



MEDICAL BOARD OF CALIFORNIA

Protecting consumers by advancing high quality, safe medical care.

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Gavin Newsom, Governor, State of California | Business, Consumer Services and Housing Agency | Department of Consumer Affairs

Double Tree By Hilton

2001 Point West Way

Sacramento, CA 95815

January 30-31, 2020

MEETING MINUTES

Thursday, January 30, 2020

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
Dev GnanaDev, M.D.
Randy W. Hawkins, M.D.
Howard R. Krauss, M.D.
Kristina D. Lawson, J.D.
Ronald H. Lewis, M.D., Vice President
Laurie Rose Lubiano, J.D.
Asif Mahmood, M.D.
Richard E. Thorp, M.D.
David Warmoth
Eserick "TJ" Watkins

Members Absent:

Felix C. Yip, M.D.

Staff Present:

Mary Kathryn Cruz Jones, Associate Governmental Program Analyst
Jenna Jones, Chief of Enforcement
Marina O'Connor, Chief of Licensing
Christine Lally, Deputy Director
Sheronnia Little, Information Technology Specialist I
Regina Rao, Associate Governmental Program Analyst
Elizabeth Rojas, Staff Services Analyst
Jennifer Simoes, Chief of Legislation
Laura Sweet, Staff Services Manager III (Retired Annuitant)
Carlos Villatoro, Public Information Officer II
Alexandria Schembra, Associate Governmental Program Analyst
Kerrie Webb, Staff Counsel
Jacoby Jorgensen, Staff Services Manager I
Regina Rao, Associate Governmental Program Analyst
Elizabeth Rojas, Staff Services Analyst

Nicole Kraemer, Information Technology Associate

Members of the Audience:

Gloria Castro, Attorney General's Office
Chris Ryan, Department of Justice, Chief of Operations
Kathleen Nicholls, Deputy Chief, Health Quality Investigations Unit
David Chriss, Chief of Enforcement, Division of Investigation
James P. Marcin, M.D., MPH, Director, Center for Health and Technology
Chris Atkinson, Corporate Personnel Service HR Consulting
Paula Norton, Corporate Personnel Service HR Consulting
Greg Hammond, Corporate Personnel Service HR Consulting
Camille Wall, Corporate Personnel Service HR Consulting
Rehan Sheikh, Physicians for Fairness
Marian Hollingsworth, The Patient Safety League
Eric Andrist, The Patient Safety League
Angela O'Hara, USD Law Center for Public Interest Law
Bennie Thompkins
Hanna Rhee, Black Patients Matter
Zennie Coughlin, Kaiser Permanente
Faith Gibson, California College of Midwives
Reji T. Varghese
Minie Varghese
Yvonne Chong, California Medical Association

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

Ms. Pines called the meeting of the Medical Board of California (Board) to order on January 30, 2020 at 2:05 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

Eric Andrist, The Patient Safety League, commented on an accusation filed against a physician and compared it to the complaints he has filed against various physicians. Mr. Andrist also commented on his public records requests, and pleaded for staff to come forward regarding working conditions at the Board.

Marian Hollingsworth, The Patient Safety League, suggested creating a task force to change how the Board responds to complaints where patients have died or suffered egregious harm. Ms. Hollingsworth also commented on the complaint she filed against Dr. A. Grant Kingsbury, who treated her father, and is now a physician being investigated through the Death Certificate Project.

Hana Rhee, Black Patients Matter, apologized for the lawsuits filed against the Board, commented on the purpose of Black Patients Matter, and discussed unconscious bias. Ms. Rhee commented on interactions with the Board and its staff prior to meetings and urged staff to vacate accusations and decisions which are racially and religiously biased.

Faith Gibson, California College of Midwives, requested an opportunity to do a two-part presentation for the Board on the practice of midwifery in California to include the history of

midwifery and the conflict, areas of cooperation between midwifery and obstetrics, and the specifics of licensing in California for midwives.

Susan Lauren commented on her ongoing case against Dr. Saul Berger and discussed the numerous liposuction injuries and deaths, providing statistics from the Los Angeles Times, and listing the names of the people on the Los Angeles coroner's list of liposuction-related deaths from 1999 to early 2019.

Christina Hildebrand, A Voice for Choice Advocacy, commented on the quality of the phone lines and webcast of the meeting. Ms. Hildebrand also requested some form of formal vaccine adverse event reporting training that is done with physicians. She also discussed adverse reactions from vaccines and suggested that the Board provide an understanding of what standard of care is. Ms. Hildebrand said patients are treated with the cutting-edge research and treatment, and that should be included in what is allowed and defined as the standard of care.

A member of the public reiterated her comments from the November Board Meeting about the discrimination against parents and children who have vaccine injuries, and pediatricians unwilling to write needed medical exemptions per the new law. Allison requested that the Board consider the comments from the numerous people who voiced their opinions regarding SB 276, and take into account various studies that have been done.

Agenda Item 3 Approval of Minutes from the November 7-8, 2019 Quarterly Board Meeting

Ms. Pines asked for a motion to approve the minutes from the November 7-8, 2019, Board meeting.

Dr. GnanaDev moved to approve the meeting minutes

Ms. Pines asked for comments from the Board members, the audience, and the telephone. Hearing none, Ms. Pines asked Ms. Cruz Jones to take the roll.

Motion carried

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 announced that Board staff has published the 2018-2019 Annual Report, which highlights information about physician and surgeon demographics throughout the state. Ms. Pines also announced Board staff has been busy preparing and implementing the new licensing changes that went into effect on January 1, 2020, requiring applicants, regardless of whether the medical school attended was domestic or international, to successfully complete a minimum of 36 months of Board-approved postgraduate training.

Ms. Pines mentioned SB 425 took effect on January 1, 2020, and requires health facilities and entities that allowed licensed healthcare professionals who provide care for patients to report allegations of sexual abuse and sexual misconduct made by a patient against a licensed healthcare practitioner to that practitioner's licensing board within 15 days and referred people

to the website for more information. Ms. Pines mentioned the Board held two expert trainings in the fall.

Finally, she presented the President's Award for 2020. As part of the Board's Strategic Plan, the award is to honor an exemplary employee, who embodies the Board's mission and action. The President's Award for 2020 was presented to Board Counsel Kerrie Webb.

Ms. Pines then asked for questions and comments from the Board members, the audience and from the phone.

Dr. GnanaDev congratulated Ms. Webb on the award. Ms. Webb thanked the Board.

Ms. Rhee commented on the expert reviewer training, saying Black Patients Matter is concerned that the medical experts that are utilized by the Board have no significant experience in racial diversity and religious tolerance.

Mr. Andrist commented on the President's Award and also reminded the Board about his challenges with the Public Records Act.

Agenda Item 5 Board Member Communications with Interested Parties

Ms. Pines inquired if any Board members had anything to report. Hearing none, Ms. Pines asked for any comments from the audience, or over the phone.

Hana Rhee asked for a general definition of Interested Parties.

Agenda Item 6 Executive Management Reports

Ms. Lally welcomed Dr. James Nuovo as the Board's Chief Medical Consultant. She provided background on Dr. Nuovo's experience and noted that he will be refining the Board's Expert Reviewer Program, advising Board staff on policy issues, and serving as a valuable in-house resource.

Ms. Lally also reported the first 2020 training for expert reviewers is scheduled for February 23, 2020, at Loma Linda University. Registration for this training and the Expert Reviewer Program is available on the Board's website. Ms. Lally noted the Board was successful last year in increasing the hourly rate for expert reviewers who complete the training and provide a satisfactory sample report. The hourly rate for case reviews increased from \$150 to \$200 and testifying from \$200 per hour to \$250, and commented that staff are making a concerted effort to have all experts trained this calendar year.

Ms. Lally gave an update on the Executive Director recruitment. She reported the deadline for applications was set for December 13th and then was extended to December 30, 2019 noting the recruitment announcement was advertised in the Capitol Morning Report and also shared with numerous state and national organizations. Ms. Lally stated she was working closely with DCA's Office of Human Resources, and the Selection Committee held the first round of

interviews in early January. The candidates recommended by the Selection Committee were to be interviewed by the full Board in closed session held on January 31, 2020.

Additionally, Ms. Lally discussed the changes to the postgraduate training and licensing requirements for physicians and surgeons. All applicants, regardless of whether the medical school attended was domestic or international, are now required to successfully complete 36 months of postgraduate training. Applicants will need to complete 24 consecutive months of training in the same program in order to be eligible for a physician and surgeon's license in California. A postgraduate training license (PTL) is now required for all residents participating in postgraduate training program in California. Ms. Lally reported that to date, the Board has received 215 PTL applications. The licensing program, the management and staff, continue to work with applicants and programs on questions regarding the new requirements.

Ms. Lally also reported that in addition to the postgraduate licensing changes, the licensing program also successfully launched a new direct online certification submission called the DOCS Portal, with three medical schools. The new portal allows the Board to electronically receive documents, verifications for medical schools, and postgraduate training programs. The automation will improve customer service and expedite license processing. Staff will be onboarding all remaining medical schools and accredited programs by next month.

She updated the Board on the mobile alert app for Apple IOS devices. She reported the app has been downloaded by nearly 11,000 consumers. The Board's IT staff anticipate beginning enhancements by the middle of this year that will provide additional functionality to the mobile app, and once the enhanced functionality has been added to the IOS version, IT staff will be able to fully focus its attention on replicating that functionality for Android devices.

Ms. Lally shared that the Board has received reports from physicians who reported extortion phone calls from people posing as DEA agents, Medical Board staff, or investigators, and the physicians were receiving messages that they were under investigation and were being asked for money. The Board sent an email blast to licensees and physician organizations throughout the state and posted it on social media, alerting physicians to the scam and how to report these fraudulent phone calls. Ms. Lally reminded everyone the Medical Board and DEA will never contact physicians by phone to demand money or any form of payment, nor will the Board or DEA request any personal or sensitive information over the phone. She said reporting scam calls will greatly assist staff in investigating and stopping this criminal activity.

Ms. Lally said the Board's fund has been updated since the last meeting to reflect changes made during the governor's budget-building process. She reported the Board's fund is at 2.1 months reserve at the end of fiscal year '19-20. By next fiscal year, the Board will be at 0.3 months reserve. She explained the fund includes a proposed Control Section 14 loan, which is a loan between the Department of Consumer Affairs (DCA) special funds and the Board. This loan adds \$8 million to the Board's fund in next fiscal year 2020-21 to ensure the Board has enough cash flow to continue operations until a fee increase can be secured. The Board must pay back this loan within 18 months and that includes with interest. She reminded members the Board has a statutory provision that it must maintain between a two and four-month reserve. She stated that without a fee increase, the Board will be insolvent by early next year. Ms. Lally stated the Board last had a fee increase in 2006 and that it recently contract CPS HR

Consulting to conduct a fee study and provide recommendations to the Board based on the results.

Finally, Ms. Lally concluded her report with an acknowledgement of Renee Threadgill, a former Board staff member who recently passed away.

Ms. Pines asked for any questions or comments from Board Members on the report.

Dr. Gnanadev commented on the number of people who have applied for the new PTL and encouraged staff to remind programs about the new PTL.

Mr. Watkins asked if on the statewide expenditure, the \$4 million was an increase.

Ms. Lally replied that is the pro rata the Board pays for state services like paychecks from the State Controller's office, Treasurer's office.

Dr. Lewis asked if there is no fee increase, when the Board would be insolvent.

Ms. Lally reminded him about the loan, but stated that without a long-term fix, and no fee increase, the Board would go insolvent at the beginning of next year.

Dr. Lewis asked how long the loan would provide a reserve.

Ms. Lally said the loan brings the Board even for this year.

Mr. Watkins asked if the loan was just a Band-Aid.

Ms. Lally replied that it was.

Ms. Pines asked if there were any additional questions or comments from the Board and Dr. Gnanadev said he will wait until after the next agenda item. Ms. Pines then asked for audience comments.

Ms. Rhee commented that instead of a fee increase, since California's fees are so high already, there should be a reduction in the number of expert reviewers and consultants.

Mr. Andrist commented on the items in the report saying the report only focuses on the good things the Board has done and not the challenges the Board faces. He also mentioned the issues with the app and commented on the number of public outreach events, saying he has not heard of the events. He reiterated his initial comments regarding complaints and investigations and again encouraged the report to include additional information regarding the challenges the board faces.

Agenda Item 7 Presentation and Possible Action on a Fee Study

Mr. Atkinson and Ms. North began their presentation with an explanation of the parameters of the study, objectives, an analysis of the revenue and expenditures, and the specifics around the methodology and specific fee levels that the Board would need to maintain solvency.

He reminded the Board that since the last physician and surgeon fee increase in January 2006, the Board has experienced significant increases in expenditures, while revenue has remained relatively stable, he stated the majority of the fees are outside of the Board's control and without a fee increase the Board will be insolvent by FY 21-22. Mr. Atkinson went over the budget numbers for FY 18-19 and FY 20-20, stating that the increase in budget equated to 1.5 percent whereas spending has increased 3.8 percent. He also stated that projections in FY 20-21 expenditures will be at \$80.4 million, and will grow to \$94.2 million in FY 24-25.

He highlighted specific costs that are out of the Board's control, specifically payments to the Attorney General's Office AGO, Health Quality Investigations Unit (HQIU), the Office of Administrative Hearings (OAH), and staff compensation and benefits. Additionally, Mr. Atkinson discussed the pro rata costs, and evidence and witness fees.

Mr. Watkins asked what the assumption is in terms of the volume. If that was just an average amount of hours or if it is a four-year period and average it.

Mr. Atkinson replied they were budgeted numbers provided.

Mr. Watkins commented that in the 2018-2019 year, that number was at \$4.1 million.

Mr. Atkinson responded that in the findings the base number there was \$2.7 million. He referred Board Members to item 7, page 5, and the pro rata cost. It identified this as the highest cost, 196.4 percent from \$2.7 million in 2006-2007 and to \$4.1 million in 2018-2019, Item G.

Ms. Lawson confirmed it's just a summary bullet point there that's supposed to be on some different period of time.

Mr. Atkinson clarified there's two different types of pro rata including the DCA pro rata and the general administrative pro rata.

Mr. Watkins said the numbers don't add up and Ms. Lawson commented that the numbers are two different numbers.

Ms. North interjected and said it's a snapshot.

Mr. Atkinson continued with his presentation moving on to specifics regarding, how the needed revenue as well as the different fee amounts were identified. He stated they analyzed the 22 fees they were asked to identify, as well as future volume projections and identified the revenue needed to achieve a four-month reserve over the next five years. Mr. Atkinson also noted the Board is just barely maintaining its solvency in 20-21 due to that Control Section Loan, which is identified in the transfers and that loan has to be paid back to DCA with interest within 18 months.

Next, he stated CPS looked at the fee type and the current proposed fee and the adjusted fee, so for physician/surgeon application, the current fee is \$442, the adjusted fee being \$625. The percent increase for that particular fee would be \$41, which would be an increase of \$183. Taking into consideration the volume for each, that arrives at about a 44.9 percent average increase across the board. He continued saying for instance, the physician and surgeon renewal, proposing a fee of \$1,150 would get the total revenue that would be generated. He reminded the Board that if this went into effect in 2021, the Board would only get half the fees from some physicians due to it being in the middle of the licensing period.

Mr. Atkinson concluded and asked if Board Members had any questions.

Ms. Pines thanked him for his presentation and commented that there should a motion before any discussion. She asked for a motion to approve the recommended fee level increases detailed in table 13 of CPS HR Consulting's Fee Study Report and the Medical Board to authorize Board staff to seek legislation to make the necessary statutory changes to the law as soon as possible with the recommended fee schedule.

Dr. Lewis moved/S: Dr. Krauss

Ms. Pines then asked for comments from the Board.

Dr. GnanaDev commented that the Board only received the report the night before and had no time to review it prior to the meeting and presentation. He also noted that there was only one option given.

Mr. Atkinson noted that CPS HR Consulting was hired in November and had only a few months to conduct the study, which would normally take five to six months to conduct the study. He noted that they completed the study within all the given timelines.

Mr. Watkins asked about ending up at \$1,150 without leaving room for changes and asked for the parameters that were laid out to base the assumption on.

Mr. Atkinson noted the number of months in reserve was the main parameter.

Mr. Watkins commented that with this reserve, one lost lawsuit puts the Board back in the position it is in now.

Mr. Atkinson agreed and stated they tried to find a middle ground between two and four months reserve and that the projections go out to FY 24-25.

Ms. Lally commented that this is a five-year projection and puts this on the same timeline as the next sunset review for the Board where future fee increases could be taken into consideration.

Dr. Krauss said he would be interested to know what the range of fees was across all boards within DCA and how other boards have reduced fees.

Ms. Pines replied that staff looked at the Podiatry Board, whose application and renewal fees are higher and with less licensees. She also commented on a few other states' application and renewal fees as a comparison.

Dr. Krauss also voiced his frustration over not receiving the fee study until the night before the Board Meeting. He also is concerned that if there is a delay, the Legislature will be unable to act in a timely fashion.

Dr. Mahmood said he is concerned about the Board all of a sudden needing to raise fees almost 50 percent when fees haven't been raised over the last few years. He is also concerned about physicians who have other expenses that also rise and if there is a way to limit the costs and expenses by the Board over the next five years.

Ms. Lally reminded Dr. Mahmood that the fees haven't been raised in 14 years, and part of the challenge is maintaining the two-to-four-month reserve. She also said the fund depletion sped up last year due to rising costs by the AGO. She stated that one that happened, the Board's budget had already been set and there was no way to get more added. She also said that costs rose due to collective bargaining for the state employees' salary increases. She reiterated the reasons the costs went up and ensured him the fund depletion wasn't for lack of planning.

Mr. Watkins commented that the Board can't be compared with other Boards because it's not the same. And he said that after reviewing the report, he found that the highest costs were investigative costs, and there is no cost-recovery program for the Board, so physicians being disciplined don't have to repay the Board its costs for investigations. He also commented on the length of time investigations taken and that those costs will continue going up. Finally, he said that he thinks the fees should be higher in order to sustain business effectively.

Mr. Warmoth followed up by asking if a study had been done on the effect of spreading out the increase over the next few years.

Ms. North replied that it was looked into and the method proposed is the healthiest way to get the Board to where it needs to be.

Ms. Lally reminded the Board that the loan still needs to be repaid within 18 months.

Ms. Lawson stated that for attorneys, the annual fee is \$544, which is similar to what the Board is proposing. She also asked what the legislation schedule would look like and what the timeline is.

Ms. Lally replied that legislation would need to be introduced this session with the likely support of the Assembly Business and Professions Committee.

Ms. Lawson asked if the bill deadline has passed.

Ms. Lally replied it hadn't.

Ms. Simoes said the bill deadline is February 21, 2020, and Assembly Business and Professions Committee staff has been assisting and the bill will need to be a committee bill because no legislator is going to carry the bill alone due to it being controversial.

Ms. Lally said if the bill passed, it wouldn't go into effect until January 2021.

Dr. Lewis inquired about how the staff will work on the bill and with all the different permutations of the study.

Ms. Lally responded that time is of the essence and she does hear the concerns about the timing. She apologized for the quick turnaround and once again reminded the Board fees haven't been raised in 14 years, the DCA loan must be repaid, and action needs to be taken.

Dr. Thorp said he understands the urgency, but is concerned the Board is setting itself up for another crisis due to the fact that there are functions out of the Board's control. He said this system is set up for failure because it will repeat in a few years.

Dr. GnanaDev showed one of the fee study graphs and commented that any business run in this manner would go bankrupt. He stated he'd like to hear from the AGO and from HQIU as to why their fees have gone up so much and would like to know why so much money is being spent on credit card processing and on BreEZe. He would like to see the Board control these types of costs.

Mr. Watkins reiterated the cost recovery option, saying that the enforcement system is filled with physicians defending their accusations with no cost recovery. He suggested looking back to the last fee increase and the cost of when you put something in place that makes no sense for a board, but makes perfect sense for the doctors, it's an association. He stated the issues need to be fixed, and to start with the fee increase because that's what's immediately needed.

Dr. Mahmood agreed saying if for the last 14 years there had been a five percent increase every year, the Board would be in a much better position now to take a loan and would have money for the better days, and would not be increasing fee 50 percent in one year. He agreed with Dr. GnanaDev about the expenses and how they should be contained to show responsibility and then increase the fee and look at stepwise approach.

Mr. Watkins commented on revenue and expenses saying there are too many expenses and right now the only option is to raise the revenue.

Dr. Gnanadev suggested that along with the motion, when the law is written that some kind of an expense containment and some cost recovery is included. He voiced his concern that physicians in rural and inner city areas or outside of California will not renew their licenses which will not bring in the right amount of money.

Ms. Pines commented that with sunset review coming up, that would be a good time to look at his suggestions.

Ms. Lubiano echoed other members' comments regarding cost containment and asked for a possible action item as part of the motion.

Ms. Pines responded there is already a motion and a second. She also reminded the Board the loan is already been provided, it is not upcoming. The Board is already in a deficit and let the Board staff do what needs to be done. She said after that, the Board can look at the nine items out of the Board's control at the next meeting and there are a few that can be included in the sunset bill.

Ms. Lawson stated that she supports the pending motion and the direction to staff to provide a plan for what may happen if the legislation doesn't pass at the next meeting.

Mr. Watkins read from 2005's SB231, stating "CMA believes it is more appropriate to recover MBC's cost of investigation through an increase in license fees, and makes allowances for MBC to increase those license fees to compensate for the loss of MBC's ability to pursue investigation cost recovery from individual physicians." He followed up saying these investigation costs that are so high bleed out of that and so it is only right to go back to the source of it and remedy it with the same remedy until we find a way to manage those nine little issues that we don't have control over, because those will need much more serious attention than what we can come up with today.

Ms. Pines thanked the Board Members for their comments, and thanked Mr. Atkinson for his presentation. She then asked if there were any comments from the audience.

Dr. Rhee commented that the Board doesn't need the AGO to represent it. It can hire an outside firm. She said the fee increases make no sense when the Board doesn't have control over them. She stated the study leaves out the endpoint. She asked if the increase in fees is a good value to implement, and it doesn't show that it decreases the number of lawsuits. She encouraged the Board to talk with her regarding her lawsuits because they can be resolved. She suggested looking into HQIU costs and understanding why is it is increasing costs. Finally, she commented that a fee increase will result in less physicians renewing their licenses.

Ms. Gibson suggested increasing the number of letters of reprimand used as a way of decreasing costs since it is a public document that can be accessed by anyone.

Mr. Andrist asked why no one has questioned why the Board is going to be insolvent and reminded the Board of its disciplinary rate. He stated he believes that physician fees funding the Board is a conflict of interest.

Ms. Pines thanks the commenters and asked if there were any comments on the phone. Hearing none, she called for a vote.

Motion carried 10-1 (Dr. Mahmood voted no)

Agenda Item 8 Update from the Attorney General's Office

Ms. Castro and Mr. Ryan provided a presentation on an Annual Report mandated by Business and Professions Code (B&P) Section 312.2. She said the Attorney General's Office (AGO) is required to file the report, which is one of three reports required by the Legislature, regarding enforcement-performance metrics. The report requires the AGO to report on 13 metrics, one for each for each DCA constituent agencies it serves.

The report contains the number of accusations received by the AGO and the number of accusations adjudicated. She stated 50 percent of the work conducted by the AGO for the Board are accusations and the data is based on metrics and milestones and information validating the milestones. In fiscal year (FY) 2018-2019, the AGO adjudicated 390 accusations on the Board's behalf. Of those, 59 cases or 14 percent, went to hearing. Nine percent of those cases, or 34 cases, were managed by default decision. The AGO obtained stipulated outcomes, which include stipulated probation or stipulated surrenders in 73 percent, or 285, of Board cases. She mentioned the AGO rarely withdraws cases, however, withdrew 4 percent of the cases, or 14 cases, on behalf of the Board in FY 18-19.

Ms. Castro said in roughly 34 percent of the cases adjudicated by the AGO during FY 18-19 resulted in the revocation of the license, or a surrender of the license.

Ms. Pines stated the Board has differing data for the FY 18-19 and requested the AGO meet with the Board to rectify the differences. She pointed out there were differences, by at least 16 cases, in the number of cases that the Board referred to the AGO.

Ms. Castro said she would welcome a meeting with the Board and possibly combine the data, or at least provide a better explanation of how the AGO compiled its report. She mentioned the AGO has been collecting the data for three years and has a framework for compiling the data, and the AGO would not be able to change its methodology for compiling the report.

She pointed out that the numbers in the report reflect the number of investigations received by the AGO from the Board, which may eventually lead to a single accusation, and that number will not match the Board's number of accusations. It will match the number of completed investigations, which is 604 individual cases and does reflect the number of accusations that were filed. The AGO may have condensed the investigations sent over by the Board into a single accusation, or used the investigations to amend an existing accusation.

She stated that the Board adjudicated 389 distinctive cases on behalf of the Board. The AGO's Justice Information Service Bureau worked closely with the Ms. Castro's team to compile the data in the report, which includes a preface and a conclusion, and a mean, median and standard deviation for the cases that provide further insight in to the numbers contained in the report.

Dr. Gnanadev asked what accounted for a projected budgetary costs of \$21.4 million in FY 24-25 from \$12 million in 18-19, given that the enforcement model of Vertical Enforcement has sunset.

Mr. Ryan stated the AGO's rate has not increased for 10 years and the increase to the hourly rate of \$220 per hour is based on the number of hours anticipated to be worked in the future and a rate of a certain amount. The \$12 million is the new rate, which is not currently being paid by the Board, which would not have an impact on the rate paid today, but would impact the rate paid in the future.

Ms. Castro added that Vertical Enforcement was a \$1.9 million a year program, the costs of reviewing cases did not go away when the program sunset because the AGO will still review the cases on behalf of the Board.

Dr. Gnanadev mentioned the AGO is partners with the Board and expressed a desire for the AGO to work with the Board to bring the costs down.

Dr. Krauss expressed interest in knowing if the Board was the top utilizer of AGO services among the other DCA Boards and if it were the top utilizer of AGO services per capita licensees.

Ms. Castro said the Board explained there are several factors that influence the Board's usage of the AGO, which are highlighted in the report and include the burden of proof, cost recovery and statute of limitations. She stated the report contains data on each board's usage of the AGO services. The report however does not contain the other work that the AGO does on behalf of the Board including civil litigation, travel to Board meetings and Panel Hearings. The AGO looks for ways to reduce costs.

Mr. Ryan added that the cases tend to be more complicated than other board cases, requiring more hours and driving up the costs for the Board.

Dr. Krauss mentioned it would be helpful for the AGO to regularly advise the Board on the expenses and how small changes can be made to lessen or contain costs.

Mr. Ryan said he would work with his staff to find a way to provide the feedback requested, by way of a new report or an ongoing collaboration.

Ms. Pines asked what percentage of accusations sent to the AGO should be adjudicated for maximum effectiveness.

Ms. Castro stated she did not have an answer to that question, however, in September 2019, the AGO sent a letter to DCA recommending methods to improve the adjudication process. In practice, the AGO should be able to adjudicate all the cases received from the Board. She encouraged the Board to review the report, flow chart and previous years' reports that were also provided in the report that is part of the Board packet. Two new members of the AGO's Health Quality Enforcement Unit were introduced to the Board.

Ms. Rhee mentioned there is not enough information about bias in the report. She spoke of a bias within the AGO that was causing the cost of adjudicating the cases to go up due to civil lawsuits.

Agenda Item 9 Update from Health Quality Investigation Unit

Mr. Chriss and Ms. Nicolls gave an update from the Health Quality Investigation Unit (HQIU). The HQIU currently has five investigator vacancies, which represents a six percent vacancy rate. Out of the five vacancies, four have been given conditional employment offers, pending results of a background check, and one vacancy currently has nine candidates undergoing background checks for it.

With the passage of Senate Bill 425, which requires a mandated report to the Board if a health facility or entity receives a written complaint regarding sexual abuse or sexual misconduct, HQIU is anticipating a significant increase in investigation referrals. A budget change proposal (BCP) was approved to add an additional 11 sworn positions to HQIU to address the increased workload. Five of the positions are slated for July 21, 2020 and the remaining six on January 1, 2021.

Mr. Chriss explained HQIU is conducting hiring panels to select the candidates for the positions so that their backgrounds can be cleared by the time the positions are awarded. HQIU has added additional staff to work on a task force to assist with the pending workload tied to SB 425. The task force has completed 37 investigations and is assigned to 144 active investigations.

Mr. Chriss asserted that HQIU's goal is reducing the timelines for all investigations and to implement a new case monitoring plan. Supervisors will be conducting case reviews with investigators every month on every case, and updates will be entered into the BreEze system. A statewide case review calendar has been established to track the monthly case reviews and a command staff will be ensure that all cases are progressing appropriately.

Mr. Chriss said DOI has also gone through an extensive review by the department's Organizational Improvement Office to identify areas to streamline processes and reduce workload and timelines. An official report is being prepared and it should be released within the next couple of months. HQIU has been working with Board staff and DCA's Executive Office to implement the streamlining efforts as soon as possible, and will have more specific updates to share at the next Board meeting.

He mentioned with the exception of FY 18-19, the number of investigation referrals has been steadily increasing. This fiscal year to date, HQIU has received 800 investigation referrals. With the year half over and at the same pace of referrals, HQIU estimates 1,600 investigations referred to them in FY 19-20, which is a 500 case increase from FY 14-15, with the same number of investigative staff.

Mr. Chriss added that HQIU has also seen a steady increase in the number of investigations completed. Fiscal year 15-16 was at the height of HQIU's vacancy crisis, which was 40 percent. Since then, HQIU has increased productivity in each fiscal year, and in FY 18-19, HQIU completed over 1,400 investigations. HQIU's ability to complete as many cases as it receives directly impacts the closed-case average, and during the FYs 15-16, 16-17 and 17-18, HQIU received more cases than it completed, and this added to the pending workload. With the vacancies filled in FY 18-19, HQIU was able to complete more cases than it received and by continuing with this trend, it will be able to reduce the pending workload and reduce the closed-case average.

Dr. Lewis asked for clarification on average days to complete investigations.

Ms. Nicholls explained the average number of days it takes to close a case versus the actual number of cases completed by HQIU.

Dr. Lewis asked what percentage of cases each year are being completed.

Ms. Nicholls said for several years in the middle, HQIU was not able to complete as many cases as it took in, and it added to the aging of the case. But the trend is that in this last year, HQIU was able to complete more cases than it received. When the trend continues, that closed case average will go down. HQIU still prioritizes and handles the most urgent cases first, so some cases being closed were older, and it affects the closed-case average, so sometimes it appears that things are getting worse, when they're actually getting better. Dr. Gnanadev asked about a projected 44.3 percent increase in HQIU's budget from \$19.6 million in 18-19 to \$28.3 million in fiscal year 24-25.

Mr. Chriss pointed out that the largest things that affected the budget increase are collective bargaining, which is out of HQIU's control, and the passing of SB 425, which calls for additional positions to be added to investigate the workload that's anticipated.

Ms. Nicholls added HQIU has been pushing for these pay raises for several years. The low pay rate led to a lot of the vacancies and the big crisis HQIU had in the vacancy rate. It was because the pay wasn't comparable, so the contract is actually a very good thing. These increases would help HQIU with retention so that it is not turning over staff.

Dr. Hawkins asked how HQIU was doing with the retention of employees.

Mr. Chriss stated HQIU is experiencing its lowest vacancy rate in a very long time, and has a number of additional people in background to fill those positions. It shows interest in this type of work, that the wages are more appropriate for the type of work and people want to have these jobs and want to stay and that's the way it's looking and trending.

Dr. Hawkins asked if they were seeing the skillset that they need

Ms Nicholls said HQIU's new investigators are extremely talented people and are super sharp, analytical, go-getters, really empathetic, have a drive for the mission to protect the public and protect patients, and is extremely happy with the new hires. Regarding retention, she informed that no one has left their position at HQIU since April 2019.

Ms. Pines inquired about an increase in the number days it takes to investigate inappropriate prescribing cases and conviction of a crime cases.

Ms. Nicholls suggested that prescribing cases are highly complex and take a long time to investigate. In regard to criminal cases, oftentimes HQIU opens a case and closes it pending the outcome of the criminal proceedings. The case will be re-opened once the criminal case reached conclusion and more time is added to the investigation of the criminal conviction case.

Ms. Lubiano asked who is referring the cases to HQIU

Ms. Nicholls clarified that the cases were referred from the Medical Board and the other boards served by HQIU, however, the vast majority are referred from the Board.

Ms. Lubiano asked if investigators are completing older cases as fast as they can to make way for newer cases being referred.

Ms. Nicholls said the investigators do focus on age of the cases, however can't just focus on the old cases because newer, more urgent cases are referred to the investigators consistently and the investigators must drop everything and handle the new case. Once the newer, more serious cases are resolved, investigators work on the older cases.

Ms. Rhee commented about the number of cases referred for investigation. When the number of referred cases drops, it doesn't justify an increase in cost. In regard to cost containment, HQIU should put a time limit on the case. If a case cannot be closed within 18 months, then HQIU can't pursue it. HQIU needs to shorten the timeline in light of 11,000 complaints the Board receives. If the cost of a medical license is increased, the Board will see a large number of physicians to drop out of the licensing process

Agenda Item 10 Discussion and Possible Action on Legislation/Regulations

Ms. Simoes stated the legislative session has started but the bill introduction deadline is not until February 21. The Board may have more bills to consider at its next Board meeting.

She spoke of two bills she would be presenting to the Board, one is a two-year bill that has been recently amended and the other is a bill that was introduced in January 2020. In addition, Ms. Simoes stated she will be providing a short update on SB 201.

Ms. Simoes said the Board had four proposals that it sent to the Senate Business and Professions Committee for inclusion in the Committee bill, and contain technical clarifying changes. She has met with legislative staff and answered questions, and the Board's proposals are going through the review process.

She said mentioned she will be working with Ms. Pines and Dr. Lewis on the timeframe for the next Legislative Day, with perhaps holding the day at the end of April or early May. She will be reaching out to Board members to see if they are interested in participating and sending out a poll to the interested members to set up a date that works for everyone.

Ms. Simoes shared that SB 201 would have prohibited treatment or intervention on the sex characteristics of a person under 6 years, unless the treatment or intervention is medically necessary as specified. The bill would have required the Board to develop regulations, however, the bill died in the Senate Business and Professions Committee. Similar language will likely be introduced in another bill and if it is, she will be bringing it to the Board at its next meeting.

Ms. Simoes said AB 1909 would prohibit a healing arts licensee from performing an examination or test on a patient to determine whether the patient is a virgin. The bill would specify that a violation of the prohibition would constitute unprofessional conduct and would be grounds for disciplinary action by the appropriate licensing board. According to the World Health Organization, virginity testing has no scientific or clinical basis.

She stated the World Health Organization says that there is no examination that can prove a girl or woman has had sex, and virginity testing is a violation of the human rights of girls and

women and can be detrimental to women and girls' physical, psychological and social well-being. The type of exam that this bill is prohibiting has no scientific or clinical basis. Board staff is recommending that the Board take a support position on this bill.

Dr. Lewis made a motion to support AB 1909 (s/Dr. Krauss). Motion carried (11-0)

Ms. Simoes explained SB 480, the bill that would require the Board to establish a radiologist assistant advisory (RA) committee. The purpose of the committee would be to identify the appropriate training, qualifications and scope of practice for an individual providing assistance to radiologists. The bill would require the RA committee to be composed of specified members, including two Members of the Board appointed by the Board.

She said the bill would require the RA committee to research and recommend potential statutory changes to grant expanded practice authority to certified radiologic technologists or medical assistants working under the supervision of a radiologist. The bill would specify that members of the RA committee are required to serve without compensation, and would require the RA committee to submit a report that includes the research and recommendations required by this bill to the Board, the Governor, and the Legislature on or before January 1st, 2022.

She noted that SB 480 would require the RA committee to serve in an advisory capacity, but the Board and the California Department of Public Health (CDPH) must adopt regulations to implement relevant recommendations and information contained in the report. This bill would be repealed on January 1st, 2023.

Ms. Simoes said it's estimated they will need a half-time, limited-term AGPA, and that would be a cost of approximately \$57,000 per year just to handle that additional workload. Requiring a new advisory committee to research and identify the scope of practice for individuals providing assistance to radiologists is not an appropriate function for the Board.

She stated the Board currently does not look at the scope of individuals who provide assistance to any type of physician specialty, and there are many different physician specialty assistants in California that may seek similar legislation if this bill were to pass.

She noted the Board already has regulations in place for medical assistants, who can provide technical and supportive services to all physicians. In addition, the Board does not have oversight over any radiologic health licensees. These individuals are currently licensed by the CDPH's Radiologic Health Branch. It may be confusing for the Board to take the lead on radiologist assistants while CDPH has oversight over all other radiologic health licensees. Board staff is recommending that Board take an opposed position on the bill.

Dr. Gnanadev asked how the bill came about.

Ms. Simoes said the Board has had this issue before, anesthesiologist assistants looked for a licensure pathway. This bill originally would have been a licensure pathway for radiologist assistants, and the reason is usually expanded scope, and they can make more money if they are actually a license. The bill got held, it became a two-year bill, and the bill was amended to its present form.

Ms. Rhee asked if the Board would consider patient safety advocates tag along during Legislative Day 2020.

Dr. Lewis made a motion to oppose SB 480 (s/Dr. Krauss). Motion carried (11-0)

Ms. Webb said the Board held a hearing last week on AB 2138 regulations regarding substantial relationship and rehabilitation criteria for revoking a license or denying the license, however, no one gave public comments via written form or in person. The Board will be moving forward with the final statement of reasons and submitting to DCA for approval to submit to the office of Administrative Law for review.

Agenda Item 11 Presentation on Telehealth

Dr. Marcin began the presentation by providing a definition of telemedicine which relates to healthcare provided over a distance using some sort of telecommunication technology. There are typically four bins of telemedicine. One has to do with live interactive video conferencing, and this is a very common, Skype types of interactions with clinicians, and either another clinician with or without the patient, or directly with the patient.

He said there is another category called Store-and-Forward Telehealth, which has to do with review of either images. A classic example of this is with teleradiology or teledermatology, where a dermatologist is able to review an image of the skin lesion, and an ophthalmologist can review an image of the back of the eye for diabetic retinopathy at some later date.

Dr. Marcin explained a third category of telehealth referred to as remote patient monitoring, or chronic disease management, and this has to do with monitoring patients at a distance, and this can be both passive and active. For example, patients with diabetes can have their glucometers monitored, patients with hypertension can have their blood pressure monitored, and patients with issues with congestive heart failure can have their weights monitored and so on. But it also extends into things like your Apple watch and iPhone that are able to measure your activity.

He presented a fourth, rapidly emerging form of telehealth which has to do with direct-to-patient or direct-to-consumer telehealth. Patients or consumers are able to access healthcare professionals, including physicians, on their smartphones or computers and in this way to be able to get consults from wherever they are.

He said the general premise upon which telehealth is established is that a lot of expertise is regionalized, typically in bigger cities such as Sacramento and we as healthcare providers know that regionalization and it helps improve efficiency and quality this way.

Dr. Marcin stated this model of care, while helping efficiency and quality, disadvantages those that live in rural and underserved communities as well as those populations that have limited mobility. The idea is that rather than having the patient always have to come to the regional expertise, that the provider and/or physician is able to use these technologies to reach out to their provider wherever they might be, and the patient where they might be. There's lots of data that has been presented and researched to show the opportunities on telehealth can

improve the overall quality of care. A common category is access to care. There are distance barriers, provider shortages particularly in rural areas, and this is also related to a lack of specialists.

Dr. Marcin explains that the patient experience is also a benefit of telehealth, and has to do with patient-centered care. It's convenient for consumers. If there is a need for a follow-up conversation with a provider or physician after changing a medication after discharge from a hospital or having a procedure, sometimes these can be just simply provided over video in the patient's home. Studies suggest that these modalities of care can improve the effectiveness of care. If you don't have to room a patient, for example, and occupy the space and all of the resources that go into it, including the medical assistants and the nurses, if it can be done simply over video then that's going to be an effective use of this technology as long as the quality of care is consistent and the patient doesn't need to be physically seen.

Dr. Marcin added that data suggests costs of care could be reduced by using these technologies. A common referred-to encounter is somebody with a cold that might otherwise go to an urgent care, or emergency department might be able to have a phone and/or video encounter with a provider and have that issue addressed without having to come to an emergency department, and it is thought to help reduce costs. There are different areas that it's being used including telehealth, mobile health, digital health is being used, outpatient, inpatient, hospital-to-hospital, urgent cares, video visits, remote patient monitoring, or devices that need to be monitored.

He stated telehealth is used in palliative care. It's being used in schools as well to see children that may not otherwise have access to healthcare, nursing facilities, and patients' homes. Regarding the future of telehealth, the two most rapidly and anticipated rapidly emerging applications are in remote patient monitoring or chronic disease management. As much as 25 percent of the population typically uses about 75 percent of the healthcare costs, and if we're able to use these technologies to help provide care and maintain health among these populations at a lower cost by more proactively monitoring them, then that will hopefully overall save the cost of care, and there's lots of data to suggest this. These are some of the devices that can be monitored at home, and even communities now are being built with this in mind, so that there's motion sensors and making sure folks are staying healthy with oximeters and devices this way.

Dr. Marcin said the other big emerging application is the direct-to-patient or direct-to-consumer care. The six largest health plans in the country all have access to their patients, so that they can contact the physician and/or nurse from their device, so it could be from a laptop, tablet, or mobile phone. Large pharmacies are providing telehealth services as well and the idea is provide convenient care to these patients and hopefully maintain health before conditions worsen.

Dr. Marcin explained one of the largest barriers to telehealth is the work force issue. Despite the fact that telehealth can provide benefits, fact is that most clinicians are quite busy and don't have the time to see patients. Payment parity has also been an issue. With the passage of AB-744 last year, health plans are now paying, providers and physicians the same rates as if they were able to see the patient in person as long as that that service can be provided at a safe

level. AB-744 relates to a lot of the commercial plans and Medicaid, but not Medicare. There's lots of restrictions on Medicare which future legislation may solve.

He spoke of the different models of payment including fee-for-service, per click, subscription, and capitated care. Doctors constantly inquire about liability and licensure, and interstate licensure. There's an interstate compact for physicians that California does not participate in and there's credentialing at the healthcare facilities as well. And all of these are rules and regulations that had been in place before the evolution of all of these technologies and so there's a little bit of catching up to do. The hard part is that clinicians are busy and that's probably the biggest barrier.

He said another issue is the integration of telehealth into clinical operations. There are compliance and privilege and credentialing issues, whether or not there can be integration with the electronic health record and what's going to be happening with this data to make sure that there's nothing recorded. Doctors must also consider if the device technologies are FDA-approved and if the data they are obtaining from devices are accurate. There's a lot of background in a multidisciplinary approach that needs to be implemented before clinicians start integrating this into clinical practice.

Dr. Marcin stated there is further research that needs to be done on telemedicine including on the direct-to-patient or direct-to-consumer method of telehealth. The idea is to keep them out of the emergency department and out of urgent care, but some of the research that has been done, including in California looking at the CalPERS data, shows that may not necessarily be what's happening, but rather this convenience results in increased utilization and increased costs, while not providing the same level of care that a patient would receive in person.

Dr. Marcin said health plans have to use the clinicians that are in the patient's own network, which is a good thing. Rather than going online and getting a doctor that may have a California license, but be living in a different state, it wouldn't be the provider doing it, but it would be one of your own providers that has access to your own medical record, so this is definitely a threat to the medical home if not used properly.

Dr. Marcin shared two studies conducted at the Mayo Clinic and UC Davis. At the Mayo Clinic, the study did not show any benefit for patient outcomes and mortality, or length of stay, but it just increased costs when the Mayo Clinic installed tele-ICUs, because more patients requested that they all be transferred to the Mayo Clinic. The other study conducted by UC Davis researched weight. Two populations of patients were assigned to nutritionist, dieticians and interventions to help reduce their weight. Half of the population was given a watch that monitored their steps and after two years of this trial, both cohorts lost weight, but it was the cohort that did not have one of these devices that lost more weight. There's lots of discussion on why that might be, but basically they think that the cohort with the Fitbits ate more unhealthy foods on the premise that they had completed all of their steps using the monitoring watch. More research is needed.

Dr. Marcin provided mentioned the California Telehealth Resource Center that offers free services, free advice on how to set these programs up, and the National Telehealth Policy Resource Center, which provides legal and regulatory assistance related to telehealth.

Dr. Thorp said in the wake of the wildfires that destroyed his practice in Paradise, California, his medical group adopted telehealth methods to treat patients with the help of Blue Shield. However there have been some challenges include financing of the technology and reimbursement rates for care.

Dr. Krauss asked about legislative gaps that need to be filled to protect consumers from being taken advantage of robo-callers selling telehealth services, or anything else that may not be in their best interest. He asked Dr. Marcin if he would be willing to be a resource for the Board to help advise people of legitimate telehealth services and what to be cautious of in providing or receiving telehealth services.

Dr. Marcin replied there is data to show in a direct-to-consumer, direct-to-patient model using telehealth platforms show that they're out to see patients rapidly and they often prescribe antibiotics and medications, and they don't adhere to evidence-based guidelines. The quality of care slips when it's in a for-profit model. AB-744 addressed some of that. He agreed to be a resource for the Board

Dr. Mahmood asked if telemedicine would be much more effective and helpful in consolidating in the beginning for preventive medicine instead of acute care medicine.

Dr. Marcin replied affirmatively and said there are brilliant minds that want to be able to do it, but it is not incentivized this way. He cited diabetes as an example, explaining that physicians have the technology to monitor patients through telehealth, but patients must come into the office to be monitored. The payment models need to catch up in order for providers to utilize telehealth for preventive medicine.

Dr. Gnanadev: Asked about the future of telehealth as it pertains to the gig economy.

Dr. Marcin replied that health plans are figuring this out, but the front-line providers are not yet incentivized to do that, nor are the hospitals necessarily, unless those patient population is capitated. Physicians need to learn how to better keep patients healthy rather than trying to get more money. California needs to change the paradigm with that, and it is a bigger health policy issue than just for telehealth.

Dr. Lewis asked Dr. Marcin to indeed be a resource for the Board should it seek legislation on telehealth and thanked him for his presentation.

Dr. Marcin agreed to be a resource.

Ms. Rhee said her license was revoked California, but was recently renewed in Hawaii. Telehealth is a normal way that physicians treat patients in Hawaii, where it can be difficult to be seen by a physician if they take a day off.

Agenda Item 12 Update on the Physician Assistant Board

Ms. Pines informed that the Board was expecting an update from the Physician Assistant Board, but Executive Officer Maureen Forsyth was unable to join the meeting.

Agenda Item 13 Update on the Health Professions Education Foundation

Dr. Hawkins said the Health Professions Education Foundation (HPEF) met January 8, 2020, in Sacramento. HPEF is a statewide, non-profit organization established to improve access to healthcare in underserved areas of California by providing scholarship and loan repayment programs to help professional students and who are committed to providing healthcare service.

He explained that in return for HPEF support, awarded recipients agree to provide services in medical underserved areas of California for a period of time of one to three years. Scott Sillers resigned as the Chairman of the Board of HPEF and Governor Gavin Newsom will be reappointing someone. HPEF is analyzing recipient surveys to gauge the success of its programs with regard to retention of allied health and physicians in underserved areas.

Dr. Hawkins stated HPEF administers its programs from six funds established by the California State Legislature; however, substantial additional funds are available from the mergers of health companies including Cigna and CVS Health. These funds will increase loan and scholarship for Allied Healthcare Advanced Practice Healthcare Scholarship, and the Steven M. Thompson Physicians Corps Loan Repayment Program (STLRP).

Dr. Hawkins said the Steven M. Thompson loan application is currently open which offers up to \$105,000 in exchange for three years in a medically underserved area of California. The deadline for the application is February 21, 2020, 5 p.m. The HPEF scholarship application cycle opened on January 2, 2020, for allied healthcare, advanced practice nursing and vocational nurses the deadline for students to apply is February 25, 2020, 5 p.m., Pacific standard time.

Dr. Gnanadev added that in addition to applying for a scholarship with STLRP, they should also apply for a scholarship through Cal Healthcare, which pays up to \$300,000 in loan in exchange for a three-to-five-year commitment.

Ms. Pines adjourned the meeting at 5:31 p.m.

Thursday, January 31, 2020

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

Dev GnanaDev, M.D.

Randy W. Hawkins, M.D.

Howard R. Krauss, M.D.

Kristina D. Lawson, J.D.

Ronald H. Lewis, M.D., Vice President

Laurie Rose Lubiano, J.D.
Asif Mahmood, M.D.
Richard E. Thorp, M.D.
David Warmoth
Eserick "TJ" Watkins

Members Absent:

Felix C. Yip, M.D.

Staff Present:

Mary Kathryn Cruz Jones, Associate Governmental Program Analyst
Jenna Jones, Chief of Enforcement
Christine Lally, Deputy Director
Marina O'Connor, Chief of Licensing
Jennifer Simoes, Chief of Legislation
Laura Sweet, Staff Services Manager III (Retired Annuitant)
Carlos Villatoro, Public Information Officer II
Kerrie Webb, Staff Counsel
Emmalee Ross, Information Officer 1
Nicole Kraemer, Information Technology Associate
Jacoby Jorgensen, Staff Services Manager 1
Regina Rao, Associate Governmental Program Analyst
Elizabeth Rojas, Staff Service Analyst
Letitia Robinson, Research Data Specialist II

Members of the Audience:

Megan Allred, California Medical Association
Eric Andrist, Patient Safety League
Rosanna Davis, L.M.M California Association of Licensed Midwives
Marian Hollingsworth, Patient Safety Action Network and Patient Safety League
Wendy Knecht
Jose Luis Gonzalez, executive director, Association of Northern California Oncologists
Nicette Short, legislative advocate, Association of Northern California Oncologists
Susan Lauren, Patient Advocate
Dr. Robin Hansen, Chief of Child Development and Behavioral Pediatrics, UC Davis Health
Dr. Khadijah Lang, President, Golden State Medical Association
Brianna Miller, Board and Bureau Services manager, Department of Consumer Affairs
Dianne Holzer, L.M., Chair, Midwifery Advisory Council

Agenda Item 14 Call to Order/Roll Call/Establishment of a Quorum

Ms. Pines called the meeting of the Medical Board of California (Board) to order on January 31, 2020 at 9:04 a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 15 Closed Session

The Board moved into closed session to consider the appointment or employment of an executive director pursuant to Government Code Section 11126(a)(1). Closed session ended and the Board reconvened in open session.

Agenda Item 16 Public Comments on Items not on the Agenda

Dr. Rhee, with Black Patients Matter, stated she is pleased with the improvements in HQUI Investigative Unit. She also said Black Patients Matter calls for the Board to vacate and withdraw all accusations and cases for which there exists evidence that a racial and religious bias was leveraged against a licensed physician.

Mr. Gonzalez, executive director for the Association of Northern California Oncologists, said he is introducing legislation in cooperation with the Cancer Society. The goal is to allow cancer patients to donate their unused oral anti-cancer medications to their prescribing physicians for use with other patients needing the same medication – programs that would be regulated by the Board. This effort is to avert the waste of expensive anti-cancer medications and minimize the time patients needing those medications have to wait for them. Mr. Gonzalez added that the proposed act would require physicians to inspect all donated medications to determine that they are unadulterated, safe, and suitable for re-distribution. The donated medication expiration dates must be at least six months away. Included in the act will be liability language to ensure patient, donors, and physicians have adequate liability protection, while ensuring both are incentivized to accurately describe the status of the donated medication.

Ms. Short, legislative advocate for Association of Northern California Oncologists and the Medical Oncology Association of California, thanked the Board staff and the California Medical Association for technical assistance through the legislative process.

A member of the public commented that the Centers for Disease Control and Prevention's (CDC) 2014 data showed an autism rate of 1 in 59. She added that according to California Department of Education, in 2018 data, 1 out of 32 students, ages four to six, enrolled in school have autism. At this rate, it is either autism prevention or economic collapse of this country, but research is not addressing the one area that health care consumers and some expert scientists are pointing to. Aluminum adjuvants. She concluded by sharing two studies surrounding aluminum vaccine adjuvants.

A member of the public completed the study from the previous speaker regarding aluminum vaccine adjuvants. She stated that there is enough scientific evidence to stop vilifying doctors and scientists that are investigating these signals. She concluded by saying it is the obligation of the Board to utilize all of its resources to find the cause and prevention of more cases.

Mr. Andrist stated that members of the public were not given timely information on the upcoming interested parties meeting, not allowing him to prepare properly, and forcing him to call the Board staff out during the meetings. Mr. Andrist stated the Board's website was outdated and added that he believed Board staff would benefit greatly from utilizing his own website. He commented on complaints filed with the Board where he felt patients did not get justice.

Ms. Knecht commented on legislation with the Center for Public Interest Law, addressing the ethics in medicine and making doctors accountable to patients by disclosing conflicts of interest. She added that the law is not intended to discourage a doctor's involvement in drug or device trials or research, but to allow patients to have fully-informed consent as they have the right to know. She stated that transparency would improve trust between the doctor and the patient. Ms. Knecht concluded urging the Board to support the legislation and to make ethics in medicine a priority.

Ms. Lauren stated she was assaulted when she went into surgery for medically-indicated breast reduction. She stated that claims of harm continue to come in from other women and that medical records are often incorrect, even with audit trails because doctors make up whatever suits them. She added that she wrote to the Department of Consumer Affairs (DCA) about the failure of the Board in handling her complaint, stating that this is gender-related medical violence, and the state of California sanctions this.

Agenda Item 19 Update on Autism Research

Ms. Pines indicated they would jump forward to agenda item 19, in order to save time.

Dr. Hansen began her presentation stating that there has been a seven-fold increase in the prevalence of autism spectrum disorders based on a systematic study through the CDC that has been going on for many years, using the same strategy in representative populations across the United States. She stated that autism is diagnosed based on two components – impairments in social communications and interactions – which are both determined by looking at behavioral concerns, changes in developmental trajectories, and also by observation.

Dr. Hansen explained that individuals with a diagnosis on the autism spectrum are required to have impairments in these categories, social and emotional reciprocity, deficits in non-verbal communication, and deficits in developing, maintaining, and understanding relationships. She explained that impairments including nonverbal communication, and repetitive patterns of behavior and interests would change over time as they look different between young children to adults. Dr. Hansen described the strong genetic component linked to autism listing statistics between siblings and family members. She stated that autism is present across all social classes and all racial groups.

Dr. Hansen said the Mind Institute is looking at multiple paths and different etiologies to get to a diagnosis of an autism spectrum disorder. She discussed two studies they are researching to look at the retrospective and prospective strategies to look at large groups of children who have, or are at a high risk for autism. One study looked into understanding prenatal, pre-conception, and prenatal folate as it relates to autism. Other studies looked into maternal prenatal health related to inflammation and found that some mothers developed antibodies that react to human proteins – these antibodies are found in mothers whose children have autism – and very rarely in mothers who have children without autism.

Dr. Hansen stated that the best treatment for the core symptoms of autism are behavioral and educational treatments – having the capacity to change both structure and function. She added that in summary, we know that autism spectrum disorders are biologically-based disorders, not created by poor parenting. The diagnosis is made through behavioral assessments, and

currently, there are no specific medical tests to diagnose autism, but early behavioral interventions are the most effective treatments available.

She concluded that the research challenges include thinking broadly about environmental contributors to risk that might be modifiable. Dr. Hansen noted the importance of continuing collaborative and interdisciplinary research – linking the clinical and biomedical phenotyping to understand the complex heterogeneity of autism, while continuing to look at gene environment data to develop more targeted biomedical treatments.

Ms. Pines asked about the ethnic/racial breakdown trends regarding autism

Dr. Hansen replied that the ratio of 4 to 1 in males is similar among racial/ethnic groups, however, children in ethnic groups are diagnosed later and tend to be less involved in many research studies.

Ms. Pines asked what the earliest studies on autism were and what year they were conducted.

Dr. Hansen replied that the first study was in 1943 she believed, and the original thoughts were that it was a biologically-based disorder, and then the thinking changed to the result of poor parenting. Now we've come back to the understanding that it is biologically-based.

Dr. GnanaDev inquired as to the preventative measure for the research.

Dr. Hansen replied that there is a concern for not only autism, but other neurodevelopmental disorders influenced by the environment. This included exposure to pesticides and insecticides in the home which are associated with increased autism risk, particularly during pregnancy. She added that the presence of prenatal and pre-conceptual folate seemed to mitigate the risk for autism. She stated that as a society, we really need to be addressing issues around pesticide exposure to children and mothers as good public health measures.

Ms. Lubiano asked what could drive this kind of research further if there were no restrictions on time and resources.

Dr. Hansen responded that there needs to be more collaboration and researchers working together. She added that another important factor is to make sure that we have connections between the clinical piece with clinicians and the basic biology research animal models.

Dr. Krauss stated that while there is profound autism and a level spectrum disorder that interferes with social interaction and is something that needs attention, there are co-morbidities that are also excellent features.

Dr. Hansen added that there is another area that we, as a society, truly need to recognize that the importance of neurodiversity, celebrating the strengths of people who are on the spectrum.

Dr. Hawkins inquired if behavioral-based diagnosis is the best study as of now.

Dr. Hansen replied that there have been many studies, including looking at saliva samples and genetic risk profiles, but that they're not a diagnostic of autism. Every time we find risk markers, they're just that – they're not a diagnostic. She stated that the risk factors add to the

complexity of autism, why the prevalence is increasing so quickly, and why it feels like an emergency.

A member of the public stated that CDC's autism rate is 1 in 59, and that the statistic is already outdated. She added that at this point, it is either autism prevention or economic collapse of the country.

Ms. Hollingsworth, Patient Safety Advocate, requested the report by Dr. Hansen be put on the Board's website.

Ms. Lauren stated that her phone line audio was inaudible previously and would like another chance for public comment. She stated she was assaulted from her waist to her shins by a surgeon while under anesthesia. She stated that claims of harm continue to come in from other women and that the Board isn't doing real investigations into these claims.

Agenda Item 17 Update on the Board of Pharmacy

Ms. Sodegren began by thanking Dr. Hawkins for his input and partnership on the recently adopted regulations, specifically SB 159, which deals with pharmacists providing PEP and PrEP.

She continued that the Board of Pharmacy has remained focused on its efforts to address prescription drug abuse and the epidemic by offering a six-hour training covering responsibility, prevention of drug losses and naloxone training.

Ms. Sodegren commented on the awareness billboards installed in Northern California, and consumer information and education listed on their website. She added that in addition to the education, regulations have also been developed that require inventory reconciliation activities and reporting requirements for all schedule II drugs. She said that the Pharmacy Board has adopted a policy statement encouraging pharmacies to report prescription drug diversion to law enforcement.

Ms. Sodegren concluded that a focus of last year was emergency preparedness and disaster response, including legislation and online resources.

Dr. Thorp expressed concern about the increasing adversarial relationship between pharmacies and physicians, and physician offices. He stated he is very interested in a work group to re-establish the relationship.

Ms. Sodegren said she'd be happy to take that suggestion to the Board.

Dr. Hawkins commented his concern about pre-exposure prophylaxis, making sure the patient has a primary care doctor for counseling and follow up.

Dr. Lang, President of Golden State Medical Association, stated that the African-American community is currently among the fastest-growing groups of new HIV infections. She added that increasing access to interventions is something of interest to their organization. Dr. Lang expressed concern about the bill and implementation due to the fact the bill does not require a

pharmacist to test the patients for other sexually transmitted infections. They added that they would like to see how the bill would implement follow-up with a primary care physician.

Dr. Rhee, with Black Patients Matter, said discrimination works against under-represented minority patients, and she hopes this is addressed accordingly.

Agenda Item 18 Update from the Department of Consumer Affairs

Ms. Miller began by introducing DCA Director Kimberly Kirchmeyer's stated priorities including the timeframe for processing regulations, obtaining fiscal reports for the department, decreasing the timeframe to perform investigations, working on ADA compliance issues, and ensuring all legislation is implemented by boards and bureaus within the department.

Ms. Miller provided an update to DCA's Regulation Unit, which assists the processing of departmental rule-making proposals. She added that another step DCA is taking to improve transparency and efficiency in the processing of regulations will be the use of a data system that will track regulation submissions in progress so that programs can monitor the status of their regulation packages upon submission to the department.

Ms. Miller updated the Board on DCA's fiscal reports saying they plan to release a new expenditure report in early 2020. She reminded the Board members of Board Member orientation, training, and mandatory forms needing to be filed. She introduced a current project, Organizational Improvement Office that provides change management and collaborative consulting.

Ms. Rhee, with Black Patients Matter, inquired about the diversity training the Board members must take, adding that she doesn't believe it is working.

Agenda Item 20 Update, Discussion, and Possible Action of Recommendations from the Midwifery Advisory Council Meeting

Ms. Holzer asked the Board to approve the following agenda items for the next Midwifery Advisory Council meeting (MAC) meeting; an update on midwifery-related legislation, a report from the MAC chair, an update on the midwifery program, a report from the TASK Force and discussion regarding the data collected on the licensed midwife's annual report, a report from the task force on recommendations to the board regarding vaginal birth after Cesarean legislation, meeting dates for 2020, discussion on revisions to the practice guidelines for California licensed midwives, selection of a new MAC member, and discussion on how MAC will prepare for future fall Medical Board meetings when legislation is proposed.

A member of the public thanked the midwives for their work and asked the Board to honor their requests.

Dr. Lewis made a motion to approve the agenda for the March 5, 2020 council meeting; s/Dr. Krauss. Motion carried (8-0, Dr. GnanaDev absent, Ms. Lawson absent, Dr. Mahmood absent).

Agenda Item 21 Update on the Strategic Plan – Ms. Robinson

Ms. Robinson introduced the Strategic Plan saying it is organized into five goal areas; Licensing, Enforcement, Legislation and Regulation, Outreach, and Board Administration.

Ms. Robinson stated that the Licensing Program launched the new post-graduate training license in BreEZe, and revised all related forms, policies, and procedures. She explained the newly-launched DOCS portal system was being used to electronically receive verification documents from medical schools and programs.

She commented that the Enforcement Program had decreased the complaint review and investigation time. Ms. Robinson noted that the Board conducted four, eight-hour expert reviewer trainings, and hired a Chief Medical Consultant. She concluded Enforcement's update by stating that Board staff met with physicians impacted by the Patient's Right to Know Act to educate them on new legislation, along with adding detailed probation summaries to the Board's website.

Ms. Robinson continued that Legislation and Regulation launched a pending legislation page on its website, outlining bills and monitoring how consumers can engage in the legislative process. She added that the Board also launched a podcast called, "A Look at the Board's Role in the Legislative Process."

Ms. Robinson moved on to Outreach, saying they posted a new brochure titled, "A Consumer's Guide to the Complaint Process," also including a new feature in the Board's newsletter dedicated to consumer information. She commented that the Board launched the physician volunteer registry, providing physicians information regarding where they would be willing to volunteer. Ms. Robinson stated that the Board administration secured an increase for trained medical experts that became effective July 1, 2019. She concluded her updating saying that Executive staff and Enforcement managers collaborated with the Food & Drug Administration regarding more detailed warning letters for the Board's investigative purposes.

Ms. Hollingsworth commented on issues she believed the Board needed to focus on to be considered a premiere consumer protection agency, including maternal mortality, revising reprimands, and improving how the Board deals with complaints about dangerous doctors.

Mr. Andrist commented that high-quality, safe medical care was lacking in all medical boards across the country, saying the Board only ever comments on the wonderful things it is doing and never on its faults. He added that the font on the website was too small for people with vision problems and that he was unsatisfied with the amount of space dedicated to consumers in the newsletter. He concluded that he believed the Board was not interested in fostering relationships with the public and advocates.

Dr. Lang thanked Ms. Robinson for her report, and thanked the Board for the demographic study that the California Research Bureau conducted regarding African-American and Latino physicians. She requested a follow-up on the study. She stated she'd like an update on the Board's implicit bias training to see if it needs additional work or revisions to be most effective. Dr. Lang asked that the Board collaborate with her organization and others alike, to provide education for physicians in terms of record-keeping, ethics, and frequent violations.

Dr. Rhee commented that it was outstanding that Dr. Lang – a leader in the community – was willing to come to the Board meeting and engage with the Board. She added that she believed the Board’s implicit bias training was not effective enough and that it was important for the Board to contract expert reviewers who’ve seen patients that are under-represented minorities.

Agenda Item 22 Future Agenda Items

Ms. Pines inquired if the board members had any future agenda items they would like to add and asked for any comments. There were no future agenda items from the Board members.

Dr. Rhee commented that she would like the implicit bias training and what it entails as a future agenda item.

Mr. Andrist commented that he’d like the Public Record Act to be placed on the agenda.

A member of the public requested that trauma-informed care training for doctors be added to the agenda.

Agenda Item 23 Adjournment

Ms. Pines adjourned the meeting at 3:42 p.m.

Signature on File	5/7/2020
Denise Pines, President	Date

Signature on File	5/7/2020
Dr. Krauss, M.D., Secretary	Date

Signature on File	5/7/2020
Christine Lally, Interim Executive Director	Date