MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 27, 2020
ATTENTION: Members, Medical Board of California
SUBJECT: Update on the Prescription Review Program, formerly known as the Death Certificate Project
STAFF CONTACT: William Prasifka, Executive Director

REQUESTED ACTION:

This report is intended to provide the Members with an update on the Prescription Review Program, formerly known as the Death Certificate Project. No action is needed at this time.

BACKGROUND:

On average, 115 Americans die every day from an opioid overdose. To combat this epidemic the Board has continued its work on the Prescription Review Program, formerly known as the Medical Board's death certificate project. This Board project was born out of vetoed legislation that would have required coroners in California to report deaths when the cause of death is the result of prescription drug use, the Board's project utilizes California death record data to identify physicians who may be inappropriately prescribing opioids to their patients through a collaboration effort with the California Department of Public Health ("CDPH"). Based upon this information, the Board has been investigating physicians who may have violated the law.

The Board understands that just because a patient death occurred it does not automatically mean the physician deviated from the standard of care or violated the Medical Practice Act. However, in cases where the Board determined that a violation occurred, the Board has taken appropriate action.

The Board is preparing to launch its second round of this project wherein the Board will be reviewing death certificate data reported during the 2019 calendar year. Previously, in the first round, the Board reviewed data reported in the 2012 and 2013 calendar years.

Approximately 2,694 deaths were reviewed in those two years, out of the 2,694 deaths reported, 520 cases were initiated against 471 physicians. To date, the Board has filed 75 Accusations involving 66 physicians, 2 Pre-Accusation Public Letters of Reprimand were issued, and 20 physicians have been placed on probation.

Other disciplinary action included 19 public reprimands and 11 surrenders. Another 133 cases were closed with simple departures and 151 cases were closed as no violation. The cases involve a great deal of work including obtaining records and then having those records reviewed to determine if possible violations occurred. It is important to emphasize that just because a patient death occurred it does not automatically mean that a violation occurred. Some deaths were due to street drugs. There were 14 cases

closed because the subject was deceased and 5 subjects had licenses revoked prior to the project.

As mentioned before, the Board has elected to change the name of the project. The name of this project was changed to give a more positive descriptive emphasis of the goal behind the project. Another thing that the Board is changing is its methodology in reviewing the data received from CDPH. The goal is to conduct a more robust review process from the beginning in order to reduce the number of physicians undergoing a formal investigation when they do not present a risk to the public.

What this means is that once the Board receives that data from CDPH, the Board will review the prescribing of each reported death as previously done by using the Controlled Substances Utilization and Review System, better known as CURES, with the help of 6 Medical Board consultants. The medical consultants will be asked to identify cases where the prescribing appears inappropriate that may have led to the death. Once the consultant identifies the physician, the Board will run an overall prescribing report on that physician and the second report will be reviewed by the consultant. This is where the methodology differs from before, physicians that do not present a risk to the public will not be reviewed further.

The Board's normal enforcement review process for those individuals presenting a risk will begin after this second review. The Board will start reaching out to the next of kin to obtain releases, gather certified medical records, coroner/toxicology reports, and summaries of the care and treatment rendered to the deceased and active patients. These records be sent to another medical consultant in the same specialty group as the identified individuals. The consultant will opine on whether or not they believe there is a violation that warrants a formal investigation. If a possible violation is identified, the case will be forwarded to the Department of Consumer Affairs Health and Quality Investigation Unit (HQIU) and HQIU will proceed with their investigative process. Further investigation may include interviewing involved parties, gathering any other evidence necessary and forwarding this to a third, final expert reviewer. This expert will determine if there are any departures from the standard of care. If departures are found, the case will proceed with a transmittal recommendation to the Attorney General's Office for the filing of a formal Accusation based on the findings of the expert. If departures are not identified, the case will be closed.

The end goal remains the same as before and that is consumer protection.