letter of Reprimand	X	
Pending Investigation		X
Investigation Completed		X
Arbitration Decision	X	
Referred to AG: Pre-Accusation	X	
Referred to AG: Post-Accusation	X	
Settlement Decision	X	
Disciplinary Action Taken	X	
Civil Judgment	X	
Malpractice Decision	X	
Criminal Violation: Felony Misdemeanor	X	 X

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

BPM provides the license type and number, address of record, podiatric medical school attended with graduation date, license status, original issue date and expiration date, and any public record or disciplinary information.

49. What methods are used by the board to provide consumer outreach and education?

BPM's website is rich with consumer information at the Consumer tab and other locations. This includes BPM's own DCA-published brochures in English and Spanish such as *You and Your DPM*, *Orthotics Can Help*,

and *Diabetics--Keep an Eye on Your Feet*. With travel restricted, BPM works closely with DCA's publications and outreach offices to have its brochures widely distributed through the Department's coordinating efforts.

Given the alphabet soup of boards and bureaus, it might be practicable for the Department of Consumer Affairs to coordinate more outreach with a single toll-free number staffed with multi-lingual referral personnel on behalf of all DCA special-funded programs. Costs, including public service advertising, could be reimbursed through assessments of special funds.

BPM's website also provides links to many consumer advocacy and advice organizations.

Section 7 –
Online Practice Issues

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

There are no plans at this time for new, additional regulatory approaches designed especially to target Internet business. With few exceptions, e.g., one case involving a Texas licensee, now revoked by the Texas State Board of Podiatric Medical Examiners and the U.S. Drug Enforcement Administration, there has not been marked evidence of DPM-related improper Internet business activity. DEA reports regarding this doctor, Salvatore DeFrank (who once held a California license that expired in 1990):

> http://www.deadiversion.usdoj.gov/fed_regs/actions/2005/fr05183.htm
>
> On September 15, 2004, Dr. DeFrank was interviewed by two detectives from the Sheriff's Department of Ventura County, California. Dr. DeFrank admitted he was then-currently managing a web site call center which employed one physician and a physician's assistant to issue controlled substance prescriptions over the Internet. The California investigation also discovered that between July 16 and 28, 2004, Dr. DeFrank personally issued 32 controlled substance prescriptions for Internet customers.

B&P Code §2052.5 provides authority for the Medical Board to develop a proposed registration program to be authorized for implementation by future legislation.

The Legislature has also amended B&P Code §2060:

> 2060. Nothing in this chapter applies to any practitioner located outside this state, when in actual consultation, whether within this state or across state lines, with a licensed practitioner of this state, or when an invited guest of the California Medical Association or the California Podiatric Medical Association, or one of their component county societies, or of an approved medical or podiatric medical school or college for the sole purpose of engaging in professional education through lectures, clinics, or demonstrations, if he or she is, at the time of the consultation, lecture, or demonstration a licensed physician and surgeon or a licensed doctor of podiatric medicine in the state or country in which he or she resides. **This practitioner shall not** open an office, appoint a place to meet patients, receive calls from patients within the limits of this state, give orders, or **have ultimate authority over the care or primary diagnosis of a patient who is located within this state.** [emphasis added].

Section 8 –
Workforce Development and Job Creation

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

The Board has published and distributes a brochure *Step Into a Rewarding Career in Podiatric Medicine*, in print and online. BPM has also posted student recruitment information on its website from the American Podiatric Medical Association.

BPM provided early technical assistance and support for the establishment of a second school of podiatric medicine in California, at Western University of Health Sciences in Pomona. As Western's first graduating class of 2013 completes its first two years of residency training, BPM anticipates many of them will apply for DPM licensure in California. If Western eventually transitions to awarding an MD degree as it has considered, then those graduates would apply for licensure directly to the Medical Board.

52. Describe any assessment the board has conducted on the impact of licensing delays on job creation.

The Board has never permitted backlogs or delays to occur in its licensing. Licenses are issued the same day all statutory requirements are met.

53. Describe any efforts that the board takes to alleviate negative impact of its regulatory mission on California business, including small and micro business.

There are no negative impacts from BPM.

54. Describe any partnering or information sharing the board has with other government agencies, such as Workforce Investment Boards or Office of Statewide Health Planning and Development.

BPM has initiated meetings with OSHPD in the past and encouraged it to include DPMs in its studies and reports.

55. Describe the board's outreach to schools.

By law, applicants must graduate from a school approved by the Board, which accepts all schools approved by the U.S. Department of Education's designated accrediting body, the national Council on Podiatric Medical Education. The Board works particularly with deans, faculty and administrators of the two California-based schools. For example, the faculty of the Western University College of Podiatric Medicine is working with the UC-San Diego School of Medicine, Physician Assessment and Clinical Education (PACE) program, to design an additional Continuing Competence pathway (extended course of study) under B&P Section 2496(g) for BPM's approval.

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

a. Workforce shortages and staffing needs
b. Successful training programs
c. Number of jobs created by its licensure program

BPM's *Step Into a Rewarding Career* quotes the U.S. Department of Labor Statistics' 2008-09 *Occupational Outlook Handbook* that "job opportunities should be good" in podiatric medicine.

BPM issues new licenses annually to all who apply and meet the statutory requirements: 60 in 2006/07, 55 in 2007/08, 47 in 2008/09, 59 in 2009/10, and 58 in 2010/11.

Section 9 – Current Issues

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

As a unit of the Medical Board utilizing MBC complaint intake, investigation, enforcement and discipline coordination personnel under Shared Services, BPM maintains uniformity of its enforcement procedures with MBC's. On September 23, BPM amended its *Manual of Disciplinary Guidelines with Model Disciplinary Orders* in conformity with MBC's 2011 *Manual* amendments in regard to substance abuse standards. These identical MBC and BPM amendments revised Conditions 9, 10 and 11 and the recommended range of penalties in the guidelines section for "Violation of Probation."

BPM is monitoring MBC's rulemaking to revise the reference to its *Manual*, from 10th Edition/2008 to 11th Edition/2011, in Section 1361 of its Regulations (Article 4 of Chapter 2, Division 13). Upon finalization of that process, BPM will file a public notice of proposed rulemaking to enable a public hearing on similarly revising Section 1399.710 of the BPM Regulations (Division 13.9).

At BPM's recommendation, the Joint Committee sunsetted BPM's Diversion Program during its first Sunset Review through SB 1981 [Greene, Statutes of 1998, Chapter 736]. The Board indicated it was not aware of any evidence that state agencies administer drug and alcohol abuse programs more efficiently than the private sector. DPMs may enter private programs confidentially on their own, or be required to enroll in one as a result of BPM-imposed discipline when appropriate. BPM does not divert impaired doctors from discipline, and, as indicated in our 1997 report, saw no justification for doing so. BPM utilizes DCA-MBC service providers and standards for substance-abusing probationers.

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

BPM was the only Board listed in the Committee's Bill Analysis in support of SB 1111. SB 1111, the CPEI, and now SB 544 were drafted to extend to all health boards the enforcement enhancements brought to BPM and MBC by the Presley bills beginning with SB 2375 of 1990, which BPM was the first State agency to support over strong bureaucratic resistance. The emphasis was on physician discipline and that legislation was then amended to delete the allied health boards and committees at their request. It never included boards not affiliated with MBC.

BPM already has the CPEI authorities and, in consultation with DCA legal counsel, has found no new BPM regulations needed.

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

BPM has provided all information to the BreEZe team and remains eager for implementation, now scheduled for FY 2012-13.

DCA advised the Board August 17 that--in addition to charging BPM budget and fund assessments of $4,000 in FY 2011-12 followed in succeeding FYs by $11,000, $9,000, $8,000, $9,000 and $9,000 consecutively through FY 2016-17 for BreEZe SPR Funding--it projects deducting another $15,000 annually for BreEZe credit card convenience fees beginning in FY 2012-13.

This additional $15,000 annual assessment is problematic.

DCA is assuming a two-percent transaction fee on average for each online renewal fee payment. Whereas this fee for a Registered Nurse, with a $140 renewal fee, will be **$2.80**, the transaction fee for each DPM renewal will be **$18.00** (two percent of the $900 renewal fee).

With fewer than 2,000 licensees, BPM has less than 1,000 renewals each year. DCA assumes 80 percent will renewal online via a credit card, i.e., 833 online renewals annually, times $900, times two percent. That calculation results in the $15,000 that DCA projects deducting from BPM's budget annually. **The $15,000 amount stands out as difficult to justify for only 833 renewals**.

BPM has the *highest* professional renewal fee and one of the *smallest* budgets and funds in DCA. For two decades, BPM has kept its fund in the black by careful, thrifty under-spending of budget and returning money to its fund for future use. BPM has kept its fund solvent by cutting expenditures for 20 years, developing a lean operation with minimum staff. Given the small size of BPM's budget, and the potential volatility of enforcement costs, this budget flexibility remains instrumental.

With BPM continuing to have the very highest renewal fee of all DCA boards ($900), as it has for two decades, there may be little if any support anywhere for raising the fee. BPM does not support raising the renewal fee or cutting licensing or enforcement programs.

Pursuant to a motion by Dr. Longobardi passed unanimously by the Board at its September 23 public meeting, BPM will initiate BreEze giving the licensee the option of online renewal with credit card payment of both the $900 renewal fee and the amount DCA charges to cover the average convenience fee (currently two percent, or $18). The current mail-in renewal with check payment will continue to be available.

This will cover the $15,000 convenience fee assessment that DCA projects deducting from BPM's budget. It will help preserve BPM's fund balance. BPM is an institution to which many have contributed much over decades. Continued stewardship of BPM's Special Fund is key to Board Members and staff.

60. Describe the board's efforts to comply with OSHPD data collection efforts.

BPM has recommended that OSHPD data collection be conducted in a professional, controlled and uniform method by its trained staff of social science survey professionals. DCA Information Services could provide OSHPD licensee mailing lists, usually available in various formats. Suggestions that each board gather varied data in its own fashion on renewal forms would not result in uniform, consistent or reliable data. Licensees should not be obligated to complete long surveys on license renewals, and such returns could result in errors and exceptions where they are centrally processed outside of DCA. Increases in delayed renewals, confusion, and unnecessarily delinquent licensure statuses could be expected. In BPM's case, it would also work against the Continuing Competence pathway check-off, which is an appropriate renewal-form question and essential to reduction of patient harm. Licensing boards do not have staff available, or trained, for collecting and tabulating data for OSHPD, and no other agencies would make up the staff time lost at licensing boards working to avoid backlogs.

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

The Medical Board has recently initiated action against unlicensed persons using lasers for treating medical conditions on the foot: http://mbc.ca.gov/board/media/releases_2011_07-12_silberman.html

Unlicensed persons also provide orthotic devices to consumers to aid in comfort and athletic performance. And they also appropriately provide orthotics for medical conditions following the diagnosis and prescription by a licensed doctor. BPM proposes an amendment to B&P Code Section 2477 to clarify this and to aid the Medical Board and District Attorneys in responding when necessary to unlicensed practice of medicine (see Section 11 and Attachment F).

Unlicensed activity by persons posing as DPMs or by DPMs with invalid licenses has not been an issue in recent years.

Pursuant to legislation BPM sponsored in the early 1990s (AB 1807, Statutes of 1994, Chapter 26), DPM licenses cancel after three years of delinquency rather than the five years still applicable for MDs. BPM sponsored this provision -- B&P Code Section 2427(b) -- upon learning that prosecutors declined to file against doctors practicing with delinquent licenses on the rationale such doctors would simply make their payments and delinquency fees current to avoid prosecution.

Also, in the early 1990s, BPM successfully addressed through citation and fine several instances of residency directors allowing podiatric medical school graduates to initiate postgraduate training prior to obtaining their Residency Licenses.

62. Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis?

Yes

Is this done electronically? -- No

Is there a backlog? -- No

If so, describe the extent and efforts to address the backlog. -- N/A

Section 10 –
Board Action and Response to Prior Sunset Issues

Include the following:

1. Background information concerning the issue as it pertains to the board.
2. Short discussion of recommendations made by the Committee/Joint Committee during prior sunset review.
3. What action the board took pursuant to the recommendation or findings made under prior sunset review.
4. Any recommendations the board has for dealing with the issue.

ISSUE #1. (CONTINUE REGULATION OF THE PROFESSION AND THE BOARD?) Should the licensing and regulation of DPMs be continued, and the profession be regulated by an independent board rather than by a bureau under the Department?

Recommendation #1: ***Recommend the continued regulation of DPMs by the Board of Podiatric Medicine.***

2002 Committee Comments

". . .Regulation of the profession continues to be in the best interest of consumers, given the health and safety implications of podiatric medicine. Podiatrists make independent medical judgments with patients including diagnosis, prescription of medication and method of treatment. The Board continues to be an effective mechanism for licensure and oversight of podiatrists and should be continued."

2011 BPM Comments

BPM concurs.

ISSUE #2. (INCREASE RESIDENCY TRAINING?) Should residency training be increased by one year?

Recommendation #2: ***The Board should thoroughly assess the need for this additional training through an occupational analysis.***

2002 Committee Comments: Although the Board is proposing to increase the residency training requirement from one year to two years, it is unclear what educational or practical deficiency necessitates this increase.

2011 BPM Comments: The American Podiatric Medical Association (APMA) has indicated since 1995 that two-years of postgraduate residency training is the minimum required to achieve entry-level competence. The Council on Podiatric Medical Education (CPME) redesigned its residency program standards accordingly requiring two- and three-year programs. BPM provided evidence that APMA and its affiliates had conducted the requisite occupational analyses and the B&P Committees backed the two-year requirement in an amendment to B&P Code §2484 as part of AB 932 [Koretz, Statutes of 2004, Chapter 88].

ISSUE #3. (ADOPT MODEL LAW?) Should the model law as proposed by the Board be adopted?

Recommendation #3: ***The DCA and the JLSRC do not have a recommendation on the Model Law which is being proposed by the BPM, but emphasize that a model law should reflect the consumer protection goals of this state.***

2002 Committee Comments: Although the Department and the Joint Committee do not yet have a position on the Model Law being proposed by the Board, any model law that is adopted must embrace the consumer protection mandate inherent in California law and not lessen or erode these standards. . . . The Board should be commended on its leadership and innovation as it looks at reforming its licensure standards. . . .

2011 BPM Comments: Many Model Law provisions were enacted with the Committee's subsequent support, following further documentation and justification, in AB 1777 [Assembly B&P, Statutes of 2003, Chapter 586] and AB 932 [Koretz, Statutes of 2004, Chapter 88].

ISSUE #4. (RENEWAL FEE?) Should the fee increase of $100 be extended?

Recommendation #4: The fee increase should be continued for two years to ensure that the Board's fund remains solvent .

2002 Committee Comments: . . .The Board instituted a fee increase, from $800 to $900, effective January 1, 2000. Although the temporary fee increase is scheduled to sunset on December 31, 2003, demands on the Board's operating fund suggest continuation of the fee increase in order for the Board to maintain its current licensing and enforcement activities. The additional revenue that will be generated as a result will enable the Board's fund condition to stabilize.

2011 BPM Comments: The initial increase was enacted as a temporary measure in AB 1252 [Wildman, Statutes of 1999, Chapter 977]. SB 724 (Senate B&P Committee [Statutes of 2001, Chapter 728] extended it through calendar 2003. SB1955 [Joint Committee, Statutes of 2002, Chapter 1150] extended it through 2005. SB 1549 [Figueroa, Statutes of 2004, Chapter 691] removed the sunset clause and the fee has remained $900, the highest in the Department, since that time. It was supported in a unanimous voice vote at the 2004 annual House of Delegates meeting of the California Podiatric Medical Association and retains consensus backing.

"CPMA and its membership have given unqualified backing to high standards and strong enforcement. Key to our members' confidence has been BPM's fairness, openness, emphasis on patient protection and quality of licensing services."

Jon A. Hultman, DPM, MBA,
Executive Director, CPMA
November 3, 2004

The decline in consumer complaints "is related to the excellent effort by the BPM to its licensees in the education, engagement, remediation and, when necessary, enforcement of the parameters regarding the quality and standard of care."

Derick Ball, DPM, *President*, LA Co.
Podiatric Medical Society
February 9, 2006

ISSUE #5. (CONDUCT AUDITS OF CONTINUING MEDICAL EDUCATION?) Should the Board conduct random audits of continuing medical education as it has done in the past?

Recommendation #5: ***The Board should resume conducting random audits of continuing medical education (CME).***

2002 Committee Comments: Faced with fiscal challenges, the Board discontinued its contract with the Medical Board to conduct random audits of CME. These audits should resume. Board staff should begin conducting random audits of CME courses and providers to guarantee that licensees are receiving CME courses of quality and relevance to the profession. This audit function is a fundamental responsibility of the Board and must be continued.

2011 BPM Comments: BPM views the Continuing Competence requirement as paramount, but podiatric CME in California is also high quality, and BPM absolutely concurs that an annual random audit of Continuing Competency/CME compliance is a good practice.

BPM resumed the annual Continuing Competence/CME random audit in 2004. It had been delayed when BPM lost its only clerical position: the Office Technician (OT) slot was abolished for being vacant six months during a hiring freeze. BPM was finally able to reestablish this position January 1, 2005 after three years of concentrated, high-priority effort, during which time BPM's professional staff was performing the OT duties as well as their own. The Licensing Coordinator actually resumed the annual audit in 2004.

BPM recruited a new Licensing Coordinator in 2009 when the incumbent transferred elsewhere for promotion potential. When the Enforcement Coordinator of 17 years did the same in 2011, BPM concluded the recruitment for that position by moving the Licensing Coordinator into enforcement and hiring from another board to fill the licensing position. These transitions and the impact of furloughs on BPM's five-person staff led to another break in the audits, but the new Licensing Coordinator has initiated an audit for FY 2011-12, which should be completed by December 2011.

The annual random audit is of one percent of licensees. It verifies self-certification under penalty of perjury in the current renewal for compliance with the Continuing Competence and 50-hour CME requirements. See also page 38, Question 20d.

ISSUE #6. (REVIEW OF COMPLAINTS BY BOARD MEMBERS?) Should the members of BPM review complaints?

Recommendation #6: ***Board Members should not review complaints and the Board should continue to contract with subject matter witnesses to do so.***

2002 Committee Comments: Although the Board has reduced expenditures, the Board should continue contracting with subject matter experts to review incoming complaints, and should not use Board members to perform this function. Board staff should conduct initial complaint review and forward select complaints to a panel of experts when technical expertise is needed. Board members who may ultimately vote to take action against a licensee should not be involved in the initial determination as to whether or not a complaint has merit. In spite of the cost, the Board should continue contracting out this service.

2011 BPM Comments: BPM concurs. Although it had experimented in about five cases with *pro bono* review by licensee Board Members (DPMs), who agreed to recuse themselves if the matters ever came before the Board, this was terminated in 1999 prior to the Joint Committee's last Sunset Review hearing on BPM December 4, 2001. The Board Members had agreed reluctantly, against staff recommendations, to the experiment in order to accommodate one lay gubernatorial-appointee who strongly advocated this. They found it impractical. The experiment ended when the DPM Board Members each refused acceptance of further cases to review.

ISSUE #7. (TRANSITION TO A NATIONAL EXAM?) Should the Business and Professions Code be amended to reflect a transition from the state oral clinical licensing examination to Part III of the National Board of Podiatric Medical Examiners (NBPME) examination?

Recommendation #7: ***The statute should be amended to reflect this change in examination requirements.***

2002 Committee Comments: The Board is in the process of transitioning from the state oral exam to giving Part III of the NBPME exam in its place. Business and Professions Codes Section 2486 should amended to reflect the requirement that all three parts of the NBPME exam are now required as part of licensure.

2011 BPM Comments: Done. SB 1955 [Figueroa, Statutes of 2002, Chapter 1150].

ISSUE #8. (REFINE CONTINUING COMPETENCY PROGRAM?) Should BPM's continuing competency program be amended to provide improved transition?

Recommendation #8: ***Based on the Board's experience to date, the Board's continuing competency program should be refined to provide additional pathways and ease compliance.***

2002 Committee Comments: Through SB 1981, Chapter 736, Statutes of 1998, the Board initiated the first continuing competence program for any doctor licensing board in this country. Under Business and Professions Section 2496, each licensee must self-certify under penalty of perjury at each biennial license renewal that she or he meets at least one of seven peer-review-based pathways for re-licensure. Licensees who have been licensed for more than 10 years, have no peer-reviewed health facility privileges, and are not board certified, must either take the BPM's licensing exam or complete a special training course sponsored by an approved school under Business and Professions Code Section 2496(g). BPM has approved such a program sponsored by the California College of Podiatric Medicine in conjunction with the California Podiatric Medical Association. However, according to the Board, administrative transitions in both of those institutions have hampered the program's development.

The Board reports that its objective has been to phase the continuing competence program in as a pilot. The continuing competence requirements need to be refined based on the Board's experience to date and would provide additional pathways and ease compliance for the few who lack health facility privileges and are not certified by an approved specialty board.

These changes would ease compliance for older licensees who are neither hospital privileged nor board certified. Of the seven original pathways, B&P Code Section 2496 (g) needs amendment because administrative changes at the California College of Podiatric Medicine and California Podiatric Medical Association hampered anticipated development of a program. The proposed eighth pathway, B&P Code

Section 2496 (h), would be more realistic for older licensees than the BPM's current oral clinical exam.

These changes will provide BPM an alternative to waiving the requirement or terminating the licenses of older practitioners. Providing for a BPM-approved course of study and the National Boards Part III as new alternatives would protect the public without forcing these older licensees out of practice for lack of a reasonable pathway. As licensees become accustomed to these requirements, e.g., maintaining certification or privileging, BPM anticipates tightening the pathways.

2011 BPM Comments: Done. B&P **§2496(h)** [SB 1955, Figueroa, Statutes of 2002, Chapter 1150]. Due to the Joint Committee's landmark legislation, lifelong learning has been reinforced and longitudinal complaint data is showing a steady 50-percent decline. Patient harm is being prevented. While some licensees have retired rather than maintain peer-reviewed skills, others have studied, taken and passed the National Board's Part III Exam, testing for clinical competence at the initial licensing level. Others comply by renewing peer-reviewed hospital privileges or specialty board certification.

Currently, the UC-San Diego Physician Assessment and Clinical Education (PACE) Program and the Western University School of Podiatric Medicine are co-developing a program for approval under §**2496(g)--"**Successful completion within the past five years of an extended course of study approved by the board."

Continuing Competence has not undermined specialty certification boards or other bodies of organized medicine. Rather, it has set a new, higher standard that podiatric medicine has internalized and made its own, as one would expect from a privileged, elite profession.

To tighten the program, BPM amended its California Code of Regulations rules [Title 16, Division 13.9, Article 3, Continuing Competence] to provide for a new subsection 1399.678(e) stating "Any licensee granted a temporary waiver may not be granted another temporary waiver at the next license renewal." [Amendment with new subsection (e) filed 7-24-2003; operative 8-23-2003 (Register 2003, No. 30).] This and the amended law made the program more workable, enforceable, and meaningful. There is a reasonable pathway for all licensees, with only a single two-year waiver possible.

Section 11 –
New Issues

List new issues raised in this report. Give a short discussion of the issues, recommendations, or actions which could be taken by the board, Department of Consumer Affairs, or Legislature to deal with issues discussed in this report, i.e., legislative changes, policy direction, budget changes.

1. New issues raised by the Committee to be addressed by the board in this report.

2. New issues identified by the board that are previously addressed in this report or by prior Sunset Review. Include new proposals for legislation, policy direction or budget changes.

Please also see Attachment F for mark up of B&P Code Sections 2460-2499.8.

a. **B&P Section 2335(c)(2)** -- The requirement that "The votes of two members of the panel or board are required to defer final decision pending discussion of the case by the panel or board as a whole," effectively prevents the BPM Board Members from discussing a case in closed session as a jury even when one member of the jury identifies an issue and wishes to have discussion with her or his colleagues prior to voting. There is no such obstacle to jury deliberation in civil or criminal courts, nor was there a problem with too many cases being held by BPM prior to enactment of the two-votes rule. Deleting this, for BPM, could empower the Board as a jury and make its role more meaningful.

b. **B&P Section 2472(d)** -- Article 22 (Podiatric Medicine) of the Medical Practice Act has provided for a two-tier license system, depending on whether a DPM was ankle licensed "on or after January 1, 1984," the date that the association's ankle bill took effect to clarify this as part of the licensed scope.

   Senate B&P Committee staff queried in 1997 whether this two-tiered system could be eliminated, upon receipt of BPM's first Sunset Review report. BPM staff commented then it was probably premature. But now, a decade and a half later, approaching three decades since 1984, BPM would support a single scope. The useful life of the 1984 two-tier licensing has run its course.

   More than 80-percent of BPM's licensees are "ankle licensed" and this percentage is increasing monthly. It is a small number of older licensees who do not perform ankle surgery, amputations or surgical assisting to MD and DO surgeons that the "ankle license" now allows.

   Doctors licensed prior to 1984 were able under the law to become ankle licensed if certified by the American Board of Podiatric Surgery (ABPS) or by passing a sophisticated, rigorous oral ankle exam administered by BPM. BPM has discontinued that exam as there is no longer any demand. Following enactment of AB 932 of 2004, there was renewed interest in taking the exam because that bill in practice disenfranchised some non-ankle-licensed doctors who had previously performed digital amputations as part of their practices to preserve diabetic limb and life. Those doctors were provided opportunities to take this "Section 2499.5(k) exam," and most who did passed:

Exam Date	Candidate Number	Pass Rate
12/11/2004	52	75%
10/1/2005	13	73%
2/3/2007*	7	57%
2/18/2010	2	100%

Single-scope licensure would simplify the statute and its administration without harm to the public.

c. **B&P Section 2472(f) --** As indicated in Office of the Attorney General: Indexed Opinion No. 09-0504 - Histories & Physicals, referencing revised CMS Medicare & Medicaid Programs; Conditions of Participation (for both documents, see http://www.bpm.ca.gov/education/healthfac.shtml#dpmshps), Medicare regulations no longer restrict DPM history and physical examinations. Section 2472(f) is thus obsolete, confusing to the public, and should be deleted.

d. **B&P Section 2475** -- BPM proposes deleting "for up to four years," thus sunsetting the four-year cap on DPM postgraduate training. Few may participate in residency and fellowship training for more than four years, but the limit on education is unnecessary. It is the only known statutory cap on education anywhere in this country for any profession or group. It will interfere with advanced training of some leading practitioners. It is a principle of medical education that there is no such thing as too much education and training.

e. **B&P Section 2477** -- BPM proposes amendment to clarify that anyone may offer special shoes and inserts without a license to aid comfort and athletic performance, but that a medical license is needed to diagnose and prescribe for medical conditions.

f. **B&P Section 2493(b) --** With the National Board of Podiatric Medical Examiners (NBPME) upgrading the national Part III licensing exam to reflect one-year of postgraduate training, in addition to graduation from podiatric medical school, BPM is recommending sunsetting of Section 2493(b), which it authored as part of the negotiations leading to enactment of AB 932 of 2004. NBPME has reported to BPM: "The June 2011 examination and all subsequent forms will include a board-adopted passing score that reflects entry-level competence by a podiatric physician with one year of post-graduate training." And the Fall 2011 *NBPME Reports* (Vol. 21 No.1) states, "The culmination of an effort begun in 2008 with an updated practice analysis survey followed by revised test specifications was the administration of a revised Part III examination in June 2011. The examination is now directed toward the competencies expected of a candidate with at least one year of post graduate training."

g. **B&P 2497.5(b)** -- This amendment modifies §2497.5 to give the Board discretion to increase cost recovery in disciplinary cases when it non-adopts a proposed decision from an administrative law judge "and in making its own decision finds grounds for increasing the costs to be assessed." It is unusual for the Board to non-adopt an ALJ's proposed decision and make its own decision based on the record and new oral and written arguments. But in the event, it should not be prohibited from ordering actual and reasonable cost recovery.

§2497.5 prevents the Board from increasing cost recovery proposed by an ALJ "in any event" and also prohibits an ALJ from increasing the cost recovery when the Board remands cases. There is no apparent rationale for these provisions other than to restrict recovery of costs. This undercuts the role of the Board Members in making the final decision and has the effect of inflating licensing fees.

h. **B&P Section 2499.5** -- Aside from BPM's renewal fee, which accounts for more than 90 percent of the Board's revenue, the fees for other specified services have not been adjusted in two decades. They are at their statutory limits. The DCA Budget Office recommended in 2004, when the $900 renewal fee was made permanent, that BPM's other fees be adjusted to reflect actual costs of service. This was to stabilize the BPM special fund and relieve pressure on the renewal fee, which has been the highest professional renewal fee in DCA for decades.

The following would bring fees more in line with current costs:

- Increase the application fee from $20 to $100
- Delete application and renewal fee discounts for recent graduates
- Add authority to waive the renewal fee for doctors working only as volunteers consistent with MBC statute (Section 2442)
- Increase the duplicate wall certificate fee from $40 to $100
- Increase the duplicate renewal receipt fee from $40 to $50, and clarify statute to include the issuance of pocket licenses under this provision so that it is consistent with current practice
- Increase the endorsement fee from $30 to $100, and clarify statute to include all of the services that are currently provided under this subsection
- Increase the resident's license fee from $60 to $100
- Sunset authorization and fees for ankle licensure exam for pre-1984 licensees
- Increase the exam appeal fee from $25 to $100
- Increase the continuing education course approval fee from $100 to $250

Given BPM's close budget management and lean operation, these fees should not require further adjustment for some years. While the renewal fee is the highest professional fee within the Department, DPMs support it to ensure the fiscal and enforcement integrity of a board dedicated to standards reflecting well on the profession.

Section 12 – Attachments

Please provide the following attachments:

A. Board's administrative manual

BPM's administrative manual information is provided and updated online from our own webpage (About Us):

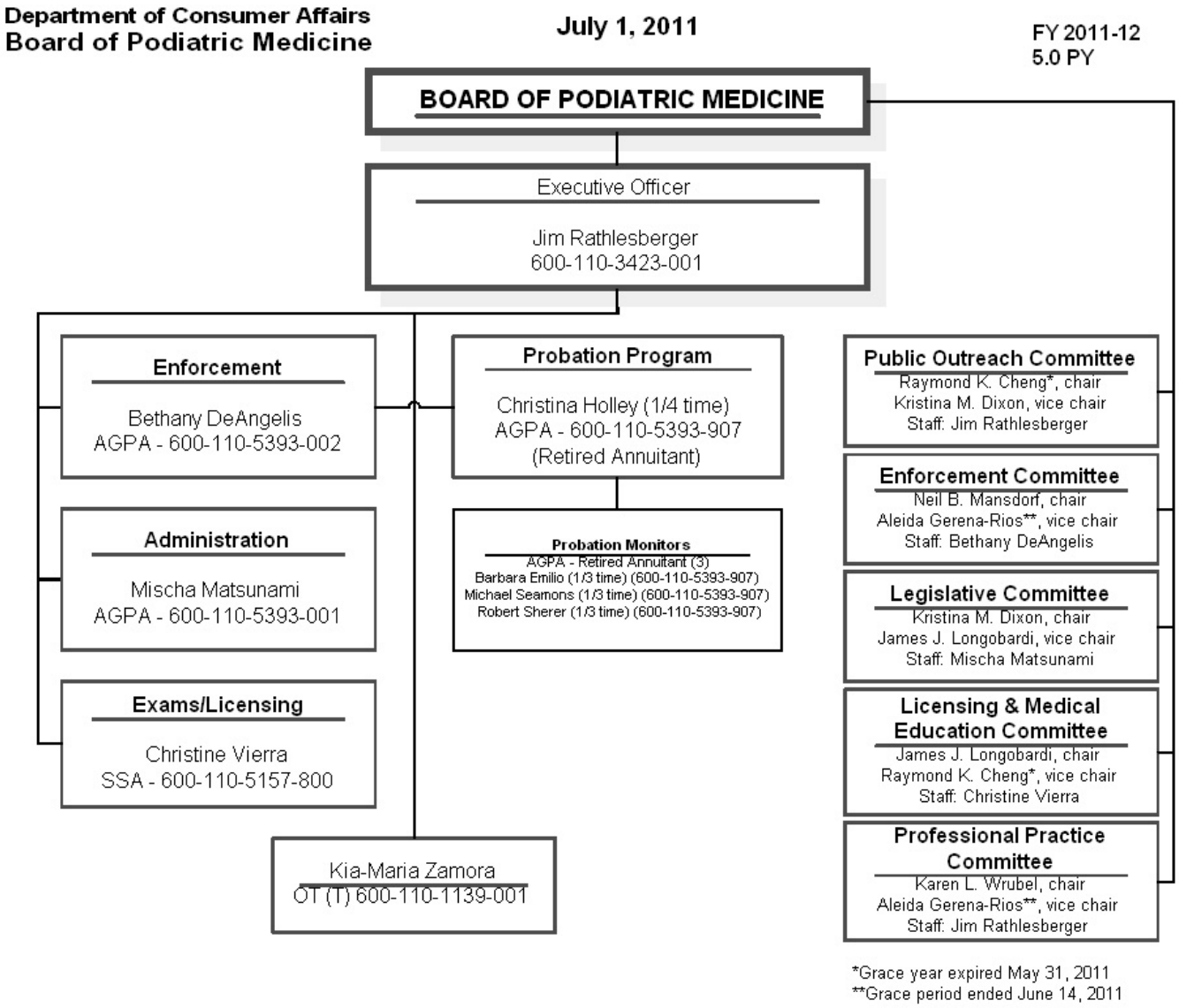
http://www.bpm.ca.gov/about_us/index.shtml

and provides additional administrative information by linking to the DCA Board Member Resource Center:

http://www.dcaboardmembers.ca.gov/index.shtml

With the Internet now widely used, the old paper, binder, photocopied and mailed Manual, with continual delete-and-insert updates to busy Board Members and others is an out-of-date and inefficient practice.

B. Current organizational chart showing relationship of committees to the board and membership of each committee



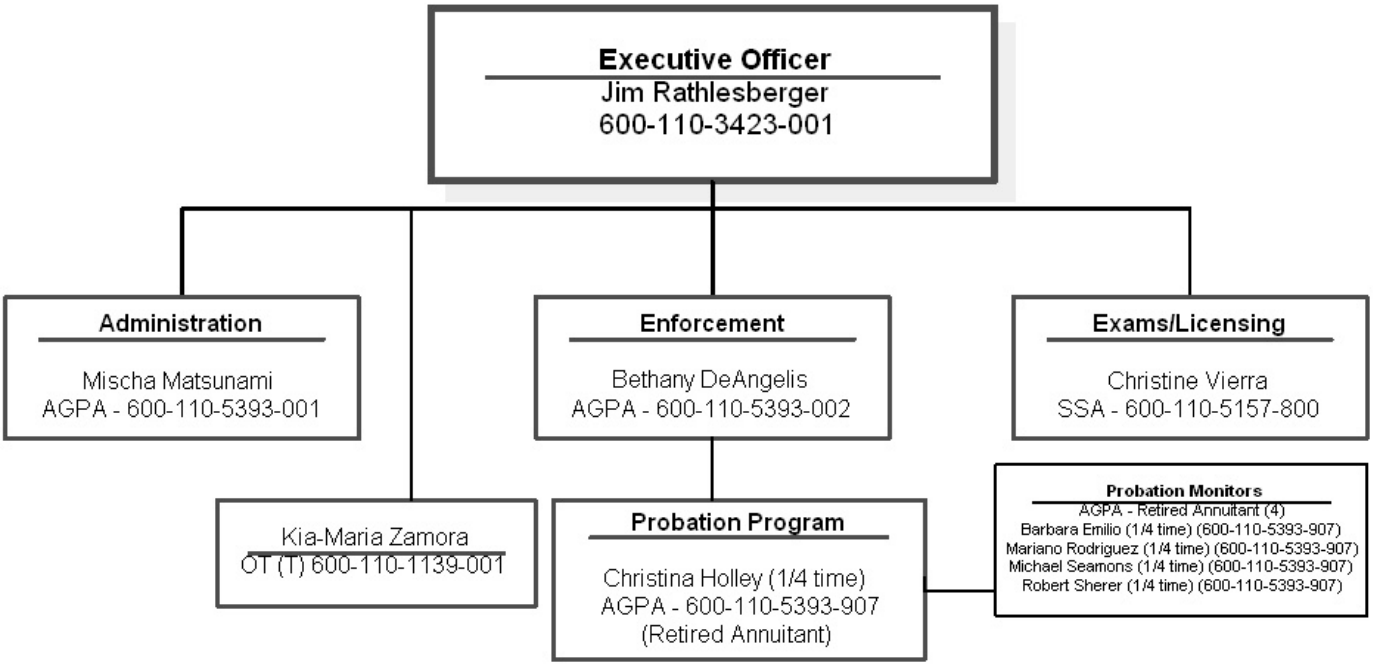
C. Major studies, if appropriate -- NONE

D. Year-end organization charts for last four fiscal years. Each chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.)

Department of Consumer Affairs
Board of Podiatric Medicine

June 30, 2011

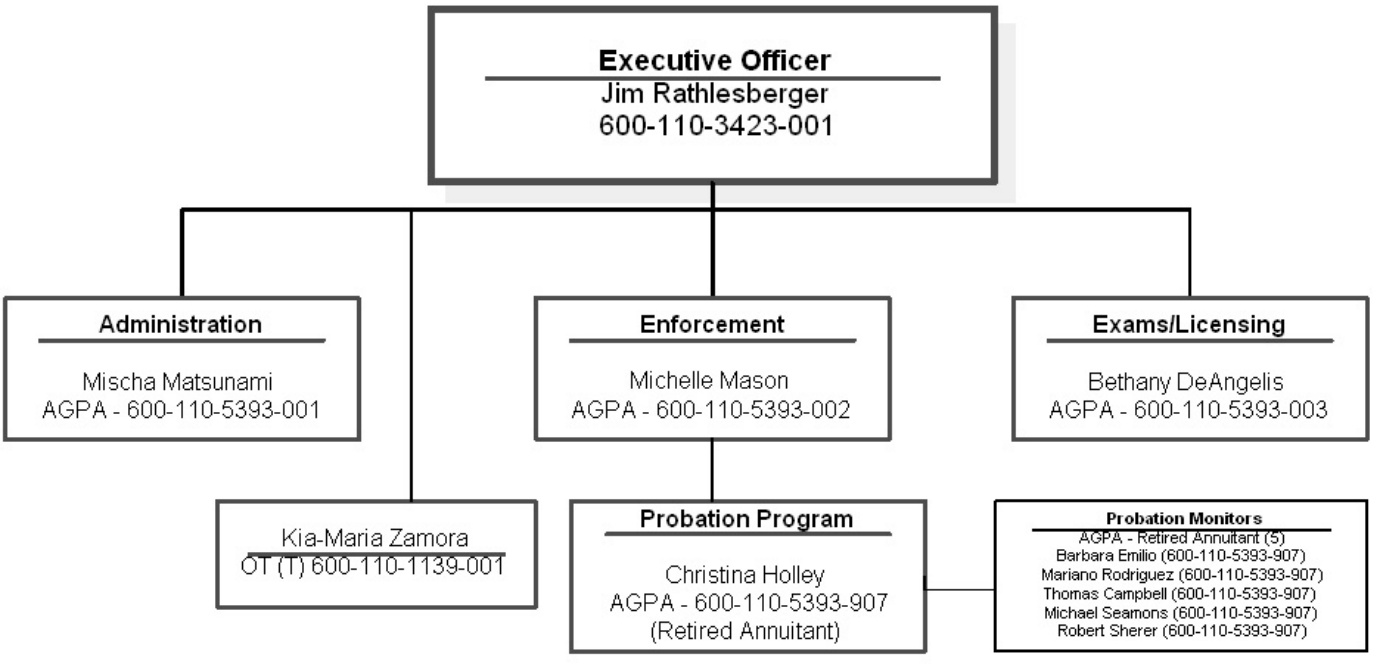
FY 2010-11
5.0 PY



Department of Consumer Affairs
Board of Podiatric Medicine

June 30, 2010

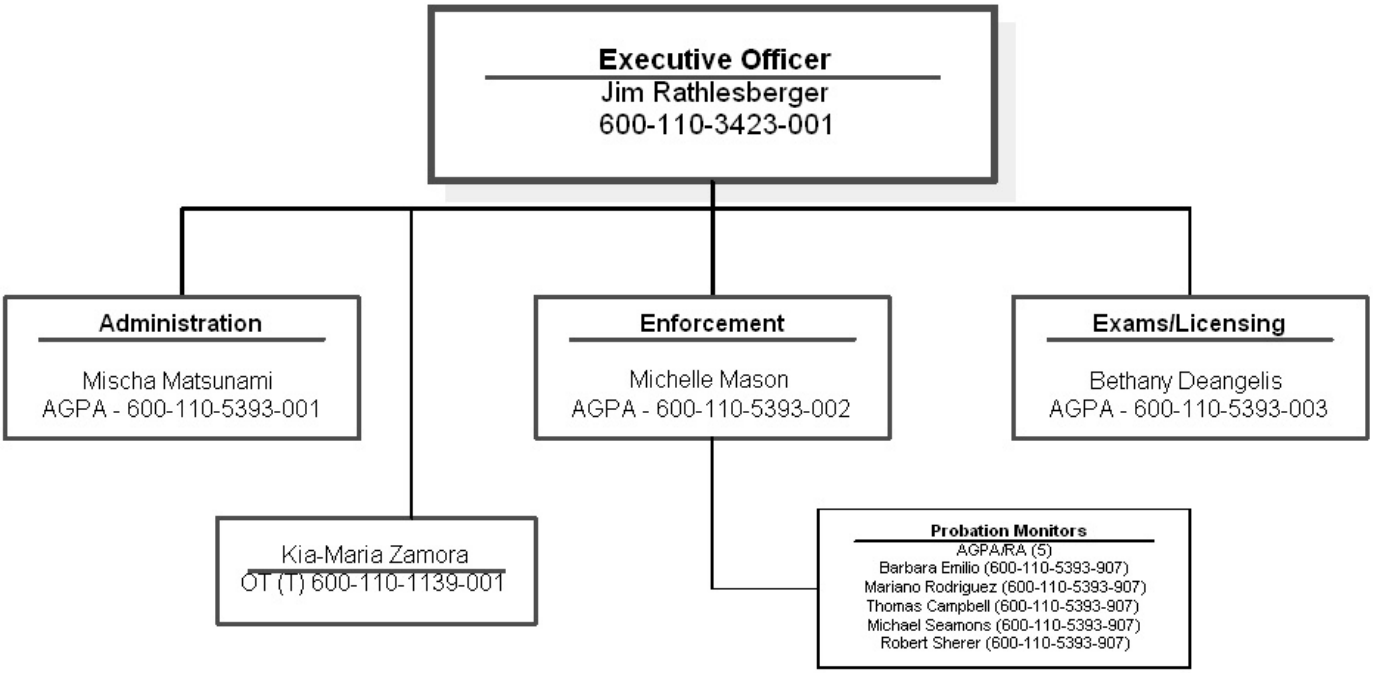
FY 2009-10
5.0 PY



Department of Consumer Affairs
Board of Podiatric Medicine

June 30, 2009

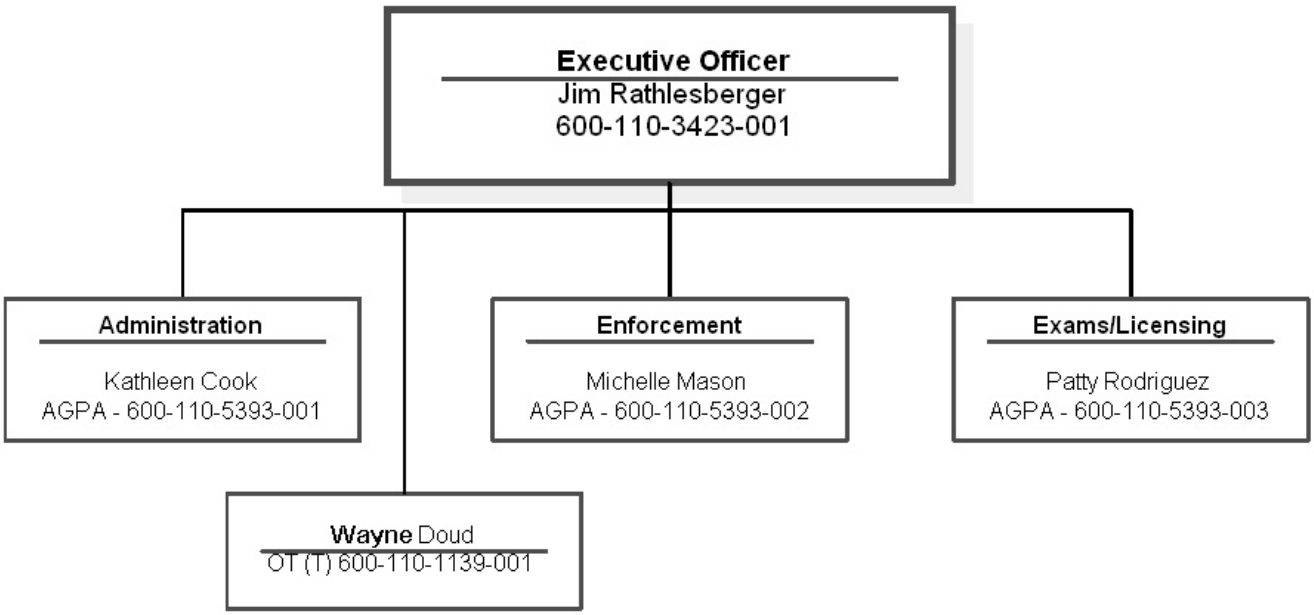
FY 2008-09
5.0 PY



Department of Consumer Affairs
Board of Podiatric Medicine

June 30, 2008

FY 2007-08
5.0 PY



E. Board's records retention schedule.

STD.73 (REV. 6/2002)
RECORDS RETENTION SCHEDULE

STATE OF CALIFORNIA – DEPARTMENT OF GENERAL SERVICES
STATE RECORDS PROGRAM

Submit three copies to: Department of General Services, California Records and Information Management, 707 Third St. 2nd Fl., W. Sacramento, CA 95605.

A CalRIM Consultant may be reached by phone at (916) 375-4404, by fax at (916) 375-4408 or by email at CalRIM@dgs.ca.gov

(1) DEPARTMENT, BOARD OR COMMISSION	(2) AGENCY BILLING CODE	(3)
Board of Podiatric Medicine	57305	PAGE 1 OF 6 PAGES

(4) DIVISION/ BRANCH/ SECTION	(5) ADDRESS
Dept. of Consumer Affairs	1420 Howe Avenue, Suite 8 Sacramento, CA. 95825

CHECK THE APPROPRIATE BOX

(6) ☐ New schedule of records that have never been scheduled. [Complete boxes (9) – (12)]
(7) ☒ Revising a previous schedule. [Complete boxes (13) –(16)] (A new approval number will be assigned.)
(8) ☐ Amending some pages of a previous schedule. [*Complete boxes (13) – (16)] (The original approval number will remain in effect.)*

	(9) SCHEDULE NUMBER	(10) SCHEDULE DATE	(11) NUMBER OF PAGES	(12) CUBIC FEET (*Total Schedule*)
NEW SCHEDULE INFORMATION (*If applicable*)	PEC-3	1-16-07	6	
PREVIOUS SCHEDULE INFORMATION (*If applicable*)	(13) SCHEDULE NUMBER	(14) APPROVAL NUMBER	(15) APPROVAL DATE (S)	(16) PAGE NUMBER(S) REVISED - ALL
	PEC-3	00-118	02/11/2000	

(17) MISSION/FUNCTIONAL STATEMENT :
The mission of the Board of Podiatric Medicine is to ensure protection of consumers under the laws of California through the setting and enforcement of contemporary standards and the provision of accurate and timely information that promotes sound consumer decision-making.

PART I – AGENCY STATEMENTS

As the program manager (*or person authorized to sign for the program manager*) directly responsible for the records listed on this records retention schedule, I certify that all records listed are necessary and that each retention period is correct. ***For revisions, all items on the previous schedule are included or accounted for on the recapitulation. Vital records identified by this schedule are protected. If protection is not currently provided but plans are underway, the details of such plans are shown in Column 45, Remarks.***

(18) SIGNATURE - MANAGER RESPONSIBLE FOR THE RECORDS	(19) TITLE	(20) PHONE NUMBER	(21) DATE SIGNED
[signature]	Executive Officer	916-263-2650	

In accordance with Government Code 14755, approval of this Records Retention Schedule by the Department of General Services is hereby requested. Retention periods shown have been established in accordance with the criteria set forth by Section 1667 of the State Administrative Manual.

(22) SIGNATURE- RECORDS MGMT. ANALYST	(23) CLASSIFICATION	(24) NAME (*Printed or Typed*)	(25) PHONE NUMBER	(26) DATE SIGNED
Teresa Vargas	RMC/SSA	Teresa Vargas	574-7260	1-16-07

PART II – DEPARTMENT OF GENERAL SERVICES APPROVAL (*Per Government Code Section 14755*)

(27) SIGNATURE –CalRIM CONSULTANT	(28) APPROVAL NUMBER	(29) DATE SIGNED	(30) EXPIRATION DATE
[signature]	07-005	1/22/2007	1/22/2012

PART III – ARCHIVAL SELECTION (*Per Government Code Section 14755*)

THE ATTACHED RECORDS RETENTION SCHEDULE:

(31) ☐ Contains no material subject to further review by the California State Archives

(32) ☒ Contains material subject to archival review. Items stamped "NOTIFY ARCHIVES" may not be destroyed without clearance by the California State Archives. (*Per Section 1671 of the State Administrative Manual.*)

(33) SIGNATURE – CHIEF OF ARCHIVES OR DESIGNATED REPRESENTATIVE	(34) DATE SIGNED
Sydney Bailey Archivist	Jan. 30, 2007

FOR ARCHIVES STAMP

CALIFORNIA STATE ARCHIVES

(35) CalRIM APPROVAL NUMBER

507-005

(36) Page 2 of 6

ITEM # (37)	CUBIC FEET * (38)	CA. STATE ARCHIVES USE ONLY (39)	TITLE AND DESCRIPTION OF RECORDS (Double spaces between items) (40)	MEDIA (41)	VITAL (42)	RETENTION OFFICE (43)	RETENTION DEPT. (44)	RETENTION SRC (45)	RETENTION TOTAL (46)	PRA (Exempt) & IPA (47)	REMARKS (48)
			ADMINISTRATIVE FILES								
1	1		Budget Change Proposals	P		Act +6			Act +6		Active until BCP is implemented.
2	1		Expenditures/Procurement	P		3 yrs			3 yrs		Until end of fiscal year.
3	1		Calstars Reports	P		6 yrs			6 yrs		Until end of fiscal year.
4	1		Contracts	P		Act +6			Act +6		Active until termination date of contract.
5	5		Cashiering: Claim Schedule/ROC Revenue Reports/Logs	P		2 yrs		4 yrs	6 yrs		Until end of fiscal year.
6	2	NOTIFY ARCHIVES	Meeting Agenda Packets	P		5 yrs		10 yrs	15 yrs		
7	1	NOTIFY ARCHIVES	Minutes	P		Perm			Perm		Retained permanently as historical records.
8	1		Personnel	P		Act +2			Act +2		Active until date of termination.
9	2	NOTIFY ARCHIVES	Regulatory Rulemaking Files	P		Act +5		5 yrs	Act+10		

ITEM # (37)	CUBIC FEET * (38)	CA. STATE ARCHIVES USE ONLY (39)	TITLE AND DESCRIPTION OF RECORDS (Double spaces between items) (40)	MEDIA (41)	VITAL (42)	RETENTION OFFICE (43)	RETENTION DEPT. (44)	RETENTION SRC (45)	RETENTION TOTAL (46)	PRA (Exempt) & IPA (47)	REMARKS (48)
10	1	NOTIFY ARCHIVES	Legislation	P		Act +2		5 yrs	Act +7		
11	0.5	NOTIFY ARCHIVES	Legal Opinions	P		10 yrs		5 yrs	15 yrs		
12	0.5	NOTIFY ARCHIVES	Reports: ASP Sunset	P		Act +4		4 yrs	Act +8		
13	1		Weekly Mail Correspondence	P		4 yrs			4 yrs		Keep 4 calendar years then shred.
			PROGRAM FILES/LICENSING Application for Licensure:	P							Licensing files are exempt from public disclosure per Public Records Act, Govt Code Sec. (6254(c).
14	0.5		Pending Completion	P		2 yrs		5 yrs	7 yrs	X	
15	1		Failed Examination	P		3 yrs		5 yrs	8 yrs	X	From date of failed examination.
16	3		Passed Exam/Pending Completion	P		10 yrs		5 yrs	15 yrs	X	
17	0.5		License Denied	P		2 yrs		8 yrs	10 yrs	X	From date of denial.
18	2		Limited License Files	P		Act +5		5 yrs	Act +10	X	Active until last expiration date.

* Provide total of office and departmental

ITEM # (37)	CUBIC FEET * (38)	CA. STATE ARCHIVES USE ONLY (39)	TITLE AND DESCRIPTION OF RECORDS (Double spaces between items) (40)	MEDIA (41)	VITAL (42)	RETENTION OFFICE (43)	RETENTION DEPT. (44)	RETENTION SRC (45)	RETENTION TOTAL (46)	PRA (Exempt) & IPA (47)	REMARKS (48)
19	60		[redacted] License Files	P		Active			Active	X I	Active until cancelled, deceased or other.
20	8		Cancelled Licenses	P		2 yrs		8 yrs	10 yrs	X I	From date of cancellation.
21	4	NOTIFY ARCHIVES	Deceased Licenses	P		1 yr		9 yrs	10 yrs	X I	From date of death.
22	2		Renewal Notices	P		2 yrs			2 yrs		Keep 2 licensing cycles then shred.
			Program Files/Continuing Medical Education	P							
23	4		Applications for Program Approval	P		5 yrs		5 yrs	10 yrs		
			Program Files/Examination								Examination data used to administer licensing exams is exepmt from public disclosure per Public records Act, Govt Code Sec. 6254(g)
24	1		Candidate Audio Tapes	M		0.5 yr			0.5 yr		
25	2		Exam Question Pool	P		Active			Active	X	Active is until Exam Committee request confidential destruction.
26	3		Exam X-rays	P		Active			Active	X	

(35) CalRIM APPROVAL NUMBER 07-005 (36) Page 5 of 6

ITEM # (37)	CUBIC FEET * (38)	CA. STATE ARCHIVES USE ONLY (39)	TITLE AND DESCRIPTION OF RECORDS (Double spaces between items) (40)	MEDIA (41)	VITAL (42)	RETENTION OFFICE (43)	RETENTION DEPT. (44)	RETENTION SRC (45)	RETENTION TOTAL (46)	PRA (Exempt) & IPA (47)	REMARKS (48)
27	2		Exam Planning and Committee Files	P	X	3 yrs		7 yrs	10 yrs	X	
			Program Files/Enforcement	P							
28	5.5		Revoked Files	P		4 yrs			4 yrs	X	
29	1		Probation Files	P		Act +1			Act +1	X	

* Provide total of office and departmental

(35) CalRIM APPROVAL NUMBER 07-005 (36) PAGE 6 OF 6 PAGES

ITEM #	CUBIC FEET	CA. STATE ARCHIVES USE ONLY	TITLE AND DESCRIPTION OF RECORDS (Double spaces between items)	MEDIA	VITAL	RETENTION				PRA (Exempt) & IPA	REMARKS
						OFFICE	DEPT.	SRC	TOTAL		
(37)	(38)	(39)	(40)	(41)	(42)	(43)	(44)	(45)	(46)	(47)	(48)
			Records Management								
30.			STD Form 70, Records Inventory Worksheet	P		Current			Current		Retain as current until next inventory, or when no longer needed for reference or analysis, whichever is later.
31.			STD Form 71, Records Transfer List	P		Current			Current		Retain as current until all records have been either destroyed, retired permanently, transferred to the State Archives, or when no longer needed whichever is later.
32.			STD Form 73, Records Retention Schedule	P		Current			Current		Retain as current until revised. NOTE: Although revision is required every five years from date approved by CalRIM, records retention schedules that are not revised remain in effect but are considered non-current.
33.			Authorization for Records Destruction (Computer Printouts)	P		4			4		Retain for two years from date destruction is authorized. Then retain two additional years or until audited, whichever occurs first (maximum of four years).
34.			Electronic Mail A. E-mail that are categorized as official records are subject to department records retention schedule and must be retained for the same period of time as the records series that most closely matches the subject matter contained within the new e-message. If there is no entry that resembles or matches the subject matter of the e-message, the "record" should be added to the schedule as a separate series (separate item number). B. Transitory e-Mail consists of electronic messages that are created primarily for the communication of informal information as opposed to the perpetuation or formalization of knowledge.	M		* 90 Days	*	*	*90 Days		*E-mail communications that have *official records status* are subject to department records retention schedule and must be retained for the same period of time as the records series that most closely matches the subject matter of the e-communication in question. Destroy transitory e-communications when they have served their purpose.

F. Board's proposed legislative changes to B&P Code, Division 2 (Healing Arts), Chapter 5 (Medicine), Article 22 (Podiatric Medicine):

BUSINESS AND PROFESSIONS CODE SECTION 2460-2499.8

2460. (a) There is created within the jurisdiction of the Medical Board of California the California Board of Podiatric Medicine.
(b) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date. The repeal of this section renders the California Board of Podiatric Medicine subject to the review required by Division 1.2 (commencing with Section 473).

2460.1. Protection of the public shall be the highest priority for the California Board of Podiatric Medicine in exercising its licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public shall be paramount.

2461. As used in this article:
(a) "Division" means the Division of Licensing of the Medical Board of California.
(b) "Board" means the California Board of Podiatric Medicine.
(c) "Podiatric licensing authority" refers to any officer, board, commission, committee, or department of another state that may issue a license to practice podiatric medicine.

2462. The board shall consist of seven members, three of whom shall be public members. Not more than one member of the board shall be a full-time faculty member of a college or school of podiatric medicine.
The Governor shall appoint the four members qualified as provided in Section 2463 and one public member. The Senate Rules Committee and the Speaker of the Assembly shall each appoint a public member.

2463. Each member of the board, except the public members, shall be appointed from persons having all of the following qualifications:
(a) Be a citizen of this state for at least five years next preceding his or her appointment.
(b) Be a graduate of a recognized school or college of podiatric medicine.
(c) Have a valid certificate to practice podiatric medicine in this state.
(d) Have engaged in the practice of podiatric medicine in this state for at least five years next preceding his or her appointment.

2464. The public members shall be appointed from persons having all of the following qualifications:

(a) Be a citizen of this state for at least five years next preceding his or her appointment.
(b) Shall not be an officer or faculty member of any college, school, or other institution engaged in podiatric medical instruction.
(c) Shall not be a licentiate of the board or of any board under this division or of any board created by an initiative act under this division.

2465. No person who directly or indirectly owns any interest in any college, school, or other institution engaged in podiatric medical instruction shall be appointed to the board nor shall any incumbent member of the board have or acquire any interest, direct or indirect, in any such college, school, or institution.

2466. All members of the board shall be appointed for terms of four years. Vacancies shall immediately be filled by the appointing power for the unexpired portion of the terms in which they occur. No person shall serve as a member of the board for more than two consecutive terms.

2467. (a) The board may convene from time to time as it deems necessary.
(b) Four members of the board constitute a quorum for the transaction of business at any meeting.
(c) It shall require the affirmative vote of a majority of those members present at a meeting, those members constituting at least a quorum, to pass any motion, resolution, or measure.
(d) The board shall annually elect one of its members to act as president and a member to act as vice president who shall hold their respective positions at the pleasure of the board. The president may call meetings of the board and any duly appointed committee at a specified time and place.

2468. Notice of each meeting of the board shall be given in accordance with the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code).

2469. Each member of the board shall receive per diem and expenses as provided in Section 2016.

2470. The board may adopt, amend, or repeal, in accordance with the provisions of the Administrative Procedure Act, regulations necessary to enable the board to carry into effect the provisions of law relating to the practice of podiatric medicine.

2471. Except as provided by Section 159.5, the board may employ, within the limits of the funds received by the board, all personnel necessary to carry out this chapter.
2472. (a) The certificate to practice podiatric medicine authorizes the holder to practice podiatric medicine.

(b) As used in this chapter, "podiatric medicine" means the diagnosis, medical, surgical, mechanical, manipulative, and electrical treatment of the human foot, including the ankle and tendons that insert into the foot and the nonsurgical treatment of the muscles and tendons of the leg governing the functions of the foot.

(c) A doctor of podiatric medicine may not administer an anesthetic other than local. If an anesthetic other than local is required for any procedure, the anesthetic shall be administered by another licensed health care practitioner who is authorized to administer the required anesthetic within the scope of his or her practice.

(d) (1) A doctor of podiatric medicine ~~who is ankle certified by the board on and after January 1, 1984,~~ may do the following:

(A) Perform surgical treatment of the ankle and tendons at the level of the ankle pursuant to subdivision (e).

(B) Perform services under the direct supervision of a physician and surgeon, as an assistant at surgery, in surgical procedures that are otherwise beyond the scope of practice of a doctor of podiatric medicine.

(C) Perform a partial amputation of the foot no further proximal than the Chopart's joint.

(2) Nothing in this subdivision shall be construed to permit a doctor of podiatric medicine to function as a primary surgeon for any procedure beyond his or her scope of practice.

(e) A doctor of podiatric medicine may perform surgical treatment of the ankle and tendons at the level of the ankle only in the following locations:

(1) A licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code.

(2) A licensed surgical clinic, as defined in Section 1204 of the Health and Safety Code, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1) and meets all the protocols of the surgical clinic.

(3) An ambulatory surgical center that is certified to participate in the Medicare Program under Title XVIII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1) and meets all the protocols of the surgical center.

(4) A freestanding physical plant housing outpatient services of a licensed general acute care hospital, as defined in Section 1250 of the Health and Safety Code, if the doctor of podiatric medicine has surgical privileges, including the privilege to perform surgery on the ankle, in a general acute care hospital described in paragraph (1). For purposes of this section, a "freestanding physical plant" means any building that is not physically attached to a building where inpatient services are provided.

(5) An outpatient setting accredited pursuant to subdivision (g) of Section 1248.1 of the Health and Safety Code.

~~(f) A doctor of podiatric medicine shall not perform an admitting history and physical examination of a patient in an acute care hospital where doing so would violate the regulations governing the Medicare program.~~

~~(g) A doctor of podiatric medicine licensed under this chapter is a licentiate for purposes of paragraph (2) of subdivision (a) of Section 805, and thus is a health care practitioner subject to the provisions of Section 2290.5 pursuant to subdivision (b) of that~~

~~section.~~ [Duplicative--covered by Section 805(a)(2)itself]

2474. Any person who uses in any sign or in any advertisement or otherwise, the word or words "doctor of podiatric medicine," "doctor of podiatry," "podiatric doctor," "D.P.M.," "podiatrist," "foot specialist," or any other term or terms or any letters indicating or implying that he or she is a doctor of podiatric medicine, or that he or she practices podiatric medicine, or holds himself out as practicing podiatric medicine or foot correction as defined in Section 2472, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as provided for in this chapter, is guilty of a misdemeanor.

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

(a) A graduate with a resident's license in an approved internship, residency, or fellowship program may participate in training rotations outside the scope of podiatric medicine, under the supervision of a physician and surgeon who holds a medical doctor or doctor of osteopathy degree wherever and whenever required as a part of the training program, and may receive compensation for that practice. If the graduate fails to receive a license to practice podiatric medicine under this chapter within three years from the commencement of the postgraduate training, all privileges and exemptions under this section shall automatically cease.

(b) Hospitals functioning as a part of the teaching program of an approved college or school of podiatric medicine in this state may exchange instructors or resident or assistant resident doctors of podiatric medicine with another approved college or school of podiatric medicine not located in this state, or those hospitals may appoint a graduate of an approved school as such a resident for purposes of postgraduate training. Those instructors and residents may practice and be compensated as provided in this section, but that practice and compensation shall be for a period not to exceed two years.

2475.1. Before a resident's license may be issued, each applicant shall show by evidence satisfactory to the board, submitted directly to the board by the national score reporting institution, that he or she has, within the past 10 years, passed Parts I and II of the examination administered by the National Board of Podiatric Medical Examiners of the United States or has passed a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric

Medical Examiners of the United States.

2475.2. As used in this article, "podiatric residency" means a program of supervised postgraduate clinical training, one year or more in duration, approved by the board.

2475.3. (a) The board shall approve podiatric residency programs, as defined in Section 2475.2, in the field of podiatric medicine, for persons who are applicants for or have been issued a certificate to practice podiatric medicine pursuant to this article.

(b) The board may only approve a podiatric residency that it determines meets all of the following requirements:

(1) Reasonably conforms with the Accreditation Council for Graduate Medical Education's Institutional Requirements of the Essentials of Accredited Residencies in Graduate Medical Education: Institutional and Program Requirements.

(2) Is approved by the Council on Podiatric Medical Education.

(3) Complies with the requirements of this state.

2476. Nothing in this chapter shall be construed to prevent a regularly matriculated student undertaking a course of professional instruction in an approved college or school of podiatric medicine from participating in training beyond the scope of podiatric medicine under the supervision of a physician and surgeon who holds a medical doctor or doctor of osteopathy degree whenever and wherever prescribed as part of his or her course of study.

2477. Nothing in this chapter prohibits the manufacture, the recommendation, or the sale of either corrective shoes or appliances for the human feet **to enhance comfort and performance, or, following diagnosis and prescription by a licensed practitioner, in any case involving medical conditions**.

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

2480. The board shall have full authority to investigate and to evaluate each applicant applying for a certificate to practice podiatric medicine and to make a determination of the admission of the applicant to the examination and the issuance of a certificate in accordance with the provisions and requirements of this chapter.

2481. Each applicant who commenced professional instruction in podiatric medicine after September 1, 1959, shall show by an official transcript or other official evidence submitted directly to the board by the academic institution that he or she has completed two

years of preprofessional postsecondary education, or its equivalent, including the subjects of chemistry, biology or other biological science, and physics or mathematics, before completing the resident course of professional instruction.

2483. (a) Each applicant for a certificate to practice podiatric medicine shall show by an official transcript or other official evidence satisfactory to the board that is submitted directly to the board by the academic institution that he or she has successfully completed a medical curriculum extending over a period of at least four academic years, or 32 months of actual instruction, in a college or school of podiatric medicine approved by the board. The total number of hours of all courses shall consist of a minimum of 4,000 hours.

The board, by regulation, shall adopt standards for determining equivalent training authorized by this section.

(b) The curriculum for all applicants shall provide for adequate instruction related to podiatric medicine in the following:

Alcoholism and other chemical substance detection
Local anesthesia
Anatomy, including embryology, histology, and neuroanatomy
Behavioral science
Biochemistry
Biomechanics-foot and ankle
Child abuse detection
Dermatology
Geriatric medicine
Human sexuality
Infectious diseases
Medical ethics
Neurology
Orthopedic surgery
Pathology, microbiology, and immunology
Pediatrics
Pharmacology, including materia medica and toxicology
Physical and laboratory diagnosis
Physical medicine
Physiology
Podiatric medicine
Podiatric surgery
Preventive medicine, including nutrition
Psychiatric problem detection
Radiology and radiation safety
Spousal or partner abuse detection
Therapeutics
Women's health

2484. In addition to any other requirements of this chapter, before a certificate to practice podiatric medicine may be issued, each applicant shall show by evidence satisfactory to the board, submitted directly to the board by the sponsoring institution, that he or she has satisfactorily completed at least two years of postgraduate podiatric medical and podiatric surgical training in a general acute care hospital approved by the Council ~~of~~ on Podiatric Medical Education.

2486. The Medical Board of California shall issue, upon the recommendation of the board, a certificate to practice podiatric medicine if the applicant has submitted directly to the board from

the credentialing organizations verification that he or she meets all of the following requirements:

(a) The applicant has graduated from an approved school or college of podiatric medicine and meets the requirements of Section 2483.

(b) The applicant, within the past 10 years, has passed parts I, II, and III of the examination administered by the National Board of Podiatric Medical Examiners of the United States or has passed a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States.

(c) The applicant has satisfactorily completed the postgraduate training required by Section 2484.

(d) The applicant has passed within the past 10 years any oral and practical examination that may be required of all applicants by the board to ascertain clinical competence.

(e) The applicant has committed no acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475).

(f) The board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.

(g) A disciplinary databank report regarding the applicant is received by the board from the Federation of Podiatric Medical Boards.

2488. Notwithstanding any other provision of law, the Medical Board of California shall issue, upon the recommendation of the board, a certificate to practice podiatric medicine by credentialing if the applicant has submitted directly to the board from the credentialing organizations verification that he or she is licensed as a doctor of podiatric medicine in any other state and meets all of the following requirements:

(a) The applicant has graduated from an approved school or college of podiatric medicine.

(b) The applicant, within the past 10 years, has passed either part III of the examination administered by the National Board of Podiatric Medical Examiners of the United States or a written examination that is recognized by the board to be the equivalent in content to the examination administered by the National Board of Podiatric Medical Examiners of the United States.

(c) The applicant has satisfactorily completed a postgraduate training program approved by the Council on Podiatric Medical Education.

(d) The applicant, within the past 10 years, has passed any oral and practical examination that may be required of all applicants by the board to ascertain clinical competence.

(e) The applicant has committed no acts or crimes constituting grounds for denial of a certificate under Division 1.5 (commencing with Section 475).

(f) The board determines that no disciplinary action has been taken against the applicant by any podiatric licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of podiatric medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.

(g) A disciplinary databank report regarding the applicant is received by the board from the Federation of Podiatric Medical Boards.

2492. (a) The board shall examine every applicant for a certificate to practice podiatric medicine to ensure a minimum of entry-level competence at the time and place designated by the board in its discretion, but at least twice a year.

(b) Unless the applicant meets the requirements of Section 2486, applicants shall be required to have taken and passed the examination administered by the National Board of Podiatric Medical Examiners.

(c) The board may appoint qualified persons to give the whole or any portion of any examination as provided in this article, who shall be designated as examination commissioners. The board may fix the compensation of those persons subject to the provisions of applicable state laws and regulations.

(d) The provisions of Article 9 (commencing with Section 2170) shall apply to examinations administered by the board except where those provisions are in conflict with or inconsistent with the provisions of this article. In respect to applicants under this article any references to the "Division of Licensing" or "division" shall be deemed to apply to the board.

2493. (a) An applicant for a certificate to practice podiatric medicine shall pass an examination in the subjects required by Section 2483 in order to ensure a minimum of entry-level competence.

~~(b) The board shall require a passing score on the National Board of Podiatric Medical Examiners Part III examination that is consistent with the postgraduate training requirement in Section 2484. The board, as of July 1, 2005, shall require a passing score one standard error of measurement higher than the national passing scale score until such time as the National Board of Podiatric Medical Examiners recommends a higher passing score consistent with Section 2484. In consultation with the Office of Professional Examination Services of the Department of Consumer Affairs, the board shall ensure that the part III examination adequately evaluates the full scope of practice established by Section 2472, including amputation and other foot and ankle surgical procedures, pursuant to Section 139.~~

2495. Notwithstanding any other provision of this chapter, the board may delegate to officials of the board the authority to approve the admission of applicants to the examination and to approve the issuance of certificates to practice podiatric medicine to applicants who have met the specific requirements therefor in routine cases where applicants clearly meet the requirements of this chapter.

2496. In order to ensure the continuing competence of persons licensed to practice podiatric medicine, the board shall adopt and administer regulations ~~in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code)~~ [Duplicates Section 2470 and other statutes] requiring continuing education of those licensees. The board shall require those licensees to demonstrate satisfaction of the continuing education

requirements and one of the following requirements at each license renewal:

(a) Passage of an examination administered by the board within the past 10 years.

(b) Passage of an examination administered by an approved specialty certifying board within the past 10 years.

(c) Current diplomate, board-eligible, or board-qualified status granted by an approved specialty certifying board within the past 10 years.

(d) Recertification of current status by an approved specialty certifying board within the past 10 years.

(e) Successful completion of an approved residency or fellowship program within the past 10 years.

(f) Granting or renewal of current staff privileges within the past five years by a health care facility that is licensed, certified, accredited, conducted, maintained, operated, or otherwise approved by an agency of the federal or state government or an organization approved by the Medical Board of California.

(g) Successful completion within the past five years of an extended course of study approved by the board.

(h) Passage within the past 10 years of Part III of the examination administered by the National Board of Podiatric Medical Examiners.

2497. (a) The board may order the denial of an application for, or the suspension of, or the revocation of, or the imposition of probationary conditions upon, a certificate to practice podiatric medicine for any of the causes set forth in Article 12 (commencing with Section 2220) in accordance with Section 2222.

(b) The board may hear all matters, including but not limited to, any contested case or may assign any such matters to an administrative law judge. The proceedings shall be held in accordance with Section 2230. If a contested case is heard by the board itself, the administrative law judge who presided at the hearing shall be present during the board's consideration of the case and shall assist and advise the board.

2497.5. (a) The board may request the administrative law judge, under his or her proposed decision in resolution of a disciplinary proceeding before the board, to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

(b) The costs to be assessed shall be fixed by the administrative law judge and shall not ~~in any event~~ be increased by the board unless the board does not adopt a proposed decision and in making its own decision finds grounds for increasing the costs to be assessed, not to exceed the actual and reasonable costs of the investigation and prosecution of the case. ~~When the board does not adopt a proposed decision and remands the case to an administrative law judge, the administrative law judge shall not increase the amount of any costs assessed in the proposed decision.~~

(c) When the payment directed in the board's order for payment of costs is not made by the licensee, the board may enforce the order for payment by bringing an action in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee directed to pay costs.

(d) In any judicial action for the recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the

order of payment and the terms for payment.

(e) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licensee who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one year period for those unpaid costs.

(f) All costs recovered under this section shall be deposited in the Board of Podiatric Medicine Fund as a reimbursement in either the fiscal year in which the costs are actually recovered or the previous fiscal year, as the board may direct.

2498. (a) The board shall have the responsibility for reviewing the quality of podiatric medical practice carried out by persons licensed to practice podiatric medicine.

(b) Each member of the board, or any licensed doctor of podiatric medicine appointed by the board, shall additionally have the authority to inspect, or require reports from, a general or specialized hospital and the podiatric medical staff thereof, with respect to the podiatric medical care, services, or facilities provided therein, and may inspect podiatric medical patient records with respect to the care, services, or facilities. The authority to make inspections and to require reports as provided by this section shall not be delegated by a member of the board to any person other than a doctor of podiatric medicine and shall be subject to the restrictions against disclosure described in Section 2263.

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

2499.5. The following fees apply to certificates to practice podiatric medicine. The amount of fees prescribed for doctors of podiatric medicine shall be those set forth in this section unless a lower fee is established by the board in accordance with Section 2499.6. Fees collected pursuant to this section shall be fixed by the board in amounts not to exceed the actual costs of providing the service for which the fee is collected.

(a) Each applicant for a certificate to practice podiatric medicine shall pay an application fee of ~~twenty~~ one hundred dollars ~~($20)~~ ($100) at the time the application is filed. If the applicant qualifies for a certificate, he or she shall pay a fee which shall be fixed by the board at an amount not to exceed one hundred dollars ($100) nor less than five dollars ($5) for the issuance of the certificate.

(b) The oral examination fee shall be seven hundred dollars

($700), or the actual cost, whichever is lower, and shall be paid by each applicant. If the applicant's credentials are insufficient or if the applicant does not desire to take the examination, and has so notified the board 30 days prior to the examination date, only the examination fee is returnable to the applicant. The board may charge an examination fee for any subsequent reexamination of the applicant.

(c) Each applicant who qualifies for a certificate, as a condition precedent to its issuance, in addition to other fees required by this section, shall pay an initial license fee. The initial license fee shall be eight hundred dollars ($800). The initial license shall expire the second year after its issuance on the last day of the month of birth of the licensee. ~~The board may reduce the initial license fee by up to 50 percent of the amount of the fee for any applicant who is enrolled in a postgraduate training program approved initial license fee.~~

(d) The biennial renewal fee shall be nine hundred dollars ($900). ~~required to pay only 50 percent of the biennial renewal fee at the time of his or her first renewal.~~ The board may waive this fee for a doctor of podiatric medicine residing in California who certifies to the board that license renewal is for the sole purpose of providing voluntary, unpaid service.

(e) The delinquency fee is one hundred fifty dollars ($150).

(f) The duplicate wall certificate fee is ~~forty~~ one hundred dollars ~~($40)~~ $100.

(g) The fee for a duplicate renewal receipt ~~fee~~ or pocket license is ~~forty~~ fifty dollars ~~($40)~~ ($50).

(h) The endorsement, certification, verification, or letter of good standing fee is ~~thirty~~ one hundred dollars ~~($30)~~ ($100).

(i) The letter of good standing fee or for loan deferment is ~~thirty~~ one hundred dollars ~~($30)~~ ($100).

(j) There shall be a fee of ~~sixty~~ one hundred dollars ~~($60)~~ ($100) for the issuance and renewal of a resident's license under Section 2475.

~~(k) The application fee for ankle certification under Section 2472 for persons licensed prior to January 1, 1984, shall be fifty dollars ($50). The examination and reexamination fee for this certification shall be seven hundred dollars ($700).~~

(l) The filing fee to appeal the failure of an oral examination shall be ~~twenty five~~ one hundred dollars ~~($25)~~ ($100).

(m) The fee for approval of a continuing education course or program shall be ~~one~~ two hundred fifty dollars ~~($100)~~ ($250).

2499.6. The fees in this article shall be fixed by the board in accordance with Section 313.1.

2499.8. Any licensee who demonstrates to the satisfaction of the board that he or she is unable to practice podiatric medicine due to a disability may request a waiver of the license renewal fee. The granting of a waiver shall be at the discretion of the board and may be terminated at any time. Waivers shall be based on the inability of a licensee to practice podiatric medicine. A licensee whose renewal fee has been waived pursuant to this section shall not engage in the practice of podiatric medicine unless and until the licensee pays the current renewal fee and does either of the following:

(a) Establishes to the satisfaction of the board, on a form prescribed by the board and signed under penalty of perjury, that the licensee's disability either no longer exists or does not affect his

or her ability to practice podiatric medicine safely.

(b) Signs an agreement on a form prescribed by the board, signed under penalty of perjury, in which the licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician.

G. DCA quarterly and annual performance measure reports.

Attached

Department of Consumer Affairs

Board of Podiatric Medicine

Performance Measures

Q1 Report *(July - Sept 2010)*

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, additional measures, such as consumer satisfaction and complaint efficiency, will also be added. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints received.*

Q1 Total: 17 ***(Complaints: 14 Convictions: 3)***

Q1 Monthly Average: 6

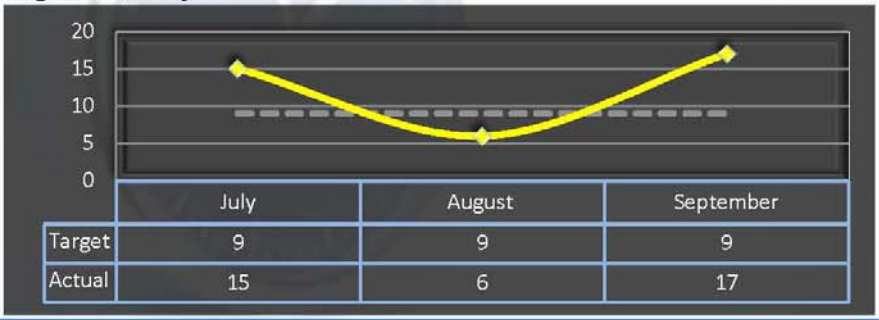
	July	August	September
Actual	5	4	8

Intake

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

Target: 9 Days

Q1 Average: 15 Days



	July	August	September
Target	9	9	9
Actual	15	6	17

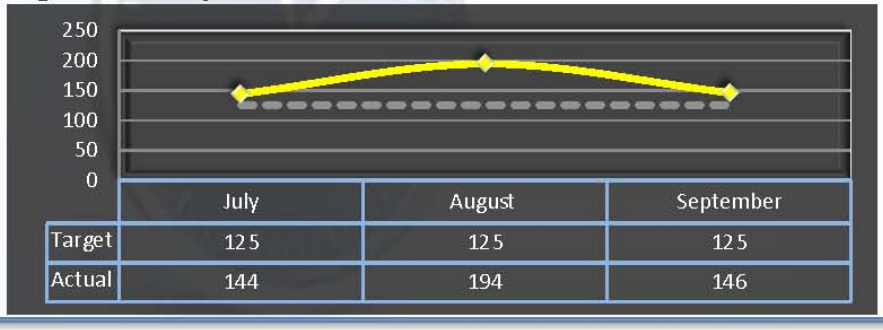
***"Complaints" in these measures include complaints, convictions, and arrest reports.**

Intake & Investigation

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

Target: 125 Days

Q1 Average: 159 Days



	July	August	September
Target	125	125	125
Actual	144	194	146

Formal Discipline

Average cycle time from complaint receipt to closure, for cases sent to the Attorney General or other forms of formal discipline.

Target: 540 Days

Q1 Average: 378 Days (only 1 data point available)

Probation Intake

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

Target: 25 Days

Q1 Average: N/A

The Board did not report any probation monitoring data this quarter.

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: 14 Days

Q1 Average: N/A

The Board did not report any probation violation data this quarter.

Department of Consumer Affairs

Board of Podiatric Medicine

Performance Measures

Q2 Report *(October - December 2010)*

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.

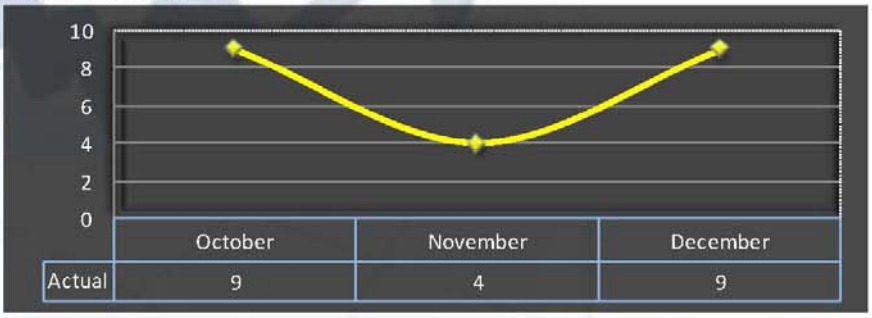
Volume

Number of complaints and convictions received.

Q2 Total: 22

Complaints: 21 Convictions: 1

Q2 Monthly Average: 7



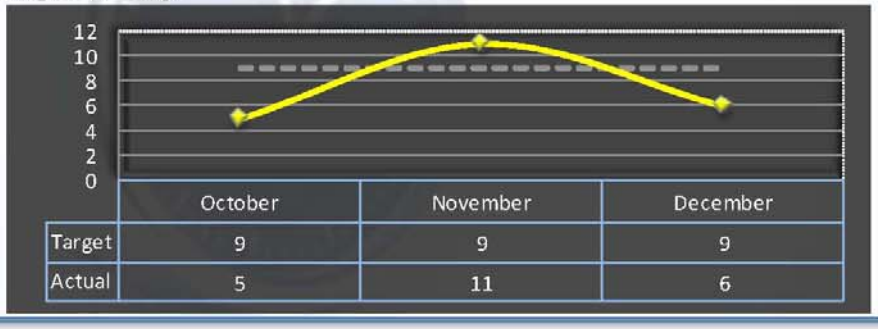
	October	November	December
Actual	9	4	9

Intake

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

Target: 9 Days

Q2 Average: 7 Days



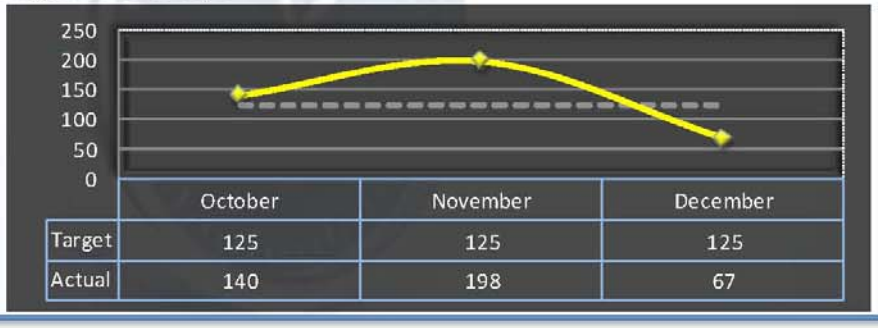
	October	November	December
Target	9	9	9
Actual	5	11	6

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: 125 Days

Q2 Average: 145 Days



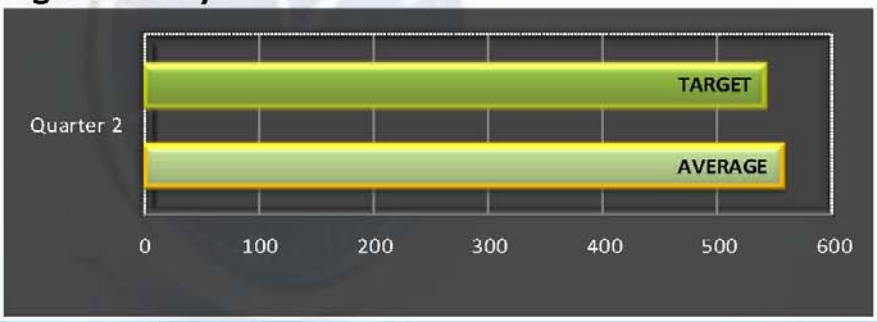
	October	November	December
Target	125	125	125
Actual	140	198	67

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

Q2 Average: 555 Days



Probation Intake

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

Target: 25 Days

Q2 Average: 1 Day

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: 14 Days

Q2 Average: N/A

The Board did not handle any probation violations this quarter.

Department of Consumer Affairs

Board of Podiatric Medicine

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.

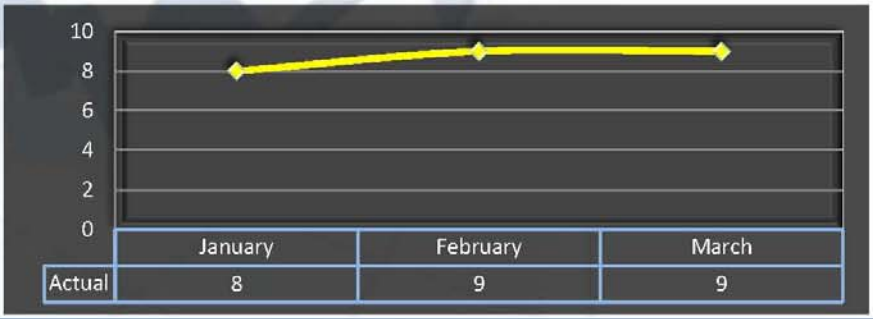
In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints and convictions received.

Q3 Total: 26

Q3 Monthly Average: 9



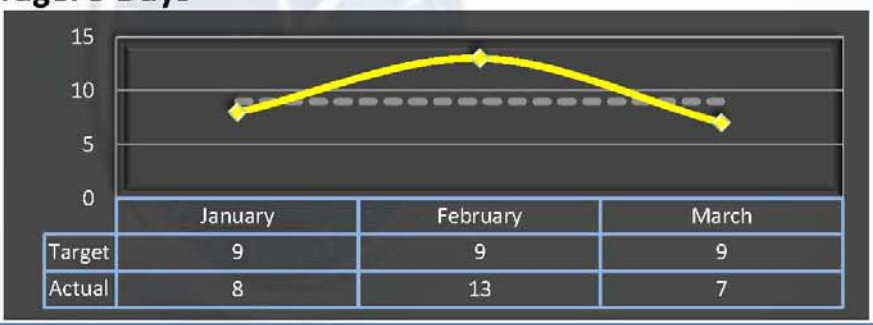
	January	February	March
Actual	8	9	9

Intake

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

Target: 9 Days

Q3 Average: 9 Days



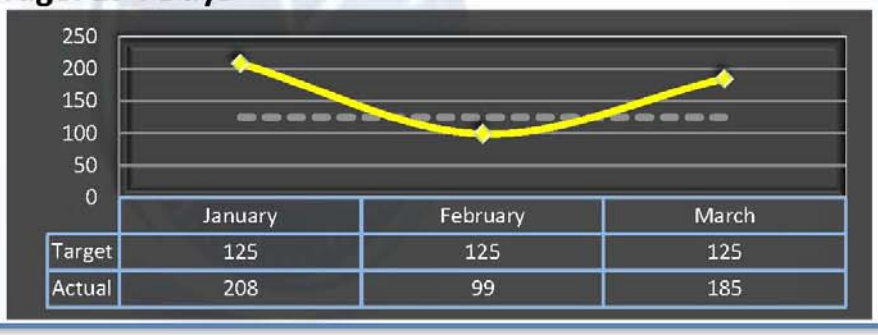
	January	February	March
Target	9	9	9
Actual	8	13	7

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: 125 Days

Q3 Average: 174 Days



	January	February	March
Target	125	125	125
Actual	208	99	185

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: N/A

The Board did not close any formal discipline cases this quarter.

Probation Intake

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

Target: 25 Days

Q3 Average: N/A

The Board did not contact any new probationers this quarter.

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: 14 Days

Q3 Average: N/A

The Board did not handle any probation violations this quarter.

Department of Consumer Affairs

Board of Podiatric Medicine

Performance Measures

Q4 Report *(April - June 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.

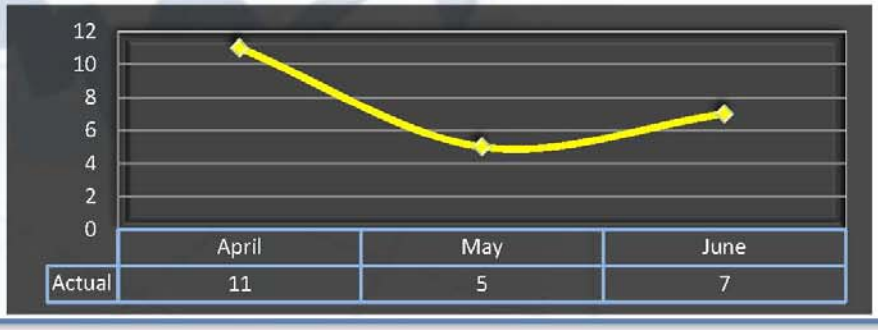
In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints and convictions received.

Q4 Total: 23

Q4 Monthly Average: 8

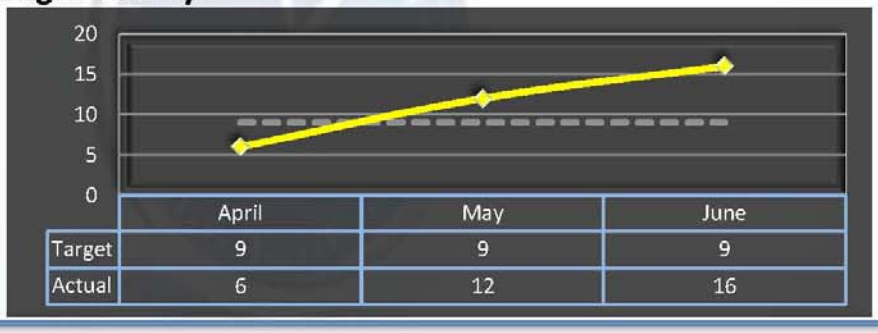


Intake

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

Target: 9 Days

Q4 Average: 11 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: 125 Days

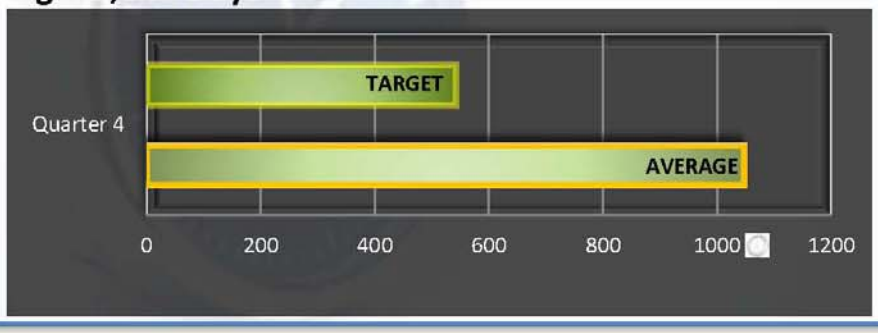
Q4 Average: 114 Days

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

Q4 Average: 1,046 Days



Probation Intake

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

Target: 25 Days

Q4 Average: N/A

The Board did not contact any new probationers this quarter.

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: 14 Days

Q4 Average: N/A

The Board did not handle any probation violations this quarter.

Department of Consumer Affairs

California Board of Podiatric Medicine

Performance Measures

Annual Report *(2010 – 2011 Fiscal Year)*

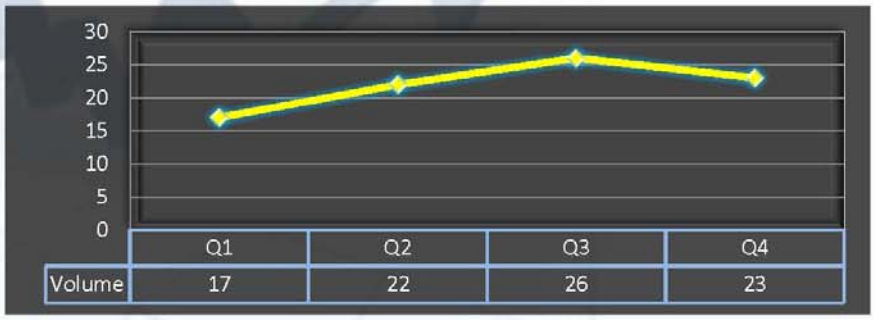
To ensure stakeholders can review the Board's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the first four quarters worth of data.

Volume

Number of complaints and convictions received.

The Board had an annual total of 88 this fiscal year.



Intake

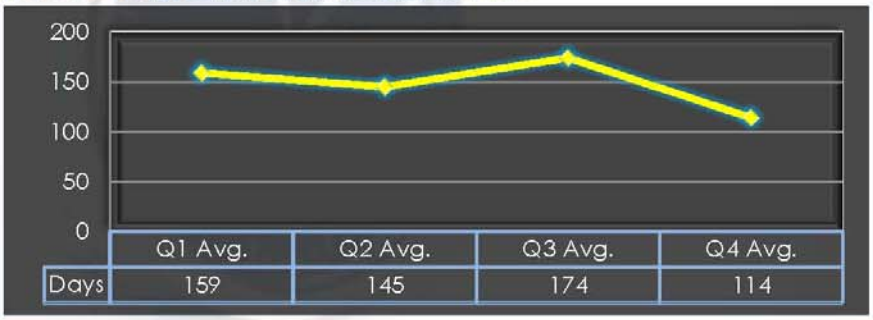
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

The Board has set a target of 9 days for this measure.

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.

The Board has set a target of 125 days for this measure.



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)

The Board has set a target of 540 days for this measure.