



**MEDICAL BOARD OF CALIFORNIA**  
Executive Office



**ENFORCEMENT COMMITTEE**  
Medical Board of California  
Long Beach Memorial Medical Center  
Miller Children's Hospital  
Room A1-A2  
Long Beach, CA 90806  
November 04, 2010

**MINUTES**

**Agenda Item 1      Call to Order/Roll Call**

The Enforcement Committee of the Medical Board of California was called to order by John Chin, M.D. A Quorum was not present. The meeting continued as a subcommittee with Agenda items; no Action Items, Motions, or Votes took place. With due notice having been mailed to all interested parties, the meeting was called to order at 9:05 a.m.

**Members Present:**

John Chin, M.D.  
Gerrie Schipske, R.N.P., J.D.

**Members Absent:**

Frank V. Zerunyan, J.D.  
Sharon Levine, M.D.  
Reginald Low, M.D.  
Mary Lynn Moran, M.D.

**Staff Present:**

Ken Buscarino, Enforcement Investigator  
Susan Cady, Enforcement Manager  
Jorge Carreon, M.D., Board Member  
Hedy Chang, Board Member  
Maksim Degtyar, Enforcement Investigator  
Eric Esrailian, M.D., Board Member  
Catherine Hayes, Probation Manager  
Kurt Heppler, Legal Counsel  
Teri Hunley, Business Services Manager  
Rachel LaSota, Supervising Inspector  
Ross Locke, Business Services Office  
Natalie Lowe, Enforcement Analyst  
Armando Melendez, Business Services Office  
Erich Pollak, M.D., Medical Consultant  
Regina Rao, Business Services Office  
Sylvia Salcedo, Enforcement Investigator  
Kevin Schunke, Regulations Manager

Anita Scuri, Department of Consumer Affairs, Supervising Legal Counsel  
Jennifer Simoes, Chief of Legislation  
Laura Sweet, Deputy Chief of Enforcement  
Cheryl Thompson, Executive Assistant  
Renee Threadgill, Chief of Enforcement  
Linda Whitney, Executive Director  
Curt Worden, Chief of Licensing  
Barbara Yaroslavsky, Board Member

**Members of the Audience:**

Hilma Balaian, Kaiser Permanente GME  
Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL)  
Neil Desai, Arizona College of Medicine Osteopathy  
Joseph P. Furman, Furman Healthcare Law  
Stan Furmanski, Member of the Public  
Daniel Giang, Loma Linda University Med. Ctr.  
Jim Hay, CMA  
Donna Kary, Member of the Public  
Arjun Makam, Arizona College of Medicine Osteopathy  
Joy Mobley, Member of the Public  
M. Monserratt-Ramos, CU SA Safe Patient Project  
Margaret Montgomery, TPMG  
Gary Nye, Member of the Public  
Rehan Sheikh, Member of the Public  
Mary Lou Tryba, Member of the Public

**Agenda Item 2      Approval of Minutes**

*As a Quorum was not present, a Motion to approve the minutes was not made.*

**Agenda Item 3      Public Comments on Items not on the Agenda**

Stan Furmanski, M.D., member of the public, stated that at the last Enforcement Committee Meeting he had mentioned several concerns with the Physician Assessment and Clinical Education Program (PACE) and had 10 additional issues with PACE that he wished to bring to the Committee's attention. Dr. Furmanski stated that PACE does not have an objective standard for Pass/Fail; PACE lacks valid assessment material for about 40% of physicians that go through the program; PACE does not have appropriate testing and or training materials for doctors in certain specialty areas, such as: Magnetic Resonance Imaging, Stem Cell Research, PET scanning, PET scanning's Positron Emission Tomography, and Transplant Science, indicating that if the incorrect test is performed there is content invalidity; PACE does not have a set way to disqualify an unqualified person who is working at San Diego performing the tests, indicating that un-licensed physicians are performing the tests; and, the Board and or PACE may be in violation of Business and Professions Code 2228, 2292, 2293, and 2294. Dr. Furmanski recommended that the Board create a Grievance and Resolution Committee to listen to and resolve problems with PACE, which could act as a non-binding arbitrator between the Board and physicians who have concerns with PACE.

Mary Lou Tryba, member of the public, provided a handout to Committee Members that contained information on the L.A. County Department of Mental Health, which is seeking

opportunities to connect with faith-based leaders. Ms. Tryba wished to bring attention to this information and urged the State to get involved.

**Agenda Item 4      Presentation of an Overview of Probation Program and Disciplinary Terms and Conditions**

Catherine Hayes, Manager, and Rachel LaSota, Supervising Inspector for the Probation Unit provided a general overview of the Probation Unit, including a Power Point presentation.

In July 2007, the Medical Board reorganized the probation monitoring function and redirected the peace officer investigators (who acted as probation monitors) back to the field investigation unit. The Probation Unit is now staffed with Inspectors whose role is focused on monitoring the probationer's compliance with the terms and conditions set forth in the Decision. The Unit consists of three main offices. The Inspector III is responsible for supervising the day-to-day activities of the Inspectors. Catherine Hayes, Manager over the Probation Unit is located in Sacramento. There are a total of 15 Inspectors statewide, each handling a caseload of 25-30 probationers. The management services technicians provide general support to the office and manage a caseload of probationers that are out-of-state (tolled) or in-state and not practicing, which are referred to as pended.

There are currently 379 active physicians on probation. This caseload is divided among each of the three probation office locations. The cases are assigned to an Inspector according to the geographic area and the address of record for the probationer. In addition, there are 148 physicians on probation that are either not practicing in California or are located out-of-state; which comprise the "pended/tolled" caseload. When probationers are in the "pended or tolled" status, they are not required to comply with most of the terms and conditions in their order with the exception of the general requirements to keep the Board apprised of their current address and contact information and they must obey all laws. The staff handling this caseload contact the probationers bi-annually to ensure they are still "not practicing" and monitor the amount of time spent in a "non-practice" status. For decisions rendered after October of 2003, the Board can cancel the physician's license if the period of non-practice exceeds two years.

The Probation Unit is there to "protect" the consumers by ensuring that probationers stay in compliance with their probation. This is done through constant monitoring by the Inspectors.

The Unit "regulates" probationers' compliance by meeting with them one-on-one on a quarterly basis and as situations arise. Certain terms and conditions require that the probationer provide to the Inspector proof of completion, such as, continuing medical education, community service, education courses, or the PACE program. The Inspector will monitor compliance with these conditions.

The Inspectors "observe" the probationer's behavior and actions. At the quarterly interviews, the Inspector is there to observe the physician's surroundings at his/her place of practice or to observe the probationer to determine behavior that might seem out of the ordinary, especially in cases where biological fluid testing is required and the probationer is exhibiting some unusual behavior.

The Inspectors must "balance" their caseload with their daily activities. Inspectors track their caseload to ensure the probationer is visited within each quarter. At times the Inspector has to

travel long distances to meet with the probationer. During this same time period the Inspectors are receiving correspondence from the probationer as well as reports, such as quarterly declarations, psychotherapy reports, medical evaluations, practice or billing monitor reports, and certificates of course completion. After each quarterly visit a written report is prepared by the Inspector. The Inspector III reviews each report and enters case status information into the notes in the database system.

Situations arise where the Inspector needs to provide “alternatives” to the probationer. In certain circumstances the probationer is not able to comply with the terms and conditions; thus the Inspector can provide alternatives such as surrendering the license, developing a payment plan (if costs are an issue), or petitioning for modification or early termination of probation.

Presently there are 23 optional and 13 standard terms and conditions. The terms and conditions provide assurance that the probationer is being monitored in the areas of deficiency that resulted in placing him or her on probation.

An integral part of the Inspector’s duties is to conduct an “intake interview” just prior to the effective date of the decision. This interview normally lasts one hour and provides an opportunity for the probationer to ask questions to clarify what is required of him or her during probation. The probationer also fills out an information sheet and signs some acknowledgments. After this initial meeting, the probationer should be well informed as to what is required and the timelines. The Inspector prepares a written report summarizing the meeting.

One of the standard terms and conditions of probation is “obey all laws.” If a probationer is convicted of a crime, violates a Medical Board statute or regulation, or violates a federal, state or local law, it will result in a violation of probation and further action will be taken against the license.

“Non-compliance” could be as a result of failing to submit written documents, not following through with required coursework, or not securing a practice monitor. In any case, Inspectors will prepare a non-compliance report identifying the deficiencies and submit it to their supervisors for a request to either issue a citation or refer the case to the Attorney General’s office for further action.

Rachel LaSota discussed the “practice monitor” condition of probation and how it functions as part of probation monitoring.

Currently, there are 183 probationers who are required to have a practice or billing monitor. This condition is recommended in cases involving clinical skills deficiencies, such as gross negligence, excessive or inappropriate prescribing, or violations related to physician impairment by drugs or alcohol, sexual misconduct, or ethical violations, such as dishonesty and criminal convictions.

This condition requires that the probationer identify and propose a practice monitor within 30 calendar days from the effective date of the Decision. The practice monitor must be someone who has no prior or current business or personal relationship with the probationer. This requirement was designed to ensure that the monitor could provide fair and unbiased reports to

the Board. The practice monitors are “reimbursed” by the probationer for any costs associated with acting as a monitor and these fees typically range from \$100 to \$600 per hour.

Once the probationer has identified a potential practice monitor, the Inspector reviews the physician’s background, including any complaint or disciplinary history and his/her qualifications. If approved, the Inspector will provide to the monitor a brief overview of the Board’s expectations and a monitoring plan.

The monitor is expected to visit the probationer’s practice location at least once a month. During the visit, the monitor randomly selects 10% of the probationer’s charts to review. The objective of the chart review is to allow the monitor to make an assessment as to whether the probationer is practicing “within the standard of care.” A quarterly report is prepared by the monitor to confirm that the reviews have taken place and identify any deficiencies noted during the chart review.

The practice monitor does not provide any on-site or direct supervision and visits the probationer’s office once a month at a scheduled appointment. While this may be considered adequate to evaluate a clinical skills deficiency, there is a concern that the random chart review does not provide adequate public protection for probationers charged with sexual misconduct or substance abuse issues.

A concern identified with the current system is the difficulty to find a practice monitor with no prior relationship with the probationer. In most cases, the physician is acquainted with the proposed practice monitor. Frequently, the probationer will indicate that he/she knew the practice monitor when they both worked at a specific hospital in the past, or they went to school together. However, the extent of the relationship in many cases is not easy to discern and the Inspector does not have the resources or time available to verify this. The purpose of this requirement is to attempt to ensure that the practice monitor can and will provide objective and unbiased assessments of the probationer’s performance.

Additionally, it is not uncommon for physicians nominated to act as practice monitors to express concern about “the liability they might be assuming”. The current statutes expressly provide immunity to the Board’s medical experts and medical consultants, however, the practice monitors do not explicitly have this same protection.

In order to formulate plans for improving the practice monitor term/condition, the Probation Unit developed several ideas it believes might strengthen the practice monitor and meet the objectives of consumer protection.

The Physician Enhancement Program is currently approved by the Board as an alternative to identifying and nominating a practice monitor. This alternative can be expensive for the probationer but the program is well developed and provides an excellent example of a mentoring program.

The Probation Unit has considered the option of developing and maintaining a pool of physicians trained to provide this service. A training program and material similar to the program currently have in place with the Expert Reviewer Program could be developed.

The Probation Unit also considered a training program for the practice monitors and requiring completion before the monitor can be used. PACE currently offers a 4 hour training class entitled "From Monitoring to Mentoring" and PACE has offered to allow the Probation Unit to use material from this course.

Several areas were identified that could be improved internally, such as, providing better instructional material for the monitors, standardizing the report formats, and providing a checklist of items to review during the quarterly visit with the probationer.

Ms. Schipske agreed probationers must be adequately monitored. Ms. Schipske felt that providing the necessary means to have an adequate practice monitor should be a top priority for the Board, including providing additional staffing, making legislative changes, or making procedural changes. Ms. Schipske agreed that the lack of immunity for the practice monitors is a concern. Ms. Schipske would like to make a recommendation to the full Board to allow immunity for practice monitors.

Dr. Chin stated that the idea of having a probationer select his/her own practice monitor was a concern. He also felt that the requirement to review 10% of office charts per office was not suitable when substance abuse or other types of abuse were involved. Dr. Chin felt that the PEP program sounded excellent but had concerns about how this type of program could be extended throughout the state, the necessary budget, and the availability of enough physicians to maintain the program.

Gary Nye, M.D., member of the public, has worked with probationers for many years and felt that the 30 day length of time to find a monitor was a major problem and would like to see that time frame extended. He also agreed that programs like PEP and granting immunity for monitors were key elements.

Rehan Sheikh, member of the public, expressed concerns that probationers could be selecting practice monitors that would be favorable to the probationer. He inquired if the Board was requiring probationers to go through UC San Diego because those monitors would be unbiased. Kurt Heppler, Legal Counsel, responded there is no requirement.

Jim Hay, CMA, supported the idea of immunity for monitors and stated that the CMA would be willing to provide assistance with getting this into statute. CMA could also provide assistance with finding monitors as their IMQ currently trains surveyors and this could be something investigated as a possibility to help. For those probationers who have substance abuse, dependence, or mental health issues, CMA could assist with creating requirements for the monitors of these types of probationers as they are currently working on a physician health program. CMA is willing to work with the Board on finding monitors, making sure the requirements for monitors are appropriate, and granting the monitors statutory immunity.

Joseph Furman, member of the public who represents physicians in Board matters, stated that granting the practice monitors immunity was an outstanding idea. He felt that for purposes of public protection, it would place the monitors at ease, allowing them to be more candid in their reports to the Board. Mr. Furman stated he would be willing to support this in any way he can.

## **Agenda Item 5**

### **Presentation of How CURES is Utilized by the Enforcement Program**

Ms. Sweet provided a presentation on the Controlled Substance Utilization Review and Evaluation System (CURES). CURES, which is administered by the Department of Justice, Bureau of Narcotic Enforcement, is an investigative tool used by the Board to investigate allegations of inappropriate prescribing and over prescribing. Ms. Sweet provided a power point presentation that included examples of reports from the CURES system.

CURES evolved from the Triplicate Prescription Program that was created in 1940. The Department of Justice collects Schedule II, III, and IV prescription information from pharmacies on a weekly basis, via an electronic data transfer system that allows for analysis and retrieval of data. The system allows registered practitioners, pharmacists, law enforcement, and regulatory boards instantaneous web-based access to controlled substance history information, 24-hours a day.

Boards that have access to CURES include: the Medical Board, Registered Nursing, Veterinary Board, Osteopathic Medical Board, Dental Board, and the Board of Pharmacy.

The two primary functions of CURES are prevention & intervention for patients and investigation & enforcement for law enforcement.

A Patient Activity Report is available to prescribers, which contains the prescribing and dispensing history contained in CURES for Schedule II, III, and IV controlled substances of patients under the requesting medical provider's care. This information is only available to prescribers and pharmacists registered with the Department of Justice. This report is beneficial for prescribers as it allows them to become aware of patients who may be drug seeking, and provides them the ability to make more informed decisions on prescribing and types of medications that are being prescribed. It is beneficial for patients, as prescribers may be able to provide intervention. For patients who are not drug-seeking, they can benefit from the prescribers' ability to feel more comfortable in prescribing medicines they need.

On September 15, 2009 the CURES Prescription Drug Monitoring Program (PDMP) database became available online. PDMP allows immediate access to the database and is available to prescribers, pharmacists, and law enforcement personnel. Once an application is received and approved, the requestor has real-time access to the database.

Ms. Sweet presented a case study.

Medical consultants and investigators are trained to look for patterns. In these types of cases, other investigative techniques are also used, including surveillance, undercover operations, search warrants, and subpoenas duces tecum. Medical records are the key pieces of evidence as they typically tell whether the physician is treating a legitimate pain patient or is prescribing indiscriminately. The basic question asked is: have the pain management guidelines been met? Medical Board investigators are trained extensively on distinguishing between patients who have legitimate pain problems and those who are seeking drugs inappropriately.

During the investigative process, the subject is interviewed, and then typically the case is sent to an expert for review. The expert's opinion will indicate if there has been: no departure from the

standard of care; a simple departure; an extreme departure; excessive prescribing' inadequate record keeping; prescribing without a legitimate medical purpose; prescribing without appropriate prior exam, or violating other drug statutes. Based on the expert's review, the case will either be closed or referred to the District Attorney or the Attorney General.

Dr. Chin inquired if it was necessary to have someone indicate to the Board a person of concern or if there was a way to set thresholds within the system to alert staff of possible prescribing concerns. Ms. Sweet responded that this is not currently done often as investigators are looking at the whole picture, as some cases indicate high volumes of prescribing and are appropriate to the case.

Dr. Chin was concerned that if this process is not being performed, then cases that are not brought to the attention of the Board would not be investigated. Ms. Sweet responded that other agencies that work with the Board, such as the DEA and Bureau of Narcotics, have tools in place to review quantities and work with thresholds, and notify the Board of identified concerns.

Dr. Chin asked if this process is something that should be re-reviewed. Ms. Threadgill responded that due to limited resources the Board is not able to pursue this at this time, however, in the future when more resources are obtained this could be looked into.

There were no public comments.

**Agenda Item 6** **Agenda Items for January 27-28, 2010 Meeting in San Francisco, CA**

Suggested agenda items included:

- Presentation of an Overview of the Enforcement Programs, Components and Processes
- Progress Report of Expert Reviewer Training

Ms. Schipske requested that cost projections be provided at the next meeting for Probation Monitoring. However, as a quorum was not present this could not be formally added to the Agenda.

There were no public comments.

**Agenda Item 7** **Adjournment**

There being no further business, the meeting was adjourned at 9:56 a.m.