# MEDICAL BOARD OF CALIFORNIA
## Executive Office

Education Committee Meeting
Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815

**July 29, 2010**

**MINUTES**

**Agenda Item 1 Call to Order**

The Education Committee of the Medical Board of California was called to order by Chair Barbara Yaroslavsky at 2:43 p.m. A quorum was present, and due notice had been mailed to all interested parties.

**Members of the Committee Present:**
Barbara Yaroslavsky, Chair
Hedy Chang
Sharon Levine, M.D.
Mary Lynn Moran, M.D.
Janet Salomonson, M.D.
Gerrie Schipske, R.N.P., J.D.

**Member of the Committee Absent:**
Jorge Carreon, M.D.

**Board Members, Staff and Guests Present:**
Fayne Boyd, Licensing Program
Yvonne Choong, California Medical Association
Candis Cohen, Public Information Officer
Zennie Coughlin, Kaiser Permanente
Eric Dang, Assembly Member Fiona Ma
Eric Esrailian, M.D., Board Member
Julie D'Angelo Fellmeth, Center for Law in the Public Interest
Gina Frisby, Assembly Member Fiona Ma
Stan Furmanski, M.D.
Gary Gitnick, M.D., Board Member
Kurt Heppler, Legal Counsel
Scott Johnson, Information Systems Branch
Therese Kelly, Licensing Program
Ross Locke, Business Services Office
Rachel McLean, California Department of Public Health
William Norcross, M.D., Physician Assessment and Clinical Education Program

Michelle Peterson, Center for Health Improvement
Carlos Ramirez, Senior Assistant Attorney General
Regina Rao, Business Services Office
Leticia Robinson, Licensing Operations
Anita Scuri, Supervising, Department of Consumer Affairs, Senior Counsel
Amara Sheikh, Member of the Public
Reham Sheikh, Member of the Public
Jennifer Simoes, Chief of Legislation
Chris Swanberg, California Prison Healthcare System
Kathryn Taylor, Licensing Program
Cheryl Thompson, Executive Office
Renee Threadgill, Chief of Enforcement
Linda Whitney, Executive Director

**Agenda Item 2 Public Comment on Items Not on the Agenda**

Chris Swanberg, California Prison Healthcare System, spoke in regard to the "Notice to Consumers" regulation recently promulgated by the Board. He said it was potentially inapplicable to the inmates of the state's 33 prisons, and to county jails, as well. He said the approximately 160,000 in our prison population have a Constitutionally guaranteed, built-in health care system, overseen by various federal entities, with a robust and active peer-review system. He said the required notice is of "absolutely no value" for this population because prisoners have neither access to phones nor the Internet. He said patients already threaten physicians that they will complain to the Medical Board, and he did not want to encourage that. He asked when this regulation is reviewed by the committee, that it consider his comments.

Stan Furmanski, M.D. commended the Education Committee for approving alternative clinical training programs other than the Physician Assessment and Clinical Education Program (PACE). He said PACE was under a cloud for "financial matters" in that he alleged it was overcharging for clinical training, and claimed there is no clinical training at PACE. He said the price of books PACE requires far exceeds their actual cost. He asked the committee to move forward to find an alternative to PACE.

**Agenda Item 3 Approval of the Minutes of the Committee's Meeting on July 23, 2009**

It was M/S/C to approve the minutes of the July 23, 2009 meeting.

**Agenda Item 4 Opening Remarks – Ms. Yaroslavsky**

Committee Chair Barbara Yaroslavsky thanked the audience and the committee's presenters for their patience, as the meeting's starting time had been delayed. She noted that the committee had one topic only to discuss, and that it had been generated by the Medical Board's review of AB 2600 (Assembly Member Ma), which would require the Board to consider including a mandatory continuing medical education course regarding the diagnosis and treatment of hepatitis, as appropriate. The Board did not take a position on the bill, but recognizing its importance to both physicians and the public, asked that the Education Committee consider other ways of educating both groups. She expressed the appreciation of the committee and the full Board to the four physician experts who were attending the meeting to offer their advice.

**Agenda Item 5 Presentations About the Education of Physicians Regarding Hepatitis**

Samuel So, M.D., director, Stanford Liver Cancer Program, introduced himself as a liver transplant surgeon from Stanford, serving on the Board of the Institute of Medicine for Public Health, and a coauthor of the recent IOM report on hepatitis B and liver cancer. He identified hepatitis B as one of the major public health problems

in this country. There are three to five times more people living in the U.S. with chronic hepatitis B or C than with HIV, and more people die every year in the U.S. of liver disease associated with hepatitis than of HIV. Two out of three people living in the U.S. with hepatitis B or C are not aware they have it, because their physicians have never tested them. The major risk factor for hepatitis C in the U.S. is a history of IV drug use, but the major risk factor for hepatitis B is foreign-born immigrants, according to the Centers for Disease Control. The CDC estimates that the majority of new cases of chronic hepatitis B in the U.S. is due to foreign-born immigrants. While it is very uncommon in white Americans, many California studies show one in 10 Asian Americans has chronic hepatitis B. Liver cancer is the second-leading cause of cancer death for Asian men living in the U.S., but is not even in the top 10 for white men in this country.

Hepatitis B is a silent killer, because most people who have it feel perfectly healthy until they develop advanced stages of liver disease or liver cancer. Two out of three are not aware they have the infection, and without appropriate, long-term management, one in four will die. The IOM found that the major issue underlying hepatitis prevention and control in the U.S. is lack of awareness by providers, who do not screen those at risk for hepatitis B or C, and providers do not know how to manage infected patients; lack of public awareness and policymakers' awareness, leading to lack of public resource allocation to provide access to testing and medical management and adequate disease-survey systems. IOM concluded that the current strategy for prevention and control of hepatitis in the U.S. is not working. IOM's recommendations include: federally funded health insurance programs and federal employees' health-benefits programs should incorporate guidelines for risk-factor screening for hepatitis B and C as a required core component of preventive care; and development of hepatitis B and C educational programs for health care and social service providers.

Providers' knowledge of chronic hepatitis B prevalence, screening, and management is very poor. A recent UCSF study showed that 30 percent of the primary care providers at UCSF do not know the correct screening test for hepatitis B. Other studies came to similar conclusions. Improving perinatal health care knowledge may help eliminate perinatal hepatitis B transmission and reduce the number of newborns who become chronically infected. Nurses' knowledge of hepatitis B is even worse than the providers', alarming because in one study only 16 percent knew that getting newborns a shot is crucial to make sure they are not infected within the first 12 hours. After education of all providers, there is significant improvement in knowledge. Providers and nurses welcomed the education and said they would use the knowledge to their patients' benefit. One-third of all Asian Americans living in the U.S. live in California. The time to act is now.

Dr. Levine asked where in Santa Clara County did Dr. So do the education of nurses, and he said in all nine birthing hospitals in the county, educating almost 500 nurses. Ms. Yaroslavsky asked how he got the word out to those not in the specific area, and he said via Stanford's Asian Liver Center's Web site: hepBmoms.org, where educational brochures in different languages can be ordered online at no cost. She also asked for clarification that within 12 hours of being born, infants should receive hepatitis immunization, and if that would keep them immune from the disease. Dr. So responded over 95 percent will be. Those who are foreign born and who have not been immunized should be tested first and, if not protected, should get the shot to immunize them from hepatitis B.

Gail Bolan, M.D., chief, STD Control Branch, California Department of Public Health (CDPH), and responsible for its adult virus hepatitis program. Viral hepatitis, a viral infection, is an important public health issue and a medical problem, caused by different kinds of viruses. CDPH has developed a strategic plan for adult viral hepatitis prevention in California, released in January 2010, that she wanted to highlight for the Board's input. She also mentioned Chlamydia, "another silent epidemic," as another condition people have and do not know that they are infected until they do not feel well and it is too late to do something about it. CDPH has a strong

public-private provider educational program about Chlamydia and wanted to share it as a model to improve provider education about viral hepatitis.
California law requires hepatitis vaccination for seventh-grade entry, which has significantly helped reduce hepatitis B. Very few new cases of hepatitis B are being seen in those under 20 years of age. The problem is that older adults are either living with the infection or acquiring it. The problem in California is primarily with Asian Americans and Pacific Islanders; at least 50 percent of them are infected with chronic hepatitis B. About 25 percent of adults with chronic hepatitis B will die of liver disease or liver cancer. Hepatitis C is another serious problem; one to four percent of adults infected with it also will die of liver disease or liver cancer. These are costly ailments, as well. However, there are cost-effective interventions that can delay the long-term consequences. Nonetheless, hepatitis has not been given serious governmental funding, so resources must be leveraged, and hence CDPH's creation of a strategic plan, mentioned above. Part of the plan involves educating the public, providers, and policy makers. Stakeholders need to work on more prevention and awareness strategies for educating the public about viral hepatitis; integrate viral hepatitis prevention content into medical and nursing school-based curriculum; non-clinical providers need to be trained if they are serving at-risk individuals. Physicians need to know how to properly ask questions about risk so they can determine who needs to be vaccinated. CDPH also wants to develop a referral guide, increase awareness, and make sure that national standards are being followed, using evidenced-based care recommendations. CDPH has a large hepatitis vaccination program and is trying to get vaccinations to adults at risk. Everyone understands resource constraints, so money alone is not the answer. CDPH is focusing on provider awareness, with a clinical task force on which a Medical Board member is welcomed to participate, and also working with medical associations and managed care organizations.

CDPH's Chlamydia Action Coalition, founded in 1999, was a public-private partnership that involved managed care, primary care providers, medical organizations, university-based researchers, etc. Physicians needed information, so CDPH developed an extensive Chlamydia quality improvement tool kit for practicing clinicians. CDPH also developed Web-based courses, CME, newsletter articles, etc., and a companion patient-education program. Screening increased considerably as a result, as Kaiser found after similar educational efforts. Providers tend to comply more if they know their actions are going on a report card. CDPH would like the opportunity to have an article on the subject of hepatitis published in the Medical Board's newsletter. A survey of physicians' knowledge also might be helpful to target educational gaps.

Eddie Cheung, M.D., director, Hepatology, VA Northern California Health Care System, has in his extensive experience as a clinician found a lack of basic provider knowledge about viral hepatitis and liver cancer, even though such information is available. This gap must be addressed. It is a serious problem with no easy solution. All physicians in California need to be better informed about basic screening and treatment of hepatitis. Between 1.25 and 2 million people in the U.S. are chronically infected with hepatitis; of those, maybe 900,000 are in the health care system, and only 180,000 are referred to or seen by a specialist. We have potentially effective treatments and vaccines, but too many physicians do not know what to do. Barriers to treatment also include income, language, religion, access to care, education, and misconceptions about Western medicine.

We should work with community networks to educate the public about what the disease is about, in a language they understand. Education of patients is key so they will demand screening and treatment. Cultural training is important. Work with professional associations should continue, as should lobbying for more funding.

Diana Sylvestre, M.D., executive director, O.A.S.I.S. Clinic, said she wanted to address the gaps in knowledge regarding hepatitis C, and also to persuade the Board to support AB 2600 (Ma). There is not as much data and education on hepatitis C as there is on hepatitis B, but one study of 217 family practitioners asked them who

they would test for hepatitis C, and the response was: transfusion before 1992 – 80 percent; incarcerated individuals – 65 percent; pregnant women – 35 percent. These results and others show major gaps in knowledge regarding hepatitis C. Her clinic has developed and provided educational materials to physicians, with success. Education about viral hepatitis is easy, but must be done right. Mandatory CME regarding this topic would work, and that conclusion is evidence-based. It is also cost-saving and would eliminate unnecessary referrals. We need to educate doctors to save money, and timely diagnosis is key. The lack of action is fueling the epidemic, and doctors have to take the lead. They must ask patients a few critical questions to diagnose and treat these major illnesses. Primary care doctors must be educated, particularly because so many patients with hepatitis do not have access to specialty care. The Medical Board should take the lead in this educational effort; it is good for patients, and will save the state a lot of money.

Glenn Backes for Eric Dang of the office of Assemblywoman Fiona Ma, and a public policy consultant for the California Hepatitis Alliance, expressed the gratitude of Assembly Member Ma for the committee's consideration of this issue. In addition to the expert testimony received, both Ms. Ma's office and the alliance have heard from patients who have had numerous contacts with physicians and experienced lost opportunities for diagnosis and treatment, resulting in poor outcomes for patients. He asked that the committee use its opportunity to improve the knowledge base of primary care providers in California.

**Agenda Item 6 Consideration of Committee's Next Steps**

Ms. Yaroslavsky commended the speakers on this topic and asked for a discussion from the committee. She noted an article can be placed in the Board's newsletter. She said this will be an ongoing dialog as to other actions that should be taken.

Dr. Levine agreed that provider education is critical but said that questions need to be answered about how to raise consumer awareness, as well. Curious patients prompt doctors to learn more. She advocated a broader approach to social marketing that uses all the modalities available today.

Ms. Chang said her younger brother is a carrier and must be tested every three to six months and have his liver checked. She has had friends die of liver problems, and asked that this issue be taken very seriously, as she knows it is real.

Ms. Yaroslavsky said many individuals and organizations do care, but the question is how to reach them. Specialty boards, hospitals that are part of groups (e.g., Kaiser, Sutter), the California Association of Community Clinics, and other groups could collaborate on a full-fledged campaign one day of the year. The Medical Board cannot do this, but she offered the Board's newsletter for an educational article for physicians. She added that most people today get their information not from conventional news programs, but from TV, radio, and movies. She asked that interested parties get together again to brainstorm ideas with others who are engaged in this issue.

Dr. Moran noted that the question was still unanswered regarding committee action on AB 2600. Ms. Yaroslavsky acknowledged she was aware of that but did not wish to move on the issue at this time.



**Agenda Item 7 Agenda Items for Future Discussion**

Ms. Yaroslavsky noted there will be a presentation on physician extenders at the next committee meeting. She

said she would work with staff on developing other ideas.

Dr. Moran said that issues may come from the next meeting of the Advisory Committee on Physician Responsibility in the Supervision of Affiliated Health Care Professionals that would be appropriate for the Education Committee's next meeting.

Ms. Chang suggested discussing best practices.

Stan Furmanski, M.D. asked that at either the next Board or committee meeting the possibility of the Board purchasing PACE's books at cost to save physicians money be discussed, as well as some pending programs to replace PACE.

**Agenda Item 8 Adjournment**
The meeting was adjourned at 4:10 p.m.