



MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING



Courtyard by Marriott – Cal Expo
1782 Tribute Road
Sacramento, CA 95815

January 26-27, 2017

MEETING MINUTES

Thursday, January 26, 2017

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

Members Present:

Dev GnanaDev, M.D., President
Michelle Bholat, M.D.
Michael Bishop, M.D.
Judge Katherine Feinstein (ret.)
Randy Hawkins, M.D.
Howard Krauss, M.D.
Kristina Lawson, J.D.
Sharon Levine, M.D.
Ronald Lewis, M.D., Secretary
Denise Pines, Vice President
Brenda Sutton-Wills, J.D.
David Warmoth
Jamie Wright, J.D.
Felix Yip, M.D.

Staff Present:

April Alameda, Staff Services Manager II
Liz Amaral, Deputy Director
Mike Briscoe, Staff Service Analyst
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Cassandra Hockenson, Public Information Officer II
Susan Houston, Staff Services Manager I
Jacoby Jorgensen, Associate Government Program Analyst
Kimberly Kirchmeyer, Executive Director
Nicole Kramer, Business Services Manager
Jennifer Simoes, Chief of Legislation
Reylina Ruiz, Administrative Services Manager
David Ruswinkle, Associate Government Program Analyst
Regina Rao, Associate Government Program Analyst
Jennifer Saucedo, Staff Service Analyst

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Elizabeth Rojas, Business Services Office
Paulette Romero, Staff Services Manager II
Lisa Toof, Administrative Assistant II
Kerrie Webb, Staff Counsel

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Eric Andrist, by phone
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Janet Coffman, Ph.D., Associate Professor, University of California, San Francisco
Zennie Coughlin, Kaiser Permanente
Shannon Smith-Crowley, American Congress of Obstetricians and Gynecologists
Evelynne Drinker
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Interest Law
Karen Fisher, Executive Officer, Dental Board of California
Fred Gardner, Editor
Louis Galiano, Videographer, Department of Consumer Affairs
Ruth Haskins, M.D., President, California Medical Association
Andrew Hegelein, Supervising Investigator II, Health Quality Investigation Unit
Marian Hollingsworth, Consumer Union Safe Patient Project
Ronald Johnson, National Association for the Advancement of Colored People
William King, by phone,
Christine Lally, Deputy Director of Board and Bureau Relations, Department of Consumer Affairs
Mark Loomis, Supervising Investigator II, Health Quality Investigation Unit
Sarah Mason, Senate Business and Professions Economic Development Committee
Brianna Miller, SOLID, Department of Consumer Affairs
Perry Solomon, M.D.
Carrie Sparrevohn, Licensed Midwife, Midwifery Advisory Council
Ann Staveren, M.D., Charles R. Drew Medical Center
Jayini Thakker, DDS, M.D., Residency Program Director, Loma Linda University

Agenda Item 1 Call to Order/Roll Call

Dr. GnanaDev called the meeting of the Medical Board of California (Board) to order on January 26, 2017, at 3:25 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. Haskins stated the California Medical Association (CMA) appreciated the Board's support of the passage of Senate Bill (SB) 1177, which provided the authority to the Board to establish a statewide physician health program. She stated that physicians and patients need the support and assistance that such a program would provide and that quality health care depends on a healthy physician workforce. Dr. Haskins noted the Board's recognition to address physician health had been critical to highlighting this important issue and that CMA looked forward to working with the Board to develop and implement the regulations that will make the program a reality. She noted that combined with the Board's upcoming sunset review, it was recognized

that 2017 would be a busy year, during which the Board would be responding to many new state and federal proposals related to the practice of medicine. Dr. Haskins stated CMA looked forward to continuing to work with the Board by providing the perspective of the practicing physicians of California.

Dr. Levine stated that February 3, 2017, was the second annual National Women Physicians Day. This date had been chosen as it was the birthdate of Elizabeth Blackwell, the first woman to matriculate in medical school in the United States. She added that California should be very proud of the extent to which it has incorporated, welcomed, and included women physicians in every aspect of the delivery of care in the state.

Agenda Item 3 Closed Session

Pursuant to Government Code Section 11126(a)(1), the Board met in closed session to conduct the annual evaluation of the executive director.

The Board returned to open session and Dr. GnanaDev stated the entire Board gave Ms. Kirchmeyer an outstanding evaluation and appreciated her hard work.

Agenda Item 4 Approval of Minutes from the October 27-28, 2016 Meeting

Dr. Krauss made a motion to approve the October 27-28, 2016 meeting minutes, as written; s/Dr. Lewis. Motion carried unanimously. (14-0).

Agenda Item 5 President's Report, including notable accomplishments and priorities

Dr. GnanaDev stated that over the past quarter, he and Ms. Pines had worked closely with Board staff to complete the Board's Sunset Review Report and ensured it met the deadline submission of December 1, 2016. He thanked the Board's staff for putting together the document. He noted it was a lot of hard work and the Board appreciated the hours that were put into it.

Dr. GnanaDev added that he and Ms. Pines had continued to have telephone calls with the Executive Staff to discuss projects and issues that had arisen during the last quarter. He noted the next few months would be very busy with the Board's Sunset Hearing and that they would be meeting with the Chairs and Members of the Senate and Assembly Business and Professions Committees prior to the Sunset Hearing. Dr. GnanaDev stated the goal was to educate the members on the Board and its new issues as well as to answer any questions the members may have.

Dr. GnanaDev added that the Board looked forward to developing a new strategic plan this year that would provide guidance to the Board for the next several years. He noted this was a very important project and looked forward to working with the Department of Consumer Affairs (DCA) through the process. He stated the Board's mission of consumer protection was very important and the Board wanted to make sure that all of the goals of the Board focus on that mission.

Dr. GnanaDev stated that the Board staff had held an interested parties meeting to discuss options for patient notification regarding physicians on probation and also to hear from the parties on regulatory language to establish the Board's Physician Health and Wellness Program. He noted those were important issues for the Board and looked forward to future meetings and discussions on that issue.

Dr. GnanaDev noted the Board continued to reach out to both public and physician groups to educate them on the Board. He added that he had the opportunity to provide presentations to physicians about

the importance of the laws contained in the Medical Practice Act and helping ensure that they know the laws and remain in compliance. He stated he believed that education about the Board was one of the most important aspects of his role as the President and he wanted to ensure that he, other Members, and staff provide these presentations to any group that was interested in having the Board present.

Dr. GnanaDev added that since the last Board meeting there had been no committee assignment changes. However, if any member wished to change their committee assignment, to feel free to contact himself or Ms. Kirchmeyer.

Agenda Item 6 Board Member Communications with Interested Parties

Dr. GnanaDev noted that he is involved with multiple organizations, but never discusses Board issues with other organizations.

Agenda Item 7 Presentation of Findings from the Supplemental Survey on Physician Med-Cal Participation

Dr. GnanaDev introduced and welcomed Dr. Janet Coffman, who is an associate professor at Philip R. Lee Institute for Health Policy Studies, the Healthforce Center, and the Department of Family and Community Medicine at the University of California, San Francisco.

Dr. Coffman provided a presentation on the findings from the supplemental survey done on physician Medi-Cal participation. The presentation included information on Medi-Cal expansion, response rates, benchmarks, and limitations, along with a summary of major findings from the survey. The full presentation can be viewed on the Board's website.

Dr. GnanaDev asked Dr. Coffman if public clinics and federally qualified health centers were eliminated, what the acceptance rates are for Medi-Cal, since those two entities get paid considerably more than a fee for service Medi-Cal provider.

Dr. GnanaDev then asked Dr. Coffman her opinion on replacing the ACA and coming up with a block grant for Medi-Cal in California.

Dr. Coffman stated that she felt elimination of the ACA would be highly problematic. She noted that in some ways, block grants offer flexibility, however, block grants often do not keep pace with growths in the costs of delivering service, which is a big concern because the State could lose a considerable amount of federal funding under a block grant. She felt it would be impossible for California to sustain what had been accomplished without commensurate federal support.

Ms. Drinker stated medical students often have tremendous student loans and wondered if reluctance to take Medi-Cal patients is related to the necessity of repaying their student loans, and if any amnesty on their students' loans for their medical school could be considered.

Dr. Yip noted that the Health Professions Education Foundation (HPEF) offers a program through the Stephen M. Thompson Loan Repayment Program that would provide a physician a grant up to \$100,000 to practice in underserved areas of California.

Agenda Item 8 Update, Discussion and Possible Action of Recommendations from the Midwifery Advisory Council Meeting

Ms. Sparrevohn gave a brief update on the December 1, 2016 Midwifery Advisory Council (MAC) meeting, stating the MAC was updated on possible changes to the licensed midwife annual report (LMAR) and decided to complete a survey that was linked to the submission of data for the LMAR, in hopes to have a better response rate in terms of how licensed midwives would like to see how the data is collected. She noted the MAC continued to work with the interested parties on coming to an agreement on regulations pursuant to Assembly Bill (AB) 1308. She added that a Midwifery Task Force meeting had been scheduled for March 2017.

Ms. Sparrevohn requested Board approval for the following agenda items for the next MAC meeting scheduled for March; task Force update on revisions to the LMARs, update on continuing regulatory efforts required by AB 1308, update on the Midwifery Task Force, update on the Hospital Transfer Form, discussion and approval of the MAC Licensed Midwife position, update on the midwifery related legislation expected to be introduced or followed this year, update on progress of midwifery assistant regulations, and update on the midwifery program.

Dr. Lewis made a motion to approve the agenda items for the next MAC meeting; s/Dr. Krauss. Motion carried unanimously. (14-0).

Agenda Item 9 Update from the Midwifery Task Force

Ms. Kirchmeyer stated that a Midwifery Task Force meeting is scheduled for March 6, 2017, and reminded the Board that the Task Force Members are Dr. Bholat and Dr. Levine. She noted the meeting would include members from American Congress of Obstetricians and Gynecologists (ACOG) and California Association of Midwives (CAM).

Agenda Item 10 Discussion and Possible Action on Amendments to Proposed Regulations for Midwife Assistants, adding Title 16, Division 13, CCR section 1379.01 through 1379.09

Ms. Webb referred Members to agenda item 10 in their packets where a summary of the changes to the proposed regulations could be found. Ms. Webb stated that looking at them, it might look like there had been major changes, when in actuality they had just been reorganized, which was the bulk of the modifications. She noted that the note for the authority is listed below each proposed section. Ms. Webb stated there would be a document incorporated by reference that would be part of the 15-day notice to alert everyone that there was a new document added to the rulemaking file. She noted the new document clarified the minimum training requirements for a midwife assistant to ensure they knew they have to have specific certifications, in addition to some other minimum requirements, before beginning work as a midwife assistant.

Ms. Webb stated the definition of a qualified midwife assistant had been identified. The language identifies who could train other midwife assistants determine what is required for a certifying agency. She stated there were also some non-substantive changes made as well. Ms. Webb stated she needed a motion to allow staff to do a 15-day comment period and if there are

not substantive negative comments during that time period, to allow the executive director to make non-substantive changes and to move forward with the rulemaking process.

Dr. Krauss made a motion to approve the 15-day comment period, and if no substantive negative comments were received, to allow the Executive Director to make any non-substantive changes and to move forward with the rulemaking process; s/Dr. Lewis. Motion carried unanimously. (13-0, Lawson – absent from vote).

Agenda Item 11 Executive Management Reports

Ms. Kirchmeyer stated she would not be going over the program summaries unless someone had a question about them. She noted that both the licensing and enforcement programs have statistics and highlights.

Ms. Kirchmeyer asked the Members to turn to page BRD11A-5, which consisted of the Board's fund condition. She noted that this document showed complete repayment of the Board's outstanding loans to the general fund. She stated it also showed that the Board's loan fund reserve was projected to be at 4.9 months at the end of the current fiscal year, if the loan was repaid as projected. She stated, however, if the loan was not repaid as shown, the Board would then be at 3.7 months' reserve. Ms. Kirchmeyer added that without the loan repayments, the Board would be below its mandate in fiscal year (FY) 18/19, however, with the loans, the Board would not be expected to be below the mandate until FY 19/20.

Ms. Kirchmeyer then noted that the Board had submitted two budget change proposals (BCPs) to DCA, and the Department of Finance. She added those BCPs had been approved and added to the Governor's budget, and would now be going through the legislative budget hearing process for final approval. Ms. Kirchmeyer stated the BCPs were for two enforcement positions in the Central Complaint Unit (CCU) as well as one staff to assist in implementing the Physician Health and Wellness Program (PHWP). Ms. Kirchmeyer noted that a BCP to continue the BreZE system was also included in the Board's fund conditions. She stated she would provide an update to the Members if these BCPs are approved. She noted these two additional staff would assist in reducing the time it takes to process a complaint. She also noted that Board staff would be reviewing this year's budget closely to ensure the Board stays in line with its budget.

Ms. Kirchmeyer commended the Board's licensing staff, as they are currently reviewing applications received within 29 days from the receipt of the application, and that at one point, it had been down to 26 days. She stated that this was great news since staff is preparing for the influx of applications that takes place from April to June with applications that need to be processed by June 30th. She added that staff was also able to bring the Board's hold time down to six minutes as well as drastically reduce the number of abandoned calls in the call center. Ms. Kirchmeyer stated this had been an area where management had been working to improve response time to callers. Through cross training, scripts being completed, additional training, and being fully staffed, she noted the call center had made great improvements.

Ms. Kirchmeyer then announced that Ms. Toof had been promoted to licensing program manager, which had been Mr. Schunke's prior position. She added that this position attends licensing fairs and orientation meetings to provide needed information on the Board's licensure process. She noted that she hoped to have Ms. Toof's position filled within the next month and

that her replacement should be in attendance at the April Board meeting, but in the meantime, asked the Members to continue to contact Ms. Toof, as she would still be in the Executive Office until the position is filled.

Ms. Kirchmeyer continued, stating that in the administrative summary, she had identified several meetings and presentations that had been conducted, but wanted to let Members know of a future presentation that she will be doing. She stated she had been invited to join a panel at a meeting that was being hosted by the Food and Drug Administration (FDA) in Maryland. She noted she would be on a panel with the FSMB, the National Governor's Association, and the University of New Mexico and would be talking about the Board's requirements for CME on pain management. She added that the FDA was looking into the issue of opioid misuse and abuse and would like to look at education to prescribers.

Ms. Kirchmeyer then stated that in regard to CURES, as of January 15, 2017, there were at least 76,102 physicians registered in CURES 2.0 and several others who were still in CURES 1.0 and have not updated their information, yet. Ms. Kirchmeyer stated that at the last meeting, she had reported that from September 15 to October 15, physicians had requested 193,815 patient activity reports, and between December 15 and January 15, physicians had requested 208,273 reports, indicating the requests continue to increase from month to month.

Ms. Kirchmeyer stated that at the last meeting, she also spoke about information being placed on the Board's website regarding CURES. She added that the Board was required to provide information and education related to CURES to physicians and to hospitals. She stated that in early January she had held a meeting with Department of Justice (DOJ), California Department of Public Health (CDPH) and other prescribing and dispensing DCA boards to brainstorm about what such education should look like. She noted she would be working with a small subcommittee to develop a brochure and information for distribution. Ms. Kirchmeyer added that she and staff would be working with subject matter experts to provide guidance on what to do with the CURES information once it is obtained. She noted that in addition to those experts, she would work with Board consultants and Members to review that information before distributing it. Ms. Kirchmeyer noted that page BRD 11D-1 shows a notice regarding the decommission of CURES 1.0. She stated that when CURES 2.0 was released, there were several individuals who did not have the updated browser needed for CURES 2.0. She noted that the Board and DOJ had done outreach to encourage individuals to update their browsers. DOJ has set an end date of March 5, 2017, for CURES 1.0. Ms. Kirchmeyer noted the Board had posted this information on the Board's website, sent out an email to physicians, sent out subscriber notices as well as tweeted the information. She had also sent information to large physician organizations and physician Board Members.

Ms. Kirchmeyer noted that pages BRD 11E-1 and 11E-2, provided an update from the HPEF as well as the Stephen M. Thompson Loan Repayment Program Annual Report.

Ms. Kirchmeyer stated that in her report, she provided an update on the overprescribing of psychotropic medications to foster children issue. She added that the Board is awaiting approval from the Department of Health Care Services (DHCS) to finalize the data use agreement as required with the passage of SB 1174. She noted the Board is working with Department of Social Services (DSS) to obtain appropriate authorizations to get medical records for the patients. She added that the Board had been contacted by DSS to explain the Board's enforcement process and what is needed.

Ms. Kirchmeyer moved on to the Federation of State Medical Boards' (FSMB) update. She noted the FSMB visited the Board's headquarters in November. She noted they met with Board management to discuss the Federation Credentials Verification Service (FCVS) process and also walked through the Board's licensing process. She stated the FSMB annual meeting would be held on April 20-22, 2017 in Texas. She added that from reviewing the draft agenda, it appeared that discussions would consist of physician wellness, medical regulation, public health priorities, regulation in the era of assisted dying, evidence-based regulations, telehealth, the role of CME in licensure, medical errors and reporting, and technology supported medical decision-making. Ms. Kirchmeyer stated that it is hopeful that she and Dr. GnanaDev will be attending.

Ms. Kirchmeyer added that the next step in the sunset process will be the Sunset Hearing, which is scheduled for February 27, 2017. Dr. GnanaDev and Ms. Pines will be attending as representatives of the Board. She noted the background paper that would identify the items to be discussed at the hearing would be released approximately two weeks prior to the hearing date.

Ms. Kirchmeyer then announced that Ms. Dobbs will no longer be attending the Board meetings, as she has taken a position as an administrative law judge for the Board of Parole Hearings. She added that Ms. Dobbs had done an outstanding job in providing guidance to the Board and thanked her for her exceptional service to the Board.

Ms. Kirchmeyer then invited Ms. Miller to come forward to talk about the strategic planning process. She noted that Ms. Miller works for DCA and would provide some background on the process, so that Members would know what staff would be doing in the upcoming months.

Ms. Miller began by noting she would be using the strategic plan roadmap that is in the Board packets for this discussion. She stated that this process begins with a preliminary meeting, that should take place in July or August, where the strategic planner will meet with the executive director to get an idea of what the Board is looking for in the new strategic plan, what focus they would like to take, and what areas they feel may be carried over from the previous plan, if any. Ms. Miller noted that once the preliminary meeting has taken place, the strategic planner would then start working on the Environmental Scan. She noted this scan normally consists of stakeholder feedback, Board Member interviews, executive director feedback, as well as staff feedback. She noted that feedback would then be compiled into a document and provided to Members, and the Executive Director in advance of the strategic planning session. She added the next step would be for the facilitator to meet with the Members and executive director to begin putting the plan together. The Board would then decide if they wish to continue working with SOLID and if so, that facilitator would then begin working on putting together action steps and delineate how each objective would be achieved.

Dr. Levine asked Ms. Kirchmeyer if there had been an interested parties meeting held on changing the requirements for licensure. Ms. Kirchmeyer noted there had been a meeting and staff had also sent out information to program directors. She added the sunset report included that change as an issue. Ms. Kirchmeyer noted that not only is the Board looking at extending the postgraduate training to three years, but with that extension, removing the medical school approval process.

Dr. Thakker stated she had heard about the possibility of increasing the Accreditation Council of Graduate Medical Education (ACGME) accredited postgraduate training to three years.

Loma Linda's oral maxiofacial curriculum consists of their residents' completing dental school and then continuing on to medical school and that the majority of their training is in oral maxiofacial surgery, which is Commission on Dental Accreditation (CODA) accredited. She noted that many programs would grant a one or two year certificate in general surgery, though she believed that California programs grant a one year certificate so the change of the postgraduate training could strongly impact these California programs. She asked what the realistic timeline was for the changes and if it would affect the currently enrolled residents.

Dr. GnanaDev noted that for conflict of interest purposes, Dr. Thakker works in his department of the Regional Medical Center and he realized that if postgraduate training was extended to three years that the DDS/MD residents would not be eligible for a physician's license. He noted that he and Ms. Kirchmeyer had discussed this issue and stated the Board's goal is to not jeopardize those residents that would have been eligible for a physician's license after the one year of PG training if they were in those combined DDS/MD programs.

Agenda Item 12 Update on the Marijuana Task Force

Ms. Kirchmeyer noted the Marijuana Task Force would be meeting on February 8, 2017, to discuss the Board's current statement on recommendations for marijuana for medicinal purposes. She added the task force would also be hearing from the Director of DCA regarding the California Bureau of Medical Cannabis Regulations, by having a discussion on SB 643 and reviewing the guidelines that had been adopted by the FSMB. She stated the task force would also hear from interested parties regarding potential changes to the Board's guidelines. The task force will then work with staff on drafting any revisions that may be necessary.

Mr. Gardner commented that when Ms. Kirchmeyer stated that the task force at its upcoming meeting would hear from interested parties, he noted that the agenda was posted and that staff would look at comments in writing up until February 5, 2017. He stated that was not the same as having an actual interested parties meeting where people could come to the meeting and comment in person. Ms. Gardner further stated he came to Sacramento to let the Board know that they were being used as pawns in a game by big players back east. He noted that the guidelines that the FSMB approved had been put together by a lobbyist back in Washington and constrains cannabis clinicians in several important ways. He added that the task force has backed off on the issue that would constrain clinicians from using cannabis themselves medically with the approval of their own physician. He then added that there has been some discrepancies found between the guidelines that were approved by the FSMB and the summary that Dr. Chaudry had put out after the guidelines had been approved. Mr. Gardner asked that the Marijuana Task Force look into those discrepancies and talk with Dr. Chaudry about this issue.

Ms. Kirchmeyer noted that the agenda for the task force meeting did state that comments in writing would be accepted before the meeting, but added that the meeting was open to the public for anyone who was interested in attending to comment and discuss their issues.

Dr. Krauss stated the FSMB is an advisory organization without authority and each state medical board takes its own action, cognizant of the FSMB guidelines, but they are not bound to follow those guidelines. He added that in reference to the journal articles that Mr. Gardner spoke of, it may be of use for the task force to acquire those articles for discussion at their meeting.

Agenda Item 13 Update on Collaboration with the Osteopathic Medical Board of California, Board of Registered Nursing, Board of Pharmacy, Board of Podiatric Medicine, and Physician Assistant Board

Ms. Kirchmeyer stated the group had met two times since the Board meeting in October 2016. One meeting was held in November and discussions included enforcement best practices and wellness programs. She stated the second meeting was held in early January, where the group discussed inter-board investigations and the importance of sharing information when an investigation by one board indicates that a violation may be occurring by a licensee from another Board. The group determined that a memo needed to be drafted to ensure all entities were made aware of this important information and then be provided to Division of Investigation (DOI) and the Attorney General's (AG) Office. She noted that they also had identified certain individuals at each board as points of contact should a violation be found early in the process. She added that the group wanted to bring the issue to the attention of everyone that processes cases for all DCA boards. She noted she felt these meetings had been invaluable and thanked the Board Members for recommending putting this group together. Ms. Kirchmeyer noted that at the next meeting, a discussion would take place regarding getting the board presidents of each entity to attend as a meet and greet.

Dr. GnanaDev then took the opportunity to recognize prior Board Member and President, Mr. Serrano Sewell. He noted that Mr. Serrano Sewell had been appointed to the Board in 2012 and had served on several committees and task force panels. He added that Mr. Serrano Sewell had served as president for two terms, and was a leader in consumer protection, as well as public and physician education. Dr. GnanaDev presented Mr. Serrano Sewell with a plaque for his service on the Board.

Mr. Serrano Sewell stated that it had been an incredible honor to serve on the Board. He noted the mission and the duties of the Board are so important. He noted that when he was first elected as vice president and president, he had asked Dr. Levine what he should be most focused on in those roles. Dr. Levine had told him that, naturally, consumer protection, but also to elevate the practice of medicine, which is the charge of the Board.

Mr. Serrano Sewell noted that he missed serving on the Board, but he also missed working with the staff of the Board, who did a great job in getting the meetings put together and kept them always running smoothly. He also thanked the AG's team and the DCA team for all the hard work and dedication. He ended by thanking the public for their participation in the interested parties meetings and those that kept the Board and the public aware of consumer issues that were of concern.

Dr. GnanaDev adjourned the meeting at 5:34 p.m.

R E C E S S

Friday, January 27, 2017

Members Present:

Dev GnanaDev, M.D., President
Michelle Bholat, M.D.
Michael Bishop, M.D.
Judge Katherine Feinstein (ret.)
Randy Hawkins, M.D.
Howard Krauss, M.D.
Kristina Lawson, J.D.
Sharon Levine, M.D.
Ronald Lewis, M.D., Secretary
Denise Pines, Vice President
Brenda Sutton-Wills, J.D.
David Warmoth
Felix Yip, M.D.

Members Absent:

Jamie Wright, J.D.

Staff Present:

April Alameda, Staff Services Manager II
Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Jacoby Jorgenson, Associate Government Program Analyst
Kimberly Kirchmeyer, Executive Director
Regina Rao, Associate Government Program Analyst
Letitia Robinson, Research Specialist
Elizabeth Rojas, Staff Services Analyst
Jennifer Saucedo, Business Services Officer
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant II
Kerrie Webb, Legal Counsel
Destiny Wells, Staff Services Analyst

Members of the Audience:

Teresa Anderson, California Academy Physician's Assistant
Adam Brearley, Investigator, Health Quality Investigation Unit
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
David Chriss, Chief, Division of Investigation, Department of Consumer Affairs
Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Interest Law
Evelynne Drinker
Karen Fischer, Executive Officer, Dental Board
Louis Galiano, Videographer, Department of Consumer Affairs
Arthur T. Glover, Centers for Medicare and Medicaid Services

Andrew Hegelein, Supervising Investigator, Health Quality Investigation Unit
 Marian Hollingsworth, Consumer Union Safe Patient Project
 Khadijah Lang, M.D., Golden State Medical Association
 Christine Lally, Deputy Director of Board and Bureau Relations, Department of Consumer Affairs
 Tim Madden, California American College of Emergency Physicians
 Sarah Mason, Senate Business, Professions and Economic Development Committee
 Lisa McGiffert, Consumers Union Safe Patient Project
 Tom Negrete, California Research Bureau
 Natalie Newman, M.D., Centers for Medicare and Medicaid Services
 Kathleen Nicholls, Health Quality Investigation Unit, Deputy Chief, Department of Consumer Affairs
 Michael Paulino, Investigator, Health Quality Investigation Unit, Department of Consumer Affairs
 Patrick Rogers, California Research Bureau
 A.R. Savage, M.D.
 Carrie Sparrevohn, Licensed Midwife, Midwifery Advisory Council
 Allen Zeng, Midwestern University

Agenda Item 14 Call to Order/Roll Call/Establishment of a Quorum

Dr. GnanaDev called the meeting of the Board to order on January 27, 2017, at 9:04 a.m. A quorum was present and due notice was provided to all interested parties.

Ms. Kirchmeyer introduced Christine Lally, Deputy Director of Board and Bureau Relations from the Department of Consumer Affairs; Karen Fischer, Executive Officer of the Dental Board; and Dr. Smith, Director of the California Department of Public Health (CDPH).

Agenda Item 15 Public Comments on Items not on the Agenda

No public comments were provided.

Agenda Item 16 Presentation on the Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup and the Office of Health Equity

Dr. GnanaDev introduced Dr. Smith from the CDPH. Dr. Smith gave a presentation on the Statewide Prescription Opioid Misuse and Overdose Prevention Workgroup and the Office of Health Quality.

The first part of Dr. Smith's presentation included overdose mortality rates, opioid related emergency room visits, the workgroup's overdose prevention background, as well as the workgroup's current activities and how the Board plays a big role in the working group. She noted that in 2013 the CDC declared the prescription drug misuse and abuse epidemic. Dr. Smith stated that in spring 2014, CDPH and other state partners convened a Prescription Opioid Misuse and Overdose Prevention Workgroup. She noted that since it began it has grown to over 20 agencies participating in the workgroup.

Dr. Smith stated that the Board has been a key partner, and a leader in this issue from the very beginning. She noted that one of the most crucial things that the Board contributed was the release of the Guidelines. She added the guidelines are a great example of the types of materials that have been posted to various agency websites. She noted that after the CDC released their guidelines, the Board did a side by side comparison and found that there were very few differences between them and the two set of guidelines complement one another. They take a different focus on several things, but using the two together make them both effective tools for prescribers on the overdose issue.

Dr. Smith added that the Board had also collaborated with the CDPH on the CURES user attitude survey, which is used to track how successful the DOJ CURES database is. DOJ is continuously improving that database by using the feedback from the survey.

Dr. Lewis noted that one thing he hadn't heard Dr. Smith mention was the collaboration with Pharma, especially with the current Purdue lawsuit.

Dr. Smith stated that the first few years of the workgroup it had been made up of only state entities, and had no role available for any external partners. She added that this had since changed, and partners had been added, largely on their request rather than solicitation to them. Dr. Smith agreed with Dr. Lewis' comment about Pharma, not just to get their perspective, but to engage them in active mitigation in the opioid overdose challenge.

Dr. GnanaDev stated that his concern is the rapid growth in Fentanyl illegally coming into the United States and asked Dr. Smith what is being done with that concern.

Dr. Smith noted that it is very difficult to get an idea of how big the problem really is. She stated that CDPH did not have good tools for surveillance of the synthetic Fentanyl. Dr. Smith added that when the outbreak had come to Sacramento, the CDPH, per standard procedure, did surveillance for the substance, throughout the state, which led them to discover that it is a huge problem, for various reasons. One, it is not tested regularly, and it is not reported as a reason for an overdose. So, with that, it was a huge challenge just to get an idea of what it was and what was happening with it. She noted that the CDPH had reached out to law enforcement to get better data on what they had found, in hopes to get a better handle on how to monitor it. She added that since it cannot be monitored, it is difficult to stop it.

Dr. Hawkins asked if the workgroup was working on developing a way to assist physicians in approaching this issue efficiently as they are being asked to do more and more things.

Dr. Smith stated that issue is the exact subject on the academic piece of the workgroup discussions. She noted they would definitely be working on the issue since every physician is unique and their patient questioning is unique as patient populations widely vary.

Dr. Bholat asked Dr. Smith, in regard to the current CDPH task forces, how much representation in emergency medicine they have on the task forces, since emergency rooms are a continued portal of entry for many patients to continue to receive their opioids.

Dr. Smith stated they do not have any emergency room physicians on their task forces currently, but what they do have is the California Healthcare Foundation (CHF), which is coordinating the work with regional coalitions, where those particular conversations and discussions are taking place. She noted that several of those coalitions do have individual emergency room physicians involved who are familiar with those concerns.

The second part of Dr. Smith's presentation was on the Office of Health Equity (OHE)'s mission, purpose, key duties, and responsibilities. She stated that the OHE is in the Director's Office of the CDPH. Dr. Smith noted that the mission of the OHE is to work toward achieving a California where everyone has an equal opportunity to be healthy.

Dr. Smith stated there are three units within the OHE. The first is the Community Development and Engagement Unit (CDEU), the Policy Unit and the Health Research and Statistics Unit (HRSU). She noted that the mission of the CDEU is to strengthen the focus and ability to assist other state departments in their mission to increase access to, and quality of, culturally and linguistically competent mental health care services. She added that the HRSU supports research that seeks to reduce health care and mental health disparities and achieve equity in vulnerable communities in California and to understand a broadened array of social, economic, and environmental determinants of disparities and inequalities in health, health care and mental health.

Dr. GnanaDev stated this subject is close to his heart and that he is involved in creating a department on social determinacy of health. He noted that whether it be mental health, mortality from high blood pressure, diabetes, cancer, they have some relationship to social and economic factors.

Dr. Levine asked Dr. Smith about violence prevention and wondered if that discussion was on the OHE's agenda. Dr. Smith stated that violence prevention was not specifically in the OHE, but that CDPH does have a very robust violence prevention plan and work group.

Dr. Levine then asked if the First 5 Commission was a part of the OHE.

Dr. Smith stated that the CDPH is working internally on this issue, but also that their partner, Centers for Family Health, work actively with the First 5 Commission, both at local and state levels.

Judge Feinstein thanked Dr. Smith for her presentation and then added she wanted to discuss mental health in regard to children and adolescents and stated that the state was doing a horrible job in meeting their needs. She noted that one of her biggest concerns was the continuous closures of residential facilities due to the Medi-Cal reimbursements being so low that the facilities cannot be maintained. Judge Feinstein asked Dr. Smith what CDPH was doing to assist in this issue.

Dr. Smith stated she was personally familiar with the mental health facility issues, and understood Judge Feinstein's concerns. Although the OHE did have a mental health unit, the mental health facilities themselves and Medi-Cal are actually under the DHCS. She noted that Judge Feinstein touched on issues that are handled by several different state entities, but fully agreed that it is an issue that needs more attention.

Dr. Lang stated that in recognizing the importance of properly controlling patients' pain, the Board appropriately made a determination and began requiring all California physicians to acquire continued medical education (CME) on how to manage pain and treat it in patients. However, Dr. Lang noted that the Golden State Medical Association had recently received several concerns from their members that their patients, in predominantly underserved areas, are having trouble filling their prescriptions of controlled drugs, even after having had a complete examination and a treatment plan in place with their physicians. She noted that more and more of the pharmacies in these same areas are developing and implementing policies that have made it extremely difficult, and often impossible, for the patients to fill their prescriptions, for both acute and chronic pain conditions. Dr. Lang added that these same physicians have had no problem getting these same prescriptions filled for their patients in suburban areas. Dr. Lang noted that even of more concern, the physicians are working with the exact same pharmacy chain, only in a different section of the city. She felt that these pharmacies had created new and inappropriate barriers to the care of the patients and represents health inequity in populations that are already suffering an increase in adverse disparities in health care, morbidity and mortality.

Dr. GnanaDev stated that the issue was a Board of Pharmacy issue, but that Ms. Kirchmeyer would follow up with the Board of Pharmacy and pass on the information.

Mr. Madden stated that Dr. Lev, an emergency physician out of San Diego, had developed emergency room guidelines for emergency physicians and that a number of counties have adopted these same guidelines. He noted that the impact had been impressive, to the extent that it had changed the behavior of what emergency physicians have seen as “frequent flyers” coming in to the emergency departments either seeking opioids for themselves, or for selling the drugs on the streets. He added that since these guidelines had been put into place, there has been a marked change. He stated that his association promotes the Board’s guidelines, as well as the California Medical Association, the California Hospital Association as well as the Emergency Nurses Association. He noted that the Medical Board had been a tremendous help in getting the guidelines over to CDPH, to become a part of their program. Mr. Madden stated his association was more than happy to help the CDPH in any way they can to get the guidelines implemented in other counties.

**Agenda Item 17 Presentation and Possible Action on the California Research Bureau’s
Demographics of Disciplinary Action by the Medical Board of California
(2003-2013)**

Dr. GnanaDev introduced Mr. Rogers, Senior Policy Analyst with the California Research Bureau (CRB). He then thanked Mr. Rogers and the CRB for conducting the study for the Board. He added that as the Members remember, this independent study was requested by the Board Members after the concerns were brought to their attention. Dr. GnanaDev stated he knew it took a lot of time and analysis, and very much appreciated the CRB for performing the study.

Mr. Rogers reported the CRB’s findings of their review of the demographic characteristics of physicians disciplined by the Board. He stated that the request for the study came from the concerns expressed by the Black American Political Association of California (BAPAC) and the Golden State Medical Association (GSMA). Their concerns were the apparent perception of disparities in how the Board disciplines physicians. They felt the Board disciplines minority physicians, particularly African American physicians more often and more severely in comparison to their white colleagues. Mr. Rogers noted that the CRB met with representatives of BAPAC and GSMA to hear their concerns in more detail. He added, following that meeting, the CRB developed a list of potential research questions to pursue, where five primary questions had been selected based on overall importance and their feasibility given the time, data, and resources available.

Mr. Rogers stated that for the study, CRB used data supplied by the Board on complaints, investigations and discipline that were drawn from the archives that were created by the Board during its transition to the BreZze record system in 2013, which covered July 2003 through June 2013. He noted that physician level data was drawn from a similarly archived data set that contained all active physicians as of June 2013. Physician demographics were drawn from a voluntary survey that the Board sent to physicians when they renew their license. Mr. Rogers noted that as part of that survey, physicians were asked about their ethnic background across 25 potential categories and were able to select more than one. They also had an option to decline to state. He added the survey responses were used to identify the race for all responding physicians. Mr. Rogers stated the CRB began by first identifying non-responders. Of the 125,000 active physicians included in the study population, 25,000 did not provide data on their ethnicity. He noted this represents a response rate of 79.98% of all physicians in the study.

Mr. Rogers stated this percentage was fractionally beyond the threshold for which the Office of Management and Budget recommends testing for non-response bias. He noted that it appeared there was non-response bias in the data and there was a difference in the likelihood of complaints for responding versus non-responding physicians; however, the effect was quite small and did not appear to be correlated with ethnicity with the exception of Latino/a physicians. He urged that anyone interpreting the results to be aware of other limitations. Although the study started with a large overall sample, complaints, investigations, and discipline are each rare events. Out of the 125,000 physicians they began with, only 1,223 could be identified as having been disciplined a total 1,267 times during the study period.

Mr. Rogers also noted that this was only an observational study and the best the review could show is statistical association, not cause and effect. He also noted that a number of variables could not be included, such as the measure of physician quality and patient characteristics, both of which are important intervening factors. Those factors limited the CRB's ability to draw robust conclusions as there were other reasonable explanations for patterns observed.

Mr. Rogers noted that in order to evaluate the relationship between physician race and disciplinary outcomes, the CRB conducted two sets of tests for each step in the disciplinary process, complaints, investigation, and discipline. He noted the Board reviews complaints submitted for a number of violations, including substandard care, prescribing issues, billing issues, sexual misconduct, impairment, unlicensed practice, unprofessional conduct and other practice issues. He added that more than 4/5 of physicians did not receive a complaint during the study period. An examination of the complaints showed there was a relationship between a physician's race, the rate of receiving a complaint and that the correlation was unlikely to be a random chance. Mr. Rogers added that to provide even further detail, the CRB conducted a multi variant logistic regression to calculate odds, ratios for key variables of interest. In addition to race indicators, the regression controls for physicians included age, sex, board certification, training status, hours reported spent on patient care, research, teaching and administration, and the county of practice were included. After controlling for those intervening factors, physicians identified as Black or Latino/a showed an increase likelihood of receiving a complaint. Mr. Rogers noted that on average, the odds of a Latino/a physician receiving a complaint were 1.1 times more likely than a white physician and likewise, a Black physician was 1.4 times more likely to receive a complaint against them. Asian, Native Hawaiian Pacific Islander and non-responding physicians were all less likely to receive a complaint compared to white physicians, while Native American, and physicians identifying with two or more races did not show a significant result.

Mr. Rogers noted that out of 32,978 complaints, 7,731 resulted in an investigation, which represents 23.4%. He added that the majority were dismissed, referred for mediation and/or minor violations that resulted in a fine. He stated once again, an examination of the complaints showed there was a relationship between a physician's race, the rate of receiving a complaint and that the correlation was unlikely to be a random chance. Mr. Rogers added that, again, to provide even further detail, the CRB conducted a multi variant logistic regression to calculate odds ratios for key variables of interest. He noted that physicians identified as Latino/a or Black continue to show an increased likelihood of a complaint leading to an investigation. On average, a complaint made against a Latino/a physician was 1.3 times more likely to escalate to an investigation than ones against white physicians. Likewise a complaint made against a Black physician is 1.2 times more likely to escalate to an investigation. Asian physicians and declined to state were the only groups showing a clear reduced likelihood of a complaint escalating to an investigation. Native American, Native Hawaiian Pacific Islander and those who identified as two or more races did not show a statistically significant relationship.

Mr. Rogers stated the likelihood of the Board disciplining a physician is generally low. He noted that out of the 7,731 investigations included in the study, only 1,267, or 16.4%, resulted in discipline. When the CRB examined disciplinary outcomes, the relationship between a physician's race and disciplinary outcome were, again, found to be correlated and the correlation was unlikely due to random chance. He added that, again, the CRB conducted a multi variant logistic regression to calculate odds ratios for key variables of interest. Mr. Rogers stated the first part of that analysis closely mirrored that used for the complaints and investigation study, however, with this one, they added a second model specification that looked for differences between the 10-years of five executive directors that served between July 2003 and June 2013, as well as differences between the two panels that review disciplinary recommendations. He added that again, Latino/a physicians showed an increased likelihood of investigation, resulting in discipline. On average, investigations leading to complaints against Latino/a physicians were 1.6 times as likely to result in discipline as ones against white physicians whom were used as the reference category. No other groups were significantly more or less likely to have investigations result in discipline.

Mr. Rogers noted that the CRB has looked at the likelihood of discipline being related to the executive director tenure and the race or ethnicity of the physician at the same time. Likewise the CRB evaluated the likelihood of discipline given by the disciplinary panel based on the race/ethnicity of the physician. These comparisons are referred to as interaction effects. He stated this analysis was unable to find an effect on either directorship or panel selection for minority physicians.

Mr. Rogers concluded by stating the purpose for this research was to evaluate a concern by stakeholders that minority physicians, especially Black physicians, are disciplined more often than their White colleagues. He added that the analysis focused on evidence of disparate outcomes for minority physicians at the level of complaints made, investigations conducted, and disciplinary decisions. Returning to the five research questions they were asked to review and re-emphasizing the necessary caution in drawing conclusions or assigning a cause to the patterns, the CRB determined the following: a higher likelihood for Latino/a and Black physicians to have received a complaint compared to their White colleagues. Latino/a and Black physicians had a higher likelihood of complaints escalating to investigations. Latino/a physicians also had a higher likelihood of investigations resulting in discipline.

The different tenures of Board executive directors were not correlated with the likelihood of minority physicians receiving discipline, and, likewise, the panel assignment was not correlated with the likelihood of physicians receiving discipline. While the data does show evidence of different impacts on the basis of race, due to the nature and limitations of the study, the CRB cannot conclude that the Board is engaging in discrimination.

Dr. Krauss stated the Board owes great thanks to the late Dr. Jackson for having brought the Board to the realization that discrimination should never be assumed to be absent from the Board's process, but that the Board should always be vigilant to prevent discrimination. He stated the Board deserves credit for launching its own preliminary analysis, but deserves greater credit for requesting an outside data analysis by the CRB. He noted that the Board owes the CRB a great debt of thanks for the very difficult and time consuming work that had been done. Dr. Krauss felt it important for the public to be reminded that the Board is driven by consumer complaints. It may be worthwhile to analyze sources of racial and ethnic disparities in complaint rates. The public must also be reminded that the CRB analysis studied disparity. Disparity, if it exists, does not mean that discrimination is the source of disparity. While the CRB analysis does not prove discrimination, the Board must be mindful that it does not prove that there is no discrimination. Purposeful anti-discrimination activity requires much more than the Board making a policy statement. The Board should assume that there will always be

discrimination and therefore must endeavor to find it, stop it, and prevent it in an on-going manner. He stated he was pleased that the Board's president would be appointing a task force, but is hopeful that a benefit may be found after hearing the work of the task force in establishing a standing anti-discrimination committee.

Dr. Hawkins asked how significant it was when a person declined to state his race or ethnicity. He also asked if there was any study done on whether any of the physicians who were disciplined had counsel representation or not.

Mr. Rogers stated the study was not able to include if anyone had counsel representation. He stated that the self-reporting was also a limiting factor as there is no way to know the reason certain individuals would decline to state their race or ethnicity.

Ms. Pines thanked Ms. Kirchmeyer for not ignoring this issue and was pleased to hear the analysis did not really demonstrate that there was an issue, yet the Board was still willing to go the next step by reaching out to the CRB. However, the report did state that there were disparities, but not what is causing the disparities, as there are several entities involved in the complaint and/or disciplinary process. She asked Ms. Kirchmeyer if the Board has any type of required diversity training, such as the sexual harassment prevention training requirement.

Ms. Kirchmeyer noted that the sexual harassment prevention training does cover a small amount of diversity in it; however, she noted she had reached out to DCA to talk to them about SOLID developing an online type of diversity training on a regular basis for all entities involved in any complaint or discipline process.

Dr. Yip asked if the study was a one-time study or if it could possibly be done every year or every couple of years and perhaps refine it each time, from what was learned from the previous one.

Dr. GnanaDev stated that would be a project that the task force would take on, not the CRB.

Dr. Bholat stated that because there are so few Latin American and African American physicians in California currently, can the data be broken down into the categories of international and U.S. medical school graduates. She also asked if training makes a difference and if where they trained made an impact.

Mr. Rogers stated he looked at training status, whether they were a current resident, a fellow and also how many years of postgraduate training each had. They also looked at if they were a California physician or an out-of-state physician. He noted that they were not able to look at the quality of the training institution, but there was a limited set for which he was able to get data on, and it made no difference in the analysis.

Ms. Sutton-Wills asked if there was information about identifiable surnames.

Mr. Rogers stated they did not have anything like that.

Dr. Krauss noted that in Mr. Rogers's comments, he recommended caution in interpreting the results and he also reemphasized to the public that 25,000 of the physicians that were included in the study practiced outside the state of California and the Board is somewhat limited to the processes that occur in other states. He stated he would like to see the Board encourage more physicians to be more accurate in their self-reporting of ethnicity.

Ms. Pines stated that often times the reason an analysis is needed is because someone has been affected by something. She recommended the task force hold a meeting to where the members could hear what some of the challenges have been, to see where the problems may lie.

Dr. GnanaDev stated that though this was an observational analysis and no conclusion could be drawn from it, he noted the Board takes the issue very seriously. He stated that after looking over the study, he wanted to put together a task force. This task force would review the existing complaint, investigation, and disciplinary process to better understand the institutional procedural issues. The task force members would also meet with the stakeholders to look at the complex process.

Dr. Lang stated that on behalf of her members, she wanted to thank Ms. Kirchmeyer and the Board for listening to them when they came forward with these concerns and the actions of the Board were very encouraging, and positive knowing the Board wanted to learn what the issues were and what was actually happening in the different communities. She asked the Board to keep in mind that the average African American physician has 3,500 to 5,000 patients per physician as compared to the average White physician who has 1000-2000 patients per physician. So when an African American physician is removed from a community for a non-patient compromising offense, it impacts a much larger number of patients that are depending on these physicians in already underserved communities.

Ms. Fellmeth stated that her appointment as the Board's enforcement monitor in 2003 closely followed the legislature's enactment in 2002, of some priority enforcement areas. She noted that in that position, she was required to look at the nature and/or the source of complaints that would most reliably lead to disciplinary action in the priority community areas. She stated that at that time, most complaints were closed without an investigation of any kind. She felt that now might be a good time to go back to that practice of review, with the recent findings of the CRB.

Dr. Savage stated that everyone has unconscious biases about many things and he felt that more time should be spent on unconscious bias training.

Ms. Choong thanked the Board and the CRB for completing the important study and that CMA represents over 43,000 physicians and they recognize the need to do whatever is needed to be done to maintain a diverse physician workforce that represent the patients of California. She stated they appreciate that the Board is taking further steps by continuing to study this issue. She noted that she hoped that the on-going work would include follow-up studies to continue to track the progress on whether changes occur over time and suggested that maybe the Board revise the survey and if so, they would be interested in being a part of that. She suggested perhaps doing a separate study on physicians who have been through discipline.

Agenda Item 26 Update, Discussion, and Possible Action on Recommendations from the Enforcement Committee

Dr. Yip stated that the Enforcement Committee had met earlier that day and that Ms. Delp had advised Committee Members that the Board had provided the Office of Administrative Hearing (OAH) six training sessions. On February 8, 2017, Ms. Delp and Executive Director Kirchmeyer would be meeting with the OAH to discuss further training and other enforcement related matters, such as the recently adopted Manual Model of Discipline Orders and Disciplinary Guidelines, which took effect January 5, 2017. Ms. Delp also reported that the Central Complaint Unit (CCU) is in compliance with Business and Professions (B&P) Code section 129 regarding notification to complainants. Staff is currently opening cases within six days of receiving a complaint. He noted that on January 4, 2017, he

met with Board staff to review the CCU's closing letters. He added that during the sunset report at the October Board Meeting, Members commented that the closing letters needed improvement. The meeting was productive and the letters were revised. Ms. Delp also advised that she would be meeting with managers to hear their suggestions about ways to modify processing methods to improve the way enforcement business is being conducted, with the goal of reducing timeframes and improving customer satisfaction and patient protection.

Dr. Yip added that Ms. Romero gave an overview of the CCU's process for handling consumer complaints and Ms. Delp also provided an update regarding the matrix being used to monitor the probation unit's performance when addressing violations of probation. He noted that Ms. Delp provided an update on the efforts being made to recruit expert reviewers and provided them the training. He noted that Enforcement Committee Members were concerned about the compensation rate for the expert reviewers that assist in case investigations. He stated that Ms. Kirchmeyer had stated that the budget of the program had been increased and in March 2017, the Board could further pursue the request for increased compensation for the expert reviewers. He noted that Ms. Kirchmeyer also advised as an incentive to the expert reviewers to attend the training, they would now receive CME credit for it. Ms. Delp stated that at the next committee meeting, there would be an update on the interim suspension orders project on the agenda.

Agenda Item 18A Discussion and Possible Action on Legislation/Regulations

Ms. Simoes referred Members to tab 18 in their packets, where she noted a 2016 Legislative Calendar could be found. She noted that the 2016 legislative session had started and the bill introduction deadline was February 17, 2017, so there would be many more bills at the next Board meeting.

Ms. Simoes informed the Members that the Assembly Business and Professions Committee had appointed all of its members, and that almost half of them are new members. She noted that she and Ms. Kirchmeyer would make every effort to meet with those new members to brief them on the Board and the upcoming sunset review. She then announced that the Senate Business, Professions, and Economic Development have four new members. She stated that the sunset hearing was scheduled for February 27, 2017 and Dr. GnanaDev and Ms. Pines would be in attendance.

Ms. Simoes noted that she did not include a tracker list in the packet as there was only one bill that needed discussion, AB 40. She stated that the bill would allow authorized health information technology systems to integrate with and automatically carry the CURES system on behalf of an authorized health practitioners. She noted this bill is simply a way for the two systems to work together, to make things more efficient for the physician user.

Dr. Lewis made a motion to support AB 40; s/Dr. Yip. (1:51:34)

Mr. Madden stated, that as the sponsor of AB 40, his organization agrees with Ms. Simoes' analysis of the bill and her recommendation to the Board. He felt it was an important step in encouraging the use of the CURES system and its integration into the health and information systems, which will make it more automatic and he encouraged the Board to support the bill.

Ms. Choong stated she had no issue with the analysis and she believed it would add great value to the CURES system, however, she noted that CMA wants to be sure that when the systems are integrated, it would accommodate the many different types of systems that physicians use and clearly identify how it

would interface with the SB 482 requirements, so that no physician would be out of compliance. She recommended the Board take a neutral position on the bill until these issues are resolved.

Dr. Levine noted that after reading the bill in full, she understands this bill was enabling legislation, rather than mandating legislation. She stated that the bill does not say anything about limiting the number of systems that the health information technology system can integrate.

Dr. Krauss agreed that any system that will assist in implementing SB 482 is great, but he understood Ms. Choong's concerns. He noted that every practitioner in their own practice had already spent a lot of money to become compliant with a Medicare approved EHR system, so if this great advantage were to be created with AB 40, and had an interface that only played with one or two other systems, then many physicians would feel obliged to maintain their own efficiency by spending more money to get the system that would interface with the one they currently use. He stated his concern is that the health information technology system not be implemented until it can be interfaced with any system.

Mr. Madden stated that this system is not limited to integrate with only certain systems and he is working with CMA to be sure that the language in the bill will cover all concerns that they have.

Dr. Levine asked Dr. Lewis if he would be willing to take a friendly amendment to his motion. She suggested the motion be changed to "support in concept" and wait for the process of language changes. Dr. Lewis agreed to the change.

Dr. Lewis amended his motion to support AB 40 in concept; s/Dr. Yip. Motion carried (13-0.)

Ms. Simoes stated that agenda Item 18 B is the last page under tab 18, status of pending regulations. She stated the only update she had on that item is that the disciplinary guidelines were approved and took effect on January 5, 2017.

Agenda Item 19 Update from the Department of Consumer Affairs, which may include Updates pertaining to the Department's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory and Policy Matters

Ms. Lally noted that on January 10, 2017, Governor Brown released the proposed 2017/2018 State Budget and earlier in the week, he had delivered his State of the State address. She noted that on January 13, 2017, the Governor appointed Jolie Onadera as the Deputy Secretary of Legislation at the Business Consumer Services and Housing Agency (BCSH). Prior to her appointment, Ms. Onadera served as the principal consultant for the Senate Committee on Appropriations.

Ms. Lally stated that with the new legislative session beginning, several of the DCA boards were scheduled for sunset hearings on February 27, 2017 and March 6, 2017.

Ms. Lally reminded Members of their required trainings and Form 700 due dates. The deadline for the Form 700 is April 3, 2017, but encouraged the Members to get it done as soon as possible. She also reminded the Members that 2017 was a mandatory sexual harassment prevention training year for DCA, which means everyone is required to take the on-line training, even if they had taken it in 2016. She noted that the new Board Member Orientation Training would be held four times in the year, all of them taking place in Sacramento.

Ms. Lally stated there were two upcoming BreEZe software releases scheduled on February 15, 2017 and March 29, 2017. These releases would implement requested system changes made by the Board as well as other DCA programs. She added that in 2016, there had been 75 Board system changes executed, and an additional 10 requests had been implemented during the first software release at the beginning of the New Year. She noted there were currently 64 outstanding requests for system changes for the Board waiting to be scheduled in future software releases.

Ms. Lally noted that DCA's annual report was now available on the website and includes each of the board's and bureaus major accomplishments for the previous fiscal year, as well as new laws and regulations. She encouraged the Members to take a look at the report to see where the Board compares to some of the other boards and bureaus.

Agenda Item 20 Vertical Enforcement Program Update from Health Quality Investigation Unit

Mr. Chriss noted that at the last Board meeting they had advised the Members of their plan to mitigate the sworn investigator vacancies by adding 15 limited-term, non-sworn special investigator positions. He stated he was pleased to announce that all 15 positions had been filled and those investigators are working on Board cases. Mr. Chriss stated that eight positions had been added to the San Bernardino office, three in the Valencia office, and four in Sacramento. He noted that the project had been so successful that five of the special investigators who started in San Bernardino on October 3, 2016, are now in background for sworn positions with the Health Quality Investigation Unit (HQIU). Mr. Chriss stated that while those five were in background, they would continue working cases and assisting with the workload. He noted they had received very good feedback from the field and the AG's office regarding the investigators and will continue using the same model until all vacancies are filled. Mr. Chriss noted that the 29 sworn investigator vacancies which is a 38% vacancy rate. He noted they currently have 12 people in background for sworn positions, and have mitigated the shortage by employing the 15 limited-term investigator positions. Additionally, they had advertised for three limited-term, non-sworn special investigator positions in the Tustin office and one in the San Diego office to backfill some of the special investigator positions that are now in background for sworn positions. Mr. Chriss stated that with the plan that had been implemented, he is confident they have turned the corner regarding vacancies and would be working diligently to fill the remaining vacancies.

Ms. Nicholls stated they had created a new brochure that included a QR code that would link potential applicants directly to the current job postings for HQIU. She added that it is often difficult to navigate through the State's hiring process and to navigate interested applicants to the specific job openings. She noted this is a unique approach that would link potential candidates directly to the available positions. Ms. Nicholls stated they are conducting outreach efforts with local law enforcement agencies, colleges, police academies, and other professional groups. She stated they were also producing a recruitment video for the DOI website.

Mr. Chriss stated they are still awaiting a decision from CalHR on their pay retention proposal. He noted that they are also working with the Board on new reporting functions through QBIRT, which would allow staff to accurately pull case aging statistics and hoped to go live with this new function in February or March 2017.

Dr. Lewis asked where they are with elevating the level of pressure on CalHR to get the retention proposal expedited.

Mr. Chriss stated they had gone to the highest level they could at DCA by taking it to Director Kidane, who had also been told that it is still being evaluated at CalHR.

Mr. Warmoth asked Mr. Chriss with the progress of the additional staff, if he had an idea of when the Board might see progress in the case aging.

Mr. Chriss stated he hoped to have better numbers to show the Board at the next meeting.

Dr. Levine stated that it is great that they are hiring more staff, but what was happening about the staff that were still continuing to leave.

Ms. Nicholls stated that staff are still leaving due to the pay inequity, etc.

Dr. Levine asked how many sworn investigators had left in the past year.

Ms. Nicholls stated they had lost 47 sworn investigators since the transition from the Board to DCA.

Agenda Item 21 Vertical Enforcement Program Update from Health Quality Enforcement Section

Ms. Castro stated that in November, they had two subject interview trainings in Northern and Southern California. She added that the Northern California session was attended by the deputy secretary and general counsel of the Business Consumer Services and Housing Agency. She noted there had been an observable contraction of non-core disciplinary work by the HQIU, which she felt was having a positive impact on the Board's cases. HQIU had shed two clients, which were moved to the DCA's non-HQIU DOI, which reduced some cases from their workload. They also redirected the work on criminal cases, thus less search warrants and criminal cases were being processed and more focus was occurring on the disciplinary cases. Ms. Castro noted that she had worked closely with Ms. Webb and DCA to clearly illustrate and enunciate the interrogatory authority that should be given to HQIU by the Board. She added that interrogatory authority allows investigators to ask very specific questions of subjects.

Ms. Castro stated they continue to operate in a shared virtual workspace with investigators, which had led to some efficiencies. She noted they had increased the level of lead prosecutors out in the field to get ahead of any statute of limitations issues.

Dr. GnanaDev stated that it would take all three entities working together, as well as working with the legislature to get some things changed to assist in getting time frames reduced.

Ms. Castro stated they were more than happy to assist with that.

Judge Feinstein stated that vertical enforcement was a big concern of hers and noted that she had yet to see it work at any point, in her 30+ years of work. She told Ms. Castro that she would like to know how many cases are actually vertically handled. She stated that in several of the panel discussions, they are seeing some cases coming to them from 2010, which could easily mean that there is a very dangerous physician out there, who is still practicing, and that is unacceptable. Judge Feinstein stated she would like to have some statistics on the Vertical Enforcement model, how long some of those cases have been pending and how many cases are assigned to the same investigator and deputy attorney general (DAG), for the whole case process.

Ms. Castro stated that traditionally, HQE had focused on the legal aspects of the work and that they do document the first investigator assigned to the case, but they do not keep records of the investigator assignment as they operate more in a team based environment, where if the original investigator is no longer there, they always know which investigator is assigned, even if one of their case coordinators did not go in and update the new investigator name in their tracking system. She stated she could tell how many DAGs have worked a case, but there could be a number of staff working a case at the same time. So with that, if the question is, did the same investigator stay assigned to a case from start to finish, though that is the goal, it is not currently a reality with the staffing challenges.

Judge Feinstein requested that Ms. Castro provide statistics on how many attorneys had been assigned to a case from the AG's Office perspective. She stated that there has to be some parts of the system that can be rearranged to make it a better, more efficient system.

Dr. GnanaDev asked Judge Feinstein to work with Ms. Castro and bring some ideas back to the Enforcement Committee for discussion.

Ms. Kirchmeyer clarified that the timeframe that Judge Feinstein mentioned is actually the date of incident, not the date the complaint was received. She stated that the current processing timeframe was 967 days, which was still much too long, but said she did want to provide clarification. Ms. Kirchmeyer encouraged anyone who wanted more statistics than what is discussed to refer to agenda item 11 in the Board documents before the Board starts pulling additional statistics, as the Board packet provides quite a bit of additional detailed information.

Agenda Item 22 Update from the Attorney General's Office

Ms. Castro thanked Ms. Dobbs for her work over the many years and thanked her for teaching them so many things about licensing and enforcement.

Ms. Castro noted that her office had a great relationship with the OAH, and stated she meets with them often to discuss efficiencies in the administrative hearing process, including how to quickly manage failures to appear at hearings by way of default and managing staff's expectation with respect to trying to get trials set quickly. She recommended that OAH put VE cases ahead of others to assist in allowing the same DAG to see a case through from start to finish.

Ms. Castro added that they had recently hired a new DAG in San Francisco, Alice Wong, who was in private practice, and had worked in the Sacramento District Attorney's office prior to coming the AG's Office.

Agenda Item 23 Discussion and Possible Action on Amending Title 16, California Code of Regulations, Section 1321 – Approved Postgraduate Training

Ms. Alameda referred the Members to agenda item 23 and stated that the Board currently approves postgraduate training accredited by the Accreditation Council for Graduate Medical Education (ACGME) and the Royal College of Physician and Surgeon of Canada (RCPSC) completed in the United States and Canada. She noted that both the ACGME and the RCPSC now have international divisions that accredit post-graduate training in other countries. She added that at the January 2013 Licensing Committee meeting, the committee had advised staff to continue to monitor changes in post-graduate training and to bring back to the Board any new information when appropriate. The postgraduate training programs accredited by the American Osteopathic Association (AOA) are also in

the process of being accredited by the ACGME. Ms. Alameda stated that Board staff had been receiving inquiries for clarification regarding the transition of the AOA accredited programs to ACGME and how it would affect an applicant's eligibility. She noted that in addition, staff had received questions regarding the international programs and whether the Board recognized the international postgraduate training programs. She added that the ACGME and the RCPSC accredited postgraduate training programs are similar to the programs in U.S. and Canada, but are not identical, therefore staff was not asking for Board approval at this time.

Ms. Alameda stated that the Board had also become aware that family medicine postgraduate training programs in Canada were now accredited by the College of Family Physicians of Canada (CFPC). With that, staff is requesting that the Board approve amendments to California Code of Regulations (CCR), Title 16, section 1321, to address the recent changes to postgraduate training.

Dr. Lewis made a motion to amend CCR, Title 16, section 1321 as provided in the Board agenda item 23; s/Dr. Levine. Motion carried unanimously. (13-0.)

Agenda Item 24 Update, Discussion, and Possible Action on the Interested Parties Meeting Regarding Disciplinary Guidelines Amendment for Patient Notification and Regulations for the Physician Health and Wellness Program

Ms. Kirchmeyer stated that on January 11, 2017, Board staff held an interested parties meeting to discuss potential changes to the Board's disciplinary guidelines to include a condition for patient notification and to discuss the potential regulation changes needed to implement the Physician's Health and Wellness Program (PHWP). Ms. Kirchmeyer stated that in the Board packet was the handout that was provided regarding options for patient notification. She added that the recommendation was that the Board use one of the options shown, in the disciplinary guidelines. She noted that by putting the requirements in the guidelines as an optional condition, the Board would be able to choose on a case-by-case basis, when to require the notification. Ms. Kirchmeyer stated the difference between the two options was that one of the options was the posting of a sign, similar to the Board of Optometry Guidelines, and the other option was a written and verbal notification to the patient. She noted that staff had received input from the interested parties. Those who were in support of the new requirement stated that both options should be available rather than choosing one over the other. Those in support also felt that they would rather have it not be optional and be required for all individuals, which the Board rejected earlier. She added that those who were opposed to the amendments stated that any type of notification is in essence a suspension for the physician and that the requirement would have an impact on physician's staff because patients would ask them about the information. In addition, some website advertising was not within physician control and that imposing this condition would require more cases to go to hearing.

Ms. Kirchmeyer stated that currently staff believed that there were some edits that could be made to the document to respond to some of the comments and concerns, and at a later date, would bring those edits back to the Board for discussion.

Ms. Webb stated she had put together a presentation that broke down the law that allowed the Board to establish the PHWP. She included thoughts on what the regulations would have to entail. She stated she broke down the Uniform Standards for Substance-Abusing Licensees, which were required to be a part of the PHWP. She added that she explained to the interested parties that attended the meeting how the Uniform Standards had to be incorporated into the PHWP. She noted that she felt it was very educational for everyone involved with how rigorous the PHWP would have to be in ensuring that the Board is informed of all violations, major or minor. She stated this was not a diversion program and

that public safety would be paramount in the implementation of the PHWP. Ms. Webb stated the next steps are to take the comments that were provided into consideration and put together draft regulations for another interested parties meeting before bringing them to the Board for discussion.

Dr. Bishop asked that with option one, how a physician could possibly know where on the internet his/her name could be listed from.

Ms. Kirchmeyer stated that is something that was also brought up at the meeting and would definitely be discussed when putting together the regulations.

Dr. Krauss asked if other states have had similar actions and if so, what they found as a result of using that option in discipline.

Ms. Kirchmeyer stated she believed that when this first came to the attention of the Board, there was no other states that have a patient notification requirement.

Ms. Webb noted that with regard to the Board of Optometry Guidelines, the option's in their guidelines, however it has never been used in a disciplinary case.

Dr. Krauss stated he saw both positive and negative in these options and hoped either of the options would not overwhelm the Board when making disciplinary decisions.

Ms. D'Angelo Fellmeth stated that currently the Board's disciplinary guidelines contain optional probation disclosure requirements, but only under two conditions. The first condition was a third party chaperone and the other is a restriction on the practice. She noted there is not an optional condition of probation to require probation disclosure in other circumstances. Ms. D'Angelo Fellmeth stated she supported the two additional options because it gives the Board yet another tool in egregious cases.

Ms. Webb noted that with the current option, while a physician has to disclose if they must have a chaperone or if they have a practice limitation, they do not have to disclose that these requirements are because they are on probation. She stated that these two new options would require the physician to disclose he or she was on probation.

Ms. Hollingsworth stated, on behalf of the Consumers Union Safe Patient Project, they strongly urged the Board to make the optional notifications a standard condition of probation in the cases of physicians who are on probation for serious offenses. She added that patients have a right to know that the physician is being disciplined and on probation. She noted the Board suggested two possible forms of this notification, a sign in a physician's office, which they strongly support as it would give the information on how to contact the Board for further information. Ms. Hollingsworth noted they also support the requirement that the physician include the information on any web-based advertising. She stated the second option was to require the physician on probation to notify each patient in writing and require that their patients sign an acknowledgment of receipt of the notification. These acknowledgement forms are to be maintained in the physician's office to guarantee the patient received the information. They recommend that the Board include both of the options in the guidelines. She noted they did not agree with CMA that this was an unfair condition for the physician. They also recommended that a report be made to the Board's public meeting annually regarding how the options are used.

Ms. Hollingsworth then stated that in regard to the Board's proposal to promulgate regulations on the PHWP, they recommend that the Board create a committee that would oversee the PHWP. Regulations should clearly require that the program follow the Uniform Standards strictly as staff had proposed and that regulations should specify that under no circumstances should the Board secretly refer a physician into the PHWP. The Board would make no referrals to the PHWP, other than those that are accompanied by an official board action. She added that the Board should not refer physicians to the program instead of taking public action, and the Board should only refer physicians into the PHWP under the circumstances of including making the referral public information on the BreEZe webpage.

Dr. Krauss reminded everyone that when Consumers Union did a national survey of every state Medical Board in terms of availability of information about physicians who had actions taken against them, that California was found to be the best state in terms of ease of access of that information.

Agenda Item 25 Update, Discussion, and Possible Action on Recommendations from the Public Outreach, Education and Wellness Committee

Dr. Hawkins stated that the committee had met the previous day and the first agenda item was a presentation on physician burnout by Dr. Searles. This presentation included physician burnout symptoms, statistics on burnout, the effect of burnout on patient care, and ways to prevent burnout. The committee then discussed the physician burnout survey that was presented by Ms. Kirchmeyer. He noted that the FSMB would like to work with the Board on that survey, which is being used in New York and the Board could include the relevant portions of the survey in its license renewal survey. The committee agreed that it was a good idea to obtain this type of information and Dr. Levine agreed to work with staff to develop the survey.

Dr. Hawkins noted that the committee then received an update on the Check Up on Your Doctor's License outreach campaign from Ms. Simoes. He added the committee viewed the tutorial posted on the Board's website which walks consumers through how to check on the doctor's license and directed staff to make some changes to the tutorial and to work on a public service announcement (PSA) regarding what the Board does in general and how to encourage the public to use the Board's website. He stated the Board continued to implement the outreach campaign and would be including flyers with all State warrants for active state civil service employees as well as UC employees in the March 2017 payroll. Dr. Hawkins stated the Board was continuing to work with counties, other state agencies, and other interested parties to encourage patients to check up on their doctor's license.

Dr. Hawkins noted that Board staff provided an update on general outreach activities. He stated the possible future agenda items included American Medical Association (AMA) staff providing a presentation on intervention on managing stress, having staff provide an update on the PHWP, and an update on marijuana as it relates to health providers.

Agenda Item 27 Update on the Physician Assistant Board

Dr. Bishop stated the Physician Assistant Board (PAB) conducted its quarterly meeting in Sacramento on January 23, 2017. Board staff informed the Members that the CME audit program was working and currently 45 licensees were randomly selected following the renewal of their license. He stated that Members were provided a sample of the initial CME audit letters and CME non-compliance letters for their review and comments. He added that following a lengthy discussion, PAB staff was directed to research how other states conducted CME audits and to provide language related to failure to respond to the letters at the next meeting.

Dr. Bishop stated that PAB President Sax, provided an overview of the National Commission of Certification of Physician Assistants (NCCPA). He noted that in order to obtain a California PA license, the applicant has to pass the national certification test, however to renew their license, re-certification is not required. He added that Mr. Sax indicated that currently 22 states require re-certification as a condition to renew their PA license and be allowed to work in that state. He added that Mr. Sax stated Board staff had contacted other allied health board within DCA and found that none of them require re-certification for renewal of licensure.

Dr. Bishop added that Members were informed that the PAB had been selected for an internal audit by DCA and a presentation had been provided for the Members regarding the process and timeline for completion of the audit.

Dr. Bishop stated that Ms. Castro from the AG's Office provided an informative overview of the VE model and the California Academy of Physician Assistants (CAPA), provided an update on legislative regulatory changes relative to PA practice in Michigan, Iowa, and the Veterans Administration (VA). He noted that Michigan legislation amends Public Act 379 to modernize the Michigan PA Practice Act, which included removal of reference to supervision and deletion to participating physician and practice agreement. He noted that Iowa legislation SF 505 required the Iowa PAB and the Iowa Board of Medicine to jointly adopt rules to establish specific minimum requirements or definition of supervision for appropriate supervision of a PA by a physician. Dr. Bishop stated on May 25, 2016, the VA proposed to amend medical regulations, part 17 of Title 38, Code of Federal Regulations to permit full practice authority for roles of VA advanced practice to registered nurses, when acting in the scope of their VA employment. Dr. Bishop noted that there was also a discussion on the fact that there were no PA experts involved in the initial evaluation of complaints against PAs and the PAB is investigating if that was something that was reasonable to include in the enforcement process.

Dr. Bishop noted that the DCA Budget Office provided a 2016/2017 expenditure report that indicated a deficit of 23.3% due to rising AG and investigative costs. A budget augmentation was requested for the two line items. He added the Members also discussed a possible BCP for FY 18/19.

Agenda Item 28 Agenda Items for the April 2017 Meeting in Orange County

Dr. Lewis requested a brief update on what Physician Assessment & Clinical Education (PACE) does and how it works, since there are new Members on the Board.

Ms. Sutton-Wills requested the Board of Pharmacy speak on the issue that Dr. Lang, Golden State Medical Association, brought up during public comment.

Ms. Pines asked that along with the PACE update, she would like to have a presentation on physician aging.

Agenda Item 29 Adjournment

The meeting was adjourned at 12:34 pm.