MEDICAL BOARD OF CALIFORNIA
QUARTERLY BOARD MEETING

Hilton LAX
Los Angeles Room
5711 W. Century Blvd
Los Angeles, CA 90045

Thursday, April 25, 2013

DRAFT MEETING MINUTES

Due to timing for invited guests to provide their presentations, the agenda items below are listed in the order they were presented.

Agenda Item 1 Call to Order/Roll Call

Dr. Levine, M.D. called the meeting of the Medical Board of California (Board) to order on April 25, 2013 at 4:10 pm. A quorum was present and due notice was provided to all interested parties.

Members Present:

Michael Bishop, M.D.
Silvia Diego, M.D., Secretary
Dev GnanaDev, M.D.
Sharon Levine, M.D., President
Reginald Low, M.D.
Denise Pines
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D., Vice President
David Serrano Sewell, J.D.
Barbara Yaroslavsky
Felix Yip, M.D.

Staff Present:

William Boyd, Investigator
Susan Cady, Enforcement Manager
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Christopher Figueroa, Investigator
Jon Genens, Investigator
Dianna Gharibian, Inspector
Kurt Heppler, Staff Counsel
Kimberly Kirchmeyer, Deputy Director
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Verdeena Richardson, Inspector
Marie Russell, M.D., Medical Consultant
Teresa Schaeffer, Associate Analyst

Kevin Schunke, Licensing 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 Analyst
Rachel Wachholz-LaSota, Inspector III
Kerrie Webb, Staff Counsel
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Hilma Balain, Kaiser Permanente
Dr. James Bersot, The Joint Commission
Jessica Biscardi, Cancer Control Society
Jeff Bonenfant, Midwestern University (AZCOM)
Jorge Carreon, M.D., Former Board Member
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Genevieve Clavreul, NRNPA
Alicia Cole, Consumers Union
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Karen Ehrlich, L.M., Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law
Jack French, Consumers Union Safe Patient Project
Joseph Furman, Furman Healthcare Law
Louis Galiano, Department of Consumer Affairs
Lisa Girion, Los Angeles Times
Jennifer Hoppe, The Joint Commission
Dorothea Johnson, Deputy Director, Department of Consumer Affairs
Jeffrey Keys, M.D., American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
Carolyn Kurtz, J.D., General Council and Vice President of Government Affairs, Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)
Christine McElyea, Midwestern University (AZCOM)
Leslie Perea
Deborah Rotenberg, PPAC
Victoria Samper, Institute for Medical Quality
Marni Shear, Midwestern University (AZCOM)
Douglas Shin, Cooperative of American Physicians
Jill Silverman, Institute for Medical Quality
Shannon Smith-Crowley, American Congress of Obstetricians and Gynecologists

Thomas Terranova, MA, Director of Accreditation, American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)
Mary Wei, Assistant Director, Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)

Agenda Item 2 Public Comments on Items not on the Agenda

No public comment was received for this agenda item.

Agenda Item 3 Approval of Meeting Minutes from the January 31-February 1, 2013

Dr. Levine noted that the Board had received an email from Carol Gottstein stating her name had been misspelled in the minutes and asking to have the spelling corrected from Godstein to Gottstein. Also, Ms. D'Angelo Fellmeth asked for a correction to the spelling of the Assembly Member's name on page 10.

Dr. GnanaDev made a motion to approve the meeting minutes with the corrections mentioned above; s/Mr. Serrano Sewell. Motion carried.

Agenda Item 4 Presentations by Approved Accreditation Agencies (pursuant to the relevant section of the Business and Profession Code and Health and Safety Code section 1248)

Mr. Heppler and Mr. Worden gave a detailed background description about how outpatient surgery settings (OSS) originated to supplement the upcoming Power Point presentations on OSS. This report included background history on each of the code sections regarding OSS. These codes include the following: California Business and Professions Code (B&P) sections 2215, 2216 and 2217; California Health and Safety Code (H&S) sections 1248-1248.85; and California Code of Regulations, Title 16, Division 1, (CCR) sections 1313.2 – 1313.6.

Dr. Levine announced there are four different Accreditation Agencies (AA) present that will be giving presentations on their particular agencies.

A. Accreditation Association for Ambulatory Health Care, Inc. (AAAHC)

Dr. Levine introduced Ms. Kurtz and Ms. Wei from the Accreditation Association for Ambulatory Health Care, Inc. (AAAHC). Ms. Kurtz and Ms. Wei stated that they understand the concerns of the Board. They have been accrediting ambulatory health care organizations for almost 35 years and are the largest accreditor of ambulatory health care organizations in the country. They are deemed by CMS to do Medicare Certified ambulatory surgery centers (ASC). They are recognized in every state that mandates accreditation for both licensed ASCs as well as office based surgery centers. Ms. Kurtz gave a presentation on the agency's mission, objectives, how to apply to their agency, and the process taken when on site while conducting their survey. They discussed how the surveyor reports are submitted and reviewed and the steps they take to be certain that the organizations maintain compliance with their agency standards as they change from year to year.

B. American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF)

Dr. Levine introduced Mr. Terranova, MA, Director of Accreditation & Dr. Keys, President of Board of Directors for the American Association for Accreditation of Ambulatory Surgery Facilities, Inc. (AAAASF). Mr. Terranova gave a presentation on their agency's mission, brief background history and goals. Mr. Terranova discussed their processes and procedures for accreditation approval, the ten areas of inspection, and their Inspector Training Program. Dr. Keys then discussed their peer review system, patient safety initiatives and statistics, and the ten most found common deficiencies. They accredit approximately 282 facilities.

C. Institute for Medical Quality (IMQ)

Dr. Levine introduced Ms. Samper and Ms. Silverman from the Institute for Medical Quality (IMQ). An overview presentation was given on their agency standards and types of facilities they accredit. They discussed their different types of surveys and the survey process as well as their surveyor training requirements and qualifications. Their accreditation decision process and facility notifications and reports were also discussed.

D. The Joint Commission

Dr. Levine introduced Dr. Bersot, Ambulatory Care Surveyor, and Ms. Hoppe, MPH, Senior Associate Director, State and External Relations. Ms. Hoppe gave a presentation in regards to the overview of the Joint Commission, their accreditation requirements, their mission and vision, their standards and onsite survey process, the post survey activities as well as the complaint process. They accredit approximately 160 facilities.

Public comment was received on this agenda item.

Alicia Cole expressed her concerns about accrediting agencies. She participated in several surveys during her two month hospital stay and her biggest concerns are patient protection and patient information. She feels that the data gathered from these surveys should be useful to the public. The rating of the hospital she was in never changed by their accrediting agency. During that time period and for two years, this hospital was cited at the highest level of infection control problems with the Department of Public Health that the law can allow. For two years consistently, they were cited for infection control and for not adhering to their own policies and procedures. This hospital almost lost their Medicare funding which is 40% of their income and during this same time, they still remained a stellar rated hospital with the accrediting agency. They had to hire an attorney to help them with a plan of correction. In addition to almost losing their Medicare funding, they had an "F" rating with the Better Business Bureau. She feels these accrediting agencies should keep tabs with other Governmental Agencies regularly and not just pay attention to the survey results.

Dr. Levine announced that she wanted to recognize a prior Board member that served from 2008 to 2012; Jorge Carreon, M.D.. He served on the Board's Access to Care Committee, the Wellness Committee, the Education Committee, and took a leading role in the Board's cultural/linguistic access standards. He was elected Board Secretary at the July 2012 meeting. She presented him with an award of recognition.

Dr. Carreon thanked the Board and expressed his appreciation for the dedicated people he worked with on the Board.

Agenda Item 5 Closed Session

Ms. Yaroslavsky made a motion to move into closed session and then recess until Friday morning at 9:00 a.m. Motion carried.

The open meeting ended at 6:25 pm and went into closed session.

Closed session adjourned at 6:45 pm.

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Friday, April 26, 2013

Members Present:

Michael Bishop, M.D.
Silvia Diego, M.D., Secretary
Dev GnanaDev, M.D.
Sharon Levine, M.D., President
Reginald Low, M.D.
Denise Pines
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D., Vice President
David Serrano Sewell, J.D.
Barbara Yaroslavsky
Felix Yip, M.D.

Staff Present:

Susan Cady, Enforcement Manager
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Kurt Heppler, Staff Counsel
Robin Hollis, Investigator
Kimberly Kirchmeyer, Deputy Director
Albert Medina, Investigator
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation
Jack Sun, Investigator
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
See Vang, Business Services Analyst

Kerrie Webb, Staff Council
Linda Whitney, Executive Director
Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Hilma Balain, Kaiser Permanente
Robert McKim Bell, Deputy Attorney General, Attorney General's Office
Jessica Biscardi, Cancer Control Society
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Genevieve Clavreul, NRNPA
Alicia Cole, Consumers Union
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Karen Ehrlich, L.M., Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law
Jack French, Consumers Union Safe Patient Project
Joseph Furman, Furman Healthcare Law
Louis Galiano, Department of Consumer Affairs
Lisa Girion, Los Angeles Times
Steve Gray, California Society of Health System Pharmacists
Dorothea Johnson, Deputy Director, Department of Consumer Affairs
Leslie Perea
Deborah Rotenberg, PPAC
Michael Roth, Attorney
Douglas Shin, Cooperative of American Physicians
Shannon Smith-Crowley, American Congress of Obstetricians and Gynecologists
Carrie Sparrevohn, L.M., Midwifery Advisory Council
Brian Warren, California Pharmacists Association

Agenda Item 6 Call to Order /Roll Call

Dr. Levine, M.D. called the meeting of the Medical Board of California (Board) to order on April 26, 2013 at 9:10 am. A quorum was present and due notice was provided to all interested parties.

Agenda item 7 Public Comments on Items not on the Agenda

Michael Roth, introduced himself as an attorney on arbitration and mediation of health care matters. Mr. Roth asked the Board to consider adopting a policy of possibly encouraging mediation of peer review disputes before situations get too out of hand, to avoid physicians and surgeons going to hearing, which can take months or years to complete and at quite an expense.

Genevieve Clavreul suggested an item for a future agenda. With the shortage of physicians, it has been discussed to replace physicians with nurses. She feels that if nurse practitioners assume some functions,

then you need to define the way the two interact with each other, and designing something more precise so there is less misunderstanding between the two professionals.

Agenda Item 21 Update on Outpatient Surgery Centers Programs

Mr. Worden gave a brief update on several items:

- How the Board is making it easier to locate an OSS on its Web site.
- The Outpatient Surgery Accreditation Agencies' renewals have been sent out.
- The Accreditation Agencies have been sending in additional information. However, all Accreditation Agencies are missing some information.
- Board staff is working on providing each Accreditation Agency (AA) with a list of specific missing data.

Ms. Threadgill gave a brief update stating that the enforcement staff continue to track complaints that are received under a separate case number and tracking system to help identify these complaints. The Board has received three complaints to date.

Dr. Levine asked to have established a regular means of reporting to the Board the status of complaints to keep the Board updated for oversight of this process. Ms. Threadgill agreed to include a status report to the Board on a regular basis.

Dr. GnanaDev requested that the staff put together a detailed process report on how to proceed with discipline actions to complaints on OSSs.

Mr. Serrano Sewell would like the report to include the actions the Board has taken in the past on those surgery centers that have lost their accreditation.

Ms. Yaroslavsky recommended the Board President appoint a group of people to look at this issue in its entirety as to the barriers that have impacted information for the consumer and the physicians.

Dr. Levine asked for two Board Members to work together on this issue and create some clear direction to the staff on certain questions and concerns that need answers to help possibly create additional regulations and laws.

Dr. Salomonson and Dr. GnanaDev agreed to work together on this issue and bring some suggestions back to the next Board Meeting.

Public comment was heard on this agenda item.

Jack French, Consumers Union, spoke on his concerns about the Board's responsibilities for physician owned OSSs. After reviewing the OSS link, it was found that of the 747 centers, basic information is still missing after two years since the law went into effect, such as the name of the physician owner as well as evidence of current accreditation. Only 154 facilities of the 747 included the physician owner name and if the accreditation was current.

He stated a radio station in Southern California did its own analysis. They reviewed 100 surgery centers listed on the Board's Web site, and only 14 included the name of the physician owner and only five

provided the owner's medical license number, which he stated is required by law. They also found missing information from most of the records including whether a surgery center had their accreditation suspended or revoked.

Julie D'Angelo Fellmeth, Center for Public Interest Law, expressed her concerns about the Board's authority and jurisdiction over the OSSs. The Board's jurisdiction used to be limited, but now the Board has significant jurisdiction over the AAs as well as the OSSs. The Board needs to be able to detect if an AA is falling down on the job, as that might trigger the Board's duty to inspect the OSS and to seek a district attorney to get an injunction shutting it down. The issue for the Board is how the Board intends to monitor the AAs, so that the Board can meaningfully carry out this new responsibility. She also noted that the Board was not provided additional resources to do this work and inspect OSSs.

Genevieve Clavreul was recently involved with an outpatient physician who at the time of her appointment was so distraught from his prior patient that he could not remember her name or why she was there. When her test results came back, the information on them was wrong. She believes that OSSs should not be in business.

Agenda Item 8 **Consideration of Revised Regulatory Language for CCR, Title 16, Division 13, Chapter 2, Article 1, Section 1355.45 – Physician Incarceration and Inactive License; Notice to Medical Board.**

Mr. Heppler stated that the current regulation for incarcerated physicians has no language regarding what type of notice a newly released person would receive during release procedures after being incarcerated. There are concerns that under the current regulation an incarcerated physician could say he/she had been released when he/she actually had not been and the Board would have no way of knowing for certain. Mr. Heppler stated that under the revised text the proper notice would be a signed statement under penalty of perjury submitted to the Board by the licensee stating that he/she had been released from incarceration. It would be provided to the Board by fax, regular mail or personal service, at the option of the licensee. He believes this is a workable solution to the problem where no records of the release currently exist. This language has been circulated for 15 days and there have been no adverse comments. He is asking that the Board approve the revised language shown in the documentation provided in the Board packet and instruct the Executive Director to complete the rulemaking file and transmit it to the Office of Administrative Law.

Ms. Schipske made a motion to accept the language change and instruct the Executive Director to complete the proper paperwork and submit it to the Office of Administrative Law: s/Dr. Levine. Motion carried.

Agenda Item 9 **Enforcement Process Overview: Role/Responsibilites of Physicians in the Enforcement Process**

Ms. Cady, Ms. Sweet, Mr. Heppler and Mr. Bell, gave an Enforcement Process Overview, which covered all the steps from the receipt of a complaint in the Central Complaint Unit to when a Decision is made by the Board.

The presentation included details on:

- The selection criteria for all Medical Reviewers

- The process from when a complaint comes in to when it gets to a reviewer
- The case management process with a Medical Consultant
- The steps for the field investigations
- The selection and approval of the Expert Reviewers
- The prosecution process with the Office of the Attorney General

Dr. Low recognized Laura Sweet and all her incredible efforts on organizing the expert reviewer program, since it is so crucial to the Enforcement Program. He encouraged the Board Members to attend the next session. He stated the course is impressive and interactive. He was impressed with the way the expert reviewers embraced the time spent learning about their true role in the process.

Public comment was heard on this agenda item.

Mr. Roth wanted to ask a couple of questions to staff, but was reminded that staff could not respond, so he made the comment that he believes there was a drafting error in one of the slides.

Joseph Furman, Health Care Attorney, who had worked in the Health Quality Enforcement Section for many years and now defends physicians in these types of cases, wanted to comment that as defense attorneys, they have to pay for their experts; however, there are many experts out there who are willing to work pro bono because they want the best outcome for their clients.

Agenda Item 10 Update of Board of Pharmacy Activities

Ms. Herold was unable to attend, so this item was postponed to the next meeting.

Ms. Schispke requested a report of activities since Ms. Herold was unable to attend rather than wait until our next Board meeting in July.

Dr. Levine said staff would request one, but also recommended reviewing the Board of Pharmacy's agenda on the Web site to get an idea of what they are working on currently.

Agenda Item 11 Update of Joint Forum to Promote Appropriate Prescribing and Dispensing

Ms. Whitney reported statistics on outcomes from the Joint Forum held in February, 2013. The Board has placed a link on the Web site with highlights related to the Forum, video clips from the speakers, and the speaker's presentations. The Board of Pharmacy has placed the same information on its Web site.

The Forum had approximately 400 attendees, most of them physicians and pharmacists. The evaluation forms have come in and two of the medical consultants that attended the forum are assisting the Board with the evaluation forms and will develop some materials for future Newsletters. One of the educational recommendations was to develop tip sheets. Board staff are working with the Board of Pharmacy on gathering tip sheets from other Departments, such as the U.S. Health and Human Services, the DEA, etc., and will be putting links to this information on the Web site as well as providing it to the Education and Wellness Committee.

Agenda Item 12 Update on Executive Committee Meeting – Consideration of Committee Recommendations

Dr. Levine reported that the Executive Committee has met twice since the last Board meeting. On April 5, 2013 the Committee reviewed legislation, took positions on some bills, and reviewed and approved revisions to the Board Member Administrative Procedure Manual that will be sent to Board Members next month. This item will be an ongoing process as the Board's work and accountabilities change. The Board will need to continue to look back at this to have a clear understanding of how the Board functions and what Board Members and staff's responsibilities are. An update of the Strategic Plan was provided. The Committee asked staff to come back to the next Board meeting with a ghant chart format to track where the Board is with progress.

The Committee also discussed the response to the 39 issues from the Sunset Review that were submitted on April 8, 2013. Prior to April 8, 2013, the Board received a letter from the Senate and Assembly Committee Chairs raising seven issues of concerns that they had in particular. The Board sent a response with detailed information of what the Board's action plans are and how the Board will deal with those issues, including providing a time line for addressing those seven issues.

The Executive Committee met again yesterday, April 25, 2013, to begin the process of the Executive Director's annual performance evaluation that will be completed at the Executive Committee meeting in July.

Mr. Serrano Sewell requested an agenda item for the next Executive Committee meeting be a closed session with all Board Members to discuss the evaluation findings and recommendations from the Executive Committee. Dr. Levine asked Ms. Dobbs to look into it and get back to her with details on how that can work.

Public comment was heard on this agenda item.

Jack French, Consumers Union stated that the Consumers Union supports SB304, which moves the Medical Board investigators into the Department of Justice's Health Quality Enforcement Section (HQES). This will allow investigators and prosecutors to work more closely together providing better communication and coordination. They believe it will create a more efficient and effective enforcement program, and provide more protection for patients.

Agenda Item 13 Legislation/Regulations

Ms. Simoes began her report on legislative outreach, pursuant to the Strategic Plan, Objective 4.1. She contacted 40 legislative district offices to let them know that the Board's quarterly Board meeting was being held in Los Angeles and extended an invitation. There are also 40 newly elected members of the Legislature (2 Senators and 38 Assemblymembers). She has met with almost all of the new Legislators, or in some cases met with their staff if the member was not available.

She referred the Members to their legislative packets. She stated that on the tracker list, the bills in green will be discussed at this meeting. The bills in blue are spot bills or 2-year bills and the bills in orange the Board has already taken a position on. However one of those bills, SB 62, has been amended, so the Board will be discussing that bill. The bills in yellow were discussed at the Executive Committee

Meeting and the Executive Committee has recommended positions. If all Members agree with those positions, it does not need to discuss the bills in yellow.

Dr. GnanaDev made a motion to approve all the positions of the bills in yellow as a consent calendar with the exception of SB 117 & AB 635; s/Mr. Serrano Sewell. Motion carried.

Public comment was heard on this agenda item.

Frank Cuny requested that SB 117 be discussed by the full Board. Dr. Levine noted that SB 117 & AB 635 had been pulled and would be discussed.

AB 127 (Medina) & SB 21 (Roth)
Both bills include similar language and would both annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside. SB 21 was recently amended to specify that the funds shall be available for planning and startup costs associated with academic programs to be offered at the UC Riverside School of Medicine. Both bills contain urgency clauses, which mean that the bills would take effect immediately once signed into law. These bills will help to increase access to care and help the Inland Empire area of California to prepare and be ready for implementation of the Affordable Care Act. Board staff suggested that the Board support both AB 27 and SB 21.

Ms. Yaroslavsky made a motion to take a support position on both AB 27 and SB21; s/GnanaDev. Motion carried.

AB 186 (Mainschein)
This bill would require all boards under DCA, including the Medical Board, to issue a 12 month temporary license to applicants that qualify for an expedited license under existing law because they are a spouse of military personnel that have moved to California based upon active duty orders of the military spouse, and who have a license in another state. The temporary license shall expire 12 months after issuance, upon issuance of the expedited license, or upon denial of the application for expedited licensure, whichever occurs first. An applicant seeking a temporary license shall submit an application to the Board and include a signed affidavit attesting that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate. The application shall also include a written verification from the applicants original licensing jurisdiction stating that the applicant's license is in good standing in that jurisdiction. This bill would specify that the applicant can only apply for expedited licensure and a temporary license if the applicant has not committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license, and a violation of this requirement could be grounds for the denial or revocation of a temporary license issued. This bill would also specify that the applicant cannot have been disciplined by a licensing entity in another jurisdiction and cannot be the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction. This bill would require the applicant to furnish a full set of fingerprints for the purposes of conducting a criminal background check.

This bill would require the applicant to meet all licensing requirements in existing law and would require fingerprints to be cleared, would require license verification through the American Medical Association and/or the National Practitioner's Data bank, and verification from the state the applicant is licensed in

before the temporary license could be issued. Board staff suggested the Board oppose this bill unless it is amended to include language that would specify if the information on the applicant's application is found to be inaccurate, contrary to the affidavit, that the Board could require the individual that has been issued a temporary license to immediately cease practice, in order to ensure consumer protection.

GnanaDev made a motion to take a support if amended position; s/Dr. Levine. Motion carried.

AB 496 (Gordon)
This bill is sponsored by Equality California and would reauthorize the Task Force on Culturally and Linguistically Competent Physicians and Dentists

This bill would specify that the duties of the Task Force would be the same as before: to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to meet linguistic competence; to identify key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices; and to assess the need for voluntary certification standards and examinations for cultural competency. This bill would require the Task Force to hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups, and this bill would add LGBT groups, to determine their needs and preferences for having culturally competent medical providers. This bill would require the hearings to be held in communities that have large populations of language and ethnic minority groups and LGBT groups. This bill would require the Task Force to report its findings to the Legislature and appropriate licensing boards by January 1, 2016. This bill would require the Board and the Dental Board to pay the administrative costs of implementing the Task Force, the hearings, and the report, the Board's portion is estimated to be the same as before, $43,000.

According to the author's office, LGBT patients have reported a reluctance to reveal their sexual orientation or gender identity to their providers, despite the importance of such information for their health care. The author believes that the ability of physicians to effectively communicate with, and to create a welcoming and safe environment for their LGBT patients, has an impact on LGBT patient health outcomes and on provider-patient relationships.

Although DCA, the Board, and the Dental Board already convened and participated in the Task Force on Culturally and Linguistically Competent Physicians and Dentists, LGBT issues were not addressed at the Task Force, the hearings, or in the final report to the Legislature. This bill would reauthorize this Task Force and include LGBT issues for the Task Force to hold hearings on and include in its report to the Legislature. This bill does not add to or change existing law related to the working group that has already been convened by the Board and that continues to exist, which is the Cultural and Linguistic Physician Competency Program (CLC) Workgroup. Since this bill does not expand the working group convened by the Board, the Board would only need to include agenda items at future meetings that address understanding and applying the roles that sexual orientation, gender identity, and gender expression play in diagnosis, treatment and clinical care.

Public comment was heard on this agenda item.

Genevieve Clavreul stated that she supports this bill.

Ms. Schipske made a motion to take a support position; s/Ms. Yaroslavsky. Motion carried.

AB 512 (Rendon)

This bill is sponsored by Los Angeles County and would extend the sunset date in existing law, from 2014 to 2018, for provisions that authorize health care practitioners who are licensed or certified in other states to provide health care services on a voluntary basis to uninsured or underinsured individuals in California at sponsored free health care events. Although the Board has only issued one physician permit under the authorization program that was created by AB 2699 since regulations became effective on August 20, 2012, the Board has already done the work to promulgate regulations; as such, it seems reasonable to extend the sunset date to allow more individuals to volunteer health care services at sponsored free health care events in California. This bill would enable all boards to collect data and track the number of out-of-state health care practitioners that request authorization to participate in sponsored free health care events. This bill would help to ensure these events have enough providers to serve more uninsured and underinsured consumers in California.

Ms. Yaroslavsky made a motion to take a support position; s/GnanaDev. Motion carried.

AB 565 (Salas)

This bill is sponsored by the California Medical Association and would amend the Steven M. Thompson Loan Repayment Program (STLRP) guidelines require applicants to have three years of experience providing health care services to medically underserved populations or in a medically underserved area, which is defined in existing law as an area that is a health professional shortage area pursuant to the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission. Existing law only requires applicants to have three years of experience working in medically underserved areas or with medically underserved populations. This bill would also delete the existing guideline that would seek to place the most qualified applicants in the areas with the greatest need and replace it with a guideline that would give preference to applicants who agree to practice in a medically underserved area as defined in existing law, and who agree to serve a medically underserved population. This bill would also require that priority consideration be given to applicants from rural communities who agree to practice in a physician owned and operated medical practice setting, defined in existing law as a medical practice located in a medically underserved area and at least 50 percent of patients are from a medically underserved population. This bill would also add to the definition of a “practice setting” a private practice that provides primary care located in a medically underserved area and has a minimum of 30 percent uninsured, Medi-Cal, or other publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

According to the author, California faces a misdistribution of physicians and there are shortages of primary care physicians in 74 percent of counties in California. In the last five years, only one physician has been selected to practice in Kings and Kern counties under the STLRP. The author and stakeholders have recognized the STLRP’s high demand and the need to tighten the criteria to ensure that scarce resources are going to the most medically underserved communities.

Adding medically underserved areas from existing law to the guidelines will help to ensure that STLRP applicants are serving in the areas with the most need.

Dr. GnanaDev made a motion to take a support position; s/Dr. Salomonson. Motion carried.

AB 635 (Ammiano)

Ms. Simoes removed this bill from the consent list per direction from the Executive Committee. She was asked to talk with the Author's office and come back.

This bill is sponsored by the Harm Reduction Coalition and the California Society of Addiction Medicine, and would allow health care providers to prescribe, dispense, and issue standing orders for an opioid antagonist to persons at risk of overdose, or their family member, friend, or other person in a position to assist persons at risk, without making them professionally, civilly or criminally liable, if acting within reasonable care. It would also extend this same liability protection to individuals assisting in dispensing, distributing, or administering the opioid antagonist during an overdose.

This bill would require a person who is prescribed an opioid antagonist or possesses it pursuant to a standing order to receive training provided by an opioid overdose prevention and treatment training program. Naloxone is used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdosing person to breathe normally. Naloxone is a non-scheduled, inexpensive prescription medication with the same level of regulation as ibuprofen. Naloxone only works if a person has opioids in their system, and has no effect if opioids are absent.

According to the most recent data released by the Centers for Disease Control and Prevention (CDC), in 2008 there were 36,450 drug overdose deaths in the United States. According to CDC, overdose prevention programs in the United States distributing naloxone have trained over 50,000 lay persons to revive someone during an overdose, resulting in over 10,000 overdose reversals using naloxone.

Language in existing law for the pilot project only provides civil and criminal liability, it does not exclude health care providers from "professional review". According to the author's office, the intent of the professional review language is to make it clear that the action of prescribing an opioid antagonist by standing order cannot be grounds for disciplinary action. Many states that have similar law include this type of language. Kentucky's statute says that a practitioner operating under the law shall not "be subject to disciplinary or other adverse action under any professional licensing statute". Illinois statute contains the same language, while Washington's statute says that actions under the law "shall not constitute unprofessional conduct". Massachusetts law declares that a naloxone script "shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice".

The Executive Committee voted to recommend that the Board support this bill in concept until staff consulted with the author's office regarding the meaning of professional review. This was done and the author's office confirmed it means disciplinary review, and similar language is included in statute in other states that have similar laws.

Public comment was heard on this agenda item.

Genevieve Clavreul does not agree with the language in this bill and does not support it.

Karen Ehrlich, speaking as a member of the public has had a family member die from an overdose and would have much preferred the possible side effects of this drug rather than death.

Dr. GnanaDev made a motion to take a support position; s/Mr. Serrano Sewell. Ms. Schipske abstained. Motion carried.

AB 809 (Logue)
This bill would revise the existing requirement on health care providers that they must verbally inform and document consent of the patient prior to delivery of health care services via telehealth and would replace it with a requirement that the provider must obtain a waiver for treatment involving telehealth services, as specified. According to the author, under existing law, in order to ensure that both physicians and patients understood that telehealth may be used to treat the patient, a physician is required to obtain verbal consent for each and every visit with the patient. Physicians have reported that this constant requirement is burdensome on their ability to treat patients effectively. This was a requirement added to statute from AB 415 (Logue, Chapter 547, Statutes of 2011). The author of this bill, who also authored AB 415, believes that the requirement included in his bill in 2011 eliminates efficiencies achieved in rendering telehealth services and was an unintended consequence that is inconsistent with the intent and principles of his bill. This bill will allow the Telemedicine Advancement Act of 2011 to be better implemented, which will help to improve access to care via telehealth.

Ms. Yaroslavsky made a motion to take a support position; s/GnanaDev. Motion carried.

AB 860 (Perea)
This bill would provide that $600,000 from the Managed Care Administrative Fines and Penalties Fund (Fund) be transferred to the Steven M. Thompson Medical School Scholarship Program (STMSSP) Account within the Health Professions Education Foundation (HPEF) for purposes of funding the STMSSP. AB 589 (Perea, Chapter 339, Statutes of 2012) created the STMSSP within the HPEF. STMSSP participants are required to commit in writing to three years of full-time professional practice in direct patient care in an eligible setting. The STMSSP is currently funded by federal or private funds only and cannot be implemented until HPEF determines that there are sufficient funds available in order to implement STMSSP.

This bill would now require $600,000 from the Managed Care Fund to be transferred to the Steven M. Thompson Medical School Scholarship Program (STMSSP) Account within the Health Professions Education Foundation (HPEF) for purposes of funding the STMSSP. This bill would not affect the amount transferred to the STLRP, as the statute still specifies that the first $1 million dollars is set aside to fund the STLRP in HPEF.

The purpose of this bill is to fund the STMSSP to make medical school more financially accessible for students who are willing to pursue careers in primary care. According to the author's office, this bill will help to address the geographical disparity of physician supply in California, as well as the increasing cost of medical education. This bill is consistent with the mission of the Medical Board of promoting access to care.

Dr. GnanaDev made a motion to take a support position; s/Dr. Low. Motion carried.

The Board recessed at 11:38 am and reconvened at 12:00 noon.

AB 1000 (Wieckowski)
This bill is sponsored by the California Physical Therapy Association, and 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.

Ms. Yaroslavsky made a motion to take an oppose position; s/GnanaDev. Motion carried. (7 ayes / 2 oppose)

AB 1003 (Maienschein)

This bill is sponsored by the California Medical Association and would specify that the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation does not limit employment of professional corporations to the licensed professionals listed in that section and would specify that any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act, may be employed to render professional services by a professional corporation listed in existing law. This bill would also add physical therapists, and other licensed professionals, to the listing in the Corporations Code.

Since 1990, the Physical Therapy Board has allowed physical therapist's to be employed by medical corporations. On September 29, 2010, the California Legislative Counsel issued a legal opinion that concluded a physical therapist may not be employed by a professional medical corporation and stated that only professional physical therapy corporations or naturopathic corporations may employ physical therapists. According to the author's office, this could result in harming quality of care by eliminating the line of communication between physicians and the licensed professionals assisting in the patient's care and it may interrupt continuity of care and convenience of care, as well as fragmenting the delivery of care and impeding a patient's right to choose integrated, comprehensive care.

This bill will codify the practice that has been allowed for over 20 years and allow physicians in medical corporations to employ physical therapists. The Board also supported AB 783 (Hayashi, 2011) which would have added licensed physical therapists and occupational therapists to the list of healing arts

practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation.

Dr. GnanaDev made a motion to take a support position; s/Mr. Serrano Sewell . Motion carried.

AB 1176 (Bocanegra & Bonta)
This bill would establish the Graduate Medical Education Fund (Fund) that would be funded by a $5.00 annual fee that would be assessed for each covered life to health insurers and health care plans that provide health coverage in California. Moneys in the fund would have to be appropriated by the Legislature and could only be used for the purpose of funding grants to GME residency programs in California. This bill would establish the Graduate Medical Education Council (Council), which would consist of 11 members, and the Council would be required to establish standards and develop criteria for medical residency training programs grants in California; make recommendations to OSHPD concerning the funding of the medical residency training programs; and establish criteria for medical residency training program grant review. The Council would be required to submit an annual report to the Legislature that includes specified information until January 1, 2018.

This bill would require OSHPD, in consultation with the Council, to develop criteria for distribution of available moneys in the Fund.

According to the author, California's current shortage of primary care physicians is projected to reach a crisis level by 2015, and will likely increase as more people become insured through the Affordable Care Act. The author believes that the additional funding for GME residency slots created by this bill will stabilize and expand medical residency training in California and help to ensure that every Californian has access to a physician when and where they need one. This bill is consistent with the mission of the Board of promoting access to care.

Dr. GnanaDev made a motion to take a support position; s/Mr. Serrano Sewell. Motion Carried. (8 ayes / 2 abstain - Levine/Yaroslavsky)

AB 1288 (M. Perez)
This bill would require the Board to develop a process to give priority review status to the application of an applicant who can demonstrate that he or she intends to practice in a medically underserved area or population. An applicant would be able to demonstrate his or her intent to practice in a medically underserved area by providing proper documentation, including a letter from the employer.

The Board does not currently have a process for priority review of applications and the application does not currently request information on where an applicant plans on practicing. However, the Board would be able to review these applications on a priority basis, but would need to revise the application to ask applicants to provide this additional information. The priority review process could be established, but it still would require the applicant to provide all the original source documentation, and this seems to be the factor that extends the time for licensure for the majority of applicants, as it takes only seven working days from receipt of all approved documentation to issue the license.

The purpose of this bill is to ensure that applicants who intend on serving in an underserved area or serve an underserved population are licensed in a timely manner. This bill may help to ensure that applicants planning on serving in underserved areas are licensed in a timely manner.

Public comment was heard on this agenda item.

Yvonne Choong, explained some of CMA's reasons for authoring this bill.

Ms. Yaroslavsky made a motion to take a neutral position; s/Dr. Levine. Motion carried.

ACR 40 (Perez)
This bill would make findings and declarations regarding the importance of organ donation. This resolution would proclaim April 9, 2013, as Department of Motor Vehicles (DMV)/Donate Life California Day and April 2013 as DMV/Donate Life California Month in California. This resolution would encourage all Californians to register with the Donate Life California Registry when applying for renewing a driver's license or identification card.

The Board recently voted to be the honorary state sponsor of Donate Life California's specialized license plate, which will help to increase awareness and raise money for organ and tissue donation, education and outreach. This resolution will also help to raise awareness by proclaiming April 9, 2013 as DMV/Donate Life California Day and April 2013 as DMV/Donate Life California Month.

Ms. Yaroslavsky made a motion to take a support position; s/Dr. Levine. Motion carried.

SB 20 (Hernandez)
This bill would require that when the California Major Risk Medical Insurance Program (MRMIP) become inoperative, all the funds in the Managed Care Administrative Fines and Penalties Fund (Managed Care Fund) must be transferred each year to the Medically Underserved Account in the Health Professions Education Foundation (HPEF) Fund for use by the STLRP. Under existing law, revenue from fines and penalties levied on health plans is deposited in the Managed Care Fund. The first $1 million is used for the STLRP, and fines and penalties above $1 million are used to augment funding for MRMIP, which provides subsidized health insurance for individuals unable to obtain coverage due to a pre-existing condition. In 2014, MRMIP will no longer be necessary due to the reforms enacted under the Affordable Care Act (ACA). This will provide the STLRP a more robust funding source by shifting monies no longer needed for MRMIP.

Ms. Yaroslavsky made a motion to take a support position; s/GnanaDev. Motion carried.

SB 62 (Price)
This bill would require a coroner to report deaths to the Board when the contributing factor in the cause of death is related to toxicity from a Schedule II, III, or IV drug. The initial report must include the name of the decedent, date and place of death, attending physicians, podiatrists, or physician assistants, and all other relevant information available. This bill was amended to allow the follow-up coroners' report and autopsy protocol to be filed within 90 days or as soon as possible once the coroner's final report of investigation is complete. The amendments now only require coroner to report deaths to the Board when the contributing factor in the cause of death is related to toxicity from a Schedule II, III, or IV drug and now only require the report to be filed with the Board and only require the initial report to include specified information when that information is known. The amendments specify that the other relevant information should include any information available to identify the prescription drugs, prescribing physicians, and dispensing pharmacy. The amendments also make similar changes to existing law on the

90-day timeline and confidentiality of the report for mandatory coroner reporting for deaths that may be the result of a physician's, podiatrists' or physician assistant's gross negligence or incompetence.

The Board voted to support SB 62 if it is narrowed to only include coroner reporting of deaths related to Schedule II and III controlled substances. These amendments have been made. The Board also requested an amendment to ensure that coroner's report these deaths to all boards responsible for licensing prescribers. This bill was recently amended to only require the coroner reports to go to the Board to make it more efficient for coroners, as they would only have to send their reports to one board, not multiple boards; this was a concern raised by the coroners in meeting with the author's office.

The Board could potentially share/disseminate the coroner reports that include a prescriber or dispenser licensed by another board to the appropriate regulatory board under the DCA, as is currently done as part of the complaint process.

Public Comment was heard on this agenda item.

Genevieve Clavreul expressed her concerns about this bill as it is. She believes this bill is not the solution and should have more consideration before passing.

Julie D'Angelo Fellmeth supports this bill as it is one bill of a multi-bill package. The requirements of this bill will guarantee the Board will receive important reports that are not currently being received. The Board is not getting reports or complaints right now about overdose deaths and the Board needs to know about these deaths. She urges the Board to support this bill as well as the many companion bills that will follow.

GnanaDev made a motion to take a support position; s/Ms. Yaroslavsky. Motion carried.

SB 117 (Hueso)
This bill is sponsored by California Citizens for Health Freedom and was formerly AB 1278 (Hueso), Assemblyman Hueso is now a Senator, so the bill has changed to a Senate Bill.

This bill would allow a physician to prescribe integrative cancer treatment, under specified circumstances. Current law (H&S Code 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.
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.

Public comment was heard on this agenda item.

Jessica Biscardi, Cancer Control Society, and a stage four cancer survivor of almost eight years urged the Board to support SB 117 and alternative cancer treatments such as those that saved her life.

Leslie Perea, second generation alternative cancer treatment survivor, also urged the Board to support SB 117 and give cancer patients a choice and allow the physicians to offer other options.

Frank Cuny also urged the Board to support SB 117.

Ms. Yaroslavsky made a motion to take a neutral position; s/Ms. Schipske. Motion Carried.

SB 304 (Price)

The Board included new issues in its 2012 Sunset Review Report to the Legislature and it its 2013 Supplemental Report. This report was submitted to the Legislature. The Board's Sunset Review Hearing was held on March 11th and Ms. Simoes personally visited all 12 of the Assembly Committee members' offices, and all 9 of the Senate Committee members' offices. She spoke to Committee staff persons, or in some cases, met with the Member. This includes meeting with the staff of both Chairs' offices. No particular concerns were raised at any of these meetings. The Legislature prepared a background paper that raised 39 issues, many of the issues raised were related to the new issues included in the Board's Sunset Review Report. The Board responded to all issues and sent the responses to the Legislature and posted them on the Board's Web site on April 8th. On April 1st, the Chairs of the Committees wrote a letter to Dr. Levine regarding the importance of the Board being proactive and addressing the issues raised by the Committees, and called upon the Board to take a more proactive approach to its consumer protection mission and stated that until the Committees receive firm commitments from the Board that shows significant progress, the sunset extensions for the Board and for its Executive Director will be removed from the sunset legislation, SB 304. The sunset extension has in fact been removed from the language in this bill. Dr. Levine responded to that letter on April 25, 2013. Ms. Simoes stated that she and Ms. Whitney will be meeting with both Chairs on May 7th and will be having regular meetings with staff of both Committees as the sunset bill moves through the legislative process.

The following are the issues included in the bill that were also included as new issues in the Board's Sunset Review Report:

- Revise existing law, Business and Professions (B&P) Code Section 2177, in order to accommodate the upcoming two parts of the United States Medical Licensing Examination Step 3 examination, and any new evolving examination requirement.
- Require all licensees who have an email address to provide the Board with an email address, and specify that the email address shall be confidential.
- The Board recommended that it be clarified in statute that residents in California accredited resident/fellowship programs are exempt from corporate practice laws related to how they are paid**.**
- The Board recommended that medical malpractice reports received pursuant to Section 801.01 be excluded from the requirements of in existing law that require review by a medical expert with the expertise necessary to evaluate the specific standard of care issue raised in the complaint.
- The Board recommended that the law be amended to allow a facility only 15 days to provide medical records, upon request, if the facility has electronic health records (EHRs).

- The Board recommended amending existing law to require a respondent to provide the full expert witness report and to clarify the timeframes in existing law for providing the reports, such as 90 days from the filing of an accusation.
- The Board recommended that the provision in existing law that requires the Board to approve non-ABMS specialty boards be deleted. The Board suggested that the law should continue to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the Board.
- The Board recommended that the issue of midwife students/apprenticeships needs to be clarified in legislation, due to confusion in the midwifery community.
- The Board suggested that existing law be amended in to include certified nurse midwives (CNM) as being able to supervise midwifery students.
- The Board recommended that language be added to existing law to allow the Board the authority to issue a cease practice order in cases where a licensee fails to comply with an order to compel a physical or mental examination.
- The Board recommended that the Vertical Enforcement Program be continued and stated that the Board and the Health Quality Enforcement Section (HQES) will continue to work together to establish best practices and identify areas where improvements can be made.

This bill would also extend the timeframe in which an accusation must be filed once an interim suspension order (ISO) is issued. Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an ISO, which must be granted by an Administrative Law Judge. In existing law there is a 15-day time restraint in law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set, which means an investigation must be nearly complete in order to file for an ISO. This bill would extend the timeframe to file an accusation from 15 days to 30 days, which would help to further the Board's mission of consumer protection.

The Board also made the following recommendations that are not included in the bill:

- The Board recommended that the requirement in existing law for the Board to post a physician's approved postgraduate training be eliminated.
- The Board recommended that, in the interest of consumer protection, legislation be written to require that regulations be adopted for physician availability in all clinical settings and for the Board to establish by regulation the knowledge, training, and ability a physician must possess in order to supervise other health care providers.
- The Board recommended an amendment to existing law to require the California Department of Public Health (CDPH) and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the Board and to require these entities to notify the Board if a hospital is not performing peer review.
- The Board recommended elimination of the ten year posting requirement in existing law in order to ensure transparency to the public.
- The Board in suggested that the transfer of the registered dispensing optician (RDO) Program to the Optometry Board or DCA should be examined.
- The Board recommended that existing law be amended to include American Osteopathic Association-Healthcare Facilities Accreditation Program as an approved accreditation agency for hospitals offering accredited postgraduate training programs.

- The Board made suggestions related to the Licensed Midwifery Program, that the issue of physician supervision and obtaining lab accounts and medical supplies should be addressed through legislation.
- The Board recommended that the issue of midwife assistants needs to be addressed in legislation, and what duties the assistant may legally perform, as it has been brought to the attention of the Board that licensed midwives use midwife assistants and currently, there is no definition for a midwife assistant or the specific training requirements or the duties that a midwife assistant may perform.
- The Board recommended that a section be added to existing law to require coroners to report all deaths related to prescription drug overdoses to the Board.
- The Board recommended that legislation be introduced to provide an adequate funding source for CURES, so it can be funded and upgraded (e.g. all individuals who prescribe or dispense medications, pharmaceutical companies, and the public). The prescribers/dispensers would include physicians, dentists, pharmacists, veterinarians, nurse practitioners, physician assistants, osteopathic physicians, optometrists, and podiatrists. This funding source would support the necessary enhancements to the computer system and provide for adequate staffing to run the system.

This bill would address many of the new issues raised in the Board's 2012 Sunset Review Report and the 2013 Supplemental Report and includes language to make the legislative changes suggested by the Board to accommodate the continuing evolution of medical training and testing, to improve the efficiencies of the Board's Licensing and Enforcement Programs, and most importantly, to enhance consumer protection. There are some issues that the committee background paper didn't address or that recommended that the Board's changes be made, but the changes are not included in this bill, e.g., removing the 10-year posting requirement in existing law, etc.. More importantly, this bill no longer extends the Board's sunset date, which must be extended in order for the Board to continue.

Ms. Simoes stated that the bill had just been amended to transfer the Board's Investigators to the Department of Justice. Ms. Simoes handed out a listing of the pros and cons for this transfer.

Dr. Levine requested that Ms. Simoes try and set up a meeting with the two Business and Professions Committee Chairs to meet and discuss the issue of moving the Board's investigators to Department of Justice in greater detail. It would be an in depth briefing.

Public comment was heard on this agenda item.

Julie D'Angelo Fellmeth, Center for Public Interest Law, discussed her experience with the Vertical Enforcement process when she worked for the Board back in 2003-2004 as an Enforcement Monitor. She and her team were required to examine the enforcement program and the diversion program . She believes that the transfer seems to be the last best hope for better informed and high quality investigations and prosecutions.

Ms. Yaroslavsky made a motion to take a support if amended position; s/ Ms. Schipske. Motion carried.

SB 305 (Price)
This bill would allow all boards under the DCA that require licensees to submit fingerprints, including the Board, to request from a local or state agency, certified records of all arrests and convictions, certified records regarding probation, and any and all other related documentation needed to complete an applicant or licensee investigation. This bill would specify that a local or state agency may provide these records and that a board may receive these records. This bill would also extend the sunset date of the Board's registered dispensing optician RDO program until January 1, 2018.

Clarifying in statute that state and local agencies can provide boards under DCA with certified arrest, conviction, and probation records, and other documentation needed to complete an applicant or licensee investigation would be beneficial to the Board's Enforcement Program. There is sometime question on what documents can be shared from agency to agency, and this bill would clarify that information can be shared with specified boards, in order to help with a Board's investigation. This will further the Board's mission of consumer protection.

Public comment was heard on this agenda item.

Yvonne Choong, stated that CMA is taking an oppose position on this bill.

Dr. Bishop made a motion to take a support position; s/Ms. Schipske. Motion carried.

SB 491 (Hernandez)
This bill is part of a package of bills intended to expand the scope of nurse practitioners (NP), pharmacists, and optometrists. Currently, NPs operate under standardized procedures, that are overseen by a supervising physician. NPs are advanced practice registered nurses who have pursued higher education and certification as a NP. There are approximately 17,000 NPs licensed by the Board of Registered Nursing in California. This bill would make findings and declarations regarding the role and importance of NPs. This bill would establish independent practice for NPs by removing provisions in existing law that require physician supervision through standardized procedures, collaboration or consultation with a physician. This bill would require a NP to maintain malpractice insurance. This bill would expand the scope of a NP and would allow a NP to do the following:

- Assess patients, synthesize and analyze data, and apply principles of health care.
- Manage the physical and psychosocial health status of patients.
- Analyze multiple sources of data, identify alternative possibilities as to the nature of a health care problem, and select, implement, and evaluate appropriate treatment.
- Examine patients and establish a medical diagnosis by client history, physical examination, and other criteria.
- Order, furnish, or prescribe drugs or devices, as specified.
- Refer patients to other health care providers, as specified.
- Delegate to a medical assistant.
- Perform additional acts that require education and training that are recognized by the nursing profession as proper to be performed by a NP.
- Order hospice care as appropriate.
- Perform procedures that are necessary and consistent with the NPs training and education.

An NP would be allowed to furnish order or prescribe drugs or devices if they are consistent with the practitioners education preparation or for which clinical competency has been established and maintained and the BRN has certified that the NP has satisfactorily completed a course in pharmacology covering the drugs or devices. An NP would not be allowed to furnish, order or prescribe a dangerous drug without an appropriate prior examination and a medical indication, unless specified circumstances apply. Beginning on and after July 1, 2016, this bill would require an applicant for initial qualification or certification as a NP to hold a national certification as a NP from a national certifying body recognized by the BRN.

According to the author, this bill will establish independent practice for NPs and enable them to perform all tasks and functions consistent with their education and training and would allow NPs to choose to see Medi-Cal patients. The author believe this package of bills will allow for better utilization of the existing infrastructure of trained medical providers to bridge the provider gap through expanded practice.

This bill significantly expands the scope of practice of a NP by establishing independent practice and deleting all provisions in existing law that currently require physician supervision, oversight, collaboration or consultation. NPs are well qualified to provide medical care when practicing under standardized procedures and physician supervision; however, the standardized procedures and physician supervision, collaboration, and consultation are in existing law to ensure that the patient care provided by a NP includes physician involvement and oversight, as physicians should be participating in the patient's care in order to ensure consumer protection. It is also unknown how this bill would affect corporate practice, as the bill does not address this issue. The Board's primary mission is consumer protection and by significantly expanding the scope of practice for a NP, patient care and consumer protection could be compromised.

Public comment was heard on this agenda item.

Genevieve Clavreul expressed her concerns on this bill.

Dr. Low made a motion to take an oppose position; s/Dr. Bishop. Motion carried.
8 Ayes / 1 Oppose (Schipske) / 1 Abstain (Levine)

SB 492 (Hernandez)
This bill would expand the scope of practice for optometrists. Under current law, optometrists are licensed and regulated by the California Optometry Board. It establishes the scope of practice for optometrists and indicates what services an optometrist is authorized to provide to patients. This bill would expand the scope of practice for optometrists which will allow them to provide more care to patients. Additional care provided by optometrists may increase overall utilization of health care, to the extent that patients are currently unable to get care from other practitioners, such as ophthalmologists or primary care physicians.

On the other hand, patients may substitute care from an optometrist for care from another practitioner. In addition, to the extent that patients are currently unable to access primary care services, those patients may ultimately end up receiving care in another setting, such as an emergency room, urgent care facility, or community clinic. Care provided in those settings is likely to be more costly than primary care (for those patients who require such care). Therefore, the overall impact on utilization and cost of health care from this bill cannot be determined and any potential impact on state health care programs, such as

CalPERS and Medi-Cal, cannot be determined. The only costs that may be incurred by a local agency relate to crimes and infractions. Under the California Constitution, such costs are not reimbursable by the State.

Ms. Salomonson made a motion to take a neutral position; s/GnanaDev. Motion carried. 7 Ayes / 2 Oppose (Dr. Bishop, Dr. GnanaDev) / 1 Abstention (Dr. Levine)

SB 493 (Hernandez)

This bill expands the scope of a pharmacist by allowing a pharmacist to do the following:

- Provide training and education to patients about drug therapy, disease management, and disease prevention.
- Participate in multidisciplinary review of patient progress, including access to medical records.
- Furnish emergency contraception drug therapy and self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by the Board of Pharmacy (BOP) and the Board.
- Furnish prescription smoking cessation drugs and devices - The pharmacist must maintain records of drugs and devices furnished for three years, notify the patient's primary care provider, be certified in smoking cessation therapy, and complete one hour of continuing education focused on smoking cessation therapy biennially.
- Furnish Prescription medications not requiring a diagnosis that are recommended by the Federal Centers for Disease Control and Prevention for individuals traveling outside of the United States.
- Independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices - *A pharmacist must complete an immunization training program, be certified in basic life support, and comply with all state and federal recordkeeping reporting requirements, in order to initiate and administer an immunization.*

This bill would require the BOP and the Board to develop standardized procedures or protocols for emergency contraception drug therapy and self-administered hormonal contraceptives. This bill would authorize both the BOP and the Board to ensure compliance with procedures or protocols, with respect to the appropriate licensees.

This bill would establish an Advanced Practice Pharmacist (APP), which means a pharmacist who has been recognized as APP by BOP. An APP may perform physical assessments; order and interpret drug therapy-related tests; and refer patients to other health care providers.

This bill would require a pharmacist who seeks recognition as an APP to meet the following requirements:

- Hold an active license to practice pharmacy that is in good standing.
- Either earn certification in a relevant area of practice from an organization approved by a BOP-recognized accrediting agency or another entity recognized by BOP; or complete a one-year postgraduate residency where at least 50 percent of the experience includes the provision of direct patient care services with interdisciplinary teams; or have actively managed patients for at least one year under a collaborative practice agreement or protocol with a physician, APP, pharmacist practicing collaborative drug therapy management, or a health system.
- File an application with BOP for recognition as an APP and pay the applicable fee to BOP.

- An APP must complete 10 hours of continuing education each renewal cycle in one or more areas of practice relevant to the pharmacists clinical practice.

This bill would expand the scope of a pharmacist and create a new APP recognition category. Currently, pharmacists do provide education to patients regarding drug therapy, and allowing this to be expanded would help in the implementation of the ACA. Allowing pharmacists to furnish self-administered hormonal contraceptives in accordance with standardized procedures developed by BOP, the Board, and stakeholders and allowing pharmacists to furnish some smoking cessation drugs and devices also makes sense and is in line with their scope (some drugs that are known to have side effects could be exempted from this provision). Allowing pharmacists to initiate and administer routine vaccines also seems to be reasonable.

The criteria for APP recognition is very broad, and could be as little as working with another APP for a year. This would allow the APP to make treatment decisions without having the benefit of knowing of the patient's medical history or the reason behind the physician's decision for the particular drug therapy choice. The Board's primary mission is consumer protection and by significantly expanding the scope of practice for a pharmacist, patient care and consumer protection could be compromised.

Public comment was heard on this agenda item.

Brian Warren, California Pharmacists Association, and sponsor of this bill stated they have recently revised the bill to remove the concerns that were put into the analysis. They are working with the CMA and other organizations on resolving several pieces of the bill.

Steve Gray, President of the California Society of Health System Pharmacists stated this bill is not much of an expansion of the scope of practice in California. The section of law that this bill refers to has been law for collaborative drug therapy management pharmacist for over 25 years. In California, there are over 1000 pharmacists that meet those special qualifications of that Code section. The real essence of this bill is there is such a demand for those pharmacists in California that there needs to be another pathway in order to qualify pharmacists for that collaborative practice. Mr. Gray urged the Board to support this bill.

Yvonne Choong, CMA, thanked the pharmacists for working with them on amending this bill but still has some concerns about the smoking cessation part of the bill.

Dr. Low made a motion to take a support if amended position in regards to the smoking cessation drug amendment; s/Dr. Salomonson. Motion carried. 1 Abstention (Schipske)

SB 670 (Steinberg)

This bill would authorize the Board to inspect the medical records of a patient who dies of a prescription drug overdose without the consent of the patient's next of kin or a court order. This bill would make it unprofessional conduct, for a licensee who is under investigation, if the licensee fails to attend and participate in an interview of the Board within 30 days of notification from the Board. Lastly, this bill would allow the Board to impose limitations on the authority of a physician to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician is overprescribing drugs or whose prescribing has resulted in the death of a patient.

Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an ISO, which must be granted by an ALJ. An ISO is considered extraordinary relief and the Board must prove that a physician's continued practice presents an immediate danger to public health, safety, or welfare. In addition, there is a 15-day time restraint in law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set, which means an investigation must be nearly complete in order to file for an ISO. The Board can currently only restrict a physician from prescribing if the physician is under probation and limits on prescribing are part of the terms and conditions of that probation that has been adopted or stipulated to by the Board.

This bill would require the Board to impose limitations on the authority of physician to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician has overprescribed drugs or engaged in prescribing behavior that has resulted in the death of a patient. This would give the Board authority to stop physicians from prescribing drugs if the Board is investigating the physician and believes the physician is overprescribing or their prescribing has resulted in the death of the patient. However, the process for when and in what circumstances that Board could put this type of a restriction on the physicians would need to be spelled out in this bill or in regulations. Also, it is not clear in the bill if there would be due process given to the physician if the Board were to impose limitations on a physician's prescribing privileges.

The author introduced this bill due to the Los Angeles Times investigation that uncovered significant issues with physicians, overprescribing and patient deaths. This bill will help to speed up investigations in cases where patients have died as a result of prescription drug overdose. This bill will also make improvements to the Board's enforcement process, which will result in timelier investigations.

Public comment was heard on this agenda item.

Joseph Furman, Health Care Attorney, expressed his concerns about making it unprofessional conduct if a licensee fails to attend an interview with 30 days. He stated that the Attorney General's Office and the Medical Consultants are not available every day and the licensee may not be able to get everyone together who may need to attend this interview.

Mr. Roth suggested keeping the 30 days, but adjust it if there is "good cause" for not attending.

Dr. Low recommended 30 working days, which would give them two extra weeks.

Dr. GnanaDev made a motion to take a support if amended position; s/Dr. Low. Motion carried.

Dr. Levine stated that items on the agenda were going to be covered within the next 45 minutes due to time constraints and the Board will find another way to cover the agenda items that were not covered during this meeting. The agenda items that will be covered today are:14, 16d, 17, 19, 23, 24 and 25.

Agenda Item 14 Board Member Communication with Interested Parties

Dr. Levine asked if any of the members had any communication with interested parties to report. With nothing to report, Dr. Levine moved on to next necessary agenda item.

Agenda Item 16 Executive Director's Report

Ms. Whitney reported that staff will provide a written summary for items 16 A through 16 C, due to time restraints.

D. 2014 Board Meeting Dates

Ms. Whitney reported there is a Board Member with a conflict on the usual January 2014 Board Meeting date and offered proposed dates for early January or mid-February. These changes may cause the Board to have to have interim Panel Meetings in between normal quarterly meeting dates. The new proposed dates are: January 16-17, 2014 or February 13-14, 2014 in the Bay area; April 17-18, 2014, May 1-2, 2014, or May 8-9, 2014 in the Los Angeles area; July 17-18, 2014 or July 24-25, 2014 in the Sacramento area; and October 23-24, 2014 or October 30-31, 2014 in the San Diego area.

Staff recommendations are: February 13-14, 2014, May 1-2, 2014, July 24-25, 2014 and October 23-24, 2014.

Ms. Whitney asked for a motion to set the first meeting of 2014 as February 13-14 and the next meeting as May 1-2.

Dr. Levine made motion to approve the proposed dates for the first two 2014 meetings; s/Dr. GnanaDev. Motion carried.

Agenda Item 17 Discussion and Consideration of Teleconferencing of Medical Board Meetings

Ms. Kirchmeyer reported that at the October Board meeting, the Board was asked to teleconference its future meetings to provide public participation from individuals not in attendance at the Board meetings. Specifically, the request was to allow individuals from any location to be able to call in, listen to the Board meeting, and provide public comment throughout the meeting. The Board Members requested staff research the feasibility of this request and provide the information back to the Members for their consideration.

Board staff identified four options the Board could consider. Further research and paperwork would need to be completed to develop and test the options and some of the options would require authorization and processing by the DCA.

Ms. Kirchmeyer pointed out that for any option the Board must still comply with the Open Meeting Act. All teleconferencing locations would need to be posted on the Board's agenda and would need to be posted 10 days prior to the meeting. Board members would need to be at one of the public locations and could not phone in from some unknown location.

The first option would be to provide an 800 number for anyone to call in and listen to the Board meeting and provide comments. A moderator would assist callers in the process and individuals on the line would remain in a "mute" mode until the Board President (or Chair at Committee Meetings) would ask for public comment. The individuals at the beginning of the call would be provided with a method of informing the moderator that they would like to make a comment. The moderator would then notify the staff monitoring the call that a comment is pending. At the appropriate time, the callers would provide

their comments. The callers would need to be limited to specified minutes per comment per agenda item (for example two minutes).

The cost for this type of function would be dependent upon the number of callers and the length of meeting, but would be $1000 to $1500 plus staff time. The system can have up to 4,000 participants on the line at one time.

She asked the Board Members to note that in contacting the DCA to gather information on this option, the Board was notified that no other DCA board or bureau has made a request for such a system that would provide the public input as described. If this option were chosen, it is recommended that this would be tested at the Sacramento Board meeting in July in order to have appropriate staff available.

She pointed out some of the pros and cons of this option. One important pro is that the public would not have to travel to the meeting, but a significant con is that the Board meeting structure may need to be reviewed due to the additional time that may be required as it could increase the meeting time by at least 4 hours. For example, the Board meeting may need to be three days rather than two.

The second option is to provide an email Web account where an individual could listen to the meeting and provide written questions that would then be provided via staff for the Board's consideration. The cost for this service is $8.50 per month ($102/year) and it would require a staff member to attend the meeting for the sole purpose of monitoring and reading the comments or questions provided via the Web. There would not be a limit to the individuals who could provide comments.

The pros and cons for this option are that again the public would not need to travel to the meeting, but again the meeting structure may need to be reviewed due to the additional time that may be required.

The third option is to hold all meetings in Sacramento at the Evergreen Hearing Room and video conference to the three other locations throughout California where the Board has video conferencing equipment (San Jose, San Diego, and Cerritos). A staff member would have to be available at each of the off-site locations to monitor the meeting and equipment, as well as be the point of contact for moderating the public comment. There would be no additional cost to the Board other than the three staff who would not be performing their normal work duties.

The final option is to teleconference the Board meeting to locations throughout California where the Board has the most space available (San Jose and Cerritos). The Board's main meeting would take place in its normal locations, and individuals would also be able to go to the two district offices and attend the meeting via teleconferencing equipment. A staff member would have to be available at each of the off-site locations to monitor the meeting and equipment as well as be the point of contact for moderating the public comment.

Ms. Kirchmeyer asked the Board Members for their thoughts and/or any recommendations on these options.

Dr. GnanaDev expressed concerns about having to take an additional day off in some cases and that would create possible problems with many of the Board Members' already busy schedules. His preferred option is the video conference to where everyone can see each other no matter what location they are scheduled.

Ms. Schipske suggested using U-Stream, where public comments can be sent in via email prior to the meeting where then staff puts a list of these emailed comments together to present to each Board Member the day of the meeting. She also suggested having a Facebook chat setup so that people can post comments the day of the meeting and have a staff person monitor it and/or read the comments as they come in during public comment time.

Dr. Levine recommended that Ms. Schipske and Ms. Kirchmeyer work together on a few other possible options that may be available and recommended not taking a vote until other options are brought to the Board at the next Board Meeting.

Public comment was heard on this agenda item.

Jack French, Consumers Union, stated he is pleased to have this be an agenda item as there are many Californians who cannot afford to travel to the Board meetings in different locations of the State to attend in person. Many of the people who would like to attend are survivors of medical harm and disabled as a result.

Genevieve Clavreul would like the Board to look into a capability that she has participated in where attendees and Board Members can communicate both ways.

Alicia Cole, Consumers Union, stated that she is a committee member of the Hospital Inquired Infection Advisory Committee through Department of Public Health. This committee holds all of their meetings in Sacramento and uses teleconferencing for their meetings and it works very well.

Agenda Item 19 Special Faculty Permit Committee Recommendation; Approval of Applicant

Dr. Low reported that the Committee held a teleconference meeting on March 14, 2013 and reviewed one application from the University of California, San Francisco, School of Medicine for a Dr. Damato . Dr. Low asked Mr. Worden to present to the Board Dr. Damato's area of expertise and qualifications. Mr. Worden stated that Dr. Damato's area of expertise is ocular oncology and proton beam therapy. He graduated from the University of Malta Faculty of Medicine and Surgery. He has a Ph.D. from the University of Glasgow in Scotland and did his post graduate training in Scotland for Surgery, Internal Medicine, Pathology and Ophthalmology. He is a professor of radiation oncology, assuming that the Board approves him for that position at the University of San Francisco. He is currently a professor at the University of Glasgow and is considered a world renowned expert in ocular oncology. He developed a specific procedure for treating cancer of the eye, which actually saves most of the eye and had never been done before. It was the direct proton beam treatment of iris melanomas. Dr. Damato receives patients from over 32 countries and receives 700 cases per year.

Dr. Low made a motion for the Board to approve Dr. Bertil Eric Damato for a Business and Professions Code section 2168.1 (a) (1) (A) at the University San Francisco School of Medicine; s/Dr. Levine. Motion carried.

Agenda Item 25 **Update on Enforcement Committee: Consideration of Committee Recommendations**

Dr. Low reported that the Enforcement Committee heard an update from Ms. Sweet regarding the February 9, 2013 Expert Reviewer Training in Irvine. The training was well-attended and well-received. As with the earlier training, feedback was quite positive. Ms. Sweet implemented the new process where in order to receive CME credit, the participants had to prepare a sample expert opinion. This is yielding interesting information that will be used to enhance the next training which will hopefully take place in October or November in San Diego.

The Enforcement Committee then heard from Ms. Sweet regarding a proposal to increase the expert reviewer hourly rate upon completion of the Expert Reviewer Training Program. She stated that when experts are surveyed, they regularly comment on the low rate of pay, particularly how incomparable the pay is to the private rate. The Board knows it cannot compete with those rates, and many experts are not doing the work for the money, but instead for the satisfaction in upholding the standard of care and helping public protection. The Board might be able to be more demanding of our experts if they were not compensated at a volunteer rate of pay. Ms. Sweet reported that the Board has a particularly difficult time procuring neurosurgery experts. One neurosurgery expert told her that he was usually paid between $500-800 per hour, and although he knew the Board could not pay that rate, he believed there would be more of a willingness to participate if the rate were higher.

Currently, all experts are compensated at a rate of $150.00 per hour to review records and prepare a report, and at $200 per hour to testify. Staff recommended that a budget augmentation be prepared that would call for experts who have successfully completed the 8 hours of training and have provided a satisfactory sample expert opinion, be compensated at a rate of $200.00 per hour for record review and report writing and $250.00 per hour for testifying for all specialties except for neurosurgery. In neurosurgery cases, staff would like to recommend compensation be increased to $300.00 per hour for record review and report writing and $400.00 per hour for testimony. The committee made a motion to bring this item to the full Board. Dr. Low asked for a motion to direct staff to prepare a budget augmentation to increase expert reviewer pay according to that schedule.

Dr. GnanaDev made a motion to direct staff to prepare a budget augmentation to increase expert reviewer pay according to that schedule; s/Dr. Diego. Motion carried.

Dr. Low reported that Ms. Threadgill gave the Enforcement Committee a presentation regarding the historical efforts the Board has made to improve retention of investigators. He stated that it is remarkable how long the Board has been trying to get higher pay for investigators (commensurate with other state agencies) and how unsuccessful these attempts have been.

The most recent effort the Board made was from Chief Threadgill requesting that the DCA submit a request to DPA to pursue pay differentials for Field Training Officers, Rangemasters, Defensive Tactics Instructor and other formal training assignments. As of this date, this request remains unheeded.

Being mindful of the economic times, staff is making a modest recommendation to at least level the playing field with other State agencies. The recommendation would be to request a differential be established for Field Training Officers, Rangemasters, Defensive Tactic Instructors, and other formal training assignments; and that investigators receive pay differentials for living in Los Angeles or other

high-cost areas where investigators in other agencies receive differentials. The Committee made a motion to recommend to the full Board that staff work with the DCA to amend the specifications for the investigator classification series to expand the subject areas of the degrees accepted for admission to the examination. Dr. Low asked for a motion for staff to pursue the differentials described above.

Dr. GnanaDev made a motion for staff to pursue the pay differentials for investigators; s/Ms. Schipske. Motion carried.

Dr. Low then reported that Ms. Cady provided the Enforcement Committee a review of the priorities established in Business and Professions Code Section 2220.05. The law was established in 2003 and identifies priorities for the Board's investigative and prosecutorial resources.

Ms. Cady and Mr. Heppler provided a briefing on the Utilization Review Process in response to public comment during the last meeting. The Board has stated that utilization review decisions do constitute the "practice of medicine" and that a physician who reviews and makes medical necessity determinations is considered to be "practicing medicine." The Board receives a very small percentage of complaints regarding physicians who perform utilization review and this function is used in a variety of settings.

The complaint handling protocol entails staff looking at the role performed by the physician named in the complaint. If the physician is acting as a treating physician providing care to the patient, regardless of whether the care is paid for by a worker's compensation carrier or the patient's health benefits, the complaint would be handled as a "quality of care" complaint. However, if the physician had no direct involvement in the patient's care and treatment and was making a decision about whether the procedure or treatment would be covered as medically indicated or necessary, the Board would consider those complaints to be "non-jurisdictional."

Staff suggested that the Board continue its established policy of performing a preliminary analysis of each new complaint. If the complaint involves a utilization review issue, Board staff should inform the complainant to pursue their appeal options. Much discussion then ensued about legal matters. The outcome of that discussion was that the Committee made a motion to recommend to the full Board that it re-affirm that utilization review is the practice of medicine and direct staff to come up with guidelines and identify any legislative amendments that may be required in order for the Board to take action on cases when utilization review results in the practice of substandard medical care. Dr. Low asked for a motion.

Dr. GnanaDev made a motion that the Board re-affirm that utilization review is the practice of medicine and direct staff to come up with guidelines and identify any legislative amendments that may be required in order for the Board to take action on cases when utilization review results in the practice of substandard medical care; s/Dr. Salomonson. Motion carried.

Dr. Low gave a brief presentation at the Enforcement Committee meeting regarding the growing problem with controlled substance prescription abuse. Historically, the pendulum has swung back and forth on this issue. In the 1990's, it was thought that drug laws were too restrictive and therefore patients were being under-medicated and their pain was not being relieved. The Legislature answered this concern with numerous pieces of law, one of which was Business and Professions Code Section 2241.5, which states that no physician and surgeon shall be subject to disciplinary action for prescribing, dispensing or administering dangerous or prescription controlled substances when they meet certain criteria. That

criteria is generally encompassed in the Board's pain management guidelines. There has been an "epidemic" of prescription drug overdoses in the United States. The Committee has been looking at ways to address this issue, and some legislation is in process that will assist in addressing these cases, but the Committee thinks this would be a good time to convene a task force to further define the best practices as it relates to prescribing controlled substances and to revisit the pain management guidelines to see if there are additional guidelines that can be added (or removed) to address this very serious problem. The Committee made a motion to support the recommendation to establish a task force to include interested parties. Volunteers to staff this task force include Barbara Yaroslavsky, who will act as the Chair, Dr. Bishop, and Dr. Levine. Yvonne Choong also offered CMA's resources to assist with this issue.

Public comment was heard on this agenda item.

Genevieve Clavreul stated that in yesterday's Committee meeting, she had asked if members of the public could be included in the requested task force and if so, she would like to participate.

Dr. GnanaDev made a motion to support Dr. Low's recommendation to establish a task force and include interested parties; s/Dr. Yip. Motion carried

Dr. Low stated that Ms. Cady had presented to the Enforcement Committee a very thorough historical review of the Model Disciplinary Guidelines and rulemaking process as it related to the implementation of the Uniform Standards set forth in Senate Bill 1441. Much discussion ensued and in the final analysis, the Committee made a motion to recommend that the full Board commence rule making procedures to be discussed at the next Board meeting in order to adopt the uniform standards set forth in SB 1441, and to direct legal counsel to draft a response to the Attorney General's Office regarding action taken by the Board. Dr. Low asked the Board for a motion for staff to initiate the rule making procedures in order to adopt the uniform standards as set forth in SB 1441 and to direct legal counsel to draft a response regarding action taken by the Board.

Public comment was heard on this agenda item.

Alicia Cole, Consumers Union just wanted to thank the Enforcement Committee and the Board for the recommendation of the adoption of rulemaking to adopt the full uniform standards.

Dr. Salomonson made a motion for staff to initiate the rule making process in order to adopt the uniform standards as set forth in SB 1441 and to direct legal counsel to draft a response regarding action taken by the Board; s/Dr. GnanaDev. Motion carried.

Agenda Item 23 Vertical Enforcement Program (VEP) Report

Ms. Gloria Castro introduced herself as the newly appointed Senior Assistant Attorney General of the HQES. She stated she is honored to work for the Board and supervise the over 56 very talented attorneys statewide operating out of five offices and working out of 12 district offices with the Board's investigative and enforcement staff. Their attorneys are public interest attorneys at heart, but prosecutors by training and take every hit that the Board takes very personally and try to address them as quickly as possible. The HQES was created in 1990 as a specialized unit in the Attorney General's Office, which is charged with representing all State Agencies, but specifically the HQES was identified as trying to

provide the best and most efficient legal services to address the Board's biggest mandate of public protection. The HQES is interested in providing excellent, high quality legal services as efficiently as possible, to do it in a professional manner and always with public protection in mind.

Ms. Castro gave a brief update on the VEP noting that they continue to meet on a quarterly basis with the Board's enforcement supervisors to iron out any deficiencies identified. The staff have met a lot of goals that include being able to focus on subpoena enforcement, and develop some thoughtful ways to address the deficiencies in being able to obtain medical records in a quick manner. She will continue to work closely with enforcement staff to pursue and identify interim relief orders quickly, including Penal Code section 23 bail restrictions and interim suspension orders. They will also work closely to identify mentally and physical impaired physicians very early on so they are not posing a danger to patients.

Agenda Item 31 Agenda Items for July 18-19, 2013 Meeting in the Sacramento Area

Ms. Schipske recommended placing a summary of our Board meeting and the presentations that were given at the meeting on our Web site after the Meeting and perhaps placing some of the presentations in our Newsletter to assist the public with a step by step of how the enforcement processes work.

Agenda Item 32 Adjournment

Dr. Levine adjourned the meeting at 4:19 pm.