



MEDICAL BOARD OF CALIFORNIA
Executive Office



ENFORCEMENT COMMITTEE

January 27, 2011

Embassy Suites Hotel - San Francisco Airport
Mendocino / Burlingame Room
150 Anza Boulevard
Burlingame, CA
650-342-4600

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

MEMBERS OF THE BOARD

Reginald Low, M.D., Chair
John Chin, M.D.
Sharon Levine, M.D.
Mary Lynn Moran, M.D.
Gerrie Schipske, R.N.P., J.D.
Frank Zerunyan, J.D.

AGENDA

9:00 a.m. to 10:00 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 / Roll Call
2. Approval of Minutes
 - A. July 2010
 - B. November 2010
3. Public Comment on Items not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125 and 11125.7(a)]
4. Review of Probation Practice Monitor Requirement – Ms. LaSota and Ms. Hayes
5. Update on Expert Reviewer Training Progress – Ms. Sweet
6. Review of Training Modules – Ms. Threadgill
7. Agenda Items for May 5-6, 2011 Meeting in Los Angeles, CA
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 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 a disability-related accommodation or modification 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 send 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



ENFORCEMENT COMMITTEE
Medical Board of California
Hearing Room
Sacramento, CA
July 29, 2010

MINUTES

Agenda Item 1 Call to Order/Roll Call

The Enforcement Committee of the Medical Board of California was called to order by the Chair, Reginald Low, M.D. A quorum was present and due notice having been mailed to all interested parties, the meeting was called to order.

Members Present:

Reginald Low, M.D.
John Chin, M.D.
Sharon Levine, M.D.
Gerrie Schipske, R.N.P., J.D.

Staff Present:

Richard Acosta, Licensing Analyst
Fayne Boyd, Licensing Manager
Susan Cady, Enforcement Manager
Ramona Carrasco, Enforcement Analyst
Hedy Chang, Board Member
Eric Esrailian, M.D., Board Member
Gary Gitnick, M.D., Board Member
Kurt Heppler, Legal Counsel
Breanne Humphreys, Licensing Manager
Teri Hunley, Business Services Manager
Scott Johnson, Information Systems Branch
Therese Kelly, Licensing Analyst
Ross Locke, Business Services Office
Natalie Lowe, Enforcement Analyst
Kelly Maldonado, Enforcement Analyst
Ian McGlone, Enforcement Analyst
Valerie Moore, Enforcement Manager
Pat Parks, Licensing Analyst
Regina Rao, Business Services Office
Letitia Robinson, Licensing Manager
Paulette Romero, Enforcement Manager
Janet Salomonson, M.D., Board Member

Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Lynn Sterba, Licensing Analyst
Laura Sweet, Deputy Chief of Enforcement
Kathryn Taylor, Licensing Manager
Cheryl Thompson, Executive Assistant/Midwifery Program
Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director
Crystal Williams, Licensing Analyst
Trish Winkler, Executive Assistant
Barbara Yaroslavsky, President of the Board

Members of the Audience:

Yvonne Choong, California Medical Association (CMA)
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Stan Furmanski, M.D., Member of the Public
David Gonzalez, Member of the Public
Brett Michelin, California Medical Association (CMA)
William Norcross, PACE Program
Carlos Ramirez, Senior Assistant Attorney General
Rehan Sheikh, Member of the Public

Agenda Item 2 Approval of Minutes

Dr. Levine moved to approve the minutes from the April 29, 2010 meeting; seconded; motion carried.

Agenda Item 3 Public Comments on Items not on the Agenda

Stan Furmanski, M.D., member of the public, provided a slide presentation including documentation which supported his concerns of the Physician Assessment and Clinical Education Program (PACE). Dr. Furmanski presented documents of a cost outcomes analysis on the PACE program. The analysis indicated that there is a high number of false positive outcomes; Dr. Furmanski's definition of a false positive outcome was a PACE failure which did not result in the revocation of a license. Dr. Furmanski opposes the use of PACE and asked the Board to look into other options for assessing physicians.

Dr. Furmanski also discussed a secret contract kept in the PACE files that detailed the cost of the booklets provided to PACE students and provided slides of documentation to support his findings. Per Dr. Furmanski, the "Secret Contract" indicates that the booklets can be obtained at a cost of \$50 to \$100 and recommends that the Board buy the booklets and sell to doctors at cost.

There were no additional public comments.

Agenda Item 4 Review/Approval of Enforcement Committee Vision Statement

Ms. Sweet presented to the Committee Members three prospective Vision Statements to be adopted for the Committee:

Vision Statement Option 1:

The vision of the Enforcement Committee is to supplement (or enhance) the Medical Board's mission of protecting health care consumers by action as an expert resource and advisory body to members of the Medical Board and its enforcement program, by identifying program improvement opportunities, and by educating board members and the public on enforcement processes.

Vision Statement Option 2:

The Enforcement Committee will act as an expert resource and advisory body to members of the Medical Board and its enforcement program by educating board members and the public on enforcement processes and by identifying program improvements in order to enhance protection of health care consumers.

Vision Statement Option 3:

In furtherance of the Medical Board's mission of protecting health care consumers and in the spirit of transparency, the vision of the enforcement committee is to act as an expert resource and advisory body for the enforcement program, to identify and implement program improvements, and to educate the public and other board members on how the enforcement program operates.

Per legal counsel, there did not appear to be any legal concerns, and after discussion by Committee Members, Vision Statement Option 2 was agreed upon.

There were no public comments.

Dr. Levine made a motion to recommend to the full Board that Vision Statement Option 2 be adopted on behalf of the Committee; s/Dr. Chin; motion carried.

Agenda Item 5 Progress Report of Expert Reviewer Training

Ms. Sweet provided an update of the Expert Reviewer Training indicating that with the assistance of Dr. Low, UC Davis Medical Center agreed to provide their state of the art training facilities for the Board's inaugural expert training, targeted for the spring of 2011. Per Ms. Sweet the facilities and equipment at UC Davis Medical Center are quite impressive and will allow for an interactive type of presentation. Sample cases are being sought for presentation purposes.

Dr. Low provided that in terms of history, the standardization of expert training throughout the state would make the expert process better and more consistent; this interactive training would allow all experts throughout the state to have the same training, getting everyone on the same page. Dr. Low felt that this training would go a long way to help the Board, as well as experts, to understand their roles.

There were no public comments.

Agenda Item 6 Presentation of an Overview of Enforcement Programs, Components and Processes

Ms. Cady and Ms. Sweet provided a presentation of the Enforcement Program indicating that one of the areas of interest identified by members was the development of training segments that focused on the Enforcement Program and the variety of work performed by staff within that program. This first segment in the series provided a general overview of the entire Enforcement Program and will be followed up with more detailed information of each unit and how they function.

Ms. Cady provided information for the units assigned to the Enforcement Operations Program. The Enforcement Program is Split into two main components under the overall direction of the Chief of Enforcement, Renee Threadgill. All sworn peace officer staff are assigned to the Investigative Services Program under the direction of Deputy Chief, Laura Sweet. All non-sworn personnel are assigned in the Enforcement Operations Program under the direction of Susan Cady, Staff Services Manager, II. The Central Complaint Unit is primarily responsible for the triage of all new complaints filed with the Board. The unit consists of 24 professional and technical staff that are divided into two units based on the type of complaints that they specialize in, either Quality of Care or Physician Conduct. In addition to the triage function, the Complaint Unit also serves as the focal point for the hospital disciplinary reports (805's) that are received by the Board. Staff ensures that the reports are complete and posts information about either the termination or revocation of privileges to the physicians profile on the Medical Board's website. In addition, staff is responsible for providing copies of the 805 reports to authorized entities such as credentialing bodies when physicians have either applied for or are renewing their application for privileges. Finally, all Citations issued by the Board are issued out of the Complaint Unit regardless of where the referral originated: from the Complaint Unit, the District Office after an investigation, or from the Licensing Program.

The Discipline Coordination Unit is staffed with 11 professional and technical staff that are responsible for processing and serving all administrative documents associated with physician discipline. Because these actions are required by law to be available on the Board's website, one staff position is solely responsible for creating all of the public disclosure information posted to the physicians profile as well as reporting the actions taken to the National Practitioner Database. In addition, staff also insures that all public documents related to actions taken by the Board are posted to our website. Finally, the Discipline Coordination Unit is the focal point for receiving and tracking all monies ordered by the Board as part of a disciplinary action such as cost recovery or probation monitoring costs or the cost associated with psychiatric or medical evaluations.

The Probation Unit is essentially responsible for monitoring physicians once probation has been ordered and insuring that the terms and conditions outlined in the decision are complied with. The unit consists of 24 staff that are located throughout the state; each inspector is assigned approximately 25-30 physicians on probation to monitor. There is one staff position which is solely dedicated to coordinating all of the scheduling for the 120 physicians who have random biological fluid testing that has been ordered as a condition of their probation.

Ms. Sweet provided information for the units assigned to the Investigative Services Unit. There are approximately 100 sworn peace officers in the field responsible for performing the field work and investigating the cases after they have passed through the triage process of the Central Complaint Unit. There are 12 District Offices located throughout the state, each staffed with approximately 5-6

investigators, a supervisor, a few attorneys, and 1-3 medical consultants. Their duties are to assess complaints, gather evidence, and to prove or disprove a violation of law. Duties can include a variety of investigative techniques including serving search warrants, subpoenas, etc. For Quality of Care cases their duty is to gather enough evidence so that an expert is able to render an unbiased and objective opinion.

The Office of Standards and Training is located out of the headquarters of the Medical Board and is responsible for conducting background investigations of all Peace Officer hires, provide specialized training for all investigative staff, handle all cases involving internet prescribing, purchase equipment for the Enforcement Program, maintain policies and procedures, and manage the Expert Reviewer Program. The Operation Safe Medicine unit specializes in investigating the allegations of unlicensed practice of medicine and is able to take a pro-active approach to protecting the public from unlicensed individuals practicing medicine.

At the next meeting of the Enforcement Committee, Ms. Cady recommended that focus be made to the specific units of the Enforcement Program, specifically the Probation Unit. Ms. Cady felt that it was important to begin with this unit as they are responsible for taking the direction given by the Board in decisions on disciplinary cases and insuring that physicians are complying with the ordered terms and conditions. There are a number of cases that have raised concerns about the effectiveness of some of the terms being ordered, such as the Practice Monitor. Difficulties that physicians have in complying with this term have been identified and Ms. Cady would like to promote a discussion on whether there are alternatives to this requirement or whether additional training may be needed for the physicians who have taken on the role of a Practice Monitor.

The floor was then opened to Public Comment:

Rehan Sheikh, member of the public, expressed interest in the Board's discipline process, specifically what precautions are taken to insure that an 805 Report received from a hospital is completed without errors prior to issuing disciplinary action. Ms. Cady provided a brief overview of the process, indicating that when an 805 Report is received in the Complaint Unit, it is reviewed to ensure that all of the requested information has been provided on the form, and the report is then sent to an investigative office for a formal investigation.

Agenda Item 7 PACE update

In addition to Dr. Norcross' presentation, additional information was provided in the Agenda packet details, starting on Page 51, Item 7a.

Dr. William Norcross, Clinical Professor of Family Medicine at the UC San Diego School of Medicine provided a Physician Assessment and Clinical Education (PACE) program update including details of the implementation of the 2007 Audit recommendations. Dr. Norcross indicated that there are no formal associations with the Medical Board; PACE is not under contract by the Medical Board; and he is not an employee of the Medical Board.

Dr. Norcross stated that to date, PACE services have been provided to California State Department of Corrections, to several hospitals, to medical boards in and outside of California, insurance companies, and to physicians who are self-referred.

Dr. Norcross stated that PACE's primary objective is to protect patients. The PACE program started in 1996 and is built around the 6 core competencies that would be required for a physician to be competent, including medical knowledge, communications, professionalism, etc. There is a rational and objective nature for how PACE decides if physicians fail or not, however as there are physicians of different specialties and different practice types within each specialty, each determination is individualized. Physicians can fall into one of four categories: Pass, Pass with Minor Recommendations, Pass with Major Recommendations, and Fail. Fail means that the physician is currently unsafe to practice and the category is set at a very low bar. The fail rate is a little above 10%.

PACE is broken into 2 phases; Phase 1 is two days and is mostly testing. Booklets provided for this phase cannot be purchased privately as they are examinations created by the National Board of Medical Examiners (NBME), and must remain secure in order to protect the testing process. Phase 2 involves bringing the doctor back for five days and provides training in the appropriate settings based on specialties, including placing the doctor in the hospital, operative rooms, cath labs, etc. Doctors do not have patient responsibility. During this phase the doctor is assessed and trained.

The floor was then opened to committee members for discussion and questions. Dr. Chin asked Dr. Norcross to discuss the cost allocations and to provide a structure of how the money is spent. Dr. Norcross stated that PACE is 100% within the UCSD School of Medicine and although the cost looks expensive, the program is comparable to other assessment programs. Money goes back to the department for educational research, faculty fees, and to other departments. Faculty is paid comparable to what they would be making in private practice, and much of the fees are prorated.

Dr. Levine inquired if PACE provided a re-entry program. Dr. Norcross stated that PACE does not provide a re-entry program as this type of program would need to be able to provide hands on training. Regarding the audit, Dr. Norcross stated that it was a routine audit, PACE passed with flying colors, and all items have been addressed. All recommendations of the audit have been implemented.

Ms. Cady was then asked to provide a discussion regarding establishing the equivalency of programs. The manual of model disciplinary guidelines outlines the requirements for a clinical training or educational program and identifies that the program must include a 2 day assessment of the physicians physical and mental health, basic clinical and communication skills common to all clinicians, and medical knowledge, skill, and judgment pertaining to the physicians specialty or subspecialty, and a 40 hour program in the area of practice in which the physician was alleged to be deficient, which takes into account data obtained from the assessment and the accusation, and any other information the Board deems relevant. The Post Licensure Assessment Program is used by PACE as part of a clinical assessment for clinical competency; details of this program were included as an Agenda Packet Item 7d.

When evaluating clinical training or education programs to determine if they are comparable to PACE, a side by side comparison of the content of each program is performed. There are several programs throughout the country which use the Post Licensure Assessment System and include a requirement that physicians perform mock histories and physicals on patients. A number of programs include the cognitive function screening tests that are used by PACE as well, however the most common deficiencies that are seen in some of the other physician assessment programs are the lack of remediation or retraining components which are required by the Board's disciplinary guidelines. Another important component that

is looked into is whether the program will identify if the physician performs so poorly as to be considered not safe to practice, which is a critical element from the Board's perspective as the clinical assessment is used to determine if the physician is safe to practice.

The floor was then opened to Public Comment:

Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL), expressed that the Medical Board is very fortunate to have a program such as PACE at their access.

Stan Furmanski, M.D., Member of the Public, asked what the secret template was, which was referred to in the Medical Board of California Enforcement Program Monitor report provided by Ms. Fellmeth to the Medical Board in 2005.

Agenda Item 8 Agenda Items for November 3, 2010 Meeting in Long beach, CA

Dr. Low requested that the following items be included on the November 2010 agenda:

- Presentation of an Overview of Enforcement Programs, Components and Processes focusing on the Probation Unit
- Progress Report of Expert Reviewer Training

There were no public comments.

Agenda Item 9 Adjournment

There being no further business, the meeting was adjourned.



MEDICAL BOARD OF CALIFORNIA
Executive Office



ENFORCEMENT COMMITTEE
Medical Board of California
Long Beach Memorial Medical Center
Miller Children's Hospital
Room A1-A2
Long Beach, CA 90806
November 04, 2010

MINUTES

Agenda Item 1 Call to Order/Roll Call

The Enforcement Committee of the Medical Board of California was called to order by John Chin, M.D. A Quorum was not present. The meeting continued as a subcommittee with Agenda items; no Action Items, Motions, or Votes took place. With due notice having been mailed to all interested parties, the meeting was called to order at 9:05 a.m.

Members Present:

John Chin, M.D.
Gerrie Schipske, R.N.P., J.D.

Members Absent:

Frank V. Zerunyan, J.D.
Sharon Levine, M.D.
Reginald Low, M.D.
Mary Lynn Moran, M.D.

Staff Present:

Ken Buscarino, Enforcement Investigator
Susan Cady, Enforcement Manager
Jorge Carreon, M.D., Board Member
Hedy Chang, Board Member
Maksim Degtyar, Enforcement Investigator
Eric Esrailian, M.D., Board Member
Catherine Hayes, Probation Manager
Kurt Heppler, Legal Counsel
Teri Hunley, Business Services Manager
Rachel LaSota, Supervising Inspector
Ross Locke, Business Services Office
Natalie Lowe, Enforcement Analyst
Armando Melendez, Business Services Office
Erich Pollak, M.D., Medical Consultant
Regina Rao, Business Services Office
Sylvia Salcedo, Enforcement Investigator
Kevin Schunke, Regulations Manager

Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement
Cheryl Thompson, Executive Assistant
Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing
Barbara Yaroslavsky, Board Member

Members of the Audience:

Hilma Balaian, Kaiser Permanente GME
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)
Neil Desai, Arizona College of Medicine Osteopathy
Joseph P. Furman, Furman Healthcare Law
Stan Furmanski, Member of the Public
Daniel Giang, Loma Linda University Med. Ctr.
Jim Hay, CMA
Donna Kary, Member of the Public
Arjun Makam, Arizona College of Medicine Osteopathy
Joy Mobley, Member of the Public
M. Monserratt-Ramos, CU SA Safe Patient Project
Margaret Montgomery, TPMG
Gary Nye, Member of the Public
Rehan Sheikh, Member of the Public
Mary Lou Tryba, Member of the Public

Agenda Item 2 Approval of Minutes

As a Quorum was not present, a Motion to approve the minutes was not made.

Agenda Item 3 Public Comments on Items not on the Agenda

Stan Furmanski, M.D., member of the public, stated that at the last Enforcement Committee Meeting he had mentioned several concerns with the Physician Assessment and Clinical Education Program (PACE) and had 10 additional issues with PACE that he wished to bring to the Committee's attention. Dr. Furmanski stated that PACE does not have an objective standard for Pass/Fail; PACE lacks valid assessment material for about 40% of physicians that go through the program; PACE does not have appropriate testing and or training materials for doctors in certain specialty areas, such as: Magnetic Resonance Imaging, Stem Cell Research, PET scanning, PET scanning's Positron Emission Tomography, and Transplant Science, indicating that if the incorrect test is performed there is content invalidity; PACE does not have a set way to disqualify an unqualified person who is working at San Diego performing the tests, indicating that un-licensed physicians are performing the tests; and, the Board and or PACE may be in violation of Business and Professions Code 2228, 2292, 2293, and 2294. Dr. Furmanski recommended that the Board create a Grievance and Resolution Committee to listen to and resolve problems with PACE, which could act as a non-binding arbitrator between the Board and physicians who have concerns with PACE.

Mary Lou Tryba, member of the public, provided a handout to Committee Members that contained information on the L.A. County Department of Mental Health, which is seeking

opportunities to connect with faith-based leaders. Ms. Tryba wished to bring attention to this information and urged the State to get involved.

Agenda Item 4 Presentation of an Overview of Probation Program and Disciplinary Terms and Conditions

Catherine Hayes, Manager, and Rachel LaSota, Supervising Inspector for the Probation Unit provided a general overview of the Probation Unit, including a Power Point presentation.

In July 2007, the Medical Board reorganized the probation monitoring function and redirected the peace officer investigators (who acted as probation monitors) back to the field investigation unit. The Probation Unit is now staffed with Inspectors whose role is focused on monitoring the probationer's compliance with the terms and conditions set forth in the Decision. The Unit consists of three main offices. The Inspector III is responsible for supervising the day-to-day activities of the Inspectors. Catherine Hayes, Manager over the Probation Unit is located in Sacramento. There are a total of 15 Inspectors statewide, each handling a caseload of 25-30 probationers. The management services technicians provide general support to the office and manage a caseload of probationers that are out-of-state (tolled) or in-state and not practicing, which are referred to as pended.

There are currently 379 active physicians on probation. This caseload is divided among each of the three probation office locations. The cases are assigned to an Inspector according to the geographic area and the address of record for the probationer. In addition, there are 148 physicians on probation that are either not practicing in California or are located out-of-state; which comprise the "pended/tolled" caseload. When probationers are in the "pended or tolled" status, they are not required to comply with most of the terms and conditions in their order with the exception of the general requirements to keep the Board apprised of their current address and contact information and they must obey all laws. The staff handling this caseload contact the probationers bi-annually to ensure they are still "not practicing" and monitor the amount of time spent in a "non-practice" status. For decisions rendered after October of 2003, the Board can cancel the physician's license if the period of non-practice exceeds two years.

The Probation Unit is there to "protect" the consumers by ensuring that probationers stay in compliance with their probation. This is done through constant monitoring by the Inspectors.

The Unit "regulates" probationers' compliance by meeting with them one-on-one on a quarterly basis and as situations arise. Certain terms and conditions require that the probationer provide to the Inspector proof of completion, such as, continuing medical education, community service, education courses, or the PACE program. The Inspector will monitor compliance with these conditions.

The Inspectors "observe" the probationer's behavior and actions. At the quarterly interviews, the Inspector is there to observe the physician's surroundings at his/her place of practice or to observe the probationer to determine behavior that might seem out of the ordinary, especially in cases where biological fluid testing is required and the probationer is exhibiting some unusual behavior.

The Inspectors must "balance" their caseload with their daily activities. Inspectors track their caseload to ensure the probationer is visited within each quarter. At times the Inspector has to

travel long distances to meet with the probationer. During this same time period the Inspectors are receiving correspondence from the probationer as well as reports, such as quarterly declarations, psychotherapy reports, medical evaluations, practice or billing monitor reports, and certificates of course completion. After each quarterly visit a written report is prepared by the Inspector. The Inspector III reviews each report and enters case status information into the notes in the database system.

Situations arise where the Inspector needs to provide “alternatives” to the probationer. In certain circumstances the probationer is not able to comply with the terms and conditions; thus the Inspector can provide alternatives such as surrendering the license, developing a payment plan (if costs are an issue), or petitioning for modification or early termination of probation.

Presently there are 23 optional and 13 standard terms and conditions. The terms and conditions provide assurance that the probationer is being monitored in the areas of deficiency that resulted in placing him or her on probation.

An integral part of the Inspector’s duties is to conduct an “intake interview” just prior to the effective date of the decision. This interview normally lasts one hour and provides an opportunity for the probationer to ask questions to clarify what is required of him or her during probation. The probationer also fills out an information sheet and signs some acknowledgments. After this initial meeting, the probationer should be well informed as to what is required and the timelines. The Inspector prepares a written report summarizing the meeting.

One of the standard terms and conditions of probation is “obey all laws.” If a probationer is convicted of a crime, violates a Medical Board statute or regulation, or violates a federal, state or local law, it will result in a violation of probation and further action will be taken against the license.

“Non-compliance” could be as a result of failing to submit written documents, not following through with required coursework, or not securing a practice monitor. In any case, Inspectors will prepare a non-compliance report identifying the deficiencies and submit it to their supervisors for a request to either issue a citation or refer the case to the Attorney General’s office for further action.

Rachel LaSota discussed the “practice monitor” condition of probation and how it functions as part of probation monitoring.

Currently, there are 183 probationers who are required to have a practice or billing monitor. This condition is recommended in cases involving clinical skills deficiencies, such as gross negligence, excessive or inappropriate prescribing, or violations related to physician impairment by drugs or alcohol, sexual misconduct, or ethical violations, such as dishonesty and criminal convictions.

This condition requires that the probationer identify and propose a practice monitor within 30 calendar days from the effective date of the Decision. The practice monitor must be someone who has no prior or current business or personal relationship with the probationer. This requirement was designed to ensure that the monitor could provide fair and unbiased reports to

the Board. The practice monitors are “reimbursed” by the probationer for any costs associated with acting as a monitor and these fees typically range from \$100 to \$600 per hour.

Once the probationer has identified a potential practice monitor, the Inspector reviews the physician’s background, including any complaint or disciplinary history and his/her qualifications. If approved, the Inspector will provide to the monitor a brief overview of the Board’s expectations and a monitoring plan.

The monitor is expected to visit the probationer’s practice location at least once a month. During the visit, the monitor randomly selects 10% of the probationer’s charts to review. The objective of the chart review is to allow the monitor to make an assessment as to whether the probationer is practicing “within the standard of care.” A quarterly report is prepared by the monitor to confirm that the reviews have taken place and identify any deficiencies noted during the chart review.

The practice monitor does not provide any on-site or direct supervision and visits the probationer’s office once a month at a scheduled appointment. While this may be considered adequate to evaluate a clinical skills deficiency, there is a concern that the random chart review does not provide adequate public protection for probationers charged with sexual misconduct or substance abuse issues.

A concern identified with the current system is the difficulty to find a practice monitor with no prior relationship with the probationer. In most cases, the physician is acquainted with the proposed practice monitor. Frequently, the probationer will indicate that he/she knew the practice monitor when they both worked at a specific hospital in the past, or they went to school together. However, the extent of the relationship in many cases is not easy to discern and the Inspector does not have the resources or time available to verify this. The purpose of this requirement is to attempt to ensure that the practice monitor can and will provide objective and unbiased assessments of the probationer’s performance.

Additionally, it is not uncommon for physicians nominated to act as practice monitors to express concern about “the liability they might be assuming”. The current statutes expressly provide immunity to the Board’s medical experts and medical consultants, however, the practice monitors do not explicitly have this same protection.

In order to formulate plans for improving the practice monitor term/condition, the Probation Unit developed several ideas it believes might strengthen the practice monitor and meet the objectives of consumer protection.

The Physician Enhancement Program is currently approved by the Board as an alternative to identifying and nominating a practice monitor. This alternative can be expensive for the probationer but the program is well developed and provides an excellent example of a mentoring program.

The Probation Unit has considered the option of developing and maintaining a pool of physicians trained to provide this service. A training program and material similar to the program currently have in place with the Expert Reviewer Program could be developed.

The Probation Unit also considered a training program for the practice monitors and requiring completion before the monitor can be used. PACE currently offers a 4 hour training class entitled "From Monitoring to Mentoring" and PACE has offered to allow the Probation Unit to use material from this course.

Several areas were identified that could be improved internally, such as, providing better instructional material for the monitors, standardizing the report formats, and providing a checklist of items to review during the quarterly visit with the probationer.

Ms. Schipske agreed probationers must be adequately monitored. Ms. Schipske felt that providing the necessary means to have an adequate practice monitor should be a top priority for the Board, including providing additional staffing, making legislative changes, or making procedural changes. Ms. Schipske agreed that the lack of immunity for the practice monitors is a concern. Ms. Schipske would like to make a recommendation to the full Board to allow immunity for practice monitors.

Dr. Chin stated that the idea of having a probationer select his/her own practice monitor was a concern. He also felt that the requirement to review 10% of office charts per office was not suitable when substance abuse or other types of abuse were involved. Dr. Chin felt that the PEP program sounded excellent but had concerns about how this type of program could be extended throughout the state, the necessary budget, and the availability of enough physicians to maintain the program.

Gary Nye, M.D., member of the public, has worked with probationers for many years and felt that the 30 day length of time to find a monitor was a major problem and would like to see that time frame extended. He also agreed that programs like PEP and granting immunity for monitors were key elements.

Rehan Sheikh, member of the public, expressed concerns that probationers could be selecting practice monitors that would be favorable to the probationer. He inquired if the Board was requiring probationers to go through UC San Diego because those monitors would be unbiased. Kurt Heppler, Legal Counsel, responded there is no requirement.

Jim Hay, CMA, supported the idea of immunity for monitors and stated that the CMA would be willing to provide assistance with getting this into statute. CMA could also provide assistance with finding monitors as their IMQ currently trains surveyors and this could be something investigated as a possibility to help. For those probationers who have substance abuse, dependence, or mental health issues, CMA could assist with creating requirements for the monitors of these types of probationers as they are currently working on a physician health program. CMA is willing to work with the Board on finding monitors, making sure the requirements for monitors are appropriate, and granting the monitors statutory immunity.

Joseph Furman, member of the public who represents physicians in Board matters, stated that granting the practice monitors immunity was an outstanding idea. He felt that for purposes of public protection, it would place the monitors at ease, allowing them to be more candid in their reports to the Board. Mr. Furman stated he would be willing to support this in any way he can.

Agenda Item 5

Presentation of How CURES is Utilized by the Enforcement Program

Ms. Sweet provided a presentation on the Controlled Substance Utilization Review and Evaluation System (CURES). CURES, which is administered by the Department of Justice, Bureau of Narcotic Enforcement, is an investigative tool used by the Board to investigate allegations of inappropriate prescribing and over prescribing. Ms. Sweet provided a power point presentation that included examples of reports from the CURES system.

CURES evolved from the Triplicate Prescription Program that was created in 1940. The Department of Justice collects Schedule II, III, and IV prescription information from pharmacies on a weekly basis, via an electronic data transfer system that allows for analysis and retrieval of data. The system allows registered practitioners, pharmacists, law enforcement, and regulatory boards instantaneous web-based access to controlled substance history information, 24-hours a day.

Boards that have access to CURES include: the Medical Board, Registered Nursing, Veterinary Board, Osteopathic Medical Board, Dental Board, and the Board of Pharmacy.

The two primary functions of CURES are prevention & intervention for patients and investigation & enforcement for law enforcement.

A Patient Activity Report is available to prescribers, which contains the prescribing and dispensing history contained in CURES for Schedule II, III, and IV controlled substances of patients under the requesting medical provider's care. This information is only available to prescribers and pharmacists registered with the Department of Justice. This report is beneficial for prescribers as it allows them to become aware of patients who may be drug seeking, and provides them the ability to make more informed decisions on prescribing and types of medications that are being prescribed. It is beneficial for patients, as prescribers may be able to provide intervention. For patients who are not drug-seeking, they can benefit from the prescribers' ability to feel more comfortable in prescribing medicines they need.

On September 15, 2009 the CURES Prescription Drug Monitoring Program (PDMP) database became available online. PDMP allows immediate access to the database and is available to prescribers, pharmacists, and law enforcement personnel. Once an application is received and approved, the requestor has real-time access to the database.

Ms. Sweet presented a case study.

Medical consultants and investigators are trained to look for patterns. In these types of cases, other investigative techniques are also used, including surveillance, undercover operations, search warrants, and subpoenas duces tecum. Medical records are the key pieces of evidence as they typically tell whether the physician is treating a legitimate pain patient or is prescribing indiscriminately. The basic question asked is: have the pain management guidelines been met? Medical Board investigators are trained extensively on distinguishing between patients who have legitimate pain problems and those who are seeking drugs inappropriately.

During the investigative process, the subject is interviewed, and then typically the case is sent to an expert for review. The expert's opinion will indicate if there has been: no departure from the



Medical Board of California Practice Monitor Condition

Probationer submits the name of the proposed practice monitor for approval within 30 calendar days from the effective date of the Decision.

Requirements for the proposed practice monitor

Probationer pays all monitoring costs



Valid license in good standing

Preferably ABMS certified

Be in the probationer's field of practice

Agree to serve as a practice monitor

186



Medical Board of California Practice Monitor

Do's

- Perform chart reviews
- Submit quarterly reports
- Evaluate performance of probationer
- Conduct monthly inspections

Don'ts

- Provide direct or on-site supervision
- Provide oversight or direction
- Review more than 10% of patient charts
- Visit the office more than once a month



Concerns With Existing Program



No prior relationship with the probationer

Random chart review, is 10% sufficient?

Should there be some “immunity” provided?

Substance abuse issues or boundary violations



Physician Enhancement Program (PEP)



Faculty members as practice monitors

Formal training provided

Training manual and structured checklist

Submittal of reports and improvement plans



Practice Monitor Options



1

- **Professional Enhancement Program**
(cost ranges from \$8,500-\$16,500 a year)

2

- **MBC develops a pool of practice monitors that receive training**

3

- **Use the current system but develop and require that monitors complete training**

4

- **Retain the existing system but develop more structured requirements for the monitors**



Practice Monitor Option #2



MBC Develops Pool of Practice Monitors

- ❖ Large investment of time/staff resources
- ❖ Develop training material
- ❖ Method of training
- ❖ Selection criteria
- ❖ Recruitment strategies
- ❖ Identify practice specialties throughout the state
- ❖ Maintain listing of trained physicians
- ❖ Assess performance of practice monitor
- ❖ Provide feedback



Practice Monitor Option #3



Retain Current System - Require Training

- ❖ Develop training material
- ❖ Determine method of training
- ❖ Produce training material for existing monitors
- ❖ Confirm training completed
- ❖ Follow-up on non-completions
- ❖ Terminate for failure to complete training
- ❖ Assess performance of practice monitor
- ❖ Provide feedback



Practice Monitor Option #4



Enhance Existing Process

- ❖ Standardize the report format
- ❖ Provide practice monitor with orientation
- ❖ Develop a monitoring plan
- ❖ Develop a checklist

Ideas for Enforcement Program Training Modules in Priority Order

Topic	Est. Presentation Length
Enforcement Program: General overview of all units and how complaints move through the process	20 minutes
Probation Unit: General overview of Unit since reorganization	10 minutes
Probation Unit: Implementing the Board's decision—conducting an intake interview	15 minutes
Probation Unit: Common complaints and challenges for new probationers	15 minutes
Probation Unit: Challenging terms and conditions – Practice Monitors. Discuss the challenges of finding a monitor, the need for training and options, benefits or alternatives to the practice monitor requirement	30 minutes
Probation Unit: Challenging terms and conditions – no solo practice. Discussion of the variety of situations presented to Probation and the goals to be accomplished with this prohibition.	30 minutes
Probation Unit: Challenging terms and conditions - third party chaperones. Is there a need to develop training for chaperones?	30 minutes
Probation Unit: Challenging terms and conditions – prohibited practice	20 minutes
Complaint Unit: General overview of complaint review process	15 minutes
Complaint Unit: A focused review of how quality of care complaints triaged in CCU. Discussion about the necessity of continuing to match the practice specialty of the physician/subject with the CCU medical consultant.	30 minutes
Complaint Unit/Field Operations: A day in the life of a quality of care case focusing on how a case is “triaged” in the Complaint Unit and investigated by the field investigator.	40 minutes
Complaint Unit/Field Operations: A day in the life of a medical malpractice case focusing on how a case is “triaged” in the Complaint Unit and investigated by the field investigator.	40 minutes
Complaint Unit: Mandated reports required by the “800” series of the Business and Professions Code and how they are triaged. <ul style="list-style-type: none"> • Medical Malpractice reports (801) • Hospital disciplinary reports (805) • Coroner reports (802.5) • Patient death in an outpatient surgery center (2240) • Physician Report of Criminal Action (802.1) • Court Clerks Reporting (803.5, 803.6) 	20 minutes
Complaint Unit: General review of the variety of complaint issues assigned to the “Physician Conduct” unit (e.g., office practice issues, medical record abandonment/destruction; failure to sign death certificates timely; sexual misconduct; physician impairment, advertising, corporate practice of medicine, etc.) and how they are “triaged”	25-30 minutes

Complaint Unit: The role of the Deputy Attorney General in providing assistance and direction to CCU	15 minutes
Field Operations: A day in the life of an investigator	20 minutes
Field Operations: Investigating hospital discipline cases (805 reports)	25 minutes
Field Operations: The challenges of investigating cases involving care in the correctional facilities	20 minutes
OSM: How unlicensed practice of medicine cases are investigated	30 minutes
OST: So you think you want to be an Investigator? The intensive training program provided to new staff to ensure they are "worthy" to investigate medical board cases.	20 minutes
OST: The challenges of investigating cases involving internet prescribing	20 minutes
Field Operations: Investigating cases involving medical marijuana	20 minutes
Field Operations: Investigating cases which allege possible physician impairment due to physical limitations or mental health concerns	20 minutes
AG's Office: The role of the DAG when a case is referred for investigation – What does a lead prosecutor do?	20 minutes
DCU: Public Disclosure requirements and challenges, lawsuits	20 minutes
DCU: Am I an analyst or an alarm clock? The analyst's role in tracking critical dates (i.e., when the statute of limitations will expire, ensuring time lines are met by AG's Office for filing accusations, setting hearings, etc. and ensuring decisions are acted upon timely).	25 minutes

Options for Combining Modules into Training Blocks of 1-2 hours in length

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HQES: The role of the DAG when a case is referred for investigation – What does a lead prosecutor do?	20 minutes

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