MEDICAL BOARD OF CALIFORNIA
Executive Office

MINUTES
Access to Care Committee

Westin LAX – Concourse A Room
5400 Century Blvd.
Los Angeles, CA 90045

January 31, 2008

Agenda Item 1 Call to Order

Dr. Gitnick called the meeting to order at 10:30 am. Roll was taken. A quorum was present and notice had been sent to all interested parties.

Members Present:
Gary Gitnick, M.D., Co-Chair
Hedy Chang
Shelton Duruisseau, Ph.D.
Gerrie Schipske, R.N.P., J.D.
Frank V. Zerunyan, J.D.
Barbara Yaroslavsky

Members Absent:
Steve Alexander, Co-Chair

Agenda Item 2 Approval of Minutes of July 26, 2007 meeting

It was Moved, Seconded, and Carried (M/S/C) to approve the minutes of the July 26, 2007, Access to Care meeting.

Agenda Item 3 Update on the California Physician Corps – Ms. Yaroslavsky

Ms. Yaroslavsky offered an update on the California Physician Corps. She stated that, in 2002, legislation created a loan repayment program, to be administered by the Medical Board. The program was quite successful; over $8 million was raised and during the first three years of operation, the MBC signed contracts with 65 physicians working in over 90 medically underserved clinics. The biggest challenge to the Board was raising funds.

Ms. Yaroslavsky stated that during the same time that the loan repayment program was operating, Dr Fantozzi and the Access to Care Committee created the Volunteer Physician Registry. This registry was intended to be used by clinics or other entities seeking volunteer physicians. The physicians on the registry had submitted a survey to the Board indicating they would like to volunteer their services.

Ms. Yaroslavsky added that in 2005, the Board sponsored legislation to transfer the loan repayment program and the volunteer registry to the Health Professions Education Foundation; they were grouped together under the umbrella of the California Physician Corps. The intent of this transfer was to improve the success of both programs because the Foundation is specifically set up to raise money, provide tax free loan payments, and to operate these types of programs.

Dr Gitnick, who also serves as the Chair of the Foundation's Board of Trustees, reiterated the Foundation's commitment to utilize all available resources to support all of the programs offered for health care professionals. He stated that it was his goal to create a program so well administered, that it would become a model for other states to use.

Agenda Item 4 Implementation of AB 329 (Nakanishi) – Ms. Johnston

Barb Johnston made a presentation on telemedicine, to offer an overview and to demonstrate how widely it is used today. She explained how beneficial telemedicine is to supplement patient care, and she offered examples of different technologies being successfully used in providing health care today.

Ms. Johnston explained the newly enacted AB 329 (Nakanishi), which allows the Board to establish a pilot program using telemedicine, to deliver health care to patients with chronic diseases. The pilot program should also focus on offering information on the best practices for chronic disease management services and techniques.

Dr. Gitnick asked questions about the requirements for examining the patient by the "distant" physician being consulted. Ms. Johnston explained that consultations being made with or without the use of telemedicine require the consulting physician to conduct an *appropriate* examination.

Ms. Johnston advised the committee that she intends to hire a Telemedicine Program Manager to work on telemedicine issues and to coordinate the Board's work on AB 329, which requires the Board to implement a telemedicine pilot program on chronic disease management and then report back to the Legislature with the findings of the pilot program.

Lastly, Ms. Johnston mentioned California's present telecommunications infrastructure and services for many clinics are inadequate for telemedicine; however, this could change through a recent $22 million FCC grant to California to establish a statewide broadband telehealth network aimed at improving access to health care.

Agenda Item 5 AB 1154 (Leno) Diabetes Model – Dr. Fantozzi

Ms. Whitney explained this bill, as amended, would require the Department of Health Care Services, in consultation with the California Health Alliance Commission, to develop a diabetes risk reduction pilot program within 24 counties to analyze and report the outcomes from integrative care to the causes of diabetes through proactive prevention.

M/S/C to recommend a support position to the full board.

Ms. Yaroslavsky asked Ms. Whitney to find out from the author's office what other states and the federal government are doing in this arena.

Agenda Item 6 Discussion of concept to have evaluations of new initiatives – Dr. Gitnick

Dr. Gitnick mentioned there are numerous new health care initiatives in California, such as Project Dolce in San Diego, the new clinics in retail facilities, and the expanded scope of practice which is considered for mid-level health care providers. With these new projects in mind, he wanted to determine if the Medical Board should be more involved in reviewing the operations and/or success of the initiatives.

There was discussion as to whether or not this would be an activity within the mission or jurisdiction of the Medical Board.

Dr. Duruisseau suggested the board could help to identify and define a model in each of these areas which works best.

Mr. Zerunyan supported Dr. Gitnick's idea, because such involvement could lead to a joint effort between government and private entities in increasing access to care. He stated he believed it was the responsibility of the board to review such projects.

The committee asked staff to prepare a report on this subject, with a recommendation of whether or not the Board should review such projects.

Agenda Item 7 Public Comment on Items not on the Agenda

None.

Agenda Item 8 Adjournment

There being no further public comment, the meeting was adjourned at 11:25 am.

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Medical Board of California
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Memorandum

Date: January 15, 2009

To: Members

From: Abbie French

Subject: Report on Medical Malpractice Coverage

AB 2342 (Nakanishi; Chap. 276, Stats. of 2006) added Business and Professions Code section 2023, requiring the Medical Board of California (Board) to study the issue of providing medical malpractice insurance for physicians and surgeons who provide voluntary unpaid services, as specified, to indigent patients in medically underserved or critical need population areas of the state and to report its findings to the Legislature. The study was to include, but not be limited to, the cost and process of administering such a program, options for providing medical malpractice insurance and how the coverage could be funded, and whether the voluntary licensure surcharge fee assessed under Section 2435.2 (as added by Chapter 293 of the Statutes of 2005) is sufficient to fund the provision of medical malpractice insurance for the physicians and surgeons. The study was to be completed by January 1, 2008, but was delayed due to problems obtaining a vendor and contract to conduct the study.

On June 30, 2008, the Board executed a contract with UC California, Davis Health Systems (UC Davis) to perform the required malpractice coverage study. On December 31, 2008, UC Davis released the attached report. After analysis of the information required, UC Davis found the following:

- California is one of the seven remaining states in the U.S. that have yet to enact any meaningful legislation that relieves the providers who render voluntary, unpaid care to patients from paying the high cost of professional liability insurance. Lack of malpractice coverage is perceived as a serious impediment to attracting volunteers.

- If California desires to promote physician volunteerism, then legislation must address the following:

  A. Adoption of one or more of the following liability protection models:

     - Enactment of immunity statutes in which the provider is not liable for common negligence, but only for gross negligence or willful misconduct.

     - Enactment of immunity statutes in which, under circumstances proscribed by the state, a physician volunteer would be considered a state employee when providing uncompensated care.

     - A State-established malpractice insurance program in which the state either purchases insurance for physician volunteers or establishes a self-insured pool.

  B. Determine settings where liability protection would apply (free clinics, non-profits, hospitals, private physician offices, etc.).

C. Determine whether there would be any limitation to the type of care that may be rendered (surgical, anesthesia, minor procedures, primary care, etc.).

D. Identify what patients would be covered under the program (medically indigent, Medi-Cal, Medicare, etc.).

E. Establish a clinic and physician registration process. Criteria would need to be developed to determine who could be a participating provider. Since there is a mechanism already established by the Board to register volunteer physicians, the Physician Volunteer Registry (www.publicdocs.medbd.ca.gov/volmd) could be the repository of names, information and insurance eligibility for those individuals who are approved as a participating provider.

- California has one of the highest medical license fees in the country, so the easiest route to generate revenue for volunteer physician malpractice insurance may be the most difficult to implement (raise license fees). If every licensed physician was assessed an additional $50 to the biennial fee, over $3 million could be generated annually, which could easily pay for malpractice coverage for 150-200 clinics (NORCAL non-profit clinic insurance data, estimated costs on page 34 of report), or provide revenue to pay for approximately 450 individual physician premiums (estimated costs on page 33 of report).

- Additional revenues could be generated by requiring those health care entities that register with the state in order to be an eligible site to receive volunteer physicians who are covered through the state program to pay a nominal annual fee, e.g. $200. This source of revenue would be limited, but would generate additional dollars.

- Most states pay for volunteer professional liability coverage out of their general fund. In California, there may be current state program funding that could pay for an insurance coverage program for volunteer physicians (i.e., Medically Underserved Account (physician volunteer program)).

- Grant opportunities, through organizations like the California Endowment, or other healthcare non profit organizations, could also present potential avenues for revenue generation to pilot this program.

- If a volunteer physician insurance program was developed in the state of California, it should not be administered by the Board but by another branch of the state (If administered by the Board, there may be a perceived conflict of interest if the Board must determine whether to take disciplinary action against a licensee to whom it has provided medical malpractice insurance).

In conclusion, the report states that California is in a favorable position to take a step forward in introducing a program that would remove the professional liability insurance barrier to providing volunteer physician services. A climate must be created which encourages volunteerism, addresses the concerns of the health care providers regarding malpractice lawsuits, ensures that patients seen by volunteer health care providers retain their rights to compensation for acts of negligence, and avoids the perception that volunteer liability protection permits a lesser standard of care for the uninsured and underinsured. Those physicians that provide voluntary, unpaid medical care to indigent California are performing a service on behalf of the state.

This report was submitted to the legislature for their review and the Legislature will ultimately decide the best route to take, if any, on this issue. Any program would need to be established through legislation.