MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

Hilton Los Angeles Airport
5711 West Century Boulevard
Los Angeles, CA 90045
May 9 - 10, 2019

MEETING MINUTES

Thursday, May 9, 2019

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

Members Present:
Denise Pines, President
Michelle Anne Bholat, M.D., Secretary
Susan F. Friedman
Dev GnanaDev, M.D.
Randy W. Hawkins, M.D.
Howard R. Krauss, M.D.
Kristina D. Lawson, J.D.
Ronald H. Lewis, M.D., Vice President
Laurie Rose Lubiano, J.D.
Brenda Sutton-Wills (arrived at 5:00 p.m.)
David Warmoth
Jamie Wright, J.D.
Felix C. Yip, M.D.

Staff Present:
April Alameda, Chief of Licensing
Mary Kathryn Cruz Jones, Associate Governmental Program Analyst
Kimberly Kirchmeyer, Executive Director
Christine Lally, Deputy Director
Sheronnia Little, Information Technology Supervisor I
Regina Rao, Associate Governmental Program Analyst
Elizabeth Rojas, Staff Services Analyst
Jennifer Simoes, Chief of Legislation
Kevin Valone, Staff Services Analyst
Carlos Villatoro, Public Information Manager
Kerrie Webb, Staff Counsel

Members of the Audience:
Megan Allred, California Medical Association
Eric Andrist, Patient Safety League
Robert Armenta, Planned Parenthood
Gaye Breyman, Executive Director, California Academy of Physician Assistants
Gloria Castro, Senior Assistant Attorney General, Health Quality Enforcement Section, Attorney General's Office
David Chriss, Chief, Health Quality Investigation Unit, Department of Consumer Affairs
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
Clinton Dicely, Supervising Investigator, Health Quality Investigation Unit, Department of Consumer Affairs
Steve Diehl, Supervising Deputy Attorney General, Health Quality Enforcement Section, Attorney General's Office
Joe Furman
Kanwar Gill, Family Healthcare Network
Bridget Gramme, Center for Public Interest Law
Jed Grant, PA-C, President, Physician Assistant Board
Katie Gonzalez, Center for Public Interest Law
Joshua Haywood, Midwestern University
Edward Hollingsworth, Patient Safety League
Marian Hollingsworth, Patient Safety League and Patient Safety Action Network
Sarah Jacobs, Deputy Attorney General, Health Quality Enforcement Section, Attorney General's Office
Susan Lauren
Patrick Le, Assistant Deputy Director, Board and Bureau Services, Department of Consumer Affairs
Lisa Matsubara, California Medical Association
Michelle Monserratt-Ramos, Consumer Union Safe Patient Project
Jonathan Nguyen, Deputy Attorney General, Health Quality Enforcement Section, Attorney General's Office
Kathleen Nicholls, Deputy Chief, Health Quality Investigation Unit, Department of Consumer Affairs
Craig Pulsipher, APLA Health
Hanna Rhee, M.D.
Brian Roberts, Deputy Attorney General, Health Quality Enforcement Section, Attorney General's Office
Robert Sachs, PA, Vice President, Physician Assistant Board
Mike Sanchez, Videographer, Department of Consumer Affairs
Michael Santiago, Senior Staff Counsel, Department of Consumer Affairs
Peter Yellowlees, M.D., University of California, Davis

Agenda Item 1 Call to Order/Roll Call/Establishment of a Quorum

Ms. Pines called the meeting of the Medical Board of California (Board) to order on May 9, 2019 at 2:36 p.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 2 Public Comments on Items not on the Agenda

Dr. Rhee, Black Patients Matter (BPM), apologized for comments that she made at the last Board meeting. She shared that as an executive member of the ethnic section of the California Medical Association (CMA) and a member of BPM, she has done quite a bit of research into bias. She explained that her research has shown that underrepresented minority patients improve significantly while under the care of providers of their own race and that recalcitrant, non-diversified, investigative and policing forces maintain racial bias. For this reason, BPM has filed another federal civil rights lawsuits against the Division of Investigation (DOI) under the Department of Consumer Affairs (DCA), since DOI lacks significant racial diversity. She concluded by requesting that the DOI have increased racial and religious diversity and that the Board's medical experts be in active practice and at least 50% of their patient population be racially diversified including underrepresented minority groups.

Mr. Hollingsworth, Patient Safety League, provided the details of a patient's medical records, sharing that a patient was diagnosed with four hernias and had laparoscopic surgery on two of them. However, months later symptoms returned and the doctor performed a second surgery and the symptoms returned again and the doctor recommended a third surgery. He noted that at this time, the patient sought a second opinion from another physician and received a third surgery that resulted in an eight inch incision that was fully opened under his bandages. Mr. Hollingsworth recited portions of the patient's medical record, highlighting how dangerous the surgeries the patient underwent were and explained that the individual filed a complaint with the Board. He stated the complaint was closed without investigation.

Mr. Andrist, Patient Safety League, explained that he was the patient in Mr. Hollingsworth's example. He added that while it has been mentioned that he was out for revenge, he believes that the Board may be taking revenge on him for speaking out since his and his sister's cases were both closed when there was clear negligence. He questioned how his case did not prove negligence when the surgeon messed up on two surgeries, causing him to have a third surgery and there were also errors in his medical record. He called into question the people making the decisions for the Board and shared that he will investigate this further in light of an allegation that came up in the panel meeting in the morning. Mr. Andrist updated the Board that the two nurses involved in his sister's case had both been disciplined. Additionally, he inquired why his partner was interviewed in his open complaint, but he was not interviewed in his own. He remarked that almost every accusation that the Board put out contains inadequate medical records as a cause for discipline and yet the Board is closing complaints based solely on medical records and pointed out that the Board is not punishing him when closing his complaints, rather they are punishing the consumers that come after and will be in danger. He concluded by noting that it is his freedom of speech and he will continue to expose the faults of the Board.

Ms. Hollingsworth, Patient Safety League and the Patient Safety Action Network, requested that the conscience ruling be put on the next agenda. She noted the concern amongst advocate groups that it could substantially affect the well-being and health of certain groups particularly women and members of the LGBTQ community. Additionally, she requested that the Board provide their plan as to how they will be dealing with the conscience ruling and how this would

affect the complaint process. She provided the example of a physician that used his religion to get his license reinstated despite the sexual misconduct accusations against him.

Ms. Lauren inquired how many more plastic surgeons will get a free pass to kill, surgically batter, or maim innocent people. She pointed out that science has shown that adipose removal is bad for people and this is reinforced with thousands of valid citizen complaints reporting that their bodies and lives were ruined by liposuction and she provided the details of her own story. She noted that what the surgeon did to her caused her serious bodily harm, against her consent, and was negligent and below the standard of care. She reminded the Board that she sent them videos, photos, and documents of her story. She informed the Board that this same surgeon was given carte blanche by the Board and has since gone on to hurt other individuals. Ms. Lauren remarked that there is a new patient safety movement in California called Epic Harm, which stands for epidemic, preventable, iatrogenic, citizen-based harm.

Dr. Gill commended the Board on their work with the Dr. Lane case, but addressed his concerns that it took seven years to process the case. He recommended that more staff or resources be allocated to pursue these matters since the time it takes to process the case is not reasonable. He suggested that the Board get the support of the Governor's Office to provide a mandatory training for medication assisted treatment for opioid office-based treatment. He provided an example of a group that he currently works with and the struggles they have to provide medication-assisted treatment (MAT). Dr. Gill added that since the opioid crisis had been partially created by the Board's previous regulation that required doctors to prescribe to treat pain more of an effort should be made.

Agenda Item 3 Approval of Minutes from the January 31 – February 1, 2019 Quarterly Board Meeting

Ms. Pines stated an edit was brought to the Board's attention on page BRD 3-34 in the second paragraph, first sentence. The word meeting should be changed to records. She clarified that the comment made was regarding the Public Records Act not the Open Meeting Act.

Dr. Lewis made a motion to approve the January 31 – February 1, 2019 Board meeting minutes with the inclusion of the edit; s/Dr. Krauss.

Mr. Andrist commented that there are quite a few items that have been brought up by the public that have not been addressed or brought up again. He notified the Board that his next project will be bringing up items that have been never dealt with or dismissed. He provided the example of Ms. Wright leaving the Board meeting to meet with Mr. Johnson and not disclosing this during Board Member Communications with Interested Parties and he requested that this be looked into and he never received an update. Mr. Andrist also reported that the person who creates the minutes skews the information provided in the minutes. He played a recording of the previous Board meeting and contrasted this with the meeting minutes. He commented that he does not understand why the Board would not want to work with him to address issues. He noted that Ms. Webb has not answered legal questions that he has posed.

Motion carried unanimously (12-0).

Agenda Item 4 President's Report, including notable accomplishments and priorities

Ms. Pines reported that the Board spent much of the first quarter working to meet the objectives for enhancing consumer protection with new laws like the Patient's Right to Know Act, Senate Bill 1448, which requires physicians who are placed on probation for certain offenses after July 1, 2019, to inform and discuss their probation status with their patients. She provided details on the Board's first ever open noticed meeting with patient advocates that occurred on February 1, 2019. She highlighted that it was an important moment for the Board to listen to patient advocates' concerns as well as share the Board's complaint process. Ms. Pines remarked that as a result of the meeting, she directed Board staff to look into several items relating to how the Board processes complaints. She identified that there was a recommendation for an online portal to allow the complainant to see the progress of a complaint, which has been discussed with DCA and the feasibility is currently being evaluated. Additionally, a work group was put together for the enforcement staff to identify better ways of communicating during the complaint process. In order to help with this effort, the work group will be reviewing the Board's website to ensure it is user-friendly, will be looking into releasing a video about the process, and will look at ways to provide more communication to the complainant.

Additionally, Ms. Pines noted that she participated in the House of Delegates meeting for the Federation of State Medical Boards (FSMB) and thanked FSMB for making the meeting accessible to her via teleconference since she could not travel due to travel restrictions.

Ms. Pines took a moment to thank Ms. D'Angelo Fellmeth for all her hard work in the field of consumer protection and her role with the Board. She also congratulated Ms. Fellmeth on her retirement.

Ms. D'Angelo Fellmeth thanked the Board and reminisced on how far the Board has come and her involvement with the Board. She concluded by noting that although the Board has made great strides, there is always room for improvement and urged the Board to continue to listen to patient advocates.

Dr. GnanaDev shared that there was a tremendous amount that was learned from Ms. Fellmeth and he shared that she will be missed.

Dr. Rhee asked to be a part of the communications that are happening between the Board and patient advocate groups. She noted that BPM might not be privy to the same information.

Ms. Pines shared that all information is publically available.

Mr. Andrist shared that he too will miss Ms. D'Angelo Fellmeth and her good work. He expressed his dislike for the patient advocate meeting due to issues with location, logistics, and set up. He added that half of the time was spent on a presentation and he did not even get to speak despite it being an advocates' meeting. He notified the Board that he spent weeks creating a packet for that meeting and was not able to share any of that information. He concluded by stating that the meeting for most of the advocates was not helpful.

Ms. Lauren provided details about how she was disabled and how this has affected her life. She commented that health care should prevent and heal, not cause death and injury to healthy people and she shared that this is what could happen with liposuction. She noted that unethical doctors and lawyers team up to keep the liposuction industry alive and the Board is a player in all of this. She provided the details of her case and stated that her doctor should have been disciplined. She concluded that the Board talks about health and wellness, but someone needs to actually step up and do the right thing.

Ms. Monserratt-Ramos thanked the Board for honoring Ms. D'Angelo Fellmeth and all her hard work and dedication.

Agenda Item 5 Board Member Communications with Interested Parties

There were no comments.

Agenda Item 6 Discussion and Possible Action on 2020 Proposed Board Meeting Dates

Ms. Kirchmeyer pointed out that agenda item six proposed a list of dates for the 2020 Board meetings. She added that for the first set of dates there were three options since one set of dates offered fell on a three-day weekend, which could be challenging for the Members and the public. Additionally, she noted that the February 6 and 7 dates pose a challenge for a location in Sacramento due to a local event. She specified that based upon the dates that are chosen for the first meeting of the year, this will dictate the following meeting dates in order for the Board to be able to process the enforcement cases.

Ms. Friedman shared the difficulty in having the meetings on August 13 and 14 due to vacation. She proposed that the meeting be earlier in August.

Ms. Kirchmeyer confirmed that the dates could be changed to August 6 and 7.

Dr. Krauss noted that although he is only one Board Member, he has a preexisting commitment on February 6 and 7, chairing an international meeting. He added that he would be available January 30 and 31. He shared that if the August meeting is moved to the 6 and 7 it would conflict with his vacation and opined that the Board may not find a date that is good for everyone.

Ms. Lawson recommended that the Board choose January 30 and 31 since the 11 and 12 is right before the President's Day holiday, which could cause conflicts. Holding those dates, would result in the Board meeting on May 7 and 8.

Dr. Krauss commented that in the past meetings have been the last weekend in July.

Ms. Kirchmeyer indicated that in trying to get all the statistics, the meeting would need to be in November, pushing the July meeting to August. She added that if the meeting is in July it will back everything up for the November meeting due to the gap in time between meetings.

Ms. Lawson asked for further clarification about the timeline.

Ms. Kirchmeyer explained that the proposed decisions received by the Board need to be acted upon within 100 days, which is about 14 weeks between Board meetings.

Dr. Lewis made a motion to approve 2020 Board meeting dates for January 30-31, May 7-8, August 13-14, and November 12-13; s/Ms. Lawson.

Mr. Andrist questioned why the meetings continue to happen at expensive hotels, for example, the Hilton LAX charges $40 for parking. He added that although he did find a cheaper lot, there are disabled consumers who cannot park far away. He remarked that since the location is in the same place as last year and there were comments about affordability, it could be that the Board is trying to keep consumers away. He commented that he understands that the meetings are held throughout the state to accommodate consumers to attend, but the places being chosen are prohibitive to many. He requested that the Board Members work to make these meetings more affordable for consumers to attend and questioned why the meetings are always held in the same part of the state. He recommended that the meetings be held elsewhere.

Ms. Hollingsworth questioned if the Board has considered the cost for members of the public to attend the meetings. She added that most working people do not want to sacrifice a day of work to go to a meeting and therefore it would be helpful if some of the meetings were held at at night. Additionally, she echoed Mr. Andrist's concerns about pricey hotels that pose as a deterrent to most people who may have to travel and spend the night. She noted that the location for the November meeting, at the Westin in San Diego, will be quite pricey considering the cost of the room and parking. Ms. Hollingsworth requested that the Board take timing and location into consideration in the future and also thanked Ms. D'Angelo Fellmeth for her dedication.

Motion carried unanimously (12-0).

Agenda Item 7 Executive Management Reports

Ms. Kirchmeyer clarified that the reason behind the venues that are picked is due to the fact that it is difficult to find a location that has two large rooms available, and the ability to webcast and provide an additional phone line for a teleconference. She added that the Board has looked into state buildings, however, they have not met the specifications needed, which is why the Board uses hotels.

Ms. Kirchmeyer shared that there is one budget change proposal that has been approved by both the Assembly and the Senate Budget Subcommittees, now awaiting final legislative approval before the Governor's Office. She noted that this proposal is to increase the hourly rate for the medical experts. She reminded the Board of two other budget change proposals, one to increase the funding for medical consultant hours at the Health Quality Investigation Unit (HQIU) and another to decrease the Attorney General's (AG) line item due to elimination of the vertical enforcement process.

Ms. Kirchmeyer explained that information has been received indicating that the Board will overspend this fiscal year. She confirmed that additional funding has been requested to meet

the needs and that the Board will be obtaining a vendor to perform a fee audit and a fee increase will most likely occur within the next year.

Ms. Kirchmeyer moved to staffing and stated that with the departure of Ms. Delp, the Board will be interviewing candidates for the Chief of Enforcement. In the meantime, Ms. Sweet has returned to the Board and has been a valuable resource. Additionally, she updated the Board that Mr. Grafillo, the director of DCA has moved into the private industry.

Ms. Kirchmeyer notified the Board the Mexico pilot program application has been finalized and released for use by the clinics and physicians. She confirmed that there has been one clinical application and six physician applications turned in to date.

Ms. Kirchmeyer reported that the Board has been working with the California Department of Public Health (CDPH) and their statewide opioid safety workgroup. She shared that CDPH has put together a dashboard to provide statistics regarding opioid deaths. Additionally, she provided updates on the Death Certificate Project, noting 23% percent of the cases have resulted in an either an accusation being filed or prior disciplinary action had been taken for prescribing issues.

Ms. Kirchmeyer addressed a new procedure that started in April and provided licensees an email 180 days prior to their renewal expiration date and encouraged the physician to renew online. If a licensee renews prior to 120 days from their renewal date, a paper renewal will not be sent to them. She reported that after this was made available, 80% of the renewals were processed online, which is the largest amount to date.

Mr. Andrist requested that the room specifications be sent to him so that he could help find a venue. He noted that in the executive report it is irrelevant how many calls came in, what would be more beneficial information is how many calls were answered by staff. He commented on the fact that employees were given a script to assist with calls and expressed that it would be better to impart knowledge than have employees reading off a script to increase customer service. He concluded by vocalizing that he would respect the process more if the Board was more honest and realistic.

Dr. Rhee shared her concerns about DCA and the new Chief of Enforcement and encouraged racial and religious diversity. She commented that the enforcement and investigative divisions are not diversified.

Ms. Hollingsworth inquired where she could find the actual total number of days it takes for a pending investigation.

Agenda Item 8 Update on the Physician Assistant Board

Mr. Sachs, Vice President, Physician Assistant Board (PAB), reported that at their April 29, 2019 meeting they discussed moving into a larger space, approved updates to regulations to allow the implementation of Assembly Bill (AB) 2138, and discussed removing some of the shared services from the Board. He added that the PAB took positions on legislation, most notably, their oppose unless amended position on Senate Bill (SB) 697. He shared that their

position stems from the reduction in the ability of the PAB to regulate. He stated the PAB had met with the author and stakeholders and agreed that that is a need for the PAB.

Dr. Yip requested a presentation on the PA curriculum and training, licensing requirements, and enforcement and complaint statistics.

Mr. Grant, President, PAB, shared that there is only one accrediting body in the country for PA programs and therefore curriculum is fairly similar. He added that it is about three academic years, where the first year is didactic, and the second and third years are clinical.

Ms. Breyman, Executive Director, California Academy of Physician Assistants, provided PA history to the Board. She noted that after 54 years in the field, PAs have proven to be safe, highly educated, and respected, for which they are now a profession in their own right and it is time for PAs to be regulated like all other healthcare professionals. She added that restrictive and unnecessary barriers for PAs must be broken down for PAs to provide care in all medical settings.

Agenda Item 9 Discussion and Possible Action on Legislation/Regulations

Ms. Simoes shared that the Board's legislative day was scheduled for May 15. The day will include 17 meetings with legislators, staff, and Board Members.

Ms. Simoes moved onto the sponsored bill update, SB 786, Committee on Business, Professions, and Economic Development, noting that it is an omnibus bill. She detailed a few changes offered by the Board, including changes to Business and Professions Code section 803.01 and deleting other outdated codes. She pointed out that the bill is moving along through the process.

Ms. Simoes transitioned to AB 241, Kamlager-Dove, which would require all continuing medical education (CME) courses for physicians to contain curriculum that includes the understanding of implicit bias and the promotion of bias reducing strategies beginning January 1, 2022. She stated this bill aims to address health disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, and socioeconomic status. Board staff recommended that Board support the bill since it could help reduce health disparities, furthering the Board’s consumer protection mission.

Ms. Wright made a motion to support AB 241; s/Dr. Lewis.

Dr. Krauss vocalized his nervousness when the legislature wants to prescribe CMEs and provided the example of mandated pain management CMEs being led by consultants of Purdue Pharma. He continued that while implicit bias is an important thing to recognize and to fight against, he is unsure if going through the legislature is the appropriate avenue and expressed his concerns regarding the language. He pointed out that the language in the bill relates to all CMEs and he explained the difficulty in that task, for this reason he suggested that the associations that develop CME programs include implicit bias in their programs rather than for the law to state that all CMEs must include implicit bias.

Ms. Simoes agreed with Dr. Krauss and remarked that the author based the bill off the cultural linguistic competency law. She added that she anticipates that it will not be a particular mandate for CMEs, but rather that implicit bias be woven into existing CME and the accrediting agencies will need to ensure the course has it included.

Dr. GnanaDev echoed the concerns of Dr. Krauss. He specified that if the CME accreditation programs will be responsible for this bill he would support it. He explained the difficulty in trying to put cultural competency into a scientific CME program.

Dr. Krauss pointed out the most current form of the bill still specifies all, and for this reason, he would prefer a support if amended position. He proposed the amended that the bill follow the same type of prescriptive recommendation in the language for cultural and linguistic competency and not require it be mandatory for all CME credit to include implicit bias training.

Ms. Simoes reiterated that she believes that is the intent of the bill.

Dr. Bholat highlighted that scientific research omits people of color often. She noted that while she does hear her colleagues on the Board and their concerns, there are some areas of medicine that are still being studied, such as genomics and precision medicine, however there is not enough information at this time. She concluded by noting that education on implicit bias raises consciousness and it should be added to the curriculum.

Dr. Rhee shared that she agreed with several of the comments made by the Board Members and emphasized the importance of implicit bias training. She noted the difference between being trained in implicit bias and having to practice implicit bias. She recommended that medical experts with the Board who maintain a medical practice have a racially diverse patient population. She concluded by thanking Ms. Wright for her diligence and her presence on the Board.

Ms. Pines agreed with the thoughts of Dr. Bholat and discussed the topic of maternal care and the increased rates of death for African-American and Hispanic women. She added that it could change the behaviors of physicians. She concluded by stating that if the Board is going to change people's perceptions, it needs to be put in front of them consistently.

Ms. Kirchmeyer clarified that the section of bill pertaining to the Board reflects the exact same language as that of the cultural and linguistic competency law.

Dr. Krauss questioned the word “all” that in the in bill.

Ms. Kirchmeyer pointed out that the section of the bill that he is referring to does not pertain to the Board.

Ms. Simoes added that the Board suggested that the language reflect what is stated in the cultural and linguistic competency law and this is an amendment that was implemented by the author.

Ms. Kirchmeyer commented that it is up to the associations that approve that CME to ensure that the criterion is met. She added that the Board does not approve CME courses; rather there are four different entities that approve CMEs.

Ms. Webb defined that there are in fact differences since there are subdivisions under the cultural and linguistic competency law.

Dr. Krauss emphasized that not all CMEs will cover cultural and linguistic topics, which does not mean that the CME credit is void, rather it is just not relevant for that CME. He suggested that there be further discussion with the author to ensure there are no unintended consequences.

Ms. Simoes offered that she would be willing to take an amendment to the author, but that the intent of the law is based upon the cultural and linguistic competency law.

Ms. Kirchmeyer reminded the Board that the motion on the table is to support the bill.

Mr. Warmoth summed up the discussion of the Board, noting that the point of contention is whether or not it would be appropriate to bring the subject in a CME course and he opined that regardless of how much it would be discussed, or how long it would be discussed, it is always worthwhile to discuss. He noted that the question should not be the time allotted, but it should be that this is an important topic that needs discussion.

Ms. Wright stated that her interpretation of the bill was that the CME would cover a certain subject and then implicit bias was referenced there in it.

Ms. Simoes stated that the intent is that it is woven into the CME and the accrediting entity would ensure that the topic is addressed. She detailed that the bill does not prescribe how much of that course has to be related to implicit bias, just that it is woven into the CME.

Ms. Wright shared that this bill is less restrictive than the state bar requirements, which mandate one hour of a certain area, versus this bill that requests that the topic be intertwined into the CME. She stated that since she made the motion she would not like to make any changes at that time.

Dr. GnanaDev inquired why the Board of Registered Nursing and the Nurses Association is opposing the bill.

Ms. Simoes clarified that this is because the Board of Registered Nursing approve their own continuing education requirements and she believes this is why they have issues.

Motion carried (11-0-1 – Krauss abstained).

Ms. Simoes moved to AB 387, Gabriel, which requires a physician to indicate the purpose for a drug or device on the prescription when providing a prescription to a patient unless the patient chooses to opt out of having that purpose on their prescription. She provided additional background on the existing law, which requires that a physician can do this only at the request of the patient. Currently, it is opt-in and this law would change that to opt-out. She identified

that the purpose is to prevent adverse drug events. Ms. Simoes stated that staff recommended a support position.

Dr. Lewis made a motion to support AB 387; s/Dr. Hawkins.

Ms. Wright proposed that some individuals might not want the reason written on the bottle in case someone else can read it.

Ms. Simoes stated that the individual could always opt-out by notifying their doctor.

Ms. Wright confirmed that a verbal disclosure needs to be given by the physician.

Ms. Simoes agreed that it requires the physician to give the patient the option to opt-out. Ms. Simoes reiterated that the physician must disclose to the patient that they can opt-out and at that point it is the patient's choice. She added that the bill is sponsored by the California Senior Legislature with the purposes of protection from adverse drug events.

Dr. Yip commented that his interpretation of the bill is that the physician is the one responsible for putting diagnosis not the pharmacy. He added that it could be a good thing to help the aging population, but not for others that need the protection of privacy. He concluded by suggesting that the bill is headed in a positive direction.

Dr. Hawkins reminded the Board that if it appears on the bottle, it is also written on the prescription.

Mr. Andrist remarked that this is a terrible idea for a bill. He pointed out that a doctor could forget to ask the patient if they would like to opt-out and the information could end up on the prescription. He added that there should not be this sort of reliance on doctors to remember to ask their patients, and for this reason, the default should not be to opt-out.

Ms. Allred, California Medical Association (CMA), shared that her organization is opposed to this version of the bill. The opposition stems from serious privacy concerns with the diagnosis being printed on the label and missing information in the bill related to refills and electronic prescriptions. She noted that CMA has worked extensively with the author's office and are looking into amendments to change the bill to allow for more autonomy with regard to prescribing to allow the electronic health record system to do this.

Ms. Friedman opined that this could be another task that could impact doctors in terms of filling out paperwork and therefore she is opposed to the bill.

Ms. Lawson clarified that her understanding of the bill is to provide consumer protection and making sure that the person ingesting the prescription has the necessary information about why they are taking it.

Ms. Simoes reminded the Board that this is already allowed in statute.

Ms. Lawson added that the Board should keep in mind their consumer protection function and that is the intent behind the legislation. She recommended that the Board support the bill since it is in the interest of consumer protection, but to continue to monitor the bill to ensure that privacy interests are also paramount.

Dr. GnanaDev stated that he opposes the bill in its current form due to privacy concerns. He shared that if the patient would like this information on the bottle, it can be requested.

Dr. Hawkins spoke from his experience with patients, noting that more often than not, a patient will not know the reason for the prescription and therefore he believes that it is a good idea. He added the privacy issue is less of a problem than patient education and safety issues.

Mr. Warmoth noted that when talking about a population that may have memory problems, asking them to remember to opt-out is not a good choice.

Dr. Bholat shared that the sticking point for her is the opt-out. She commented that she is behind having the training and education and this is how she trains her residents since patients can leave the hospital with many medications. Additionally, the patient has an after visit summary with the prescription information and a discussion with the doctor to notify the patient about what they are taking and the reasoning.

Ms. Simoes noted that the entire purpose of the bill is opt-out since current law is opt-in.

Dr. Bholat recommended that the author's office should amend the bill to remove sensitive conditions.

Dr. Hawkins expressed that he believes that the Board should take a stance on the bill that is not neutral. He suggested that a doctor can put an abbreviation or infection instead of chlamydia and both the patient and physician would know the intended use.

Ms. Pines agreed with Dr. Hawkins and added that people are living longer, which could mean that people are taking medications to help them live longer. Therefore, there could be a larger group of people on prescription drugs who will need to know what they are taking and this could make things safer. She concluded by vocalizing her support of the bill.

Dr. Yip reminded the Board that this bill would also affect pharmacists and there are certain logistics that should be considered.

Motion carried (6-3-2, Friedman, GnanaDev, and Lewis nay, Krauss and Wright abstained, and Lawson absent).

Ms. Simoes continued to AB 407, Santiago, which allows a physician or a doctor of podiatric medicine to provide fluoroscopy services without a fluoroscopy permit or certification if the services are provided in a setting in compliance with the Centers for Medicare and Medicaid Services for coverage relating to radiation safety. She noted that as of January 1, 2019, all fluoroscopy operators working in facilities accredited by the Joint Commission are required to undergo radiation safety training to maintain their privileges. She added that since there are

new radiation safety training requirements, it is reasonable that physicians and doctors of podiatric medicine no longer need to obtain a fluoroscopy permit or certification. She concluded by noting that Board staff recommends a neutral position on the bill.

Dr. GnanaDev vocalized his support for the recommendation staff since these services are very rarely provided.

Dr. GnanaDev made a motion to take a neutral position on AB 407; s/Dr. Bholat. Motion carried (11-0, Lawson absent).

Ms. Simoes presented AB 528, Low, which changes the timeframe for dispensers to report dispensed prescriptions to the Controlled Substance Utilization Review and Evaluation System (CURES) from seven days to the following business day. She explained the intent behind the bill is to reduce the reporting deadline, which will provide up-to-date information in CURES, making it more effective for physicians and to assist with preventing doctor shopping. She recommended the Board take a support position on the bill.

Dr. Hawkins inquired about the pharmacist's perspective on the bill.

Ms. Kirchmeyer responded that although she cannot speak for pharmacists, she understands that there are some concerns about whether or not they can comply with the bill. She added that those that utilize electronic records may have an easier ability to do so and that the Board of Pharmacy does support the bill.

Dr. Hawkins added that his reservations were rooted in whether or not pharmacists could actually comply and if there was concerns about prescriptions being slower to process.

Dr. GnanaDev made a motion to support AB 528; s/Dr. Krauss. Motion carried (11-0, Lawson absent).

Ms. Simoes explained AB 544, Brough, which limits the maximum fee for the renewal of an inactive license to no more than 50% of the renewal fee for an active license. She noted that this bill would prohibit a board from requiring payment of accrued and unpaid renewal fees as a condition of reinstating an expired license or registration. She clarified that the Board does not currently have a status for positions that would allow them to pay a reduced licensing fee to hold their license if they decide to stop practicing for a period of time or if they moved to another state, except for retired status. She remarked that the Board currently charges the full renewal fee for an inactive license and that it may be more reasonable to only charge a 50% renewal fee for an inactive license. However, if a physician is delinquent on their renewal fees, they should be required to pay accrued fees before they can renew their license. Ms. Simoes concluded by recommending that the Board take an oppose unless amended position, keeping the 50% renewal fee for inactive status licenses, but deleting the provisions that do not allow the Board to charge accrual fees for licensees that are delinquent.

Dr. Krauss made a motion to oppose AB 544 unless amended with the amendment of allowing the Board to charge accrual fees for licensees that are delinquent; s/Dr. GnanaDev.

Dr. GnanaDev confirmed that this would allow a physician to be inactive and just pay half of the licensing fees.

Ms. Simoes confirmed that is what the bill is proposing in hopes to incentivize physicians to stay in California and yet not require the full fees.

Dr. GnanaDev questioned how this revenue loss would impact the Board.

Ms. Simoes answered that it would result in the revenue loss of $261,000 per year for the Board, specifically the loss due to 50% reduction for inactive status would be $96,000 and the elimination of the accrued delinquent fees would be $165,000.

Ms. Kirchmeyer clarified that the $96,000 would be cut in half, generating $48,000 and the staff recommends an oppose unless amended position in order to enable the Board to keep the $165,000.

Dr. GnanaDev posed a hypothetical situation of a physician living in New York with a California license with no intent of return to California. He inquired what their options are in terms of retaining their license in California or if they would have to reapply.

Ms. Kirchmeyer responded that one option would be to put their license in inactive status and pay the full renewal fee annually. The second option would be to put their license in retired status in which they would not have to pay a fee to maintain the license, but they would have to pay a fee to take it out of retired status. The third option would be to let their license expire. She explained that if the license is delinquent for five years, the license will be canceled, and they would have to reapply for licensure all over again, meeting the present-day requirements.

Dr. Krauss inquired how this bill is affecting other boards.

Ms. Kirchmeyer responded that other boards are having a larger fiscal impact to their revenue and for this reason they are opposing the bill.

Ms. Simoes shared that she had spoken with the author's office and they seemed to be amenable to amendments recommended by the Board.

Motion carried (11-0-1, Lawson abstained).

Ms. Simoes discussed AB 613, Low, which authorizes boards under DCA to raise their licensing fees once every four years by an amount not to exceed the increase in the California Consumer Price Index for the preceding four years, with specified limitations. She added that the bill would provide a tool for the Board to use in the future to prevent significant fee increases for licensees, however this bill does not prevent the Board from pursuing a larger fee increase through statute if needed. She noted that this bill offers a tool to the Board, and for this reason, Board staff recommends the Board support the bill.

Mr. Warmoth made a motion to support AB 613; s/Dr. Krauss. Motion carried (11-0, Lewis absent).

Ms. Simoes presented AB 714, Wood, which is intended to provide clarification on AB 2760 that passed last year. She reminded the Board that AB 2760 required naloxone to be offered in certain circumstances, however there were many implementation issues and AB 714 is a bill meant to address those issues. She noted that it clarifies the existing requirement for a prescriber to offer naloxone when prescribing an opioid or benzodiazepine when specified at-risk conditions are present. Additionally, it clarifies that a concurrent prescription of an opioid and benzodiazepine means that the benzodiazepine medication was dispensed to the patient within the last year, clarifies that the condition related to increased risk for overdose is related to an opioid overdose, and that education is required when a prescriber is prescribing an opioid or benzodiazepine. Ms. Simoes detailed that it also defines exemptions when prescribing in inpatient or outpatient settings and to the terminally ill, specifically for hospice. She recommended the Board support the bill.

Dr. Krauss made a motion to support AB 714; s/Dr. GnanaDev. Motion carried (11-0-1, Lewis abstained).

Ms. Simoes shared information about AB 845, Maienschein, which allows for an optional CME in maternal mental health to address best practices and screening for maternal mental health disorders. She added that Board staff is recommending a neutral position.

Dr. Hawkins confirmed that it is an important subject, but questioned the value of making it optional.

Ms. Simoes responded that since it is not a required CME it has less opposition and this bill is bringing attention to the issue.

Ms. Friedman stressed the importance of this topic and recommended that any physician that deals with maternity issues should take these CMEs.

Dr. Rhee expressed her concern that the Board is utilizing medical experts that have an implicit bias. She recommended that this could be guarded against by utilizing medical experts with the Board that have a diverse patient population.

Dr. Lewis made a motion to take a neutral position on AB 845; s/Dr. Krauss. Motion carried unanimously (12-0).

Ms. Simoes moved to AB 888, Low, which would expand the requirements in existing law, put in place by SB 1109, and would now require a prescriber to have a discussion with any patient before directly dispensing or issuing the first prescription for controlled substances containing an opioid. She added that exemptions include addiction treatment or hospice patients and that the bill would require discussion of the availability of non-pharmacological treatments with the patient. Additionally, the bill mandates informed written consent when prescribing. She reminded the Board that this bill expands upon a bill that the Board supported last year, is

something the Board could enforce, increases education to patients, and therefore Board staff recommended a support position.

Dr. Krauss made a motion to support AB 888; s/Dr. Lewis.

Dr. GnanaDev responded that the opioid issue is not about one prescription for acute pain, it is the issuing of the large amounts of opioids for minor issues and then continuing to prescribe inappropriately. He added that he was not sure about the bill and wondered whether it should be a support position.

Ms. Simoes pointed out that the requirements remain on the physician while still allowing them to use their professional judgment.

Ms. Lawson stated that a significant number of the disciplinary and enforcement cases that come before the Board involve opioids and therefore it is the duty of the Board to support this bill.

Dr. Yip shared that the bill is good in concept, but his doubts stem from implementation. He noted that although he does have these discussions with his patients, if he were asked additional questions about non-pharmacological treatments he would not know who to refer them to.

Ms. Allred expressed her organizations opposition to AB 888 since referrals to non-pharmacological treatments tend to not be covered by insurance and conducting these discussions with the patient may not be appropriate. For example, if a patient gets their wisdom teeth removed, the physicians would have to discuss acupuncture and chiropractic alternatives, when the most appropriate course of action would be to prescribe a painkiller. She added there would be a large administrative burden that this bill would place on the physician.

Motion carried (11-2, GnanaDev and Lewis).

Ms. Simoes introduced, AB 890, Wood, which creates a new board within DCA called the Advanced Practice Registered Nursing Board. She went over the two pathways for licensure for the licensees of this board and listed the responsibilities that would be given once licensed. She highlighted that the bill subjects nurse practitioners (NP) to the existing law banning the corporate practice of medicine, and requires that NPs are subject to Business and Professions Code section 805 peer reporting. She concluded by noting that this is the most restrictive bill that has been proposed for NPs.

Ms. Kirchmeyer shared that there was no recommended position, since Board staff wanted to obtain the Board's feedback.

Dr. Krauss commented that those who wish to expand their scope need to demonstrate an education program and a clinical training with supervision program to give the Board the confidence that they are being well educated and supervised. Additionally, he added that there should be oversight between this new board and the Board as was done with the Podiatric Board, and through time, the new board can oversee itself.

Ms. Simoes noted that the idea here was to create a new board with both physicians and nurses. She added that the difficulty in this is having two board oversee one licensee.

Dr. Krauss expressed that he believes that every consumer has the right to a high level of care. He added that all procedures should be done in a setting where the consumer can trust that the person is licensed and that a uniform standard of care will be followed. He vocalized his concerns that a new board might have different standards of care and although it may seem cumbersome to have oversight of two boards, the consumer can complain to both boards. He concluded by noting that he would rather the Board have oversight over expanding scopes of practice rather than create new boards.

Dr. Lewis echoed the concerns of Dr. Krauss and added that in the state of Washington, NPs can call themselves doctors. He expressed the confusion that this may cause and identified the level of training that a doctor receives versus an NP. He vocalized his fear of NPs being allowed to practice as a physician without the proper training.

Dr. Bholat stated her support for healthcare teams, but specified that the number of training hours does matter and noted the disparity between NPs and physicians. She noted her belief that some of the concerns may be surrounding the misdistribution of physicians in areas of need, however, as the bill is currently written, she shared that she cannot support it.

Dr. GnanaDev reiterated that the job of the Board is consumer protection and noted the recent law change to require three years as the minimum requirement for residency. He added that since this bill does not meet that requirement, he does not support the bill.

Ms. Sutton-Wills inquired if this would put NPs in the same category as midwives, podiatrists, or clinical social workers in terms of their licensing.

Ms. Kirchmeyer clarified that they are advanced practice nurses.

Ms. Sutton-Wills commented that she did not see how a consumer would confuse an NP with a physician.

Ms. Kirchmeyer noted that she believes that NPs would be able to call themselves doctors.

Ms. Simoes clarified that one of the requirements is to hold a doctorate of nursing practice degree and if they held this degree, they would technically be called a doctor.

Ms. Kirchmeyer added that they would not be a medical doctor, but they would be a doctor of nursing. She added that there have already been complaints of this nature filed with the Board. More specifically, consumers have gone in to be treated, are treated by an NP and they do not disclose that they are an NP, they wear a white coat, but there is confusion in the end.

Ms. Simoes shared that the big difference will be that they will be practicing independently.

Dr. Hawkins acknowledged that while he appreciates the increasing requirements for NPs to be able to be more autonomous, he can confirm the confusion in his own hospital setting with NPs, PAs, and physicians. He echoed the concerns over the increase in scope of practice and expressed his opposition of the bill.

Dr. Lewis made a motion to oppose AB 890; s/Dr. Hawkins.

Ms. Allred shared that although CMA has been working extensively on the current language in the bill, they maintain an oppose unless amended position due to significant details surrounding the duties of the new board, training required, and consumer protection issues. She added that CMA believes that the bill will not increase access to care as the data shows that NPs in other states are not moving to rural, underserved areas and therefore there is no data to show that this change will occur in California either.

Mr. Andrist added that he went to the doctor and was led to believe that the person attending him was a doctor, but they were an NP, which he found out later. He continued that the NP used a prescription pad that was not her own and misdiagnosed him. He confirmed that the entire experience was very misleading.

Motion carried (11-1-1, Sutton-Wills nay, Warmoth abstained).

Ms. Simoes moved to AB 1030, Calderon, which requires the Board on or before July 1, 2020, in coordination with the American College of Obstetricians and Gynecologists (ACOG), to develop an informational pamphlet for patients undergoing gynecological examinations. She noted this bill would require physicians to give information on gynecological exams to patients, which will help protect consumers by providing them information on a proper examination. Specifically, it may help to prevent sexual misconduct and ensure misconduct is reported to the Board. She shared that Board staff is recommending a support position.

Ms. Wright made a motion to support AB 1030; s/Dr. Lewis.

Dr. GnanaDev noted that ACOG took a support unless amended position and questioned why.

Ms. Simoes believes that ACOG took issue with the signing of the form, but noted that she wanted to double check the specific concerns.

Motion unanimously carried (13-0).

Ms. Simoes transitioned to AB 1264, Petrie-Norris, which expressly clarifies that an appropriate prior examination does not require a synchronous or real-time interaction between a healing arts licensee and a patient for purposes of prescribing, furnishing, or dispensing a self-administered hormonal contraceptive following the use of a self screening tool. She added that this bill had an urgency clause and it would become effective immediately upon the Governor's signature. She noted that since the bill is clarifying in nature, Board staff recommends the Board take a neutral position on this bill.

Dr. Krauss made a motion to take a neutral position on AB 1264; s/Dr. GnanaDev.

Dr. Bholat asked about what will be happening with the video and noted that this will be an issue for the future. Additionally, she inquired what a good faith examination means.

Ms. Simoes remarked that when the Board receives calls inquiring what an appropriate prior examination is, she clarifies that it is determined by the standard of care on a patient by patient basis.

Motion unanimously carried (13-0).

Ms. Simoes moved to AB 1467, Salas, which authorizes ophthalmologists to enter into delegated service agreements with optometrists, which will increase the two professions collaboration in the treatment of patients. She added that it does not require the ophthalmologist to supervise the optometrists; it would be a collaboration, however, it does state that the delegated services agreement can only authorize the optometrist to perform services consistent within their existing act, which is a part of existing law.

Dr. Krauss confirmed that this already happens in practice, where there is co-managing and collaboration in patient care. Since this has been happening for quite some time, he questioned why this bill is needed.

Ms. Simoes pointed out that the intent is to improve access to quality care options for screening early diagnosis of systemic diseases.

Dr. Krauss noted that he did not see the need for the bill, but he would support a neutral position.

Dr. Krauss made a motion to take a neutral position on AB 1467; s/Dr. Hawkins.

Motion unanimously carried (13-0).

Ms. Simoes explained AB 1468, McCarty, establishes the Opioid Prevention and Rehabilitation Act, which would be funded by manufacturers and wholesalers of opioid drugs. She stated that this law would be repealed January 1, 2028. She noted that the bill creates an opioid prevention and rehabilitation program fund that will be appropriated to CDPH to carry out the requirements of the bill. She pointed out that CDPH would be responsible for distributing the monies in the fund to counties or local nonprofit community-based organizations based on county needs. She concluded by recommending that the Board take a support if amended position on the bill, with amendments to include not allowing manufacturers and wholesalers to pass along the costs to patients.

Dr. GnanaDev made motion to take a support if amended position on AB 1468, with the amendment being to not allow manufacturers and wholesalers to pass along the costs to patients; s/ Dr. Hawkins.

Dr. GnanaDev asked if this this bill would prevent the Attorney General's (AG) Office or the State of California from suing opioid manufacturers.

Ms. Simoes stated that it should not prevent it.

Motion unanimously carried (13-0).

Ms. Simoes detailed AB1544, Gipson, which authorizes a local emergency medical services authority within a county to elect to develop a community paramedicine program or a triage to alternate destination program. She reminded the Board that there was a similar bill that the Board had opposed due to oversight and she highlighted the changes in this bill to correct those issues. Additionally, Dr. Krauss worked with Board staff on HWPP 173 with regard to patient safety concerns, however, this bill is very similar to a bill that the Board took a neutral position on due to the important role emergency responders play.

Dr. Krauss made a motion to take a neutral position on AB 1544; s/Dr. Lewis. Motion unanimously carried (13-0).

Ms. Simoes transitioned to SB 159, Wiener, which allows pharmacists to furnish pre-exposure prophylaxis (PrEP) and post exposure prophylaxis (PEP) in accordance with protocols established by the bill. She noted that although the purpose of the bill is well-intended, PrEP has risks from long-term use and allows patients to obtain a full regimen of PrEP without any requirement to see a physician for follow-up care, and therefore Board staff recommends an oppose position.

Mr. Warmoth disagreed and noted the lifesaving effects that PrEP and PEP have had. He vocalized that he would hope the Board would take a support is amended position.

Ms. Simoes clarified that the oppose position is not in opposition of PrEP or PEP, rather it is in opposition of who can provide the prescription.

Mr. Warmoth confirmed that there are significant current barriers that the bill is attempting to address.

Dr. Hawkins echoed the importance of PrEP and PEP, his opposition of the bill stems from putting too much pressure on the pharmacist. He added that the prescriber should be a physician or mid-level practitioner and this bill could create a number of unintended consequences that do not address the problem sufficiently.

Dr. Lewis vocalized his support for a physician administering PrEP and shared his support for a pharmacist administering PEP.

Dr. Krauss elaborated that these drugs are so critical that the Board should try to find a way to support if amended or oppose unless amended. He added that it is not good to allow patients to take a drug for a long period of time without having a medical evaluation, at the same time, it would not be good to delay or limit access to the drugs.

Ms. Sutton-Wills agreed that it is an important community access issue and would send the wrong message to oppose the bill. She added that the necessary medical reasons should be added to the amendments.

Dr. Bholat added that she would also like to take a support position on the bill.

Dr. GnanaDev identified that the concept is great but stated he had concerns about the lack of follow up with a primary care provider. He added that pharmacists cannot do the follow up, therefore if the amendments included follow up with a primary care provider, he would support the bill.

Dr. Lewis made a motion to support SB 159 if amended and delegated Dr. Hawkins to work with Board staff on the specific amendments; s/Dr. Hawkins.

Ms. Allred shared that CMA has opposed this bill. She pointed out that SB 159 seeks to increase access to PrEP and PEP at a standard lower than the standard of care provided at a physician's office, which increases the patient's risk. She stated that the only thing SB 159 is likely to do is to increase the patient's challenges for adherence and therefore increasing the patient's overall risk of HIV infection. She added the dangerous precedent that this bill would set, allowing a patient who is at a higher risk of contracting HIV to not see a doctor or be monitored by their doctor. She concluded by sharing that the author has been unwilling to accept any medical guidance on the provisions of the bill or to negotiate to remove PrEP, and therefore CMA opposes the bill since there are concerns about patient safety and the standard of care.

Mr. Pulsipher, APLA Health, stated he was asked to come on behalf of Senator Wiener to explain the importance of the bill. He noted that this is a response to the HIV epidemic and could most benefit communities of color, youth, and women, especially trans women. He pointed out that the bill allows pharmacists to furnish an initial 30-day supply of PrEP and then the patient is connected with a primary care physician for ongoing care, and then it is the full course of PrEP. He reiterated that PEP can be extremely difficult to access on the weekend or late at night. Mr. Pulsipher highlighted that the bill strikes an important balance between providing improved access to the medication while also ensuring that the patient receives appropriate testing and follow-up care. He added that studies have shown that providing rapid access to PrEP makes it more likely that patients will continue taking the medication for a longer period.

Motion unanimously carried (13-0).

Ms. Simoes moved to SB 377, McGuire, which requires a juvenile court officer to authorize the Board to review the minor’s medical records, limited to the diagnosis for a prescription, in order to determine if there is inappropriate prescribing of psychotropic medications. She reminded the Board that an expert pediatric psychiatrist reviewed cases and it was determined that 86 children were identified as potentially being prescribed to inappropriately. However, the Board only received releases from four individuals allowing the Board to investigate those cases. She explained that without authorization, the Board cannot move forward to investigate. Ms. Simoes added that currently the bill is limited to diagnosis, which is not enough for an expert to

make a determination, and therefore an amendment will be needed to allow the Board to obtain more information from the medical records. She recommended that the Board taken a support if amended position on the bill.

Dr. Krauss made a motion to support SB 377 if amended to expand on the medical records the Board will be able to obtain; s/Dr. Bholat.

Dr. GnanaDev expressed his biggest concern is how can the Department of Social Services provide better services so doctors are not being dumped on to prescribe medications. He shared that there are not a lot of child psychiatrists, and his concern is that if pushed, there will be a loss of psychiatrists willing to work in this area.

Ms. Kirchmeyer shared that there was a Bureau of State Audits undertaking that addressed many of the concerns that were brought up. She added that those concerns have been addressed through that report and there have been several meetings with those entities, including follow up to ensure compliance.

Ms. Friedman commented that in Los Angeles County foster youth cannot be prescribed psychotropic drugs. She added that the oversight is given to the judges and they are in control of this area.

Ms. Allred shared CMA's opposition of SB 377 since it bypasses patient privacy on sensitive and confidential mental health records by authorizing their release without patient permission. She added that alternative methods should be sought to receive consent without forgoing patient permission.

Motion carried (12-0-1, Lewis abstained).

Ms. Simoes explained that SB 425, Hill, included language from the Board's approved legislative proposals. She stated the bill also requires a health facility, clinic, or other entity under which a healing arts licensee practices or provides care to patients, to report any allegations of sexual abuse or sexual misconduct made against a healing arts licensee. She added that this must be done within 15 days and needs to be filed with the appropriate licensing board. Additionally, this bill would require the same reporting requirements for any employee that has knowledge of sexual abuse or sexual misconduct. Ms. Simoes pointed out that the licensing board would be required to investigate the allegations and explained the fiscal implications of the bill. She stated that since this bill promotes the Board's mission of consumer protection, Board staff's recommendation is to take a support position.

Dr. Krauss made a motion to support SB 425; s/Mr. Warmoth.

Dr. GnanaDev asked if the only the licensing board would investigate the allegation, or if the entity would as well.

Ms. Simoes responded that the requirement for the entity is that they report the allegation to the board. She added that this would not change their internal process, rather it would be parallel to that process. She confirmed that what it does is ensures that the licensing board is made

aware of the allegation and the double reporting by the entity and the employee is in place to serve as a check and balance.

Dr. GnanaDev inquired what would happen if the entity conducts the investigation and then determines that nothing happened.

Ms. Simoes answered that nothing would change for the Board; it would still review the matter and if no violations were found, close the case. She added that this notification would function as a new tool for the Board to obtain the information.

Dr. Yip noted the typical process for allegations to be filtered within a hospital and asked if this bill would cut through that process due to the reporting timeframe.

Ms. Simoes clarified that the main difference is that the licensing board would get an earlier report and the facilities' internal process as well as the Board's would not change.

Ms. Allred commented that CMA has an opposed unless amended position on SB 425 due to the broad approach to address a narrow, yet egregious issue. She added that the bill needs more specificity regarding the circumstances that trigger the reporting requirements to ensure that the allegations have some merit and that there are proper training and policies in place to ensure that employees and staff are aware of their reporting obligations. She noted that while there is support of the intent of the bill, there are also technical changes that are necessary to ensure that the issue is properly being addressed.

Ms. D'Angelo Fellmeth pointed out that there are a number of laws that have been in place for decades that require hospitals and clinics to report certain peer review actions to the Board and to other appropriate licensing agencies. She added that the Board is not getting the amount of 805 reports that it should be getting since there is widespread confusion due to the 805 being incomprehensible and dispute about when the reports need to be submitted to the Board. She stated this has led to widespread non-compliance. She explained that the Board was not appropriately receiving 805.01 reports since there was no penalty for violating the reporting requirement. She concluded by sharing that entities do not want to file the reports since they want to avoid being sued by a doctor, and therefore there needs to be a law with clear immediate reporting requirements so investigations can begin quickly as this bill proposes.

Ms. Hollingsworth thanked the Board for including the doctor interview issue in SB 425 and working with Senator Hill on the bill. She conveyed her support for the bill and highlighted the importance of it.

Mr. Andrist noted the importance of informing potential patients about doctors who are sexually assaulting their patients. He mentioned a 2567 report from CDPH, which outlines a doctor that had sexually assaulted numerous patients while unconscious. He noted that when he submitted a Public Records Act request to CDPH to see if this had been reported to the Board, he confirmed that it had not. For this reason, he knows that CDPH is also not reporting this information to the Board and questioned if 2567 reports should also be provided to the Board.

Motion carried unanimously (13-0).

Ms. Simoes introduced SB 697, Caballero, which revises the Physician Assistant Practice Act to align PA supervision requirements to that of an NP. She highlighted that the bill strikes all references to the delegated services agreement and replace those with a practice agreement. She noted that the bill defines a practice agreement as a writing developed through collaboration among one or more physicians and one or more PAs to outline the medical services that the PA is authorized to perform. She added that there have been many stakeholders that have worked on the bill and it involved much negotiation to obtain the current format.

Dr. GnanaDev questioned if the reason why emergency room doctors are opposing this bill is due to the increase in the number of PAs that a physician would supervise.

Ms. Simoes responded that they did raise concerns about the number.

Dr. GnanaDev made a motion to support SB 697; s/Dr. Hawkins.

Dr. Hawkins inquired what the major difference is between what is currently in effect and the changes that this bill will make.

Ms. Simoes commented that this bill will broaden what PAs can do, similar to NPs and instead of working with one physician, they can work with multiple. Additionally, it would put standardized protocols and procedures in effect.

Dr. GnanaDev noted that it does not change anything; they continue to be under the supervision of a physician and their function will be similar to an NP.

Ms. Allred explained that the bill in its current form addresses many of the concerns from PAs while maintaining adequate physician supervision. She noted that CMA believes that many of the concerns expressed by the PAB can be addressed through clarifying technical amendments.

Ms. Breyman, Executive Director, California Academy of Physician Assistants, echoed the comment of Dr. GnanaDev, noting that not every physician should be on a delegation of services agreement, rather it should be done at the practice level. She added that it was originally introduced as optimal team practice and was misconstrued as PAs wanting independent practice which is not the case. Moreover, this bill is more about addressing how PAs will be regulated and getting rid of current barriers that exist. She confirmed that they will be talking to the author about bringing the number of PAs down from six to four.

Dr. Krauss asked that Mr. Grant, President of the PAB, address the PAB's amendments as set forth in the letter he provided to the Members.

Ms. Breyman commented that earlier Mr. Grant spoke in opposition of the bill, which was due to the restrictive language, however, this is something that is being worked on with CMA.

Mr. Grant shared that there was a meeting with the author and stakeholders and the letter outlines some of those issues, but does not provide a solution. He pointed out that the bill is a work in progress. He highlighted that the Board and the Board of Registered Nursing have foundational rules set in place to take action after harm is done, whereas the PA Act places restrictions prior to practice and harm takes place. He believes that the intent is to make the regulation the same for all three of those medical professionals and once this is worked out, he hopes that the PAB can take a support position.

Ms. Sutton-Wills asked if the PAB is taking a different position than the letter indicates.

Mr. Grant clarified that the language of the bill has not changed and the position of the PAB has not changed, but he does anticipate working with CAPA and CMA. He stated that this bill does not allow them to regulate very well, which is why there is opposition.

Motion carried (8-0-5; Lawson, Sutton-Wills, Warmoth, Wright, and Yip abstained).

Ms. Simoes commented on the regulatory actions, noting that a regulatory hearing was held on the Approved Postgraduate Training regulations on March 11, 2019. She added that there were no public comments at the hearing and only one written comment was received, which was non-substantive. She concluded that the regulatory package is currently in the final review stage.

Agenda Item 10 Discussion and Possible Action on Recommendation from the Special Faculty Permit Review Committee

Dr. Bholat reported that on March 14, 2019, the Special Faculty Permit Review Committee (Committee) held a teleconference to review and discuss Dr. Frederick J. Kolb and his special faculty appointment with the University of California, San Diego School of Medicine. She shared that his area of expertise is surgery, specifically in the area of reconstructive microsurgery of the head, neck, and breast. She added that Dr. Kolb currently holds the position of Chief of Plastic and Reconstructive Surgery at the Institut Gustave Roussey, is a consultant for the French National Oncology Organization, and is the founder and educational coordinator of the European School of Reconstructive Microsurgery and European Master of Free Flap Reconstructive Microsurgery at the University of Catalonia and University of Paris. Additionally, he became internationally recognized for his work at the treatment center for cancer therapy and reconstructive surgery. Dr. Bholat added that if approved by the Board, Dr. Kolb would hold a full-time faculty appointment as professor of clinical surgery at University of California, San Diego and would work with its affiliated medical centers where he will perform surgeries pertaining to cancer resections, microsurgical breast reconstruction, and other complex post oncological reconstruction. She concluded by reporting that the Committee reviewed Dr. Kolb's application and qualifications and recommended that the Board approve Dr. Kolb's application.

Dr. Krauss made a motion to approve Dr. Kolb for a Busienss and Professions Code section 2168.1 Special Faculty Permit; s/Ms. Lawson. Motion carried (12-0-1, Lewis abstained).

Agenda Item 11 Discussion and Possible Action on Questions Pertaining to Impairment on the Applications for Licensure and Registration

Ms. Kirchmeyer reminded the Board that at the last meeting, staff provided suggestions for amending the impairment questions on the licensing application based upon information received from interested parties and the FSMB's policy on physician wellness and burnout. She noted that Members voted to table the discussion and requested the creation of a Task Force to look into the issue and provide recommendations. She shared that Ms. Pines and Dr. Lewis made up the Task Force and they were provided information on other states' applications as well as other California boards' applications. She noted that after discussion with the Task Force, the recommendation is to make amendments as listed on page BRD 11-2. Ms. Kirchmeyer pointed out that these updates intend to eliminate all of the open and unlimited questions and still ensure that the Board can still perform its role of consumer protection.

Dr. Krauss made a motion to approve the changes to the application as recommended on page BRD 11-2; s/Ms. Friedman.

Ms. Lubiano inquired why the question in number three, the part stating, "impairs your ability to practice," would be left on the application, thinking that not very many people would say yes. Additionally, she added that it would be in the opinion of the applicant. She recommended that this part be left out.

Ms. Webb explained that decisions need to be made on those conditions that impact their ability to practice medicine safely.

Ms. Lawson asked if the way that this question is worded would invite some type of opinion on the applicant's part where the Board might disagree.

Ms. Kirchmeyer responded that this would depend on what the Board obtains from the postgraduate training program, or another licensing board. This information will be compared to determine if there is an impairment issue.

Dr. Krauss noted that even though ultimately it is the applicant's opinion it is important to have the information on the record.

Ms. Friedman inquired if anyone had answered yes to the question.

Ms. Kirchmeyer confirmed that this has happened.

Ms. Webb remarked that the Board has the ability to give a limited practice license and that it is better for the applicant to disclose information, so that options can be provided to them. She pointed out that everything is cross checked. She stated these amendments are being brought to the Board to get ahead of pending litigation that the Board can expect if not addressed.

Dr. GnanaDev shared that his understanding was that the questions were too broad and this is why FSMB reviewed the issue.

Ms. Kirchmeyer confirmed that this was the case in other states.

Ms. D'Angelo Fellmeth inquired why question six would be deleted.

Ms. Webb clarified that it is not asking about their ability to practice now. She added that essentially all people who are licensed have a progressive condition, because everyone ages. She noted that the thought behind it is that a physician can come before the Board to explain their condition, list their limitations and have it reviewed with a medical doctor rather than have someone else report them.

Ms. D'Angelo Fellmeth asked if the limited license application is different from the normal licensing application.

Ms. Kirchmeyer confirmed that they are different.

Ms. Matsubara, CMA, remarked that the Board should seek to keep the questions worded generally to focus on the applicant's ability and competency to practice safely without regard to the type of impairment and not to stigmatize one type of impairment over another. She pointed out on question one, it can be perceived as stigmatizing substance use and it does not include all the ways an applicant could be receiving treatment for a condition. She recommended that question one be removed and question two be more broadly worded. Ms. Matsubara commented that question three is confusing and duplicative of question two.

Mr. Andrist expressed that he does not understand the fear of asking potential licensees about their past since they will be treating the public. He noted that according to the Journal of American Medical Association 40 to 60% of people with substance use disorders relapse, and that relapsing is a normal part of recovery. For this reason, he believes that the Board would be asking for trouble if it was not understood what a potential licensee's true history with drugs and alcohol is.

Ms. Lawson inquired if it is unlawful to ask those questions.

Ms. Webb answered that it may be.

Ms. Lawson asked if the Board would be exposed to litigation if the Board continued to ask these questions.

Ms. Webb responded that there could potentially be future litigation. She added that if there is a problem, including long-standing substance use, there will be an opportunity for it to be discovered if it is something that impairs their ability to practice safely, through other documentation received.

Dr. Yellowlees, M.D., a psychiatrist and Chief Wellness Officer at the University of California, Davis, explained that he has been treating physicians as patients for many years. He confirmed that there are many doctors that do not seek treatment or find it threatening to seek treatment due to concerns over losing their license. He pointed out that ultimately this is all about patient safety. Dr. Yellowlees recommended that question one on the list of the original

six questions should not be included at all. He added that since California does not have a physician health program, there will be definition problems. He supported the CMA view that there should be a comment included about this disorder and going untreated since this is what is trying to be prevented. He concluded by noting that if three is included, five becomes duplicative.

Ms. Monserratt-Ramos stated that as a consumer and as a person that has been involved in this issue for the past twelve years, since a loved one lost his life due to surgical mistakes made by an impaired physician that was addicted to crack cocaine, she requested that the Board leave the questions as is, especially question one. She shared that had the Board been accessing the National Practitioner Data Base, the Board would have had this information, however, since it had not been done, it is vital to have this information to protect consumers.

Motion carried unanimously (13-0).

Ms. Pines adjourned the meeting at 6:58 p.m.

Friday, May 10, 2019

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

Members Present:
Denise Pines, President
Michelle Anne Bholat, M.D., Secretary
Susan F. Friedman
Dev GnanaDev, M.D.
Randy W. Hawkins, M.D.
Howard R. Krauss, M.D.
Kristina D. Lawson, J.D.
Ronald H. Lewis, M.D., Vice President
Laurie Rose Lubiano, J.D.
Brenda Sutton-Wills, J.D.
David Warmoth
Felix C. Yip, M.D.

Members Absent:
Jamie Wright, J.D.

Staff Present:
April Alameda, Chief of Licensing
Mary Kathryn Cruz Jones, Associate Governmental Program Analyst
Kimberly Kirchmeyer, Executive Director
Christine Lally, Deputy Director
Sheronnia Little, Information Technology Supervisor I
Regina Rao, Associate Governmental Program Analyst
Elizabeth Rojas, Staff Services Analyst

Jennifer Simoes, Chief of Legislation
Kevin Valone, Staff Services Analyst
Carlos Villatoro, Public Information Manager
Kerrie Webb, Staff Counsel

Members of the Audience:
Megan Allred, California Medical Association
Eric Andrist, Patient Safety League
Gloria Castro, Senior Assistant Attorney General, Health Quality Enforcement Section, Attorney General's Office
David Chriss, Chief, Health Quality Investigation Unit, Department of Consumer Affairs
Zennie Coughlin, Kaiser Permanente
Clinton Dicely, Supervising Investigator, Health Quality Investigation Unit, Department of Consumer Affairs
Steve Diehl, Supervising Deputy Attorney General, Health Quality Enforcement Section, Attorney General's Office
Shelly Gartner, Investigator, Health Quality Investigation Unit, Department of Consumer Affairs
Stephen Henry, M.D., University of California, Davis
Edward Hollingsworth, Patient Safety League
Marian Hollingsworth, Patient Safety League and Patient Safety Action Network
Sarah Jacobs, Deputy Attorney General, Health Quality Enforcement Section, Attorney General's Office
Khadijah Lang, M.D., President, Golden State Medical Association
Susan Lauren
Patrick Le, Assistant Deputy Director, Board and Bureau Services, Department of Consumer Affairs
Lisa Matsubara, California Medical Association
Michelle Monserratt-Ramos, Consumers Union Safe Patient Project
Kathleen Nicholls, Deputy Chief, Health Quality Investigation Unit, Department of Consumer Affairs
Philip Peters, M.D., Office of AIDS Medical Center, California Department of Public Health
Hanna Rhee, M.D.
Mike Sanchez, Videographer, Department of Consumer Affairs
Marianne Skolek-Perez, Freedom Outpost

Agenda Item 13 Call to Order/Roll Call/Establishment of a Quorum

Ms. Pines called the meeting of the Medical Board of California (Board) to order on May 10, 2019 at 9:05 a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 14 Public Comments on Items not on the Agenda

Mr. Andrist shared an experience with a Dr. GnanaDev where he felt that he was being blamed for the doctor's errors during his surgery, since he had chosen a bad doctor. He added that the Board constantly pushes the public to consult BreEZe and check up on their doctor, however if you look at the profile of the doctor he chose, there is nothing listed on their profile. He opined that the reason why there is nothing listed is due to the fact the Board closes 96% of the consumer complaints. He advised the Board to listen to the Panel A hearing to listen to the case against Dr. Hughes, where the Supervising Deputy Attorney General, Mr. Bell, recommended dropping the charges due to the medical expert's unscrupulous activity. Mr. Andrist shared that the expert changed his story five times and noted allegations of corruption, and then questioned how many other cases were closed by corrupt experts.

Dr. Rhee detailed that her organization is against funding investigative and policing agencies that pay medical experts who are not in active practice and who do not care for and treat a racially diversified patient population. She concluded by providing an update on her federal civil rights lawsuit against members of the Board and expressed her concern that individuals affiliated with the Board align themselves with non-racially diversified hate groups.

Ms. Lauren provided details about her story and shared how the Board has done nothing to help her case. She remarked that the previous day Mr. Andrist made a comment about the meeting minutes and she opined that what she heard was lies. She detailed how the surgeon who attended her incorrectly conveyed their conversations and performed surgeries on her body for which she did not provide consent. She concluded by noting that she is an advocate and has been following how plastic surgeons are given carte blanche to do innately bad procedures, can kill, cause serious harm, and it is a public safety concern. Ms. Lauren requested that liposuction and liposuction cover-up be a future agenda item.

Dr. Lang, President of the Golden State Medical Association, discussed the epidemic of black maternal mortality in America. She elaborated that this has been an issue for decades, however, it has only recently been publically known despite certain government agencies being aware of this issue. She specified that there are 18 to 48 deaths per hundred thousand African-American pregnant women, which is two to four times higher for African-American women than for Caucasian women. Dr. Lang noted that a significant cause is racial bias and for this reason, requested that the Board mandate that any licensed personnel who come into contact with pregnant women or could be anticipated to come into contact with pregnant women be required to undergo bias training. Dr. Lang moved to her second topic, which was that there be an update on the findings of the 2017 Demographic report. She added that she would also like an update on the implicit bias training that has been given to Board staff.

Agenda Item 12 Update on the Health Professions Education Foundation

Dr. Hawkins stated the Health Professions Education Foundation (HPEF) met in March and May. He thanked those that participated in the scoring of the Stephen M. Thompson loan repayment program applications. He noted that overall, they received 275 applicants, 130 were not eligible, 144 were eligible, and 42 were awarded. He shared that awards are also given to individuals in allied health professions. Dr. Hawkins concluded by stating that awards will be given in May.

Agenda Item 16 Discussion and Possible Action on Midwifery Advisory Council Appointments

Ms. Alameda reported to the Board that effective June 30, 2019, there will be four Midwifery Advisory Council (MAC) member appointments that will expire. She shared that Board staff went through the recruitment process, presented the applications to the MAC members at the March meeting, and members made recommendations. She explained that the members voted to recommend reappointing Ms. Holzer to the midwife position, reappointing Dr. Adams to the physician position, reappointing Ms. Dugan to the public position, and appointing Ms. Abe to the second public position.

Dr. Lewis made a motion to approve all four appointees to the MAC; s/Dr. Yip.

Dr. Rhee provided information about the historical role of the African-American midwife. She expressed her concerns that the MAC and the appointments do not show racial diversity.

Motion unanimously carried (12-0).

Agenda Item 17 Presentation on HIV and Pre-Exposure Prophylaxis (PrEP): an Update on PrEP use for HIV Prevention in California

Dr. Peters from the Office of AIDS Medical Center under the Department of Public Health began his presentation by noting the number of people diagnosed with HIV in California from 2007 to 2017 and continued to discuss the rate of newly diagnosed HIV patients by race and ethnicity in 2017. He discussed the key differences between PEP and PrEP. He detailed the effectiveness of PrEP when adhered to, as well as the steps physicians and patients take when prescribing and taking PrEP. Additionally, Dr. Peters elaborated on the adverse effects and common concerns related to PrEP, presented the risks versus the benefits when using PrEP, and general access to PrEP. He concluded the presentation by discussing PrEP awareness and the use among men who have sex with men, the overall utilization of PrEP in California, and how PrEP access has expanded.

Dr. Hawkins asked about the impact of the mandated CME related to this topic.

Dr. Peters shared that he does not have metrics to share on this topic, however, an interesting thing that has been done in Florida is that they have an extensive state-based PrEP program where all of their state-run sexually transmitted infection clinics provide PrEP free of cost. He opined that since every physician in Florida has had the HIV CME training, more progressive

programs have been initiated to address the HIV epidemic. He confirmed that there is an added benefit there that the physicians have embraced this program where there have previously not been too may programs of its kind.

Dr. Lewis inquired about the handoff to a provider if a person does not live in the same area where they need to obtain PEP.

Dr. Peters responded in terms of the general issue of the handoff, stating that the perfect cannot be the enemy of good. He noted that he believes that doctors respond to demand and the demand needs to be increased.

Mr. Warmoth noted that all the focus is on PrEP rather than PEP and with PrEP there are key communities that would be better served if they have an easier access to PrEP. He asked about the current rate of adoption and any ideas for improvement.

Dr. Peters pointed out that there are many barriers such as issues of violence, legal issues, issues of racism, and issues of medical mistrust. He added that he has heard many stories about doctors that do not prescribe PrEP. He noted that there are many community partners that are working with clinicians to help them understand the importance of this service. Dr. Peters explained why PrEP has been successful among gay white men and attributes it to the fact that there was consumer pressure. He concluded by highlighting physician mistrust and pushed for a multi-pronged approach to reach a solution. He suggested that telemedicine may be one option. In addition, he stated that individuals who have benefited tend to disseminate the information to their social networks.

Dr. Yip opined that CMEs is a good option since there is still some ignorance and fear regarding AIDS in the primary physician community. He recommended that there be a website or a publication to identify areas where people can easily go for treatment to increase access. He shared that urgent care is a place that a patient could go that is open all hours.

Ms. Lubiano asked for the average duration when a patient is taking this medication.

Dr. Peters confirmed that this information varies, however, there is a significant drop off over the first six months. He explained some of the factors that convolute the data. He pointed out that it is much different from HIV treatment, which most people stay on for a length of time.

Ms. Lubiano inquired about how she can get the word out about this in her community.

Dr. Peters invited her to contact him for more information and extrapolated upon the wealth of resources that are in California. He noted that there is both a state wide effort and a local community effort. He reiterated that the way that most of this has happened is due to the community demanding that it be done.

Dr. Bholat inquired if the 12 to 17 year olds are covered under Title IX family pact.

Dr. Peters responded that he does not believe that Title IX family pact will cover this. He continued that if they would like it to be covered under their parents' insurance that can be

done, but most likely the adolescent does not want that. He added that it would be covered by the PrEP program.

Dr. Bholat commented that although the training from the Los Angeles DPH is informative, there is a gap on the science.

Dr. Rhee commented that part of the solution may be found in the racial disparity. She let Dr. Peters know she will be in touch and added that she will be sharing this information with her community. She pointed out that the map from the presentation correlates with the number of African-American physicians and utilization of PrEP and inquired if African-American patients seeing African-American doctors is part of the solution.

Dr. Lang explained that it takes a more intense hand-holding approach to get African-American and Latino patients to use PrEP. She noted that equally as challenging, it is difficult to find a pharmacy in these communities that are able to fill the prescriptions. She recommended that PrEP be covered by Medicare. She commented that the general topic of a patient's sex life is challenging and when touching on this topic with minority populations, trust must be established first. Dr. Lang recommended that Dr. Peters work on eligibility so that African-American and Latino patients do not rank as high in the statics and can get treatment.

Agenda Item 15 Presentation on the Waiver for Physicians to Prescribe or Dispense Buprenorphine

Dr. Henry from the University of California, Davis, provided an overview of buprenorphine. He explained that buprenorphine is used to treat opioid use disorder since it has a ceiling effect in respiratory depression side effects, which is uncommon in most opioid medication. He added that the more buprenorphine that is taken, the more pain management or pain effect will happen, but the respiratory depression effects level off. He clarified that buprenorphine can be abused and the risk of overdose is much less. Dr. Henry discussed the different advantages of buprenorphine. He provided the history of the X waiver and explained that a practical use for buprenorphine is that it can be prescribed in a clinic and dispensed in any pharmacy. He explained that physicians must complete a training to obtain an X waiver and provided additional reasoning as to why this is a barrier. He shared that a study conducted by the Urban Institute in 2016 estimated that approximately 2,000 Californians with an opioid use disorder lack access to local treatment via buprenorphine or methadone, which demonstrates that the need in California is greater than the current bandwidth to treat. He transitioned into detailing the eight pathways to obtain an X waiver. Dr. Henry provided examples from other states like Rhode Island and Arizona to demonstrate what they are doing to eliminate the barriers to entry with the X waiver and proposed a solution in California, noting both the benefits and limitations.

Ms. Friedman inquired who manufactures buprenorphine.

Dr. Henry responded that he was not aware of who manufactures buprenorphine and reiterated that although the pill has many benefits, it can be abused.

Dr. Bholat described the current issue with limited members of staff having the X waiver to prescribe and pointed out that physicians are able to prescribe far more dangerous drugs than buprenorphine and needed no additional license for it.

Dr. Krauss echoed Dr. Bholat's comments and added that it puzzles him as to why there are regulations restricting access when buprenorphine is safer than other drugs that physicians are authorized to prescribe. He added that the Board should assist in all ways possible to make this more available through legislative advocacy.

Dr. GnanaDev referred to the section of the presentation where Dr. Henry spoke about the University of California Opioid Curriculum Workgroup and modified curriculum in University of California schools and reminded Dr. Henry that there are four other medical schools in California. He then inquired how Dr. Henry is disseminating the curriculum plan to those schools.

Dr. Henry responded that the plan is to write it up and publish it. He confirmed that the curriculum plan was recently finalized and if it were deemed to be competent, this would make it easier for other schools to implement it.

Dr. Yip inquired about the meaning of MAT.

Dr. Henry explained that it means medication assisted treatment.

Dr. GnanaDev commented that if all the medical schools in California follow the curriculum, including osteopathic doctors, the Board and the Osteopathic Board could go to the legislature. He emphasized that this is the importance of including all medical schools versus just the University of California.

Dr. Henry agreed with Dr. GnanaDev and confirmed that he would bring that back to the workgroup.

Ms. Kirchmeyer added that legislation would not be needed since it is federal legislation.

Ms. Hollingsworth pointed out her concerns with waving the requirement to prescribe buprenorphine since it is dangerous and reckless for any doctor to have less training when it comes to prescribing. She provided a personal story of a cardiologist she saw that did not know that metroprolol is a black box drug. Additionally, she provided the story of an individual that overdosed while in the care of a drug rehab facility and shared that they had buprenorphine in their system; she then posed the question of how dangerous this would be for a prescriber that does not have training on buprenorphine. Ms. Hollingsworth concluded by noting that training is in the interest of public safety and urged the Board to keep the training for the X waiver in place.

Mr. Andrist pointed out and provided examples of the conflict of interest between Dr. Fishman and Purdue Pharma. He highlighted deceptive messaging that had been given to the public related to opioid prescribing with the backing of Purdue Pharma. He questioned Dr. Fishman's affiliation and the content of the presentation.

Agenda Item 18 Discussion and Possible Action to Amend Title 16, California Code of Regulations, Sections 1309, 1360,1360.1, and 1360.2 Regarding Rehabilitation Criteria and Substantial Relationship Criteria, and to Repeal Sections 1379.68, 1379.70, and 1379.72 Regarding Rehabilitation Criteria and Substantial Relationship Criteria

Ms. Webb explained that these regulations are needed to be completed to be in compliance with AB 2138, which passed last year and will become effective July 1, 2020. Specifically, on that effective date, the Board will no longer be able to ask applicants to disclose convictions. She clarified that the goal of the bill is to reduce licensing barriers and applies to all boards under DCA with a few exceptions. She added that although the Board already had regulations in place, the additions would enable the regulations to be consistent with AB 2138.

Ms. Webb noted that the Board regulates both physicians and other allied professionals and pointed out that polysomnographers had their own regulations in place. She proposed that the regulations for polysomnographers be repealed and the Board provide a single set of regulations for all licensees. She highlighted the changes that she is proposing to the substantial relationship criteria and pointed out three things that the Board must consider when determining whether a crime or act is substantially related to the professional practice: the nature and gravity of the crime, the number of years elapsed since the date of the crime, and the nature and duties of the licensee.

Ms. Webb continued to discuss the rehabilitation criteria for denial of licensure, which asks the Board to consider deeming a person who has met all the requirements of parole or probation and has completed their criminal sentence to be considered rehabilitated. She noted that although this is an option that the Board can take, it is not an option that Board staff would recommend. She added that there is an option to add more factors to consider. She pointed out that if the applicant has not demonstrated rehabilitation under subdivision (a), then the Board goes to subdivision (n), to see if under that criteria they are able to demonstrate rehabilitation. She confirmed that this is what is required under the law and what is reflected in the regulations that are being proposed.

Dr. Lewis made a motion to approve the proposed amendments, to submit the regulatory package to the appropriate oversight agencies, to authorize staff to make non-substantive changes, and if no negative comments are received, to allow staff to finalize the process without bringing it back to the Board. Further, staff is authorized to amend the language for polysomnographic if reviewing entities object to their repeal without bringing it back to the Board; s/Dr. Krauss.

Ms. Hollingsworth vocalized that she is in support of AB 2138 with respect to nonviolent offenders that committed a crime while being young and stupid, however, she expressed her opposition when established adult professionals who knew the laws break them. She pointed out that there is considerable recidivism among doctors who offend and provided the example of addicted doctors who routinely violate their probation by skipping their mandated drug tests. She urged the Board to be vigilant when granting licenses to those that come under this program and to consider the duty to protect the public.

Motion unanimously carried (11-0, Sutton-Wills absent).

Agenda Item 19 Presentation and Update on Changes to Postgraduate Training Requirements Effective January 1, 2020

Ms. Alameda explained that effective January 1, 2020, the postgraduate training requirements have been extended to three years for all applicants regardless of the medical school they attended. She specified that of the three years, 24 months need to be completed in one program, and four months of general medicine is required. She pointed out that the Board will issue postgraduate training licenses (PTL) that do not need to be renewed. She noted that an individual will have a hundred and eighty days to obtain the license in order to continue their training and specified that the Board will no longer recognize international medical schools. She listed the ways in which the Board has been active to disseminate the changes as well as internal measures that have been taken to update the Board on this change. Ms. Alameda went through commonly asked questions that had been directed to the Board over the last year. She concluded by assuring the Board that all applicants will be notified of the changes by September.

Dr. GnanaDev requested that this information be sent out to all graduate medical education departments since program directors are concerned as to how to proceed.

Ms. Alameda confirmed that the information is published on the website and an email went out to all California programs to let them know that the information is posted.

Dr. GnanaDev inquired if the four months of general medicine is completed in residency.

Ms. Alameda confirmed that this is done in residency. She clarified that this was not a new requirement.

Dr. Yip commented that PTL holders should be allowed to take a fluoroscopy examination.

Ms. Kirchmeyer pointed out that there is a bill that aims to eliminate the fluoroscopy permit. She added that the Board can make a recommendation to the author to include both licensees of the Board.

Dr. Bholat asked about the situation in which a holder of a PTL requests enrollment as a medical fee for service provider. She noted that the PTL holder is not going to be billing unless they are moonlighting.

Ms. Alameda confirmed that they can moonlight as long as the program director authorizes that to be part of their residency.

Dr. Bholat indicated that it will be tricky since patients go between fee for service and medical managed care.

Agenda Item 20 Update from the Attorney General's Office

Ms. Castro covered two court of appeals cases that weigh heavily in the favor of patient privacy. She provided the details of *Grafilo v. Cohanshohet* case, which investigated a physician for overprescribing and shared that the court imposed additional requirements on the Board in order to establish good cause. She noted that specifically the Board needed to make a higher showing of how often similarly situated physicians who specialized in pain management might prescribe the same drugs in question, offer the percentage of the total number of patients, and demonstrate the likelihood that the prescriptions could have been properly issued. She proceeded to explain *Grafilo v. Wolfsohn*, which also investigated a physician for overprescribing and noted that this case expanded upon the *Cohanshohet* findings. Ms. Castro explained that it set forth the need to show more in order to weigh in favor of good cause to obtain patient medical records. She pointed out that these two cases solidified that more is needed to prove good cause and will be necessary in all pain management cases due to the concern of patient privacy.

Ms. Castro identified new hires to Health Quality Enforcement (HQE), noting the onboarding of Ms. Jacobs, Ms. Ross, Ms. Park, Mr. Nguyen, and Mr. Roberts, and provided background information on each individual. She shared that although HQE went from being jointly responsible for 1800 cases to now 60 cases, an open dialogue has been maintained and steps have been taken to assist in the transition.

Dr. GnanaDev inquired about the two cases that Ms. Castro mentioned and asked if the cases could be appealed, or if the only option was to make internal corrections.

Ms. Castro explained that all options had been considered and what she presented is published case law. She highlighted that even though Vertical Enforcement has been repealed, HQE remains very involved with interim actions, which includes subpoena enforcement cases and means that the Board has a strong legal hand. She shared that the Board had a very long line of subpoena enforcement successes and these are the first two losses in at least seven years.

Dr. GnanaDev asked if her recommendation was that the court ruling was clear enough and not worth an appeal.

Ms. Castro responded that the appeals process has expired.

Dr. GnanaDev stated that medical records are very important and asked if these rulings will hinder the process.

Ms. Castro answered that live patients are the individuals that have more privacy interest under the California Constitution.

Ms. Lubiano asked about the steps that will be taken to help meet the burden for the good cause requirement for future cases.

Ms. Castro answered that she would prefer to make those recommendations within the confines of attorney-client privilege.

Dr. Yip requested more information on the two cases mentioned be sent to Board Members. He recommended that the Board create a system or a platform for consumers to appeal a case if they feel that the medical consultant or expert did not do their job.

Ms. Castro shared that these two cases provide a good starting point to discuss what medical consultants can be looking at when they review these cases.

Dr. Rhee shared her concern that family members of patients do not get interviewed or provided updates. She added that DCA appears to be pretty homogeneous with little racial diversity. She stated that decisions being made and the hiring practices of DCA and HQIU are questionable and could be adding to the problems of racial disparities.

Mr. Andrist suggested that the public listen to the Hughes hearing and noted that it shows problems within the Board. He played a clip of Judge Feinstein referencing a case and pointed out that he has asked several times for the same update that Judge Feinstein is requesting and no information has been given. He reiterated that there are things brought up in meetings that are then ignored and disappear.

Agenda Item 21 Update from the Health Quality Investigation Unit

Mr. Chriss, Chief, Department of Consumer Affairs Division of Investigation, shared that there are ten investigator vacancies, 11 candidates in background with HQIU and three attending the academy. He added that there will be a mini academy offered for 17 newly hired investigators to provide specialized training on all investigation types. He pointed out that vacancies have contributed to the case aging, however, this is changing as the vacancy rate has been brought down to nine percent. He added that an additional factor contributing to case aging is the reduction of medical consultant hours and detailed that with the budget augmentation proposal for additional funding, this should alleviate this issue. Mr. Chriss shared that the death certificate project has added an additional 247 complex death investigations for HQIU to process. He requested additional positions to keep up with the workload of this project. He recommended that there be a permanent non-sworn investigative unit, a change to the process to consider centralizing the expert review process, and a report that differentiates the time that the Board spends on a case as compared with HQIU.

Dr. GnanaDev complimented HQIU on a nine percent vacancy rate and inquired when the Board will see a decrease in the processing timeline.

Mr. Chriss shared that he anticipates being fully staffed by late summer and once staff is fully trained he anticipates seeing a reduction in the numbers.

Ms. Nicholls, Deputy Chief, Department of Consumer Affairs Division of Investigation, commented that some issues stem from pending caseloads dating back to 2012-2013 and fewer cases to process compared to today where they have more cases to process with the same amount of staff. She added that creating permanent non-sworn positions to deal with the less serious less complex cases will help.

Dr. Lewis expressed his concerns about the attrition rate.

Ms. Nicholls shared that other programs do not handle the expert process and have a reduced workload. She remarked that if this was taken off of the investigator there would be a better work product and quality control in the communication with experts.

Mr. Chriss commented that HQIU has been working with Board staff to look into efficiencies and address his recommendations as a solution.

Dr. Bholat inquired what percentage of the records that are received are handwritten versus coming from an electronic health record.

Ms. Nicholls reported that the majority are now electronic health records.

Dr. Bholat remarked that the time consuming part would be the volume of records that needed to be gone through as an expert. She noted that with the majority being electronic health records, it should help expedite the process.

Ms. Pines asked if the non-sworn officers were put in place to deal with temporary vacancies.

Mr. Chriss confirmed this.

Ms. Pines clarified that these positions were never considered to be an add-on, rather they were known to be limited term.

Ms. Nicholls pointed out that the situation is not up to par because even if they are fully staffed, it will not be enough to deal with the workload. She added that in 2010 the Board received approval to hire 20.5 non-sworn positions in addition to sworn positions and to date six have been hired, which is still a gap.

Ms. Kirchmeyer clarified that the Board had 20.5, of which all but what the Board currently has were swept under a State budget letter.

Ms. Nicholls acknowledged that the Board was not able to fill those positions and recommended that the Board ask for those positions again.

Dr. Yip asked if the HQIU investigator positons are exclusive to the Board.

Ms. Nicholls responded that the 77 HQIU investigators positions are for the Board. She added that there are some cases for the PA Board, the Podiatry Board, and the Board of Osteopathic Medicine.

Mr. Andrist provided the details of a doctor from Chowchilla who was charged with sexual misconduct in his accusation, however, he was charged with incompetence and repeated negligence acts, which has fewer years of probation. He commented that it is no wonder why so many doctors are offending and sexually assaulting patients since the Board protects

physicians over public safety. He pointed out that egregious crimes are being bartered down so that they can get less probation time, which is not patient safety.

Dr. Rhee vocalized her concerns over HQIU not being racially diversified. She encouraged the Board to not lower the standards of the medical consultants. She recommended that the medical consultants have a diversified patient population to decrease the racial disparity and underrepresented patients.

Agenda Item 22 Update from the Department of Consumer Affairs, which may include updates on the Department's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory, and Policy Matters

Mr. Le, Assistant Deputy Director, Board and Bureau Services, DCA, announced that Mr. Grafilo, Director, left DCA in April. He updated the Board to let them know that the executive officers salary study is delayed due to the portion of the study related to a benchmark comparison of salaries in different states. He confirmed that the information has now been obtained and the aim is to release the study within the next few weeks. He reminded the Board of technical changes made to Uniform Standards number four by the Substance Abuse Coordination Committee (SACC) and shared that the SACC also voted to look at the other fifteen standards. Mr. Le noted that a survey went out to executive officers and stakeholders to get a sense of common threads or topics that need to be discussed when modifying or adding to the Uniform Standards. He introduced a new addition to DCA, the Technology Advisory Council, which aims to provide guidance on how DCA can use technology and innovation, existing technology, or emergent technology to improve day-to-day operations. He remarked that high-level concepts are currently being developed. He detailed that DCA launched an open data portal, which is a publicly available one-stop shop for all licensing and enforcement data across all DCA boards, bureaus, and commissions. Mr. Le specified that the goal of the portal is to make DCA data more transparent and accessible and serve as a tool for stakeholders.

Mr. Le reminded the Board that at the last Board meeting he was asked about the status of reclassifying Board staff from inspector positions to special investigator positions. He shared that on June 29, 2018, DCA submitted a proposal to Cal HR to reclassify the Board's inspector positions into special investigators. He detailed that Cal HR denied the request and since then DCA Human Resources has been working with Board staff to identify alternative solutions.

Dr. GnanaDev expressed that he was pleased that the executive officer salary study was almost complete since it has been five years in the making. He asked for a confirmation that the report would be ready for the next Board meeting.

Mr. Le responded that is the intent.

Dr. GnanaDev replied that good people could be lost with the time that it has taken. He reminded Mr. Le that this money is not general fund, rather it is the money of the Board.

Mr. Andrist shared that he liked the data portal and requested that more be seen, especially the Board's searchable reports. He provided the example of having submitted a public records act request to obtain a list of doctors who are sexual offenders in a certain city and the response has been that in order to obtain the information, he would need to pay thousands of dollars. He confirmed that although currently he cannot get this information, it would be useful for consumers to be able to search and to extract this data from the portal.

Dr. Rhee commented that with investigation times being so long, it could be that the Board is trying to fit a square peg into a circle hole. She elaborated that it could be that there is nothing there. She expressed her concern that cases are being selected for other than honorable reasons for investigation.

Ms. Pines recognized Dr. Bholat and Ms. Wright for all of their hard work on the Board and shared that their terms will be expiring on June 1, 2019. She listed their contributions to the Board and thanked them for their role in consumer protection.

Dr. Bholat shared that she was very proud to have served on the Board and thanked all the Members for the tremendous amount that she has learned from them.

Agenda Item 23 Future Agenda Items

Ms. Pines requested an update on the demographic study, a presentation on the state of maternal health in California, a presentation on telehealth, and a discussion on the proposed conscientious objection rule.

Ms. Kirchmeyer notified the Members that there will most likely be a telephone conference to discuss the conscientious objection rule since time is of the essence with regard to when the regulations will be released.

Ms. Lubiano requested a presentation on recruiting efforts for expert reviewers and proposed a discussion to talk about more creative ways to recruit.

Dr. Rhee confirmed that the conscientious objection rule is very important to physicians on the front lines.

Mr. Andrist recommended that Mr. Johnson and his foundation come and speak on the topic of maternal health. Additionally, he asked that the public records act be put on the agenda.

Agenda Item 24 Adjournment

Ms. Pines adjourned the meeting at 12:38 p.m.

Signature on File	8/8/19
Denise Pines, President	Date
Signature on File	8/8/19
Dr. Lewis, Vice President	Date
Signature on File	8/8/19
Kimberly Kirchmeyer, Executive Director	Date