MEDICAL BOARD OF CALIFORNIA
QUARTERLY BOARD MEETING

Embassy Suites by Hilton Santa Ana
1325 E. Dyer Road
Santa Ana, CA 92705

April 27 – 28, 2017

MEETING MINUTES

Thursday, April 27, 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.
Randy Hawkins, M.D.
Howard Krauss, M.D.
Kristina Lawson, J.D.
Ronald Lewis, M.D., Secretary
Denise Pines, Vice President
David Warmoth
Jamie Wright, J.D.
Felix Yip, M.D.

Members Absent:
Judge Katherine Feinstein (ret.)
Sharon Levine, M.D.
Brenda Sutton-Wills, J.D.

Staff Present:
April Alameda, Staff Services Manager II
Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dennis Frankenstein, Staff Services Analyst
Kimberly Kirchmeyer, Executive Director
Regina Rao, Associate Governmental Program Analyst
Elizabeth Rojas, Staff Services Analyst
Jennifer Simoes, Chief of Legislation
Lisa Toof, Staff Services Manager I
Kerrie Webb, Staff Counsel

Members of the Audience:
Teresa Anderson, California Academy of Physician Assistants

Eric Andrist, by phone
Jonathan Burke, Assistant Deputy Director, Boards and Bureaus, Department of Consumer Affairs
Gloria Castro, Senior Assistant Attorney General, Health Quality Enforcement Section, Attorney General's Office
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
Rosanna Davis, Licensed Midwife, California Association of Licensed Midwives
Sarah Davis, Licensed Midwife, California Association of Licensed Midwives
Clinton Dicely, Supervising Investigator, Health Quality Investigation Unit
Robert N. Eberhart, Midwestern University, Arizona College of Osteopathic Medicine
Karen Ehrlich, Licensed Midwife
Louis Galiano, Videographer, Department of Consumer Affairs
Bridgette Gramme, Center for Public Interest Law
Marian Hollingsworth, Consumers Union Safe Patient Project
Sara Howard, Horizon Midwifery
L. Khadijah Lang, M.D., President, Golden State Medical Association, by phone
John Leag, Midwestern University, Arizona College of Osteopathic Medicine
Sonya Logman, Deputy Secretary, Business, Consumer Services and Housing Agency
Michelle Monseratt-Ramos, Consumers Union Safe Patient Project
Faren Moreno Garay, Investigator, Health Quality Investigation Unit
James Murdoch, Midwestern University, Arizona College of Osteopathic Medicine
Kathleen Nicholls, Deputy Chief, Health Quality Investigation Unit, Department of Consumer Affairs
Shaut Pezeshkian, Midwestern University, Arizona College of Osteopathic Medicine
Robert Pulido, Supervising Investigator II, Health Quality Investigation Unit
Alicia Sanchez, California Medical Association, by phone
Shannon Smith-Crowley, American Congress of Obstetricians and Gynecologists

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

Dr. GnanaDev called the meeting of the Medical Board of California (Board) to order on April 27, 2017 at 2:59 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

Mr. Andrist stated he had phoned into the October 2016 meeting and had requested a future agenda item. He stated that the January and now April meetings have taken place and it still had not been added to an agenda. He noted that he had sent numerous emails to both staff and Board Members with little or no response from any of them. He stated he had put together his own website to assist others in searching for physicians.

Dr. Lang asked if the Board would be providing more information on an issue that she brought up at the January 2017 Board meeting regarding pharmacies. She had requested a follow up regarding narcotics and their availability in intercity pharmacy neighborhoods.

Agenda Item 3 Approval of Minutes from the January 27-28, 2017 Meeting

Dr. Lewis made a motion to approve the January 27-28, 2017 meeting minutes, as written; s/Dr. Krauss. Motion carried unanimously. 11-0.

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

Dr. GnanaDev stated he and Ms. Pines had been working closely with staff to prepare for the Sunset Review hearing. He noted they had also met with the chairs of the Senate and Assembly Business and Professions (B&P) Committees. He added that staff had also met with these committees prior to the hearing. Both B&P Committees had specific items the Board had to provide testimony on at the hearing, and he and Ms. Pines worked with staff to prepare the testimony. He stated that after the hearing he and Ms. Pines worked with staff to prepare responses to the sunset report background paper that was issued prior to the hearing. Those responses were submitted to the B&P Committees on the due date. He added that many of the items submitted would require legislative changes, and were included in Senate Bill SB 798, the Board's sunset bill. Dr. GnanaDev thanked the B&P staff for all of the hard work they put into the bill. He added that on April 24, 2017, he testified at the hearing on SB 798.

Dr. GnanaDev noted that since the January Board meeting, he and Ms. Pines had regular calls with the Board's executive staff to discuss Board projects. He added that he had also met with the new Director of Department of Consumer Affairs, Mr. Grafilo.

Dr. GnanaDev stated he had the pleasure of giving presentations to physicians on the importance of the laws contained in the medical practice act and ensuring they know the laws and remain in compliance. He encouraged other Board Members to make themselves available to provide updates on the Board and to explain Board processes in an effort to educate physicians on the functions of the Board.

Dr. GnanaDev noted that there had been no committee changes since the last Board meeting, but if anyone wanted to consider making a change to contact himself or Ms. Kirchmeyer.

Agenda Item 5 Board Member Communications with Interested Parties

Dr. GnanaDev stated he is involved with multiple organizations and meets with their boards regularly as a member, but never discusses Medical Board issues.

Agenda Item 6 Discussion and Possible Action on 2018 Proposed Board Meeting Dates

Ms. Kirchmeyer referred the Members to an updated document that was handed out in reference to updated 2018 proposed meeting dates. She stated the reason there is an updated version was due to the fact that staff had recently learned of a large event happening in Sacramento in January, 2018 on the original proposed dates and stated it would be difficult to find an available hotel for those dates. Ms. Kirchmeyer went over each of the dates for consideration and asked the Members for their input on which dates would be best for their schedules. Dr. Krauss noted the January 18-19, April 19-20, and July 26-27 work fine for him, however, the October 25-26 dates conflict with an obligation he already had scheduled out of state, and asked the Members if they could possibly change the October dates to the 18-19.

Dr. Lewis added that staff just needs to be sure that none of those dates fall on any type of religious holiday as well.

Dr. Lewis made a motion to accept the amended 2018 Board meeting dates as follows: January 18-19 in the Sacramento area, April 19-20 in the Los Angeles area, July 26-27 in the San Francisco area and October 18-19 in the San Diego area; s/Ms. Wright. Motion carried unanimously 11-0.

Agenda Item 7A Discussion and Possible Action on Legislation/Regulations

Ms. Simoes referred the Members to the Legislative Packet and noted that an updated tracker list and several updated analyses and bills had been handed out. She added that the bills in blue were either 2-year bills or bills that the Board had already taken a position on, so they would not need to be discussed. Ms. Simoes noted the bills in green and the bill in pink would require discussion and a position.

Ms. Simoes began with **AB 148 (Mathis)**. She stated the bill would revise the definition of a practice setting for the purposes of Physician Corps Loan Repayment Program (Program) eligibility (which includes the Steven M. Thompson Loan Repayment Program (STLRP) and the Physician Volunteer Program) to allow community clinics and physician offices that are in rural areas to be eligible if 30% of their patient population qualifies as medically underserved. She stated the current practice setting definition specifies that community clinics and physician offices are eligible for the Program if 50% of their patient population qualifies as medically underserved. Ms. Simoes noted the bill would only change the definition for rural areas, as suburban areas still must meet the 50% threshold in order to be eligible. She added this bill would also specify that the revised definition only applies to program participants that enroll in the Program on or after January 1, 2018.

Ms. Simoes noted the bill is designed to give rural areas a greater chance to obtain the benefits of the STLRP and recruit physicians to these areas. She added according to a report submitted by the Health Profession Education Foundation (HPEF), only 15 of the total 126 STLRP awardees were in rural areas in 2015/16, and although the Board supported the bill in 2013 that originally added the 50% medically underserved patient population requirement, it appeared that some rural areas could not meet this requirement and as a result would not be eligible for the Program. This bill would not increase the funding for the Program, but it would expand eligibility for practice settings in rural areas, which may help to incentivize physicians to practice in those areas. She noted that staff is suggesting the Board take a neutral position on this bill.

Dr. Lewis made a motion to take a neutral position on AB 148; s/Dr. Krauss. Motion carried unanimously 11-0.

Ms. Simoes stated **AB 182 (Waldron)** would require the Department of Health Care Services (DHCS), in consultation with stakeholders, as appropriate, to develop, coordinate, implement and oversee a comprehensive multicultural public awareness campaign, to be known as the Heroin and Opioid Public Education (HOPE) Program, to combat the growing heroin and opioid medication epidemic in California. She stated this bill would require the HOPE Program to provide for the coordinated and widespread public dissemination of individual case stories and other generalized information using appropriate types of media, including new technologies in media, print media, television and radio, Internet and social media. She added in disseminating this information, the HOPE program shall employ a variety of complementary educational themes and messages that shall be tailored to appeal to different target audiences. Ms. Simoes noted this

bill would require DHCS to submit a report to the Governor and the Legislature on at least an annual basis that summarizes the actions undertaken by DHCS to implement this bill and to include an assessment of the effectiveness of the HOPE Program. She added the report shall provide any recommendations for legislative or executive action that may be necessary to facilitate the ongoing success of the HOPE Program, and the bill would increase awareness and provide education to help prevent heroin use and opioid medication abuse, which furthers the Board's mission of consumer protection. She noted staff recommended the Board take a support position on this bill.

Dr. Bholat made a motion to take a support position on AB 182; s/Dr. Krauss.

Dr. Bishop stated he agrees with the bill in concept, but asked if there was any evidence that this type of outreach actually has an effect. He stated it is critical that this be done appropriately and in a way that will truly reach out to the public.

Ms. Simoes stated she is not aware of any actual statistics; however, the California Department of Public Health (CDPH) workgroup has deliverables that are required. Board staff felt that any type of information that can be disseminated would be beneficial.

Motion carried unanimously 11-0.

Ms. Simoes stated **AB 505 (Caballero)** would prohibit the Board from entering into a stipulation for disciplinary action if the stipulation places a licensee on probation and the operative accusation includes a felony conviction involving harm to patient safety or health, drug or alcohol abuse directly resulting in harm to patient safety or health, or a sexual act or sexual exploitation. She noted any settlement recommendation agreed to by the Board must provide an appropriate level of public protection and rehabilitation and settling cases by stipulations that are agreed to by both sides facilitates consumer protection by rehabilitating the physician in a more expeditious manner. Ms. Simoes added by entering into a stipulation, it puts the individual on probation or restriction sooner and the public is able to see the action taken by the Board more timely than if the matter went to hearing. In addition, the Board may get more terms and conditions through the settlement process than would have been achieved if the matter went to hearing. Ms. Simoes noted if the Board is required to go to hearing for certain cases, there will be a significant fiscal impact to the Board, over 3 million dollars, and it will also significantly increase the Board's enforcement timelines. She noted this bill would not enhance consumer protection, as it will result in physicians practicing longer with no monitoring or restrictions by the Board. Board staff suggested the Board take an oppose position on this bill.

Dr. Lewis made a motion to take an oppose position on AB 505; s/Dr. Hawkins.

Ms. Sanchez stated that the California Medical Association (CMA) is the sponsor of AB 505 and noted they believe this bill enhances the integrity of the profession by ensuring that serious allegations are fully investigated and that probation can only be offered after there is a finding of fact, since it is important that serious allegations be treated in a manner that ensures the public can trust the disciplinary process. She asked the Board to take a neutral position on this bill.

Motion carried unanimously 11-0.

Ms. Simoes stated **AB 715 (Wood)** would require CDPH to convene a workgroup to review existing prescription guidelines, including, but not limited to, guidelines developed by the Centers for Disease Control (CDC) and the Board, and develop a recommended statewide guideline addressing best practices for prescribing opioid pain relievers for instances of acute, short-term pain. She added that in developing the statewide guideline, the workgroup may consider, among other things, evidence-based, peer-reviewed research, lessons learned from demonstration pilot projects, or other policies that have been successful in reducing opioid use and abuse. Ms. Simoes added the guidelines shall include, but are not be limited to, the appropriateness of limiting initial prescription duration and the appropriateness of a differing prescribing protocol for individuals under 21 years of age. Ms. Simoes stated the bill would require CDPH to submit a report to the Legislature on or before March 1, 2019, which shall contain the workgroup's conclusions and required recommendations. The bill would sunset the workgroup on January 1, 2020. She added that although the Board has already drafted guidelines on this issue through a very extensive process that included stakeholder and expert input, a third party review of all existing guidelines may allow for additional input and updates for state guidelines. Ms. Simoes noted Board staff recommended taking a neutral position on AB 715.

Dr. Krauss made a motion to take a neutral position on AB 715; s/ Dr. Hawkins.

Dr. Lewis asked if the reason staff is recommending taking a neutral position is because it is early in the process and staff does not have enough information to recommend a support position.

Ms. Simoes stated the Board could support the bill, but since the Board already has its own set of guidelines, this new requirement for development of another set of guidelines may not be necessary, but it does look to see if something different should be developed. She noted that the development of new guidelines could change the ones that the Board had already worked so hard to develop.

Dr. GnanaDev stated there had been a lot of work put into the Board's guidelines and that the Legislature had even mentioned that the Board's guidelines are better than the current CDC guidelines, so he is not sure what could be added to the Board's current guidelines to improve them.

Dr. Bholat noted that she agrees with the neutral position at this point and appreciates the idea of the workgroup because often, physicians are confused and are asking for guidance. She noted that it does not seem to be the opioid prescriptions that are confusing, it is also the other substances that are prescribed with the opioids that is challenging for many physicians.

Motion carried unanimously 11-0.

Ms. Simoes stated **AB 845 (Wood)** would allow a physician to prescribe and a pharmacist to dispense cannabidiol (CBD), if it is removed from Schedule 1 of the federal Controlled Substances Act (Act) and placed on a schedule other than Schedule I, or if a product composed of CBD is approved by the federal Food and Drug Administration (FDA) and either placed on a schedule of the Act other than Schedule I or is exempted from the Act. She stated if a physician and pharmacist prescribes and dispenses CBD in accordance with federal law, they shall be deemed to be in compliance with state law. Ms. Simoes added this bill would state that upon the effective date of one of the federal changes specified in this bill, the prescription, furnishing, dispensing, possession, or use of a product composed of CBD, in accordance with federal law, is for a legitimate medical purpose and is authorized pursuant to state law. Ms. Simoes noted this is an urgency bill and will take effect immediately upon being signed into law. According to the author, the purpose of the bill was to ensure Californians with uncontrolled seizures will have

continued access to FDA approved epilepsy treatments derived from CBD. She noted the bill merely aligns state law with federal law to allow treatments authorized by the federal government in the future. Board staff suggested taking a neutral position on this bill.

Dr. Krauss made a motion to take a neutral position on AB 845; s/Dr. Lewis. Motion carried unanimously 11-0.

Ms. Simoes stated **AB 893 (Garcia, E.)** would authorize, until January 1, 2022, Pioneers Memorial Health Care District (District) to employ physicians and charge for professional services. She stated the District can only employ physicians if the medical staff concurs by an affirmative vote that employing physicians is in the best interest of the communities served by the District and if the District does not interfere with, control or otherwise direct the professional judgment of a physician in a manner prohibited by existing law. This bill would require the District to submit reports to the Office of Statewide Health Planning and Development (OSHPD) on an annual basis. Ms. Simoes added the District includes one hospital, Pioneers Memorial Hospital, and one health center in Calexico, and would expand on AB 2024 from last year and allow the District, which is a rural healthcare district, to better recruit and employ physicians, in order to assure physician retention in a rural setting. She noted the Board has always believed that the ban on the corporate practice of medicine provides a very important protection for patients and physicians from inappropriate intrusions into the practice of medicine. Ms. Simoes stated that being said, the bill only applies to one hospital and one health center and would help this hospital to recruit and retain physicians, which will improve access to care in these rural communities. She added, the bill is a pilot program that will be evaluated and also makes it clear that the District must not interfere with, control or otherwise direct the professional judgment of a physician. She noted the bill is modeled after AB 2024 from last year in which the Board took a neutral position**.** Ms. Simoes stated staff recommended the Board take a neutral position on this bill.

Dr. Krauss made a motion to take a neutral position on AB 893; s/Dr. Bholat. Motion carried unanimously 11-0.

Ms. Simoes stated **AB 1048 (Arambula)** would authorize a pharmacist to dispense a Schedule II controlled substance, including opioids, as a partial fill if was requested by the patient or prescriber. She noted the bill would specify that subsequent fills, until the original prescription is completely dispensed, shall occur at the pharmacy where the original prescription was partially filled. She added the bill would require the full prescription to be dispensed not more than 30 days after the first partial fill. Thirty-one days after the initial partial fill, the prescription shall expire and no more of the drug shall be dispensed without a subsequent prescription. Ms. Simoes noted the bill would require the pharmacist to record in the state prescription drug monitoring program only the actual amounts of the drug dispensed. Ms. Simoes noted the bill would require the pharmacist to notify the prescriber that the prescription was partially filled and the amount of the drug that was dispensed, as specified. She added the bill would also remove the requirement that pain be assessed at the same time as vital signs, and would instead include pain as an item to be assessed, which shall be noted in the patient's chart. Ms. Simoes noted the bill would increase consumer protection by allowing for partial fills of opioids, which will likely reduce the supply of opioids that could potentially be misused or diverted and that the bill takes reasonable steps to address the opioid epidemic and would further the Board's mission of consumer protection. Board staff recommended the Board support this bill.

Dr. Krauss made a motion to take a support position on AB 1048; s/Dr. Lewis.

Dr. Hawkins asked if there had been any input by the Board of Pharmacy or Pharmacy Association on the bill, as it seemed to have the potential to increase the amount of work they would have to do.

Ms. Simoes stated that at the time the analysis was written, they had not given their input.

Ms. Kirchmeyer added that the Board of Pharmacy's meeting was the following week, so they may not have taken a position on the bill just yet.

Ms. Sanchez noted that as the sponsors of AB 1048, CMA appreciated the staff analysis and recommendation and stated the idea of this bill is to reduce the supply of opioids, but maintain the flexibility for the provider and the patient to ensure there is appropriate care.

Dr. Lang stated she would like to get clarification on the bill. She understood it to be that the bill would allow the pharmacy to give a partial refill of a prescription and that the patient had 30 days to come back and get the completion of the prescription and if so, she asked why the pharmacy would not fill the full prescription at the initial fill.

Ms. Simoes stated that it would be an option to only partially fill, not a requirement.

Motion carried unanimously 11-0.

Ms. Simoes stated **AB 1204 (Mayes)** would allow a physician to prescribe a one-month supply of a life-saving medication, as defined, to a patient to be stored for the use of that patient in case of a natural disaster or other emergency. She added this bill would specify that a life-saving medication does not include medications that are primarily prescribed to relieve pain. According the author's office the bill is a district bill and the purpose is to ensure that once a year a doctor can prescribe a life-saving medication, over and above what is normally prescribed, so the patient can store that medication at home in case of a natural disaster or other emergency that prevents the individual from going to the pharmacy and having their prescription filled. Ms. Simoes noted that ensuring that patients have access to life-saving medications is important and will ensure that these patient's lives are not at risk. She added, however, the bill as written does not make it clear that the 30-day supply is in addition to their regularly prescribed dosage. Ms. Simoes added that although the bill does say that life-saving medications do not include medications that are primarily prescribed to relieve pain, the bill should specifically prohibit controlled substances used for pain management. Board staff suggested that the Board take a neutral position on the bill if these amendments are made.

Dr. Lewis made a motion to take a neutral if amended position on AB 1204 with the amendments as recommended by staff; s/Ms. Wright.

Dr. Bholat expressed her concerns about how the bill is going to work since there is often times a limit to how many prescriptions a patient can receive in a years' time. She noted she understands why the bill would be considered, her concern is how it would be carried out.

Dr. Hawkins stated his concern is that many prescriptions could expire before they are needed and they would be more harmful to patients than helpful.

Dr. Bishop stated his concern is how these prescriptions get disposed of when they are not used. He noted one could sell them illegally, or dispose of them in an inappropriate way. He stated the physician who prescribed this extra medication should be required to learn from the patient if it was used appropriately, and if not, have it disposed of at the physician's office.

Motion carried unanimously 11-0.

Ms. Simoes stated **AB 1340 (Maienschein)** would require the Board to consider including a course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues in children and young adults and their appropriate care and treatment. She noted the sponsor felt it is imperative that all medical professionals are trained in recognizing the early signs of mental health issues in children and young adults. Ms. Simoes stated although the Board has historically opposed mandated continuing medical education (CME), the bill would not mandate particular CME for physicians. She added the bill would only require the Board to consider a course on integrating mental and physical health care in primary care settings. Ms. Simoes noted the Board does not track employment information for physicians, so the Board would not know which physicians practice in primary care settings, however, if the Board decides that it is important to get out information to physicians on this particular type of CME, it could include an article in its Newsletter or put information out on the Board's website**.**

Ms. Wright made a motion to take a neutral position on AB 1340; s/Dr. Lewis.

Dr. Bishop stated he did not understand why the Legislature would put something in legislation that says you "may" do something, but you do not have to do so. He noted he did not see the purpose in proposing that type of option.

Ms. Simoes stated it is usually because if it is mandated CME, the Board would oppose it, so this is the Legislature's way of saying they would like to work with the Board on encouraging physicians to attend, which is the reason staff is suggesting the Board take a neutral position.

Motion carried unanimously 11-0.

Ms. Simoes stated **AB 1368 (Calderon)** would authorize a physician to designate a physician assistant (PA) or a nurse practitioner (NP) to sign any authorization form required for benefits and services under the Medi-Cal Program, provided that the physician and the PA or NP are each enrolled as Medi-Cal providers, and that allowing PAs and NPs to sign off on authorization forms for Medi-Cal seems reasonable, as PAs and NPs are already recognized as primary care providers in Medi-Cal. Ms. Simoes noted the bill would only allow PAs or NPs to sign off on authorization forms if their physician supervisor has designated them to do so, may prevent delays in access to care for Medi-Cal patients, and will not compromise consumer protection.

Ms. Wright made a motion to take a neutral position on AB 1340; s/Dr. Hawkins. Motion carried unanimously 11-0.

Ms. Simoes stated **AB 1512 (McCarty)** would create the Opioid Addiction Prevention and Rehabilitation Act (Act), which would, on and after January 1, 2018, impose a tax upon the distribution of opioids by every person, including, but not limited to, a manufacturer or wholesaler, that makes the first sale of opioids in California, where the sale is for the purpose of resale in the regular course of business, at the

rate of one cent per milligram of active opioid ingredient. She noted the Board of Equalization (BOE) would collect the tax pursuant to existing law. She added it is the intent of the Legislature to enact legislation that would provide for distribution of the funds for addiction prevention and rehabilitation programs. She stated the bill will tax the wholesalers and manufacturers of opioids, which seems to be a reasonable funding source to contribute to the growing opioid abuse epidemic. The bill would ensure that the funds go to the counties to provide resources for addiction prevention and rehabilitation programs, which is much needed in California. In addition, she stated the bill will increase awareness and help to treat and rehabilitate individuals in California.

Dr. Lewis made a motion to support AB 1512; s/Dr. Krauss.

Dr. Bishop expressed his concern of this tax being passed on to the consumer, and although it is not a big tax, he noted that for someone on a limited income, it could become an issue.

Dr. Lewis stated he too was concerned about the tax being passed on to the consumer at some point, and he noted his concern also about the Board taking a support position on something that has to do with a tax. He then suggested taking a neutral position.

Dr. Bishop added that perhaps an amendment of a support if amended position be taken with the clear understanding that the amendment state that this tax is not to be passed on to the consumer by any entity.

Dr. Lewis agreed to change the motion to a support, if amended position on AB 1512 with the amendment stating the tax is not to be passed on to the consumer by any entity; s/Dr. Bholat. Motion carried unanimously 11-0.

Ms. Simoes stated **AB 1560 (Friedman)** would amend existing law (Business and Professions Code section 2836.1 (e)), which limits the number of NPs who are furnishing or ordering drugs, that may be supervised by a physician, to four. She noted the bill would eliminate that cap entirely allowing physicians to supervise as many NPs as they choose. She stated that allowing physicians to have no limits in the number of NPs they supervise could be problematic, as it may lead to physicians supervising too many NPs at one time, and may result in consumer harm due to a lack of supervision. Ms. Simoes noted that NPs are well qualified to provide medical care when practicing under standardized procedures and physician supervision. The standardized procedures and physician supervision, collaboration, and consultation are in existing law to ensure that the patient care provided by an NP includes physician involvement and oversight, as physicians should be participating in the patient's care in order to ensure consumer protection. She noted that if the cap were to be removed, it may lead to less physician involvement and oversight, which could impact consumer protection. She stated that staff suggested an oppose unless amended position be taken, with the amendment being to put in a reasonable cap on the number of NPs a physician can supervise.

Dr. Lewis made a motion to take an oppose unless amended position on AB 1560; s/Dr. Bishop. Motion carried unanimously 11-0.

Ms. Simoes stated **AB 1612 (Burke)** is similar to bills in the past and would remove physician supervision for Certified Nurse Midwives (CNM). She noted in the past, the bill had parameters as to what kind of services could be provided, and what kind of patients could be seen by CNMs. She added this bill removes physician supervision for CNMs and although the Board was supportive of the bill in 2013 that removed physician supervision for licensed midwives (LM), it was because the bill was very

restricted and clear on what types of patients LMs could accept, and required physician consultation and approval for patients that did not meet the requirements. She added that high risk patients cannot be accepted by an LM, whereas, this bill would allow a CNM to accept all patients as there are no clear limits on what types of patients a CNM could accept. She noted the bill would provide that the practice of nurse-midwifery emphasizes informed consent, preventive care and early detection and referral of complications. However, the bill does not define informed consent or when a CNM has to refer a patient to a physician and for what types of complications. She added it is also unknown how the bill would affect corporate practice, as the bill does not address this issue. Ms. Simoes stated the Board's primary mission is consumer protection and the bill does not currently include parameters on independent CNM practice that would ensure consumer protection. Ms. Simoes noted that staff suggested the Board take an oppose unless amended position to clearly outline the limits and parameters to what type of patients a CNM could accept.

Dr. Lewis made a motion to take an oppose unless amended position on AB 1612, with amendments as recommended by Board staff; s/Dr. Krauss.

Ms. Smith-Crowley, American Congress of Obstetricians and Gynecologists (ACOG), author of AB 1308, stated even though AB 1308 is not perfect, it has made tremendous improvements in out of hospital care, especially at the point of when a midwife transfers a patient in a crisis situation into a hospital. The physicians report significantly improved relationships and outcomes. She stated the midwives have said that if they have resistance at the hospitals, they say that they are legally required to do this transfer at that point. She noted that ACOG policy is while they support independent practice of CNMs, it is only when it is in parity with physicians, where all of the same laws apply, including the ban on the corporate practice of medicine along with anti-kickback requirements. Ms. Smith-Crowley asked the Board to request those amendments as well.

Ms. Davis, California Association of Licensed Midwives (CALM), stated she represents the LMs, not the CNMs that are represented in AB 1612, but that they support the bill and encourage the Board to support this process as CALM supports their CNM colleagues and their ability to provide evidence-based autonomous care to the extent of their training.

Ms. Sanchez, CMA, stated they align with their colleagues at ACOG in wanting to see protection as afforded by the LM construct in terms of out of hospital birth transfers and consent. She also pointed out that the bill, as drafted, includes a requirement for standardized procedures and protocols for furnishing medications, which they believe would create confusion for patients and increase liability for physicians. She requested the Board oppose AB 1612.

Motion carried unanimously 11-0.

Ms. Simoes stated **AB 1650 (Maienschein)** would create the Community Paramedic Program (Program) in the Emergency Medical Services Authority (EMSA). She noted the bill would sunset the Program on January 1, 2022, and would allow the Program to authorize a local emergency medical services (EMS) agency that opts to participate in the Program to provide, through a local community paramedic program, any of the following services: post-discharge follow up services for targeted and eligible patients recently discharged from a hospital participating in the Program; directly observed therapy for eligible patients undergoing tuberculosis treatment in partnership with a county public health department; hospice rapid response service for eligible and enrolled patients to administer comfort care, coordinate services with the hospice nurse, and, as appropriate, avoid patient transport to an acute care hospital emergency

department; and case management services and linkage to non-emergency services for frequent EMS system users.

Ms. Simoes stated the bill would require EMSA to develop criteria that qualifies local community paramedic services to participate in the Program. She noted the criteria must include minimum training and certification requirements for a community paramedic and would require EMSA to provide OSHPD with an annual report regarding all local community paramedic programs that shall include, but not be limited to, information regarding program effectiveness, cost-savings, and patient safety, including details regarding any adverse patient outcomes. She noted that OSHPD would be required to publish the report on its website. Ms. Simoes stated that beginning in late 2014, thirteen community paramedicine pilot projects began in California, testing six concepts as part of the Health Workforce Pilot Project (HWPP) #173. She noted these HWPP pilot projects are coordinated through OSHPD. Ms. Simoes added the bill would authorize four of the original six concepts allowed for in the HWPP. She stated that she, Ms. Kirchmeyer, and Dr. Krauss provided input to OSHPD on HWPP #173 and raised patient safety concerns. She stated one of these concerns was that persons recently discharged from the hospital should be seen by their primary care physician for follow-up care. Ms. Simoes noted the additional training that would be required would not be sufficient enough to teach paramedics the basics of disease management or how to diagnose and treat medical conditions. She added that the other concern raised was that the HWPP did not specifically delineate what services will be allowed to be performed by community paramedics as part of the post-discharge follow up services and case management services. Ms. Simoes stated the same is true for AB 1650. Board staff believed the bill could have a negative impact on consumer protection and recommended the Board take an oppose position on this bill.

Dr. Lewis made a motion to take an oppose position on AB 1650; s/Dr. Krauss.

Dr. Krauss stated his concerns were that this bill would be a method of promoting ambulance businesses and arose as an economic desire from the ambulance industry rather than a desire to improve public health and well-being. He also stated his other concern was that creating a regime not under the direct supervision of a physician could end up being harmful to the community.

Dr. Bholat stated her concerns were that several very large, well-respected health systems are, in many cases, using administrative staff to do physician duties. She understands where the meaning of the bill is coming from but hopes that extending the physician workforce in meaningful ways to increase access is looked into further.

Dr. Bishop stated he has had discussions with ambulance personnel and they do get a bit frustrated when a patient calls for them when it is not truly an emergency as it could take them away from a true emergency. He noted it would be great if there were a secondary system that could take care of this type of issue and patients would not be calling the emergency services when it was not necessary. He stated he was just not certain this is the best way to go about it and putting it in the private sector may not be in the best interests of the public. He noted he hoped that the Legislature would work directly with the EMS entities to develop a system where the proper levels of primary care could be handled separately.

Motion carried unanimously 11-0.

Ms. Simoes stated **SB 241 (Monning)** would conform existing patient access to health records law to HIPAA and would clarify that a patient or patient representative is entitled to a paper or electronic copy of their record. In addition, the bill would require a health care provider, if the requested patient records

are maintained electronically and if the patient or their representative requests an electronic copy of those records, to provide them in the electronic format requested if they are readily producible in that format, or, if not, in a readable electronic format as agreed to by the health care provider and the patient or their representative. She added the bill would also specify what a health care provider can charge a patient, or their representative, and would allow a health care provider to impose a reasonable cost-based fee for providing a paper or electronic copy or summary of patient records, provided the fee only includes specified costs. Ms. Simoes added that the bill would conform existing California law to federal law to allow for electronic requests for patient records and would allow patients and their representatives to receive electronic copies of those records. She stated the bill would also make it clear that any fee imposed must be reasonable and cost-based, which may help to clarify what actual costs can be charged. She noted the bill would also help ensure that patients have better access to their medical records**.** As such, Board staff suggested that the Board take a support position on the bill.

Dr. Hawkins made a motion to take a support position on SB 241; s/Dr. Krauss. Motion carried unanimously 11-0.

Ms. Simoes stated **SB 554 (Stone)** would allow NPs and PAs to administer or provide buprenorphine to a patient when done in compliance with the provisions of the federal Comprehensive Addiction Recovery Act (CARA), as enacted on July 22, 2016, as specified. She stated the bill would conform California law to federal law enacted in 2016. The bill would allow NPs and PAs to administer or provide buprenorphine, as long as they meet the requirements specified in the bill and in federal law. Ms. Simoes added this would help to ensure expanded access to buprenorphine, which is used to treat opioid addiction. She noted this expansion seems reasonable and is in line with federal law. As such, the bill will help further the Board's mission of consumer protection and Board staff recommended that the Board support the bill.

Dr. Lewis made a motion to support SB 554; s/Ms. Pines.

Dr. Bholat stated she would like to have an amendment added to include that the supervising physician must have an X-Waiver to grant authorization to an NP or PA to administer buprenorphine to a patient.

Dr. Lewis changed the motion to support if amended as indicated by Dr. Bholat; s/Ms. Pines. Motion carried 11-0.

Ms. Simoes stated **SB 641 (Lara)** would specify that the Department of Justice (DOJ) shall only provide data obtained from the Controlled Substance Utilization Review and Evaluation System (CURES) to a federal, state, or local law enforcement agency pursuant to a warrant based on probable cause and issued at the request of the law enforcement agency engaged in an open and active criminal investigation regarding prescription drug abuse or diversion of controlled substances involving the individual to whom the requested information pertains. She stated the bill would not change the Board's access to CURES, although the original version of the bill would have and that this bill only affects law enforcement agencies. Ms. Simoes noted that although the Department of Consumer Affairs, Health Quality Investigation Unit (HQIU) investigators that perform the Board's investigations are peace officers, they are performing the investigations on behalf of a regulatory board, so this bill would not apply to the Board's administrative investigations. However, there are a small portion of criminal investigations performed by HQIU investigators on behalf of the Board. She stated this bill would impact those investigations, but there are only approximately 20 criminal investigations per year conducted on behalf of the Board. Board staff did request a technical amendment to make it clear the bill only applies to

criminal investigations. Ms. Simoes stated this technical amendment was made, as such, Board staff suggested the Board take a neutral position on the bill**.**

Dr. Lewis made a motion to take a neutral position on SB 641; s/Dr. Hawkins.

Dr. Bishop asked if there was a concurrent investigation by both law enforcement and the Board, would the Board be restricted in giving law enforcement information from the Board's CURES search. Ms. Simoes stated, yes, the Board would be restricted in providing that information.

Ms. Sanchez, CMA, sponsors of SB 641, stated they had been consistently raising questions about the CURES privacy over several years and looking at the state statute in comparison to other states. She stated California is out of alignment as it does not articulate what privacy looks like and it is not as clear as it is in other states. She stated they feel as if, when it comes to medical records, this bill would align the law enforcement requirement with what is generally required for information in medical records and asked that the Board to take a support position on the bill.

Motion carried unanimously 10-0. (Wright absent from vote).

Ms. Simoes stated **SB 746 (Portantino)** would allow doctors of chiropractic, naturopathic doctors, and NPs to perform physical examinations for students in interscholastic athletic programs. She noted that chiropractors are authorized to perform certain types of limited examinations and evaluations, but there is currently no specific authorization for a chiropractor to perform sports physicals for student athletes. Ms. Simoes added that existing law only allows PAs and physician and surgeons to perform physical examinations for interscholastic athletic programs. These sports physicals require a review of cardiac, neurologic and internal organ functioning, which is outside of the chiropractic and naturopathic scope of practice. She noted that allowing a chiropractor or naturopathic doctor to perform and sign off on these physical examinations, which include an evaluation and possible diagnosis, could negatively impact the students receiving these examinations, as chiropractors do not receive the same level of medical education and training as physicians. Ms. Simoes added the Board's primary mission is consumer protection and the Board should oppose this change. However, she noted that allowing an NP, who is under the supervision of a physician, to perform these examinations seems reasonable. PAs are already allowed to perform these examinations in existing law. Board staff suggested that the Board oppose the bill unless it is amended to only add NPs to the list of providers who can perform physical examinations for student athletes.

Dr. Hawkins made a motion to take an oppose unless amended position on SB 746; s/Dr. Lewis. Motion carried 10-0-1. (Wright abstained.)

Ms. Simoes stated **SB 790 (McGuire)** would prohibit a manufacturer of a prescribed product or a wholesale distributor of medical devices from offering or giving a gift to a health care provider. She noted this bill would prohibit a manufacturer of a prescribed product or an entity on behalf of a manufacturer of a prescribed product from providing a fee, payment, subsidy, or other economic benefit to a health care provider in connection with the provider's participation in research. She added that the bill would authorize the Attorney General (AG) to bring an action to enforce a violation of these prohibitions and to seek injunctive relief and imposition of a civil penalty for each violation. Ms. Simoes added the bill would define an allowable expenditure and would provide exemptions to the gift prohibitions. She noted this bill would state that it is the intent of the Legislature that the requirements and prohibitions in the bill would complement and operate in conjunction with the federal Physician

Payments Sunshine Act. If the Physician Payments Sunshine Act is repealed or becomes inoperative, it is the intent of the Legislature to enact similar legislation requiring manufacturers to disclose payments or other transfers of value made to health care providers in California. Ms. Simoes noted the bill would ensure that physicians are not influenced by gifts or economic benefits when deciding what brand of drug to prescribe, but would still allow for some reasonable expenditures. She stated the bill would further the Board's mission of consumer protection and Board staff recommended the Board take a support position on the bill.

Dr. Lewis made a motion to take a support position on SB 790; s/Dr. Yip.

Dr. Krauss stated that although it is important to protect the public, he takes umbrage when every physician is painted as corruptible by laws such as this one. He noted that if there is evidence of where this level of corruption has caused harm to the public, then the Board should take a support position, but the thesis that a physician receiving some value from a pharmaceutical company or device manufacturer is always bad for the patient may not be correct. He added that most times, samples that are left with a physician are distributed to patients who may often have trouble paying for pharmaceuticals.

Ms. Simoes noted that the bill currently states that samples of a prescribed product or reasonable quantities of an over-the-counter drug, do not apply to the prohibition.

Dr. GnanaDev noted that one of the things implied regarding opioid abuse is that the pharmaceutical companies promoted opioids by stating they are not addictive, so he feels there is a significant reason why this bill was introduced.

Dr. Bishop asked if this bill would prevent a physician from acting on a consulting basis, for example, with a medical device manufacturer, who is requesting input on the use of their device.

Ms. Simoes noted the bill states that a research project that constitutes a systematic investigation, is designed to develop or contribute to general knowledge, and reasonably can be considered to be of significant interest or value to scientists or health care professionals is defined as an allowable expenditure.

Dr. Krauss stated that it should be noted that in federal law, all things of value provided to physicians are reported and that information is available to the public.

Mr. Andrist stated he would be curious to know how Dr. Yip feels about this bill, as he appears on Propublica Dollars for Docs' website, which shows him receiving $30,842 from the pharmaceutical and medical device industry in 2013/14, $18,000 of that came from the makers of a drug called Rapaflo, and he has a 41% brand name prescribing rate, which is considered very frequent.

Motion carried unanimously 11-0.

Ms. Simoes provided an update on the Board's sunset hearing. She noted that on February 27, 2017, Dr. GnanaDev, Ms. Pines, and Ms. Kirchmeyer appeared on behalf of the Board to testify at the Sunset Review Hearing, where they provided a brief summary of the Board and its activities and improvements, followed by responses to questions specifically requested by the Senate Business, Professions, and Economic Development Committee and the Assembly Business and Professions Committee. Ms. Simoes stated the Committees asked for testimony on the vertical enforcement model, data sharing between the

Board and other state agencies, disparity in enforcement actions, and complaint processing. Testimony was given by Dr. GnanaDev and Ms. Pines as they were authorized by the Board to speak on behalf of the Board regarding sunset. She noted that patient notification by a physician on probation was also an issue that was discussed. Ms. Simoes stated that prior to the hearing, the Committees had provided a background paper to the Board identifying 30 issues for the Board. On March 27, 2017, after review by Dr. GnanaDev and Ms. Pines, the Board provided a response on all 30 issues, and several of the issues were items that the Board had raised in its Sunset Review Report. She added, several of the issues required proposed legislative language, which Board staff provided to Senate Committee staff on March 10, 2017, and April 4, 2017.

Ms. Simoes noted that **SB 798 (Hill)** is the Board's sunset bill, which includes language on a portion of the new issues from the Board's 2016 Sunset Review Report, and will extend the Board's sunset date for four years, until January 1, 2022. The new issues that were included in the Board's Sunset Review Report are included in the bill.

Ms. Simoes stated the bill includes language for a two-year license for all of the Board's licensees. It also includes technical language to clean-up existing law for licensees not under the purview of the Board. The bill includes language that would require an applicant to complete three years of postgraduate training in order to be eligible for licensure. She added that the bill includes some exceptions for applicants who have a medical degree from a combined dental and medical degree program. She noted this bill would create a postgraduate training license with specified application requirements that must be obtained within 180 days after enrollment in a postgraduate training program and would be valid until 90 days after the holder has completed 36 months of postgraduate training. The bill would delete the requirement for the Board to approve international medical schools. She added the bill would also determine that an international medical school is recognized if they are listed on the World Federation for Medical Education and the Foundation for Advancement of International Medical Education and Research World Directory of Medical Schools joint directory or the World Directory of Medical Schools.

Ms. Simoes stated the bill included language largely based on what was included in previous legislation and existing law regarding data that surgical clinics are required to report to OSHPD. and would also revise the adverse events that are required to be reported to the Board to only include those that relate to outpatient settings.

Ms. Simoes the bill would amend existing law to allow the Board to require more information about the Board in a more consumer friendly manner on notice to consumers' postings..

Ms. Simoes noted the bill included language that would amend Business and Professions Code (BPC) section 805.01 to allow the Board to fine an entity up to $50,000 per violation for failing to submit an 805.01 report to the Board, or $100,000 per violation if it is determined that the failure to report was willful. It would also require state agencies and hospital accrediting agencies to report to the Board any peer review incidents subject to 805 reporting that are found during an inspection of a health care facility or clinic.

Ms. Simoes added the bill also included language that would amend existing law regarding the Health Professions Education Foundation (HPEF) to require two members to be appointed by the Board, as was previously required.

Ms. Simoes stated the bill contained language to eliminate the Board from reviewing and approving non-ABMS specialty boards.

Ms. Simoes added the bill included language that would make technical, clarifying changes to make it clear that the Board of Podiatric Medicine is its own board that performs its own licensing functions.

Ms. Simoes noted that the bill also included language that would delete the requirement in existing law that the Board president cannot be on a disciplinary panel.

Ms. Simoes stated the bill included language that would amend existing law regarding the prompt revocation of physicians who are required to register as sex offenders, and change it to an automatic revocation to allow the revocations to be processed in a more expeditious manner.

Ms. Simoes added the bill also included language that would amend BPC Section 2225 to make it clear that invocation of the psychotherapist-patient privilege is not a barrier to the Board obtaining psychotherapy records via a subpoena upon a showing of good cause.

She noted the bill would allow the Board to issue a cease practice order in cases where a licensee delays or does not comply with an order to undergo a physical or mental health examination.

Ms. Simoes explained the bill included language that would amend existing law related to expert witness reports, to include additional information that the reports must include and to ensure the Board receives these reports in a timely manner.

Ms. Simoes stated existing law, Government Code Section 11529, requires that if the Board pursues and obtains an interim suspension order, it has 30 days to file an accusation. She noted a petition to revoke probation is very similar to an accusation in that it is still the charging document identifying what the physician has done to violate the law. The bill adds a petition to revoke probation to this section of law.

Ms. Simoes added the bill would delete outdated sections of law related to the Board's Licensing Program.

Dr. GnanaDev stated all these issues had been previously approved by the Board, and with the other Members' approval, these items did not need to be discussed again and requested Ms. Simoes move on to the next set of issues, which are included in the bill but were not raised in the Board's sunset report.

Ms. Simoes stated the bill would require, on and after July 1, 2018, the Board to require a licensee on probation, pursuant to a probationary order made on or after July 1, 2018, before a patient's first visit following the probationary order, to provide the patient or the patient's guardian or health care surrogate, with a separate disclosure containing all the following information: the licensee's probationary status; the length of the probation and the end date; all practice restrictions placed on the licensee by the Board; the Board's telephone number; and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the Board's online license information site.

Ms. Simoes noted the bill would specify that a licensee required to provide a disclosure shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of the disclosure.

Ms. Simoes stated the bill would specify that a licensee on probation is not required to provide a disclosure if any of the following applies:

- The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure and a guardian or health care surrogate is unavailable. In that instance, the licensee shall disclose his or her status as soon as the patient can comprehend and sign the disclosure, or a guardian or health care surrogate is available.
- The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled.
- The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

Ms. Simoes added the bill would require the Board, on and after July 1, 2018, to provide the following information for licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the Board's website:

- For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.
- For probation imposed by an adjudicated decision of the Board, the causes for probation stated in the final probationary order.
- For a licensee granted a probationary license, the causes by which a probationary license was imposed.
- The length of the probation and end date.
- All practice restrictions placed on the licensee by the Board.

Dr. Krauss stated he had concerns about a law that required a physician on probation to spend time discussing their probationary status, as this will be viewed by physicians in general as something that would make their continued practice economically unfeasible. He added that this would present to the Board a circumstance where physicians will be reluctant to accept probationary status via stipulations, making the Board overwhelmed with cases that must be set for hearing.

Ms. Kirchmeyer stated that with the way the language is currently written, it is significantly different than it was previously proposed, as the physician does not have to discuss the reason for their probation, just that they are on probation and to direct them to the Board for further details. She added that a physician may still not want to tell their patient they are on probation and, depending on the allegations and charges, will have their case taken to hearing rather than pursue a stipulation. Ms. Kirchmeyer stated that it is more costly to go to hearing than to go through the settlement process. She also noted that there would be an additional fiscal impact in that the two entities that are involved in the disciplinary process would also have to hire additional staff to handle the increased work.

Dr. Krauss asked if this would delay the timeline on other cases, and possibly harm the public, rather than protect them.

Ms. Kirchmeyer responded that as long as the correct fiscal costs are included in the bill when it goes through its process, additional staffing would be able to be obtained at both the AG's office and the Office of Administrative Hearings to absorb that additional workload. She noted that staff had discussed other options, such as the regulation process, which would allow the Board to choose which cases they thought best for this process, or to seek changes to the bill such as only requiring notification for sexual misconduct, conviction of crimes in the practice of medicine, those who have had prior probation, etc.

Ms. Kirchmeyer pointed out it is up to the Board to make that decision, but the Board could choose to take a support if amended position, to include any changes the Board would like to see.

Ms. Lawson stated that she feels that the more information the patient ends up with, the better. With that being said, she is concerned about the issue of a bill like this having unintended consequences for patient safety, as the enforcement timelines could be extended. She noted there could be physicians who use the process to delay the imposition of discipline. She stated she would like to see the Board either focus the discussion on the most egregious cases or how to solve those unintended consequences.

Dr. Lewis stated he agrees with the statement that the more information the patient gets, the better. So, he recommended that perhaps the Board take a support if amended position on the bill and rather than determine what those amendments should be right now, ask Ms. Kirchmeyer and Ms. Simoes to sit down with the author and discuss possible amendments in greater detail.

Ms. Kirchmeyer noted that staff has to work at the Board's discretion, so this is the time to discuss desired amendments and requested the Board provide staff what the Members would consider egregious violations.

Ms. Simoes stated that staff would not need detailed amendments, but more specifics on what the Board would like to see changed.

Ms. Kirchmeyer added that since the next Board meeting is not until the end of July that would be too late into the legislative process to add amendments at that point.

Dr. Krauss stated that the principal concern is to protect the public and as part of that the Board needs to be able to continue to do the job they have been doing. He noted that the give and take with the author of the bill has to be in relation to having a Board that can continue to do its job.

Ms. Pines stated she felt the Board should add to the disciplinary guidelines the option for the Board to add a condition to require notification if a physician gets put on probation, because if it is specified, for example, a criminal offense, that could include tax evasion, which does not necessarily result in patient harm. She noted there are so many reasons something like that could occur and stated that this would give a blanket indication that all physicians on probation are all bad physicians, which is just not true. She stated that she would like to see some language added to the disciplinary guidelines on this issue to allow the Board to consider the option when a probation case is reviewed by the Board.

Dr. GnanaDev stated that after having some discussions with staff, the first thing that comes to mind as far as egregious acts is sexual misconduct. It is inexcusable. The next one is criminal prosecution related to practice of medicine, such as fraud, specific to practice of medicine. He added the third is an individual who has already been on probation and the fourth is, practicing while under the influence.

Dr. Hawkins agreed with Dr. GnanaDev's recommendation and suggested having a discussion with the author to add those four egregious acts to the language in the bill.

Dr. Krauss noted he agreed with Ms. Pine's suggestion, and stated that rather than the law prescribing which class of physicians must inform their patients, that the Board be authorized to set that as an additional requirement in the probationary process, since the Board Members are the ones that are reviewing the individual circumstances of each case.

Ms. Simoes noted that she and Ms. Kirchmeyer had already met with Senator Hill and brought that option to his attention and he was not satisfied with that level of required notification.

Dr. Yip suggested doing both, adding to the disciplinary guidelines for the Board to be allowed to make the decision of which physicians would be required to provide notification, but also to have the specific egregious acts added to language.

Dr. Bishop suggested having a hybrid type option, where there are specific acts that are included, but also add that the Board has the option to impose something additional for patient safety, so that the author knows there are cases that are going to get flagged every time, but could then give the Board the option on other certain cases.

Mr. Warmoth suggested putting a sunset on this issue, to identify what costs and enforcement timeframes are after a certain time frame.

Dr. Krauss noted that Consumers Report had published a survey last year on access to information available to the public in each state and California was listed as the best. He stated with that, it is ironic that California is the only state facing this requirement. He then acknowledged staff for the work that had been done in bringing California to the top of the list.

Ms. Monserrat-Ramos, Consumers Union Safe Patient Project, asked the Board to support the patient notification portion of the bill. She stated that consumers are relying on the Board for information to help them make the best health care decisions. Consumers have the right to know their physicians' backgrounds, as the impact on the physician would be minimal and the Board's mission is to protect consumers in California. She noted that Consumers Union has been advocating for this issue for some time and urged the Board to support this section of the bill.

Ms. Hollingsworth, Consumers Union Safe Patient Project, urged the Board to support patient notification. To protect the public, the Board needs to provide this information to them, not hide it from them. She noted it should be required for all egregious cases. She stated this would only effect a few hundred physicians and does not understand why these few hundred should be protected, when they are dragging down the reputation of all physicians and the reputation of the Board. She noted that this really comes down to informed consent. A patient is supposed to know all of the risks and benefits of their treatment and the background of their physician should be a part of that informed consent process. Ms. Hollingsworth noted that California should lead the nation in this and be a guiding light for other states afraid of facing this issue.

Ms. Fellmeth stated she agreed with the four egregious acts that Dr. GnanaDev mentioned that should be put in the language, but also suggested that the Board look at the pages in the Background Paper that shows the many different types of violations and pick a few others to add to that list.

Ms. Sanchez stated that CMA is opposed to the provision in regard to patient notification. The CMA feels that physicians would be unlikely to settle cases with probation notification and disagrees with the assertion of the impact on the physician. She stated the CMA believes that physicians would seek to have their cases heard at hearing.

Mr. Andrist stated Dr. Krauss had said that physicians would probably try to avoid getting probation, but Dr. GnanaDev made the comment at the sunset hearing that the Board did not want to put people on

probation, he thinks they should all just be revoked. He noted that Dr. Krauss also made the comment about Consumers Report and the Board's website being the number one in providing information to the public about physicians, but Mr. Andrist stated he had a letter from Lisa McGiffert with Consumers Union about how disappointed they were in the results and stated the Board needs to stop patting themselves on the back for the great job they are doing.

Dr. Lang stated she is concerned that this issue puts physicians of color at risk because of the profit margin, which would make it very difficult financially to fight a Board charge, so they would need to take a probationary option in order to continue to serve the patients they are serving, which are quite often, in underserved communities.

Dr. Krauss stated that it was the April 2016 Consumer Reports that reviewed all of the medical boards' public access to information in which California was rated top of all states in the nation.

Ms. Simoes continued to discuss SB 798 and stated the bill would repeal the existing vertical enforcement and prosecution model (VE). Although VE is an issue that the Board has reported on in the past, the Board has not yet offered any suggested language, as staff is still working on some language. She noted that at the hearing, staff was asked to look at which types of cases where VE would be most appropriate. Staff is recommending that any complaint presenting sexual abuse or misconduct as described in BPC sections 726 and 729; any complaint presenting issues of mental or physical illness as described in BPC section 820; any complaint filed against a licensee who has a prior disciplinary history, is currently on probation and/or has an accusation pending; and any other complaint presenting issues of endangerment as described in Government Code section 11529, including complaints regarding prescribing should be handled in the VE. Ms. Simoes stated this is where the Board needs to decide if they want the VE to handle these types of cases or be eliminated altogether.

Ms. Kirchmeyer noted that after meeting with Agency, the AG's Office, and DCA, it was determined that the outright elimination of VE is not the best option, due to the unintended consequences it could cause. However, she stated that there needs to be some changes made and limiting the types of cases that would go through the VE process is a step in the right direction.

Ms. Fellmeth noted this bill proposed numerous changes to the Medical Practice Act, and she has no position on any of them, except this one, the repeal of VE. This involves the amendment of BPC section 2006 and the repeal of Government Code section 12529.6, which they strenuously oppose. She stated that as of the date of the Board's sunset hearing, there was a 41% investigator vacancy rate and that is the problem for the delays in case files. VE is not the problem. The VE stats have increased since the investigators were moved to DCA. Ms. Fellmeth stated this bill does not give the Board the discretion to determine which types of cases should or should not go through VE, it simply repeals the entire VE with statutes, without replacing them with anything.

Mr. Andrist stated that per an email from Ms. McGiffert at Consumers Union, dated March 29, 2016, it reads that they too, were dismayed that California came in on top since they have been complaining about the Board's website for quite some time. He stated that this review was comparative and most of the other sites had a lot less information and was a lot more unfriendly. He stated the Board's site was reviewed based on 61 criteria and a lot of the things mentioned were not on the list. Not that they were not important, but the list had to be limited in some way. Mr. Andrist stated that all sites came up as being less than optimal. He noted the summary of the report reads that the highest rated website had comprehensive information gathered in a physician profile for each licensee, but most sites were difficult

to navigate with a variety of user barriers, confusing entry points, long drop down menus, security codes or information in multiple places and there were medical board websites that were very slow in bringing up names, such as California and Hawaii.

Dr. Krauss asked whether the move of the investigators to the DCA had made the Board's job more difficult.

Dr. GnanaDev stated that the Board requested that the investigators not be moved to the DCA. However, the law was still changed.

Dr. Krauss noted that it is important to engage the Senate as a partner in the mission to protect the public and to remind them that sometimes well-intended acts have unintended adverse consequences.
Dr. GnanaDev stated that staff will work with the Senate and explain the intention is to streamline the process. He felt that having the investigators back at the Board would be much better than it is currently.

Ms. Simoes continued by discussing the section of the bill that would allow a DPM to advertise and use the phrase, "podiatric physician and surgeon" and would allow a DPM to advertise as, "podiatric physician," "podiatric surgeon," "podiatric physician and surgeon," and "foot and ankle physician and surgeon." She added that this bill would also add DPMs to the definition of "attending physician" in Health and Safety Code Section 11362.7, which would allow DPMs to recommend medical cannabis.

Ms. Simoes stated that currently the Board is prohibited from recovering costs for investigations and prosecutions for disciplinary proceedings. She added the bill would allow the Board to recover these costs from licensees. She noted the bill would not make changes to the additional $15 fee all licensees are charged in lieu of cost recovery.

Ms. Sanchez stated that CMA is opposed to this provision. She noted that when this provision was amended into the statute it did accommodate for the change with a fee increase across all licensees and allowing cost recovery without lowering the current fees are going to have physicians paying twice the fee to cover the cost recovery. The CMA would like to either have the provision added back in to maintain the prohibition against cost recovery or see the current fee lowered.

Ms. Simoes stated that in response to stakeholder feedback, the bill would include LMs in the peer review reporting requirements and provisions in existing law and would also add LMs to the listing of medical corporations.

Ms. Davis, President of CALM, stated this bill has provisions for LMs for the benefit of patient safety and quality improvement. She requested the Board's support of the provisions in this bill related to LMs, which are in the interest of public safety, patient safety, and quality improvement.

Ms. Howard urged the Board's support of the legal protection peer activities for LMs, as it supports the quality assurance measures that LMs already do.

Ms. Simoes noted the bill would also transfer research psychoanalysts to the Board of Psychology. This was brought up in the background paper, as psychoanalysis is a discipline of psychology.

Ms. Kirchmeyer stated that based upon the comments and discussion, Members were accepting everything currently in the bill with the amendments as follows:

- For the patient notification – require notification for cases involving sexual misconduct, conviction of a crime involving the practice of medicine, practicing while under the influence, and physicians who have previously placed on probation or who have been revoked or surrendered. Further, there would be an addition that would allow the Board to require notification for any other serious violation.
- For VE – to amend the current language to require VE for sexual misconduct cases; physical and mental illness cases; cases on a physician who is on probation, had prior disciplinary action, or has a pending accusation; and any other case presenting issues of endangerment as described in Government Code section 11529.

Dr. GnanaDev asked if it is a reasonable request to add an amendment to request the investigators be transferred back to the Board. He stated that the enforcement timeline has increased since the transition and the Board's goal is to keep the timelines down.
Dr. Krauss recommended that a cost analysis be done to determine the cost of the delayed enforcement timeline due to the patient notification.

Ms. Kirchmeyer stated that she and Ms. Simoes always do a fiscal analysis, however completing one is difficult as there is no way of knowing the exact costs before it takes place. However, she stated that staff will work to get a percentage of the cases that they believe would end up going to hearing, and determine those costs to the Board.

Dr. Yip asked Ms. Kirchmeyer if she felt that bringing the investigators back to the Board would possibly change the vacancy rate of investigators.

Ms. Kirchmeyer stated that by the investigators going over to DCA, they are working alongside individuals whose caseloads are lower and often times not nearly as complex as VE cases. She stated that the investigators will leave since they are all paid the same, but responsible for different workloads.

Dr. Lewis made a motion to take a support if amended position on SB 798, with the amendments as discussed by the Board; s/Ms. Wright.

Ms. Pines asked if there were any other issues that staff felt were important that were not included in the bill.

Ms. Simoes stated the returning to practice issue is one item that was not included in the bill because staff needs to have a meeting with legislative staff to explain the proposal in more detail as they were not comfortable currently adding any type of language in the bill at this point in time.

Ms. Crowley Smith, representing the American Board of Cosmetic Surgery (ABCS), stated an item that was mentioned but not discussed is the elimination of the equivalency procedure in which they are taking an oppose, unless amended position. She noted that ABCS is in the middle of their application for the equivalency recognition determination and to have a sunset date of January 1, 2018 for that would likely interfere with their application. She added that the Board has approved four out of six applications, which she feels show that the established process is working and if there is something the Board does not want to do, to please continue the current process until an alternative process can be established.

Ms. Simoes noted that Senator Hill had mentioned at the hearing that he was planning to do a delayed implementation date of one year, but she had not seen the actual language yet.

Dr. GnanaDev stated that the Board is looking to get out of accrediting any boards other than those that are nationally accredited.

Ms. Fellmeth stated that the extensively long investigations do not benefit anyone. They delay the filing of the accusation, which is what protects patients and is a matter of public record, and they certainly do not benefit the physicians who have to work under a cloud for an artificially lengthy time. The Board's investigators need to be paid the same amount as their counterparts at the DOJ. She suggested perhaps adding that into the language of SB 798.

Ms. Castro stated that she agreed with Ms. Kirchmeyer's comment in regard to the fact that the investigators did enjoy the prestige of being associated with the Board. She noted that having three state agencies involved in what is admittedly a very complex process, with very important cases, adds to the frustration for investigators who do a lot of hard work on the Board's behalf. Ms. Castro stated that if the Board did consider adding language to SB 798, to return the investigators to the Board, it would facilitate discretion that is trying to be applied to VE, topic by topic.

Ms. Nicholls stated the investigators do still feel they are part of the Board. They still do all of the Board's cases, are in it 110%, work very closely with the Board's executive group, and tugging them back and forth is not the answer. She stated they need to be paid appropriately. She stated that appropriate pay and modifications to VE is very important to help maintain the staff that are finally being hired.

Motion carried unanimously 11-0.

Ms. Simoes then moved to agenda item 7B noting that the matrix for the regulatory actions can be found in the Board packet under tab 7 and asked if the Members had any questions in regard to the regulatory matrix.

No questions or comments were heard.

Agenda Item 8 **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**

Mr. Burke provided an update stating that in February, Governor Brown appointed Alexis Podesta as the Secretary of the Business, Consumer Services and Housing Agency, where she had served as Undersecretary since 2015. He noted that also in February, DCA Director Kidane accepted a new opportunity and Governor Brown appointed Mr. Grafilo as the new DCA Director. Prior to Mr. Grafilo's appointment, he served as Chief of Staff for Assembly Member Bonter since 2012. Mr. Burke noted the Executive Director would be receiving an invitation to meet with Director Grafilo soon.

Mr. Burke stated that DCA had hosted an Executive Brown Bag gathering on April 25, 2017, which is an opportunity for Executive Directors throughout the Department and Board to come together and collaborate on issues. The April 25th meeting included a presentation on how to

constructively manage difficult or confrontational conversations as well as a panel discussing the regulation process.

Mr. Burke noted that also in May 2017, DCA would be releasing its new strategic plan. Like the Board's strategic plan, DCA developed it with the assistance of SOLID and it outlines DCA's goals and objectives for the next four years. When it is released, he noted that it would be emailed to all Board Members.

Mr. Burke stated that regarding the BreEZe system, testing is underway for a standard software release that is scheduled to deploy May 24, 2017. He noted the Board has 13 system change requests in this release. He added that as of April 19, 2017, there were 66 outstanding Board change requests that are not yet scheduled for resolution in an upcoming software release. He stated the new license lookup feature that has been developed by DCA and Board staff is scheduled for release on September 3, 2017.

Mr. Burke thanked the Board Members for completing their Form 700s and reminded them that 2017 is a mandatory sexual harassment prevention training year for DCA, which means that all employees and Members are required to complete the training in the 2017 calendar year, even if it had been completed in the 2016 calendar year.

Dr. GnanaDev stated the remaining agenda items shown on the agenda for Thursday would be discussed on Friday, April 28, 2017.

Dr. GnanaDev adjourned the meeting at 6:10 p.m.

R E C E S S

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

Friday April 28, 2017

Members Present:
Dev GnanaDev, M.D., President
Michelle Bholat, M.D.
Michael Bishop, M.D.
Randy Hawkins, M.D.
Howard Krauss, M.D.
Kristina Lawson, J.D.
Ronald Lewis, M.D., Secretary
Denise Pines, Vice President
Brenda Sutton-Wills, J.D.
David Warmoth
Felix Yip, M.D.

Members Absent:
Judge Katherine Feinstein (ret.)

Sharon Levine, M.D.
Jamie Wright, J.D.

Staff Present:
April Alameda, Staff Services Manager II
Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dennis Frankenstein, Staff Services Analyst
Kimberly Kirchmeyer, Executive Director
Regina Rao, Associate Governmental Program Analyst
Elizabeth Rojas, Staff Services Analyst
Joseph Silva, M.D., Medical Consultant
Jennifer Simoes, Chief of Legislation
Lisa Toof, Staff Services Manager I
Kerrie Webb, Staff Counsel

Members of the Audience:
Teresa Anderson, California Academy of Physician Assistants
Eric Andrist, by phone
David Bazzo, M.D., UC San Diego Physician Assessment and Clinical Education (PACE) Program
Peter Boal, UC San Diego PACE Program
Jonathan Burke, Assistant Deputy Director, Board and Bureaus, Department of Consumer Affairs
Lisa Buschell, by phone
Gloria Castro, Senior Assistant Attorney General, Health Quality Enforcement Section Attorney General's Office
Genevieve Clavreul, National Registered Nurses Professional Association
Zennie Coughlin, Kaiser Permanente
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Interest Law
Rosanna Davis, Licensed Midwife, California Association of Licensed Midwives
Sarah Davis, Licensed Midwife, California Association of Licensed Midwives
Nate Floyd, UC San Diego PACE Program
Louis Galiano, Videographer, Department of Consumer Affairs
Bridgette Gramme, Center for Public Interest Law
Sara Howard, Horizon Midwifery
L. Khadija Lang, M.D., President, Golden State Medical Association, by phone
Tanya Meadows, Investigator, Health Quality Investigation Unit
Michelle Monseratt-Ramos, Consumers Union Safe Patient Project
Kathleen Nicholls, Deputy Chief, Health Quality Investigation Unit, Department of Consumer Affairs
Kavita Noble, Certified Nurse Midwife, California Nurse Midwives Association
Alicia Sanchez, California Medical Association
Shannon Smith-Crowley, American Congress Obstetricians and Gynecologists
Anne Stavern, M.D., by phone
Natalie Zellmer, Supervising Investigator, Health Quality Investigation Unit

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

Dr. GnanaDev called the meeting of the Medical Board of California (Board) to order on April 28, 2017 at 9:04 a.m. A quorum was present and due notice was provided to all interested parties.

Dr. GnanaDev stated there were still some agenda items from the previous day that had not been discussed and that they would be discussed at the end of the meeting before adjournment.

Agenda Item 14 Public Comments on Items not on the Agenda

Ms. Clavreul stated the Board is doing a great job in allowing the public to participate even when they cannot attend the meetings in person. She then noted that she had received a letter from Board staff in regard to her complaint and it only stated the analyst's first name and no last name. She stated that concerns her, especially with the concerns of the ability to falsify medical records.

Agenda Item 15 Presentation on the Scope of Practice and Training for Medical Assistants

Ms. Webb gave a presentation on the scope of practice and training for medical assistants (MA). She noted Board staff regularly gets questions in regard to what MAs can and cannot do within their scope of practice. She stated staff gets these questions from MAs themselves, wondering if maybe they are being asked to do something that is not appropriate for them, as well as from physicians making sure they are making appropriate requests of the MAs. There was also a request from a Board Member recently to have a presentation done as a reminder of the laws, regulations and scope of practice for MAs.

Ms. Webb stated MAs are set forth in statute because many of the things they do would be considered something that would normally require a medical license, if certain exceptions were not specified for them. She added the statue specifies the exceptions that authorizes an MA to perform certain tasks. She noted that the regulations make the statute more specific and puts forth a list of more specific examples of things MAs are allowed to do, as well as add details about the required training an MA needs in order to perform these tasks without being a licensed physician.

Ms. Webb noted that it is important to remember that MAs are not licensed individuals. They are not required to go through the same background and verification checks that licensed physicians do. She stated they have to be at least 18 years of age, they must have appropriate training for each task that they are requested to perform, and these tasks must be performed under the specific authorization and supervision of a licensed physician, podiatrist, PA, NP or CNM in a medical office or clinical setting. The supervisor must be on the premises in order for the MA to perform the support services.

Ms. Webb stated that the definition of "specific authorization" is a specific written order prepared by the supervising physician, podiatrist, PA, NP or CNM authorizing the procedures to be perform on a patient, which shall be placed in the patient's medical record; or a standing order prepared by the supervisor authorizing procedures to be performed. Ms. Webb added that a notation of the standing order shall also be placed in the patient's medical record.

Ms. Webb added there are two pathways for training. The first is on-the-job training. This training must be received under a licensed physician who shall ascertain the proficiency of the MA; or a registered nurse, licensed vocational nurse, PA, or qualified MA acting under the direction of a licensed physician who shall be responsible for determining the content of the training and proficiency of the MA. She

noted that all of this training must be documented by the employer physician, who must maintain a certification showing all the training the MA received, the content and duration of the training, and that the requisite competence was demonstrated by the MA. The employer physician must also sign and date the certification.

Ms. Webb continued with the second pathway for training, which is training received from a secondary, postsecondary, or adult education program in a public school authorized by the Department of Education; a community college program provided for in Part 48 of Division 7 of the Education Code; or a postsecondary institution accredited by an accreditation agency recognized by the United States Department of Education or approved by the Bureau for Private Postsecondary Education.

Ms. Webb provided some overriding principles and general guideline regarding MAs. She noted that MAs cannot diagnose, treat or perform any task that is invasive or requires an assessment. They cannot make a decision about what an appropriate test is, what the next step would be or perform any invasive task. She stated it is illegal to use MAs to replace highly-trained licensed professionals, and that MAs are there to assist and perform appropriate support services that are routinely done in the physician's office that is appropriate with their training and experience.

Ms. Webb then provided several example of tasks the MAs are allowed to do as well as examples of tasks they are not allowed to do. Ms. Webb provided the Board's web address that can provide additional resources and information, such as FAQs and specific laws and regulations in regard to MAs.

Dr. Bholat stated her concerns about delegation of responsibilities. She noted that the standard regulations work well when there are only a few people in an office, however, her concerns are more with the delegation of systems in a particular set of offices and how that impacts the MAs. Dr. Bholat stated another concern she had was since she does not see where the regulations state that an MA cannot draw from a multi-dose vial she would like to have that looked into a bit more. Another thing she stated was a concern is the standardized protocol. She noted that often times it is a group of physicians that create that protocol, so she wonders who is signing off on that standardized protocol and what happens if other physicians do not agree with the protocol as written by this group of physicians.

Ms. Webb noted that any physician who is unsure or uncomfortable assigning a task they believe may be out of the scope for an MA, should not assign that task, because if something were to go wrong, it would be the responsibility of the supervising physician.

Dr. Yip noted that there are probably more MAs in medicine than PAs or NPs and he wondered which agencies should take a closer look at the regulations. He stated the MAs have been unrecognized for years and feels they deserve more clear and updated regulations.

Ms. Kirchmeyer noted those changes would be more appropriate coming from a physician organization as opposed to the Board.

Mr. Andrist made a comment stating that Dr. GnanaDev cut Dr. Yip off the day before when Dr. Yip was trying to respond to Mr. Andrist's comment about Dr. Yip's pharmacy company payments. He stated that Dr. GnanaDev told Dr. Yip that he did not have to respond to the comment since it was a public comment period only. Mr. Andrist quoted a section of the Brown Act on public meetings that stated Dr. Yip could have responded according to the law. He also stated that no Board should consist of the same people that the Board is trying to protect the public from and that his goal is to make it so that the Board

only consists of public members in the future. He requested an investigation of a disciplinary action of the Board and that it be put on the Board's next agenda.

Ms. Buschell stated she is referring to volume 141, page 5 of the Board's winter Newsletter that states physicians can give MAs patient specific verbal orders. She stated she feels that the statement in the Newsletter contradicts BPC section 2069, which states that an MA may do additional technical support services upon specific authorization, which is a specific written order by the supervising physician. She noted it is also very difficult for a licensee to validate and authorize that the MA is about to perform a task without a written order.

Ms. Webb stated that the task can be performed through the use of a standing order, but it is still documented in a patient's chart.

Agenda Item 16 Executive Management Reports

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

Ms. Kirchmeyer then referred Members to page BRD 16A-5, which is the fund condition statistics. She stated this fund condition includes the Board's complete repayment of the Board's outstanding loans to the general fund and as indicated, the Board's fund reserve is projected to be at 4.9 months at the end of the current FY, if the loan is paid as projected. However, if the loan is not repaid, the Board would be at 3.5 months' reserve. She noted that the two budget change proposals (BCPs) had been approved by the legislature and are just awaiting signature from the Governor's Office. She added the document also shows two DCA wide BCPs that, if approved, would affect the Board's budget, as well.

Ms. Kirchmeyer noted that at the last Board meeting, the Licensing Unit had reported that they were reviewing licensing applications within 29 days of receipt of application. She added that it is important to point out that the Licensing Unit is going into the busiest time of the year, yet are still currently reviewing licensing applications within 28 days. Ms. Kirchmeyer noted the licensing staff are doing a great job and have a great routine right now. She will be anxious to see what the statistics look like at the end of July, which is the busiest time of the year for the Licensing Unit.

Ms. Kirchmeyer stated that the Board's Information Systems Branch (ISB) has been working on updating staff's computers, as well as the email system. She noted that the email system upgrade would impact the Members as well, and that the ISB staff would be contacting the Members to let them know of the changes and assist them with the upgrade.

Ms. Kirchmeyer added that she and some of the Members had done several presentations over the last quarter to different entities and thanked the Members for their participation and support with these presentations.

Ms. Kirchmeyer noted that in regard to CURES, as of April 15, 2017, there were 90,901 physicians registered in the CURES system. She added that at the last meeting, she had reported that between December 2016 and January 2017, there had been 208,273 patient activity reports

requested and within the last month, there have been 260,000 reports requested, which shows how system use is growing.

Ms. Kirchmeyer added that also at the last meeting, Members were given a presentation by Dr. Smith, the Director of the California Department of Public Health (CDPH) on the Statewide Prescription Opioid Misuse and Prevention Workgroup and its joint efforts to battle the opioid epidemic. She referred the Members to pages BRD 16A-17 and 16A-18, which is a letter provided by the workgroup to providers and prescribers. She stated this letter would be emailed out to all physicians, posted to the Board's website, and in the Board's Newsletter, as well as emailed to those on the Board's subscribers list.

Ms. Kirchmeyer stated that on pages BRD 16E-1 to BRD 16E-3 is an update from the Health Professions Education Foundation and the Stephen M. Thompson Loan Repayment Program (STLRP). She added that Board staff, Ms. Simoes, Ms. Alameda and Ms. Robinson were invited to sit in on the applicant review process for the STLRP, and provided valuable information in the process.

Ms. Kirchmeyer stated her update in the Board packet provided an update on the prescribing of psychotropic drugs to foster care children and stated that the Board had finalized the data use agreement (DUA), pursuant to the passage of Senate Bill (SB) 1174, and received information for the 2015 calendar year. She noted that since the report, Board staff had made progress in working with the Department of Social Services (DSS) and the Department of Health Care Services (DHCS) to obtain appropriate authorization to get medical records for the patients. Ms. Kirchmeyer added that by the next Board meeting, a letter will have been sent to those individuals with the authority to authorize the Board to obtain the medical records for the patients that have been identified that may have received inappropriate prescribing. She noted the additional data would be sent to the Board's experts for review to identify physicians from this time frame who need further investigation.

Ms. Kirchmeyer stated that she and Dr. Krauss had recently attended the Federation of State Medical Boards' annual meeting in Texas. She noted they heard presentations regarding physician wellness and burnout, international mobility of physicians, telemedicine, regulation in an era of assisted dying, evidence based regulation, the role of CME in licensure, and technology supported medical decision making. She stated another presentation that was informative was one on Board governance and leadership.

Ms. Kirchmeyer noted that Dr. Krauss had suggested an idea of a Board Member Mentoring Program that would have previous Board Members who could mentor new Board Members.

Dr. Krauss stated this had been the third FSMB meeting he has attended, and again, found it invaluable. He noted that each state is a social experiment and for California to remain in isolation and not view and exchange ideas with other states is a loss. Dr. Krauss stated that he had several different people say to him how lucky California was to have Ms. Kirchmeyer as the Executive Director of the Board. He added that Ms. Kirchmeyer is an active participant in the FSMB, in their committees of executive leaders of state boards, and is incredibly well respected nationally. He stated that often times when you step out of the confines of your own Board and state, you realize what a gem you have, and Ms. Kirchmeyer is a gem.

Dr. Krauss added that he was embarrassed at the fact the other states had several representatives for their states and California only had he and Ms. Kirchmeyer. He noted that there are numerous committee meetings that take place simultaneously at the FSMB annual meeting, and with just the two of them in attendance, there were several meetings where California was not able to be represented. Dr. Krauss stated this is a problem, especially when the FSMB provides up to three scholarships for Board Members to travel to the FSMB annual meetings, yet California is not allowed to accept any of those scholarships, due to the fact that FSMB is a CME granting agency. He understands the government is worried about potential corruption by Board Members who would accept a scholarship to attend. He added that California, one of the wealthiest in the world, is pecuniary in funding Members and Board staff to attend such meetings. He noted that he will continue to encourage Ms. Kirchmeyer and Board staff to be sure that other avenues of government know that sometimes California is impaired and is not necessarily serving the public best if it cannot actively participate in national meetings.

Dr. Hawkins stated that he and other fellow physicians are using CURES regularly and even with the hesitation when it first began, he is finding that physicians are now embracing it.

Dr. Bazzo stated that he is very happy, as a physician and an educator on pain management and trying to get the opioid issue under control, that CURES is ramping up and folks are taking advantage of it. He stated there is a process where CURES 2.0 needs to be certified and it is after the certification period that physicians will be required to check the CURES database before prescribing an opioid to patients and wondered if Ms. Kirchmeyer knew of the estimated time that this certification would be taking place.

Ms. Kirchmeyer stated she had not heard of an estimated time, but knows that it will be after the Department of Justice obtains the staffing and resources for CURES 2.0.

Ms. Clavreul asked how long the physician has to input patient information into the CURES system.

Ms. Kirchmeyer stated that if the physician does direct dispensing in his office, or if a pharmacy dispenses the medication, the law states they have seven days to input the information, and it would take a legislative amendment to change that requirement.

Agenda Item 17 Update on the Implementation of the Physician Health and Wellness Program

Ms. Kirchmeyer stated that at the last meeting it was noted that the Board held an interested parties meeting on the regulations pertaining to the physician health and wellness program. She noted that Board staff is currently working on regulations to implement this program. Ms. Kirchmeyer stated that unless there are any changes, Board staff may have another interested parties meeting with the actual language prior to the next Board meeting and may provide the language at the July Board meeting for review, depending on stakeholder feedback. The plan is still to have the regulations completed and the vendor hired to begin the program at the end of 2018, however this is timeframe is dependent on the regulatory and contract process.

Agenda Item 18 Presentation on the Clinical Competence Assessment Program and the Physician Enhancement Program

Mr. Boal and Mr. Floyd gave a presentation on UC San Diego's PACE Clinical Competence Assessment Program and the Physician Enhancement Program. The presentation consisted of an overview of both programs, a discussion on how these programs have changed, why they have changed, and how they are better, as well as a review of the assessment program logistics. The full presentation can be viewed on the Board's website.

Dr. Lewis stated that the presentation showed that 91% of UC San Diego's faculty participate. He noted that he imagined that participants come from all over the state, so he asked why there is a lack of local mentors that are not UC San Diego faculty.

Mr. Boal stated that most new faculty are added to the PACE staff, however, if they do not work for UC San Diego, they have to get a clinical appointment. He pointed out the majority of the physicians they are monitoring are within 200 miles of the university. He noted that they are outgrowing the UC San Diego setting and are expanding the program and faculty into other areas outside of San Diego.

Dr. Lewis stated that he felt that only two face-to-face physical interactions a year with the participants of the program and the rest being done by just charting or email does not seem like enough interaction. He wondered if maybe they had considered a skype type of meeting or something that would give them more of a face-to-face feel.

Mr. Boal noted that the monthly phone call with the physician is the main point of interaction and that several of the faculties do currently use a skype type of meeting.

Dr. Lewis added that this seemed to him like it was more of a charting improvement program as the presentation did not mention anything about physical examination skills.

Mr. Boal stated the reason they did the review with the charts was to determine whether or not these physicians were improving in their skills, as several of the physicians in the program are lacking in charting skills. He noted that at the end of the day, that is not their biggest concern, they want to be sure they are practicing adequately, but charting is a big part of that as well.

Dr. Yip suggested contacting the patients of the physicians that are in the program as a follow up to see how the patient felt the physician is doing, and using this as another step to evaluate their progress. He feels that charting is important but appropriate practice is just as important.

Dr. Hawkins noted that he realizes that PACE is a fairly expensive program and asked if there is some sort of payment plan or financial assistance plan available to those who may need it.

Mr. Boal stated the price of the program can get expensive and it is an expensive program to run, however, they pick and choose what type of evaluation each physician needs on an individual basis, which makes the cost of the program vary for each physician. He added that the program states that the physician is to pay for the program before beginning it, but often times, when the Board is making the decision to send the physician to the program, when there is a financial issue, they will give the physician some time to perhaps make payments to the program before they are required to attend.

Dr. Bishop noted his concern was whether the faculty of the program is spending enough time reading through the charts to make sure that not only what is being charted is legible, but practical and thorough treatment is being given.

Mr. Boal stated one of the main goals for the monthly monitoring calls to the physician is to have the physician go over the chart with the faculty to explain their thought process and treatment plan for the patient. He noted that is the most important goal; adequate practice and diagnosis.

Dr. Bholat stated the presentation had noted that 45% of the faculty that works this program are not board certified, and that 26% of the graph showed other specialties. She said she felt it was important to know what those other specialties are. She noted she also would like to see a breakdown of the physicians that work in the health professional shortage areas and medically underserved areas. Dr. Bholat stated she felt it is important that they look at race and ethnicity as well. As for the legibility area, she would like to see a breakdown of how many physicians in the program currently use electronic health records.

Dr. Bholat also stated she would like to see the current breakdown separate general practitioner from family medicine since they are different as far as areas of training. She also noted that as far as patient satisfaction, she would like to see that become more of the process, and asked how much time is being spent, on average, on each monthly phone call.

Mr. Floyd stated that each call varies, but on average between 15 and 30 minutes.

Dr. Bholat added that she thinks it is very important to get the patients' perspective to make sure that consumer safety and satisfaction are being met appropriately.

Ms. Clavreul stated the Board should consider bringing back the idea of having it be a violation if the physician writes illegibly. She also stated her concern about the criteria of the judging of charting and feels it has little to do with quality of care.

Dr. Lang noted she would like to see the Board try and find a way for physicians to continue to practice while making payments to the PACE program when they are being required to attend, especially since statistics show that many of the physicians in the program are solo practitioners and most often are working in medically underserved areas.

Agenda Item 19 Presentation on the Aging Physician

Dr. Bazzo gave a presentation on the evaluation of the aging physician. The presentation included facts on risk factors other than aging that may affect a physician's clinical competence, typical changes and diseases associated with aging, unintended consequences of age-based competence decisions, and mandatory retirement.

The presentation also included the screening criteria and overall rationale used in the PACE program, age group statistics, recommendations, and PACE aging physician assessment data. The full presentation can be viewed on the Board's website.

Dr. GnanaDev asked Dr. Bazzo what UC San Diego is doing with the clinically practicing physicians and also physicians who only teach and do not practice at the university.

Dr. Bazzo stated that UC San Diego does not have an aging physician policy, however one is in development. The policy started out in the Credentials Committee and will proceed to the Medical Executive Committee. He stated this type of policy is often incident driven.

Dr. Bazzo noted what they would like to see happen is to be able to give physicians some data that they can use themselves to make some decisions about how their career is progressing before something happens. He noted that many of the physicians that have come through the program gained confidence about themselves because it showed them that they are still doing a good job in both physical status as well as cognitive abilities. Dr. Bazzo stated that approximately 30% of physicians do not have their own physician. So, with that being the case, this program is a way to give some data to the physicians to assist them in making an informed decision and not wait until a tragedy happens.

Dr. GnanaDev asked if there was any information regarding the educators.

Dr. Bazzo stated there has not been much discussion on educators.

Dr. Krauss noted that physicians practice what is called, evidence-based medicine, however often times in the legislative and regulatory process it is not evidence based. He asked at this stage, if there is enough evidence that there is value in cognitive screening to where Members should proceed to the legislators and regulators to seek requirements for cognitive screening of physicians in the state of California.

Dr. Bazzo stated that when looking at evidence, an individual has to look outside of the United States, to a place such as Canada, who is actually collecting this data and publishing some of it. He noted an individual should also look at processes for recommendations in the history of medicine. The lowest level of evidence is expert opinion, based on what is occurring. He added that he believes they are in that expert opinion phase while trying to gather needed information, as they are doing at the PACE program, to really understand if it is a good process or not.

Mr. Andrist stated that it is interesting and encouraging that PACE feels it necessary to have an unbiased party to do their screenings, but the Board feels it is appropriate for physicians to pass judgment on other physicians, and a single physician expert to decide if a consumer complaint is worth investigation. He stated that when the Board closes a consumer's complaint, they have no recourse to question if that expert was being unbiased at all or even qualified to be rendering such a decision. Mr. Andrist stated that no board should be governed by the very people that the board is meant to protect the public from.

Agenda Item 20 Update, Discussion and Possible Action on Recommendations from the Licensing Committee

Dr. Krauss began by thanking Ms. Alameda for taking on Mr. Worden's duties since his retirement. He noted that at the Licensing Committee meeting, Ms. Alameda provided an update on the amendments to the physician postgraduate training requirements in response to issues raised in the Sunset Review Report. On April 4, 2017, proposed statutory language was provided to the Senate Business, Professions, and Economic Development Committee to change California's postgraduate training requirements from one or two years to three years for all applicants regardless of where they went to medical school. Additionally, the amendment would eliminate the Board's process for recognizing medical schools. He noted that Ms. Alameda explained that current law requires one year of postgraduate training for applicants who graduate from an LCME accredited medical school and two years of postgraduate training

for applicants graduating from an international medical school. He stated that changing the postgraduate training requirements for all applicants will assist the Board in ensuring that applicants are safe and competent to practice. He noted that increasing these minimum requirements to three years would also eliminate the need for Board staff to review international medical schools and instead utilize the list of medical schools on the World Directory of Accredited Medical Schools.

Dr. Krauss stated that Ms. Kirchmeyer had provided an update on the Board's Sunset Review Report regarding applicants that have been out of practice in excess of two years and informed the Committee that Board staff is working on proposed language to address this issue.

Dr. Krauss added that Ms. Alameda provided a presentation on re-entry and the length of time an individual may be out of practice before additional training is needed prior to re-enter into practice. He stated the Committee directed Board staff to conduct further research on this issue and bring it back to the Committee for further discussion.

Agenda Item 21 Discussion and Possible Action on Charles University, 2nd Faculty of Medicine

Ms. Alameda referred the Members to page BRD 21-1 through BRD 21-6 in their packets, where they would find Dr. Silva's report regarding the 2nd Faculty of Medical Charles University in Prague. She noted that Board staff had conducted a review of the University's self-assessment report and then requested a review by licensing medical consultant, Dr. Silva. She added that Dr. Silva had been training medical students and residents for over 50 years at three different medical schools. He has had a productive career in providing clinical and laboratory research, medical practice, and public service. She added that Dr. Silva's career had also involved leadership positions in several academic societies and consultants to the U.S. Department of Defense, National Academy of Sciences, and the American Association of Advancement for Sciences. She noted Dr. Silva had previously been chairman of International Medicine, and Dean of Medicine at California School of Medicine. He has been a consultant to California North State University and is now Dean of that University.

Dr. Silva stated he felt the 2nd Faculty of Medical Charles University should be approved. He said it is an old school that has added a new school. He noted that he believed the reason the Board had some difficulty in evaluating this school is because they use different terminologies. He stated this school has been around a long time and does represent excellence in medical education. Dr. Silva noted that this school is a 3 + 3 year program, which means three years basic education and three years of clinical. The school has all of the proper entry requirements and he stated the education and curriculum are excellent and well detailed. Dr. Silva noted that one element is that they have to prove the speaking knowledge of Czech by the end of their third year in order to converse with patients. He noted it is set up by the Czech government for the English language program, but is run in parallel with the regular program.

Dr. Silva noted that all of the items are measured, including professionalism, mission process, monitoring, assessment of curriculum, student remediation, etc. He added that they do several things that the United States does not do, such as their students are required to be in class 90% of the time. He noted that looking at our BPC sections, they require students to have 4000 hours, and they address the 26 topics that are required by the BPC. He stated they also offer curriculum that the United States does not offer, such as basic lessons in oral disease.

Dr. Silva stated that overall it is a great program, it meets all of the laws and regulations as well as the Boards' requirements and he recommended approval of this university.

Dr. Lewis confirmed with Dr. Silva that he does recommend the approval of the school retroactive back to 1992, as that approval would allow anyone who had graduated from this University since 1992 to apply for California licensure.

Dr. Silva stated he certainly felt that there was enough construct in that University at that time to approve the retroactive recommendation.

Dr. Krauss made a motion for retroactive approval back to 1992 of the 2nd Faculty of Medical Charles University in Prague with no site visit needed; s/Dr. Lewis. Motion carried unanimously 11-0.

Agenda Item 22 Update and Possible Action on Recommendations from the Midwifery Task Force

Dr. Bholat referred the Members to pages BRD 22-1 through BRD 22-3 in their packets. She noted that she and Dr. Levine had met with Board staff and representatives on March 8, 2017, to discuss the status of the regulations to define pre-existing maternal disease or condition likely to affect the pregnancy and significant disease arising from pregnancy under BPC section 2507. The meeting consisted of a discussion of the current language in this code section, which requires a licensed midwife to refer a client with a pre-existing maternal disease or condition to a physician for an examination and determination by the physician that the risk factors presented by the client's disease or condition are not likely to significantly affect the course of the pregnancy and/or delivery.

Dr. Bholat noted that under the proposed changes listed in the report, if the client has an existing maternal disease or condition likely to significantly affect the course of the pregnancy and/or delivery, the midwife would still be required to refer the client to a physician trained in obstetrics for an assessment of the risk factors. She added the midwife would have to include the physician's assessment in evaluation whether the client's disease or condition is likely to significantly affect the course of the pregnancy or delivery. It would ultimately be the midwife making the determination within the midwifery standard of care, rather than the physician, as to whether the client should continue with midwifery care.

Dr. Bholat stated that if the client does have a pre-existing maternal disease or condition, the midwife would have to refer the client to a physician and surgeon for care, with the midwife providing collaborative care, as appropriate. She noted that if the proposed amendments are made to the statute, the Board staff will move forward with the regulatory process to define "pre-existing maternal disease or condition likely to affect the pregnancy" and "significant disease arising from the pregnancy." Conditions falling within the definitions put forth in regulations, which would include prior cesarean section, would prompt the referral to the physician for the assessment of the risk factors, and when appropriate, for the transfer of care.

Dr. Bholat stated the Board's regulations on this issue was raised in the sunset review background paper, and she asked for a motion to approve the language with the proposed changes and authorize staff to submit the amendments to the Senate Business, Professions, and Economic Development Committee for review and consideration.

Dr. Lewis made a motion for the Board to approve the language with the proposed changes and authorize staff to submit the amendments to the Senate Business, Professions, and Economic Development Committee for review and consideration; s/Dr. Krauss.

Ms. Rosanna Davis thanked Drs. Bholat and Levine for meeting with the LMs on this issue. She stated that in 2013 AB 1308 attempted to design a framework for a client whose medical history indicated a need for physician participation in her care to obtain that care and still continue in the care of the midwife if the disease or condition was not likely to effect the pregnancy or delivery. She noted that unfortunately, the language choice in the statute, particularly the word "determine," inadvertently created an unreasonable expectation on the physician to predict what the patients' medical future might be.

Ms. Sarah Davis stated one of the key points that had kept them from succeeding in the regulatory process is the question of whether or not a potential client who had had a prior caesarean would be able to continue with a licensed midwife in a subsequent pregnancy to plan an out-of-hospital birth. She stated there are a couple of 2017 studies regarding vaginal birth after caesareans (VBAC) that are taking place in other states; states that do not license midwives for outside of hospital care, so in many of those states there were midwives practicing illegally, which more than likely accounts for most of the adverse outcomes of VBACs. With this current data statistics, it shows that California should have LMs able to care for women who will have planned out of hospital VBACs.

Ms. Smith-Crowley stated ACOG has been working with CMA on out-of-hospital birth settings, regardless of the provider, in the two-year bill SB 457. She added it was important for consumers to understand that it should be one uniform standard, however, deciding on the standard has been very difficult. She would like to see some language that changes the word "likely" to "a risk above normal," to make it more clear.

Ms. Howard noted that the practice that she has been working in asks all potential clients who have had a previous cesarean section to have a detailed discussion with their physician regarding informed consent. Though this is above and beyond what the law requires, they do it because it is very important to their care. She noted they also provide their own one-on-one, face-to-face, informed consent that is about a 60 minute meeting. If they continue in care, they have several more requirements of them in order to continue.

Ms. Noble noted that in California licensed midwives and nurse midwives have different, but overlapping scopes of practice that reflect the difference in their skills and education, as well as preparation. She noted that the California Nurse Midwives Association supports language that maintains client autonomy and self-determination. Each woman has a right to make an informed decision about where to give birth. They support language that reinforces the clinical decision making capabilities of license midwives consistent with their training. An initial and ongoing risk assessment, in order to refer to an OB/GYN as needed is consistent with the Board's guidelines of practice and professional standards of care.

Ms. Sanchez, CMA, stated this is a complicated area and they have their own bill where they have articulated a framework and a plan they believe resolves some of these questions. She added it is the vehicle they feel should be pursued, and with all of the different perspectives being brought to the table this year, they recommend including it in the sunset review.

Dr. Lang asked for clarification on what role the physician would play in these scenarios.

Ms. Webb stated the physician would make an assessment on what past medical history may impact the current pregnancy and delivery as well as what diseases may have arisen since this pregnancy. The new language will change from the physician making the determination to the physician providing an

assessment to the patient and midwife, where LMs will then use the standard of care to determine if the woman should or should not continue under midwifery care.

Dr. Bholat stated that in regard to the meeting that they had, there have been things learned that are involved in medicine, since physicians did not used to do trial of labor after caesarean and now they do. The Board needs to look at the decrease in caesarean rates in hospitals. She stated the meeting contained differences of opinion, but if there is any instrument that has been used on the uterus, which could present a risk during a future pregnancy and delivery, and some feel that such deliveries should only be done in a hospital. During the meeting, there was discussion that LMs would continue to ask for home deliveries and that there is a subset of patients who may not have access to physicians. There were some differences, but also defined ways to work collaboratively, which is why this language is being presented to the Board for review.

Motion carried 10-1. (Bishop)

Agenda Item 23 Discussion and Possible Action on the Midwifery Advisory Council Appointment Set for Expiration on June 30, 2017

Ms. Alameda asked the Board to approve the Midwifery Advisory Council's (MAC) recommendation to appoint Chemin Perez, LM, to the LM position effective July 1, 2017, for a three-year term that will expire on June 30, 2020. She noted that the Board received four applications for the positon. Three of the applicants were present at the March 16, 2017 MAC meeting, and addressed the MAC regarding their interest to be a MAC member. One applicant withdrew her application. The MAC members voted to recommend to the Board the appointment of Ms. Perez.

Dr. Krauss made a motion to appoint Ms. Perez to the MAC LM position; s/Ms. Sutton-Wills. Motion carried 9-0. (Lewis and Pines – absent from vote.)

Agenda Item 24 Vertical Enforcement Program Update from Health Quality Investigation Unit

Ms. Nicholls provided an update stating that for the past year, she and Mr. Chriss had been discussing with the Board the need for investigator retention pay. A retention pay proposal was sent to DCA who then submitted it to CalHR. She noted that for the past several Board meetings, the status had been that it was still at CalHR for review. She added she was pleased to announce there had been progress on this issue. CalHR and CSLEA had signed an agreement to award a 7.44% pay increase to all DCA investigators who are and have been topped out of their salary range for at least 12 months. Ms. Nicholls stated that this pay increase is a step in the right direction. She added that the agreement still needed to be ratified by the legislature and is not final. She stated that the pay increase only addressed rank and file investigators and does not include HQIU supervisors and managers. She noted that she had been assured that if the retention pay is ratified, CalHR would address any compaction issues the raise would cause and make the necessary adjustments. Ms. Nicholls stated they are confident that this increase will assist in attracting qualified candidates with prior investigative experience, as not all bargaining unit seven investigative agencies were included in the pay increase. Ms. Nicholls stated they are re-advertising vacancies with the confidence that it will attract a more qualified candidate pool. She then thanked the Board for all of their support over the years in obtaining higher pay for all HQIU investigators and that it is truly appreciated.

Ms. Nicholls stated that in addition to the pay increase, they are working with Ms. Kirchmeyer and the Board's executive staff on modifications to the current VE legislation and she feels that these two positive changes were needed to improve investigator retention and they fully support legislation to change VE.

Ms. Nicholls added that they are also in the process of creating an official recognition program for investigators statewide to recognize their important work and accomplishments.

Ms. Nichols stated in regard to their vacancies, they have 31 vacant positions which equates to a 40% vacancy rate, however, there are 21 candidates currently in background for those 31 sworn vacancies. She noted that all candidates for Northern California have been selected and they are working on selecting the remaining candidates for Southern California. She added that they have 15 non-sworn special investigators working statewide to assist with caseloads and seven of the 15 are in background for HQIU. Ms. Nicholls stated this process has been so successful that they have added a new special investigator position to the San Diego office, interviews were held last week, and a candidate was chosen. They hope to have final clearance for that candidate soon so they can determine a start date.

Ms. Nicholls added that evidence training is beginning May 9, 2017, to all HQIU evidence custodians and supervisors and these same staff are also completing an extensive 14 hour online course on evidence collection and management. The training unit is also developing a mini training academy, which is a three week course for newly hired HQIU investigators. They are also developing some case specific training for HQIU investigators.

Ms. Nicholls stated another exciting project they are working on with Board staff is the newly designed QBIRT reports to keep track of all case information per investigator. Supervisors will obtain training on May 9, 2017, along with the evidence training. Ms. Nicholls noted they are also in the process of changing their case disposition process with the Board, which will streamline the process and ensure timely disposition of the cases. The Board is in the process of hiring a position that will fulfill most of these duties, and the Board's ISB staff is currently working on creating a brand new statistics reporting system, which will accurately keep track of all completed, assigned cases statewide. She then thanked the Board's ISB staff for their work on this major project and noted they are an extremely talented group and they have enjoyed working with them on the project.

Ms. Nicholls ended by stating their Pleasant Hill field office is moving to a new location in Concord and will be operational in that office on May 1, 2017.

Dr. Lang suggested that in lieu of the demographic study results that were announced at the last Board meeting, she would like to see unconscious bias training added to the list of upcoming investigator training.

Agenda Item 25 Vertical Enforcement Program Update from Health Quality Enforcement Section

Ms. Castro reminded the Board that VE is a low cost process, as the Board is billed by the hour and the cost on average is $1,200 per case, for a total of $1.25 million per year, which included 12 lead prosecutors in each of the district offices assigning themselves cases of low priority and making sure the most important ones are assigned appropriately. She added that fortunately, the unintended consequences of eliminating VE are clear and spelled out pretty well in the final monitor's report from November,

2005. She stated there would be detriments if the old hand off model were reinstituted. Ms. Castro compared the VE program handling Board cases to a team-based approach in a health care model. She stated the investigators, sworn or non-sworn, would be part of that team along with the expert reviewers, who would be compared to a consultant one would hire to look at a patient. The DAG could be compared to an attending. She noted that the most highly valued investigator, one who knows the process well could be analogized to a physician assistant, but those investigators are few and far between as HQIU has lost a lot of them. Ms. Castro stated that without a DAG actively involving themselves in the investigations, the case could go to an individual who is untrained in law. She added that with the hiring of non-sworn, that is a reality until they are trained. Those individuals may be unfamiliar with the presentation of evidence and perhaps the causes of action that are available under the Medical Practice Act, and could be responsible for making evidentiary and acquisition decisions such that expert witness decisions could be affected. She continued with other possible scenarios that could negatively affect case outcomes if the VE model were removed.

Ms. Castro noted that at the last Board meeting Judge Feinstein had requested some statistics from her, but the request has since been withdrawn so she did not have those statistics to report.

Dr. GnanaDev reiterated that the Board is not working to eliminate VE, but just to make some modifications to make it more efficient.

Dr. Bishop stated that he believed that the team approach is always the best option and was pleased to hear Dr. GnanaDev remind everyone that the Board is not looking to eliminate it, just to make it more efficient.

Agenda Item 26 Update from the Attorney General's Office

Ms. Castro announced that the *Lewis vs. Medical Board* case is going to be heard before the Supreme Court on May 3, 2017, in San Francisco. She noted the case will be webcast for those who would like to watch it. She added that Solicitor General Amy Feinberg and Deputy Attorney General Edward Kim will be presenting this case. She added they are both very talented and will do a fantastic job and she hopes to be able to bring a positive outcome update to the next Board meeting.

Ms. Kirchmeyer thanked the Solicitor General, Ms. Feinberg and Mr. Kim for their work on the *Lewis* case. She stated they have put in many hours on the case.

Agenda Item 27 Update on the Interim Suspension Order (ISO) Study

Ms. Delp stated that at the direction of the Board, she and Ms. Kirchmeyer met with staff from HQES and the HQIU to identify ways to recognize cases as quickly as possible where an ISO should be pursued. In addition, the group also identified improvements in the investigation process in order to expedite obtaining an ISO, thus protecting consumers. She noted the group identified 14 improvements or policy changes to meet the stated goals and these changes are listed under tab 27 of the Board packets. Ms. Delp stated that nine of the fourteen strategies have already been implemented and the remaining five are in process.

Ms. Delp stated that since the last update, which was provided at the July 2016 Board meeting, the following had transpired regarding the recommended changes. In regard to improvement number one, Board staff has enhanced its database of extra reviewers to easily identify experts who evaluate both

physical and mental impairment evaluations, and staff have begun to develop an online training tutorial for those experts that will supplement the primary expert reviewer training already being provided to all experts. She added that with regard to improvement number four, pursuant to BPC section 2220(a), the Board, within 30 days of receipt of an 805 or 805.01 peer review report, must investigate the circumstances to see if an ISO should be issued. Unless the information in the report is straight forward, HQIU and HQES staff are unable to make a determination as to whether an ISO should be sought within the 30-day time frame. The medical records and peer review investigation report must be obtained to make this determination. She noted that on average, it could take 90 days or longer to receive the required documentation, factoring in time to assign the case to an investigator, prepare and issue a subpoena for records, and wait for the facility to return the requested documentation. To reduce this time frame, enforcement staff now prepares and serves the subpoena to the facilities to submit the mandated documents to the Board. Ms. Delp noted that this improvement will not only reduce the time frame to receive the necessary documentation, but will eliminate the task for the HQIU investigators resulting in an overall reduction in the investigation time frame. She noted that she and staff had training on preparing and issuing subpoenas and staff has completed its first subpoena, which is currently being reviewed.

Ms. Delp continued with an update on improvement number eight, stating that the Office of Administrative Hearing (OAH) received training on physical impairment including how fitness for duty can be measured for impaired physicians.

Ms. Delp stated strategies three and four are those where the improvements will take the longest to implement. They require the development of new BreEZe activity codes to track, monitor and capture statistics for ISO cases at the field and at the AG's Office. She noted that it is a priority for the Board's enforcement user group to develop the codes; however the BreEZe change request may not be considered the highest priority in all of the change requests submitted to DCA by all of the boards and bureaus. Ms. Delp noted that it is important that the Board continues to make ISOs a priority to ensure that licensees who practice medicine are not engaging in acts that endanger consumers.

Agenda Item 10 Update on the Marijuana Task Force

Ms. Lawson stated that on February 8, 2017, the task force held an interested parties meeting in Sacramento with the goal to begin the process and discussion to revise the Board's statement on marijuana for medical purposes. She noted that many interested parties attended the meeting, including representatives from medical associations, other state entities, telemedicine companies, physicians who recommend marijuana, and consumers. The task force first heard a presentation from Lori Ajax, Chief of the California Bureau of Medical Cannabis Regulation. Ms. Lawson noted this Bureau is responsible for issuing distribution, transportation, laboratory testing, and dispensary licenses for marijuana. Ms. Ajax provided an update on the activities of the Bureau including information on meetings they have held to discuss the Bureau's responsibilities, and holding pre-regulatory hearings to discuss concepts for the regulations they are drafting to implement the program. Ms. Ajax stated she hoped to have those regulations finalized by January 2018. Ms. Lawson noted that Ms. Ajax had stated there is a lot of ongoing state coordination meetings and several licensing authorities involved in the oversight including the Department of Food and Agriculture and the California Department of Public Health. They have been working together to make the regulations consistent and it is the intent to start issuing licenses on January 1, 2018.

Ms. Lawson added the task force also heard an overview of the Board's current statement on recommending marijuana for medical purposes in addition to the history and background of the statement. The task force determined any future document would be called a guideline, not a statement. Ms. Simoes provided a presentation on the requirements that were included in SB 643 (McGuire), which passed in 2015 and its implementation. Ms. Lawson stated that Dr. Krauss and Ms. Kirchmeyer then provided an overview of the FSMB's model guidelines for the recommendation of marijuana in patient care and a side-by-side chart was shown to compare the FSMB's guidelines to the Board's statement. She stated that while there were some similarities found between the two, there were also some areas where more information was provided in the FSMB's guidelines than in the Board's statement.

Ms. Lawson stated the last agenda item provided an opportunity for all interested parties to provide recommendations regarding revisions to the Board's statement. She noted there was significant discussion and several comments were received from those in attendance. Ms. Lawson added that Board staff is currently working on drafting the new guidelines for recommending marijuana for medicinal purposes that will take into consideration the FSMB's guidelines as well as the comments received at the task force meeting. Once the guidelines have been drafted, Board staff will meet with staff from the California Marijuana Research Program also known as the Center for Medicinal Cannabis Research to receive its input into the Board's guidelines. Once that meeting is held, the task force will hold another interested parties meeting to review the draft guidelines with all stakeholders and to receive their input. She noted that after that meeting takes place, the task force will finalize the guidelines and present them to the full Board for review and approval. She noted the task force would like to be able to present the final draft at the October 2017 Board meeting where the Members will hopefully approve the guidelines so they can be sent to physicians and posted to the Board's website. Ms. Lawson noted the goal of the task force is to have a document that can educate providers and assist in appropriate recommendation of marijuana for medical purposes.

Agenda Item 11 Update on the Disciplinary Demographics Task Force

Dr. Krauss stated that on February 24, 2017, and April 25, 2017, he and Ms. Wright met with staff telephonically to discuss the study by the California Research Bureau (CRB), the Board's enforcement process, and recommendations to be put forward to the Board on these issues. He noted the goal of the task force is to evaluate claims of discrimination, and the findings of the CRB demographic study, in order to proactively prevent bias in any and all processes of the Board and of actions of anyone who may be involved in the investigative or disciplinary processes.

Dr. Krauss noted that discussing this issue with staff, and as discussed at the last Board meeting, one of the first actions that is being recommended to the Board is to research and identify training that can be provided to all individuals involved in the enforcement process, which would include all Board staff, Members, investigators, medical consultants, experts, attorneys and administrative law judges. He added during the discussions and research on this issue, it was determined that some entities had already received training on bias, however, that training needs to be evaluated to determine if it included everything the Board would like it to cover. If it is determined that it does not, then the Board will have those entities take the training that the Board will be providing.

Dr. Krauss stated Board staff had been working to identify a training course and vendor and has located five different vendors that offer this type of training; however, the chosen vendor not only would have to be able to offer in-person classroom training in both Northern and Southern California, but also must be able to offer a webinar interactive training that can be completed online for the Board Members and expert reviewers. Therefore, staff is working with the various vendors as well as DCA SOLID training unit to develop a program that would meet this need. He stated the Board would need to enter into a contract with a vendor for these services. Dr. Krauss noted that there are a number of suitable trainings available and the goal is to have a contract in place by July and training completed by the end of this year. It is recommended that this training be completed every two years.

Dr. Krauss stated that looking at the enforcement process, there is no ability to de-identify the physician due to potential conflicts among those who review the Board's cases and also due to the need to review the physician's history and obtain necessary licensure information. However, based upon comments received by staff at a presentation discussing this issue, the task force believes that certain information should be removed from the complaint, investigation, and prosecution process. This information would be any information regarding the medical school the licensee attended, and the location where post graduate training took place, as this information could inject unconscious bias into the process and they are irrelevant to the action taken by the Board. Dr. Krauss stated that they also recommend that any such information be removed from investigation reports, physician interviews, AG memos, and administrative law judges proposed decisions. He stated that the task force believed that any descriptive information on a licensee, including physical description, birth place, work location, etc., be removed from all of the documents, as well.

Dr. Krauss noted that although the CRB study was an observational study, and did not find any party to the process acted with bias, the task force is working to identify and eliminate, where possible, any factors that could be identified as leading to unconscious bias in the enforcement process. He stated they believe these steps will assist in the elimination of the Board's potential for unconscious bias in the enforcement process. He asked that Ms. Kirchmeyer meet with staff from HQIU and the AG's Office to provide feedback that was received during the review process, as they believe it is important for the individuals that investigate and prosecute these cases to receive this information in order to hear outside perspectives on the Board's enforcement process.

Dr. Krauss noted that the next steps for the task force will be to meet with interested parties to obtain more information, hear their concerns, and consider additional solutions.

Dr. Anne Stavern stated she wanted to commend the Board for having the study done, and noted her organization is an affiliate of the National Medical Association representing African American physicians in the Los Angeles area. She stated she would like to become part of the list of interested parties and they would offer significant feedback with regard to the outcome of the study and some recommendations that may address some of the findings.

Dr. Lang thanked the Board for the very thorough input that was given on how to address unconscious bias as a starting step in defining the demographic study. She noted she appreciates what is being done and thanked the leadership for allowing this issue to move forward, and she looks forward to working with the Board further as this issue progresses.

Agenda Item 12 Update on the Physician Assistant Board

Dr. Bishop stated the Physician Assistant Board (PAB) conducted its quarterly meeting on April 24, 2017, in Sacramento. He noted the National Committee on Certification for Physician Assistants (NCCPA) is currently lobbying various states for legislation to mandate that PAs retain certification through their agency in order to retain their PA licenses in that state. He noted that recently the state of West Virginia vetoed a bill that would remove the current NCCPA certification requirements of completing 100 hours of CME every two years and successfully pass the NCCPA recertification exam every ten years. The NCCPA believes this veto protects patient safety and holds PAs to higher standards. Dr. Bishop added that currently California law requires PAs renewing their license be NCCPA certified and complete 50 hours of Category 1CME every two years. He noted that following a discussion, it was determined that PAB would investigate the possibility of working with a new national certifying body, such as the American Academy of Physician Assistants to create a new certifying exam.

Dr. Bishop stated PAB Members discussed amending the current PA Practice Act and regulations to address provisions that may no longer be relevant, such as supervisor license fees, program fees, and approval of training programs. He noted the PAB also discussed updating the obligation of delegation of services agreement (DSA) that is currently available on the PAB's website to reflect the amended laws and regulations. Dr. Bishop added that the DSAs were provided as a sample for PAs and supervising physicians to use regarding services that are delegated to the PA. It was noted that currently the PAB has six regulations that have either been submitted to DCA for the 45-day notice or will be submitted to the Office of Administrative Law in the near future. Dr. Bishop stated that California Code of Regulations section 1399.617 addresses the possible fines that could be imposed if a licensee is not in compliance with the CME audit as required.

Dr. Bishop added that the Board discussed legislative bills that could impact the DCA boards and health care professions, such as AB 710 which would mandate that the PAB have one meeting every two years to be conducted in a rural Northern California area.

Dr. Bishop noted that the PAB's Executive Officer, Lynn Forsyth, announced that the part-time Office Technician position was filled on March 1, 2017, and the full time enforcement position would be filled on May 1, 2017, so with that, after two years, the office will be fully staffed.

Dr. Bishop then thanked the Medical Board staff, including Ms. Kirchmeyer for their continued support and guidance.

Agenda Item 9 Presentation on the Outpatient Surgery Setting Program (OSS)

Ms. Kirchmeyer began by explaining the Board has a role in outpatient surgery settings (OSS), which was greatly expanded due to a court decision several years ago. She stated the law requires that if a surgical procedure requires anesthesia to be administered in doses that have a probability of placing a patient at risk of losing their life preserving reflexes, then the surgery must be performed in an accredited, licensed or certified setting. She added that a setting that wants to be accredited, must be accredited by an accreditation agency approved by the Board. Currently, the Board has approved five accreditation agencies including the Accreditation Association of Ambulatory Health Care, the American Association for Accreditation of Ambulatory Surgery Facilities, the Joint Commission, the Institute of Medical

Quality, and the American Osteopathic Association or Healthcare Facilities Accreditation Program. These agencies must go through a renewal approval process with the Board every three years.

Ms. Kirchmeyer noted that through this renewal process, the accreditation agency must provide a document outlining how they still comply with all of the elements of the law. Board staff reviews these documents and determines if there are any deficiencies in compliance with the law and requests additional information from the accreditation agency when needed. She stated it is important to remember that the Board does not accredit the facility, but the Board approves the accreditation agencies that do the accreditation. She pointed out that the prior court decision language stated that any facility that had any percentage of physician ownership had to be accredited, not licensed. So, with that the number of agencies that needed to be accredited grew drastically.

Ms. Kirchmeyer stated that the Board has made significant improvements in the OSS database, and further improvements are anticipated when the Board has the resources available to make these improvements. She added that currently the accreditation agencies provide the Board with all of the information about these settings on an excel spreadsheet, then Board staff takes that information and enters it into the Board's database. Staff is working on a database where the accreditation agencies can enter the information into that database directly. Once this improvement to the database is made, it will flag staff with any missing documentation that the accreditation agency still needs to provide. Ms. Kirchmeyer stated, however, the current database is still working well and does provide the public with good information. With the current database, consumers can search for a facility by the name of the OSS and by the name of the physician owner as well. Once the information is located, it states which accreditation agency actual accredited that facility.

Ms. Kirchmeyer stated the information on the Board's website provides the facility information such as the location, the phone number, the type of OSS, the type of approval it has, and their accreditation status and past history, in addition to the ownership information. She stated the database also provides the specialty areas being provided at each facility, and inspection data including deficiencies that had to be addressed, any corrective action plans, and the outcome report. She noted the website also contains the actual documents from these inspections and plans.

Ms. Kirchmeyer stated the site also provides a side-by-side chart that shows the inspection responsibilities of the accrediting agency along with the responsibilities of the Board. She stated that from January 1, 2012, to present, the Board has received almost 1800 inspection reports and of those, there had been 853 corrective action plans received. She noted these corrective action plans are either received in response to a complaint the Board had sent the accreditation agency or from the routine inspection that is done every three years.

Ms. Kirchmeyer stated that prior to 2013, OSS adverse event reports were sent to CDPH per the law. However, in 2013 the Board asked for a legislative change for those reports to come to the Board instead to better assist in consumer protection. She noted that adverse event reports are required for the following types of errors: any type of surgical, product/device, patient protection, care management, environmental, or criminal event. Ms. Kirchmeyer added that the Board is seeking changes to the adverse event reporting, based on the fact that some adverse events listed in current law do not pertain to an OSS and other events that should be reported are not required. She noted that once the adverse event takes place in the facility, it is required to fill out a form that the Board has put together and then send it to the Board. She added that in FY 14/15, the Board received 104 adverse event reports, and in FY15/16, 111 reports were received, out of the 896 accredited facilities that are currently in the Board's database.

She added that 72% of those reports had to do with surgical events, 11% had to do with product/device issues, 12% were case/care management, 1% was an environmental event and 4% were categorized as "other."

Ms. Kirchmeyer stated, once the Board receives the adverse event report, it determines if the facility is accredited by an agency approved by the Board. If it is, the report gets forwarded to the accreditation agency with a request for them to do an inspection. If it is found that this facility is not accredited by a Board approved accreditation agency, the report gets forwarded to enforcement for action based upon no accreditation or gets forwarded to the appropriate agency for possible action. Ms. Kirchmeyer noted that once the inspection survey results are received from the accreditation agency, staff reviews them to be sure the appropriate action was taken, which is then posted on the Board's website. If deficiencies in the report are found, staff ensures that a corrective action plan is provided, which is also posted to the website. If it is found that the information received indicates a physician has departed from the standard of care, the event and inspection report are then referred to the Board's enforcement unit. Often times a report matter is referred to the Board's complaint unit as it appears there is a possible violation.

Dr. GnanaDev asked if he understands correctly that if a facility is licensed, rather than accredited, they do not have to send the Board an adverse event report.

Ms. Kirchmeyer stated that is correct, they are not required to send the Board an adverse event report.

Dr. Krauss stated that as a board member of the California Ambulatory Surgery Association (CASA), he noted that patient safety is the number one concern of their organization also. They are not just an advocacy organization looking out for the financial well-being of ambulatory surgery centers (ASC). He added that CASA has collaborated with the Board and the legislature in terms of trying to create legislation and regulations that would hold ASCs to the same standard that hospital outpatient settings are held and CASA has been pushing for similar reporting requirements that exist in hospitals. Dr. Krauss added that he knows Ms. Kirchmeyer's participation in this effort has been greatly appreciated. He added that he believes it is moving in the right direction, and that there have been terrible circumstances where patients have been harmed and have died during or following care in an OSS and it is the intent of both the Board and CASA to make outpatient surgery in California safe.

Ms. Kirchmeyer stated the reporting requirements are included in SB 798, the Board's sunset bill. She noted that she has found that in working with the Executive Director of CASA, Dr. Krauss is correct about them having the heart for patient protection and they are always willing to meet with the Board to improve the OSSs.

Dr. Bholat asked if there is a difference in reporting requirements for the ASCs and office-based surgery, or if reporting requirements are the same.

Ms. Kirchmeyer stated what makes the difference between those facilities is the level of anesthesia they use. Any facility that uses an amount to where a patient could lose their life reserving reflexes has to be accredited, licensed, or certified. Entities that do not involve physician ownership can be accredited or licensed.

Dr. Yip asked if there are any regulations for hospitals to report adverse action events when a patient has surgery at an OSS, but then gets transferred to a hospital.

Ms. Kirchmeyer stated there are limited requirements for reporting transfers. She stated if an entity has to transfer a patient to the hospital it has to be reported, however, this report does not help any, as it is an anonymous report to OSHPD. If there is the death of a patient, then it has to be reported to the Board. She noted that she believed in the SB 798 language, a transfer to a hospital would have to be reported as an adverse event, but currently there is no cross-reporting from the hospital, if that takes place.

Dr. GnanaDev noted that some of these patients do need to be transferred to the hospital, and he would rather see that happen than to have the OSSs be concerned that doing so would require them to file an adverse action report.

Dr. Krauss stated he personally feels that hospital transfers should be reported, but another concern he has is for those who have surgery at an OSS and then have to be admitted to the hospital shortly after, due to some complication from that surgery. He noted that he hopes there could, one day, be some type of mechanism that could track such a situation. He stated that the Board had lobbied in the past for coroners reporting to be sent to the Board when people passed away from opioid excess, and the Governor failed to sign it because of a concern of an unfunded mandate placed on the coroner. Similarly, he would also be interested in receiving coroners' reports for anyone who had passed away from an event that took place in an OSS. Dr. Krauss stated it is very important for the Board to have a complete data set in order to work to make the OSSs as safe a place as possible in California.

Dr. GnanaDev stated all of this information is needed, but they should not necessarily be called adverse event reports.

Dr. Yip stated perhaps CASA can assist with some data from the last five years. Maybe what types of surgeries and outcomes, and maybe see if they have information on if patients are receiving the option of having surgery done in an OSS or hospital.

Dr. Krauss recommended inviting Ms. LaBouyer from CASA to a future Board meeting to provide an overview of what currently occurs in ASCs in California.

Ms. Clavreul stated she had shoulder surgery at an OSS back in August 2016. She stated she went into full cardiac arrest during surgery. She noted that they put her in their ICU but had no qualified medical faculty, such as RNs. The physician did not come to check on her until seven hours later and now eight months later, she still has not heard from the surgeon that did not provide adequate care. She stated she had requested to have the surgery done at a hospital and they made her go to the OSS. She stated these types of stories need to stop. She stated she had also filed a complaint with the Board regarding this incident.

Ms. Webb requested that since Ms. Clavreaul had a pending matter before the Board, that she not discuss this complaint, but could provide general information.

Mr. Andrist stated that Ms. Webb has stated that no comments should be made in regard to an open complaint and he asked why that is.

Ms. Webb stated it is to avoid any conflict for the Board Members when the matter comes before them for decision. They are to make their decision on the information in the record, not anything obtained outside of the record.

Agenda Item 28 Agenda Items for the July 2017 Meeting in the San Francisco Area

Dr. Bholat requested some type of information be provided in regard to what is considered a dangerous drug and what are some of the most common problems with these drugs. She noted it would be helpful to Board Members who are not physicians and may not realize what would be considered a dangerous drug, beside opioids.

Agenda Item 29 Adjournment

The meeting was adjourned at 1:45 p.m.

Dr. GnanaDev, President — Date 7/28/17

Dr. Lewis, Secretary — Date 7/28/17

Kimberly Kirchmeyer, Executive Director — Date 7/28/17