MEDICAL BOARD
OF CALIFORNIA
Protecting consumers by advancing high quality, safe medical care.

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Governor Edmund G. Brown Jr., State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

Four Points by Sheraton
8110 Aero Drive
San Diego, CA 92123
October 18 – 19, 2018

MEETING MINUTES

Thursday, October 18, 2018

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

Members Present:
Denise Pines, President
Michelle Anne Bholat, M.D., Secretary
Dev GnanaDev, M.D.
Randy W. Hawkins, M.D.
Howard R. Krauss, M.D.
Sharon Levine, M.D.
Ronald H. Lewis, M.D., Vice President
David Warmoth
Jamie Wright, J.D.
Felix C. Yip, M.D.

Members Absent:
Kristina D. Lawson, J.D.
Brenda Sutton-Wills, J.D.

Staff Present:
April Alameda, Chief of Licensing
Mary Kathryn Cruz Jones, Associate Governmental Program Analyst
Diane Curtis, Information Technology Technician
Kimberly Kirchmeyer, Executive Director
Nicole Kraemer, Staff Services Manager I
Christine Lally, Deputy Director
Elizabeth Rojas, Staff Services Analyst
Jennifer Simoes, Chief of Legislation
Sharlene Smith, Staff Service Manager II
Kevin Valone, Staff Services Analyst
Carlos Villatoro, Public Information Manager
Kerrie Webb, Staff Counsel

Members of the Audience:
Eric Andrist, Patient Safety League
Norlyn Asprec, Executive Director, Health Professions Education Foundation

Elizabeth Becker, Inner Solutions for Success
Mason Bettencourt, Center for Public Interest Law
Aaron Byzack, Health Professions Education Foundation
Claudia Breglia, Midwifery Advisory Council
Peter Canalia, Executive Director, American Board of Cosmetic Surgery
Gloria Castro, Senior Assistant Attorney General, Health Quality Enforcement Section, Attorney General's Office
Yvonne Choong, California Medical Association
Cheryl Clark
Julie D'Angelo Fellmeth, Center for Public Interest Law
Matt Davis, Supervising Deputy Attorney General, Health Quality Enforcement Section, Attorney General's Office
Kevin Duplechain, American Board of Cosmetic Surgery
Husam Elias, M.D., California Academy of Cosmetic Surgery
Neal Fleming, M.D., Medical Consultant
Whitney Florin, M.D., Inland Cosmetic Surgery
Doug Free, California Society of Plastic Surgeons Kanwar Gill, M.D.
Andrew Hanna, M.D.
Kenneth Harar, Investigator, Health Quality Investigation Unit, Department of Consumer Affairs
Jacob Haiavy, M.D., American Board of Cosmetic Surgery
Richard Hawkins, American Board of Medical Specialties
William Hendry, Health Professions Education Foundation
Patrick Hermes, Director of Government Affairs, American Society of Plastic Surgeons
Marian Hollingsworth
Debra Johnson, M.D., Director, American Board of Plastic Surgery
Wael Kouli, M.D.
Susan Lauren
Tim Madden, California Society of Plastic Surgeons
Paul Marchand, M.D.
Babak Moeinolmolki, M.D., Healthy Life Bariatrics
Laura Norton, M.D.
Maryan Rohan
Michael Schwartz, M.D., American Board of Cosmetic Surgery
Robert Singer, M.D., California Society of Plastic Surgeons
Maurice Sherman, M.D., American Board of Cosmetic Surgery
Yvonne Slater-Grigas
Alex Sobel, D.O., President, American Board of Cosmetic Surgery
Steven Teitelbaum, M.D., University of California Los Angeles
Juan Tran, M.D.
John Valencia, American Board of Cosmetic Surgery
Cesar Victoria, Videographer, Department of Consumer Affairs
Tatyana Wepplo
Josie Wilder
Michael Wong, M.D., President, California Society of Plastic Surgeons
Ryan Yates, Deputy Attorney General, Attorney General's Office

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

Ms. Pines called the meeting of the Medical Board of California (Board) to order on October 18, 2018, at 2:04 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

Ms. Becker thanked the Board for the opportunity to speak and provided background information about herself. She noted that she is the original developer of the professional boundaries program that used to be with the Physician Assessment and Clinical Education Program (PACE) and she used to be the director of behavioral programs with the University of California, San Diego PACE for several years. She added that her experience through PACE taught her the value of preventive measures and the opportunities to learn things that are not being taught in medical school. Ms. Becker vocalized her concern that physicians who are issued public letters of reprimand are not being given the opportunity to engage in any kind of professional growth or self-corrective measures. She requested that the Members of the Public Outreach, Education, and Wellness Committee consider issuing a public letter of reprimand along with a list of resources where physicians can get support. She pointed out that this would create a preventative model.

Ms. Hollingsworth, patient safety advocate with the Patient Safety League, shared her concerns that the Board is not adequately protecting local consumers. She provided examples of where she believed the Board sided with doctors over the safety of San Diego residents. She noted that what she provided were just a few examples of how the Board fails the local consumer. Ms. Hollingsworth questioned how the Medical Board can put patient safety first, when preference is given to doctors. She detailed her expectation that the Board follow its disciplinary guidelines when making decisions but added that this rarely happens. She concluded by remarking that the consumers deserve an agency that will truly put patients first.

Mr. Andrist remarked that it was his first meeting as representative of the Patient Safety League, a new, non-profit organization. He provided details about the company including website information and their goal to monitor the Board and track stories of consumers who have been mistreated by the Board. He added that these findings would then be shared with the Legislature and the media. Mr. Andrist explained the organization developed a doctor database and provided statistics about the amount of entries logged, a breakdown of wrongdoings and locations, and visitor trends on the website. He shared the short comings of BreEZe, since it does not let consumers know when a doctor is a registered sex offender, which should be readily available information. He provided the history of why the organization was formed and asked that the Board collaborate with his organization to keep the consumers of California safe from doctors who misbehave, harm, and kill.

Ms. Slater-Grigas commented that with the passage of Senate Bill (SB) 277 into law, it allows a licensed medical doctor to use their medical discretion to assess, diagnose, and write medical exemptions. She implored the Board to add discussion of how it will hold doctors and medical institutions accountable for not reporting adverse events to vaccinations as a future agenda item. She noted that the best way to fully comprehend the extent of injury and fully understand

the dynamics within a population at risk for injury is if the aftermarket surveillance system is used, however, this tool is not currently in use. Ms. Slater-Grigas pointed out the lack of knowledge in the community and requested a written response.

Ms. Lauren shared her personal story of being surgically assaulted and noted her concern for other citizens of California. She detailed that since she has reported her assault, other consumers have been harmed. She continued that there are many procedures that board certified plastic surgeons perform that harm healthy people. Ms. Lauren added that doctors and their boards mislead the public, perform innately bad procedures with carte blanche, and lie to cover up crimes. She listed the number of dangers and negative side effects associated with liposuction. She concluded by reminding the Board of their mission and asked that her case be reopened.

Dr. Gill echoed the concerns of the callers before him, but remarked that the leader in the aiding and abetting of unlicensed practice of medicine is the California Department of Public Health (CDPH) licensing clinics. He added that CDPH has not shown up for operational site or compliance visits to ensure that the clinics are in compliance with the law. He specified that there are unlicensed people making decisions in these clinics and in non-profit community clinics, and therefore the Board should collaborate to work on the complaints about unlicensed practice of medicine. Dr. Gill asked that the Board take a look into this matter.

Agenda Item 3 Approval of Minutes from the July 26-27, 2018 Quarterly Board Meeting

Dr. Lewis made a motion to approve the July 26-27, 2018 meeting minutes; s/Dr. Bholat. Motion carried (9-0-1, Levine).

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

Ms. Pines shared that she and Dr. Lewis had calls with executive staff to discuss the meeting agenda and other board projects. She added that in late September, she, Ms. Kirchmeyer, and Ms. Simoes met with Senator Hill and Assemblymember Low to discuss the vision and priorities of the Board. Additionally, Ms. Pines noted that she and Ms. Kirchmeyer presented at the Administrators in Medicine (AIM) fall workshop. She discussed engaging the public and stakeholders and provided attendees with strategies for involving the community. She also provided updates on the Board's new iOS license alert mobile application and the Controlled Substance Utilization Review and Evaluation (CURES) mandate that began on October 2, 2018.

Agenda Item 5 Board Member Communications with Interested Parties

Dr. Krauss shared that he spoke with Dr. Jacob Haiavy for a few minutes about the American Board of Cosmetic Surgery (ABCS).

Dr. GnanaDev noted that he has corresponded with individuals at the California Medical Association (CMA) and the Legislature, but the Board and Board business is not discussed.

Agenda Item 6 Presentation and Update on Health Professions Education Foundation

Ms. Asprec, the Executive Director of the Health Professionals Education Foundation (HPEF), provided an overview and history of the HPEF program. She provided information about the programs and scholarships that it offers and award statistics. She discussed some of the underserved areas that the program benefits and noted the upcoming application cycles. Ms. Asprec detailed the purpose, funding, award information, and eligibility requirements for the Steven M. Thompson Loan Repayment Program. She concluded by detailing where in California the Steven M. Thompson awardees are working.

Dr. Hawkins inquired about statistics regarding the retention of these physicians in shortage areas.

Ms. Asprec responded that this is something that is currently being developed. She added that HPEF is seeking to conduct a survey on retention this year.

Dr. GnanaDev remarked that the program Physicians for Healthy California is receiving a lot of money and recommended that HPEF work with them. He added that there is a need to make sure that appropriate people get the funding, specifically economically disadvantaged and socially economically disadvantaged applicants. He noted that these programs may entice people to come to California for school.

Dr. Lewis asked how HPEF determines the recipients of the awards.

Ms. Asprec shared that HPEF considers a variety of criteria such as career goals, dedication to service in underserved areas, number of years of practice in an underserved area, and geographic spread. She noted that HPEF seeks to award physicians in rural areas of the state that have not been awarded in the past.

Dr. Lewis inquired if current salary is a criterion.

Ms. Asprec answered that current salary is not a consideration, rather it is educational debt and designation of service.

Agenda Item 7 Discussion and Possible Action on the American Board of Cosmetic Surgery's Application for the Specialty Board Equivalency Recognition in California

Ms. Alameda explained that the American Board of Cosmetic Surgery (ABCS) had applied to the Board to request recognition as a specialty board, allowing their members to advertise as board certified pursuant to Business and Professions (B&P) Code section 651. She added that for approval as a specialty board, ABCS must demonstrate compliance with the laws and regulations and show that they are equivalent to member boards of the American Board of Medical Specialties (ABMS). She introduced Dr. Fleming, a professor of clinical anesthesiology at the University of California, Davis, in the department of anesthesiology and pain medicine. He is also the director of cardiovascular and thoracic anesthesiology and vice chair for

education. Additionally, Dr. Fleming is board certified, spent the majority of his career in academic practice of anesthesiology, and is knowledgeable in the area of fellowship levels overseen by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS).

Dr. Fleming began his report by acknowledging the materials that he received and reviewed in order to form his expert opinion. He stated that he received three volumes of materials pertaining to the application, reports regarding ABCS' former application for recognition, and a copy of the report filed by the American Board of Sleep Medicine that was provided for guidance related to format for his report. He shared that he also spent time on the website of the American Academy of Cosmetic Surgery (AACS), which oversees the training of the ABCS program and read the rebuttal comments submitted by ABCS.

Dr. Fleming began by providing some historical context, explaining that a similar request had been made previously. He shared that an underlying concern is applicants come from a variety of residency backgrounds and are disparate in their training. He provided the example of a background in dermatology and whether or not this provides appropriate or adequate preparation for the fellowship training in cosmetic surgery. He noted that as a result of those discussions and decisions a number of fundamental changes were made in the fellowship program that should be highlighted. Dr. Fleming pointed out one change, which was condensing a set of four separate sub certifications into one common certification. Secondly, there was an elimination of a background pathway of clinical experience as a means of entry into the certification program. Thirdly, dermatology was eliminated as a core residency training program for entrance into the certification program. Dr. Fleming pointed out that there was a query from the Board with respect to the grandfathering of individuals from a dermatology pathway. He found that it was only a small number of individuals that entered this way and that it was a trivial number that were still certified in the program with this background. He noted that there was no information provided for the clinical experience pathway, and therefore he could not speak to that.

Dr. Fleming pointed out that there are a number of components of the application that are straight forward and more administrative, such as percent of representation on governing boards, examination processes, and procedures. He stated that this was all reasonable and appropriate. Therefore, based on historical background and the primary concerns, the focus of his review was on the fellowship training programs themselves and whether or not they meet the criteria for equivalency. He pointed out that his report highlighted one inconsistency, specifically the packet still included the dermatology pathway for entrance into the certification process. However, this has been updated and a more current copy of the fellowship training guidelines has clarified that inconsistency. Dr. Fleming indicated that he was also unable to find any core content outlines for the educational materials of the fellowship training programs and subsequent to his comment, the American Board of Plastic Surgery pointed out that the core content outlines are available in a component of the fellowship handbook. He noted that he did not receive this packet, but that the information is available online. He commented that upon review, the version available provides a content outline to guide the didactic component of the training. Dr. Fleming identified that it is extensive and primarily procedure based. He pointed out that the content outline in the fellowship and handbook is in the range of 100 pages, which is extensive and would be difficult to be handled in a year. Comparatively, the content

outline for anesthesiology, which is a three-year training program, is forty pages. He opined that the content outline for anesthesiology is more condensed, distilled, and provides better guidance. Dr. Fleming made note of a residual concern, which is an outlier pathway for entrance into certification, specifically through ophthalmology followed by a two-year ophthalmologic plastic surgical fellowship, which provides entrance into the cosmetic surgery fellowship training program. He added that this pathway is felt to be a little bit different and consequently requires a two-year fellowship training in cosmetic surgery rather than the standard one year. He shared that it is of some concern that the didactic and educational component to compensate for that has no modification other than an increased duration and caseload requirement. He highlighted the opportunity for inconsistency in the training recognized that this may be akin to the dermatology background.

Dr. Fleming commented that with the training as a focus, he made note of a few things that are key to the assessment of the fellowship training guidelines. He explained that the guidelines are straightforward and consistent if not identical to many standard ACGME fellowship training guidelines. He noted that the key was to figure out if the fellowship training programs adhere to those guidelines. However, a problem was that there is no self-evaluation, feedback, or follow-up information on any of the fellowship training programs. He shared that in in an attempt to get a sense of the quality of the training, he spent a fair amount of time on the fellowship training website to determine whether or not these programs met the requirements as outlined. Dr. Fleming contended that this was not an ideal source of material and he understood the limitations. Similarly, he realized that that evaluation cannot be quantitative, rather it was intended to be qualitative, to get a sense of how these programs adhered to the training guidelines. For this reason, he highlighted the particular items that are listed in the report. Dr. Fleming pointed out that subsequent to the comments by ABCS, he found that distinction is provided as to which two fellowship training programs the American College of Cosmetic Surgery supervises. He noted that the numbers that he provided are not accurate in terms of total numbers of programs and should be about 25 programs. However, he indicated that the general comments made are still applicable.

Dr. Fleming continued to explain that program directors have the expectation to have academic appointments, be engaged in verifiable scholarly activities, and foster an environment that educates the fellows in the core competencies, while also maintaining a high quality didactic and clinical education. He noted that this core competency of medical education that evolves from the requirement was what posed a challenge to see if it was met. He continued that he could not determine if academic appointments exist or if they just were not highlighted or emphasized in the program presentations. Dr. Fleming added that the verifiable scholarly activity had a wide variation in terms of quantity and quality. He shared that in order to get an objective measure he used PubMed search to obtain known, indexed publications by each of the program directors. He noted that results varied from zero to over a hundred depending upon the individual, which shows no consistency. He concluded that the final item was to get a sense of whether the program director meets the expectation of fostering an environment that educates in the core competencies that are required and expected within an ACGME certified fellowship training. Dr. Fleming pointed out the importance of maintaining this environment for both a clinical experience pathway and to establish the didactic foundation that allows a graduate to continue to practice in a specialty. He added that the core didactic foundation

allows a graduate to evolve as the practice evolves. He reiterated that this is the part that is missing and could not be found.

Dr. Fleming elaborated that in the overall assessment summary, he reemphasized that his comments with respect to the dermatology pathway and the absence of a content outline have been clarified by ABCS, therefore his current summary in the packet is outdated. However, he opined that components of the content outline provided do not address the expectations of the fellowship, especially with respect to scholarly activity training in data analysis and quality improvement projects. He clarified that although it was not a component of the content outline, it is an expectation in the fellowship training program, which poses as a problem. Additionally, he shared that ophthalmology and ophthalmologic plastic surgery as an alternative pathway presents an opportunity for inconsistent background and training, which is concerning. He reiterated that the primary problem was his inability to obtain the data demonstrating that the fellowship training programs truly adhere to the spirit of the training guidelines as written, especially with an emphasis on the core competency in terms of medical knowledge. Dr. Fleming detailed that the focus really appears to be on clinical service and clinical exposure, which is too limited to make the fellowship program equivalent to ABMS.

Dr. Wong, President of the California Society of Plastic Surgeons and a professor and program director of Plastic Surgery at UC Davis School of Medicine, clarified what ABCS needs to do in order to be deemed equivalent. He specified that first ABCS needs to be deemed as equivalent to a related ABCS board and the most appropriate board would be the American Board of Plastic Surgery.

Dr. Wong continued that prerequisite training of ABCS diplomats is not sufficient nor equivalent to plastic surgery residency training. He added that because of the varied acceptance entrance pathways, there is variable exposure to relevant anatomy, knowledge of disease processes that affect anatomy, and surgical experience. Training in surgical anatomy and pathology is required for safe surgical practice. He noted that the general cosmetic surgery fellowship of the AACS purports to train in total body cosmetic surgery training from head to toe, however variable prerequisite training pathways result in variable training in surgical anatomy. He provided examples of these differences. Dr. Wong pointed out that the AACS program requirements look very similar to ACGME accredited programs, however as Dr. Fleming shared, it is hard to say if all the requirements are met in terms of program directors, institutional commitments, facilities and resources, educational programs, adherence and attention to core competencies, required scholarly activities, and salary and stipends. He explained that the ABCS fellowship training is insufficient and not equivalent to plastic surgery residency training and provided a list supporting his statement.

Dr. Wong directly compared AACS program directors to the plastic surgeon directors, noting all the differences and insufficiencies of the AACS program directors. He discussed academic affiliations, verifiable published scholarly activity, and selecting and supervising additional faculty. He moved onto training facilities and noted that the AACS training occurs in non-academic, stand alone, private practices, versus California residency programs that are academic and occur in large facilities with universities backing them. He moved on to explain how the resources and personnel are not equivalent. He compared and contrasted the number of personnel and resources available in each program. Dr. Wong discussed the educational

programs and noted that in the description of AACS fellowships, only 28% mentioned an educational program and only 16% discuss weekly didactics, which recognizes the isolation of their learners. He pointed out that the AACS programs do not spend a concentrated amount of time on core competencies, compared to his program that has both core competencies and milestone evaluations, which are all designed around the six core competencies. Dr. Wong discussed the required scholarly activities, sharing that AACS only mentioned it in 28.1% of the descriptions of fellowships, with only 18.8% discussing an expectation for academic output and the support to an annual meeting, and 15.6% only mentioned that they require some manual to be published. He suggested that this poses a doubt as to if they are adhering to this requirement of scholarly activity and explained what is done in his program to meet this requirement. He concluded with salary and touched on the topics of moonlighting and adherence to the 80 hour work restrictions, which are put in place to give learners ample time to study, rest, and for recreation. He demonstrated the differences between the ACGME resident's salaries and highlighted the strict adherence to no moonlighting and the 80 hour work week.

Dr. Johnson, a private practice plastic surgeon, former president of the California Society of Plastic Surgeons, past president of the American Society of Plastic Surgeons, and current Director of the American Board of Plastic Surgery began by discussing professionalism. She shared that this is a key part of their trainee's core curriculum, and is evaluated in their candidates for certification, and in their diplomats as they participate in the continuing certification program. She noted that they obtain from each candidate and diplomats, their marketing materials and billing codes to ensure that everything follows the standard of practice.

Dr. Johnson reiterated what Dr. Wong presented, highlighting the concerns that a one-year fellowship does not adequately prepare a surgeon to work outside the scope of his or her primary training to be a safe cosmetic surgeon. She shared that they did some secret shopping and emailed a California ABCS fellowship director's office regarding an interest in breast augmentation, wondering whether the doctor or his fellow would perform the surgery. She provided the reply from the office, which states that the fellow watches the surgery while the doctor does all the work. She added that the fellow is present only every other week, of which they are only present three of those work days. Dr. Johnson concluded that this would mean the fellow watches surgery three days a week for 26 weeks of the year, which means they spend 78 days learning how to perform whole body cosmetic surgery. She reminded the Board that a determination needs to be made as to whether or not ABCS can advertise themselves as board certified, however their perusal of each of the California members of ABCS showed that 26 of them already claimed to be board certified. She noted that the national website for ABCS touts its board-certified cosmetic surgeons, provided examples from the websites, and pointed out that this is a violation of California law. She shared that she has in her possession 26 complaints, which she will be filing with the Board and the Osteopathic Medical Board regarding these board certification claims.

Dr. Johnson concluded by discussing the ABCS requirements for membership. She shared that many of the 81 California members cannot meet current standards. She noted that several of them have no prerequisite surgical training, have never been board certified at all, and/or have joined under the experience route that was available until 2014. She added that others never completed a fellowship. Dr. Johnson stated that if the Board decides to approve this

request for equivalency, these non-qualifying members would be able to ride on the coattails of the ABCS and claim board certification. She asked that the Board understand that board certification is a high mark of achievement for physicians and the ABPS certified surgeons have worked hard to achieve their certification and continue to work hard to maintain that certification. Dr. Johnson explained that board certification informs the public that a physician has been trained, tested, and evaluated, and that certification provides an assurance of the knowledge and safe practice to the public. She expressed that certification matters and she hopes that the Board does not allow it to be diminished by this application.

Mr. Valencia, Legal Counsel for the ABCS, AACS, and the California Academy of Cosmetic Surgery, explained that they are there for specialty recognition of the cosmetic surgery specialty for advertising in California in order to use the phrase board certified pursuant to state law. He pointed out ABCS's application provided voluminous additional materials submitted for the record since the December 2015 application and he detailed that the following presentation will demonstrate that ABCS exceeds the criteria required in California law. He provided information about key national developments in the field of state regulation of health professional advertising and cited samples of cases. Mr. Valencia pointed out that ABCS will rebut the deficiencies in the reviewer's presentation and in the opinions reached by the Board.

Mr. Canalia, Executive Director of ABCS, provided an overview of ABCS history and its mission. He noted that the mission of ABCS is to serve the public by promoting the safe and ethical practices of cosmetic surgery. He added that it is important to note that ABCS is the only board dedicated exclusively to certifying physicians in cosmetic surgery. He provided a definition of physician board certification. Mr. Canalia explained ABCS will illustrate that ABCS is a valid and credible certifying board.

Dr. Sobel, President of ABCS, specifically addressed the deficiencies submitted by Dr. Fleming and noted that there were multiple inaccuracies. He questioned if the reviewer went beyond the online summaries of the AACS fellowship and explained that there are hyperlinks on the AACS website that directly link to the fellowship training guidelines and the clinical program training requirements. He continued to inquire if the reviewer conducted any site visits of the fellowship program, or speak with the fellowship director, or a fellow in training. He responded that the reviewer did not, and if he had, he would have been more informed about not only the environments of care but it would have cleared the concerns surrounding academic environments. Dr. Sobel commented that this too would have cleared up doubts about educational training and surgical experience. His third point was that the reviewer did not request the AACS fellowship curriculum, which was not accessible online, however it was made available to him. He highlighted corrections that Dr. Fleming pointed out, including the dermatology item; specifically that dermatologists have not been certified by any ABCS pathway since 2004.

Dr. Sobel outlined the impact of AACS fellowships. He pointed out that they provide quality clinical training in accredited facilities to ensure patient safety and care. He commented that the number of cases performed in AACS fellowships are reflective of concentrated training that exceeds ACGME requirements within aesthetic plastic surgery residency. He added that ABCS has submitted studies to the Board that demonstrate that an increased surgical case volume correlates with better patient outcomes. Dr. Sobel provided statistics about the current ACGME

requirements in aesthetic plastic surgery training as well as the median number of procedures performed in cosmetic surgery fellowships. He demonstrated that there is incredible disparity between the minimum requirements in ACGME programs versus what ABCS median numbers performed in the actual fellowships. He highlighted the significance of density, breadth, and depth of his program. He concluded that this affects the performance level of a post graduate trainee in their program versus another.

Mr. Canalia went over the requirements of the program and demonstrated how ABCS met those requirements. He began by sharing the structure of ABCS, discussing its non-profit status, the structure of term limits, and revenue apportionment. He provided proof of ABCS's certificate for general cosmetic surgery.

Dr. Haiavy spoke about the substantive requirements. He explained that ABCS has been in existence for nearly 40 years and the reason for existence is to make sure that people that are practicing in this arena are practicing to higher standards for patient safety. He explained that the American Medical Association (AMA) recognizes cosmetic surgery as a subspecialty and that ABCS has two delegates to the House of Delegates at the AMA. He added that ABCS serves on multiple committees in the AMA and the ABCS qualifies and examines candidates across the breadth of cosmetic surgery.

Dr. Haiavy moved onto the second criteria, the specialty board shall not restrict itself to a single modality. He explained that the many different backgrounds have contributed to this field. He added that cosmetic surgery does not belong to one specialty and provided a short list of different procedures that cosmetic surgeons perform. He moved onto requirement three, where he explained that ABCS only certifies physicians. He also pointed out that ABCS only certified those that have completed a primary surgical residency and that already have primary board certification. Dr. Haiavy discussed criteria five, which entails the requirements and policies for certification. He detailed that ABCS certification is psychometrically evaluated and requires the completion of a primary ACGME residency in an approved specialty. He added that in addition to completing that residency, all applicants must have a primary board certification. He provided examples. Dr. Haiavy explained that all applicants must complete an accredited AACS fellowship and provided insight into what this includes. He noted that evidence of privileges in a hospital or an accredited outpatient facility must be provided as well as maintaining an advanced cardiac life support (ACLS) certification. He then explained how ABCS promotes public interest and he provided a few examples such as appointments to State Boards, the Federation of State Medical Board (FSMB), and expert reviewers. Dr. Haiavy discussed the determination of article preparation by their applicants and the process of ABCS. He confirmed that ABCS requires that their fellows perform a minimum of 300 procedures.

Dr. Haiavy transitioned to requirement six, the standard for determining who possesses the knowledge and skills essential to provide competent care as designated in the specialty. He shared that all ABCS board-certified physicians must recertify every 10 years and they must maintain operating privileges in good standing at a hospital or an accredited facility. He continued to note that all board certified physicians must maintain a current ACLS certification, and have no reprimands from any professional organization, federally funded program, or medical staff memberships. He added ABCS utilizes the FSMB physician disciplinary reporting

services, which monitors any practice violation or accusations against their diplomats and that they then open an investigation and take action.

Dr. Haiavy discussed requirement eight, post residency training. He shared that ACGME residency training in cosmetic surgery does not exist. He detailed that ACGME residences are federally funded and are paid by taxpayer dollars. He then expressed his doubts that a federally funded residency in cosmetics will ever exist. He called for greater oversight and regulations so that everyone may collectively ensure the safety of the patients. He identified that the six core competencies are provided in primary residency. He pointed out that there are additional identifiable trainings in cosmetic surgery that Dr. Fleming could not find online, but do exist. Dr. Haiavy pivoted to criteria nine and explained that the AACS fellowship training guidelines for certification in cosmetic surgery are consistent with other specialty residency and fellowship training guidelines. He shared that they are online and available. He clarified that there are 27 general cosmetic surgery programs, not 32. He explained that after completing a fellowship, they must pass the exam that is psychometrically evaluated, which is very tedious. He concluded with criteria 12, which pertains to maintaining and elevating standards of graduate medical education and assisting accrediting agencies. Dr. Haiavy shared that this requirement is met in multiple ways and provided an example.

Dr. GnanaDev spoke to ABCS and detailed that from the 1970s on there were no boards that were created by multiple specialties. He provided examples of pediatric surgery, vascular surgery, and colorectal surgery, which are all brand new boards created with ABMS approval and ACGME certification. He inquired why they too did not take this pathway.

Dr. Haiavy clarified the question and answered that during the presentation he mentioned that cosmetic surgery is an elective surgery. He added that ACGME programs are funded by Medicare and taxpayer dollars. He continued that there are no ACGME programs in cosmetic surgery and he does not believe that there will be. He agreed that there is another process, however this model does not fit their program. Dr. Haiavy reminded the Board of approvals that they had made for other boards to retain this equivalency.

Dr. Krauss shared that the decision-making process for many on the Board is a continual learning process. He added that much information has been digested. He inquired what other states have done on this issue. He also mentioned that this matter came before the Board before any of the current Members were on the Board and noted its denial. He asked if the facts and the circumstances of that denial are different today.

Mr. Canalia confirmed that ABCS is a different organization than it was the last time that they applied for equivalency. He shared that after the results of the last petition they hired outside counsel and specialists, who worked with them in order to meet and they have exceeded all the requirements of the Board. He elaborated that it was an extensive period of time, but they now believe that they meet and exceed all those requirements.

Mr. Canalia added that there are three states in which they have applied for recognition. He listed that one was Oklahoma, where they were recognized as equivalent to an ABMS board. The second was Texas, where they were also recognized as equivalent. He added Florida,

where a person can advertise as board certified, but there must be a disclaimer that they are not an ABMS board.

Dr. Levine confirmed that there are 27 fellowships. She then inquired about the range of the size of the fellowships among the 27, in terms of faculty and also number of fellows in each program. She also asked what the AACS does in terms of site visits to review prior to approving a fellowship program.

Dr. Sobel answered that the Fellowship Review Committee requires site visits as well as affirmative evidence that the fellowship program has met each and every element of the fellowship training program requirements. He added that some have been alluded to erroneously in the prior presentation, but they include the availability of a substantial library as well as online journal access. He noted that the fellowship training programs need to demonstrate that if they are housed in one single facility that the fellows have access to accredited associate faculty for a variety of exposure. Dr. Sobel continued that ongoing process of recertification for the fellowship training programs in terms of major survey is now set every three years. He explained that an annual affirmation from the programs that they are in compliance with the clinical training is required.

Dr. Levine inquired about the size and number of fellows.

Dr. Sobel responded that the size or the number of fellows range from one to two depending on the availability of the training faculty. He noted that in his case, he trains two.

Dr. Lewis inquired how many ABMS certified physicians are with ABCS.

Dr. Sobel clarified that he could answer the question on a much broader level. He asked that the Board understand that the academic organization, AACS has several member plastic surgeons. He added that many serve as faculty among the training programs.

Dr. Haiavy commented that there was a list provided in the presentation under academic representation that shows all faculty.

Dr. Yip asked what percent of the applicants failed the fellowship application or certification.

Mr. Canalia answered that the percentage of passing varies, however it is normally in the high 70s to low 80s. He noted that they have been as high as upper 80s. He specified that results of the examination are a result of the validation layer and the psychometric consultant to establish an appropriate and accurate score for the exam.

Dr. Yip inquired how long it took Dr. Fleming to review the documents and create the report.

Dr. Fleming answered that he has been working on the report over the course of the last two months and that he has spent between 40 to 80 hours on this project.

Dr. Yip explained why he inquired about the amount of time that Dr. Fleming had spent on the report. He suggested that the Board create a task force to make a decision.

Dr. Krauss shared that to his knowledge the Board has granted board equivalency to four non-ACGME boards. He inquired if there was criteria for granting that status or were those approvals done in a similar fashion.

Ms. Webb commented that the criteria the Board has to go through is in the regulations as set forth in California Code of Regulations (CCR), Title 16, section 1363.5. She explained that there are several requirements that have to be met and the one that is of issue today is subdivision (b)(8), regarding the training requirements. She reiterated some of the more basic requirements and shared that the training requirements need expert review and that is why Dr. Fleming reviewed the application.

Dr. Krauss commented that his understanding is that there is still a difference of opinion as to whether or not the training requirements are equivalent. He inquired if there was any other matter standing between the ABCS and the Board determining that there is Board equivalency, or is it just the training at this point.

Ms. Webb confirmed that it is the training.

Dr. Levine asked if there are there any board certified plastic surgeons that subsequently apply for a fellowship in cosmetic surgery.

Dr. Haiavy responded yes, that they have had several board certified plastic surgeons that have applied to the fellowship and completed it successfully. These individuals are dually board certified.

Dr. Levine asked for the total number of fellows that ABCS have successfully trained.

Dr. Haiavy remarked that although he does not know the exact number, approximately 80% of their members are fellowship trained.

Dr. Levine asked for the total.

Mr. Canalia added that there is a total of 375 members.

Dr. Johnson explained that there are two members of the ABCS listing in California who are certified by the ABPS. She noted that one, Dr. Ordon, said that he has no knowledge that he is still a member, since he has not paid dues for several years. She noted that he is still listed on their website. Dr. Johnson added the second is Dr. Kivett, who is no longer practicing plastic surgery. She announced that he is working as a medical director for a medical spa. She explained that there are some plastic surgeons that have been involved with ABCS. She detailed that ABCS talked about the fact that their members have no more disciplinary actions than plastic surgeons, but that is not true based upon their perusal of the Board's website. Dr. Johnson added that it showed that 24% of ABCS members have had disciplinary actions, compared to less than 4% of CSPS members who have had disciplinary actions.

Dr. Haiavy remarked that Dr. Ordon was a featured speaker at the AACS three years ago and suggested that Dr. Ordon knows that he is certified by ABCS, since he mentioned it during his speech at the academy. He elaborated that with regard to the reprimands, he would like to show the Board that the reprimands are the same.

Dr. GnanaDev reminded the Board Members that this would be the last equivalency case to be heard before the Board due to the change in legislation.

Dr. Bholat asked why this is needed for the California health consumer, given ABCS's small numbers.

Dr. Haiavy explained that it is to allow for honest communication and for patient safety. He noted that cosmetic surgery has exploded in the last 20 to 30 years. He continued that it has become a vast field that is practiced by many specialties. He detailed that many people are not trained, will take a weekend course, and then perform a surgical procedure and ABCS would like to distinguish themselves. Specifically, they would like to be able to communicate to their patients that they have gone through specific training in this field, passed an examination, and are certified by a board that is reputable.

Dr. Levine asked Ms. Webb if there is a difference under the law in saying certified by ABCS versus board certified in cosmetic surgery. She wondered if those two things are the same. She asked if those individuals who have completed the fellowship training advertise that they certified by the ABCS.

Ms. Webb responded that pursuant to B&P Code 651(h), the restriction is that they cannot claim to be board certified or certified by a board unless the board is an ABMS board or has been deemed equivalent by the Board.

Ms. Pines asked Dr. Fleming if based on what he heard thus far, if there was anything that he would like to add.

Dr. Fleming shared that despite the fellowship program training guidelines, which are solid, he could not find any clear and convincing evidence that they are truly followed. He noted that he does not have the assurance that what is said to be done is actually being done.

Dr. Haiavy invited Dr. Fleming to visit their fellowship to obtain a better perspective. He included that it is difficult to make that decision reviewing a website.

Dr. Fleming remarked that this was not a test of his internet searching skills, rather he was left with an application packet that was missing this information. For this reason, he was looking for some reassurances.

Dr. Haiavy asked Dr. Fleming if he had been involved in ACGME residency evaluations and fellowship trainings. He asked when Dr. Fleming evaluates those programs if he goes to visit those programs, or if he just reviews paperwork.

Dr. Fleming responded that the ACGME review process had changed. He explained that now it is much more dependent upon internal reviews and self-evaluations. He added that there is a large volume of internal reviews and assessments, which are now presented for review. He stated that this has caused the on-site visits to plummet and are now relatively infrequent. Dr. Fleming concluded, that this was the equivalent data that he could not find for these programs.

Dr. Yip inquired what would happen if the Board did not make a decision prior to December 31, 2018 and the next Board meeting is in January.

Ms. Kirchmeyer explained that the law is repealed after January 1, 2019, and the Board would no longer be able to deem equivalency.

Dr. Levine asked what the recourse would be for ABCS prior to December 31, 2018.

Ms. Kirchmeyer remarked that it would depend on how the Board votes.

Dr. Levine questioned what it would look like if the Board did not come to a decision.

Ms. Kirchmeyer explained that this would mean that in California, physicians would not be able to state they are ABCS board certified in advertising. She added that if a decision is not made the application would not be approved or denied.

Dr. Levine asked if the application were to be granted by the Board, how ABCS would deal with the fellows who achieved fellowship certification status through pathways that are no longer available.

Dr. Sobel answered that no board removes their diplomats of certificates. He added that there is prior evidence of this through other boards and organizations, however in the prior presentation the slide was very misleading with confusing information related to those who are eligible to take AACS fellowships versus those who become board certified by ABCS either now or historically.

Dr. Haiavy explained the particular slide was confusing the AACS with the ABCS. He explained that the people that were examined by the ABCS and have gotten the certificate through the experience route will retain their certificate, since at the time that they took the exam, that was the criteria and they met the criteria.

Dr. Krauss expressed that he was puzzled, since the well-respected academic authority who has been retained to analyze the situation found no evidence for training equivalency and would not support the Board approving board equivalency. He added that there was also a comment by a well-respected Board Member suggesting that the legislature has removed the Board's equivalency. For this reason, he morally feels obliged to abstain from voting on this issue, since he does not have confidence that the Board is the right authority to grant this privilege.

Dr. Yip echoed Dr. Krauss' comments.

Dr. Bholat agreed with Dr. Yip and Dr. Krauss.

Dr. Lewis reiterated the comments of his colleagues and expressed that he felt that he did not have enough information to make a decision.

Mr. Valencia noted that the ABCS has contributed as much as what was asked of them. He continued that this process is anomalous to California and other states do nothing unless they have a comparable statute and statute is driven by interests that want to restrain physician advertising. Mr. Valencia commented that he believes the only term that cannot be used is board certified.

Ms. Webb explained that the Board was also required to do regulations, which are applicable, as well.

Mr. Valencia responded that it is a matter of history. He added that ABCS would welcome a motion, because it is inconsistent for the members of Board not to make a determination as it did in the 1990s and in the early 2000s. He continued that the Board back then grappled with the issue, heard the evidence, and it made a determination on equivalency and the expertise is comparable to what is on the current Board. Mr. Valencia commented that ironically the last application was criticized for supporting multiple certification pathways with one qualification pathway, which has been distilled so that one eligibility pathway supports one criteria. He noted that now the reviewer contends contradictorily that it may support too broad an engagement in the practice of medicine. He urged the Board to compel additional information and meet by whatever means and vote by whatever means it has at its disposal prior to January 1, 2019.

Ms. Kirchmeyer laid out the options for the Board Members. She noted that they have the evidence there in front of them, including the medical consultant's review, and she highlighted that his opinion had not changed from the written report. She mentioned that they have heard evidence from ABCS, and the opposition. She then remarked that they can either make a motion to approve the application of ABCS, make a motion to deny the application of ABCS, or move to request additional information, which would require an interim board meeting before December 31, 2018. She concluded that if additional information is requested, the Board needs to be specific about what additional information is needed in order to make a determination.

Dr. Yip asked his fellow Board Members what they thought would be necessary in order to make the decision. He commented that if that is communicated, he would then make a motion for a task force and an interim Board meeting.

Dr. Krauss expressed that he did not think that it would be fruitful to spend more time or effort.

Dr. GnanaDev remarked that he did not think that additional information was necessary. He added that they have heard all the information and should make a decision today.

Dr. Lewis made a motion to deny the application for equivalency by ABCS; s/Mr. Warmoth.

Dr. Sherman, a cosmetic surgeon and facial plastic surgeon, who has been in practice for 35 plus years remarked that he has the unique capability of being able to contrast the competency

of plastic surgeons versus cosmetic surgeons. He noted that his job is a medical director for the past ten years at a large plastic surgery company where they have three clinics in California. He remarked that it was his personal opinion in taking care of patients and having to correct problems associated with surgical results, that there have been more problems with board certified plastic surgeons. He clarified that this did not only refer to surgeons fresh out of their residency and fellowship programs, but to plastic surgeons who have been in practice for 20 to 30 years. Dr. Sherman identified that these are people who have come in and worked at his clinics. He added competency is not bestowed upon board certification, rather competency is something that is learned primarily through experience and exposure. He concluded noting how much more experience cosmetic surgeons who have gone through the fellowship program have in relationship to plastic surgeons. He remarked that this has been also documented in the plastic surgery literature.

Dr. Schwartz, a practicing cosmetic surgeon in Pasadena, shared that he is certified by the American Board of Otolaryngology. He noted that he has been serving as an expert reviewer for the Board for over three years, primarily on cosmetic surgery related cases. He shared that although he is able to review cases for the Board, which are cosmetic surgery cases, and he is able to testify in court as a representative of the Board pertaining to cosmetic surgery cases, he is not able to inform his patients or the public that he is a board certified cosmetic surgeon. Dr. Schwartz requested that the Board approve the application and not pass the motion made by Dr. Lewis. He added that he believes that it has been demonstrated that the standards were met and exceeded.

Dr. Moeinolmolki, a general surgeon who later trained in bariatric surgery, explained that after practicing for ten years in bariatric surgery and minimally invasive surgery he found that many of his patients needed body contouring afterward. He shared that many of these patients had a difficult time finding the correct plastic surgeon that could do their cases at an affordable price. Since he felt that this is something that would be unique to his practice, he did an additional year of fellowship in AACS. Dr. Moeinolmolki explained that when he first went to their meeting as a general surgeon he was very biased, but when he saw their fellowship training he realized that it is truly organized, they teach well, and they mentor well. He explained the value of this, since in many residency programs this is what is currently lacking. He commented that the example of a fellow watching the surgery is probably not uncommon when you look at a lot of fellowship trainings. Dr. Moeinolmolki remarked that in his experience all the trainings that he has seen in cosmetic surgery have been hands-on and very rigorous. He concluded by stating that as a person who has gone through the system, he can testify to the legitimacy of the board, the training, and the mentorship.

Dr. Norton, a board certified general surgeon, fellow of the American College of Surgeons, and a fellowship trained breast surgeon, explained that she has worked alongside gifted and extremely talented plastic surgeons her entire career, performing mastectomy and reconstruction operations. She noted that many women with breast cancer do not need and do not want a mastectomy and she detailed that oncoplastic breast surgery is a new and exciting field in the United States. Dr. Norton commented that at its most basic level, oncoplastic breast surgery challenges breast surgeons to perform more cosmetically pleasing lumpectomies without sacrificing oncological safety. She added that oncoplastics is limited to breast fellowships and courses.

Dr. Norton detailed that over the years she has expanded the techniques that she learned in her breast fellowship by taking every oncoplastic course available in the United States. She noted that despite this, she felt that there were many patients that she could not meet their needs. For this reason, she decided to do a fellowship. She evaluated both plastic and cosmetic surgery fellowships and when she compared the fellowship she realized the exposure to the cosmetic breast procedures was greater in the cosmetic fellowships. She shared that she started her cosmetic surgery fellowship three months ago and listed the benefits of the program. She explained that she is disappointed to learn that her efforts to go above and beyond in her training will not be recognized by the Board and she urged the Board to keep an open mind in recognizing the unique subspecialty of cosmetic surgery.

Dr. Florin, an oral and maxillofacial surgeon who completed a fellowship through the ABCS, echoed some of the things that Dr. Norton brought up, noting that cosmetic surgery is a unique field and that the fellowships through ABCS do perfectly train the students in that field. She expressed her thoughts about it being unfair to compare the plastic surgery residency, which is a residency training in an academic setting that is in a hospital to a post residency fellowship in cosmetic surgery. She believes that today has been more of a plastic surgery versus cosmetic surgery conversation. Dr. Florin clarified that they are not trying to advertise as being the same as plastic surgeons. Cosmetic surgery is very different than plastic surgery. She hoped that the Board can look at the clear evidence that has been given to the Board, which shows that the ABCS fellowships meet the criteria. She added she hopes the Board is not clouded by Dr. Fleming's ambivalence over what he researched and expressed her surprise in that he did not look at this evidence. She added that she believes that things would be very different if he did spend time going to fellowships to see what the setting was and to see whether that curriculum really was met, which of course it is.

Ms. Wilder, a consumer, shared that she recently had a breast lift and implants done by a board certified plastic surgeon in Beverly Hills. She noted that her outcome was terrible and below the standard of care. She provided more details about her experience with her doctor. She noted that as a consumer, she has been conditioned to finding a doctor simply by looking for the term board certified. After this experience, Ms. Wilder sought a cosmetic surgeon and compared this experience with the plastic surgeon, explaining the latter experience being far more positive. She noted that through this experience she understood the different degrees of experience that certain titles hold and questioned how a consumer like her or any other patient differentiate between board certified cosmetic surgeons and non-certified surgeons if the doctor is not allowed to say it. Ms. Wilder asked how patients are supposed to choose safely and expressed that she feels that the representation of these certifications are not consumer friendly and that consumers deserve to know exactly whose hands they are placing their bodies and health.

Ms. Wepplo, a patient, explained that 11 years ago she went to a board certified plastic surgeon to have several procedures done. She added that at this time she did not know the difference between a plastic surgeon and a cosmetic surgeon, but had she known, she would have preferred to use a board certified cosmetic surgeon. She described a past experience that she had with a plastic surgeon, specifically contracting a bacteria. She noted that this is a main difference in a plastic surgeon versus a cosmetic surgeon, a plastic surgeon works in a hospital.

As a result of the bacteria that she contracted and the plastic surgeons' error, she spent countless days in the hospital with intravenous antibiotics, went through a total of three surgeries, and spent over $50,000 out-of-pocket.

Dr. Kouli, a board certified general surgeon and fellow of the American College of Surgeons, shared that he is fellowship trained in bariatric surgery and has been practicing for 15 years and recently got trained by ABCS. He noted that he has one of the busiest bariatric practices in San Diego. He detailed that unfortunately a lot of the plastic surgeons refuse to take care of weight loss patients. He expressed that he felt the expert opinion was biased. Dr. Kouli commented that he went to one of the highest programs in training in general surgery and bariatric surgery and there is no difference in these programs with that of ABCS.

Mr. Hermes, Director of Government Affairs for the ASPS, touched on one component that had not been discussed, which is the program oversight aspect. He reminded the Board that Dr. Fleming talked about how there is no verifiable data and outcomes on program requirement adherence in the AACS fellowship programs. He added that if the Board looks at the structure that the AACS has to review its programs, the concerns associated with that program requirement adherents grow even more. Mr. Hermes pointed out that the fellowship review committee that reviews the actual fellowship programs is dominated by current program directors. He listed that based on his research, nine of the ten members of the committee are current program directors, which creates the incentive to be more lackadaisical than would be ideal in in verifying that these things are happening.

Mr. Hermes continued that with regard to previous comment that the Board is not qualified to make these evaluations, he would opine that the Board is fully qualified to make these decisions, it may just be that the Board is not resourced to do it. He noted that with these non-independently accredited programs each one needs to be examined to determine how they are operating, looking into oversight structure in place, and seeing if this is adequate enough to ensure that program requirements are being followed. He clarified that the structure that ACGME uses in working with institutions is vigorous. He commented that after these reviews there is really certainty that these program requirements are being met or not. He concluded noting that there is variability in the quality of individuals and ACGME programs, but the main question is consistency and if the diplomat that they are producing is sufficient to protect public safety.

Mr. Madden, representing the CSPS, reminded the Board that the decision at hand relates to physicians advertising the use of the term board certified. He noted that there have been some comments from some individuals saying that if they are not allowed to advertise as board certified they will go out of business, but there is nothing stopping them from talking about the very training that they are discussing right here. He continued that this is done on their websites and they still are in business. He reiterated that he wanted to remind the Board that the decision is fairly narrow and limited to advertising the use of the term board certified

Ms. Lauren explained that she was a licensed deep tissue massage therapist and movement teacher for 25 years. She added that she formed a group called Lipo Coalition to educate about the dangers and long-term harm of liposuction. She commented that she is against this proposal and the reason being that the public is already at risk because of board certified

plastic surgeons who are doing procedures that make people sick or dead. She provided more details about what plastic surgeons do that is not in the interest of the public. Ms. Lauren detailed parts of her life that have been affected by a plastic surgeon and she confirmed that she is not alone. She continued on to discuss the harms of liposuction and quoted the Clinical Anesthesiology Journal and the Advisory Technology Committee to support her comments. She proposed that liposuction and body sculpting ads be banned.

Mr. Free, a healthcare attorney on behalf of the CSPS, shared that he has been involved with this issue for many years. He opined that Dr. Fleming reached the right conclusions in finding that the training is not equivalent. He expressed his belief that the average consumer accords great weight to the terms board certified and that if physicians who do not have the requisite training are allowed to advertise using that term, he believes that significant harm would be endured by the public for many years to come.

Dr. Teitelbaum, an associate clinical professor at the University of California Los Angeles, stated that this law is whether their training is equivalent in scope, content, and duration to a related ABMS board. He provided reasons why this training and its scope, content, and duration is not safe as compared to an ABMS board. He stated the program is only one year long and there is no one year ABMS specialties in the experience track. He explained what the experience track is and noted that if they are approved, the Board would be approving a lot of doctors who never had the training that board certified doctors have. He continued to add this matter went to Appellate Court in 1997 and in 2005 and both times it was rejected. Therefore accepting the application would mean that they erred in 1997 and in 2005. Dr. Teitelbaum suggested that if the Board approves the application, he would suggest that the Board point out when it believes that ABCS became equivalent. He then discussed violations and cited that 25% of cosmetic surgeons have significant Board violations compared to less than 4% of the plastic surgeons. He added that their requirements only require assisting in surgery versus every ABMS board that requires a resident do a significant part of the case -- all of the important aspects of the case. He commented that this change was made in order for the individual to learn more. He concluded by stating that fellowships have never led to board certification.

Dr. Levine inquired if it was true that a one year fellowship has never lead to board certification.

Dr. GnanaDev answered there were one year fellowships that received certification, but many are now changing to two years for certification.

Dr. Hawkins asked that the motion be restated.

Ms. Pines stated that the motion is to deny the application for equivalency.

Motion failed (5-0-5, Krauss, Levine, Lewis, Wright, and Yip).

Ms. Webb explained that under B&P Code section 2013 the Board must have an affirmative vote of a majority of the Members present for a motion to pass.

Ms. Pines asked for another motion and asked if the Board Members needed more information.

Ms. Wright voiced that she felt more information was needed for the decision to be made. She noted that there are competing statements on equivalency and whether it works and whether it does not.

Dr. Lewis agreed with Ms. Wright and explained that he did not get enough information for this level of discussion.

Dr. Yip asked what the motion failing would mean.

Ms. Webb answered that the application is not approved.

Mr. Warmoth asked if that means that the matter is dead.

Dr. Krauss commented that someone needs to make another motion.

Ms. Pines stated that a vote may end up the same way and stated the Board may need an interim meeting.

Ms. Kirchmeyer suggested that a motion be made to ask for more information and it be clearly identified what information needs to be given.

Ms. Wright made a motion to receive additional information about the application of ABCS and whether it meets the requirements.

Ms. Kirchmeyer explained that the motion needs to include the specific information that is needed.

Ms. Pines stated that in the presentations there were at least three times that ABCS mentioned that the materials were not online. She noted that this is the information that would be needed.

Mr. Valencia answered that they would be happy to provide it. He suggested that the missing information should be pointed out by Dr. Fleming, but added that they would comply with any missing materials.

Dr. Lewis seconded the motion.

Dr. Fleming stated that he would be willing to help in any way desired.

Dr. Levine remarked that one of the things Dr. Fleming noted was the absence of evidence and the extent to which the individual fellowship sites actually operated according to the principles. She opined that absence of evidence is not the same thing as evidence of absence and asked that Dr. Fleming demonstrate the extent to which he can provide evidence that the individual fellowships actually abide by the criteria. She also asked for clarification regarding whether the fellows were watching versus performing, and only practicing three days a week and every other week. She stated that to the extent to which he can respond to these concerns he should

do so regarding individual fellowships sites, how they are reviewed, and how the reviewers ascertain that these individual programs are actually following their own rules.

Dr. Levine stated that it is not about picking an ideal program. She noted that it is about ensuring that within the 27 sites there is consistency among them.

Dr. Krauss suggested that if the Board does meet again on this issue, one thing that needs to be resolved is in relation to what was asserted that the ABCS today is better and more rigorous than the ABCS of 15 to 20 years ago. He reiterated the concern of Dr. Teitelbaum that if the Board grants equivalency that it will grandfather in every ABCS board certified person going back to 1979. He noted that this is an important thing to consider.

Ms. Pines reminded the Board that the motion is to gather additional information and have an interim meeting to discuss the ABCS application for equivalency prior to December 31, 2018.

Motion carried (5-4-1, GnanaDev, Hawkins, Warmoth, and Pines; Krauss).

Agenda Item 8 Executive Management Reports

Ms. Kirchmeyer brought to the Board's attention that the Board was still unable to obtain any budget details since the Department of Consumer Affairs (DCA) switched over to a new accounting database. She shared that the database, Fi$Cal, has yet to be able to provide the needed reports, thus staff cannot provide updates on the Board's revenue and expenditures. She added that Board staff is uncertain as to when the reports will be received. She pointed out that the Board's final outstanding loan to the general fund had been repaid. Ms. Kirchmeyer mentioned that with the Board's current budget and the revenue there may need to be a fee increase within the next two years.

Ms. Kirchmeyer continued that for the last two months the Board has been working diligently to answer questions about CURES. She thanked Ms. Webb, Ms. Lally, and Ms. Cruz Jones for their help answering calls and emails. She added that the Board released a document of frequently asked questions, which is now posted on the Board's website. She commented that additions to the document will be made as more commonly asked questions arise. Ms. Kirchmeyer pointed out that that Board has also been active giving presentations and webinars about the new requirements.

Ms. Kirchmeyer noted that she and Ms. Pines attended and provided presentations at the AIM workshop in Sacramento. She added that best practices were discussed as well as ways to continue to share information.

Ms. Pines remarked that at the AIM workshop there were differences amongst boards with regard to the interim suspension orders (ISO) and asked that Ms. Kirchmeyer share more information about this topic with the Board.

Ms. Kirchmeyer remarked that in some states the executive director can issue a temporary suspension order, whereas in other states the board or a subcommittee of the board can issue an ISO. She continued that these states do not have any time requirements for filing an action,

which is far different than California. Ms. Kirchmeyer explained that in California an ISO has to be issued by an administrative law judge. Additionally, an accusation needs to be filed within 30 days of the ISO being issued or the ISO is dismissed. Therefore, to petition for an ISO the Board must have the investigation complete or near completion in order to have the evidence to file the accusation within 30 days. Ms. Kirchmeyer pointed out that additionally in California the Board must be ready to go to hearing within 30 days after the doctor requests a hearing, whereas most other states do not have any time limitations.

Dr. Hawkins asked for clarity about the vote on agenda item seven. He was under the impression that a five to five vote would mean fail.

Dr. GnanaDev echoed the concern.

Ms. Webb clarified that in the first vote there were the same number of people abstaining as voting, meaning the majority of Members were not casting a vote. She added that in the second vote, there were nine Members voting and the majority passed the motion.

Dr. Lewis commented that abstentions do not count toward the vote.

Dr. GnanaDev continued that if you remove the abstentions, the vote was five to zero.

Ms. Webb answered that there was not a majority of the Members voting.

Dr. Lewis remarked that it is the majority that overrules everything.

Ms. Kirchmeyer elaborated that the first vote did not have a majority of the members actually voting, since there were five abstentions. The second vote there were nine members voting; five supporting the motion and four opposing the motion and one abstention.

Agenda Item 9 Discussion and Consideration of Committees and Task Forces

Ms. Kirchmeyer reminded the Board that the prior strategic plan required the Board to review the committees, task forces, and subcommittees of the Board every two years. She pointed out that although the new strategic plan does not include this requirement, it would be prudent to continue this practice. She requested that the Board look at the makeup of the Board's Executive Committee, since it contains the Board's officers, past president, and the chair of each standing committee. Ms. Kirchmeyer explained that depending on who sits in these positions the ratio of physicians to public members may not provide adequate representation and furthermore, no additional members can be added since it is a full committee.

Ms. Pines recommended to change the makeup of the committee. She proposed that the committee be made up of officers of the Board, past president, and two to three Members appointed by the Board President. She explained that this will allow the committee to be adjusted for the purposes of ensuring a better ratio of physicians to public members. She noted that she will revisit the Enforcement Committee membership to ensure proper ratio of physician and public members. Ms. Pines concluded by stating there would also be the addition of a Stem Cell Task Force and a Compounding Task Force. She appointed Dr. Krauss and Dr.

Hawkins to the Stem Cell Task Force and Dr. GnanaDev and Dr. Yip to the Compounding Task Force. She requested a motion to change the makeup of the Executive Committee as discussed.

Dr. Krauss made a motion to approve the Executive Committee be made up of officers of the Board, past president, and two to three Members appointed by the Board President; s/Dr. Lewis.

Dr. Krauss requested that the name of the task be the Stem Cell and Regenerative Therapy Task Force.

Motion carried (11-0-0).

Agenda Item 10 Presentation and Update on the Controlled Substances Utilization Review and Evaluation (CURES) Program, including registration, mandatory usage, and outreach information

Ms. Kirchmeyer provided a presentation on CURES, highlighting registration, mandatory usage, and outreach information. She began by providing background on CURES, including important dates relating to its development. She provided insight into how to register for CURES and tips on how to navigate the dashboard within the CURES database including receiving alerts, prescriber messages, and patient activity reports (PARs). Ms. Kirchmeyer noted that one of the biggest benefits of CURES is the patient safety alerts and she provided more detail about what they mean and who receives them. She listed the features of the global navigation bar including account information, search history, PARs, and prescription theft or loss forms. She continued to explain the meaning and the role of delegates versus the role of the prescriber. She elaborated on how to generate a PAR, search criteria needed for a PAR, opening patient results, and sample PARs. She explained what compacts are, how to see them in the CURES database, and explained the benefit of peer-to-peer communication with regard to compacts.

Ms. Kirchmeyer elaborated on the mandatory requirements of CURES. She defined the meaning of “first time,” explained when PARs need to be requested. She also clarified all the exemptions set forth in the law. She noted that Health and Safety Code section 11165.4 is posted on the Board’s website and within the webpage are links that provide further clarification on the requirements for the exemptions.

Dr. Levine inquired if hospice care includes palliative care.

Ms. Kirchmeyer clarified that it does not. She noted that hospice care is defined in Health and Safety Code section 1339.40 and requires that the patient be registered in the hospice system.

Ms. Kirchmeyer continued on to discuss the technical exemptions. She explained that various types of administrative sanctions can be taken due to non-compliance with the law and noted that although citation and fine can be a pathway in the future, it is not currently listed in the citation and fine regulations. She listed other forms of disciplinary action that may be taken including a public reprimand, suspension, probation, or revocation. She answered some of the common questions that the Board has received and provided clarity on those answers. Ms.

Kirchmeyer commented that the Board has developed a CURES website with mandatory use, registration, and direct dispensing information in addition to the FAQs and Department of Justice (DOJ) tutorials. She also pointed out the flyer that was developed to provide more information and helpful tips.

Dr. Krauss inquired about the integration of the CURES database with electronic health records (EHR) systems.

Ms. Kirchmeyer responded that as of October 1, 2018, Assembly Bill (AB) 40 required that DOJ be able to integrate with EHRs and it is her understanding that the DOJ has prepared the system to do so. She reiterated that the PAR cannot be printed out by another individual for the healthcare practitioner but must be reviewed by the prescriber that will be writing the prescription unless an exemption applies. However, with CURES integration with EHRs, CURES can be consulted by the prescriber through their EHR system. She added that the facility will incur an additional cost for this feature and pointed out that it is the responsibility of the facility to contact DOJ to sign a memorandum of understanding setting up this integration.

Dr. Yip asked for the timeline of when pharmacists will notify doctors that their patients have not picked up prescriptions.

Ms. Kirchmeyer answered that she was unsure of a timeline, however, the prescription will not go into the CURES system until it has been dispensed to the patient. She noted that the pharmacy does have seven days after the prescription has been dispensed to update the system.

Dr. Yip commented that he believes that it is arbitrary and that there is no standard timeline of when pharmacies notify the prescriber.

Dr. Levine voiced that she believes that the practice is established by the pharmacy.

Ms. Kirchmeyer shared that a representative from the Board of Pharmacy will be at the January meeting and suggested the Board seek answers from them with regard to whether this is a requirement or best practice.

Dr. GnanaDev remarked that emergency room doctors in his facility are complaining that they have noticed a pattern of repeat patients trying to obtain pain medication. He questioned why it costs the facility to integrate CURES into EHR.

Ms. Kirchmeyer replied that this question would have to be posed to the Legislature that passed the bill, allowing DOJ to charge the fee.

Dr. GnanaDev added that what Ms. Kirchmeyer presented should be presented to primary care doctors. He stated that primary care doctors have strict time limits and having to consult CURES or refusing a patient a medication within the visit adds more time to the visit. He noted that patients then complain about the doctors that do not want to prescribe, so there are many issues that the integration of CURES has sparked.

Dr. GnanaDev provided the example of a resident looking through CURES, determining that a patient does not need certain medications, or referring the patient to an addiction specialist,and some patients listen and comply whereas other patients are irritated that their medications are being changed since it was something they had been previously prescribed without issue.

Ms. Kirchmeyer commented that she understood, but the positive is that it may help with individuals receiving inappropriate prescriptions.

Dr. Hawkins questioned if the pharmacists are complaining that they have to put the data into the system.

Ms. Kirchmeyer responded that this has be a requirement since CURES was initiated. She noted that pharmacists and veterinarians were exempted from the requirements in AB 482.

Dr. Bholat asked if there was a time where you could not put the CURES record in the patients' medical record.

Ms. Kirchmeyer answered that a bill just passed allowing the CURES record to the put into the patient's file. She added that this report can also be given to the patient, which could not be previously done. She noted that another change is that doctors can also run this report on themselves to verify if their prescription pads have been stolen.

Dr. GnanaDev asked when the system will be completely online with no time delay.

Ms. Kirchmeyer shared that she does not believe that the system will ever be completely online, however most pharmacies are entering the information within a day. She added that there was a bill that would have required the dispensing information to be entered within a day, but the bill did not pass. She added this bill could possibly be reintroduced in the next legislative session.

Mr. Andrist congratulated fellow advocate, Bob Pack, for helping bring CURES to where it is today. He also posed the question of if a doctor prescribes the medication during a surgery in anticipation of sending it home with the patient at discharge, would it change how they consult CURES.

Ms. Kirchmeyer answered that a doctor would not have to query CURES if they provide a prescription ahead of time as long as the prescriber believes it is part of the surgical procedure.

Mr. Andrist commented that it would be beneficial if BreEZe worked as well as CURES and patients could look up information on doctors as well as doctors can look up patients.

Mr. Madden on behalf of the California Chapter of the American College of Emergency Physicians remarked that the emergency departments were excited to be able to integrate with EHRs. He suggested that it would be beneficial if the hospital EHR system could query CURES on behalf of the physician when a patient first comes into the emergency department and registers with the hospital. He added that the CURES information would go into the medical record so that doctors could have the PAR before meeting with the patient. He noted that currently they will consult the patient and then run a PAR. Mr. Madden remarked that the

question comes down to what the law says is that the prescriber needs to consult the database and for emergency physicians in the continuity of care the initial physician may not be the same physician prescribing at discharge. He suggested that the FAQs be updated to if a physician consults CURES and has a hard copy of CURES, this would satisfy the requirement. He concluded there may be a need for clarifying legislation.

Ms. Pines adjourned the meeting at 6:10 p.m.

RECESS

Friday, October 19, 2018

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

Members Present:
Denise Pines, President
Michelle Anne Bholat, M.D., Secretary
Dev GnanaDev, M.D.
Randy W. Hawkins, M.D.
Howard R. Krauss, M.D.
Sharon Levine, M.D.
Ronald H. Lewis, M.D., Vice President
David Warmoth
Jamie Wright, J.D.
Felix C. Yip, M.D.

Members Absent:
Kristina D. Lawson, J.D.
Brenda Sutton-Wills, J.D.

Staff Present:
April Alameda, Chief of Licensing
Mary Kathryn Cruz Jones, Associate Governmental Program Analyst
Diane Curtis, Information Technology Technician
Kimberly Kirchmeyer, Executive Director
Nicole Kraemer, Staff Services Manager I
Christine Lally, Deputy Director
Elizabeth Rojas, Staff Services Analyst
Jennifer Simoes, Chief of Legislation
Sharlene Smith, Staff Service Manager II
Kevin Valone, Staff Services Analyst
Carlos Villatoro, Public Information Manager
Kerrie Webb, Staff Counsel

Members of the Audience:
Eric Andrist, Patient Safety League
Kelly Blake, Arizona College of Osteopathic Medicine

Jonathan Bloomfield, Adapt Pharma
Alec Bloor, Arizona College of Osteopathic Medicine
Derek Booth, Arizona College of Osteopathic Medicine
Ginger Breedlove, March of Moms
Claudia Breglia, Midwifery Advisory Council
Gloria Castro, Senior Assistant Attorney General, Health Quality Enforcement Section, Attorney General's Office
Elena Cho, Arizona College of Osteopathic Medicine
Jae Choe, Arizona College of Osteopathic Medicine
Yvonne Choong, California Medical Association
Genevieve Clavreul
Zennie Coughlin, Kaiser Permanente
Amanda Dacud, Arizona College of Osteopathic Medicine
Virginia Farrugia
Julie D'Angelo Fellmeth, Center for Public Interest Law
Rachel Dennis, Arizona College of Osteopathic Medicine
Regina Fu, Arizona College of Osteopathic Medicine
Laura Gardhouse, Commander, Special Projects, Health Quality Investigation Unit, Department of Consumer Affairs
Kanwar Gill, M.D.
Madison Gina, Arizona College of Osteopathic Medicine
Jed Grant, PAC, Vice President, Physician Assistant Board
Marian Hollingsworth, Patient Safety League
Diane Holzer, L.M., Chair, Midwifery Advisory Council
Charles Johnson IV
Lourash Kabirisamani, Arizona College of Osteopathic Medicine
Andrew Keldgord, Arizona College of Osteopathic Medicine
Amber Lau, Arizona College of Osteopathic Medicine
Susan Lauren
Ryan Leachman, Arizona College of Osteopathic Medicine
Patrick Le, Assistant Deputy Director, Board and Bureau Services, Department of Consumer Affairs
Daniel G. Lee, Arizona College of Osteopathic Medicine
Kaval Lodhie, Arizona College of Osteopathic Medicine
Sonya Logman, Deputy Director, Business, Consumer Services and Housing Agency
Garrett Long, Arizona College of Osteopathic Medicine
Cameron Lucitt, Arizona College of Osteopathic Medicine
Brandon Lup, Arizona College of Osteopathic Medicine
Sino Mehrmal, Arizona College of Osteopathic Medicine
Michael Mora, Investigator, Health Quality Investigation Unit, Department of Consumer Affairs
Turakarama Musunuri, Arizona College of Osteopathic Medicine
Sasikanth Nagisetty Rawi, Arizona College of Osteopathic Medicine
Thai Nguyen, Arizona College of Osteopathic Medicine
Trevor Nguyen, Arizona College of Osteopathic Medicine
Piper Olmsted, Arizona College of Osteopathic Medicine
Maria Pakhdikian, Arizona College of Osteopathic Medicine

Tom Riley
Mayra Rodriguez, Investigator, Health Quality Investigation Unit, Department of Consumer Affairs
Alan Rupp, Arizona College of Osteopathic Medicine
Robert Sachs, PA, President, Physician Assistant Board
Ryan Sadakane, Arizona College of Osteopathic Medicine
Naira Sargsyan, Arizona College of Osteopathic Medicine
Sandra Shi, Arizona College of Osteopathic Medicine
Stacey Stewart, March of Dimes
Moinuddin Syed, Arizona College of Osteopathic Medicine
Erika Terzani, Dr. Lavinia Chong's Office
Tam Tran, Arizona College of Osteopathic Medicine
Prabhdeep Uppal, Arizona College of Osteopathic Medicine
Cesar Victoria, Videographer, Department of Consumer Affairs
Alena Yarema, Arizona College of Osteopathic Medicine
Anthony Zaffino, Arizona College of Osteopathic Medicine
Agnieszlea Zak, Arizona College of Osteopathic Medicine

Agenda Item 11 Call to Order/Roll Call/Establishment of a Quorum

Ms. Pines called the meeting of the Medical Board of California (Board) to order on October 19, 2018, at 9:05 a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 12 Public Comments on Items not on the Agenda

Mr. Andrist from the Patient Safety League shared their website, www.4patientsafety.org. He shared that the Board is tasked with looking at cases where the doctors have done wrong. He elaborated that his new group will be for consumers to come forward when the Board has done them wrong. He shared that they have been brining before the Board cases where consumers have been dissatisfied with the outcomes of their complaints, including his own. Mr. Andrist explained that the Patient Safety League intends to monitor the Board and will inform the Legislature and media about any wrongdoings. He noted that the next speaker exemplifies a case where the Board did not follow the guidelines.

Mr. Johnson explained that he is the father of two sons and the husband of Kyra Johnson, who walked into Cedars-Sinai Medical Center on April 12, 2016, in exceptional health and underwent what was supposed to be a routine scheduled caesarean section. He shared that he trusted his wife to the care of Cedars-Sinai Medical Center and Dr. Naim. Mr. Johnson elaborated that for more than ten hours post caesarean section his wife was allowed to hemorrhage internally and by the time she was taken into surgery there were more than three and a half liters of blood in her abdomen and her heart stopped immediately. He shared that in an investigation conducted by the Board, Dr. Naim was found to be negligent and he was facing serious complaints of negligence from five other women, three of which were within a three-month span of his wife's death. He remarked that the Board made the decision to give Dr. Naim four years of probation. Mr. Johnson pointed out this decision allows Dr. Naim to continue to practice medicine and surgery without consequence while his family and the other

families he has affected will have to struggle for the rest of their lives to put the pieces back together. He concluded by noting that if the Board continues to make exceptionally lenient judgments for discipline, every single Member on the Board is complicit in the death of his wife, and in the injuries of women, and is sending a message to California and the nation that women can be killed without consequence.

Ms. Pines thanked Mr. Johnson for sharing his story and expressed her sorrow for his loss.

Ms. Hollingsworth, a patient safety advocate with the Patient Safety League and the Patient Safety Action Network, brought up the disciplinary guidelines that the Board reported they use when making decisions. She requested that a report be given at the next meeting showing how closely the guidelines are followed, since from recent alerts it seems as if they have not been followed even in the most egregious cases. She provided the example that the guidelines reporting minimum of seven years' probation for sexual misconduct, however a doctor from Bakersfield doctor received 42 months, half the recommended probation.

Ms. Hollingsworth noted that the worst decision to come from the Board was the case of Kara Johnson. She shared that maternal mortality in the U.S. has skyrocketed in recent years. She continued that in addition to Kara, there were five other harmed women in Dr. Naim's accusation and all the victims had bleeding problems. She elaborated that one of them also went into cardiac arrest but was resuscitated and documents show there were near misses and one death in just three months with Dr. Naim. She pointed out that the guidelines for gross negligence have a minimum of five years and this doctor received four and a few classes. She provided another example of a San Diego doctor who allowed a woman to bleed to death and this doctor received seven years' probation and restricted from delivering babies. She questioned the differences between the physicians. She concluded by stating that if medical boards do not take responsibility for regulating dangerous doctors, they contribute to the high mortality rate and there are patient advocates watching the Board's disciplinary alerts.

Ms. Lauren commented on agenda item seven from the day prior, indicating that subgroups within the medical profession increase public confusion about dangerous and harmful plastic surgery procedures. She continued that board certified surgeons fault dermatologists who do not have hospital privileges for using local anesthesia and not being plastic surgeons, whereas dermatologists fault board certified plastic surgeons for performing too much toxic aggressive surgery at once via general anesthesia. She commented that the internal finger-pointing implies that the bad effects are related to the doctors training and technique, when in fact the biology of fat is at fault. She requested that the Board not to overlook the invasive technique, guess work, and negligent surgeons. Ms. Lauren pointed out that there are competitive groups of doctors who benefit handsomely from doing surgery and they have convinced the public that liposuction is safe. She added that board certified plastic surgeons above the fray should be questioned. She provided examples of what plastic surgeons do that increases risk and how it relates to her own case.

Agenda Item 13 Discussion and Possible Action on Legislation/Regulations

Ms. Simoes noted that the 2018 legislative session ended, and the legislature does not reconvene until December 3, 2018. She added that the Governor has taken action on all bills

where the Board took a position. She added that it the second year of a two-year session, which means that if a bill did not pass in the year, it is dead. She explained that each bill will have a brief summary, followed by the Board's implementation plan.

Ms. Simoes shared that AB 505, Caballero, is a bill that allows an administrative law judge (ALJ) to extend the deadline for the exchange of expert witness reports upon a motion and based upon a showing of good cause. She added that this bill specifies that the ALJ may extend the timeline for the exchange for a period no longer than 100 calendar days, but no less than 30 calendar days before the hearing date, whichever comes first. She reminded the Board that amendments to this bill were requested, however, they were not taken. She remarked that the Board's implementation plan is to provide a newsletter article and notification to staff.

Ms. Simoes explained AB 710, Wood, is a bill that allows a physician, pharmacist, or other authorized healing arts licensee, acting within his or her scope of practice to prescribe, furnish, or dispense cannabidiol if it is excluded from Schedule I of the Federal Controlled Substances Act and placed on a Schedule other than Schedule I, or if a product composed of cannabidiol is approved by the 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 added that if a physician, pharmacist, or other authorized healing arts licensee prescribes, furnishes, or dispenses cannabidiol in accordance with federal law then they shall be deemed to be in compliance with state law. She noted that this bill is an urgency statute and took effect upon being signed into law. The Board's implementation plan is to update the Board's website to include information on this new law.

Ms. Simoes commented that AB 1751, Low, is a bill that allows information sharing between California's prescription drug monitoring program, CURES, and other states' prescription drug monitoring programs. She specified that the bill requires DOJ to adopt regulations by July 1, 2020, regarding the access and use of information within CURES and allows DOJ to enter into an interstate data sharing agreement as specified. She indicated that the Board's implementation plan is to include a standalone article in the Board's newsletter and update the Board's webpage on CURES.

Ms. Simoes moved to AB 1791, Waldron, which allows for an optional continuing medical education (CME) course in integrating HIV/Aids pre-exposure prophylaxis and post-exposure prophylaxis medication maintenance and counseling in primary care settings. She explained that this is not mandated CME, but the Board's implementation plan is to include a standalone article in the Board's newsletter and update the Board's website, including adding a page on CME topics that are in existing law.

Ms. Simoes introduced AB 2086, Gallagher, a bill that allows a prescriber to access the CURES database for a list of patients for whom the prescriber is listed as a prescriber. The Board's implementation plan is to include a standalone article in the Board's newsletter and update the Board's webpage on CURES.

Ms. Simoes clarified that AB 2138, Chiu and Low, which becomes effective July 1, 2020, limits the current discretion given to boards, bureaus, and committees within DCA to apply criminal conviction history for a license denial. She explained that the bill prohibits regulatory boards

from requiring an applicant to self-disclose criminal history information and requires boards to collect and publish demographic data regarding applicants who are denied licensure, and who have licenses revoked or suspended. She noted that this bill changes the way that the Board can deny licenses regarding criminal convictions. Ms. Simoes reported that the Board turned in a fiscal impact report, demonstrating that there will be a need for additional staff to handle the workload. The implementation plan includes requesting additional staff to handle the workload, updating the Board's processes and procedures for licensing denials related to criminal convictions, establishing codes in BreEZe to track data required by this bill, and to gather data for the reporting required on an annual basis. Additionally, the Board will change the record retention requirements to three years, work with other DCA boards on regulations to develop the criteria for determining whether a crime is substantially related to the qualifications, functions, or duties of the professions the Board regulates, and post that criteria on the Board's website. Ms. Simoes stated that the Board will also have to work with other DCA boards on regulations to develop criteria to evaluate the rehabilitation of a person when considering the denial of a license under B&P Code section 480, or when considering suspension or revocation of a license under B&P Code section 490.

She explained that Board staff has already begun to work with DCA and that DCA is taking an active role in this matter since it affects all boards and bureaus. DCA has already started meeting with the boards and bureaus to develop an implementation plan that all boards and bureaus can use.

Ms. Simoes concluded that the Board will also have to update the Board's licensing application to no longer request criminal conviction information and then update the Board's application page on the website to include the changes.

Dr. GnanaDev asked whether this bill means that the Board cannot ask if an applicant is criminally convicted.

Ms. Simoes confirmed that with the Board cannot ask about criminal convictions under this bill.

Dr. GnanaDev inquired if any other state has this law.

Ms. Kirchmeyer commented that she would have to double check that information, but that most states, she would assume, asks for criminal conviction history on the application. She reminded the Board that they did oppose this bill and that the Board tried to have the Legislature change the bill to let the Board ask if an applicant has been convicted. She pointed out that with the bill going into effect, the Board will have to rely solely on results from the applicant being fingerprinted.

Dr. Krauss noted that this bill is antithetical to the Board's mission.

Ms. Simoes agreed, that this point was made and it was also echoed by all other boards, however, the bill still passed.

Dr. Krauss commented that although he respects the rights of the individual, as the hands of the Board become more and more tied, the Board has a diminished ability to protect the public.

Therefore the Board needs to do whatever it can do to minimize the damage that will be done by this law.

Ms. Simoes continued onto AB 2193, Maienschein, which requires that by July 1, 2019, a licensed healthcare practitioner who provides prenatal or postpartum care for a patient to ensure that the mother is offered screening, or is appropriately screened for maternal mental health conditions. She added that this bill also requires health insurers and healthcare service plans to develop a maternal mental health clinical case management program as specified. The Board's implementation plan is to include a standalone article in the Board's newsletter and update the Board's citation and fine regulations to include a violation of this law as a reason to issue a citation and fine.

Ms. Simoes explained AB 2311, Arambula, which the Board co-sponsored with the University of California Office of the President, removes the pilot program status from existing law for the University of California Los Angeles International Medical Graduate Program, allowing trainees to engage in and supervise patient care activities. The Board's implementation plan is to include a standalone article in the Board's newsletter.

Ms. Simoes shared that AB 2461, Flora and Obernotle, requires the DOJ to provide all subsequent state and federal arrest or disposition notifications to specified entities including the Medical Board of California for any licensee whose fingerprints are maintained on file at DOJ or the Federal Bureau of Investigation. She noted that the Board's implementation plan is to set up a meeting with DOJ to establish implementation and an information exchange process.

Ms. Simoes specified that AB 2487, McCarty, allows physicians the option of using the currently required one-time 12-hour CME course on pain management and the treatment of terminally ill and dying patients, or the one-time 12-hour CME course on the treatment and management of opiate dependent patients, which must include eight hours of training on buprenorphine treatment or other similar treatment for opioid use disorders. She explained that the Board's implementation plan is to include a standalone article in the Board's newsletter, update the Board's webpage on CMEs, and update BreEZe and the renewal notice to require physicians to verify that they have taken one of the required courses.

Ms. Simoes elaborated that AB 2760, Wood, requires a healthcare practitioner authorized to prescribe controlled substances to offer a prescription for naloxone, or another drug approved by the FDA for the complete or partial reversal of opioid overdose, under specified conditions. The bill also requires a prescriber to provide education to a patient on overdose prevention and the use of naloxone. She detailed that the Board's implementation plan is to include a standalone article in the Board's newsletter, update procedures for both complaints and investigations related to violations of the requirements in this bill, and update the Board's citation and fine regulations to include a violation of this law as a reason to issue a citation and fine.

Ms. Simoes moved onto AB 2789, Wood, which requires all prescriptions issued by licensed prescribers on or after January 1, 2022, to be issued as an e-prescription. The Board's implementation plan is to include a standalone article in the Board's newsletter, provide outreach to physicians regarding the new requirement including email blasts, posting

information on social media, and posting the information on the Board's website. She noted that additionally, the Board will update the citation and fine regulations to include a violation of this law as a reason to issue a citation and fine.

Ms. Simoes introduced AB 2968, Levine, which updates and modernizes the informational brochure for victims of psychotherapist patient sexual impropriety. She commented that the Board's implementation plan is to include a standalone article in the Board's newsletter when the brochure is revised, update the Board's website with the revised brochure, and ensure that the updated brochure is disseminated to consumers who make these complaints.

Ms. Simoes explained that AB 3115, Gibson, was a bill that was not discussed by the Board, however, the Board did discuss SB 944. She detailed that SB 944 died in Appropriations Committee, but that the language from SB 944 was put into AB 3115 and it made it to the Governor, however it was vetoed. She clarified that no bill passed regarding community paramedicine in this legislative cycle.

Ms. Simoes detailed SB 1109, Bates, which requires existing pain management CME courses to include the risks of addiction associated with the use of Schedule II drugs. She added that the bill requires a warning label on all Schedule II controlled substance prescription bottles on the associated addiction and overdose risks and requires a prescriber to discuss specified information with a minor or the minor's parent or guardian before prescribing an opioid for the first time. She detailed that SB 1109 requires that a youth sports organization annually give the Opioid Factsheet for Patients to each athlete, and for the athlete's parent or guardian to sign a document acknowledging receipt. She concluded that the Board's implementation plan is to include a standalone article in the Board's newsletter, provide outreach to CME providers regarding the new requirement, update the Board's webpage on CMEs, and post the Centers for Disease Control (CDC) Opioid Factsheet for Patients on the Board's website.

Ms. Simoes discussed SB 1448, Hill, which is the Patient's Right to Know Act of 2018. She explained that the Board's implementation plan will be a standalone article in the Board's newsletter, train Board staff to prepare a statement that goes out to physicians when their probation order falls under the patient notification requirements in this bill, and train Health Quality Enforcement Section (HQES) staff at the Attorney General's (AG's) Office to ensure that settlements for cases that fall under the patient notification requirements of this bill include an express acknowledgement for patient notification. She noted that, additionally, Board staff will update the probation unit monitor's checklist to ensure that physicians whose orders fall under the patient notification requirements are aware of the law and the requirements they must follow. She added that the Board would seek an increase in the budget line items for the AG's Office and the Office of Administrative Hearings (OAH) by $220,000 to cover the costs of this bill, and submit a BreEZe change request to require the physician profiles to include the required information for physicians on probation and physicians with probationary licenses. Ms. Simoes elaborated that the Board will create new codes in BreEZe to track statistics related to how many cases go to hearing instead of settling due to the patient notification requirements and how many physicians violate the law regarding patient notification. In addition, the Board will provide outreach to physicians regarding the new requirement including email blasts, posting information on social media, and posting information on the Board's website.

Ms. Simoes explained that SB 1480, Hill, was amended after the last Board meeting and now includes technical and clarifying changes that were mostly requested by staff. She provided a comprehensive list of all of the amendments to the bill. She advised that the implementation plan for the Board is to write a newsletter article, provide notification to all interested parties, and training to staff.

Dr. GnanaDev asked if residents can apply for a DEA license with a training license and noted that when someone finishes 36 months they can get a job the next day, meaning they will need their license prior to that time.

Ms. Webb commented that the postgraduate training license allows a person to practice medicine within the confines of their program and as permitted by the program director. She added that up to this point, licensees will have turned in everything for licensure except proof of completion of the 36 months. Additionally, they can practice on that postgraduate training license for an additional 90 days while the full license is being processed. She reiterated that this process should be expedited, since only one additional document is needed.

Dr. GnanaDev noted that this is the process for California and inquired what this would look like for out of state licensees.

Ms. Kirchmeyer clarified that this will not impact a licensee getting a license in another state.

Ms. Webb indicated that other states may require three years, however if they have completed one year and if that is acceptable in another state, they can apply for a license in that state.

Dr. GnanaDev asked for more clarification about the DEA license.

Ms. Kirchmeyer responded that as long as a licensee holds a postgraduate training license, they should be able to apply for a DEA and get a DEA license. She noted that Ms. Alameda has been working with people throughout the state to ensure the Board is aware of any unintended consequences.

Ms. Simoes added that if there is something that does in fact need to be fixed, the Board still has an opportunity to get it into a committee bill this year and get it fixed before it is effective.

Ms. Simoes wrapped up with SB 1495, Committee on Health, which made technical and clarifying changes to SB 512 from last year regarding non FDA approved stem cell therapies. She shared that the Board's implementation plan is to do the usual newsletter article and notification to staff.

Dr. GnanaDev thanked Ms. Simoes for a job well done since everything the Board supported and was neutral on passed.

Ms. Simoes transitioned to 2019 legislative proposals. She began with the first technical change, to delete B&P Code section 2234(g), which becomes operative upon implementation of the proposed registration program described in B&P Code section 2052.5. She stated that this subdivision is no longer needed because 2052.5 was repealed. She continued that Board staff

recommends deletion of B&P Code sections 2155 to 2167, regarding loans to medical students and 2200 to 2213, regarding physician and surgeon incentive pilot programs, since these programs are not active and they have never been active. Lastly, Ms. Simoes discussed inconsistent language in B&P Code section 803.1 that should be amended.

Ms. Simoes transitioned to bill proposals. She shared that the first is to amend B&P Code section 2234(h) regarding physician interviews to strike the word repeated.

Ms. Webb clarified that failure in this section refers to the failure to show up to an interview in the absence of good cause. She reiterated that good cause will be left in, but striking the word repeated will be helpful to the Board's process.

Dr. GnanaDev agreed with the change and added that this will be a way to help shorten the timelines for complaints.

Dr. Lewis made a motion to approve the legislative proposal to amend B&P Code section 2234(h); s/Dr. GnanaDev.

Ms. Farrugia acknowledged that she understands the Brown guidelines, however the matter which concerns her is cutting off people that have experienced trauma as a patient. She noted that this harms the patient and does not address the concerns in future meetings. She continued that there are doctors that have saved countless lives, but there are also doctors that have harmed countless lives. Ms. Farrugia provided details of her own personal story. She shared that patients of trauma end up financially ruined, homeless, and have traumatic stress. She noted that this needs to be addressed along with diagnosis and treatment of traumatic stress, proper documentation including open notes, and dissemination of evidence-based practice.

Motion carried (9-0-1, Wright).

Ms. Simoes moved to the next proposal, to amend B&P Code section 800(c)(1) to strike the word "comprehensive" in front of the word "summary." She explained that this is the summary that a physician can request when a complaint is filed against them. She noted that there is controversy over the meaning of the word comprehensive that then delays the investigative process.

Ms. Webb pointed out there is no requirement in the law requiring the Board to provide an 800(c) before the physician goes to the interview, but it is a point of contention.

Dr. Lewis inquired if the 800(c) letter needed to be requested.

Ms. Kirchmeyer explained that in addition to the request for medical records this information is also included. She did note that if they would like to obtain an 800(c), they would have to make a formal request to the Board, however the Board was trying to mitigate this upfront.

Dr. GnanaDev vocalized his fears about case delays and pointed out that a comprehensive summary is an oxymoron.

Ms. Kirchmeyer confirmed that a summary is sent, however not all information is given in all cases since it may impact the investigation. She echoed Dr. GnanaDev's comment about a comprehensive summary.

Dr. Bholat inquired why an individual would ask for an 800(c) letter if the information were already provided in the request for records.

Ms. Kirchmeyer explained what an 800(c) letter is, what it explains, and the process of obtaining one.

Ms. Webb noted that this letter can also be requested if a physician wanted to know all their complaints on file.

Dr. Levine made a motion to approve the legislative proposal to change B&P Code section 800(c); s/Dr. Bholat. Motion carried (10-0-0).

Ms. Simoes moved to the final proposal, which was to amend B&P Code section 2221, to require probationary license information to stay on the Board's website after probation is completed for a period of 15 years.

Dr. GnanaDev inquired how long the public letter of reprimand (PLR) stays on the Board's website.

Ms. Simoes stated three years.

Ms. Kirchmeyer clarified that when a person gets a PLR at licensure it will stay on for three years, however if the licensee gets a PLR as a result of a disciplinary action, it will stay on the website for ten years.

Dr. GnanaDev asked for the reason behind 15 years.

Ms. Kirchmeyer stated it was just staff's recommendation but said it was something the Board should discuss.

Dr. Lewis echoed Dr. GnanaDev's concern for the posting to be 15 years.

Ms. Kirchmeyer reminded the Board that all documents being referenced are public indefinitely. The matter at hand is how long the documents will remain on the doctor's profile.

Dr. GnanaDev made a motion to approve the legislative proposal to require probationary licenses remain on the Board's website for ten years; s/Dr. Lewis. Motion carried (10-0-0).

Agenda Item 14 Presentation on Changes to the Vertical Enforcement Program

Ms. Kirchmeyer explained that the Board's sunset bill, SB 798, put in a sunset date of January 1, 2019, for the vertical enforcement (VE) program. She noted that in the signing message, the Governor directed his staff to work with the Legislature and the AG's Office to determine what changes were needed to the VE program. She shared that despite discussion, no bill was introduced to extend VE, and therefore the Board will return to the process that it used prior to VE. She explained the differences between the current process and what the process will look like after January 1, 2019. Ms. Kirchmeyer detailed that one of the biggest differences will be that the Health Quality Investigation Unit (HQIU) will make the recommendation for the disposition of the case to the Board instead of the AG's Office. If the Board agrees a case should be transmitted for disciplinary action that is when the Deputy Attorney General (DAG) gets involved and reviews the matter to ensure that there is sufficient evidence to file an accusation.

Dr. GnanaDev noted that this was one of two items left from sunset and unfortunately no agreement was made. He added that the Board's main concern is how long it takes to conclude an investigation and hopefully this new process will help streamline things but also provide assistance where needed from the AG's Office.

Ms. Kirchmeyer noted that an additional benefit is that HQIU has been working with the AG's Office for the last several years, so they understand what it takes to prosecute a case and what the DAGs are looking for during their analysis of the case.

Dr. Bholat asked for clarification as to when the Board begins processing the cases.

Ms. Kirchmeyer explained that once the case goes to the AG's Office, they file the accusation, which either goes to settlement, default decision, or a hearing and then the Board is involved.

Dr. Bholat encouraged everyone to review the material on the website to get a better understanding of timelines.

Ms. Kirchmeyer confirmed that the Board is keeping a watchful eye to see how timeframes change after VE. She added that one difference is that HQIU is now fully staffed and although ten to twelve employees are in the academy, once they are fully trained, this will have an effect on the timelines.

Ms. Pines ensured everyone that the Board will help to make this an easy transition. She added that only through continued teamwork and collaboration between the Board, HQIU, and the AG's Office will the public be protected. She assured the Board that this only changes procedures and all players are committed to the same goals.

Ms. Kirchmeyer shared that there will be a meeting in November with the Board, the AG's Office, and HQIU to work through the transition. Dr. Yip will be included in this meeting.

Dr. Levine asked if the intent of this was to eliminate redundancy.

Ms. Kirchmeyer explained that there is no redundancy in the current process. She explained that in 2006 this was a legislative change that was made and now the Board will go back to how it was.

Ms. D'Angelo Fellmeth, Center for the Public Interest Law and former Board enforcement monitor, reminded the Board that they stated that it was never the intent of the Board to repeal the statutes requiring VE, yet that is what happened. She added that it was also stated that complex cases benefited from VE, but these cases were not identified and the benefits were not explained. She noted that the proposal to repeal or amend the VE laws were not included in the 2016 sunset review report. Ms. D'Angelo Fellmeth pointed out that the Board has not discussed this matter publically since 2013, but this is prior to the time that many Members were on the Board. She detailed that with a lack of VE the Board's enforcement program will be where it was in 1992. She vocalized that these changes will result in delays and lower the quality of the decision making. She pointed out that she does not believe that there is any law that prevents the Board from sitting down with the AG's Office and HQIU to negotiate a new manual that sets forth those kinds of cases and calls for VE to be used in those cases.

Agenda Item 15 Presentation on Medi-Cal Provider Oversight

Ms. Homman, Chief of the Provider Enrollment Division of the Department of Health Care Services (DHCS), presented information on the physician provider enrollment process, noting the types of enrollment and enrollment actions, as well as the life cycle of the actions. She explained the provider application and validation for enrollment (PAVE), which is a web-based portal that allows for easier registration. She also discussed PAVE statistics, including the number of users, business profiles, applications submitted, and processing times. She continued to explain inappropriate opioid prescribing in Medi-Cal, covering the managed care quality monitoring division, the drug utilization review board, audits, and investigations.

Dr. Hawkins inquired about the provider enrollment division and if it is part of the managed care medical model.

Ms. Homman confirmed that it is a part of the same model and provided some examples.

Dr. Levine inquired about the slide that discussed over prescribers of non-opioid meds that are being identified through peer comparison, and if there are specific drugs or categories of drugs that the department is focusing on.

Ms. Homman noted that she will get back to Dr. Levine later with more information.

Dr. GnanaDev shared that this is the first time he has heard about electronic enrollment.

Ms. Homman indicated that she will add Dr. GnanaDev to the list serve and provide more history about PAVE.

Dr. Yip inquired about providers being dropped.

Ms. Homman elaborated that if the department has not been billed within at least 12 months Medi-Cal will pull that provider out of the system since there are no services being provided.

Dr. Bholat asked about the relationship between Department of Health Care Services (DHCS) and the Department of Managed Care and the individual patients that go in and out of care. She provided an example of how she observes this in her work.

Ms. Homman began by noting that her department and the Department of Managed Care are two separate departments. She explained that previously when there was a transition of a provider, her department did require that there be a communication to place the beneficiary in the proper care with the records following them. She noted that she is uncertain what happens in current practice, but that she would look into a specific area if it is not working effectively.

Dr. Yip echoed that he knows that this has been a challenge for some of his patients as well.

Ms. Homman confirmed that this is something that she will relay to her department. She expressed that her agency would like to provide excellent customer service to their beneficiaries and providers. She added that they intend to be fair and do the right thing.

Dr. Bholat noted that Ms. Homman's agency has a database that is being assembled with a plethora of information on morphine milligram equivalents that could be relevant for the individual provider, although often times it does not get to the provider. She asked if there is a transfer of information regarding overprescribing.

Ms. Homman responded that there is not enough communication. She noted that she would be open to collaborating and shared that in enrollment there is a small unit of the department that is focused on the Board, their licensing, actions being taken, and limitations on licenses. She commented that they are taking advantage of the information that the Board provides.

Ms. Kirchmeyer reported that the Board met with the DHCS and discussed information sharing. She noted that recently DHCS provided a presentation to Board staff about investigations and audits and the Board provided a presentation on what the Board does. The purpose is to share information since there is overlap in the roles that each agency has. Ms. Kirchmeyer confirmed that this relationship has been fostered with DHCS and California Department of Public Health (CDPH).

Ms. Homman agreed that their audits and investigations would have more information that would be of help to the Board, and she would like to be of service with anything that provider enrollment can do.

Agenda Item 16 Update, Discussion, and Possible Action on Recommendations from the Midwifery Advisory Council Meeting

Ms. Holzer detailed that at the August 16, 2018, Midwifery Advisory Council (MAC) meeting, the MAC was provided with information about the new licensed midwife mentorship program and how the California Association of Licensed Midwives plans to seek legislation, and hopefully will resolve the impasse relating to AB 1308. Additionally, there were updates on the midwifery

program and the Licensed Midwife Annual Report (LMAR) task force. Lastly, the MAC tabled the discussion of term limits and elections.

Ms. Holzer requested approval of the following agenda items for the next meeting: update on revisions to the LMAR; update on the Midwifery Task Force, including an update on regulatory efforts pursuant to AB1308; update on midwifery related legislation; selection of a new Vice Chair for MAC; discussion and possible adoption of term limits for members of the MAC; discussion and possible adoption of an administrative manual for MAC members; presentation on protected peer review; discussion and action on MAC meetings for 2019; report from the Chair; update on the Midwifery program; and overview on the enforcement process for complaints and investigations.

Dr. Lewis made a motion to approve the agenda items as discussed for the next MAC meeting; s/Dr. Hawkins. Motion carried (8-0-0, GnanaDev and Levine absent).

Agenda Item 17 Discussion and Possible Action to Amend Title 16, California Code of Regulations, Sections 1320 and 1321 Regarding Postgraduate Training

Ms. Alameda shared that effective January 1, 2020, SB 798, will require a minimum of three years of Board approved postgraduate training for all applicants regardless of whether the medical school attended is domestic or international. She stated that changes also required residents participating in an approved postgraduate training program in California to obtain a postgraduate training license issued by the Board. Additionally, SB 798 made changes to the process for recognizing international medical schools. Ms. Alameda explained that once the changes go into effect, Board staff will need to submit a request to the Office of Administrative Law (OAL) to repeal regulations that will no longer apply. Board staff will also need to begin the rulemaking process to amend section 1320 and 1321 of the CCR.

Ms. Alameda identified that the proposed amendments for section 1320 are to remove the reference to the two-year and three-year exemption period and replace that with the 36 months of training that will be required. She explained that additionally B&P Code section 2066 will be deleted, since the program will be repealed. She detailed that the Board has already approved previous amendments regarding postgraduate training, however to keep language consistent, additional amendments are needed. Ms. Alameda indicated the proposed amendments for section 1321 include clarifying the requirement that an applicant must complete the 36 months of Board-approved postgraduate training with at least 24 continuous months in a single program to be licensed.

Ms. Webb stated that Board staff would like a motion to approve the suggested amendments and deletions, to allow Board staff to begin the rulemaking process with pre-approval through DCA and Agency, to allow staff to make non-substantive changes to the language as necessary, and to allow staff to present the package to OAL for formal notice and formal public comment period.

Dr. Lewis made a motion to approve suggested amendments and deletions to 16 CCR, sections 1320 and 1321, to allow Board staff to begin the rulemaking process

with pre-approval through DCA and Agency, to allow staff to make non-substantive changes to the language as necessary, and to allow staff to present the package to OAL for formal notice and formal public comment period; s/Dr. Bholat.

Motion carried (10-0-0).

Agenda Item 18 Update on the Physician Assistant Board and Discussion of Optimal Team Practice

Mr. Sachs, President of the Physician Assistant (PA) Board, provided a brief history of the PA profession.

Mr. Grant, Vice President of the PA Board, provided insight into PA programs. He noted that there are 236 programs, and Pas complete around 120 semester units or three academic years, with over 2,000 hours of supervised clinical practice experiences. He noted some changes in the profession but shared that the PA Practice Act does not reflect current times. He detailed that the American Academy of PAs developed optimal team practice (OTP), which allows PAs to practice to the full extent of their license at the practice level. Additionally, he explained the four main pillars of OTP. He concluded by noting that they would like the PA Practice Act to reflect what is currently happening in the field. He highlighted that congruent with the pillars of OTP, the PA Board was looking into the PA Board becoming fully independent. Mr. Grant added that the PA Board will be undergoing changes to laws and regulations that deal with supervision, which would alleviate the Board of reviewing PA regulations if the PA Board was separate.

Dr. GnanaDev shared that some of the items Mr. Grant pointed out are somewhat concerning, whereas other are appropriate. He opined that the profession was created to be part of the team, not to be independent.

Mr. Grant reiterated that PAs do not want to be independent practitioners, rather the intent is to always be part of a team with physicians.

Agenda Item 19 Update from the Attorney General's Office

Ms. Castro thanked the Board for its support of the VE for 12 years. She notified that she is actively preparing the HQE staff for the handoff model that will take effect on January 1, 2019. She then echoed what Ms. Kirchmeyer had previously explained about the role of HQE and the role of the Board in terms of processing complaints. She assured the Board that the AG's Office will continue to help the Board on cases that require supplemental investigations, apply its high standards for prosecuting cases, and report as relevant to the different parts of the administrative process.

Dr. Levine inquired if the definition of a professional license as a property right is determined individually by each state.

Ms. Castro answered that she cannot speak for other states. She added that the burden is different depending on how difficult it was to it obtain the property right. She detailed that where it is a licensee, such as in health care professions, clear and convincing is the best method. She explained the differences with different licenses.

Dr. GnanaDev shared that all the entities seriously tried to reach a resolution including the Governor's Office, the Board, DCA, and HQIU. He affirmed that it was the goal of the Board to work out a solution and work together.

Mr. Andrist noted that the average number of days to complete a complaint in the central complaint unit is 138 days and inquired what complete means. He noted that there are thousands and thousands of legitimate complaints that are being tossed out, falsely lowering that average and he asked if those complaints are being taken into account. Mr. Andrist provided the details of a closed case and compared the dates from that case with the dates in the report found in agenda item 8B and suggested that the Board is providing skewed data. He provided more statistics and opined that the enforcement numbers are minuscule when considering the overall number of complaints the Board obtains.

Mr. Andrist updated that in a recent complaint he filed, he was told that he would not be interviewed, even though it is his story to tell. He was told that the Board's expert would make a decision based solely on his medical records, some of which were secured without a signed release. He added that the Board is often relying on medical records alone to decide whether a complaint is legitimate even though over 90% of the accusations that are filed accuse doctors of poor record-keeping. Mr. Andrist provided details about his complaint when his sister died and how the complaint was closed based on her medical records, but this should not have been the case. He asked if the Board sees the flaws in the system. He concluded by reminded Ms. Castro that there was information that should have been provided to Judge Feinstein in 2017, but this update has yet to be provided.

Agenda Item 20 Update from the Department of Consumer Affairs, which may include updates on the Department's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory, and Policy Matters

Mr. Le remarked that on August 6, 2018, there was a Director's quarterly meeting. He noted that there were presentations from the Department of General Services, DCA's Equal Employment Opportunity Office, and DCA's Office of Human Resources. He shared that the Department of General Services previewed their plan for new construction that will house all of DCA in 2024, the Equal Employment Opportunity office provided a primer on implicit bias, and the Office of Human Resources shared some new improvements on their own internal human resources processes specific to recruitment and adverse action. Mr. Le added that the next Director's quarterly meeting is scheduled for October 29, 2018.

Mr. Le continued by discussing the DCA leadership training. He detailed that DCA held its kickoff meeting for the second cohort of the Future Leadership Development (FLD) program in September. He reminded the Board that the FLD was an initiative launched in August 2017 to

develop and mentor DCA staff across various boards and bureaus. He noted that the program includes executive mentoring, customized leadership training, and project management.

Mr. Le shared that the monthly workgroups made up of DCA board staff to identify best practices in the areas of licensing and enforcement met in August. He added that the licensing work group discussed a tool to streamline and automate a generated letter to licensees. He indicated that this tool will be available to all programs in DCA soon.

Mr. Le notified the Board about the Substance Abuse Coordination Committee, which is required to examine Uniform Standard #4, related to drug-testing standards for substance-abusing licensees in a diversion program or who are on probation. The Committee is tasked with determining if the existing criteria needs to be updated based on recent developments in testing research and technology. He clarified that the Committee needs to report to the Legislature by January 1, 2019. He noted that per statute the Committee is made up of all the healing arts executive officers, a designee from the DHCS, and is chaired by the Director of DCA. Mr. Le wrapped up by stating that the Committee will meet on October 30 in Sacramento and will specifically examine the issue of drug testing frequency and whether or not those frequencies need to be adjusted.

Mr. Le provided his last update, regarding the executive officer salary study. He shared that DCA awarded a contract to conduct a salary study of executive officers. He detailed that the contractor will be expected to provide a comprehensive independent review and assessment of board executive officer salary levels and evaluate changes that have occurred after the previous salary study conducted in 2011. He pointed out that the new study will assess the programmatic changes that occurred over the years and how these changes have increased the operational complexity of the boards. Additionally, Mr. Le noted that the study will help determine the degree to which these changes will support compensation augmentation. He listed the key goals that the department would like to focus on through the salary study. He concluded, noting that the study is currently underway and is estimated to be complete in early 2019.

Dr. GnanaDev thanked Mr. Le and reminded him that the executive officers compensation is something that has been in the works for some time. He confirmed that when he was Board president, he was pushing for it, as well as his predecessor, and now Ms. Pines. He explained his concern is the amount of work there is to manage in the largest medical board in the entire country and remarked that the salary is not equitable compared with other executive officers. He specified that one out of six doctors in the country is a California licensee. Dr. GnanaDev urged that this study be concluded quickly.

Mr. Le voiced that he understands the Board's frustrations and communicated that there are multiple layers of review and approval before an increase can happen. He reiterated that the goal is to give the boards the tool that they need to justify and go through all these layers.

Dr. Lewis inquired if DCA must wait for a new budget from the new governor before salary changes can be made.

Mr. Le answered that he would take that question back to DCA and provide a response at a later time.

Dr. Hawkins asked about the status of the implicit bias training for all boards and bureaus.

Ms. Kirchmeyer responded that the Board is in the process of finalizing the webinar for implicit bias and is currently looking into another vendor for the upcoming year. She added that in the last executive officers meeting there was an implicit bias training.

Dr. Lewis remarked that attending the Board Member Orientation Training two or three times feels a bit redundant. He hoped that there was an easier and less expensive solution for members other than attending this training in person. He requested that Mr. Le share this information with DCA.

Agenda Item 21 Future Agenda Items

Ms. Pines stated that in January the Board is going to invite the patient advocate groups to come meet with the Board in person. The idea is to listen, allow patient advocate groups to share their concerns, see how everyone can work together to make the Board more effective, and how to better protect the consumers of the state.

Dr. Yip requested an update on the outpatient surgery accreditation, adverse event reporting, and credentialing. He recommended that the Board have this presentation once a year.

Mr. Andrist recommended that the Board create a committee of patient advocate groups to work in conjunction with the Board, similar to what CDPH has. He remarked that a committee that would allow dialogue would be helpful.

He added his request for the Public Records Act (PRA) be added to the agenda. He shared that there is a recent case that has come out and two entities, himself and a news station, and the two parties received diametrically opposed dollar amounts to complete the PRA. He concluded that the PRA guarantees transparency, but that he feels like he is being blocked at every turn when he puts in a PRA.

Agenda Item 22 Adjournment

Ms. Pines adjourned the meeting at 12:54 p.m.

Denise Pines, President — Date: 1-31-19

Dr. Bholat, Secretary — Date: 1/31/2019

Kimberly Kirchmeyer, Executive Director — Date: 1/31/2019

The full meeting can be viewed at http://www.mbc.ca.gov/About_Us/Meetings/2018/