MEDICAL BOARD OF CALIFORNIA
Executive Office

ACCESS TO CARE COMMITTEE

MEMBERS OF THE COMMITTEE

Steve Alexander, Co-Chair
Gary Gitnick, M.D., Co-Chair
Hedy Chang
Shelton Duruisseau, Ph.D.
Gerrie Schipske, R.N.P., J.D.
Frank V. Zerunyan, J.D.
Barbara Yaroslavsky

January 31, 2008

The Westin Los Angeles Airport
Concourse B Room
5400 West Century Blvd.
Los Angeles, CA 90045

Action may be taken on any item listed on the agenda.

AGENDA

10:30 a.m.. – 11:30 a.m.
(or until the completion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

If a quorum of the Board is present, members of the Board who are not members of the Committee may attend only as observers.

1. Call to Order
2. Approval of Minutes of July 26, 2007 meeting
3. Update on California Physician Corps – Ms Yaroslavsky
4. Implementation of AB 329 (Chap. 386, Statutes of 2007, Nakanishi) – Ms. Johnston and Mr. Schunke
5. AB 1154 (Leno) Diabetes Model – Ms. Whitney
6. Discussion of concept to have evaluations made of new initiatives:
   A. Project Dolce
   B. Clinics in retails outlets
   C. Expanded scope of practice for mid-level health care providers (Nurse Practitioners, Physician Assistants, etc.)
7. Public Comment on Items not on the Agenda
8. Adjournment

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

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Public Meetings Act. The audience will be given appropriate opportunities to comment on any issue before the Board, but the Chair may apportion available time among those who wish to speak. For additional information call Kevin A. Schunke at(916) 263-2368.

NOTICE: The meeting is accessible to the physically disabled. A person who needs disability-related accommodations or modifications in order to participate in the meeting shall make a request to the Board no later than five working days before the meeting by contacting Teresa Schaeffer at (916) 263-2389 or sending a written request to Ms. Schaeffer at the Medical Board of California, 1426 Howe Avenue, Suite 54, Sacramento, CA 95825. Requests for further information should be directed to the same address and telephone number

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DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • ARNOLD SCHWARZENEGGER, GOVERNOR

MEDICAL BOARD OF CALIFORNIA – Executive Office
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Agenda Item 2

Access to Care Committee

Embassy Suites
Union Square/Ghirardelli Rooms
250 Gateway Boulevard
South San Francisco, CA 94080

July 26, 2007

MINUTES

Agenda Item 1 Call to Order

Dr. Gitnick called the meeting to order at 4:05 pm. Roll was taken. A quorum was present and notice had been sent to all interested parties.

Members Present:

Steve Alexander, Co-Chair
Gary Gitnick, M.D., Co-Chair
Hedy Chang
Shelton Duruisseau, Ph.D.
Gerrie Schipske, R.N.P., J.D.
Barbara Yaroslavsky
Frank V. Zerunyan, J.D.

Agenda Item 2 Approval of Minutes of April 26, 2007 meeting

It was M/S/C to approve the minutes of the April 26, 2007, Access to Care meeting.

Agenda Item 3 Presentation by Rebecca Hafner-Fogarty, MD, MBA, Medical Director, Minute Clinic

Ms. Chang introduced Becki Hafner, M.D., who is the Medical Director of Minute Clinic. Minute Clinic is a retail-based health care provider, offering affordable, convenient, and accessible health care. Their centers are staffed by board-certified nurse practitioners and physician assistants who specialize in family healthcare and are trained to diagnose and treat patients for common illnesses and to offer common vaccinations. Dr. Hafner made a presentation to the Committee.

Committee members asked questions about the level of care and the organization of the business.

Agenda Item 4 **Proposed Mission Statement – Mr. Alexander/Dr. Gitnick**

Following discussion at the previous Committee meeting, staff had modified the Committee's proposed Mission Statement. M/S/C to adopt the Mission Statement.

Agenda Item 5 **Diabetes Prevention and Management Initial Workgroup Draft Plan – Dr. Fantozzi**

Dr. Fantozzi reported that he serves as the Board's representative to the Governor's Task Force on Diabetes Prevention and Management, together with representatives from over 25 other major stakeholders of diabetes management. The Task Force has completed its work and in the agenda packet is a copy of the chronic care model, which will be presented to the Governor. And, while this one project is complete, Dr. Fantozzi reassured that diabetes care is an ongoing issue, and he will stay involved.

Agenda Item 6 **California Physician Workforce Roundtable: Meeting Summary – Dr. Gitnick**

Dr. Gitnick reported on his participation in the Governor's Physician Workforce Workgroup. This group met in April to consider California's physician workforce needs and long-term strategies, which would address the estimated need of up to 17,000 additional physicians in California. A summary of the meeting discussion is in the agenda packet.

Dr. Gitnick also mentioned that the Governor directed Office of Statewide Health Planning and Development to convene a Healthcare Workforce Diversity Advisory Council. The first meeting was attended by Ms. Chang who gave a brief report from the meeting. Committee members were invited to the two meetings still to be held.

Agenda Item 7 **Report on meeting regarding Best Practices Model – Dr. Fantozzi**

Through his involvement in the diabetes area, the Department of Managed Health Care (DMHC) asked Dr. Fantozzi to get the Board involved in identifying best practices models. Specifically, they wanted to explore how a best practice models might work at a specific medical group to give some direction to DMHC in setting up their contracts with HMOs.

Dr. Fantozzi reported that he brought together WellPoint (Blue Cross/Blue Shield) and Mercy Hospitals to see if they would be interested in undertaking a pilot program. The outline for a pilot program would include a larger, multi-specialty group – possibly 100+ doctors – that currently is not doing a chronic care management plan. It would give them a plan, which has been developed, ask them to participate and evaluate it, with the goal being to start developing chronic care models for other disease entities. At the end of the meeting, the various partners indicated that they would consider what internal procedures would be needed to allow this project to move forward.

Dr. Fantozzi indicated that he would like to use the Board's list of volunteer physicians in this project.

Agenda Item 8 Telemedicine Pilot, AB 329 – Dr. Fantozzi

Dr. Fantozzi reported he would like the Board to continue moving forward with telemedicine pilot programs. He stated he believes this has always been within the authority of the Board in carrying out its mission of consumer protection and that AB 329 clarifies this interpretation.

Agenda Item 9 Public Comment on Items not on the Agenda

Tara Kittle, health care consumer, suggested the Board consider using guidelines to ensure that the clinics meet their qualifications and expressed concern over the idea of free health care for people who are unable to pay.

There being no further public comment, the meeting was adjourned.

Assembly Bill No. 329

CHAPTER 386

An act to add Section 2028.5 to the Business and Professions Code, relating to medicine.

[Approved by Governor October 10, 2007. Filed with Secretary of State October 10, 2007.]

LEGISLATIVE COUNSEL'S DIGEST

AB 329, Nakanishi. Chronic diseases: telemedicine.

Existing law, the Medical Practice Act, creates the Medical Board of California that is responsible for issuing a physician and surgeon's certificate to practice medicine and for regulating the practice of physicians and surgeons. The act also regulates the practice of telemedicine, defined as the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, or data communications.

This bill would authorize the board to establish a pilot program to expand the practice of telemedicine, and would authorize the board to implement the program by convening a working group. The bill would specify that the purpose of the pilot program would be to develop methods, using a telemedicine model, of delivering health care to those with chronic diseases and delivering other health information. The bill would require the board to make recommendations regarding its findings to the Legislature within one calendar year of the commencement date of the pilot program.

The people of the State of California do enact as follows:

SECTION 1. Section 2028.5 is added to the Business and Professions Code, to read:

2028.5. (a) The board may establish a pilot program to expand the practice of telemedicine in this state.

(b) To implement this pilot program, the board may convene a working group of interested parties from the public and private sectors, including, but not limited to, state health-related agencies, health care providers, health plan administrators, information technology groups, and groups representing health care consumers.

(c) The purpose of the pilot program shall be to develop methods, using a telemedicine model, to deliver throughout the state health care to persons with chronic diseases as well as information on the best practices for chronic disease management services and techniques and other health care information as deemed appropriate.

(d) The board shall make a report with its recommendations regarding its findings to the Legislature within one calendar year of the commencement date of the pilot program. The report shall include an evaluation of the improvement and affordability of health care services and the reduction in the number of complications achieved by the pilot program.

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AMENDED IN ASSEMBLY JANUARY 7, 2008

AMENDED IN ASSEMBLY APRIL 10, 2007

CALIFORNIA LEGISLATURE—2007–08 REGULAR SESSION

ASSEMBLY BILL No. 1154

Introduced by Assembly Member Leno

February 23, 2007

An act to add and repeal Section 131086 of the Health and Safety Code, relating to diabetes.

LEGISLATIVE COUNSEL'S DIGEST

AB 1154, as amended, Leno. Diabetes.

Existing law authorizes the State Department of *Public* Health ~~Services~~ to perform studies, demonstrate innovative methods, and disseminate information relating to the protection, preservation, and advancement of public health. ~~Effective July 1, 2007, these duties will be transferred to the State Department of Public Health.~~

This bill would require the department, in consultation with the California Health Alliance Commission, to develop *and administer* a diabetes risk reduction pilot program within 24 counties to *review,* analyze, and report *on* the outcomes from integrative care ~~to the causes~~ of diabetes through proactive prevention. *The bill would establish the Diabetes Prevention and Treatment Pilot Program Fund in the State Treasury, and would require the department to deposit any moneys received from the federal government or from private donations into the fund to be used, upon appropriation by the Legislature, for the pilot program. The bill would provide that it shall only become operative if adequate funds, as determined by the department, are appropriated in the annual Budget Act for the pilot program. The bill would provide*

that its provisions shall become inoperative on July 1 following the 4th fiscal year after the first appropriation is made for purposes of the bill and are repealed on the January 1 following that date.

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

The people of the State of California do enact as follows:

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Clear and substantial evidence indicates that a combination
4 of better food and hydration, with prudent activity and a healthy
5 attitude, promotes health and reduces the risk of chronic diseases,
6 particularly diabetes. The benefits of this combination range from
7 restorative sleep to enhanced hormone and neurochemical balance.
8 All of these contribute to, and are synergistic in achieving, a
9 healthy balance of sugar and energy in the body. As a result,
10 effective habit modification is able to reduce the risk of diabetes,
11 particularly in at-risk participants.
12 (b) Recent research confirms a rapid and accelerating increase
13 in diabetes, particularly in California's children. The human and
14 financial costs are staggering and avoidable. Access to healthier
15 choices and resources facilitates the practice of healthy habits.
16 (c) Diabetes and its antecedents and consequences drain precious
17 resources from the state.
18 (d) Diabetes negatively impacts productivity and quality of life,
19 while increasing substantially the risk of complications ranging
20 from heart attacks to kidney failure, stroke to blindness, and fragile
21 blood vessels to amputation. The promotion of healthy habits that
22 is reinforced with information and documentation of perceived
23 and tangible benefits is more effective than communicating a
24 general message of prevention while largely focusing on early
25 disease detection and communicating the principles of prevention
26 in the abstract rather than actionable terms.
27 (e) Proactive prevention in diabetes risk mitigation is a public
28 health concept that supports community health promotion habits
29 and practices that show evidence-based efficacy in at-risk
30 populations. Proactive prevention programs include incentives for
31 more whole foods, fruits, vegetables, pulses, nuts, seeds, and herbs
32 along with adequate water, regular physical activity, and expression

or receipt of appreciation and for the help we can be to ourselves and those in need. All this contributes to better weight maintenance by eating a balanced variety of nourishing foods and drinking adequate amounts of water and herbal teas, choosing moments in which to appreciate what we have, and enjoying the kind of regular activity appropriate to our functional age and abilities.

(f) A primary strategy of proactive prevention is to increase access to health enhancing practices, resources, and choices. Reinforcement of healthier choices and reduction of barriers coupled with incentives for use are components of this approach. Incentives for health promoting actions are both financial and emotional.

(g) Existing law requires the State Department of Health Services to promote the public health and welfare.

(h) It is the intent of the Legislature that the program established pursuant to this act will document the program outcomes in rigorous tests and formal statistical measures, as well as by consumer quality of life outcome surveys performed by the California Health Alliance.

(i) It is the intent of the Legislature that the program established pursuant to this act will document the benefits of proactive prevention in diabetes risk mitigation at its cause.

(j) It is also the intent of the Legislature for the pilot program established pursuant to this act to improve the health and well-being of at-risk Californians by addressing the causes of diabetes and monitoring the benefits people enjoy through the application of proactive prevention.

SEC. 2. Section 131086 is added to the Health and Safety Code, to read:

131086. (a) As used in this section:

(1) "Commission" means the California Health Alliance Commission, a private nonprofit organization focused upon the health of the state's citizens.

(2) "Department" means the State Department of Public Health.

(3) "Director" means the state public health officer.

~~(b) The department shall, in consultation with the California Health Alliance, develop a diabetes risk reduction pilot program within 24 counties to analyze and report the outcomes from integrative care to the causes of diabetes through proactive prevention.~~

~~(c) The program shall include all of the following components:~~

~~(1) The use of information technology and media to facilitate and reinforce messages of the benefits of more nutritious whole foods, including fresh fruits and vegetables, seeds, nuts, and herbs along with good hydration. These messages and resources to increase physical activity shall be coupled with an appreciation of those who take these constructive steps. Specially trained pharmacists and nurses shall provide reminders that include, for example, the importance of mineral and water intake during exercise or exposure to temperatures over 80°F or cold and dry conditions.~~

~~(2) The monitoring of risks that predict diabetes development or progression.~~

~~(3) Reporting, after review by the California Health Alliance Commission, to the director on the opportunities to improve quality of life outcomes and reduce lifetime costs through the application of the pilot program.~~

~~(4) Quarterly internal updates on how the program increases access, reinforces the benefits, and documents the results of the program. These quarterly updates shall be delivered to the commission no later than 30 days after the close of each quarter and to the department at least annually.~~

~~(5) Strategies to reduce diabetes risk within low-income, at-risk communities and populations.~~

~~(6) Strategies to promote the health of food stamp recipients and reduce health risk behaviors. These strategies shall be a priority of the program.~~

~~(7) Inclusion of the federal Centers for Disease Control and Prevention's Diabetes Prevention Guidelines to document the risk and harm reduction as well as to document the outcomes of this program.~~

~~(d) In communities selected to enroll in the pilot program, the department shall provide dedicated health professionals and support personnel to implement the pilot program, as recommended by the commission's Diabetes Risk Reduction Update.~~

~~(e) The department shall provide technical and logistical support as needed and predicated upon funding of the public-private partnership responsible for this pilot program.~~

~~(f) The department, in consultation with the State Department of Social Services, shall seek any necessary federal government~~

~~approvals to allow the use of the Food Stamp Electronic Benefits Card, as provided in Chapter 3 (commencing with Section 10065) of Part 1 of Division 9 of the Welfare and Institutions Code, to provide incentives, and to implement this pilot program during the 2008–09 fiscal year.~~

(b) The department shall, in consultation with the California Health Alliance Commission, develop and administer a diabetes risk reduction pilot program within 24 counties to review, analyze, and report on the outcomes from integrative care of diabetes through proactive prevention.

(c) The department, in consultation with the commission, shall design the pilot program to include all of the following components:

(1) Strategies aimed at diabetes risk reduction that are directed at low-income, at-risk communities and populations. In communities invited to participate in the pilot program, the pilot program shall provide dedicated health professionals and support personnel to implement this pilot program as recommended by the California Health Alliance Commission's Diabetes Risk Reduction Update.

(2) The department shall provide technical and logistical support as needed and predicated upon funding of the public-private partnership responsible for this pilot program. Nothing in the pilot program shall be in conflict with the federal Diabetes Prevention Guidelines of the Centers for Disease Control and Prevention (CDC). This proactive prevention pilot program shall document the risk and harm reduction as well as the outcomes of this community-based public health initiative.

(3) Strategies aimed at providing incentives for food stamp recipients to promote their health and reduce health risk behaviors shall be a priority of this program. Increasing access, reinforcing the benefits, and documenting the results of those strategies as implemented under the pilot program shall also be included, the department shall report quarterly to the California Health Alliance Commission no later than 30 days after the close of each quarter on the effectiveness of the pilot program.

(4) The department shall seek any necessary federal government approval to allow the use of food stamp electronic benefits cards, as provided in Chapter 3 (commencing with Section 10065) of Part 1 of Division 9 of the Welfare and Institutions Code, to

provide those incentives, and to implement this pilot program as an essential priority for the 2009–10 fiscal year.

~~(g)~~

(d) In developing the pilot program, the department shall include all of the following:

(1) At least two counties that have above the food stamp average county participation.

(2) At least two counties that have below the food stamp average county participation.

(3) At least two counties with above-average rates of diabetes.

(4) At least two counties with above-average rates of obesity.

(5) At least two counties with above-average rates of cardiovascular diseases.

(6) At least two counties with a predominantly Native American population.

(7) At least two counties with a predominantly African-American population.

(8) At least two counties with a predominantly Hispanic population.

(9) At least two urban counties.

(10) At least two rural counties.

~~(h)~~

(e) The department shall consider all of the following in choosing counties to participate in the program.

(1) The level of need in the community.

(2) The size of the food stamp population.

(3) The need for geographic diversity.

(4) The availability of technology in targeted counties and communities to implement the program and collect the data necessary to evaluate the pilot program.

(f) The department shall develop a process for evaluating the effectiveness of the pilot program. The evaluation shall examine the impact of the various strategies employed in the pilot program regarding the use of healthier choices, particularly those aimed at diabetes risk reduction. The evaluation shall also consider options that are appropriate to each community and implement those options with the highest likely benefit for that community. The department shall also conduct and perform real time data collection and prompt data analysis of outcomes. The department shall, at the earliest feasible time, make recommendations to the

Legislature regarding the continuation of the pilot program, and shall include a statement of any federal policy changes needed to support the goals of the pilot program.

(g) The Diabetes Prevention and Treatment Pilot Program Fund is hereby created in the State Treasury. The department shall deposit any moneys received from the federal government or from private donations, and, notwithstanding Section 16305.7 of the Government Code, any interest earned on moneys in the fund, into the fund to be used, upon appropriation by the Legislature, for the pilot program.

(h) This section shall only be implemented if adequate implementation funds, as determined by the department, are appropriated in the annual Budget Act or other statute.

(i) This section shall become inoperative on July 1, following the fourth fiscal year after the first appropriation is made for purposes of this section in the annual Budget Act or other statute, and, as of the following January 1, is repealed, unless a later enacted statute, that is enacted before the date on which this section is repealed, deletes or extends the dates on which it becomes inoperative and is repealed.

~~(i) The department shall seek all necessary approvals to establish the pilot program, and shall apply for available, prequalified federal matching funds to support the work of the pilot program.~~

~~(j) The department shall develop, in consultation with the commission, a process for evaluating the effectiveness of the pilot program. The evaluation shall examine the impact of the various strategies employed in the pilot program on the use of healthier choices, particularly those aimed at diabetes risk reduction. The evaluation shall also test options that are appropriate to each community and implement those options with the highest likely benefit for that community. The department shall contract with the commission to conduct and perform real-time data collection and prompt data analysis of outcomes. The department shall make recommendations to the Legislature regarding the continuation of the pilot program, and any state or federal policy changes needed to support the goals of the pilot program.~~

~~(k) This section shall become inoperative on July 1 following the fourth fiscal year after the first appropriation is made in the annual Budget Act or other statute, and as of the following January~~

1 ~~1 is repealed, unless a later enacted statute, that is enacted before~~
2 ~~that date deletes or extends that date.~~

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