



MEDICAL BOARD OF CALIFORNIA
Executive Office



EDUCATION COMMITTEE

MEMBERS OF THE COMMITTEE

Barbara Yaroslavsky, Chair
Jorge Carreon, M.D.
Hedy Chang
Sharon Levine, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

January 27, 2011

Embassy Suites – San Francisco Airport
 Mendocino/Burlingame Room
 150 Anza Blvd.
 Burlingame, CA 94010
 650-342-4600

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

AGENDA

10:00 – 10:30 a.m.
 (or until the conclusion 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. Public Comment on Items Not on the Agenda
Note: The Committee may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 1125.7(a)]
3. Approval of the Minutes of the Committee's Meeting on July 29, 2010
4. Update on Hepatitis Outreach Efforts – Ms. Yaroslavsky
5. Discussion on Applying the Notice to Consumers Regulation to Correctional Facilities and Potential Recommendation to the Board - Ms. Scuri
6. Agenda Items for Future Discussion
7. 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 Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak.

For additional information call (916) 263-2389.

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 may make a request by contacting Cheryl Thompson at (916) 263-2389 or Cheryl.Thompson@mbc.ca.gov or sending a written request to Ms. Thompson. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.*



MEDICAL BOARD OF CALIFORNIA
Executive Office



Education Committee Meeting
Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815

July 29, 2010

MINUTES

Agenda Item 1 Call to Order

The Education Committee of the Medical Board of California was called to order by Chair Barbara Yaroslavsky at 2:43 p.m. A quorum was present, and due notice had been mailed to all interested parties.

Members of the Committee Present:

Barbara Yaroslavsky, Chair
Hedy Chang
Sharon Levine, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

Member of the Committee Absent:

Jorge Carreon, M.D.

Board Members, Staff and Guests Present:

Fayne Boyd, Licensing Program
Yvonne Choong, California Medical Association
Candis Cohen, Public Information Officer
Zennie Coughlin, Kaiser Permanente
Eric Dang, Assembly Member Fiona Ma
Eric Esrailian, M.D., Board Member
Julie D'Angelo Fellmeth, Center for Law in the Public Interest
Gina Frisby, Assembly Member Fiona Ma
Stan Furmanski, M.D.
Gary Gitnick, M.D., Board Member
Kurt Heppler, Legal Counsel
Scott Johnson, Information Systems Branch
Therese Kelly, Licensing Program
Ross Locke, Business Services Office
Rachel McLean, California Department of Public Health
William Norcross, M.D., Physician Assessment and Clinical Education Program

Michelle Peterson, Center for Health Improvement
Carlos Ramirez, Senior Assistant Attorney General
Regina Rao, Business Services Office
Leticia Robinson, Licensing Operations
Anita Scuri, Supervising, Department of Consumer Affairs, Senior Counsel
Amara Sheikh, Member of the Public
Reham Sheikh, Member of the Public
Jennifer Simoes, Chief of Legislation
Chris Swanberg, California Prison Healthcare System
Kathryn Taylor, Licensing Program
Cheryl Thompson, Executive Office
Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director

Agenda Item 2 Public Comment on Items Not on the Agenda

Chris Swanberg, California Prison Healthcare System, spoke in regard to the “Notice to Consumers” regulation recently promulgated by the Board. He said it was potentially inapplicable to the inmates of the state’s 33 prisons, and to county jails, as well. He said the approximately 160,000 in our prison population have a Constitutionally guaranteed, built-in health care system, overseen by various federal entities, with a robust and active peer-review system. He said the required notice is of “absolutely no value” for this population because prisoners have neither access to phones nor the Internet. He said patients already threaten physicians that they will complain to the Medical Board, and he did not want to encourage that. He asked when this regulation is reviewed by the committee, that it consider his comments.

Stan Furmanski, M.D. commended the Education Committee for approving alternative clinical training programs other than the Physician Assessment and Clinical Education Program (PACE). He said PACE was under a cloud for “financial matters” in that he alleged it was overcharging for clinical training, and claimed there is no clinical training at PACE. He said the price of books PACE requires far exceeds their actual cost. He asked the committee to move forward to find an alternative to PACE.

Agenda Item 3 Approval of the Minutes of the Committee’s Meeting on July 23, 2009

It was M/S/C to approve the minutes of the July 23, 2009 meeting.

Agenda Item 4 Opening Remarks – Ms. Yaroslavsky

Committee Chair Barbara Yaroslavsky thanked the audience and the committee’s presenters for their patience, as the meeting’s starting time had been delayed. She noted that the committee had one topic only to discuss, and that it had been generated by the Medical Board’s review of AB 2600 (Assembly Member Ma), which would require the Board to consider including a mandatory continuing medical education course regarding the diagnosis and treatment of hepatitis, as appropriate. The Board did not take a position on the bill, but recognizing its importance to both physicians and the public, asked that the Education Committee consider other ways of educating both groups. She expressed the appreciation of the committee and the full Board to the four physician experts who were attending the meeting to offer their advice.

Agenda Item 5 Presentations About the Education of Physicians Regarding Hepatitis

Samuel So, M.D., director, Stanford Liver Cancer Program, introduced himself as a liver transplant surgeon from Stanford, serving on the Board of the Institute of Medicine for Public Health, and a coauthor of the recent IOM report on hepatitis B and liver cancer. He identified hepatitis B as one of the major public health problems

in this country. There are three to five times more people living in the U.S. with chronic hepatitis B or C than with HIV, and more people die every year in the U.S. of liver disease associated with hepatitis than of HIV. Two out of three people living in the U.S. with hepatitis B or C are not aware they have it, because their physicians have never tested them. The major risk factor for hepatitis C in the U.S. is a history of IV drug use, but the major risk factor for hepatitis B is foreign-born immigrants, according to the Centers for Disease Control. The CDC estimates that the majority of new cases of chronic hepatitis B in the U.S. is due to foreign-born immigrants. While it is very uncommon in white Americans, many California studies show one in 10 Asian Americans has chronic hepatitis B. Liver cancer is the second-leading cause of cancer death for Asian men living in the U.S., but is not even in the top 10 for white men in this country.

Hepatitis B is a silent killer, because most people who have it feel perfectly healthy until they develop advanced stages of liver disease or liver cancer. Two out of three are not aware they have the infection, and without appropriate, long-term management, one in four will die. The IOM found that the major issue underlying hepatitis prevention and control in the U.S. is lack of awareness by providers, who do not screen those at risk for hepatitis B or C, and providers do not know how to manage infected patients; lack of public awareness and policymakers' awareness, leading to lack of public resource allocation to provide access to testing and medical management and adequate disease-surveillance systems. IOM concluded that the current strategy for prevention and control of hepatitis in the U.S. is not working. IOM's recommendations include: federally funded health insurance programs and federal employees' health-benefits programs should incorporate guidelines for risk-factor screening for hepatitis B and C as a required core component of preventive care; and development of hepatitis B and C educational programs for health care and social service providers.

Providers' knowledge of chronic hepatitis B prevalence, screening, and management is very poor. A recent UCSF study showed that 30 percent of the primary care providers at UCSF do not know the correct screening test for hepatitis B. Other studies came to similar conclusions. Improving perinatal health care knowledge may help eliminate perinatal hepatitis B transmission and reduce the number of newborns who become chronically infected. Nurses' knowledge of hepatitis B is even worse than the providers', alarming because in one study only 16 percent knew that getting newborns a shot is crucial to make sure they are not infected within the first 12 hours. After education of all providers, there is significant improvement in knowledge. Providers and nurses welcomed the education and said they would use the knowledge to their patients' benefit. One-third of all Asian Americans living in the U.S. live in California. The time to act is now.

Dr. Levine asked where in Santa Clara County did Dr. So do the education of nurses, and he said in all nine birthing hospitals in the county, educating almost 500 nurses. Ms. Yaroslavsky asked how he got the word out to those not in the specific area, and he said via Stanford's Asian Liver Center's Web site: hepbmoms.org, where educational brochures in different languages can be ordered online at no cost. She also asked for clarification that within 12 hours of being born, infants should receive hepatitis immunization, and if that would keep them immune from the disease. Dr. So responded over 95 percent will be. Those who are foreign born and who have not been immunized should be tested first and, if not protected, should get the shot to immunize them from hepatitis B.

Gail Bolan, M.D., chief, STD Control Branch, California Department of Public Health (CDPH), and responsible for its adult virus hepatitis program. Viral hepatitis, a viral infection, is an important public health issue and a medical problem, caused by different kinds of viruses. CDPH has developed a strategic plan for adult viral hepatitis prevention in California, released in January 2010, that she wanted to highlight for the Board's input. She also mentioned Chlamydia, "another silent epidemic," as another condition people have and do not know that they are infected until they do not feel well and it is too late to do something about it. CDPH has a strong

public-private provider educational program about Chlamydia and wanted to share it as a model to improve provider education about viral hepatitis.

California law requires hepatitis vaccination for seventh-grade entry, which has significantly helped reduce hepatitis B. Very few new cases of hepatitis B are being seen in those under 20 years of age. The problem is that older adults are either living with the infection or acquiring it. The problem in California is primarily with Asian Americans and Pacific Islanders; at least 50 percent of them are infected with chronic hepatitis B. About 25 percent of adults with chronic hepatitis B will die of liver disease or liver cancer. Hepatitis C is another serious problem; one to four percent of adults infected with it also will die of liver disease or liver cancer. These are costly ailments, as well. However, there are cost-effective interventions that can delay the long-term consequences. Nonetheless, hepatitis has not been given serious governmental funding, so resources must be leveraged, and hence CDPH's creation of a strategic plan, mentioned above. Part of the plan involves educating the public, providers, and policy makers. Stakeholders need to work on more prevention and awareness strategies for educating the public about viral hepatitis; integrate viral hepatitis prevention content into medical and nursing school-based curriculum; non-clinical providers need to be trained if they are serving at-risk individuals. Physicians need to know how to properly ask questions about risk so they can determine who needs to be vaccinated. CDPH also wants to develop a referral guide, increase awareness, and make sure that national standards are being followed, using evidenced-based care recommendations. CDPH has a large hepatitis vaccination program and is trying to get vaccinations to adults at risk. Everyone understands resource constraints, so money alone is not the answer. CDPH is focusing on provider awareness, with a clinical task force on which a Medical Board member is welcomed to participate, and also working with medical associations and managed care organizations.

CDPH's Chlamydia Action Coalition, founded in 1999, was a public-private partnership that involved managed care, primary care providers, medical organizations, university-based researchers, etc. Physicians needed information, so CDPH developed an extensive Chlamydia quality improvement tool kit for practicing clinicians. CDPH also developed Web-based courses, CME, newsletter articles, etc., and a companion patient-education program. Screening increased considerably as a result, as Kaiser found after similar educational efforts. Providers tend to comply more if they know their actions are going on a report card. CDPH would like the opportunity to have an article on the subject of hepatitis published in the Medical Board's newsletter. A survey of physicians' knowledge also might be helpful to target educational gaps.

Eddie Cheung, M.D., director, Hepatology, VA Northern California Health Care System, has in his extensive experience as a clinician found a lack of basic provider knowledge about viral hepatitis and liver cancer, even though such information is available. This gap must be addressed. It is a serious problem with no easy solution. All physicians in California need to be better informed about basic screening and treatment of hepatitis. Between 1.25 and 2 million people in the U.S. are chronically infected with hepatitis; of those, maybe 900,000 are in the health care system, and only 180,000 are referred to or seen by a specialist. We have potentially effective treatments and vaccines, but too many physicians do not know what to do. Barriers to treatment also include income, language, religion, access to care, education, and misconceptions about Western medicine.

We should work with community networks to educate the public about what the disease is about, in a language they understand. Education of patients is key so they will demand screening and treatment. Cultural training is important. Work with professional associations should continue, as should lobbying for more funding.

Diana Sylvestre, M.D., executive director, O.A.S.I.S. Clinic, said she wanted to address the gaps in knowledge regarding hepatitis C, and also to persuade the Board to support AB 2600 (Ma). There is not as much data and education on hepatitis C as there is on hepatitis B, but one study of 217 family practitioners asked them who

they would test for hepatitis C, and the response was: transfusion before 1992 – 80 percent; incarcerated individuals – 65 percent; pregnant women – 35 percent. These results and others show major gaps in knowledge regarding hepatitis C. Her clinic has developed and provided educational materials to physicians, with success. Education about viral hepatitis is easy, but must be done right. Mandatory CME regarding this topic would work, and that conclusion is evidence-based. It is also cost-saving and would eliminate unnecessary referrals. We need to educate doctors to save money, and timely diagnosis is key. The lack of action is fueling the epidemic, and doctors have to take the lead. They must ask patients a few critical questions to diagnose and treat these major illnesses. Primary care doctors must be educated, particularly because so many patients with hepatitis do not have access to specialty care. The Medical Board should take the lead in this educational effort; it is good for patients, and will save the state a lot of money.

Glenn Backes for Eric Dang of the office of Assemblywoman Fiona Ma, and a public policy consultant for the California Hepatitis Alliance, expressed the gratitude of Assembly Member Ma for the committee's consideration of this issue. In addition to the expert testimony received, both Ms. Ma's office and the alliance have heard from patients who have had numerous contacts with physicians and experienced lost opportunities for diagnosis and treatment, resulting in poor outcomes for patients. He asked that the committee use its opportunity to improve the knowledge base of primary care providers in California.

Agenda Item 6 Consideration of Committee's Next Steps

Ms. Yaroslavsky commended the speakers on this topic and asked for a discussion from the committee. She noted an article can be placed in the Board's newsletter. She said this will be an ongoing dialog as to other actions that should be taken.

Dr. Levine agreed that provider education is critical but said that questions need to be answered about how to raise consumer awareness, as well. Curious patients prompt doctors to learn more. She advocated a broader approach to social marketing that uses all the modalities available today.

Ms. Chang said her younger brother is a carrier and must be tested every three to six months and have his liver checked. She has had friends die of liver problems, and asked that this issue be taken very seriously, as she knows it is real.

Ms. Yaroslavsky said many individuals and organizations do care, but the question is how to reach them. Specialty boards, hospitals that are part of groups (e.g., Kaiser, Sutter), the California Association of Community Clinics, and other groups could collaborate on a full-fledged campaign one day of the year. The Medical Board cannot do this, but she offered the Board's newsletter for an educational article for physicians. She added that most people today get their information not from conventional news programs, but from TV, radio, and movies. She asked that interested parties get together again to brainstorm ideas with others who are engaged in this issue.

Dr. Moran noted that the question was still unanswered regarding committee action on AB 2600. Ms. Yaroslavsky acknowledged she was aware of that but did not wish to move on the issue at this time.

Agenda Item 7 Agenda Items for Future Discussion

Ms. Yaroslavsky noted there will be a presentation on physician extenders at the next committee meeting. She

said she would work with staff on developing other ideas.

Dr. Moran said that issues may come from the next meeting of the Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals that would be appropriate for the Education Committee's next meeting.

Ms. Chang suggested discussing best practices.

Stan Furmanski, M.D. asked that at either the next Board or committee meeting the possibility of the Board purchasing PACE's books at cost to save physicians money be discussed, as well as some pending programs to replace PACE.

Agenda Item 8 Adjournment

The meeting was adjourned at 4:10 p.m.

DRAFT

Chronic Viral Hepatitis: Screening Recommendations for Primary Care Clinicians
 by Sharon Adler M.D., M.P.H., Clinical Specialist
 STD Control Branch, California Department of Public Health

In January 2010, the Institute of Medicine released a report entitled *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C* (www.iom.edu/Reports/2010/Hepatitis-and-Liver-Cancer-A-National-Strategy-for-Prevention-and-Control-of-Hepatitis-B-and-C/Report-Brief-Hepatitis-and-Liver-Cancer.aspx?page=1) and the California Department of Public Health released the *California Adult Viral Hepatitis Prevention Strategic Plan, 2010-2014* (www.cdph.ca.gov/programs/Documents/California_Adult_Viral_Hepatitis_Prevention_Strategic_Plan_2010-2014_Final.pdf). Both reports called for increased awareness and use among primary care clinicians of the Centers for Disease Control and Prevention (CDC) viral hepatitis screening, prevention, and clinical management guidelines.

Viral hepatitis is a significant public health problem in California and nationwide. In the United States, there are 3.5 to 5.3 million people living with chronic hepatitis B virus (HBV) or chronic hepatitis C virus (HCV).¹ Hepatitis A and hepatitis B can be prevented by a vaccine; however, there is no vaccine against hepatitis C. If not diagnosed and treated promptly, chronic HBV and chronic HCV can cause serious complications, such as cirrhosis, hepatocellular carcinoma, and death.

Chronic HBV and chronic HCV also have enormous human and economic costs. One in four people with chronic hepatitis B infection will die of liver disease or liver cancer. Hepatitis C is the leading reason for liver transplants nationwide and the leading cause of non-AIDS death among HIV-infected individuals. By 2030, annual hepatitis C-related Medicare costs alone are expected to increase 600 percent, from \$5 billion to \$30 billion per year.² While it is unknown exactly how many people in California are living with viral hepatitis, in 2007 alone, HBV- and HCV-related hospitalization costs in California totaled \$2 billion.³ These costs and complications can be prevented by early detection, treatment, and education.

For many adults with chronic HB, the virus was transmitted from mother to child at birth. Asian Americans and Pacific Islanders comprise more than half of all persons living with chronic HBV in the U.S.¹ Hepatitis C prevalence is highest among individuals born between the years 1945 and 1964; many of whom were infected with hepatitis C through blood transfusions conducted prior to 1992 or through past injection drug use.⁴

Unprotected sex with an infected individual is the leading cause of hepatitis B transmission among adults, while sharing syringes and other equipment used for injection drug use is the leading cause of hepatitis C transmission. For these reasons, CDC recommends screening for hepatitis B and hepatitis C in clinical settings serving adults at risk for viral hepatitis.

Primary care providers play an important role in prevention, diagnosis, and management of chronic viral hepatitis infection. **Identifying appropriate patients for hepatitis B vaccination is critical in preventing infection.** With health reform implementation

under way, primary care settings will soon see an influx of new patients, many of whom have chronic diseases, including viral hepatitis. Recognizing which patients should undergo serologic testing for chronic viral hepatitis is crucial as infected persons are often asymptomatic. CDC has recommendations to guide providers in identifying appropriate patients for chronic hepatitis B and hepatitis C screening. A summary of this guidance in easy-to-use, pull-out charts follows on pages [X-Y].

References

¹ IOM (Institute of Medicine). *Hepatitis and Liver Cancer: A National Strategy for Prevention and Control of Hepatitis B and C*. Washington, D.C.: The National Academies Press; January 2010.

² Pyenson B, Fitch, K, Iwasaki, K. *Consequences of Hepatitis C Virus (HCV): Costs of a Baby Boomer Epidemic of Liver Disease*. New York: Milliman; May 2009.

³ California Department of Public Health, Immunization Branch. *Hospitalization Costs Associated With Liver Disease, Liver Cancer and Liver Transplants for Patients Infected With Hepatitis B or Hepatitis C, California 2007*.

⁴ Armstrong GL, Wasley A, Simard EP, McQuilan GM, Kuhnert WL, Alter MJ. The prevalence of hepatitis C virus infection in the United States, 1999 through 2002. *Ann Intern Med*. May 16 2006;144(10):705-714.

Hepatitis B and Hepatitis C: Whom to Test

Most people with chronic viral hepatitis do not know they are infected. Chronic hepatitis B infection and chronic hepatitis C infection are associated with cirrhosis, liver cancer, and liver failure. These complications can be prevented by early detection, treatment, and education. Serologic testing is the means for identifying persons with chronic viral hepatitis.

I. Populations recommended for hepatitis B testing¹

- All pregnant women
- Infants born to hepatitis B surface antigen (HBsAg)-positive mothers
- Persons born in geographic regions with HBsAg prevalence ≥ 2 percent²
- U.S.-born persons not vaccinated as infants whose parents were born in geographic regions with HBsAg prevalence of ≥ 8 percent³
- Household contacts, sex partners, and needle-sharing partners of hepatitis B-infected persons
- Persons with behavioral exposures to hepatitis B
 - Injection drug users
 - Men who have sex with men
- Persons with selected medical conditions
 - Elevated liver enzymes of unknown etiology
 - Renal disease requiring hemodialysis
 - HIV infection
 - Any disease requiring immunosuppressive therapy
- Persons who are the source of blood or body fluid exposures that might warrant postexposure prophylaxis (e.g., needlestick injury to a healthcare worker)

II. Populations recommended for hepatitis B vaccination, without pre-vaccination serology¹

- Persons under 19 years of age who have not been vaccinated against hepatitis B
- Persons having more than one (>1) sexual partner in the past six months
- Persons seeking evaluation or treatment for a sexually transmitted disease
- Health care or public safety workers with reasonably anticipated occupational exposures to blood or infectious body fluids
- Persons with select medical conditions:
 - Chronic (long-term) liver disease
 - End-stage renal disease
- Persons planning to travel to a country where at least two percent of the population has hepatitis B (Asia, Africa, the Amazon Basin in South America, the Pacific Islands, Eastern Europe or the Middle East)
- Persons who live or work in a facility for developmentally disabled persons
- Anyone who wishes to be protected from hepatitis B infection

III. Populations recommended for hepatitis C testing¹

- Persons who have ever injected illegal drugs, including those who injected only once many years ago
- Persons with selected medical conditions
 - All persons with human immunodeficiency virus (HIV) infection
 - Patients with signs or symptoms of liver disease (e.g., abnormal liver enzyme tests)
 - Recipients of clotting factor concentrates made before 1987
 - Recipients of blood transfusions or solid organ transplants before July 1992
 - Recipients of blood or organs from a donor who later tested hepatitis C virus (HCV)-positive
 - Patients who have ever received long-term hemodialysis
- Children born to HCV-positive mothers (to avoid detecting maternal antibody, these children should not be tested before age 18 months)
- Persons with known HCV exposures (e.g., healthcare workers after needlesticks involving HCV-positive blood)

¹ Source: Centers for Disease Control and Prevention (CDC). Access CDC recommendations and other clinical guidelines for viral hepatitis prevention, testing, management, and care as well as patient education materials at www.cdc.gov/hepatitis or www.cdph.ca.gov/programs/Pages/ovhp.aspx.

² Regions with ≥ 2 percent HBsAg prevalence include the regions described below as well as South, Central, and Southwest Asia, Japan; Russia; Eastern and Southern Europe; Honduras; Guatemala; North America (Alaska Natives and indigenous populations of Northern Canada); and the areas surrounding the Amazon River basin. (A complete list is available at wwwnc.cdc.gov/travel/destinations/list.aspx.)

³ Regions with ≥ 8 percent HBsAg prevalence include Southeast Asia; South and Western Pacific Islands; Africa; the Middle East (except Israel); Haiti; the Dominican Republic; and the interior Amazon River basin. (A complete list is available at wwwnc.cdc.gov/travel/destinations/list.aspx.)

Hepatitis B and C: Patient Self-Administered Risk Assessment

Hepatitis B and C are transmitted in different ways. Most people do not know they are infected until they are tested. Hepatitis vaccination and testing are available at this clinic. Please check if these statements apply to you.

I. Have you been exposed to hepatitis B?

- Were you born in an area of the world where at least two percent of the population has hepatitis B (Asia, Africa, the Amazon Basin in South America, the Pacific Islands, Eastern Europe, or the Middle East)?
- Were you not vaccinated for hepatitis B as infants?
- Was your mother infected with hepatitis B when you were born?
- Are you pregnant?
- Are you HIV-positive, have an HCV infection, or on immunosuppressive therapy?
- Did you have abnormal liver enzyme test results for an unknown reason?
- Have you ever been on hemodialysis?
- Have you had a sexual partner who was infected with hepatitis B?
- Have you lived in the same house with someone infected with hepatitis B?
- Are you a man who has sex with men?
- Have you ever injected illicit drugs or shared drug injection equipment?
- Have you shared needles with someone infected with hepatitis B?
- Are you a health care or public safety worker with a known, recent occupational exposure to hepatitis B-infected blood or bodily fluids (e.g., through an accidental needle stick)?

_____ None of the above

_____ Yes, at least one of the above applies to me

II. Do you need to be vaccinated against hepatitis B?

- Are you under 18 but have not been vaccinated against hepatitis B?
- Have you had more than one sexual partner in the past six months?
- Are you seeking evaluation or treatment for a sexually transmitted disease?
- Are you a health care or a public safety worker with reasonably anticipated occupational exposures to blood or infectious body fluids?
- Do you have chronic (long-term) liver disease?
- Do you have end-stage renal disease?
- Are you planning to travel to a country where at least two percent of the population has hepatitis B (Asia, Africa, the Amazon Basin in South America, the Pacific Islands, Eastern Europe or the Middle East)?
- Do you live or work in a facility for developmentally disabled persons?
- Do you wish to be protected from hepatitis B infection?

_____ None of the above

_____ Yes, at least one of the above applies to me

III. Have you been exposed to hepatitis C?

- Have you ever injected illicit drugs, even once, many years ago?
- Did you receive donated blood or donated organs before 1992 and/or blood clotting products before 1987?
- Have you ever been on hemodialysis?
- Are you a health care or public safety worker with a known, recent occupational exposure to hepatitis C-infected blood or bodily fluids (e.g., through an accidental needle stick)?
- Are you HIV-positive?
- Have you had signs or symptoms of liver disease (e.g., abnormal liver enzyme tests, jaundice)?
- Was your mother infected with hepatitis C when you were born?

_____ None of the above

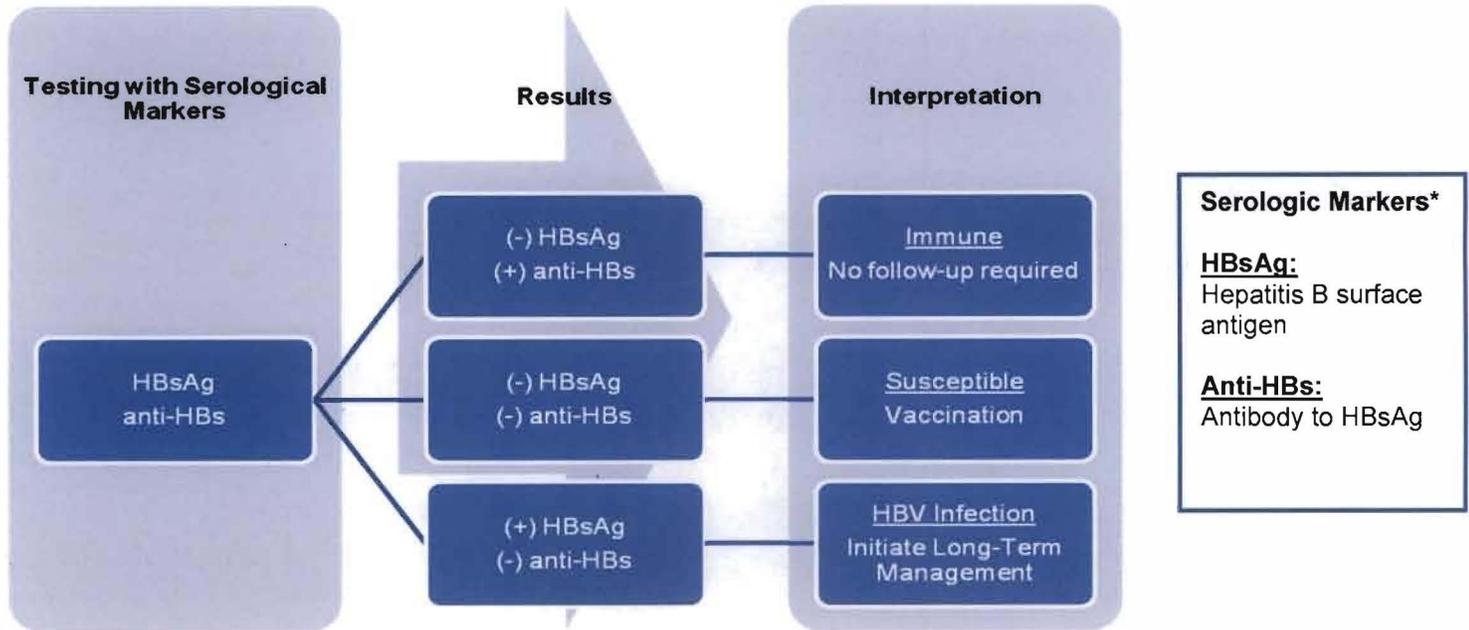
_____ Yes, at least one of the above applies to me

For administrative use only:

If yes to I, order test for HBV (HBsAg and anti-HBs)	<input type="checkbox"/>
If yes to II, administer first dose of HBV vaccine	<input type="checkbox"/>
If yes to III, order test for HCV (anti-HCV)	<input type="checkbox"/>

Hepatitis B: Testing and Serology

Hepatitis B is an infection caused by the hepatitis B virus (HBV). Chronic infection with HBV is associated with cirrhosis, liver cancer, and liver failure. These complications can be prevented by treatment and patient education (e.g., regarding alcohol use and liver self-care). Serologic testing is the primary means for identifying persons with chronic HBV infection. An effective vaccine is available to prevent HBV infection.



* Note: Another HBV test is total antibody to hepatitis B core antigen (anti-HBc), which can be used to distinguish whether immunity is due to past infection (anti-HBc-positive) or to previous vaccination (anti-HBc-negative). In patients with chronic HBV infection, anti-HBc is also present. In the absence of HBsAg or Anti-HBs, an anti-HBc-positive test result has one of four interpretations: 1) recovering from acute HBV infection; 2) distantly immune, test not sensitive enough to detect very low level of anti-HBs in serum; 3) susceptible with a false positive anti-HBc; or 4) chronically infected with an undetectable level of HBsAg in serum.

Hepatitis B Vaccination

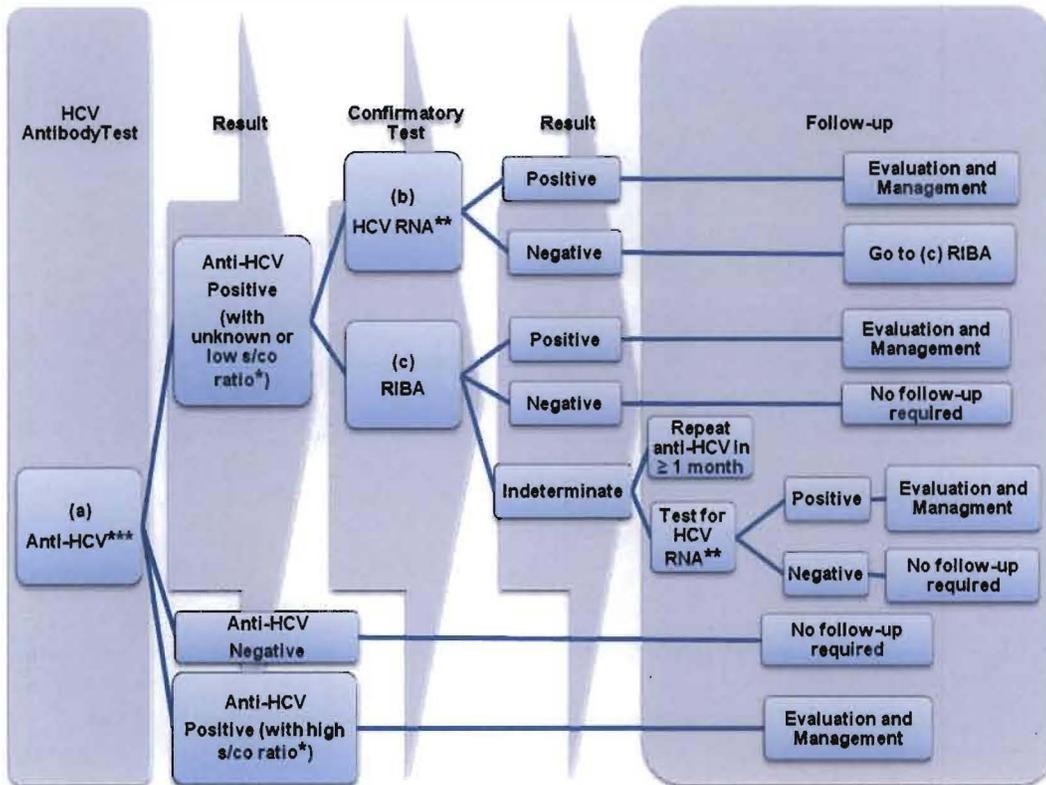
- 3 doses are administered at 0, 1, 6 months; a combination hepatitis A/hepatitis B vaccine is available and follows the same dosing schedule
- If partially vaccinated, the patient does not need to restart the series
- Vaccine is safe for pregnant and HIV-infected persons
- Post-vaccine serology testing (anti-HBs) is recommended for household, needle-sharing, and sexual contacts of HBsAg-positive persons, HIV-positive persons, and healthcare workers
- Booster doses may be indicated for hemodialysis patients, HIV-infected persons, and other immunocompromised persons

Principles of Long-Term Hepatitis B Management

- Provide patient with culturally and linguistically appropriate educational materials (see links below)
- Report case to local health department within seven days
- Vaccinate against hepatitis A unless immune
- Encourage patient's sex partners, household members, and injection-drug sharing contacts to seek HBV testing, medical evaluation, and vaccination
- Counsel patient to minimize alcohol consumption and other liver toxins
- Counsel patient to avoid sharing razors, toothbrushes or personal injection equipment
- Seek a hepatitis B-experienced clinician to evaluate for, manage, and treat chronic HBV infection
- Access clinical guidelines for HBV prevention, testing, management, and care as well as patient education materials at www.cdc.gov/hepatitis or www.cdph.ca.gov/programs/Pages/ovhp.aspx.

Hepatitis C: Testing and Serology

Hepatitis C is an infection caused by the Hepatitis C virus (HCV). Chronic infection with HCV is associated with liver failure, cirrhosis, and liver cancer. Serologic testing is the primary way to identify persons with chronic HCV infection. These complications can be prevented by treatment and patient education (i.e., regarding alcohol use and liver self-care). Currently, no vaccine is available to prevent HCV infection.



Serologic Markers

Anti-HCV:

Hepatitis C surface antibody is used to detect the presence of antibodies to the virus, indicating exposure to HCV

HCV RNA:

Test used to detect the presence (qualitative) or amount (quantitative) of virus and distinguish between a current or past infection

RIBA:

Recombinant immunoblot assay used as an additional and more specific test to confirm the presence of HCV antibodies and rule out false positives

* Note: 95 percent of samples with a high signal-to-cutoff (s/co) ratio will be predictive of a true antibody positive result, regardless of the anti-HCV prevalence or characteristics of the population being tested. A list of the s/cos (or threshold values) that are predictive of a true positive for available commercial assays can be retrieved at www.cdc.gov/hepatitis/HCV/LabTesting.htm. If a false positive test result is suspected, supplemental HCV antibody and/or HCV RNA testing should be conducted.

** Note: A single HCV RNA test result cannot determine chronic HCV infection status, as persons may have intermittent viremia. Two positive HCV RNA tests six months apart are needed to diagnose a case of chronic HCV infection.

*** Note: Patients with recent (< 6 months) exposure who test anti-HCV-negative may not have yet developed detectable antibodies. HIV-infected persons may not develop hepatitis C antibodies. HCV RNA testing should be considered for immunocompromised persons.

Principles of Long-Term Chronic HCV Evaluation and Management

- Provide patient with culturally and linguistically appropriate educational materials (see links below)
- Report case to local health department within seven days
- Vaccinate patients against hepatitis A and B unless immune
- Advise patients to reduce or eliminate intake of alcohol and other liver toxins
- Counsel patients to practice safer injection, follow infection control guidelines in healthcare and in settings such as tattoo parlors, and avoid sharing personal items that might have blood on them, such as razors
- Counsel patients to practice safer sex when engaging with multiple sex partners or infected with HIV
- Seek a hepatitis C-experienced clinician to evaluate for, manage, and treat chronic HCV infection, either by referral or through clinical consultation
- Access clinical guidelines for HCV prevention, testing, management, and care as well as patient education materials at www.cdc.gov/hepatitis or www.cdph.ca.gov/programs/Pages/ovhp.aspx



MEDICAL BOARD OF CALIFORNIA
Executive Office



MEMORANDUM

Date: January 13, 2011

To: Members of the Education Committee

From: Jennifer Simoes, Chief of Legislation

Subject: Applying the Notice to Consumers Regulation to Correctional Facilities

Effective June 27, 2010, the notice to consumers regulation, mandated by Business and Professions Code Section 138, went into effect. This regulation requires physicians in California to inform their patients that they are licensed by the Medical Board of California, and include the Medical Board's contact information.

On June 25, 2010, the Medical Board (the Board) received a letter from the California Department of Corrections and Rehabilitation (CDCR) that stated its belief that the notice to consumers regulation should and does not apply to physicians working within CDCR institutions or Department of Juvenile Justice (DJJ) facilities and requested confirmation from the Board on this issue.

CDCR stated in its letter that the regulation should not be applicable to physicians working for CDCR for the following reasons: There are already numerous mechanisms in place to address medical concerns of inmates and youths, so the notice to consumers requirement is already in effect; inmates and youths do not have access to the internet and have limited telephone access, so the contact information in the required notice is ineffective; inmates and youths may see medical providers not licensed by the Board, which creates confusion; and as a result of the Federal class action case *Plata v. Schwarzenegger*, CDCR's medical providers and facilities are under the direct control of the Federal Receiver, not the Secretary of the CDCR.

A spokesperson came to the July 29, 2010 Committee meeting and asked, during public comment period for Items Not on the Agenda, that the Committee consider the letter and his comments (see minutes) and exempt CDCR from the regulations. At that time, CDCR was told that the notice to consumers regulation does apply to physicians working for CDCR, but that this issue would be considered again in the future. This issue has been placed on your agenda to consider this request from a sister agency.

Potential Recommendations to the Board from the Education Committee:

- Recommend to the Board that the notice to consumers regulation be modified to create an exemption for CDCR and DJJ facilities.
- Recommend that the Board not make any changes at this time.

STATE OF CALIFORNIA — DEPARTMENT OF CORRECTIONS AND REHABILITATION

ARNOLD SCHWARZENEGGER, GOVERNOR

OFFICE OF LEGAL AFFAIRS

Benjamin T. Rice
General Counsel
P.O. Box 942883
Sacramento, CA 94283-0001



June 25, 2010

Via U.S. Mail and facsimile to (916) 263-2387

Linda Whitney, Executive Director
The Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: Notice to Consumers

Dear Ms. Whitney:

I am writing to you on behalf of the California Department of Corrections and Rehabilitation (CDCR) regarding the application to physicians working for CDCR of the new Notice to Consumers requirement under Title 16, California Code of Regulations (C.C.R.), section 1355.4, effective June 27, 2010. Specifically, the regulation requires medical doctors to notify their patients they are licensed and regulated by the Medical Board of California (Board) and to provide the Board's phone number and website. The stated purpose of the new requirement, according to the Board's website, is "to inform consumers where to go for information or with a complaint about California medical doctors."

This new regulation does not appear applicable to physicians working for CDCR for several reasons. Medical care is limited to inmates in state prisons and youths in Department of Juvenile Justice (DJJ) facilities, a patient population with numerous internal, statutory and constitutional mechanisms through which they can address any medical concerns. In particular, inmates and youths have ready access to systems for filing appeals regarding any medical care issues relating to access and quality, as well as venues to file grievances for alleged medical staff misconduct or abuse. Additionally, federal class actions provide notice to the same population that they may seek relief by contacting the law firms representing the inmates in these suits. With these systems in place, the stated purpose of the new Notice to Consumers requirement is already in effect throughout our institutions.

Inmates and youths have limited telephone access and use and have no access to the internet. Consequently, providing these patients with the Board's phone number and website address would be ineffective. In addition, CDCR's clinical spaces are not assigned to specific providers. Inmates or youths may be seen by medical providers who are not licensed by the Board. Posting the notice would potentially create confusion among our consumer population.

Linda Whitney, Executive Director
The Medical Board of California
Page 2

Finally, as a result of the Federal class action case *Plata v. Schwarzenegger*, CDCR's medical providers and medical facilities are under the direct control and supervision of a Federal Receiver, not the Secretary of CDCR.

For the reasons explained above, we do not believe that the new Notice to Consumers requirement in 16 C.C.R. § 1355.4 can or should apply to physicians working within CDCR institutions or DJJ facilities and would appreciate confirmation from the Board. We would also appreciate the opportunity to discuss our above-noted concerns with the Board, including our concerns with inmates' use of the Board's patient complaint processes. My contact information is listed below. I look forward to speaking with you.

Sincerely,



THOMAS L. GILEVICH
Assistant General Counsel
(916) 323-0268