MEDICAL BOARD OF CALIFORNIA

EXECUTIVE COMMITTEE MEETING AGENDA

MEMBERS OF THE EXECUTIVE COMMITTEE
Sharon Levine, M.D., President
David Serrano Sewell, J.D., Vice President
Silvia Diego, M.D., Secretary
Dev GnanaDev, M.D.
Barbara Yaroslavsky, Past President

Historic Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501

Wednesday, October 23, 2013

2:00 pm – 4:00 pm
(or until the completion of business)

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

While the Board intends to webcast this meeting, it may not be possible to webcast the entire open meeting due to limitations on resources.

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. Public Comment of 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 §§11125, 11125.7(a)]

3. Approval of Minutes from April 5, 2013 Meeting

4. Discussion on and Approval of Revisions to the Strategic Plan, Goals and Objectives – Dr. Levine/Mr. Roy

5. Adjournment

The mission of the Medical Board of California is to protect health care consumers through the proper licensing and regulation of physicians and surgeons and certain allied health care 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.

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 Lisa Toof at (916) 263-2389 or email lisa.toof@mbc.ca.gov or send a written request to Lisa Toof at the Medical Board of California, 2005 Evergreen Street, Ste. 1200, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meeting 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.
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For additional information, call (916) 263-2389.

MEDICAL BOARD OF CALIFORNIA
Executive Office

MEDICAL BOARD OF CALIFORNIA
Executive Committee
Medical Board of California
2005 Evergreen Street
Lake Tahoe Conference Room
Sacramento, CA 95815

April 5, 2013
MINUTES

Agenda Item 1 **Call to Order/Roll Call**
The Executive Committee of the Medical Board of California was called to order by the Dr. Levine at 1:30 p.m.. A quorum was present and notice had been sent to interested parties.

Committee Members Present:
Sharon Levine, M.D., President
Silvia Diego, M.D
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D., Vice President
Barbara Yaroslavsky

Committee Members Absent:
Reginald Low, M.D.

Staff Present:
Gloria Castro, Attorney General's Office
Dianne Dobbs, Department of Consumer Affairs' Legal Counsel
Kurt Heppler, Staff Counsel
Cassandra Hockenson, Public Affairs Manager
Kimberly Kirchmeyer, Deputy Director
Regina Rao, Business Services Analyst
Kevin Schunke, Outreach Manager
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
See Vang, Business Services Assistant
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:
Frank Cuny, California Citizens for Health Freedom
Victoria Edwards, California Citizens for Health Freedom
GV Ayers, Senate Business and Professions Committee

Agenda Item 2 **Public Comment on Items Not on the Agenda**

No Public Comments were heard on this agenda item.

Agenda Item 3 **Approval of Minutes from January 31, 2013 Meeting**

Dr. Levine asked for a motion for approval of January 31, 2013 meeting minutes. Ms. Yaroslavsky made a motion to approve minutes; s/Salomonson. Motion Carried.

Agenda Item 4 **Consideration of 2013 Legislation**

Ms. Simoes directed the Committee members to refer to their packets as she discussed the following Legislative Bills:

AB 154 (Atkins)
This bill would eliminate the distinction in existing law between "surgical" and "nonsurgical" abortions and would allow physician assistants (PA's), nurse practitioners (NP's), and certified nurse-midwives (CNM's to perform an abortion by medication or aspiration techniques tint he first trimmest of pregnancy, if specified training is completed and clinical competency if validated. The sponsors of this bill believe that increasing the number of providers for aspiration abortions will increase the ability of women to receive safe reproductive health care from providers in their community. Staff suggested the Committee recommend that the Board take a "Neutral" position on this bill. Ms. Simoes asked for a motion.

Dr. Salomonson made a motion to recommend that the Board take a "neutral" position; s/Yaroslavsky. Motion Carried.

AB 635 (Ammiano)
This bill would amend the civil code to allow a licensed health care provider that is authorized by law to prescribe an opioid antagonist, to prescribe and subsequently dispense or distribute an opioid antagonist to a person at risk of on opioid-related overdose or a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose. This bill would allow the licensed health care provide to issue standing orders for the administration of the opioid antagonist. This bill would specify that if health care provider or person who possesses, distributes, or administers an opioid antagonist pursuant to a prescription or order acts with reasonable care, they shall not be subject to professional review, be found liable in a civil action, or be subject to criminal prosecution for issuing a prescription or order or possessing, distributing, or administering the opioid antagonist.

Existing law (SB 797 (Ridley-Thomas, Chapter 477, Statutes of 2007)) established a three-year overdose prevention pilot project in 2008. The pilot granted immunity from civil and criminal penalties to licensed health care providers in seven counties (Alameda, Fresno, Humboldt, Los Angeles, Mendocino, San Francisco, and Santa Cruz) who worked with opioid overdose prevention and treatment training programs, if the provider acted with reasonable care when prescribing, dispensing, or distributing naloxone. The pilot was extended in 2010 and extended liability protection to third party administrators of naloxone. This pilot is now scheduled to sunset on January 1, 2016.

Of note, language in existing law for the pilot project only provides civil and criminal liability, it does not exclude health care providers from "professional review". Board staff is unsure of what the reasoning behind including professional review is, and would like to work with the author's office on this point and bring this bill back to the Board at the April Board Meeting. However, this bill will help to further the Board's mission of consumer protection.
Staff is suggesting that the Committee recommend that the Board support this bill in concept, and staff will continue to work with the author's office. Ms. Simoes asked for a motion.

Ms. Yaroslavsky made a motion to recommend that the Board take a "support in concept" position: s/Dr. Salomonson. Motion Carried.

AB 831 (Bloom)
This bill would require the California Health and Human Services Agency (CHHS) to convene a temporary working group to develop a plan to reduce the rate of fatal drug overdoses in California. The bill would allow experts and staff from the Office of Emergency Services, State Department of Alcohol and Drug Programs, State Department of Public Health, Office of AIDS, and any other staff that the Secretary of CHHS designates may participate in the working group. This bill would also allow staff from the Medical Board of California (Board) and the Board of Pharmacy to participate for the purpose of identifying promising practices to reduce accidental drug overdose among patients and other at-risk groups. This bill would require the working group to make recommendations to the Chair of the Senate Committee on Health and the Chair of the Assembly Committee on Health on or before January 1, 2015. This bill would sunset the working group on January 1, 2016.

This bill would appropriate $500,000 from the General Fund for fiscal year 2014/15 and in later years if included in CHHS' budget. This bill would require CHHS to make grants to local agencies from the $500,000 appropriation for the following purposes:

- Drug overdose prevention, recognition, and response education projects (in jails, prisons, drug treatment centers, syringe exchange programs, clinics, and other organizations that work with or have access to drug users, their families, and communities).
- Drug overdose prevention, recognition, and response training for patients and their families (when the patient is prescribed opiate-based medications for which there is a significant risk of overdose).
- Naloxone hydrochloride prescription or distribution projects.
- Development and implementation of policies and projects to encourage people, (including drug users,) to call the 911 emergency response system when they witness potentially fatal drug overdoses.
- Programs to educate Californians over 65 years of age (about the risks associated with using opiate-based medications, ways to prevent overdose, or how to respond if they witness an overdose.)
- The production and distribution of targeted or mass media materials on drug overdose prevention and response.
- Education and training projects on drug overdose response and treatment for emergency services and law enforcement personnel, (including, but not limited to, volunteer fire and emergency services.)
- Parent, family, and survivor education and mutual support groups, (distributing, or administering the opioid antagonist during an overdose.)

This bill will help to protect consumers and potentially save lives in California, which will further the Board's mission of consumer protection. Staff is suggesting that the Committee recommend that the Board take a support position on this bill. Ms. Simoes asked for a motion.

Ms. Yaroslavsky made a motion to recommend that the Board take a "support" position: s/ Dr. Salomonson. Motion Carried.

AB 916 (Eggman)

This bill would prohibit physicians from using the terms "Board", "certified" or "certification" when advertising unless the terms are used in connection to a specific certifying Board and that Board has been approved by the American Board of Medical Specialties (ABMS), is a Board or association with equivalent requirements approved by the Medical Board of California (Board), or is a Board or association with an Accreditation Council for Graduate Medical Education (ACGME)-approved postgraduate training program that provides complete training in that specialty or subspecialty. This bill does not address the proposal included in the Board's sunset report that would remove the provision in existing law that requires the Board to recognize equivalent Boards or associations.

Existing law prohibits physicians from advertising in public communications that they are "Board certified" unless the Board advertised is a member of ABMS, or the Board or association with equivalent requirements is approved by the Board, or a Board or association with an Accreditation Council for Graduate Medical Education (ACGME) approved postgraduate training program that provides complete training in that specialty or subspecialty.

According to the author's office, there are some physicians misrepresenting themselves and their qualifications by providing misleading statements in public communications. Physicians can imply that they are "Board certified", by using the terms "Board", "certified", or "certification" in their advertising. When these terms are used, it circumvents the prohibition in existing law, because they aren't using the term "Board certified".

This bill clarifies existing law to further protect the public and to ensure that patients better understand the training and qualifications of physicians from whom they are seeking care.

Staff is suggesting that the Committee recommend that the Board take a support position on this bill. Ms. Simoes asked for a motion.

Ms. Yaroslavsky made a motion to recommend that the Board take a "support" position: s/ Dr. Salomonson. Motion Carried.

AB 1000 (Wieckowski)

This bill would allow a physical therapist (PT) to make a "physical therapy diagnosis", defined as a systemic examination process that culminates in assigning a diagnostic label identifying the primary dysfunction toward with physical therapy treatment will be directed, but shall not include a medical diagnosis or a diagnosis of a disease.

This bill would also allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope of a PT and if the following conditions are met:

- If the PT has reason to believe the patient has signs or symptoms of a condition that requires

treatment beyond the scope of practice of a PT, the PT shall refer the patient to a physician, an osteopathic physician, or to a dentist, podiatrist or chiropractor.

- The PT shall disclose to the patient any financial interest in treating the patient.
- The PT shall notify the patient's physician, with the patient's written authorization, that the PT is treating the patient.

This bill would specify that it does not expand or modify the scope of practice of a PT, including the prohibition on a PT to diagnose a disease. This bill would also specify that it does not require a health care service plan or insurer to provide coverage for direct access to treatment by a PT.

This bill changes the scope of practice of a PT by allowing a PT to make a "physical therapy diagnosis" and allowing a PT to treat patients without a referral from a physician. The Board has taken oppose positions in the past on bills that allowed for direct patient access to PT services. The Board was opposed to these bills because they expanded the scope of practice for PT's by allowing them to see patients directly, without having the patients first seen by a physician, which puts patients at risk. A patient's condition cannot be accurately determined without first being examined by a physician, as PTs are not trained to make these comprehensive assessments and diagnoses. Staff is suggesting that the Committee recommend that the Board oppose this bill. Ms. Simoes asked for a motion.

Public Comment was heard on this agenda item.

Victoria Edwards spoke as a physical therapist for that past 34 years and said the term diagnosis should not be used. She never "diagnoses", she uses "suggests" or "recommends" to her patients.

Dr. Salomonson made a motion to recommend that the Board take an "oppose" position: s/Dr. Levine. After discussion among Committee Members, Dr. Salomonson withdrew the motion to take an "oppose" position; Dr. Levine also withdrew her second on that motion.
Dr. Levine deferred this bill and issue to the full Board for further discussion. No position was taken at this time.

AB 1278 (Hueso)
This bill would allow a physician to prescribe integrative cancer treatment, under specified circumstances. Current law (HSC 109300) restricts cancer therapy exclusively to conventional drugs, surgery, and radiation (those approved by the Food and Drug Administration).

This bill would define integrative cancer treatment as the use of a combination of evidence-based substances or therapies for the purpose of reducing the size of cancer, slowing the progression of cancer, or improving the quality of life of a patient with cancer. This bill would specify that a treatment meets the evidence-based medical standard if the methods of treatment are recognized by the Physician's Data Query of the National Cancer Institute; or if the methods of treatment have been reported in at least three peer reviewed articles published in complementary and alternative medicine journals to reduce the size of cancer, slow the progression of cancer, or improve the quality of life of a patient with cancer; or if the methods have been published in at least three peer-reviewed scientific medical journals.

This bill would prohibit a physician from recommending or prescribing integrative cancer treatment, unless specified informed consent is given; the treatment meets the evidence –based medical standard; the physician complies with the patient reevaluation requirements; and the physician complies with the standards of care for integrative cancer treatment.

In order to comply with the informed consent requirements, the physician must have the patient sign a form that either includes the contact information for the physician who is providing the patient conventional care, or that the patient has declined to be under the care of an oncologist or other physician providing conventional cancer care. The form must also include a statement that says the type of care the patient is receiving or that is being recommended is not the standard of care for treating cancer in California; that the standard of care for treating cancer in California consists of radiation, chemotherapy, and surgery; that the treatment the physician will be prescribing or recommending is not approved by the federal Food and Drug Administration for the treatment of cancer; that the care that the patient will be receiving or is being recommended is not mutually exclusive of the patient receiving conventional cancer treatment. The form must also include specified written statements.

This bill would require a physician prescribing integrative cancer treatment to comply with patient reevaluation requirements:

- The patient must be informed of the measurable results achieved (within an established timeframe and at regular and appropriate intervals during the treatment plan.)
- The physician must reevaluate the treatment when progress stalls or reverses (in the opinion of the physician or the patient, or as evidenced by objective evaluations.)
- The patient must be informed about and agree to any proposed changes in treatment, (including but not limited to, the risks and benefits of the proposed changes, the costs associated, and the timeframe in which the proposed changes will be reevaluated.)

This bill would also set forth the standards of care in prescribing integrative cancer treatment that the physician must comply with, as follows:

- The physician must provide the patient information regarding the treatment prescribed, (including its usefulness in treating cancer; a timeframe and plan for reevaluation the treatment using standard and conventional means in order to assess treatment efficacy; and a cost estimate for the prescribed treatment.)
- The physician must make a good faith effort to obtain all relevant charts, records and laboratory results relating to the patient's conventional cancer care, prior to prescribing or changing treatment.
- At the request of the patient, the physician must make a good faith effort to coordinate the patient's care with the physician providing conventional cancer care to the patient.
- At the request of the patient, the physician must provide a synopsis of any treatment rendered to the physician providing conventional cancer care to the patient, (including subjective and objective assessment of the patient's state of health and response to the treatment.)

This bill would specify that failure to comply with this bill's provisions would constitute unprofessional conduct and cause for discipline by that individual's licensing entity.

According to the author, integrative cancer treatment gives consumers options for care and helps patients cope with the common side effects of chemotherapy and radiation. The author believes this bill will provide cancer patients with more options to complement conventional therapy. Staff is suggesting that the Committee recommend that the Board take a neutral position on this bill. Ms. Simoes asked for a motion.

Public Comment was heard on this agenda item.

Frank Cuny, Director of California Citizens for Health Freedom stated that this bill is strictly for physicians but that it opens up the door for physicians who work with health products that are in the health field, such as herbs and nutritional supplements, to be able to be utilized. There has been a whole range of research done in that area that shows deep benefits for this. It allows patients to move away from a harsh approach to an easier and much healthier approach.

Ms. Yaroslavsky made a motion to recommend that the Board take a "neutral" position: s/Ms. Schipske. Motion Carried.

AB 1308 (Bonilla)

This bill would allow a licensed midwife (LM) to directly obtain supplies, order testing, and receive reports that are necessary to the LM's practice of midwifery and consistent with the scope for practice for a LM. This bill would also require the Medical Board of California (Board) to adopt regulations by July 1, 2015 defining the appropriate standard of care and level of supervisions required for the practice of midwifery and identifying complications necessitating referral to a physician. This bill would require a LM to disclose in oral and written form to a prospective client the specific arrangement for the referral of complications to a physician and surgeon.

Although required by law, physician supervision is essentially unavailable to LMs performing home births, as California physicians are generally prohibited by their malpractice insurance companies from providing supervision of LMs who perform home births. The physician supervision requirement creates numerous barriers to care, in that if the LM needs to transfer a patient/baby to the hospital, many hospitals will not accept a patient transfer from a LM as the primary provider who does not have a supervising physician. California is currently the only state that requires physician supervision of LMs. Among states that regulate midwives, most require some sort of collaboration between the midwife and a physician.

LMs also have difficulty securing diagnostic lab accounts, even though they are legally allowed to have lab accounts. Many labs require proof of physician supervision. In addition, LMs are not able to obtain the medical supplies they have been trained and are expected to use; oxygen and medical supplies that are included in approved licensed midwifery school curriculum (CCR section 1379.30). The inability for a licensed midwife to order lab tests often means the patient will not obtain the necessary tests to help the midwife monitor the patient during pregnancy. In addition, not being able to obtain the necessary medical supplies for the practice of midwifery adds additional risk to the LMs patient and child.

The Board, through the Midwifery Advisory Council (MAC) has held many meetings regarding physician supervision of licensed midwives and has attempted to create regulations to address this issue. The concepts of collaboration, such as required consultation, referral, transfer of care, and physician liability have been discussed among the interested parties with little success. There is disagreement over the appropriate level of physician supervision. MAC has also held meetings regarding the lab order and medical supplies/medication issues and has attempted to create regulatory language to address this issue. However, based upon discussions with interested parties, it appears that both issues will need to be addressed through the legislative process.

This bill would address one of the barriers of care by allowing a LM to directly obtain supplies, order testing and receive reports necessary to the LM's practice of midwifery, which would help to ensure consumer protection. This bill would also require the Board to adopt regulations to address physician supervision and to identify complications necessitating referral to a physician; however, the Board has been

unsuccessful in endeavors to adopt regulations regarding physician supervision in the past. Board staff will continue to work with the author's office and sponsors on language that will help to solve the issue of physician supervision and remove barriers to care, while at the same time help to ensure consumer protection. Board staff is suggesting that the Committee recommend that the Board support this bill if it is amended to better clarify what the supervision requirements should be in statute, versus in regulation.

Frank Cuny, Director of California Citizens for Health Freedom, said he salutes the Board for creating the advisory committee and suggested that when talking about supplies, that it be put in the bill that LM's can use medications or supplies that are within their scope of practice.

Ms. Yaroslavsky made a motion to recommend that the Board take a "support if amended" position: s/Ms. Schipske. Motion Carried.

SB 352 (Pavley)

This bill would allow a physician assistants (PAs), nurse practitioner (NPs) and nurse-midwives (NMs) to supervise medical assistants (MAs).

MAs are unlicensed personnel trained to perform basic administrative, clerical, and technical support services in a medical office or clinical setting. These services include, but are not limited to, taking blood pressure, charting height and weight, administering medication, performing skin tests, and withdrawing blood by venipuncture. The Bureau of Labor and Statistics (2011) reports nearly 82,000 MAs are employed in California.

Currently, a physician must be present in the practice site to supervise an MA in most settings. PAs and NPs can currently supervise MAs in licensed community and free clinics. If a physician is not present, MAs are limited to performing administrative and clerical duties and cannot perform or assist with simple technical supportive services if the physician is not on the premises, except in community and free clinics.

According to the sponsors, physicians have been delegating the task of supervising MAs when the physician is not in the office for over a decade in community clinics and the Physician Assistant Board and the Department of Consumer Affairs have not reported any patient safety issues or disciplinary action related to PA supervision of MAs.

With the health care reform being implemented in 2014, this bill may help to accommodate the expected increase in patients, as well as help to ensure that MAs are being supervised while a physician is not physically present in the office. Given that PAs, NPs, and NMs are currently allowed to supervise MAs in some settings now, and that this authority would have to be delegated by the physician, it makes sense for this to be allowed in all settings. However, existing law (BPC 2264) prohibits physicians from aiding and abetting unlicensed individuals from engaging in the practice of medicine. Board staff suggests that this bill be amended to include language to ensure that if a PA, NP, or NM were to allow the MA to perform tasks that are not in the approved scope of responsibility, that the PA, NP, or NM would be held responsible and subject to discipline by their licensing Board. Staff suggests that the Committee recommend that the Board take a neutral if amended position on this bill. Ms. Simoes asked for a motion.

Ms. Yaroslavsky made a motion to recommend that the Board take a "neutral if amended" position: s/Ms. Schipske. Dr. Salomonson questioned why the staff is not asked for a "support, if amended" position. Ms. Simoes stated that the reason is because the Medical Board does not oversee NP's, MA's or PA's which is why staff suggested a "neutral, if amended" position. Dr. Salomonson stated that

indirectly we do oversee the NP's, MA's and PA's, since they work directly with Physicians.

Ms. Yaroslavsky changed her motion to a "support, if amended" with clarity on the amendment. Ms. Simoes stated that the amendment would be what is similar in law for what Physicians are liable for. Motion Carried.

SB 809 (DeSaulnier and Steinberg)

This bill would establish the CURES Fund that would be funded by an annual 1.16% licensing, certification and renewal fee increase for licensees of Boards that are authorized to prescribe or dispense Schedule II, III, or IV controlled substances. (Medical Board of California; Dental Board of California; Board of Pharmacy (including wholesalers non-resident wholesalers, and veterinary food-animal drug retailers); Veterinary Medical Board; Board of Registered Nursing; Physician Assistant Board; Osteopathic Medical Board of California; State Board of Optometry; and the California Board of Podiatric Medicine.) This bill would make the money in the CURES Fund available for allocation to DOJ, upon appropriation by the Legislature, for the purposes of funding the CURES Program. This bill would specify that the fee increase shall not exceed the reasonable costs associated with maintaining CURES.

The 1.16% annual fee would result in an increase of $18 for physician renewal fees ($9 each year of the two-year renewal cycle), and a $9 initial licensing fee increase.

This bill would impose an unspecified one-time tax on health insurers for the purposes of upgrading the CURES system. This bill would impose an unspecified on-going tax on manufacturers of controlled substances for the purposes of creating and maintaining a new enforcement team in DOJ, which would focus on prescription diversion and abuse and criminal activity associated with bringing large quantities of illegal prescription drugs into California. The team would coordinate with state, federal and local law enforcement entities, and work with the various health care Boards and departments to conduct investigations based on CURES data and intelligence.

Once CURES is funded, upgraded, and able to handle inquiries from all eligible prescribers and dispensers in California, this bill would require DOJ to notify all prescribers and dispensers who have submitted applications to CURES that they are capable of accommodating this workload. DOJ would also be required to notify the Legislature and post the notification on DOJ's Web site. Once DOJ issues this notification, all prescribers and dispensers eligible to prescribe and dispense Schedule II, III, and IV controlled substances would be required to access and consult the electronic history of controlled substances dispensed to a patient under his or her care, prior to prescribing or dispensing a Schedule II, III, or IV controlled substance.

This bill contains an urgency clause, which means it would take effect immediately once signed into law by the Governor.

Board staff has a concern in relation to the collection of the renewal fee. There needs to be an implementation schedule included, as the Board sends out renewal notices 90 days in advance and would need to give licensees appropriate notice of the renewal fee increase. Board staff is also suggesting the fee increase not be an annual fee increase, but be a 1.16% increase on licensing and renewals. This bill requires physicians to utilize CURES prior to prescribing Schedule II, III, and IV controlled substances once DOJ has provided notice that the system is capable; however, there is no penalty associated if a physician does not comply. Requiring a physician to utilize CURES each time they prescribe a Schedule

II, III, or IV controlled substance and also requiring the pharmacist to utilize CURES before they dispense that same prescription, may be overly excessive. In addition, placing a tax on manufacturers to support a new enforcement team in DOJ may be premature, as CURES will not be upgraded for some time.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping". Although the Board currently helps to fund CURES at a cost of $150,000 this year, these funds cannot be used for staffing. The Board is aware of the issues DOJ is facing related to insufficient staffing and funding for CURES/PDMP, and due to the importance of this program, staff is suggesting that the Board support any effort to get CURES more fully funded in order for the PDMP to be at optimum operating capacity. Board staff suggests that the Committee recommend that the Board take a Support in Concept position, as this bill is still a work in progress, with the following noted concerns:

- Fee increase for renewals should be biennial versus annual.
- An implementation schedule for the fee increase should be addressed, as it is impossible to implement on the day the bill is signed.
- The requirement for use of CURES should include a minimum penalty if it is not used (cite/fine).
- DOJ enforcement team should not be funded until CURES system is fully operational and upgraded.

Ms. Simoes asked for a motion.

Public Comment was heard on this agenda item.

Long Do, California Medical Association (CMA) commented that the CMA's views are very similar to what has been expressed at today's meeting. This bill is aimed at a very important problem and they have some concerns to share with the Board. The CMA shuns abusive overprescribing of schedule two, three and four controlled substances or the diversion of such prescription drugs The CMA has been and continues to be in support of the CURES program as it can be an effective tool for enforcement, regulators, licensing Boards and the physician community to address the abuse of overprescribing. The CMA has some concerns that this bill may carry some unintended consequences that could impede the appropriate practice of medicine. Depending on how CURES is set up and operates, it may create undue burdens for its users. It must be adequately funded and staffed. They believe that tax revenue that is collected from drug manufacturers and from health insurers is the most appropriate funding source because the CURES program adheres to the benefit of the public.

Ms. Yaroslavsky made a motion to recommend that the Board take a "support in concept" position: s/Ms. Schipske. Ms. Schipske stated that she agrees with the "support in concept", however doesn't feel that the physician should take the brunt of the cost. She recommends that the pharmaceutical companies cover the costs of this system. Dr. Levine recommended that the cost be a flat dollar amount, not a percentage. She also stated that she would like to see a way to deem prescribers that are already authenticated through a secure electronic health system so that once a patients name is entered into the system, CURES will automatically pull up a patient activity report, not requiring an enrollment as long as the authentication is current in the system that connects to CURES. Motion Carried.

Agenda Item 5 **Review and Consideration of Revisions to the Board Member Administrative Procedure Manual**

Ms. Kirchmeyer reported that at the last Committee meeting held on January 31st, the Committee approved the recommended edits and requested further edits in the section on the role of the Board Officers, Committee Chair and Panel Officers. All of those edits have been made and incorporated into the manual that is currently in front of the members. The members had also requested edits be made in regards to written comments to the Board, meetings requested with members by interested parties, and procedures for members when contacted by the media. Board staff also added in a section on process for members to follow when they are served with a lawsuit. Mr. Heppler asked that if a Board Member is served with a lawsuit directly to go ahead and accept it and let the Medical Board staff know right away. Mr. Heppler also stated that if a Board Member get a media call, to please refer that call directly to the Medical Board Public Information Officer.

Ms. Kirchmeyer asked for a motion to accept the current edits.

Dr. Salomonson made a motion to accept the edits: s/???. Motion Carried.

Agenda Item 6 **Update of Strategic Plan**

Ms. Kirchmeyer gave an update on the strategic plan. She presented a chart that has been color coded to indicate the status of each activity within each objective. In addition to the color coding, each objective has been updated to indicate the status or completion of the activity. All activities are now included in this newest document. The Chiefs of Licensing, Enforcement and Legislation will continue to give updates during their Committee Meetings or updates where the items they are discussing tie to the objectives of the strategic plan, so the members will know that the items are being completed. The staff will continue to provide updates at each Committee meeting with the progress of such items.

Agenda Item 7 **Update on Sunset Review Hearing**

Dr. Levine stated that the Legislature has a great deal of interest in the Medical Board of California, which was evidenced by a full hearing room of members of the public as well as staff. Their questions were thoughtful, probing and not easy and staff is in the process of preparing responses to all of the issues raised at the hearing. Ms. Yaroslavsky suggested giving each Board member a copy of the questions and answers that the hearing brought up. Ms. Kirchmeyer stated that the Members were sent the questions prior to the hearing. The responses have been prepared and will be provided to the Members after Dr. Levine has reviewed and finalized them.

Ms. Kirchmeyer reported that as Ms. Simoes had stated earlier, the Sunset Bill has been introduced and the staff awaits the language that has been provided to the Business and Professions Committee on March 5, 2103 on all of our issues.

Dr. Levine announced that there will be an Executive Committee meeting scheduled for the morning of April 25th prior to the Panel Meetings to begin the process of the Executive Director's annual evaluation. Ms. Schipske and Dr. Levin will review the form that was used last year as well as the one sent out by DCA this year to see if modifications need to be made. The updated form will be distributed to all Committee Members prior to the April 25th meeting asking members to take a look at it and fill it out for

discussion on April 25th meeting. Between the April 25th Meeting and the July Meeting, the Board will ask Ms. Whitney to come up with some goals for the next year and then meet again in Executive Committee meeting in July to finalize the evaluation and complete the process.

Agenda Item 8 **Adjournment**

Dr. Levine asked for a motion to adjourn the meeting. Ms. Yaroslavsky made a motion to adjourn the meeting. Meeting adjourned at 2:45p.m.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 10, 2013
ATTENTION: Members, Executive Committee
SUBJECT: Strategic Plan Revisions
STAFF CONTACT: Kimberly Kirchmeyer, Interim Executive Director

RECOMMENDED ACTION:

Review and approve recommended changes to revise the Board's 2012 Strategic Plan.

BACKGROUND AND ANALYSIS:

The Board's Organizational Effectiveness Committee (Committee) has revised the Strategic Plan due to the Board's need to incorporate issues from the Sunset Review Report and to bring it in line with the direction of the Board.

Board staff and the Department of Consumer Affairs' Solid Planning Solutions team have been working with the Committee to create a strategic plan which accurately reflects the Board's future goals and objectives.

Two versions of the recommended changes to revise the Board's Strategic Plan are attached. The first version has the recommended changes incorporated into a final document. The second version has the recommended changes with text strike-outs for deletions and text underlined in red for additions.

Please note that all activities for each objective have been removed. After the full Board approves the revisions to the goals and objectives, Board staff and the Solid team will develop activities for each objective. The Strategic Plan will be brought to the Board at the February Board meeting for review of the entire plan and approval.

<u>Goal 1: Professional Qualifications</u>: Promote the professional qualifications of medical practitioners by setting requirements for licensure and relicensure, including education, experience, and demonstrated competence.

Objective 1.X
Examine the Federation of State Medical Boards' (FSMB) Maintenance of Licensure and the American Board of Medical Specialties' (ABMS) Maintenance of Certification initiatives to determine if changes are needed to existing requirements (continuing medical education) in order to ensure maintenance of competency of California physicians.

Objective 1.3: Define what is necessary to promote safe re-entry into medical practice after extended absences, including looking at the difference between the licensure requirement of re-entry (5 years) and the disciplinary re-entry (18 months).

<u>Goal 2: Regulations and enforcement</u>: Protect the public by effectively enforcing laws and standards.

Objective 2.5: Study disciplinary and administrative cases, including looking at physicians in training, to identify trends or issues that may signal dangerous practices or risks.

Objective 2.6: Examine the Expert Reviewer Program and policies to determine how it may be improved, including recruitment, evaluation of experts, opportunities for education, and policies governing the Board's use of experts.

Objective 2.7: Partner with the Office of Administrative Hearings (OAH) and Health Quality Enforcement Section (HQES) of the Attorney General's (AG) office to identify opportunities, and design curriculum, for the ongoing education of judges.

Objective 2.8: Review the laws and regulations pertaining to the Board's responsibility to regulate outpatient surgery centers and, if necessary, suggest amendments.

Objective 2.9: Determine whether the Registered Dispensing Optician Program should remain within the authority of the Board.

Objective 2.10: Identify methods of ensuring the Board is receiving the required reports pursuant to Business and Professions Code section 805.

<u>Goal 3: Consumer and Licensee Education</u>: Increase Public and Licensee awareness of the Board, its mission, activities and services.

Objective 3.X: Expand all outreach efforts to educate physicians, medical students, and the public, regarding the Board's laws, regulations, and responsibilities.

Objective 3.X: Establish a proactive approach in communicating via the media, and other various publications, to inform and educate the public, including California's ethnic communities, regarding the Board's role in protecting consumers through its programs and disciplinary actions.

Objective 3.7: Examine opportunities for the Board to provide training to licensees via the internet, including hosting webinars on subjects of importance to public protection and public health.

Objective 3.8: Establish a method of holding public seminars taught by legal or enforcement personnel on disciplinary cases, the laws violated, and other issues of importance to the profession and public.

Objective 3.X: Review the Board's public disclosure laws regarding posting postgraduate information and the 10-year retention of disciplinary information/documents.

<u>Goal 4: Organizational Relationships</u>: Build relationships with related organizations to further the Board's mission and goals.

Objective 4.1: Build relationships with elected officials and their staffs. Build and strengthen collaborative relationships to work toward shared interests in consumer protection and advancing the profession.

Objective 4.3: Optimize relationships with the accreditation agencies, associations representing hospitals and medical groups, professional associations and societies, the Federation of State Medical Boards, Federal government agencies, and other state agencies, including Department of Consumer Affairs and Business, Consumer Services and Housing Agency.

Objective 4.4: Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs.

<u>Goal 5: Organizational Effectiveness</u>: Evaluate and enhance organizational effectiveness and systems to improve service.

Objective 5.1: Licensing applications to be reviewed within 45 days.

Objective 5.2: Reduce discipline, complaint processing, and investigation timelines by 10-20%; reduce complaint processing average to less than 70 days, with 50-60% less than 50 days.

Objective 5.4: Conduct a review every two years of each of the Committees established by the Board to determine if they are still needed, if they are fulfilling the purpose ~~of~~ for which they were established, and determine if they should continue, be reconfigured, or eliminated.

Objective 5.6: Establish a consistent approach to educating staff about the Board's activities and priorities set by Board Members, including, but not limited to, facilitating staff attendance at meetings.

Objective 5.8: Establish a method of obtaining feedback from users about Board services.

Goal 6: Access to Care, Workforce, and Public Health: Understanding the implications of Health Care Reform and evaluating how it may impact access to care and issues surrounding healthcare delivery, as well as promoting public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.

Objective 6.1: Educate the Board on the Affordable Care Act and how it ~~may~~ will impact physician practice, workforce, and utilization of allied healthcare professionals.

***Goal 1: Professional Qualifications*: Promote the professional qualifications of medical practitioners by setting requirements for licensure and relicensure, including education, experience, and ~~examination.~~ demonstrated competence.**

Objective 1.X
Examine the Federation of State Medical Boards' (FSMB) Maintenance of Licensure and the American Board of Medical Specialties' (ABMS) Maintenance of Certification initiatives to determine if changes are needed to existing requirements (continuing medical education) in order to ensure maintenance of competency of California physicians.

~~**Objective 1.1: Examine current continuing medical education (CME) structure, its effectiveness, the current California requirements, and opportunities for improvement.**~~

~~**Objective 1.2: Examine and identify methods available to the Medical Board to ensure physicians remain current in knowledge and skills.**~~

Objective 1.3: Define what is necessary to promote safe re-entry into medical practice after extended absences, including looking at the difference between the licensure requirement of re-entry (5 years) and the disciplinary re-entry (18 months).

~~**Objective 1.4: The Licensing Committee (or subcommittee) will examine the FSMB Maintenance of Licensure (MOL) and ABMS Maintenance of Certification (MOC) initiatives and study what should be adopted in California, and determine how it can collaborate with the FSMB and ABMS certifying boards.**~~

~~**Objective 1.5: Conduct a comprehensive review of international schools.**~~

~~**Objective 1.6: Conduct a literature review and internal study of the performance of physicians in training and how it may predict later performance in practice. (See objective 2.5)**~~

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.

~~Objective 2.1: Develop a plan to conduct a complete review of all laws and regulations relating to licensing to identify those no longer relevant and what needs to be added or eliminated. Identify requirements that are not necessary to the safety of practice but may be serving as barriers for qualified applicants, as well as simply updating requirements to be congruent with current educational environments. (To be done in conjunction with Objective 2.2)~~

~~Objective 2.2: Develop a plan to conduct a complete review of all laws and regulations relating to enforcement. Identify those laws /regulations that are no longer useful and augment those that are needed for public protection. Identify the Board's regulatory authority for promulgating new regulations and also identify those issues that require legislation. (To be done in conjunction with Objective 2.1)~~

~~Objective 2.3: Conduct a review of the Vertical Enforcement/Prosecution (VEP) model to assure uniform implementation in all offices and identify any aspects of the model that are increasing cost without producing benefits.~~

~~Objective 2.4: Examine complaint handling priorities. Educate Board members on how complaints are prioritized, as well as the legislatively mandated priorities. Determine if there is a need to change the priorities.~~

Objective 2.5: Study disciplinary and administrative cases, including looking at physicians in training, to identify trends or issues that may signal dangerous practices or risks. ~~(Done in conjunction with Objective 1.6)~~

Objective 2.6: Examine the Expert Reviewer Program and policies to determine how it may be improved, including recruitment, evaluation of experts, opportunities for education, and policies governing the Board's use of experts.

Objective 2.7: ~~Identify opportunities to better educate judges/hearing officers.~~ Partner with the Office of Administrative Hearings (OAH) and Health Quality Enforcement Section (HQES) of the Attorney General's (AG) office to identify opportunities, and design curriculum, for the ongoing education of judges.

Objective 2.8: Review the laws and regulations pertaining to ~~Work to clarify~~ the Board's responsibility to regulate outpatient surgery centers~~, and obtain the resources to be effective~~ and, if necessary, suggest amendments.

Objective 2.9: ~~**Examine Board responsibilities that could be eliminated or moved to a more appropriate board, bureau, or program. (Midwives, Registered Dispensing Opticians, Spectacle Lens Dispensers, Research Psychoanalysts, approval of non-ABMS specialty boards, etc.)**~~ **Determine whether the Registered Dispensing Optician Program should remain within the authority of the Board.**

Objective 2.10: ~~**Examine the decline of the number of reports received pursuant to Business and Professions Code section 805 (reporting peer review actions).**~~ **Identify methods of ensuring the Board is receiving the required reports pursuant to Business and Professions Code section 805.**

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.

Objective 3.X: Expand all outreach efforts to educate physicians, medical students, and the public, regarding the Board's laws, regulations, and responsibilities.

Objective 3.X: Establish a proactive approach in communicating via the media, and other various publications, to inform and educate the public, including California's ethnic communities, regarding the Board's role in protecting consumers through its programs and disciplinary actions.

~~**Objective 3.1: Improve and expand professional educational outreach, including outreach to students and new graduates, about the laws and regulations that govern medical practice.**~~

~~**Objective 3.2: Improve public education by expanding current outreach efforts and initiating more outreach programs to educate the public on the board's programs, the rights of patients, and how to file complaints.**~~

~~**Objective 3.3: Identify more effective methods to promote the Expert Review Program to recruit qualified physicians.**~~

~~**Objective 3.4: Establish a more proactive approach in communicating with the media to educate consumers and publicize disciplinary cases and criminal investigations, including those done in cooperation with other agencies.**~~

~~**Objective 3.5: Expand the Newsletter to better inform physicians, medical students, and the public.**~~

~~**Objective 3.6: Expand the Web site capabilities to create a portal to provide intuitive and searchable web experience. Develop more online services and surveys to help improve Board's program (see Objective 3.2)**~~

Objective 3.7: Examine ~~how the~~ opportunities for the Board ~~might~~ to provide training to ~~the profession~~ licensees via the internet, including hosting webinars on subjects of importance to public protection and public health.

Objective 3.8: Establish a method of holding public seminars taught by legal or enforcement personnel on disciplinary cases, the laws violated, and other issues of importance to the profession and public.

~~**Objective 3.9: Conduct outreach to ethnic and other language publications and groups.**~~

Objective 3.X: Review the Board's public disclosure laws regarding posting postgraduate information and the 10-year retention of disciplinary information/documents.

Goal 4: Organizational Relationships: ~~Improve effectiveness of~~ Build relationships with related organizations to further the Board's mission and goals.

Objective 4.1: ~~Improve~~ Build relationships with elected officials and their staffs. Build and strengthen collaborative relationships to work toward ~~common goals – create partnerships on areas of common interests~~ shared interests in consumer protection and advancing the profession.

~~**Objective 4.2: Work with California medical schools and training programs on common needs and goals. Create a better partnership with them on educational issues beyond licensing requirements, such as those relating to professionalism, ethics, unprofessional behavior, etc.**~~

Objective 4.3: ~~Work to establish better~~ Optimize relationships with the accreditation agencies, associations representing hospitals and medical groups, professional associations and societies, the Federation of State Medical Boards, Federal government agencies, and other state agencies, including Department of Consumer Affairs and ~~State and Consumer Services Agency~~ Business, Consumer Services and Housing Agency.

Objective 4.4: Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs.~~ Educate the health care profession not only about the Medical Board, but all the health boards in the Department of Consumer Affairs. Re-establish a speakers' bureau or some other outreach for this purpose.~~

Goal 5: Organizational Effectiveness: Evaluate and enhance organizational effectiveness and systems to improve service.

Objective 5.1: Licensing applications to be reviewed within 45 days.

Objective 5.2: Reduce discipline, complaint processing, and investigation timelines by 10-20%; reduce complaint processing average to less than 70 days, with 50-60% less than 50 days.

~~**Objective 5.3: Conduct a review of all outside agencies' billing (Department of Consumer Affairs, Attorney General, Office of Administrative Hearings, etc.) to identify redundancies, cost savings, and promote efficiency.**~~

Objective 5.4: Conduct a review every two years of ~~all~~ each of the Committees established by the Board to determine if they are still needed, if they are fulfilling the purpose ~~of~~ for which they were established, and determine if they should continue, be reconfigured, or eliminated~~, or be merged with other committees~~.

~~**Objective 5.5: Establish and conduct an annual self-evaluation.**~~

Objective 5.6: Establish a ~~means of better~~ consistent approach to educating staff about the Board's activities and priorities set by ~~the membership~~ Board Members, including, but not limited to, ~~encouraging staff to attend meetings.~~ facilitating staff attendance at meetings.

~~**Objective 5.7: Establish a means of better educating the Board membership about operational activities by providing tours of headquarters, district or regional offices when they are at or near the location for Board meetings.**~~

Objective 5.8: Establish a method of obtaining feedback from ~~our~~ users about Board services.

Goal 6: Access to Care, Workforce, and Public Health: Understanding the implications of Health Care Reform and evaluating how it may impact access to care and issues surrounding healthcare delivery, as well as promoting public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.

Objective 6.1: Educate the Board on the ~~new healthcare reform law~~ Affordable Care Act and how it ~~may~~ will impact physician~~s'~~ practice, workforce ~~(possible shortages)~~, and utilization of allied healthcare professionals.