OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Board Meeting, Thursday, January 17, 2019
10:00 a.m.

Osteopathic Medical Board of California
1747 North Market Blvd.
Hearing Room
Sacramento, CA 95834

OMBC Phone (916) 928-8390

TABLE OF CONTENTS

TAB 1 **AGENDA**

TAB 2 **MINUTES BOARD MEETING**

- **September 27, 2018**
- **October 15, 2018**
- **December 13, 2018**

TAB 3 **ADMINISTRATIVE HEARING**
(*MATERIAL FOR BOARD MEMBERS ONLY*)

TAB 4 **BUDGET UPDATE**

TAB 5 **STRATEGIC PLAN UPDATE**

TAB 6 **MBC - GUIDELINES for the RECOMMENDATION of CANNIBIS for MEDICAL PURPOSES**

TAB 7 **OMBC OUTREACH and EDUCATION**

- **AB 1753 – Controlled Substance Prescription Form Serial Number Requirement**
- **AB 2760 – Prescription drugs: prescribers: naloxone hydrochloride and other FDA-approved drugs**

TAB 8 **EXECUTIVE DIRECTOR'S REPORT – ANGIE BURTON**

- **Enforcement Report – Corey Sparks**

TAB 9 **AGENDA ITEMS FOR NEXT MEETING**

TAB 10 **FUTURE MEETING DATES**

Tab 1

Osteopathic Medical Board of California

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
DEPARTMENT OF CONSUMER AFFAIRS • OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834
P (916) 928-8390 | www.ombc.ca.gov

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

BOARD MEETING NOTICE AND AGENDA

Date: Thursday, January 17, 2019
Time: 10:00 a.m. – 5:00 p.m. (or until the end of business)

Location(s): **Department of Consumer Affairs**
Headquarters Building 2 (HQ2)
1747 North Market Blvd.
Hearing Room
Sacramento CA 95834
(916) 928-8390

AGENDA

(Action may be taken on any items listed on the agenda and may be taken out of order, unless noticed for a certain time.) The Board plans to webcast this meeting on its website at https://thedcapage.wordpress.com/webcasts/ . Webcast availability cannot, however, be guaranteed due to limited resources or technical difficulties. The meeting will not be cancelled if webcast is not available. If you wish to participate or to have a guaranteed opportunity to observe, please plan to attend at a physical meeting location. Adjournment, if it is the only item that occurs after a closed session, may not be webcast.

Open Session

1. Call to Order and Roll Call / Establishment of a Quorum

2. Public Comment for Items Not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section except to decide whether to place the matter on the agenda of a future meeting [Government Code Sections 11125, 11125.7(a)]

3. Introduction of New Board Member(s)

4. Election of Officers

5. President's Report

6. Review and Approval of Minutes:

   - September 27, 2018 Board Meeting
   - October 15, 2018 Teleconference
   - December 13, 2018 Board Meeting

7. Petition for Reinstatement of License, John Wogec, D.O., 20A 6934

8. Petition for Early Termination of Probation, David Orringer, D.O., 20A 15139

CLOSED SESSION

Pursuant to section 11126(c)(3) of the Government Code, the Board will meet in closed session for discussion and to take action on disciplinary matters, including the above petitions.

RECONVENE IN OPEN SESSION

9. DCA Update – Patrick Le, Assistant Deputy Director, DCA

10. Budget Update – Sarah Hinkle, DCA Budget Office

11. Strategic Plan Update

12. Review and Discussion - Medical Board of California Guidelines for the Recommendation of Cannabis for Medical Purposes

13. Discussion of OMBC outreach and education efforts related to:

    - AB 1753 - Controlled Substance Prescription Form Serial Number Requirement
    - AB 2760 - Prescription drugs: prescribers: naloxone hydrochloride and other FDA-approved drugs

14. Executive Director's Report – Angie Burton

    - Licensing
    - Staffing
    - CURES
    - Enforcement Report / Discipline – Corey Sparks

15. Introduction and Swearing in - New Executive Director

16. Agenda Items for Next Meeting

17. Future Meeting Dates

18. Adjournment

For further information about this meeting, please contact Machiko Chong at 916-928-7636 or in writing 1300 National Drive, Suite 150 Sacramento CA 95834. This notice can be accessed at www.ombc.ca.gov

Government Code section 11125.7 provides the opportunity for the public to address each agenda item during discussion or consideration by the Board prior to the Board taking any

action on said item. Members of the public will be provided appropriate opportunities to comment on any issue before the Board, but the Board President may, at his or her discretion, apportion available time among those who wish to speak. Individuals may appear before the Board to discuss items not on the agenda; however, the Board can neither discuss nor take official action on these items at the time of the same meeting. (Gov. Code, sections 11125, 11125.7(a).)

In accordance with the Bagley Keene Open Meeting Act, all meetings of the Board are open to the public and all meeting locations are accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting, may make a request by contacting Machiko Chong, ADA Liaison, at (916) 928-7636 or via e-mail at Machiko.Chong@dca.ca.gov or may send a written request to the Board's office at 1300 National Drive, Suite 150, Sacramento, CA 95834-1991. Providing your request at least five (5) business days before the meeting will help to ensure availability of the requested accommodation.

Tab 2

Minutes - September 27, 2018

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991
P (916) 928-8390 F (916) 928-8392 | www.ombc.ca.gov

BOARD MEETING
MINUTES

Thursday, September 27, 2018

BOARD MEMBERS PRESENT: Joseph Zammuto, D.O., President
Cyrus Buhari, D.O., Secretary/ Treasurer
Andrew Moreno, Board Member
Claudia Mercado, Board Member
Cheryl Williams, Board Member
Elizabeth Jensen, D.O., Board Member

STAFF PRESENT: Angelina Burton, Executive Director
Terri Thorfinnson, J.D., Asst. Executive Director
Sabina Knight, Esq., Legal Counsel, DCA
Machiko Chong, Executive Analyst
James Lally, D.O., Medical Consultant
Corey Sparks, Lead Enforcement Analyst

BOARD MEMBERS ABSENT:

The Board meeting of the Osteopathic Medical Board of California (OMBC) was called to order by President, Joseph Zammuto, D.O. at 10:00 a.m. at Department of Consumer Affairs (HQ2) - 1747 North Market Blvd., Sacramento, CA 95834.

1. Roll Call

Ms. Chong called roll and Dr. Zammuto determined that a quorum was present.

2. Public Comment for Items Not on the Agenda

No Public Comment was received by the Board.

3. Review and Approval of Minutes

Dr. Zammuto called for a motion for approval of the Board meeting minutes of the May 17, 2018, and July 10, 2018 Board meetings.

- **Motion to approve the May 17, 2018 and July 10, 2018 Board meeting minutes with no corrections. Motion** – Dr. Buhari **Second** – Dr. Jensen
- Roll Call Vote was taken
  - **Aye** –Dr. Buhari, Dr. Jensen, Ms. Mercado, Mr. Moreno, Ms. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – None
  - **Absent** – None

Motion carried to approve minutes with no corrections.

4. Board President's Report

Dr. Zammuto informed the Board that he attended the annual meeting of the American Association of Osteopathic Examiners (AAOE) in Chicago on July 19th. There were 16 state boards in attendance consisting of individual licensing boards which process licensing applications of only osteopathic physicians, as opposed to composite boards which process applications for allopathic and osteopathic physicians. The AAOE provides the osteopathic state boards with the ability to discuss national policy and concerns within the osteopathic profession. At the meeting Dr. Chaudhry, President and CEO of the Federation of State Medical Boards (FSMB) met with attendees to discuss current issues. The FSMB is composed of 70 boards consisting of 50 state medical boards, 16 state osteopathic medical boards, and 4 territories (Guam, Virgin Islands, Puerto Rico, & Commonwealth of the Northern Mariana Islands). Attendees also received a presentation from the President of the National Board of Osteopathic Medical Examiners (NBOME) with updates on the status of testing for medical students. The American Osteopathic Association (AOA) provided representatives with a legislative update and informed attendees that a Canadian organization has recently surfaced and claims to not only offer certification in osteopathic medicine utilizing online programs but allows attendees to call themselves "trained in osteopathic medicine." The program is not duly sanctioned in the United States and licensing boards have been fielding calls from applicants inquiring whether they are able to obtain osteopathic licensure with the Canadian certification received online. It has become not only a state concern but a national concern regarding a misrepresentation of physicians within the profession and also misleading to the public/consumer.

Mr. Moreno asked if there were any other states that have been willing to accept applications from Canadian certified osteopaths and was informed by Dr. Zammuto that

unfortunately those applicants do not meet the Federally mandated requirements that have been implemented which require that physicians applying for licensure be educated in the United States.

Ms. Williams inquired if there would be a competency test compiled and administered in the future to test the aptitude of nationally trained osteopaths and was advised by Dr. Zammuto that he was not aware of any at this time.

Unfortunately, the board(s) does not have authority over these individuals as they are not licensed by the regulatory agencies, which is a matter of concern. Therefore, the AOA and its legal department have been looking into the issue and will provide updates as they become available.

They also discussed the issue of preventing physician burnout and safe-haven protection for physicians. Kathleen Creason, the new Executive Director of Physician Wellness Institute -California Medical Association, which is a joint effort with Stanford University, will be addressing this issue. Dr. Zammuto applauded Ms. Creason's decision to move into the new position and noted that it would greatly impact not only the healthcare profession and physicians, but also medical students, residents, and interns. There is a major risk of burnout at each of these stages as well as increased risk of substance abuse and suicide. There is a realization that the profession needs to be more proactive and reactive at assisting physicians to prevent future burnout.

Dr. Zammuto found it interesting that postgraduate training licenses were also discussed at the meeting, as the Board is currently preparing to implement the new postgraduate training license created by Senate Bill 798 (Hill). He informed the Board that there are other states who currently issue both postgraduate training licenses as well as the unrestricted licenses. Dr. Zammuto also stated the FSMB will be more than willing to assist the Board with the implementation of the postgraduate training license as well as provide any additional legislative updates that are introduced as they become available.

5. Budget Update – Mark Ito, DCA Budget Office

Mr. Mark Ito provided the Board with a detailed overview of the Board's up to date fund condition for this fiscal year.

Mr. Moreno inquired whether there is a standard range for months in reserve that the Board should remain within and was informed by Mr. Ito that the Board is in a good place right now,and should maintain between 6-12 months in reserve. Dr. Zammuto inquired if there were any markers that would prompt the Board to consider a fee increase to ensure that there are sufficient funds. Mr. Ito indicated that there is a process including a fee audit to look at the entire program costs, etc. to determine the

amount of increase, if any needed. The Board will need to have statutory changes made to increase the current licensing fees unless there is something already in statute with a higher ceiling amount. Then the Board will only need to promulgate regulations to increase the fees. The Board was reminded that they have already approved a fee increase at a prior Board meeting.

6. Executive Director's Report

Angie Burton updated the Board on licensing statistics, staffing, CURES statistics and the Postgraduate Training License, which were included in the Board packet.

Staffing - Ms. Burton informed the Board that they have concluded the search for a new Medical Consultant and was happy to announce that James Lally, D.O. was hired as the Board's new Medical Consultant.

Nicole Le, Chief, DCA Office of Human Resources (OHR), provided the Board with information regarding the process of hiring a new Executive Director when Ms. Burton retires.

Ms. Le explained that OHR would be working closely with the selection committee who will be reviewing applications and conducting interviews of candidates who have applied for the executive director position. Ms. Le stated that OHR has been working closely with Ms. Burton on revising the proposed duty statement as well as the vacancy posting which would be used on the ECOS system. Ms. Le advised that the Board should consider setting a date to conduct a teleconference regarding review and approval of the proposed documents so that they may continue with the recruitment process. She stated that additional advertising could be published through the Capitol Morning Report and could also be posted on social media outlets such as Facebook, Twitter, etc. She stated that the members of the selection committee should have a well-rounded understanding of the Board as well as be able to address any challenges that they foresee being an issue for this Board to ensure selecting the best candidate to fill the position.

Mr. Moreno inquired whether remaining Board members would be able to interview the final candidates and was advised by Ms. Le that the selection committee would be doing all preliminary interviews to narrow down the candidate pool and that the full Board will interview the top candidates. Ms. Le recommended that the interviews be conducted near the end of November, with the full Board meeting in December. If the Board members are unable to select a qualified applicant, the Board would have the option of appointing an Interim and/or Acting Executive Director. Ms. Le explained that Interim and Acting appointees would have the same duties and responsibilities,

however an Interim Executive Director would need to be voted in by the Board members and would be eligible to receive compensation for services rendered. On the contrary, an Acting Executive Director need only be appointed by the Board President and would need to be a current Board employee, however they would not receive any compensation for serving as an Acting Executive Director.

Ms. Burton informed the Board that she was not able to provide an accurate detailed report of the Board's budget as there have been issues with monthly report productions under the new system being utilized. However, the information that was provided by the DCA budget office should be comparable to the actual fund projection. She also provided updates regarding the remodeling of the Board's office space and notified the members that the Board was approved to purchase a high density filing system, which should provide major space saving in the suite.

CURES – Dr. Zammuto noted that there have been many physicians who have experienced issues when changing their passwords at the 90-day mark, and the result has been that some security questions previously utilized by enrolled physicians no longer worked. The physician would need to contact the help desk for assistance. Another issue Dr. Zammuto noticed was that the CURES database created by DOJ does not coincide with other databases outside of the state to ensure that there are not multiple prescriptions being issued to patients.

Ms. Burton notified the Board that there are currently 6,116 osteopathic physicians registered in CURES. Representatives at the CURES unit have notified the Board and provided them with a list of physicians who are not yet registered for one reason or another.

Enforcement/ Discipline - The Board's Lead Enforcement Analyst Corey Sparks presented the enforcement report to the Board and provided written materials showing various enforcement data.

7. Discussion Regarding Mental Health Question on OMBC Initial Application

Concerns have recently been raised regarding mental health questions asked on the Physicians and Surgeons application for licensure. Ms. Creason noted that the FSMB has released numerous documents regarding physician burnout and the questions that they feel should be used by regulatory boards asking about the mental health status of an applicant. Ms. Creason has reviewed numerous documents in her new role with the Physician Wellness Institute and noted that one of the causes leading to physician burnout is the stigma surrounding mental health issues. Physicians are trained to be resilient individuals and to be strong and may not admit to weakness for fear of potential impact on licensure. Ms. Creason added that a recommendation has been made to ask

about the current mental and/or physical health conditions which may impact their ability to safely practice medicine. By asking questions that are not directly related to the physician's ability to provide quality patient care it allows them to focus more directly on the physician's mental state. She recommended consideration and adoption of the FSMB's language which was provided to Ms. Burton and the Board members.

Dr. Zammuto added that the American Osteopathic Foundation (AOF) is in the process of developing a funded process specifically targeting osteopathic medical students who are at risk of burnout or suicide. The AOF is in the process of compiling the resources necessary to fund such a project. They are very much involved and concerned about the health and well-being of up-and-coming physicians within the profession.

Dr. Lally inquired on the current verbiage regarding mental health on the Board's application and Ms. Burton provided him with the current language. Dr. Zammuto noted that nationally there may be some physicians who may be at risk of burnout but are not willing to disclose the specifics of their condition. Therefore, the hope is that the revised question will remain more open ended which will allow physicians the ability to be more open and willing to disclose any conditions that may be present.

Ms. Burton noted that the Medical Board of California (MBC) application was also included in the Board packet so that the Board can review their mental health verbiage however, the MBC is also in the process of revising their mental health status information. The MBC will be reaching out to the Board to provide them with updates as they progress.

Ms. Mercado asked what the Board would do in the event that a physician chooses to disclose their mental health information? She was advised by Ms. Burton that it is a case by case scenario and that the Board does request mental health evaluations for those physicians who provide the Board with notification of mental health impairments.

8. Title 16 California Code of Regulations: Update, Discussion, and Possible Action

<u>Section 1690 – Postgraduate Training License Non-Refundable Application Fee</u>

Ms. Thorfinnson provided the Board with background information and policy memo explaining the justification for the Postgraduate Training License Non-Refundable Application Fee regulation packet.

Ms. Thorfinnson noted that the Board would not be able to implement the fee change in BreEZe until the Board has promulgated regulations. Ms. Thorfinnson is hoping to expedite the regulation process for this packet to ensure that the language is approved in time for the fees to be implemented, as she is aware that the average time frame could take upwards of 2 years.

Dr. Zammuto inquired on the last time the Board increased its fees and was advised by Ms. Burton that the last fee increase took place in 1995, however it was only a temporary 2-renewal cycle increase which raised the biennial renewal fees from $200/yr. to $300/yr. In 1999 the Board reduced the biennial fee back to $200/yr. for the renewal cycle.

Ms.Thorfinnson noted that she is bringing the regulatory proposal to the Board because it would be considered new workload and cost attributed to implementation and ongoing maintenance of the new license type. The Board may promulgate fees for new workload without respect to their reserve as fees cover workload. If the fees are raised for the current workload, it would be more complex. For the proposed postgraduate training license fee, the Board needs to consider the new workload and expense attributed to the new workload, implementation and ongoing management costs. The proposed fees will not cover the implementation in its entirety, however the Board was also provided with some considerations to review with regards to covering those costs.

Dr. Zammuto inquired if any of the finances consider the money that may possibly be received between FY 19-20 and was advised that revenue for this new license type would not begin until January 1, 2020. The fiscal impact of the new license fee not covering its implementation and ongoing maintenance expenditures, is that it will add to the Board's structural deficit. Ms. Thorfinnson explained that currently the Board has a structural deficit which reflects that the Board is consistently spending more money than it receives in revenue each year. Fiscally, the Board will to have to raise its fees in the future to eliminate this structural deficit. The Board may possibly need to consider raising fees around FY 20-21, in order to maintain a healthy reserve fund condition.

If the Board opts to implement the proposed $400 application fee, which would be nonrefundable and last 3 years, the Board would generate $120,000, however it would not meet the $350,000 cost to create the positions needed to implement, issue and enforce this license. However, if the Board was opting to cover the costs then it would need to charge roughly $1,100.

Dr. Zammuto asked what the MBC charges its licensees and was advised that their application fee was roughly $491, and their license renewal fees were $780. For their Postgraduate applications they are considering charging $491 for the application fee and roughly $400 for the initial license.

Ms. Thorfinnson informed the Board that the application fee for implementation of the new license would not likely be the largest revenue generator, as the licensure renewal fee generates the most revenue. The Board staff is proposing the idea of not charging another application fee for any postgraduate training licensee that later requests a full unrestricted license after completing the 36 months of training; however, they would still

pay a licensing fee upon approval of their licensing application. Additionally, the Board will still take a loss of $130,000 from implementation of the Postgraduate Training license fees if the implemented fees is set at $400; however, the Board can still recoup that loss on the back end by increasing the renewal fees.

The implementation cost for BreEZe was estimated to be $80,000, however DCA notified the Board that the charge would instead be included in the regular overhead cost charged to the Board.

Ms. Burton asked Ms. Knight whether the Board had an option of going over the statutorily mandated ceiling for the application fee charged on the new license or if it had to remain at $400. She was advised by Ms. Knight that because no ceiling has been set for the Postgraduate Training License that the Board has flexibility to set it at a rate the Board determines reasonable and approves.

Dr. Lally noted that the Board should take into account the Graduate Medical Education (GME) accreditation, which is now a single pathway process for both allopathic and osteopathic physicians. He noted that the Board should be aware that the GME offices may have an issue cutting different check amounts for the Postgraduate Training License applications for each board. Dr. Zammuto inquired if the Board could adopt the same financial structures of the MBC instead of recreating one. Ms. Knight stated that she would do some research and asked to table to the conversation until she could find the MBC's fee structure as set forth. The MBC's Postgraduate Training License application fee is $491.

Ms. Burton expressed concerns regarding implementing an application fee over $400 for the Postgraduate Training license and noted that it may not look good if it costs more than the initial application fee for an unrestricted license. However, the Board did note that the application fees for residents are generally paid by the training program, so it may not be an issue when it comes to the perception of the fees being more for application type versus the other.

Dr. Zammuto called for a motion to set the fee for the Board's Postgraduate Training License application and processing fee at $491.

- **Motion to approve the proposed text for a 45 day public comment period and delegate to the ED the authority to adopt the proposed regulatory changes if there are no adverse comments received during the public comment period, to follow established procedures and processes in doing so, and also delegate to the ED the authority to make any technical and non-substantive changes that may be required in completing the rulemaking file. Motion** – Dr. Zammuto **Second** – Dr. Jensen
- Roll Call Vote was taken

- **Aye** –Dr. Buhari, Dr. Jensen, Ms. Mercado, Mr. Moreno, Ms. Williams, Dr. Zammuto
- **Nay** – None
- **Abstention** – None
- **Absent** – None

Motion carried to set the Board's Postgraduate Training License application and processing fee amount to be $491.

Discussion Section 1690 – Initial Licensing Application Fee Increase

Ms. Thorfinnson provided the Board with background information and policy memo explaining the justification for the proposed Physician and Surgeon Certificate Application Fee regulation packet.

Ms. Thorfinnson explained the proposed language was being amended to increase the fee amount from $200 to $400 for the Physicians and Surgeon Certificate application fee. The workload and staffing has significantly increased since the fee was last increased. The fee amount has not been amended since 1999. Additionally, the Board's structural deficit warrants a fee increase. The current statutory ceiling is $400 so the Board has the regulatory authority to raise it to $400.

Ms. Thorfinnson provided the Board with some future projections of the Board's financial health should the fee not be increased and added that the increase of workload in office should justify the Board's request to increase the fee.

Dr. Zammuto called for a motion to increase the Board's initial license application fee from $200 to $400.

- **Motion to approve the proposed text for a 45 day public comment period and delegate to the EO the authority to adopt the proposed regulatory changes if there are no adverse comments received during the public comment period, to follow established procedures and processes in doing so, and also delegate to the EO the authority to make any technical and non-substantive changes that may be required in completing the rulemaking file. Motion** – Dr. Zammuto **Second** – Dr. Jensen
- Roll Call Vote was taken
    - **Aye** –Dr. Buhari, Dr. Jensen, Ms. Mercado, Mr. Moreno, Ms. Williams, Dr. Zammuto

- **Nay** – None
- **Abstention** – None
- **Absent** – None

Motion carried to increase the Board's initial license application fee from $200 to $400.

Discussion Section 1663 – Disciplinary Guidelines

Ms. Thorfinnson provided the Board with background information and policy memo explaining the justification for the proposed Disciplinary Guidelines regulation packet.

Ms. Thorfinnson informed the Board that the proposed language remained relatively same since the Board last approved the update of the Disciplinary Guidelines; however, there was one amendment made to page 31 of the Disciplinary Guidelines adding Section 2052 Unlicensed Practice by Physicians and Surgeons.

At the Board meeting held in May, Kathleen Creason, Executive Director of Osteopathic Physicians and Surgeons of California expressed concern that BPC section 2052 was a serious offense and should be considered part of formal discipline. In response to this concern, Dr. Buhari asked if the Board could list BPC section 2052 in both the Board's citable offenses regulation and Disciplinary Guideline. Legal counsel advised that the initial motion for CCR section 1659.31 Citable Offenses to include BPC section 2052 should stand as is until further research could be done. The Board was since been advised by legal counsel that this provision could be both a citable offense and formal discipline. The Board had wanted the flexibility to cite and fine in cases involving minor violations and to formally discipline physicians and surgeons for serious violations. An additional reason to have this flexibility is to deal with situations in which a physician has a revoked license and the Board no longer has jurisdiction over the licensee for formal discipline.

Mr. Moreno inquired what the Board would do if a licensee was practicing with an expired license and the lapsed license was due to carelessness and/or a licensee was practicing 2 or more days after their license has expired and wanted to know how the Board would determine the amount of time the physician would have to serve on probation. He was advised by Ms. Burton that it could fall under the cite and fine if it was a minor violation. Or, as an example of a serious violation, in the case that involves a physician and surgeon who is on probation and practicing while on suspension, by including BCP section 2052 in the Disciplinary Guidelines, the Board could take formal disciplinary action in this case.

Dr. Zammuto motioned for approval of the amended language as proposed of CCR section 1663 – Disciplinary Guidelines

- **Motion to approve the proposed text for a 45 day public comment period and delegate to the EO the authority to adopt the proposed regulatory changes if there are no adverse comments received during the public comment period, to follow established procedures and processes in doing so, and also delegate to the EO the authority to make any technical and non-substantive changes that may be required in completing the rulemaking file. Motion** – Dr. Zammuto **Second** – Dr. Jensen
- Roll Call Vote was taken
    - **Aye** –Dr. Buhari, Dr. Jensen, Ms. Mercado, Mr. Moreno, Ms. Williams, Dr. Zammuto
    - **Nay** – None
    - **Abstention** – None
    - **Absent** – None
- Motion carried to accept amended language of CCR section 1663 – Disciplinary Guidelines.

Discussion Section 1659.31 – Citable Offenses

Ms. Thorfinnson provided the Board with background information regarding the Citable Offenses regulation packet and briefly discussed the citations being amended.

Ms. Thorfinnson informed the Board that the document made only one amendment to the version approved by the Board at the May 2018 Board meeting. The proposed amendment adds Health and Safety Code (HSC) section 11165.4 to the list of citable offenses. This section requires physicians and surgeons to consult CURES database prior to prescribing controlled substances to their patients. Effective October 1, 2018, failure to consult the CURES database would be a violation of this HSC section.

Dr. Zammuto motioned to add the CURES requirement as a citable offense.

- **Motion to approve the proposed text for a 45 day public comment period and delegate to the EO the authority to adopt the proposed regulatory changes if there are no adverse comments received during the public comment period, to follow established procedures and processes in doing so, and also delegate to the EO the authority to make any technical and non-substantive changes that may be required in completing the rulemaking file. Motion** – Dr. Zammuto **Second** – Dr. Jensen
- Roll Call Vote was taken

- **Aye** –Dr. Buhari, Dr. Jensen, Ms. Mercado, Mr. Moreno, Ms. Williams, Dr. Zammuto
- **Nay** – None
- **Abstention** – None
- **Absent** – None

- Motion carried to add the CURES requirement as a citable offense.

9. Pending Legislation: Discussion and Possible Action

Ms. Burton briefly went through the legislative bills brought forth that pertained to the osteopathic profession and noted which bills had been chaptered since the last Board meeting.

10. Discussion Regarding Guidelines for the Recommendation of Cannabis for Medical Purposes – Update

Dr. Zammuto recommend that the Board review BPC sections 2525.3 and 2290.5 prior to taking action on adoption of the Guidelines for the Recommendation of Cannabis for Medical Purposes. Action will be postponed until a future Board meeting.

11. Agenda Items for Next Board Meeting

- Discussion and Possible Action Regarding Guidelines for the Recommendation of Cannabis for Medical Purposes SB 1448 (*Dr. Zammuto*)

- DCA Update – Board & Bureau Relations (*Dr. Zammuto*)

12. Future Meeting Dates

- Thursday, January 17, 2019 @ 10:00 am - Sacramento, CA
- Thursday, May 16, 2019 @ 10:00 am – Pomona, CA ***(TBD)***

13. Adjournment

There being no further business, the meeting was adjourned at 2:26 p.m.

Minutes - October 15, 2018

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G BROWN JR
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991
P (916) 928-8390 F (916) 928-8392 | www.ombc.ca.gov

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
TELECONFERENCE MINUTES

Tuesday, October 15, 2018

BOARD MEMBERS PRESENT:
Joseph Zammuto, D.O., President
Cyrus Buhari, D.O., Secretary Treasurer
Elizabeth Jensen, D.O., Board Member
Claudia Mercado, Board Member
Andrew Moreno, Board Member
Cheryl Williams, Board Member

STAFF PRESENT:
Angelina Burton, Executive Director
Machiko Chong, Executive Analyst
Sabina Knight, Esq., Legal Counsel, DCA
Nicol Le, Chief, OHR, DCA

BOARD MEMBERS ABSENT:

The meeting of the Osteopathic Medical Board of California was called to order by President Joseph Zammuto, D.O., at 2:15 PM via teleconference at the noticed site of 213 Crest Road, Woodside, CA 94062. This teleconference site was open and accessible to the public. No public was present at this location. Board staff was in the Board's conference room at 1300 National Drive, Suite 150, Sacramento, CA 95834. The meeting site was open and accessible to the public.

1. Call to Order and Roll Call/Establishment of a Quorum:

   Dr. Zammuto asked Machiko Chong to call the roll. Each of the Board Members in attendance gave their name, teleconference address, and telephone number:

   - **Cyrus Buhari, D.O.,** Sheraton Grand London Park Lane; Piccadilly, Mayfair; London W1J 7BX, UK; +44 20 7499 6321; No members of the public were present at this location;
   - **Elizabeth Jensen, D.O.,** 1900 Sullivan Ave., Daly City CA 94015, (650) 992-4000; No members of the public were present at this location;
   - **Andrew Moreno**, 1505 North Wishon Ave., Fresno CA 93728, (559) 449-0400; No members of the public were present at this location;
   - **Claudia Mercado**, 421 23rd Avenue, Oakland CA 94606, (510) 735-5999; No members of the public were present at this location; and

- **Cheryl Williams**, AFLAC in San Diego, 5050 Murphy Canyon Rd., Suite 150, San Diego CA 92123, (858) 429-5432; No members of the public were present at this location.

2. Public Comment for Items Not on the Agenda:
   Note: The Board may not discuss or take action on any matter raised during this public comment section except to decide whether to place the matter on the agenda of a future meeting [Government Code Sections 11125, 11125.7(a)]

   No public comments for items not on the agenda were received.

3. Review and Approval of:
   - Proposed Duty Statement (Executive Director) – DCA HR
   - Recruitment Announcement (Executive Director) – DCA HR

Ms. Le presented the Board with a copy of the Proposed Duty Statement that would be utilized for recruitment of a new Executive Director and inquired if the Board felt that any amendments were necessary. Dr. Zammuto and Dr. Buhari thanked Ms. Le for her thoroughness on the document and stated that it was fine in its present state.

Dr. Buhari moved to approve the Proposed Duty Statement with no revisions. Motion – Dr. Buhari, **Second** – C. Mercado

- Roll Call Vote was taken
  - **Aye** –Dr. Buhari, Dr. Jensen, Ms. Mercado, Mr. Moreno, Mrs. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – None
  - **Absent** – None
- Motion carried to accept approve the Proposed Duty Statement with no revisions.

Ms. Le presented the Board with a copy of the proposed Recruitment Announcement which is required to be posted on the CalCareer website for all recruitment purposes for at least 30 calendar days. Ms. Le directed the Board's attention to the desirable qualifications and experience section and inquired if the Board had any amendments that they felt were necessary. Dr. Zammuto noted that the document was drafted well and felt that it was consistent with the duties and responsibilities of the current Executive Director.

Ms. Le redirected the Board to bullet point number four and noted that the years of desired experience working for a regulatory board had been left blank so that the Board could discuss and determine an appropriate amount of experience. Dr. Zammuto asked Ms. Le if she had any recommendations and was informed that anywhere between three to four years should be sufficient. The Board decided to list the desired minimum experience working for a regulatory board as three years.

Ms. Le discussed the submission requirements for the Statement of Qualifications (SOQ) completed by applicants and recommended that the documents be restricted to no more than four pages. Additionally, Ms. Le noted that applicants will be required to submit at least three letters of professional reference to ensure that OHR is able to contact an individual regarding the applicant's previous work performance.

Dr. Buhari moved to approve the Recruitment Announcement for a posting period of 30 days with the recommended revisions to the desired work experience, SOQ, and professional contact bullet points. Motion – Dr. Buhari, **Second** – Dr. Jensen.

- Roll Call Vote was taken
  - **Aye** –Dr. Buhari, Dr. Jensen, Ms. Mercado, Mr. Moreno, Mrs. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – None
  - **Absent** – None
- Motion carried to accept the Recruitment Announcement with revisions.

Ms. Le informed the Board that they also had the option of posting the impending vacancy in the Capitol Morning Report however it would cost $155 to run the recruitment announcement. OHR could also list the vacancy on social media sites such as Facebook, Twitter, etc.

Mrs. Burton recommended that the Board also schedule a meeting date for the full Board to interview the final candidates. She noted that the 30-day posting requirement of the recruitment announcement would postpone any further hiring action to be completed after November 16th and recommended that Dr. Zammuto and Ms. Mercado hold the interviews of candidates during the last week of November either via teleconference or in person. Once the initial interviews have been completed and the top candidates have been selected, the full Board would have the opportunity to interview the candidates in person.

Dr. Zammuto recommended that the Board reconvene on Thursday, December 13, 2018. All members of the Board agreed with the date so long as the meeting was held in the morning.

4. Agenda Items for Next Meeting

5. Future Meeting Dates

- Thursday, December 13, 2018 @ 9:00 am – Sacramento, CA

6. Adjournment

Meeting adjourned at 2:45 p.m.

Minutes – December , 2018

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991
P (916) 928-8390 F (916) 928-8392 | www.ombc.ca.gov

BOARD MEETING
MINUTES

Thursday, December 13, 2018

BOARD MEMBERS PRESENT: Joseph Zammuto, D.O., President
Cyrus Buhari, D.O., Secretary/ Treasurer
Claudia Mercado, Board Member
Andrew Moreno, Board Member
Cheryl Williams, Board Member
Elizabeth Jensen, D.O., Board Member

STAFF PRESENT: Angelina Burton, Executive Director
Terri Thorfinnson, Asst. Executive Director
Sabina Knight, Esq., Legal Counsel, DCA
Machiko Chong, Executive Analyst
James Lally, D.O. Medical Consultant

BOARD MEMBERS ABSENT:

The Board meeting of the Osteopathic Medical Board of California (OMBC) was called to order by President, Joseph Zammuto, D.O. at 10: 04 a.m. at Department of Consumer Affairs (HQ2) - 1747 North Market Blvd., Sacramento CA 95834.

1. Roll Call

Mrs. Chong called roll and Dr. Zammuto determined that a quorum was present.

2. Public Comment for Items Not on the Agenda

No Public Comment was received by the Board.

3. Review and Approval of Minutes

Board Minutes from the September 27, 2018 Board Meeting and October 15, 2018 Teleconference were tabled as legal was not allotted enough time to adequately review both documents. Both drafts will be brought back to the Board in January 2019 for review, discussion, and possible approval.

4. Discussion and Possible Action Regarding Proposed Revisions to:

- Required Continuing Medical Education - Title 16, California Code of Regulations (CCR) section 1635.
- Continuing Medical Education Progress Report - Title 16, CCR section 1636.
- Sanctions for Noncompliance - Title 16, CCR section 1641.

Ms. Knight provided the board with background information regarding the sections of the CCR that were being brought to the Board and briefly discussed the amendments that were made to the proposed language.

Dr. Zammuto motioned for approval of the revisions made to the proposed language (Title 16, CCR, Section 1635; Section 1636; and Section 1641).

- **Motion to approve the proposed text for a 45 day public comment period and delegate to the EO the authority to adopt the proposed regulatory changes if there are no adverse comments received during the public comment period, to follow established procedures and processes in doing so, and also delegate to the EO the authority to make any technical and non-substantive changes that may be required in completing the rulemaking file. Motion** – Dr. Zammuto **Second** – Dr. Jensen
- Roll Call Vote was taken
  - **Aye** –Dr. Buhari, Dr. Jensen, Ms. Mercado, Mr. Moreno, Ms. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – None
  - **Absent** – None

Motion carried to approve all revisions made to the proposed language of Title 16, CCR, CCR, Section 1635; Section 1636; and Section 1641.

5. <u>Closed Session</u>

Pursuant to Government Code Section 11126(a)(1), the Board met in Closed Session to consider the employment of a New Executive Director

Return to Open Session

Dr. Zammuto indicated that the Board has made a decision regarding the new Executive Director.

6. Agenda Items for Next Board Meeting

- Strategic Plan – Update
- Discussion and Possible Action Regarding Guidelines for the Recommendation of Cannabis for Medical Purposes SB 1448 (*Ms. Mercado*)
- Board Logo and Branding (*Ms. Mercado)*
- Election of Board Members
- DCA - Update
- Budget Report - Update

7. Future Meeting Dates

- Thursday, January 17, 2019 @ 10:00 am - Sacramento, CA
- Thursday, May 16, 2019 @ 10:00 am – Chino Police Dept., Chino CA ***(TBD)***
- Thursday, September 5, 2019 @ 10:00 am - ***(TBD)***

8. Adjournment

There being no further business, the meeting was adjourned at 2:26 p.m.

Tab 3

This page has intentionally been left blank

Tab 4

OSTEOPATHIC MEDICAL BOARD - 0264
BUDGET REPORT
FY 2018-19 EXPENDITURE PROJECTION
Oct-2018

FISCAL MONTH 04

OBJECT DESCRIPTION	FY 2015-16 ACTUAL EXPENDITURES (MONTH 13)	FY 2016-17 ACTUAL EXPENDITURES (MONTH 13)	2017-18 ACTUAL EXPENDITURES (MONTH 13)	2018-19 BUDGET ALLOTMENT 2018-19	CURRENT YEAR EXPENDITURES 10/31/2018	PERCENT SPENT	PROJECTIONS TO YEAR END	UNENCUMBERED BALANCE
PERSONNEL SERVICES								
Salary & Wages (Staff)	582,326	635,329	625,584	706,000	201,481	29%	661,559	44,441
Statutory Exempt (EO)	89,728	89,949	96,621	76,000	32,680	43%	98,040	(22,040)
Temp Help Reg (Seasonals)	500	17,143	500	0	505		1,515	(1,515)
Board Member Per Diem	600	1,200	3,100	3,000	1,000	33%	3,100	(100)
Overtime	0	1,214	23,043	0	0	100%	60,000	(60,000)
Staff Benefits	331,722	367,521	384,409	450,000	125,808	28%	408,111	41,889
TOTALS, PERSONNEL SVC	**1,005,676**	**1,112,356**	**1,133,257**	**1,235,000**	**361,474**	**29%**	**1,232,325**	2,675
OPERATING EXPENSE AND EQUIPMENT								
General Expense	8,652	9,027	10,480	112,000	1,750	2%	9,386	102,614
Fingerprint Reports	36,456	41,695	30,829	25,000	11,172	45%	36,327	(11,327)
Minor Equipment	1,081	1,352	13,132	9,000	0	0%	30,000	(21,000)
Printing	10,125	8,881	13,610	5,000	1,344	27%	10,872	(5,872)
Communication	5,544	5,923	4,736	16,000	1,095	7%	5,401	10,599
Postage	1,110	7,506	10,509	6,000	0	0%	10,000	(4,000)
Insurance	0	11	3,361	0	0		4,000	(4,000)
Travel In State	12,725	10,942	5,666	14,000	261	2%	9,778	4,222
Training	1,485	457	0	5,000	0	0%	647	4,353
Facilities Operations	61,344	62,144	138,801	110,000	20,676	19%	87,430	22,570
C & P Services - Interdept.	0	0	45	101,000	0	0%	15	100,985
C & P Services - External	52,872	74,826	35,901	151,000	8,304	5%	75,000	76,000
DEPARTMENTAL SERVICES:								
Office of Information Services	157,690	139,754	191,000	220,000	73,333	33%	220,000	0
Administration Pro Rata	138,854	141,450	161,000	180,000	60,000	33%	180,000	0
Interagency Services	0	0	0	5,000	1,667	33%	5,000	0
IA w/ DOI Direct	0	90,570	116,675	0	0		0	0
DPO-ProRata Internal	3,933	3,680	4,000	0	0		0	0
Communications Pro Rata	9,000	17,335	9,000	11,000	3,667	33%	11,000	0
Program Policy Review Division Pro Rata	0	654	9,000	10,000	3,333	33%	10,000	0
INTERAGENCY SERVICES:								
Consolidated Data Center	18,404	18,852	3,479	1,000	0	0%	1,000	0
DP Maintenance & Supply	1,850	1,218	362	4,000	0	0%	4,000	0
Central Admin Svc-ProRata	81,892	0	0	0	0		0	0
EXAM EXPENSES:								
C/P Svcs-External Expert Administrative	0	880	0	0	0		0	0
C/P Svcs-External Expert Examiners	0	578	0	0	0		0	0
ENFORCEMENT:								
Attorney General	199,446	291,561	177,478	324,000	41,212	13%	222,828	101,172
Office Admin. Hearings	67,950	95,131	21,265	52,000	0	0%	61,449	(9,449)
Court Reporters	3,270	3,096	850	0	300		2,405	(2,405)
Evidence/Witness Fees	74,695	59,245	26,805	8,000	10,941	137%	53,582	(45,582)
Invest SVS - MBC ONL	70,848	25,630	3,130	0	0		150,000	(150,000)
Major Equipment	0	0	0	35,000	2,037	6%	35,000	0
Special Items of Expense	0	0	12,112	0	0		0	0
TOTALS, OE&E	**1,019,226**	**1,112,398**	**1,003,225**	**1,404,000**	**241,092**	**17%**	**1,235,119**	**168,881**
TOTAL EXPENSE	**2,024,902**	**2,224,754**	**2,136,482**	**2,639,000**	**602,566**	**46%**	**2,467,444**	**171,556**
Sched. Reimb. - External/Private			(3,055)	(28,000)			(28,000)	0
Sched. Reimb. - Fingerprints	(38,367)	(42,434)	(41,699)	(25,000)	(19,281)		(25,000)	0
Sched. Reimb. - Other	(3,760)	(3,055)		0	(13,137)			0
Distributed - From Naturopathic				(14,000)				0
Unsched. Reimb. - Other	(137,965)	(82,666)	(64,493)	0	(940)			0
NET APPROPRIATION	**1,844,810**	**2,096,599**	**2,027,235**	**2,572,000**	**569,208**	**22%**	**2,414,444**	**171,556**
							SURPLUS/(DEFICIT):	**6.7%**

0264 - Osteopathic Medical Board of California Contingent
Analysis of Fund Condition

Prepared 1/16/19

(Dollars in Thousands)

Governor's Budget 2019	PY 2017-18	CY 2018-19	Governor's Budget BY 2019-20
BEGINNING BALANCE	$ 3,136	$ 2,837	$ 2,373
Prior Year Adjustment	$ -	$ -	$ -
Adjusted Beginning Balance	$ 3,136	$ 2,837	$ 2,373
REVENUES AND TRANSFERS			
Revenues:			
4121200 Delinquent fees	$ 17	$ 15	$ 15
4127400 Renewal fees	$ 1,696	$ 1,680	$ 1,680
4129200 Other regulatory fees	$ 26	$ 31	$ 33
4129400 Other regulatory licenses and permits	$ 429	$ 531	$ 546
4163000 Income from surplus money investments	$ 9	$ 37	$ 24
Totals, Revenues	$ 2,177	$ 2,294	$ 2,298
Transfers from Other Funds			
F00001 GF loan repayment per Item 1485-011-0264, BA of 2002	$ -	$ -	$ 1,500
Totals, Revenues and Transfers	$ 2,177	$ 2,294	$ 3,798
Totals, Resources	$ 5,313	$ 5,131	$ 6,171
EXPENDITURES			
Disbursements:			
1111 Department of Consumer Affairs Program Expenditures (State Operations)	$ 2,353	$ 2,572	$ 2,997
8880 Financial Information System for California (State Operations)	$ 4	$ -	$ -1
9892 Supplemental Pension Payments (State Operations)	$ -	$ 25	$ 53
9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations)	$ 119	$ 161	$ 160
Total Disbursements	$ 2,476	$ 2,758	$ 3,209
FUND BALANCE			
Reserve for economic uncertainties	$ 2,837	$ 2,373	$ 2,962
Months in Reserve	12.3	8.9	11.0

Tab 5

2016–2019 Strategic Plan

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Adopted: January 2016

Table of Contents

Board Members 1

Message From the Board President 2

About the Osteopathic Medical Board 3

Our Mission, Our Vision, and Our Values 6

Strategic Goals 7

Goal 1: Licensure 9

Goal 2: Enforcement 9

Goal 3: Outreach and Communication 10

Goal 4: Regulation and Legislation 11

Goal 5: Board Administration 12

Strategic Planning Process 13

Board Members

Joseph A. Zammuto, D.O., President

Keith Higginbotham, Esq., Vice-President, Public Member

Cyrus Buhari, D.O.

Michael Feinstein, D.O.

Elizabeth Jensen-Blumberg, D.O.

James Lally, D.O.

Alan Howard, Public Member

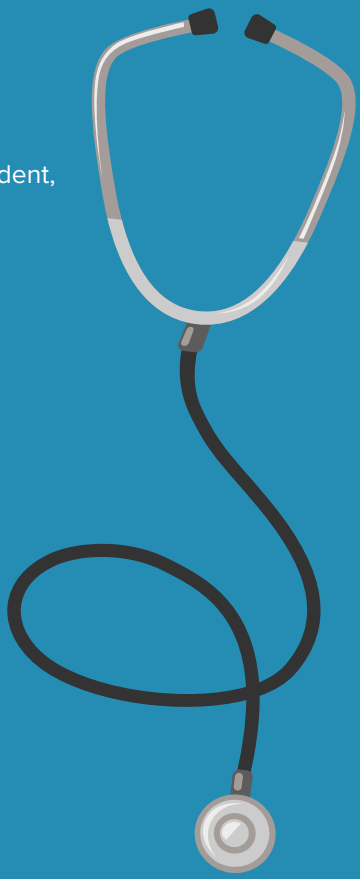
Claudia Mercado, Public Member

Cheryl Williams, Public Member

Former Board members who also participated in the development of this strategic plan:

David Connett, D.O.

Jane Xenos, D.O.



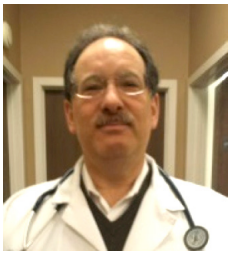
Edmund G. Brown Jr., Governor

Alexis Podesta, Acting Secretary, Business, Consumer Services, and Housing Agency

Awet Kidane, Director, Department of Consumer Affairs

Angie Burton, Executive Director, Osteopathic Medical Board of California

Message From the Board President



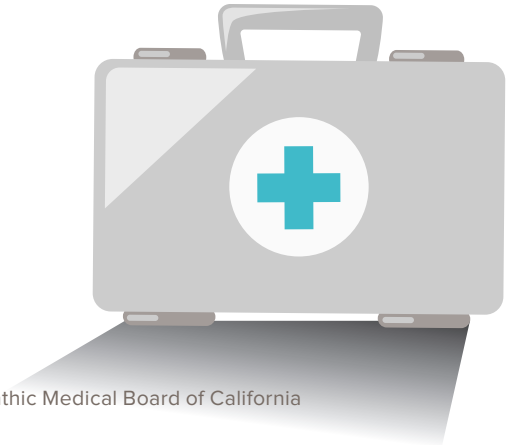
On behalf of the Osteopathic Medical Board of California, it is my sincere pleasure to present the 2016–2019 Strategic Plan. I want to thank the California Department of Consumer Affairs' (DCA's) SOLID Unit for its leadership in the process. I want to thank all the Board members, the Executive Director, Assistant Executive Director, Board staff, and the public for putting together this plan.

The mission of the Board is to protect the public by requiring competency, accountability, and integrity in the safe practice of medicine by osteopathic physicians and surgeons. The Board continually strives to attain meaningful improvement to service our physicians, protect the public, and maintain the highest standards in health care.

The vision of the Board is to uphold the highest standards of quality and care by our physicians, continuing to utilize technology and innovation to enhance and deliver an outstanding level of public protection.

The success of this strategic plan depends on an ever-evolving relationship with all the stakeholders in the State of California. We look forward to our relationship involving licensure, enforcement, outreach and communication, regulation and legislation, and Board administration.

Joseph A. Zammuto, D.O.
President, Osteopathic Medical Board of California



About the Osteopathic Medical Board

Developed more than 130 years ago by Andrew Taylor Stills, M.D., D.O., osteopathic medicine brings a unique philosophy to traditional medicine. Osteopathic physicians (D.O.s) are fully licensed to prescribe medication and practice in all medical specialty areas, including surgery, just as any M.D. D.O.s are trained to consider the health of the whole person and use their hands to help diagnose and treat their patients.

D.O.s are one of the fastest-growing segments of health care professionals in the United States. California has the fourth-largest osteopathic population in the country.

The Business and Professions (B&P) Code section 3600 (Osteopathic Initiative Act) and the California Code of Regulations (CCR) Title 16, Professional and Vocational Regulations, Division 16., section 1600 et. seq. authorizes the Osteopathic Medical Board of California (Board/ OMBC) to license qualified osteopathic physicians and surgeons to practice osteopathic medicine and to effectuate the enforcement of laws and regulations governing their practice (Medical Practice Act). The Osteopathic Initiative Act provides that consumer protection is its highest priority in exercising its licensing, regulatory, and disciplinary functions.

The Board is a fully functioning board within DCA with the responsibility and sole authority to issue licenses to physicians and surgeons (D.O.s) to practice osteopathic medicine in California. The OMBC is also responsible for enforcing legal and professional standards to protect California consumers from incompetent, negligent, or unprofessional D.O.s. The OMBC regulates D.O.s only. There are 6,227 D.O.s in California with active licenses at this time and another 1,006 D.O.s who maintain active licenses in California while residing in other states. There are 588 D.O.s who maintain inactive licenses. Total number of osteopathic physicians and surgeons currently holding a California license is 7,821.

D.O.s are similar to M.D.s in that both are considered to be “complete physicians”; in other words, one who has taken the prescribed amount of premedical training, graduated from an undergraduate college (typical emphasis on science courses), and received four years of training in medical school. The physician has also received at least one more year of postgraduate training (residency or rotating internship) in a hospital with an approved postgraduate training program.

After medical school, D.O.s may choose to practice in any specialty or subspecialty as do M.D.s. Examples are, but not limited to, family practice, internal medicine, pediatrics, and any surgical specialty. These programs may range from on average two to six years of additional postgraduate training. Licensing examinations are comparable in rigor and comprehensiveness to those given to M.D.s. Whether one becomes a D.O. or an M.D., the process of receiving complete medical training is basically the same. The same laws govern the required training for D.O.s and M.D.s who are licensed in California. D.O.s utilize all scientifically accepted methods of diagnosis and treatment, including the use of drugs and surgery. D.O.s are licensed in all 50 states to perform surgery and prescribe medication. D.O.s practice in fully accredited and licensed hospitals and medical centers. Section 2453 of the Business and Professions Code states that it "is the policy of this State that holders of M.D. degrees and D.O. degrees shall be accorded equal professional status and privileges as licensed physicians and surgeons."

A D.O. may refer to himself or herself as a "doctor" or "Dr." but in doing so, must clearly state that he or she is a D.O. or osteopathic physician and surgeon. He or she may not state or imply that he or she is an M.D. while being licensed in California as a D.O.

A key difference between the two professions is that D.O.s have additional dimension in their training and practice—one not taught in medical schools giving M.D. degrees. Osteopathic medicine gives particular recognition to the musculoskeletal system (the muscles, bones, and joints), which makes up more than 60 percent of body mass. The osteopathic physician is trained to recognize that all body systems, including the musculoskeletal system, are interdependent, and a disturbance in one can cause altered functions in other systems of the body. The osteopathic physician is also trained in how this interrelationship of body systems is facilitated by the nervous and circulatory systems. The emphasis on the relationship between body structure and organic functioning is intended to provide a broader base for the treatment of the patient as a unit. These concepts require a thorough understanding of anatomy and the development of special skills in diagnosing and treating structural problems through manipulative therapy. D.O.s use structural diagnosis and manipulative therapy along with all of the other traditional forms of diagnosis and treatment to care effectively for patients and to relieve their distress.

To meet its responsibilities for regulation of the D.O. profession, the OMBC is authorized by law to:

- Monitor licensees for continued competency by requiring approved continuing education.
- Take appropriate disciplinary action whenever licensees fail to meet the standard of practice, or otherwise commit unprofessional conduct.
- Determine that osteopathic medical schools and hospitals are in compliance with medical education curriculum and post-graduate training requirements.
- Provide rehabilitation opportunities for licensees whose competency may be impaired due to abuse of alcohol or other drugs.

Additionally, the OMBC is charged with enforcement of laws proscribing unlicensed osteopathic medical practice.

Our Mission

To protect the public by requiring competency, accountability, and integrity in the safe practice of medicine by osteopathic physicians and surgeons.

Our Vision

The Osteopathic Medical Board upholds the highest standards of quality and care by our physicians, continuing to utilize technology and innovation to enhance and deliver an outstanding level of public protection.

Our Values

Consumer Protection
Professionalism
Accountability
Honesty and Trust
Integrity and Transparency

Strategic Goals

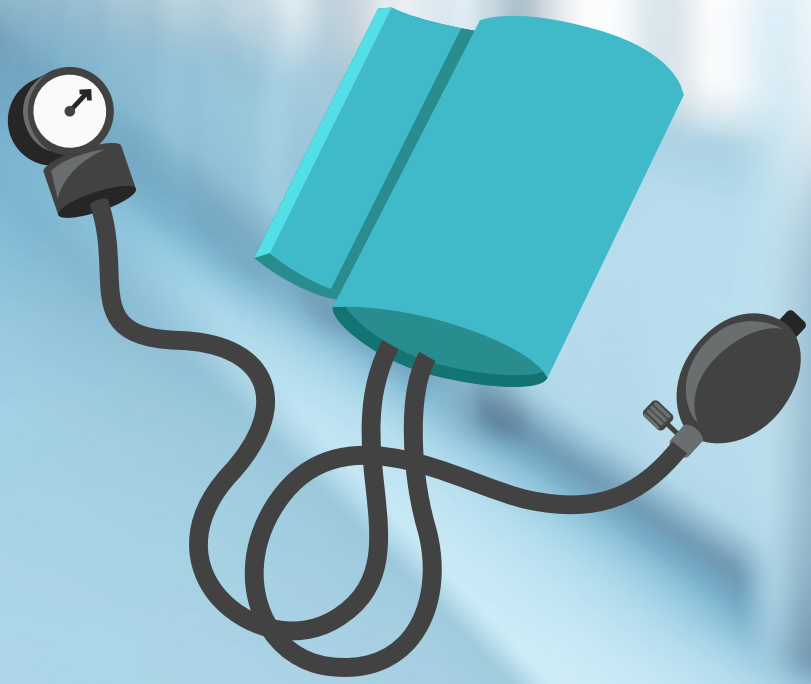
1. **Licensure**
   The OMBC requires that only qualified individuals are licensed as osteopathic doctors.

2. **Enforcement**
   Protect the health and safety of consumers through the enforcement of the laws and regulations governing the practice of osteopathic medicine.

3. **Outreach and Communication**
   Consumers and licensees are able to make informed decisions regarding the safe practice of osteopathic medical services.

4. **Regulation and Legislation**
   Monitor and uphold the law, and participate in the regulatory and legislative process.

5. **Board Administration**
   The Board builds an excellent organization through proper Board governance, effective leadership, and responsible management.



Goal 1: Licensure

The OMBC requires that only qualified individuals are licensed as osteopathic doctors.

1.1 Implement online application processing to reduce cycle times and improve stakeholder service.

1.2 Create an online renewal process to reduce cycle times and improve stakeholder service.

1.3 Enhance customer service by implementing telephone procedures, seeking improvement of the phone-tree configuration, and requiring additional customer-focused staff training.

Goal 2: Enforcement

Protect the health and safety of consumers through the enforcement of the laws and regulations governing the practice of osteopathic medicine.

2.1 Review and assign a time limit for expert reviewer contract processing to reduce response times to cases.

2.2 Recruit additional expert reviewers to increase efficiency of case review and leverage the resources of subject matter experts with specific background in osteopathic medicine.

2.3 Hire one complaint intake staff member to eliminate backlog, improve customer service, and meet performance measures.

2.4 Hire one Enforcement Analyst to address excess workload, providing enhanced customer service and meeting performance measures targets.

2.5 Utilize aging reports in BreEZe to bring the Board into compliance with statutes.

2.6 Initiate a Budget Change Proposal (BCP) to fund travel for enforcement personnel to perform onsite check-ins of probationers.

Goal 3: Outreach and Communication

Consumers and licensees are able to make informed decisions regarding the safe practice of osteopathic medical services.

3.1 Develop printed materials to provide consumer information regarding the differences between the D.O. and M.D. designation, philosophies of osteopathy, and Board contact information to increase awareness of the Board's role as a consumer protection entity.

3.2 Produce and post instructional videos on initial application and renewal processes, common disciplinary actions, Board purpose, and a description of the osteopathic profession to help licensees and consumers understand the Board's functions.

3.3 Investigate options to enhance the website by including sections on licensing and discipline, frequently asked questions, and a quarterly newsletter to communicate Board activities to stakeholders.

3.4 Develop a stakeholder e-mail distribution list (or LISTSERV) to provide up-to-date information to stakeholders.

3.5 Modify renewal form to include explanation of the benefits of providing an e-mail address to the Board.

3.6 Engage colleges, students, and professional organizations providing in-person speaking, webinar, and teleconference events to promote student and professional organization s relations with the Board.

3.7 Reach out to professional organizations to request a hyperlink to the OMBC website be added to the organizations' websites in order to inform the public that they are separate entities from the Board.

3.8 Investigate the practicality of adding the website address to OMBC pocket license to increase awareness of the Board's resources.

Goal 4: Regulation and Legislation

Monitor and uphold the law, and participate in the regulatory and legislative process.

4.1 Review the need for, and, if necessary, hire a legislative analyst to keep the Board up-to-date on pending legislation and potential obstacles to patient safety.

4.2 Enhance legislative relationships to maintain contact with lawmakers regarding health care issues.

4.3 Implement a review of the OMBC's regulations (including telemedicine) to update or strengthen regulatory language, providing clarity and consistency with professional standards.

4.4 Review the Cite and Fine Schedule and revise if necessary to provide for the application of appropriate levels of enforcement citations.

4.5 Change the Continuing Medical Education (CME) cycle to coincide with the license renewal cycle.

4.6 Assess feasibility to change CME requirement verification to an audit system to streamline the renewal process.

4.7 Create a licensee placard requirement for D.O. places of practice to increase consumer protection through awareness.

Goal 5: Board Administration

The Board builds an excellent organization through proper Board governance, effective leadership, and responsible management.

5.1 Coordinate with the DCA's Office of Information Services to research the capability of altering the phone tree in order to improve customer service.

5.2 Analyze call log data (if available) to justify a BCP for additional staff to answer and route calls.

5.3 Relocate the OMBC office to house all program staff in a single location and effectively store physical files.

5.4 Create an Architectural Revolving Fund account to fund office relocation.

5.5 Schedule, convene, and document monthly staff meetings to share challenges and accomplishments with the Board.

5.6 Establish a change management process for developing or modifying policies, procedures, program requests, and forms to implement changes in policies, laws, and regulations.

5.7 Develop and disseminate an anonymous training needs assessment to staff to identify and provide training to fulfill gaps and program needs.

5.8 Provide information technology and customer service training to staff in order to increase technical troubleshooting skills and enhanced customer service.

Strategic Planning Process

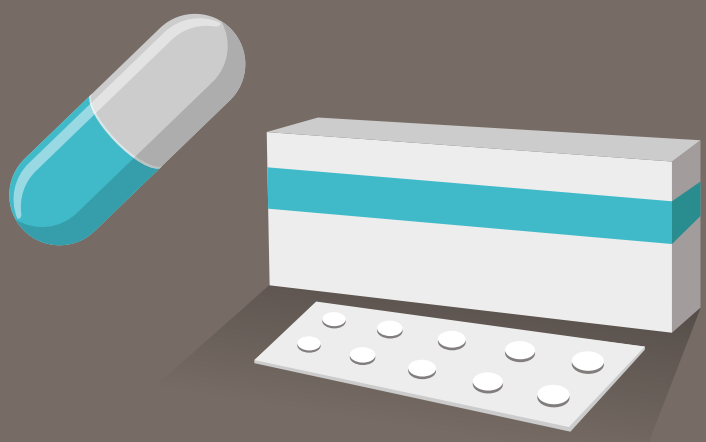
To understand the environment in which the Board operates and to identify factors that could impact the Board's success, DCA s SOLID unit conducted an environmental scan of the internal and external environments by collecting information through the following methods:

- Interviews conducted with eight members of the Board, the Executive Director, the Assistant Executive Director, and the staff medical advisor completed during the month of September 2015 to assess the challenges and opportunities the Board is currently facing or will face in the upcoming years.

- One focus group with Board staff on September 3, 2015, to identify the strengths and weaknesses of the Board from an internal perspective. Seven Board staff participated.

- An online survey sent to 3,899 randomly selected external Board stakeholders in September 2015 to identify the strengths and weaknesses of the Board from an external perspective; 236 stakeholders completed the survey.

The most significant themes and trends identified from the environmental scan were discussed by the Board executive team during a strategic planning session facilitated by SOLID on October 30, 2015. This information guided the Board in the development of its mission, vision, and values, while directing the strategic goals and objectives outlined in this 2016–2019 Strategic Plan.



Osteopathic Medical Board of California
www.ombc.ca.gov

1300 National Drive, Suite 150
Sacramento, CA 95834-1991
Phone: (916) 928-8390
Fax: (916) 928-8392
E-mail: osteopathic@dca.ca.gov

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

Prepared by
SOLID Planning Solutions

California Department of Consumer Affairs
1747 N. Market Blvd., Suite 270
Sacramento, CA 95834

This strategic plan is based on stakeholder information and discussions facilitated by SOLID for the Osteopathic Medical Board of California in September and October 2015. Subsequent amendments may have been made after Board adoption of this plan.

PDE_16 014

Strategic Plan Follow Up
January 17, 2019

Goal 1: Licensure

1.1 Implement online application processing to reduce cycle times and improve stakeholder service.

The Board approved the new fee schedule that calculates the prorated initial license fee by birth month. The regulation is currently being promulgated to fix the initial prorated license fee. The breeze implementation will follow. Both have lengthy timelines.

1.2 Create an online renewal process to reduce cycle times and improve stakeholder service.

The on-line license renewal process was implemented in the summer of 2016. Approximately two-thirds of our licensees are now renewing on-line. However, renewing on line does not shorten the time needed to renew licenses as CME documentations are still being reviewed prior to approving a renewal. On-line renewal process provides a convenient method of paying the renewal fee and saves a few days by electronically submitting the renewal verses mailing in the hardcopy

Once the regulation for the CME audit system is approved, the renewal process time will decrease.

1.3 Enhance customer service by implementing telephone procedure, seeking improvement of the phone tree configuration, and requiring additional customer-focused staff training.

There are now three staff who back up the reception line, so all calls coming into the main line are being answered. Staff who answer the incoming calls are able to answer general licensing questions.

Goal 2: Enforcement

2.1 Review and assign a time limit for expert reviewer contract processing to reduce response times to cases.

Contracts for new Expert Reviewers are taking approximately 3 weeks for approval.

2.2 Recruit additional expert reviewers to increase efficiency of case review and leverage the resources of subject matter experts with specific background in osteopathic medicine.

OMBC has created an “Expert Reviewers” tab on the OMBC website. The site includes information regarding the OMBC expert reviewer program. The site also includes an application form so that interested individuals may apply to be expert

reviewers for OMBC. Additionally, request for additional funding for expert reviewers was approved for the upcoming fiscal year.

Our experts have been attending the expert reviewer course put on by the Medical Board of California

2.3 Hire one complaint intake staff member to eliminate backlog, improve customer services, and meet performance measures.

We have not been able to hire new staff. However, the current enforcement team has been able to improve the intake time line. We have been approved for an additional enforcement staff in FY 19/20 as a result of the implementation of the new Postgraduate Training License. This additional staff position will come with additional workload but overall it should result in further improvement of the Board's enforcement workload.

2.4 Hire one Enforcement Analyst to address excess workload, providing enhanced customer service, and meeting performance measures targets.

Due to budget constraints, we were not able to hire new staff. However, we are currently in the process of re-structuring our enforcement unit and hope to bring in a program manager to enhance our probation monitoring and complaint intakes.

2.5 Utilize aging reports in BreEze to bring the Board into compliance with statutes.

Enforcement staff has started utilizing periodical aging reports to ensure all complaints are being worked on in a timely manner.

2.6 Initiate a Budge Change Proposal (BCP) to fund travel for enforcement personnel to perform onsite check-ins of probationers.

We have not submitted a BCP to increase funds for probation monitor travels. However, the probation monitor has been attending the diversion evaluation committee meetings where he has an opportunity to meet face to face with probationers who are required to be in the board's diversion program. Additionally, we have included practice monitoring in the language on most probationary orders to ensure that those on probation are being properly monitored.

<u>Goal 3: Outreach and Communication</u>

3.1 Develop printed materials to provide consumer information regarding the difference between the D.O. and M.D. designation, philosophies of osteopathy, and Board contact information to increase awareness of the Board's role as a consumer protection entity. (see response to 3.2)

3.2 Produce and post instructional videos on initial application and renewal processes, common disciplinary actions, Board purpose, and a description of the

osteopathic profession to help licensees and consumers understand the Board functions.

OMBC staff have met with staff from DCA's Office of Publications, Design and Editing and started a dialogue on what the Board would like published for outreach and consumer education. We are hoping to create an informational video and some printed material on "What is a DO". We hope to have additional meetings in the coming months and meet our goals in 2019.

3.3 Investigate options to enhance the website by including sections on licensing and discipline, frequently asked questions, and a quarterly newsletter to communicate Board activities to stakeholders.

With the current level of staffing, the staff has not been able to materialize a newsletter. However, the board staff has been adding useful information on our website. Staff have added helpful information regarding legislative changes and resources helpful to physicians and surgeons for issues such as CURES, prescription pads rule change, and other key legislative changes. We hope to be able to complete the video and printed materials to enhance our website during 2019.

3.4 Develop a stakeholder e-mail distribution list (or LISTSERV) to provide up-to-date information to stakeholder

We have added "Subscribe to E-Mail Alerts" on our website which allows all interested parties to sign up for all e-mail alerts. Stakeholders have the option to receive Licensee Notice and Alerts, Enforcement actions, General information, or all. General information may include, board meeting agendas and minutes, legislative changes, and other miscellaneous information and alerts. We added a physician and surgeon only list to E-Mail list serve last year which is intended to alert physicians and surgeons about key legislative changes that may impact their practice.

3.5 Modify renewal form to include explanation of the benefits of providing an e-mail address to the Board.

Staff has not yet made changes to the renewal form. Emails are still an option, although, most licensees have been providing their email addresses.

3.6 Engage colleges, students, and professional organizations providing in-person speaking, webinar and teleconference events to promote student and professional organization's relations with the Board.

Staff have attended hospital's "resident day" to assist with license application processes and answer questions from postgraduate trainees. We plan to attend more of these events. We are also hoping to be able to include students in the making of the "what's a DO" video.

We have also held board meetings at osteopathic medical schools to encourage students to attend our board meetings.

3.7 Reach out to professional organizations to request a hyperlink to the OMBC website be added to the organizations' websites in order to inform the public that they are separate entities from the Board.

OMBC has links to outside organizations such as the State's Osteopathic association (OPSC), the national association (AOA), Department of Consumer Affairs, and Department of Justice.

3.8 Investigate the practicality of adding the website address to OMBC pocket license to increase awareness of the Board's resources.

All changes in design of documents printed from BreEze must be completed by creating a ticket through BeEZe team. This has not yet been completed, however, staff sends out an information sheet with each initial license issued with information regarding our website.

<u>Goal 4: Regulation and Legislation</u>

4**.1 Review the need for, and if necessary, hire a legislative analyst to keep the Board up-to-date on pending legislation and potential obstacles to patient safety.**

We have not been able to create new positions or hire new staff due to budget constraints. However, staff has been attending the DCA Legislative Roundtable meetings in order to keep up on current and new legislation. There is also staff from the DCA Legislative Unit who is assigned to each board, who assists in keeping board's updated on legislation. When budget allows, OMBC should still consider hiring a legislative analyst.

4.2 Enhance legislative relationships to maintain contact with lawmakers regarding health care issues.

Staff needs to continue with their efforts to create a better line of communication with legislative staffers.

4.3 Implement a review of the OMBC's regulations (including telemedicine) to update or strengthen regulatory language, providing clarity and consistency with professional standards.

OMBC staff have been working on several regulations, (see below). Staff has not written any regulations on telemedicine at this time.

4.4 Review the Cite and Fine Schedule and revise if necessary to provide for the application of appropriate levels of enforcement citations.

OMBC staff have revised the Cite and Fine Schedule. The regulatory language to amend the Cite and Fine section of our regulation was approved by the Board and we are currently working on promulgating this regulation.

4.5 Change the Continuing Medical Education (CME cycle to coincide wit the license renewal cycle.

This was accomplished during the Board's sunset review. The CME cycle has been changed effective January 2018 to a two- year reporting cycle to coincide with the biennial renewal.

4.6 Assess feasibility to change CME requirement verification to an audit system to streamline the renewal process.

The regulatory language of the audit system has been approved by the board and staff is working on promulgating regulation at this time.

4.7 Create a licensee placard requirement for D.O. places of practice to increase consumer protection through awareness.

The regulatory language for "Notice to Consumer" has also been approved by the board and staff is working on promulgating regulation at this time.

<u>Goal 5: Board Administration</u>

5.1 Coordinate with the DCA's Office of Information Services to research the capability of altering the phone tree in order to improve customer services.

Staff has reached out to DCA's telecommunications unit. The main line can now be answered by three back up staff so all calls coming into the main line could be answered.

5.2 Analyze call log data (if available) to justify a BCP for additional staff to answer and route calls.

Due to budget constraints, we are unable to add any staff at this time. However, with the three back up staff being able to answer the main line and answer general questions and/or route calls to the appropriate staff, our phone services have improved.

5.3 Relocate the OMBC office to house all program staff in a single location and effectively store physical files.

OMBS staff have always been located at a single location. Staff weighed the difference in cost of moving to another location vs remodeling the existing office to accommodate additional staff and create additional file space. We opted to stay and remodel the existing office. The renovation is currently in progress. The Board purchased a hi-density filing system, which is a tremendous space saver and the remodeling of the suite is adding four additional work stations.

5.4 Create an Architectural Revolving Fund account to fund office relocation.

Staff was able to create fund reserved for this renovation and was able to stay within budget to complete the renovation.

5.5 Schedule convene and document monthly staff meetings to share challenges and accomplishment with the Board.

Staff manager has been meeting separately with the licensing unit and enforcement unit staff and updating the staff through emails. However, the meetings are not held on a monthly basis and staff needs to work to make sure that monthly meetings will take place.

5.6 Establish a change management process for developing or modifying policies, procedures, program requests and forms to implement changes in policies, laws and regulations.

Staff recently held mapping sessions with staff from DCA SOLID team. Each unit created a step by step mapping of all their procedures. These mapping documents will assist the staff in creating updated desk procedure manuals.

5.7 Develop and disseminate an anonymous training needs assessment to staff to identify and provide training to fulfill gaps and program needs.

Annually, staff are provided the opportunity to complete and submit an Individual Development Plan (IDP) to their supervisor. So, far staff have not submitted any; and the union rules prohibit supervisor from insisting all staff complete an IDP. However, if any staff notifies management of their desire to attend any training courses provided by DCA or outside affiliated programs, we encourage staff and provide them with time to attend these courses.

5.8 Provide information technology and customer service training to staff in order to increase technical troubleshooting skills and enhanced customer service.

Staff have learned to provide help to licensees seeking assistance with online renewals and other online services. OMBC staff still rely upon DCA's Office of Information Services for all their technical support. Due to budget constraints, we cannot hire a staff dedicated only to IT needs. All staff who answer calls at the Board office can answer questions related to their respective units, i.e., licensing and enforcement.

Tab 6

April 2018

Guidelines for the Recommendation of Cannabis for Medical Purposes

MEDICAL BOARD OF CALIFORNIA

Edmund G. Brown, Jr., Governor
Dev GnanaDev, M.D., President, Medical Board of California
Kimberly Kirchmeyer, Executive Director, Medical Board of California

Medical Board of California's
Guidelines for the Recommendation of Cannabis for Medical Purposes
April 2018

Adopted October 27, 2017, revision adopted April 20, 2018.

PREAMBLE

The Medical Board of California (Board) developed these guidelines since cannabis is a permissible treatment modality in California under qualifying circumstances. The Board wants to assure physicians who choose to recommend cannabis for medical purposes to their patients, as part of their regular practice of medicine, that they will not be subject to investigation or disciplinary action by the Board if they arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility. The mere receipt of a complaint that the physician is recommending cannabis for medical purposes will not generate an investigation absent additional information indicating that the physician is not adhering to accepted medical standards.

These guidelines are not intended to mandate the standard of care. The Board recognizes that deviations from these guidelines may occur and may be appropriate depending upon the unique needs of individual patients. Medicine is practiced one patient at a time and each patient has individual needs and vulnerabilities. Physicians should document their rationale for each recommendation decision.

BACKGROUND

On November 5, 1996, the people of California passed Proposition 215. Through this Initiative Measure, Section 11362.5 was added to the Health and Safety Code, and is also known as the Compassionate Use Act of 1996 (Act). The purposes of the Act include, in part:

> "To ensure that seriously ill Californians have the right to obtain and use cannabis for medical purposes where the medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of cannabis in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which cannabis provides relief; and
>
> To ensure that patients and their primary caregivers who obtain and use cannabis for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."

The Act provides that physicians will not be subject to investigation or disciplinary action by the Board if they arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility.

Although the Act allows the use of cannabis for medical purposes by a patient upon the recommendation of a physician, California physicians should bear in mind that cannabis is listed in Schedule I of the federal Controlled Substances Act. The use and recommendation of cannabis is an evolving issue and physicians should be aware of the current administration's policies.

GUIDELINES

The Board has adopted the following guidelines for the recommendation of cannabis for medical purposes.

Physician-Patient Relationship: The health and well-being of patients depends upon a collaborative effort between the physician and the patient. The relationship between a patient and a physician is complex and based on the mutual understanding of the shared responsibility for the patient's health care. The physician-patient relationship is fundamental to the provision of acceptable medical care. Therefore, physicians should document that an appropriate physician-patient relationship has been established, prior to providing a recommendation, attestation, or authorization for cannabis to the patient. Consistent with the prevailing standard of care, physicians should not recommend, attest, or otherwise authorize cannabis for themselves or family members.

Pursuant to Business and Professions (B&P) Code section 2525.2, a physician shall not recommend cannabis for medical purposes to a patient, unless the physician is the patient's attending physician. Health and Safety (H&S) Code section 11362.7(a) defines an "attending physician" as a physician who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient. The physician must also have conducted a medical examination of the patient before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the use of cannabis for medical purposes is appropriate.

Patient Evaluation: A documented medical examination and collection of relevant clinical history commensurate with the presentation of the patient must be obtained before a decision is made as to whether to recommend cannabis for a medical purpose. The examination must be an appropriate prior examination, and at minimum, should include the patient's history of present illness; social history; past medical and surgical history; alcohol and substance use history; family history with emphasis on addiction, psychotic disorders, or mental illness; documentation of therapies with inadequate response; and diagnosis requiring the cannabis recommendation. At this time, there is a paucity of evidence for the efficacy of cannabis in treating certain medical conditions. Recommending cannabis for any medical conditions, however, is at the professional discretion of the physician acting within the standard of care. The indication, appropriateness, and safety of the recommendation should be evaluated in accordance with standards of practice as they evolve over time.

The initial evaluation for the condition that cannabis is being recommended must meet the standard of care; accepted standards are the same as any reasonable and prudent physician would follow when recommending or approving any other medication.

It is important to note that B&P Code section 2525.3 states that physicians recommending cannabis to a patient for a medical purpose without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. The use of telehealth in compliance with B&P Code section 2290.5, and used in a manner consistent with the standard of care is permissible.

Informed and Shared Decision Making: The decision to recommend cannabis should be a shared decision between the physician and the patient. The physician should discuss the risks and benefits of the use of cannabis with the patient. (See Decision Tree in Appendix 1) Patients should be advised of the variability and lack of standardization of cannabis preparations, as well as the issue that it affects individuals differently. Patients should be reminded that cannabis use may result in cognitive changes that affect function, including driving, and that they should not drive, operate heavy machinery, or engage in any hazardous activity while under the influence of cannabis. As with any medication, patients may be charged with driving under the influence of drugs if they drive while impaired by the substance. If the patient is a minor or without decision-making capacity, the physician should ensure that the patient's parent, guardian or surrogate is fully informed of the risks and benefits of cannabis use, is involved in the treatment plan, and consents to the patient's use of cannabis.

Treatment Agreement: Treatment plans with objectives should be established with the patient as early as possible in the treatment process and revisited regularly, so as to provide clear-cut, individualized objectives to guide the choice of therapies, both pharmacologic and non-pharmacologic. It also should specify measurable goals and objectives that will be used to evaluate treatment progress, such as relief of pain and improved physical and psychosocial function. The plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered. The treatment plan should also include an "exit strategy" for discontinuing cannabis use in the event tapering or termination of cannabis use becomes necessary.

A physician should document a written treatment plan that includes:

- Advice about other options for managing the terminal or debilitating medical condition (pursuant to the Act conditions include cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which cannabis provides relief).
- Determination that the patient with a terminal or debilitating medical condition may benefit from the recommendation of cannabis.
- Advice about the potential risks of the medical use of cannabis and reminders to safeguard the cannabis, including but not limited to, the following:
    - The variability of quality and concentration of cannabis;
    - Cannabis use disorder;
    - Potential adverse events, such as exacerbation of psychotic disorder, adverse cognitive effects for children and young adults, falls or fractures, and other risks;

- Using cannabis during pregnancy or breast feeding[1];
- The need to safeguard all cannabis and cannabis-infused products from children, pets, or domestic animals; and
- The reminder that the cannabis is for the patient's use only and the cannabis must not be sold, donated, or otherwise supplied to another individual.

- Additional diagnostic evaluations or other planned treatments.
- A specific duration for the cannabis authorization for a period no longer than twelve months.
- A specific ongoing treatment plan as medically appropriate.

Qualifying Conditions: At this time, there is a lack of evidence for the efficacy of cannabis in treating certain medical conditions. Recommending cannabis for medical purposes is at the professional discretion of the physician. The indication, appropriateness, and safety of the recommendation should be evaluated in accordance with current standards of practice and in compliance with state laws, rules and regulations which specify qualifying conditions for which a patient may qualify for cannabis for medical purposes.

The Compassionate Use Act names certain medical conditions for which cannabis may be useful, although physicians are not limited in their recommendations to those specific conditions (cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, and migraine). In all cases, the physician should base his or her determination on the results of clinical trials, if available, medical literature and reports, or on experience of that physician or other physicians, or on credible patient reports. In all cases, the physician must determine that the risk/benefit ratio of cannabis is as good, or better, than other treatment options that could be used for that individual patient. A patient need not have failed on all standard medications in order for a physician to recommend or approve the use of cannabis for medical purposes.

Ongoing Monitoring and Adapting the Treatment Plan: The physician should regularly assess the patient's response to the use of cannabis and overall health and level of function. This assessment should include any change in the overall medical condition, any change in the physical and psychosocial function, the efficacy of the treatment to the patient, the goals of the treatment, and the progress of those goals. Recommendations should be limited to the time necessary to appropriately monitor the patient. There should be a periodic review documented at least annually or more frequently as warranted.

When a trial of cannabis for medical use is successful and the physician and patient decide to continue the use of cannabis, regular review and monitoring should be undertaken for the duration of treatment. Continuation, modification or termination of cannabis for medical use should be contingent on the physician's evaluation of (1) evidence or the patient's progress toward treatment objectives and (2) the absence of substantial risks or adverse events, such as diversion. A satisfactory response to treatment would be indicated by an increased level of

[1] Please be aware that the risks of cannabis use on a fetus or breast-feeding infant are unknown. The American College of Obstetricians and Gynecologists (ACOG) Committee Opinion (Number 722 - October 2017) states physicians should be discouraged from recommending cannabis for medicinal purposes during pregnancy and lactation.

function and/or improved quality of life. The physician should regularly assess the patient's response to the use of cannabis.

Consultation and Referral: A patient who has a history of substance use disorder or a co-occurring mental health disorder may require specialized assessment and treatment. The physician should seek a consultation with, or refer the patient to, a pain management physician, psychiatrist, psychologist, and/or addiction or mental health specialist, as needed. The physician should determine that cannabis use is not masking symptoms of another condition requiring further assessment and treatment (e.g., substances use disorder, or other psychiatric or medical condition) or that such use will lead to a worsening of the patient's condition.

Medical Records: Proper record keeping and maintenance should support the decision to recommend the use of cannabis for medical purposes. B&P Code section 2266 requires a physician to maintain adequate and accurate medical records. Medical records need to be complete and legible. In addition, each entry should be dated and signed. Any changes, additions, and/or removal to the medical record made at a later date should also be dated and either signed or initialed.

Information that should appear in the medical record includes, but is not limited to the following:

- The patient's medical history, including a review of health risk factors and prior medical records as appropriate;
- Results of the appropriate prior examination, patient evaluation, diagnostic, therapeutic, and laboratory results;
- Other treatments and prescribed medications, including a review of the Controlled Substance Utilization Review and Evaluation System (CURES);
- Authorization, attestation or recommendation for cannabis, to include date, expiration, and any additional information required by state statute;
- Instructions to the patient, including discussions of risks and benefits, side effects and variable effects;
- Results of ongoing assessment and monitoring of patient's response to the use of cannabis;
- A copy of a signed treatment agreement, including instructions on safekeeping and instructions on not sharing cannabis.

Physician Conflicts of Interest: B&P Code section 2525 includes a provision that makes it unlawful for a physician who recommends cannabis for a medical purpose to accept, solicit, or offer any form of remuneration from or to a facility, as defined, if the physician or his or her immediate family have a financial interest in that facility. A violation of this law is a misdemeanor punishable by up to one year in county jail and a fine of up to five thousand dollars or by civil penalties of up to five thousand dollars and constitutes unprofessional conduct.

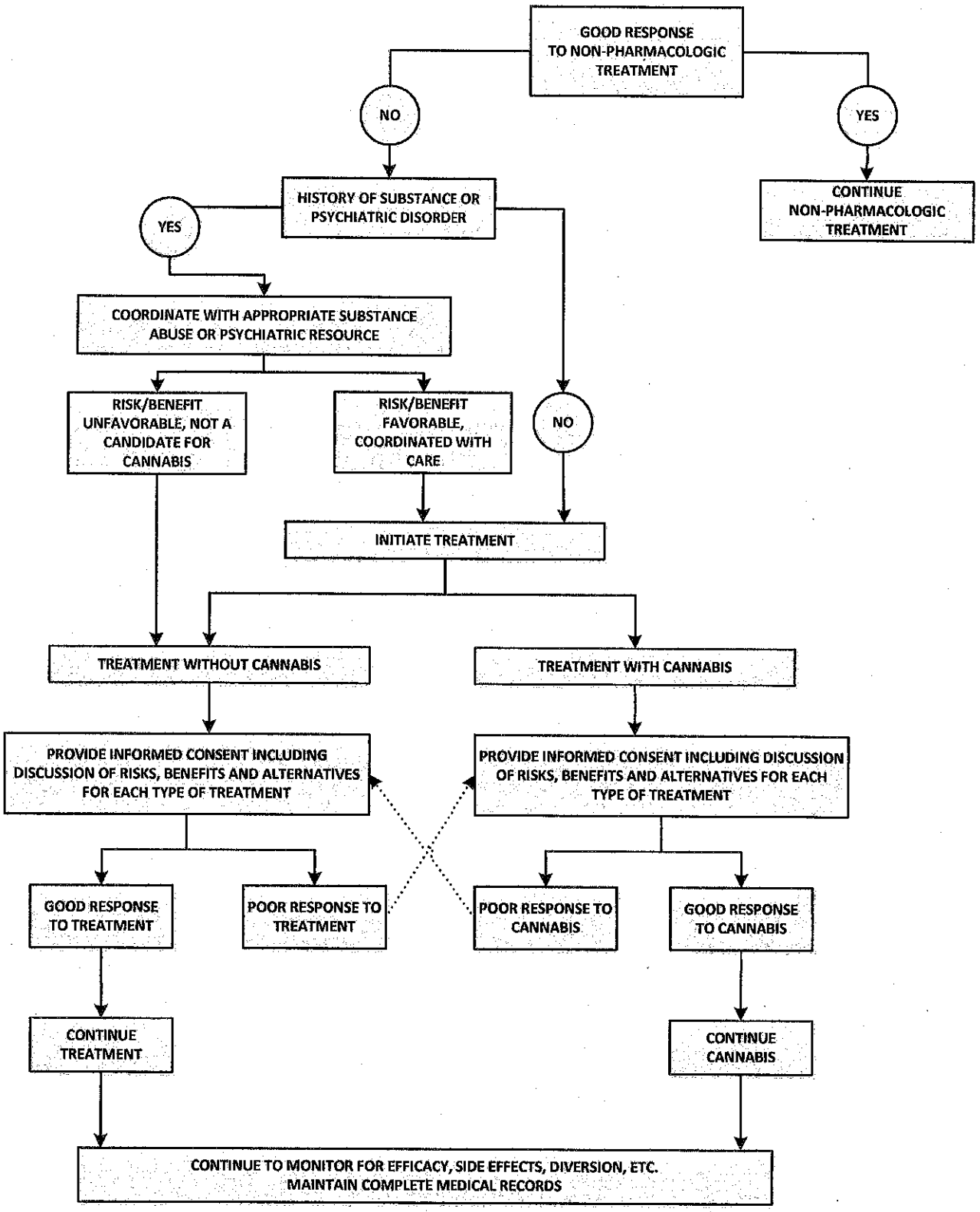
"Financial Interest" includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and

a person or entity to whom the licensee refers a person for a good or service. For further information on the full definition of "financial interest" see B&P Code section 650.01.

Additionally, B&P Code section 2525.4 indicates that it is unprofessional conduct for any attending physician recommending cannabis for medical purposes to be employed by, or enter into any other agreement with any person or entity dispensing cannabis for medical purposes.

Accordingly, a physician who recommends cannabis should not have a professional office located at a dispensary or cultivation center or receive financial compensation from or hold a financial interest in a dispensary or cultivation center. Nor should the physician be a director, officer, member, incorporator, agent, employee, or retailer of a dispensary or cultivation center. A cannabis clinic or dispensary may not directly or indirectly employ physicians to provide cannabis recommendations.

Appendix 1 – Decision Tree



Business & Professions Code 2290.5

State of California

BUSINESS AND PROFESSIONS CODE

Section 2525.3

2525.3. Recommending medical cannabis to a patient for a medical purpose without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

(Added by Stats. 2015, Ch. 719, Sec. 5. (SB 643) Effective January 1, 2016.)

Business & Professions Code 2525.3

State of California

BUSINESS AND PROFESSIONS CODE

Section 2290.5

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means either of the following:

(A) A person who is licensed under this division.

(B) An associate marriage and family therapist or marriage and family therapist trainee functioning pursuant to Section 4980.43.3.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(Amended by Stats. 2018, Ch. 743, Sec. 2.5. (AB 93) Effective January 1, 2019.)

Tab 7

AB 1753 – Controlled Substance Prescription Form Serial Number Requirement

BE AWARE AND TAKE CARE:
Talk to your pharmacist!
CALIFORNIA STATE BOARD OF PHARMACY

Joint Statement from the California Department of Justice, California State Board of Pharmacy, and the Medical Board of California Regarding Secure Prescription Forms

January 10, 2019

As of January 1, 2019, California law requires prescription forms for controlled substances to be printed with a uniquely serialized number. Notices explaining the serial number format and reporting requirements have been released by the Department of Justice (DOJ). Additionally, notices to prescribers and pharmacists were issued by the California State Board of Pharmacy (Pharmacy Board), and by the Medical Board of California (Medical Board), yet questions remain about implementation. This joint statement by DOJ, the Pharmacy Board, and the Medical Board is therefore being issued to provide further clarification and guidance on implementation.

As explained in previous notices from the Pharmacy Board and Medical Board, because of the absence of a grandfathering or transition period in Assembly Bill (AB) 1753 (Low), which enacted this change, as of January 1, 2019, only security forms with unique serialized numbers may lawfully be used to write paper controlled substance prescriptions. As of that date, any paper controlled substance prescription written on a controlled substance security prescription form that does not bear all of the 15 security features will be presumptively invalid.

DOJ has issued guidance to the Security Printers and the pharmacy and direct dispense data reporters regarding the approved serialized number format and reporting requirements. The DOJ has approved 38 security printers that are compliant with the new requirement. However, the signatories to this joint statement recognize that it may take some time for all prescribers to begin using the new, fully-compliant security forms. And that there may be a period of weeks or months during which prescribers continue to use outdated security forms, and those outdated forms are presented to dispensers.

Prescribers are encouraged to procure compliant security forms at their earliest opportunity. In the interim, however, none of the signatory agencies want to see patients denied access to necessary medications during this transition period. With that in mind, the Enforcement Committee of the Pharmacy Board has recommended to the Pharmacy Board and the Executive Officer that, prior to July 1, 2019, enforcement staff not make an enforcement priority of actions against and/or investigations of pharmacists (or their employing pharmacies) who, in the exercise of his or her best professional judgment, determine that it is in the best interest of patient or public health or safety to fill a controlled substance prescription written on a security form that would have been compliant prior to January 1, 2019. Further, to assist pharmacists, pharmacies, and other dispensers with implementation challenges, the Pharmacy Board has told its licensees to consider the following responses to presentation of an outdated form:

(a) Communicating with the prescriber about the need for a compliant security prescription;
(b) Advising the prescriber to substitute an electronic prescription;
(c) Consulting with the prescriber about whether the patient might be terminally ill and eligible for a "11159.2 exemption" prescription under Health and Safety Code section 11159.2;
(d) Treating prescription orders written on the outdated forms for Schedule III, IV and V medications as oral prescriptions, and verifying the order telephonically with the prescriber's office, pursuant to Health and Safety Code section 11164, subdivision (b);
(e) Schedule II prescriptions on non-compliant security prescription forms present unique challenges, because of the inability to substitute an oral prescription. It is therefore especially important that pharmacists use their best professional judgment to get needed Schedule II medications to their patients, and the same lack of enforcement priority will be applied to these dispensing decisions until July 1, 2019.
(f) If failure to dispense may result in loss of life or intense suffering, dispensing pursuant to the emergency situation requirements of Health and Safety Code section 11167, and curing with a compliant controlled substance security prescription form within seven (7) days; or
(g) Refusing to fill the prescription.

Prescribers should expect to receive calls from dispensers seeking to validate such prescriptions.

<u>Frequently Asked Questions</u>

1. Who is responsible for enforcing the provisions required of the Security Printers?

   Answer: The DOJ oversees the Security Printer Program and the approved printers who are required, beginning on January 1, 2019, to print controlled substance prescription forms with uniquely serialized numbers. There is no transition or grace period for printers to become compliant with the requirement to print controlled substance prescription forms with uniquely serialized numbers. Security printers that are not compliant with the new printing requirement, as of January 1, 2019, may have their security printer status suspended.

2. Previous communications have indicated that there is no transition period for prescriptions written after January 1, 2019 without a serial number. Who would enforce provisions against dispensers that determine it is in the best interest of the patient to dispense a medication issued on a form that does not include a serial number?

   Answer: The Enforcement Committee of the Pharmacy Board has recommended to the Pharmacy Board and the Executive Officer that, prior to July 1, 2019, investigative staff not make an enforcement priority of actions against and/or investigations of pharmacists (or their employing pharmacies) who, in the exercise of his or her best professional judgment, determine that it is in the best interest of patient or public health or safety to fill a controlled substance prescription written on a security form that would have been compliant prior to January 1, 2019.

   The DOJ does not have the authority to enforce such provisions on dispensers.

3. Previous communications have indicated that there is no transition period for prescriptions written after January 1, 2019, without a serial number. Who would enforce provisions against prescribers that determine it is in the best interest of the patient to prescribe on a form that does not include a serial number?

Answer: The Medical Board is responsible for enforcing the provisions related to physician prescribers and is encouraging physician prescribers to obtain and utilize the new controlled substance security prescription forms that contain the serial number as soon as possible. If you are a licensee of another board, you are encouraged to contact the appropriate licensing board for direction.

The DOJ does not have the authority to enforce such provisions on prescribers.

4. As a prescriber, will I be assigned or issued a serial number?

   Answer: No, prescribers will not be issued a serial number. The serial number is a number printed on prescription forms produced by approved security printers.

5. Is there a sample of what the new security forms look like?

   Answer: The Health and Safety Code establishes the required elements, but does not specify the placement of all security form features. As such, not all forms look the same. The DOJ has a list of approved Security Prescription Printers on its website that can be accessed using the following link - - https://oag.ca.gov/security-printers/approved-list. Some of the vendors have a sample of the compliant form on their respective website.

6. Is there a standardized format for the serialized number?

   Answer: Yes. The serial number is a 15-digit alphanumeric in the following format:

   AAANNNNNNANNNNN (A represents an alpha character and N represents a numeral)

7. Are electronic prescriptions required to include the unique serial number?

   Answer: No

8. Who should I contact if I have questions?

   Answer: Questions regarding the security printers or the serialized number format should be directed to the DOJ, (916) 210-3216 or securityprinter@doj.ca.gov.

   Questions regarding prescriber or pharmacist/dispenser requirements should be directed to the respective board under the Department of Consumer Affairs. The following link can be used to access the respective prescribing boards - - https://www.dca.ca.gov/about_us/entities.shtml.

   Questions regarding pharmacy requirements should be directed to the Pharmacy Board, (916) 574-7900.

Please watch for additional advisories to be released as all agencies are working to identify further real-time solutions.

Thank you.

California Department of Justice
California State Board of Pharmacy
Medical Board of California

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

To: California Licensed Osteopathic Physicians and Surgeons

RE: Controlled Substance Prescription Form Serial Number Requirement

Effective January 1, 2019 Assembly Bill 1753 (Low, 2018) will require an additional improvement to controlled substance security prescription forms: the addition of a unique serialized number to each form in a format approved by the Department of Justice (DOJ).

Thus, as of January 1, 2019:

(1) Each controlled substance security prescription form used for prescribing on or after that date must include a unique serialized number in an approved format (Health & Safety Code, section 11162.1, subdivision (a)(15)); and
(2) No person shall prescribe a controlled substance on or after that date, nor fill, compound, or dispense a prescription for a controlled substance written on or after that date, without this security feature (Health & Safety Code, section 11164, subdivision (a)).

Under the new statutes, the new security forms will be the exclusive means to write paper-controlled substance prescriptions as of January 1, 2019, and as of that date any prescription written on a controlled substance security prescription form that does not bear all of the 15 security features will be presumptively invalid.

The Osteopathic Medical Board encourages you to order new forms with the new serial number requirement and utilize e-prescribing when applicable. Visit DOJ's website here for more information. Also, attached is a notice released Friday, December 27th by DOJ to Pharmacies and Direct Dispense Data Reporters regarding submission of data into CURES and a notice released Thursday, December 27 by the California State Board of Pharmacy providing implementation guidance to their licensees.

California State Board of Pharmacy
1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone: (916) 574-7900
Fax: (916) 574-8618
www.pharmacy.ca.gov

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

December 27, 2018

To: California Licensed Pharmacists and California Pharmacies

In the most recent legislative session, Assembly Bill 1753 (Low) was enacted to require an additional improvement to controlled substance security prescription forms: the addition of a unique serialized number to each form in a format approved by the Department of Justice. This change takes effect January 1, 2019.

Thus, as of January 1, 2019:

(1) Each controlled substance security prescription form used for prescribing on or after that date must include a unique serialized number in an approved format (Health & Safety Code, § 11162.1, subdivision (a)(15)); and
(2) No person shall prescribe a controlled substance on or after that date, nor fill, compound, or dispense a prescription for a controlled substance written on or after that date, without this security feature (Health & Safety Code, § 11164, subdivision (a)).

The legislation did not include any transition or grandfathering period to allow for continued use of old controlled substance security prescription forms on or after January 1, 2019. Under the new statutes, the new security forms will be the exclusive means to write paper controlled substance prescriptions as of January 1, 2019, and as of that date any prescription written on a controlled substance security prescription form that does not bear all of the 15 security features will be presumptively invalid.

The board anticipates that some prescribers will nonetheless continue to use old prescription forms on and after January 1, 2019. And that pharmacists and pharmacies will be placed in the uncomfortable position of having to decide between providing needed medications to patients, and compliance with the law.

On or after January 1, 2019, a pharmacist may be presented with a Schedule II, III, IV or V controlled substance prescription written on a security prescription form that was compliant prior to January 1, 2019 but is no longer compliant. This may be especially true for Schedule II prescriptions. In this circumstance, the Enforcement Committee has recommended to the board and to the executive officer that prior to July 1, 2019 the board not make an enforcement priority any investigation or action against a pharmacist who, in the exercise of his or her professional judgment, determines that it is in the best interest of patient or public health or safety to nonetheless fill such prescription.

The board urges pharmacists and pharmacies to exercise your best judgment in handling these situations, and reminds you of the following possible responses:

(a) Communicating with the prescriber about the need for a compliant security prescription;
(b) Advising the prescriber to substitute an electronic prescription;
(c) Consulting with the prescriber about whether the patient might be terminally ill and eligible for a "11159.2 exemption" prescription under Health and Safety Code section 11159.2;
(d) Treating prescription orders written on the outdated forms for Schedule III, IV and V medications as oral prescriptions, and verifying the order telephonically with the prescriber's office, pursuant to Health and Safety Code section 11164, subdivision (b);
(e) Schedule II prescriptions on non-compliant security prescription forms present unique challenges, because of the inability to substitute an oral prescription. It is therefore especially important that pharmacists use their best professional judgment to get needed Schedule II medications to their patients, and the same enforcement priority will be applied to these dispensing decisions until July 1, 2019.
(f) If failure to dispense may result in loss of life or intense suffering, dispensing pursuant to the emergency situation requirements of Health and Safety Code section 11167, and curing with a compliant controlled substance security prescription form within seven (7) days;
(g) Refusing to fill the prescription.

Licensees are encouraged to identify prescribers who do not timely begin the transition to the new security prescription forms to the appropriate prescribing board, so that compliance can be encouraged. Use this link to identify the addresses of the respective prescribing boards https://www.dca.ca.gov/about_us/entities.shtml.

For your information, attached is a copy of Health and Safety Code section 11162.1 as it will take effect January 1, 2019. Also attached is a notice released Friday by the California Department of Justice regarding submission of data into CURES.

AB 2760 – Prescription drugs: prescribers: naloxone hydrochloride and other FDA-approved drugs

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991
P (916) 928-8390 F (916) 928-8392 / www.ombc.ca.gov

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
POLICY ALERT

DATE: January 3, 2019

TO: Osteopathic Physicians and Surgeons

FROM: Angie Burton, Executive Director

SUBJECT: AB 2760 Naloxone Hydrochloride Access and Other FDA-approved Drugs

---

Summary: AB 2760 signed into law by Governor Brown, effective January 1, 2019 creates Article 10.7 Opioid Medication of the Business and Professions Code. This bill requires a health care practitioner authorized to prescribe controlled substances (prescriber) to offer a prescription for naloxone hydrochloride (naloxone) or another FDA-approved drug for the complete or partial reversal of opioid depression, under specified conditions. This bill also requires a prescriber to provide education to a patient (or the patient's parent/guardian or designee) on overdose prevention and the use of naloxone or other similar FDA-approved drugs.

Background: The legislative intent of this bill is to combat the opioid crisis in California. The Legislature finds and declares that *abuse and misuse of opioids is a serious problem that affects the health, social, and economic welfare of the state. After alcohol, prescription drugs are the most commonly abused substances by Americans over 12 years of age. Deaths involving prescription opioid pain relievers represent the largest proportion of drug overdose deaths, greater than the number of overdose deaths involving heroin or cocaine. Driven by the surge in drug deaths, life expectancy in the United States dropped for the second year in a row in 2016, resulting in the first consecutive decline in national life expectancy since 1963. Should 2017 also result in a decline in life expectancy as a result of drug deaths, it would be the first three-year period of consecutive life expectancy declines since World War I and the Spanish flu pandemic in 1918.*

Policy Implications: This bill seeks to increase access to naloxone hydrochloride and other FDA approved prescription drugs. If patients fit the specified patient criteria, then prescribers are required to offer the patient a prescription for naloxone or similar FDA-approved drug. Prescribers are also required to educate these patients about the risks of taking these drugs including risks for overdose. If physicians and surgeons are found to have not complied with this new mandate, they may be subject to discipline by the Osteopathic Medical Board of California.

Text of Business and Professions Code sections 740, 741 and 742:

740.

For purposes of this article, "prescriber" means a person licensed, certified, registered, or otherwise subject to regulation pursuant to this division, or an initiative act referred to in this division, who is authorized to prescribe prescription drugs.

741.

(a) Notwithstanding any other law, a prescriber shall do the following:

(1) Offer a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression to a patient when one or more of the following conditions are present:

(A) The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.

(B) An opioid medication is prescribed concurrently with a prescription for benzodiazepine.

(C) The patient presents with an increased risk for overdose, including a patient with a history of overdose, a patient with a history of substance use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

(2) Consistent with the existing standard of care, provide education to patients receiving a prescription under paragraph (1) on overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression.

(3) Consistent with the existing standard of care, provide education on overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression to one or more persons designated by the patient, or, for a patient who is a minor, to the minor's parent or guardian.

(b) This section does not apply to a prescriber when prescribing to an inmate or a youth under the jurisdiction of the Department of Corrections and Rehabilitation or the Division of Juvenile Justice within the Department of Corrections and Rehabilitation.

742.

A prescriber who fails to offer a prescription, as required by paragraph (1) of subdivision (a) of Section 741, or fails to provide the education and use information required by paragraphs (2) and (3) of subdivision (a) of Section 741 shall be referred to the appropriate licensing board solely for the imposition of administrative sanctions deemed appropriate by that board. This section does not create a private right of action against a prescriber and does not limit a prescriber's liability for the negligent failure to diagnose or treat a patient.

Tab 8

Executive Director - Report

BOARD MEETING – JANUARY 17, 2019

This report is to provide the Board Members with an update on licensing statistics, staffing issues, CURES and enforcement functions at the Osteopathic Medical Board of California

License Statistics for 2018

As of January 15, 2019, OMBC's licensee count:

Active/current:	9,059
Inactive/current:	578
TOTAL:	9,637

Additionally, there are 1,133 licenses in a delinquent status, bringing the total number of licensees within the jurisdiction of the board to 10,770.

Number of licensees practicing/residing in California as of January 15, 2019 is 7,916. Of this number, 55 hold inactive licenses.

In the year 2018, OMBC received 892 applications for licensure. 895 applications were approved. 851 certificates were issued.

In the year 2018, staff renewed 5302 licenses. Licenses are currently renewed every other month (2018 was an even year so licenses were renewed every even month: Feb. April, June, August, October and December.) This averages out to approximately 884 licenses renewed each renewal period. With two staff reviewing CME and approving renewals, each staff was responsible for reviewing approximately 442 licensee's CME compliance, every other month.

OMBC received 139 fictitious name permit applications and renewed 864 fictitious name permits.

Staffing

OMBC has been working with the same number of staff for the past several years. We have three enforcement staff, two CME compliance/license renewal staff, one fulltime licensing staff and two others who assist with licensing. One of the two is our cashier and the other works as our receptionist. In addition to these eight staff, we have one administrative analyst, one Assistant Executive Director who also serves as staff manager, our half-time Medical Consultant and the Executive Director.

With the implementation of the Postgraduate Training License, our Budget Change Proposal (BCP) submitted in 2018 requesting two additional staff was approved. We

will be able to hire these two new positions as of July 1, 2019. One will be in enforcement and the other will be in licensing. Additionally, our second BCP requesting additional funding for our investigation and expert reviewer programs was also approved. The budget for investigation will be increased by $200,000 and the expert reviewer budget program will be increased by $50,000.

The OMBC office renovation is now in progress. The renovation began on January 4, 2019. DCA facilities has kindly provided OMBC with a temporary home in their Headquarters building. OMBC currently occupies Suite 202 at the 1625 North Market location, sharing this space with a couple other DCA entities. Our property management also was extremely generous in providing us with an office suite in an adjacent building where all our files and other belongings are being securely stored during this process. Staff have been checking in on the progress of the rebuilt. The interior walls have been moved to meet our needs, the hi-density files were being installed and the walls have been painted. We are getting all new cubicles and carpeting. The estimated completion and OMBC's staff returning to the National Drive office date is currently set for January 28, 2019.

DCA IT and Telecommunications staff have been extremely helpful in making this temporary transition a success. All phone calls and faxes are re being routed to our temporary location and each staff's work stations were ready for use as planned. The down time was limited to two days and currently business is as usual.

My last day at OMBC is January 30, 2019. Your New Executive Director, Mr. Mark Ito will be joining his staff on January 31, 2019.

CURES

The CURES December 2018 Statistics report is attached for information. As of December 2018, there are 6,784 osteopathic physicians registered as CURES users. Osteopathic physicians ran 87,360 separate patient activity reports while accessing the system 48,350 times.

This report also identifies the number of Scheduled prescriptions filled by dispensers on page 5.

Staff have updated the website with information on AB 2760 Naloxone Hydrochloride Access and information regarding AB 1753 Controlled Substance prescription forms and sent out informational email blasts to licensees and interested parties.

December 2018 Statistics

Registered Users			
			DECEMBER
Total Registered Users			**210,297**
Clinical Roles			
	Prescribers		157,900
	Dispensers		43,281
		Sub-Total A	**201,181**
License Type			
	Doctor of Podiatric Medicine		1,364
	Registered Nurse Practitioner/Nurse Midwife		14,819
	Medical Doctor		106,583
	Naturopathic Doctor		290
	Osteopathic Doctor		6,784
	Physician Assistant		9,538
	Doctor of Optometry		659
	Pharmacist		42,861
	Doctor of Dental Surgery/Dental Medicine		14,455
	Doctor of Veterinary Medicine		2,888
	Other (Out of State)		940
		Sub-Total B	**201,181**
Other Roles			
	LEAs		1,345
	Delegates		7,516
	DOJ Administrators		14
	DOJ Analysts		78
	Regulatory Board		163
		Sub-Total C	**9,116**

NOTE:
1. Subtotal A = Subtotal B
2. Subtotal A + Subtotal C = Total Registered Users
3. Stats are from the 1st of the month to the last day of the month

December 2018 Statistics

Number of PARs Ran			
			DECEMBER
Total PARs Ran			**1,898,266**
Clinical Roles			
	Prescribers		1,103,201
	Dispensers		770,495
		Sub-Total A	**1,873,696**
	License Type		
		Doctor of Podiatric Medicine	2,862
		Registered Nurse Practitioner/Nurse Midwife	139,564
		Medical Doctor	743,068
		Naturopathic Doctor	1,081
		Osteopathic Doctor	87,360
		Physician Assistant	120,593
		Doctor of Optometry	7
		Pharmacist	768,212
		Doctor of Dental Surgery/Dental Medicine	6,713
		Doctor of Veterinary Medicine	60
		Other (Out of State)	4,176
		Sub-Total B	**1,873,696**
Other Roles			
	LEAs		253
	Delegates		23,231
	DOJ Administrators		46
	DOJ Analysts		138
	Regulatory Board		902
		Sub-Total C	**24,570**

NOTE:
1. Subtotal A = Subtotal B
2. Subtotal A + Subtotal C = Total PARs Ran
3. Stats are from the 1st of the month to the last day of the month

CURES 2.0

December 2018 Statistics

Times System was Accessed			
			DECEMBER
Total Times System was Accessed			**984,423**
Clinical Roles			
	Prescribers		602,247
	Dispensers		365,742
		Sub-Total A	**967,989**
	License Type		
		Doctor of Podiatric Medicine	1,945
		Registered Nurse Practitioner/Nurse Midwife	66,388
		Medical Doctor	420,097
		Naturopathic Doctor	441
		Osteopathic Doctor	48,350
		Physician Assistant	57,768
		Doctor of Optometry	51
		Pharmacist	364,585
		Doctor of Dental Surgery/Dental Medicine	5,898
		Doctor of Veterinary Medicine	217
		Other (Out of State)	2,249
		Sub-Total B	**967,989**
Other Roles			
	LEAs		337
	Delegates		14,683
	DOJ Administrators		181
	DOJ Analysts		911
	Regulatory Board		322
		Sub-Total C	**16,434**

NOTE:
1. Subtotal A = Subtotal B
2. Subtotal A + Subtotal C = Total Times System was Accessed
3. Stats are from the 1st of the month to the last day of the month

CURES 2.0

December 2018 Statistics

Number of CURES Help Desk Requests			
			DECEMBER
Emails [Note: Email requests are not included in the breakdown below]			**1,342**
Total Phone Calls			**2,886**
Clinical Roles			
	Prescribers		2,329
	Dispensers		517
		Sub-Total A	
	License Type		
		Doctor of Podiatric Medicine	16
		Registered Nurse Practitioner/Nurse Midwife	229
		Medical Doctor	1,673
		Naturopathic Doctor	12
		Osteopathic Doctor	86
		Physician Assistant	129
		Doctor of Optometry	-
		Pharmacist	517
		Doctor of Dental Surgery/Dental Medicine	142
		Doctor of Veterinary Medicine	42
		Other (Out of State)	0
		Sub-Total B	**2,846**
Other Roles			
	LEAs		3
	Delegates		36
	DOJ Administrators		0
	DOJ Analysts		0
	Regulatory Board		1
		Sub-Total C	**40**

NOTE:
1. Subtotal A = Subtotal B
2. Subtotal A + Subtotal C = Total Help Desk Phone Calls

December 2018 Statistics

Prescription Counts	DECEMBER
Number of Distinct Prescriptions	**3,277,853**
Number of Prescriptions Filled by Schedule	
Schedule III	269,018
Schedule IV	1,454,407
Schedule V	48,446
R	11,770
Unknown	27,506
TOTAL	**3,279,120**

NOTE:
1. Each component of a compound is submitted as a separate prescription record. The number of distinct prescriptions rolls compound prescriptions into a single count
2. The number of distinct prescriptions and the number of prescriptions filled by schedule will not be equal because a compound can consist of multiple drugs with varying schedules
3. R = Not classified under the Controlled Substances Act; includes all other prescription drugs
4. Unknown = Over the counter product

Enforcement - Report

OMBC Enforcement Report

January 17, 2019

The following OMBC Enforcement Report covers a 12-month period starting from January 1, 2018 through December 31, 2018. The OMBC Enforcement Report is divided into five sections; Intake, Investigations, Enforcement, Performance Measures, and Probation. The data is reproduced from the Breeze Enforcement Reports.

COMPLAINT INTAKE

	1Q 2018			2Q 2018			3Q 2018			4Q 2018			
COMPLAINTS	01/18	02/18	03/18	04/18	05/18	06/18	07/18	08/18	09/18	10/18	11/18	12/18	Totals
Received	42	37	67	55	46	36	44	37	41	65	43	32	545
Assigned	31	37	52	29	25	105	25	7	53	105	70	36	575
Aging	34	30	31	37	42	64	18	13	93	33	17	11	35
	1Q 2018			2Q 2018			3Q 2018			4Q 2018			
CONV/ARRESTS	01/18	02/18	03/18	04/18	05/18	06/18	07/18	08/18	09/18	10/18	11/18	12/18	Totals
Received	2	0	1	2	3	1	2	4	3	0	2	2	22
Assigned	1	1	1	2	2	2	2	4	3	0	1	2	21
Aging	2	30	1	4	4	7	11	5	1	0	17	10	8
	1Q 2018			2Q 2018			3Q 2018			4Q 2018			
TOTAL INTAKE	01/18	02/18	03/18	04/18	05/18	06/18	07/18	08/18	09/18	10/18	11/18	12/18	Totals
Received	44	37	68	57	49	37	46	41	44	65	45	34	567
Assigned	32	38	53	31	27	107	27	11	56	105	71	38	596
Aging	33	30	30	34	39	63	17	10	88	33	17	11	34
Pending	53	52	67	92	114	43	62	92	80	40	14	10	10

Data Table 1: Complaint Intake with Convictions/Arrests

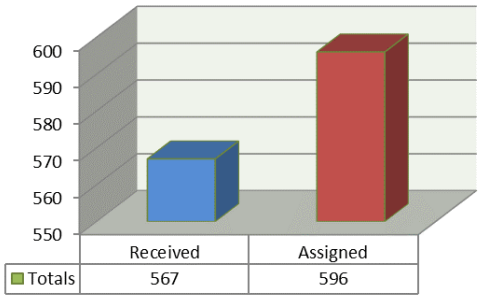


Figure 1.1: Intake Totals

In Data Table 1 above, under TOTAL INTAKE, OMBC received 567 complaints. 22 of these cases were convictions/arrests. During this period, 596 cases were referred to desk investigations. The aging for intake measures the period from the date the complaint was received (date stamped) to the date the complaint was entered into the system and referred to investigations (assigned). In Figure 1.2 below we see an increase in pending cases from March to May 2018 and then a spike in assigned cases in June. This was the result of a backlog and was immediately addressed. Then another increase in pending cases in August and then an increase in assigned cases in October. The backlog was addressed by the new analyst.

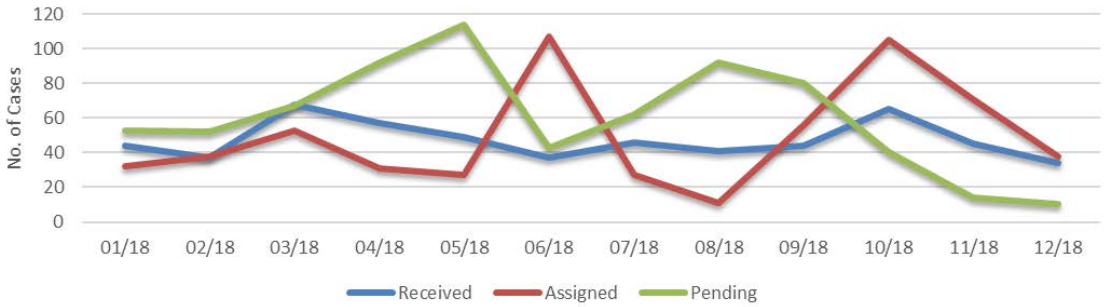


Figure 1.2: Intake Totals Per Month

In Figure 1.3 below, the bar graph illustrates the monthly average number of days for the intake process (the date received to the date referred to investigations). The performance target for intake is 30 days. The Board did not meet the performance target in April through June and September due to the staff shortage. The overall average for the last 12 months was 34 days.

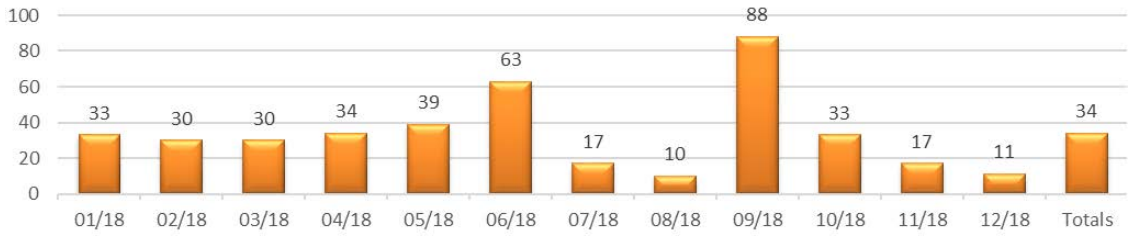


Figure 1.3: Average Number of Days to Assign

INVESTIGATIONS

Desk (internal) Investigations

	1Q 2018			2Q 2018			3Q 2018			4Q 2018			
Desk Inv.	**01/18**	**02/18**	**03/18**	**04/18**	**05/18**	**06/18**	**07/18**	**08/18**	**09/18**	**10/18**	**11/18**	**12/18**	**Totals**
Assigned	32	38	53	30	27	36	62	12	89	107	72	38	596
Completed	26	38	56	43	55	44	32	40	35	75	60	83	587
Aging	61	107	80	110	118	92	92	195	73	52	72	72	94
Pending	163	163	161	150	124	117	148	120	175	211	223	179	179

Data Table 2: Desk Investigations

For all desk investigations during this period, Data Table 2 above breaks down the monthly totals for how many complaints were assigned and completed; the monthly aging and cases pending. During this period, a total of 596 cases were assigned to an enforcement analyst and 587 were completed. The average number of days to complete a desk investigation was 94 days. In Figure 2.2 below, the assigned and completed caseloads averaged 50 cases per month until the 4th quarter the caseloads increased to around 100.

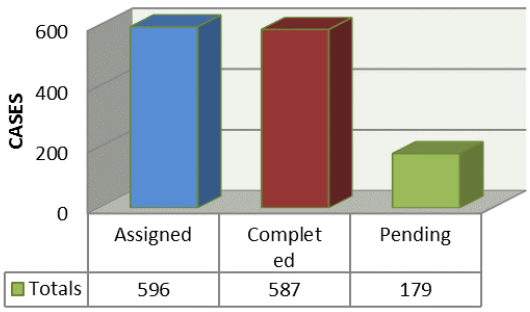


Figure 2.1: Desk Inv. Totals

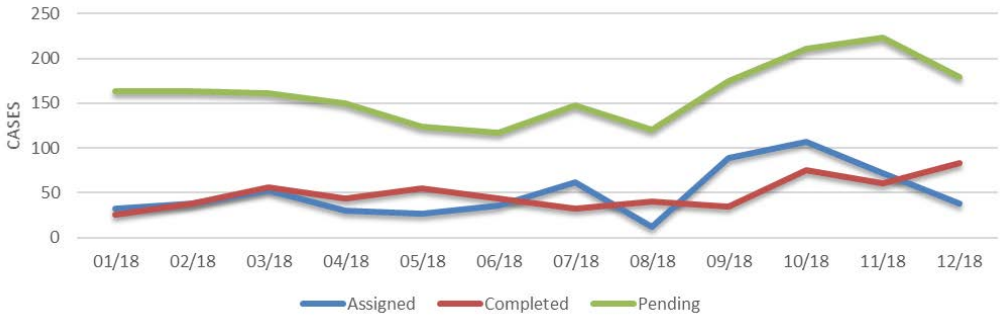


Figure 2.2: Desk Investigations Monthly Totals

Division of Investigation (DOI) Field Investigations

	1Q 2018			2Q 2018			3Q 2018			4Q 2018			
Field Inv.	**01/18**	**02/18**	**03/18**	**04/18**	**05/18**	**06/18**	**07/18**	**08/18**	**09/18**	**10/18**	**11/18**	**12/18**	**Totals**
Assigned	1	3	3	3	2	0	3	3	2	2	1	2	25
Completed	3	4	3	1	3	1	1	2	1	2	2	0	23
Aging	901	443	596	37	450	49	946	402	604	870	129	0	452
Pending	26	26	26	29	28	28	30	31	32	32	31	33	33

Data Table 3: Field Investigations

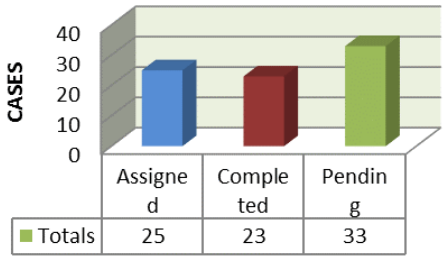


Figure 3.1: DOI Inv. Totals

Data Table 3 above breaks down the monthly totals for cases assigned to the Division of Investigations. Completed cases are either closed with insufficient evidence or referred to the Attorney General's office for disciplinary action. During this 12-month period, 25 cases were assigned to field investigations; 23 were completed; and 33 cases were pending at the end of June 2018. The average number of days to complete an investigation was 452.

The case complexity is the breakdown of the specific allegations. In Figure 3.2, for all competed field investigations (23 cases), there were 9 excessive prescribing cases (39%); 2 Hospital Discipline case (9%); 2 sexual misconduct cases (9%); 1 criminal/DA case (4%); 1 fraud cases (4%); 4 negligent/injury cases (18%); and 4 substance abuse cases (17%).

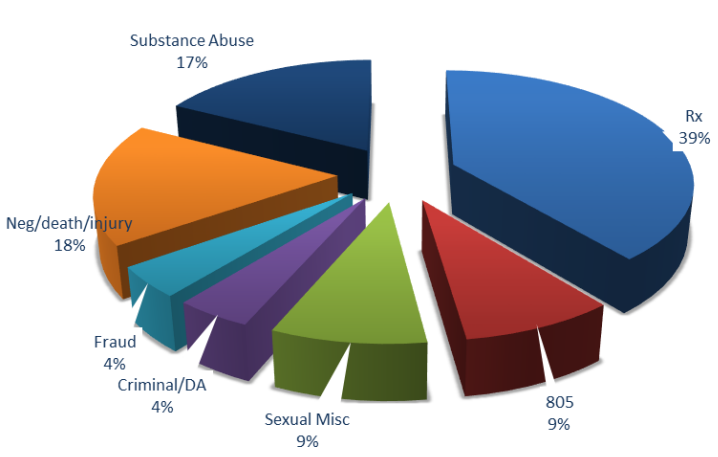
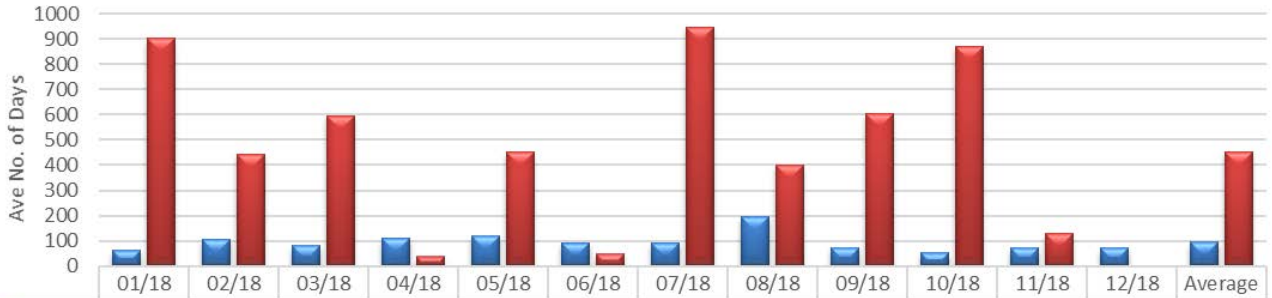


Figure 3.2 Complexity for completed Field Investigations

Figure 3.3 below compares the aging of completed Desk and Field Investigations per month. The aging is the average number of days to complete an investigation starting from the complaint received date to the date that the investigation is completed. Of the 587 desk investigations completed, the average number of days was 94. Of the 23 field investigations completed, the average number of days was 452.



	01/18	02/18	03/18	04/18	05/18	06/18	07/18	08/18	09/18	10/18	11/18	12/18	Average
Desk Inv	61	107	80	110	118	92	92	195	73	52	72	72	94
Field Inv	901	443	596	37	450	49	946	402	604	870	129	0	452

Figure 3.3: Completed Investigations Monthly Aging

Aging for Desk and Field Investigations

	1Q 2018			2Q 2018			3Q 2018			4Q 2018			
All Inv Aging	01/18	02/18	03/18	04/18	05/18	06/18	07/18	08/18	09/18	10/18	11/18	12/18	Totals
90 days	19	19	29	18	21	30	17	18	7	41	39	65	323
91-180 days	5	10	22	17	24	8	13	6	22	26	12	12	177
181-1 yr	2	7	4	5	7	3	0	2	3	3	4	6	46
1 yr-2 yrs	0	1	2	0	3	2	1	8	0	2	2	0	21
2 yrs-3 yrs	2	1	1	1	1	0	1	1	0	2	1	1	12
Totals	**28**	**38**	**58**	**41**	**56**	**43**	**32**	**35**	**32**	**74**	**58**	**84**	**579**

Data Table 4: All Investigations Aging

In Data Table 4 and Figure 4.1 we see the aging matrix for the number of all investigations that were closed per month within a specific time-period. 323 cases (56%) were completed within 90 days; 177 cases (30%) were completed between 91-180 days; 46 cases (8%) were completed between 181-365 days; 21 cases (4%) were completed between 1 – 2 years; and 12 cases (2%) were completed between 2-3 years. 86% of the investigations were completed within 6 months; and 94% were completed within a year.

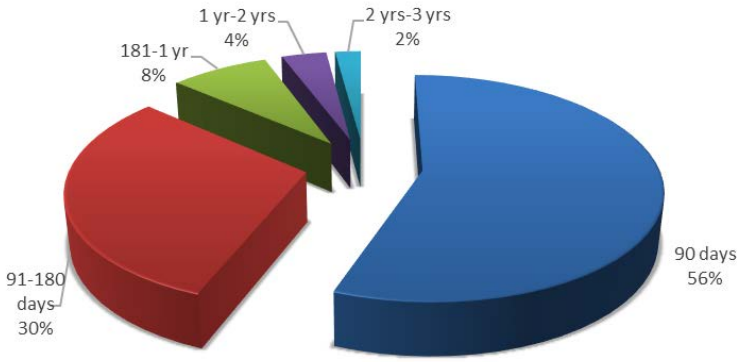


Figure 4.1 All Investigations Aging

ENFORCEMENT ACTIONS

	1Q 2018			2Q 2018			3Q 2018			4Q 2018			
	01/18	02/18	03/18	04/18	05/18	06/18	07/18	08/18	09/18	10/18	11/18	12/18	Totals
AG Cases Initiated	5	4	4	2	3	2	2	1	1	2	0	1	27
Acc/SOI Filed	0	2	2	2	2	2	2	2	0	2	0	2	18
Final Discplinary Order	1	1	1	0	3	0	3	3	2	3	2	1	20
Acc W/drawn/declined	0	1	0	0	0	0	0	0	0	0	0	0	1
Closed w/out Disc Acti	0	0	0	0	0	0	0	0	0	0	0	1	1
Citations	0	0	0	1	0	0	0	1	0	1	0	1	4
Suspension Orders	0	1	1	0	0	1	0	0	0	0	0	0	3
AG Cases Pending	24	24	25	27	27	29	28	26	25	23	21	19	19

Data Table 5: Enforcement Actions

For all enforcement actions, Data Table 5 above breaks down the monthly totals for each disciplinary action. During this 12-month period, 27 cases were transmitted to the Attorney General's Office for disciplinary actions; 18 Accusations and Statement of Issues were filed; 20 Final Disciplinary Orders were filed; 1 case was declined by the AG; 1 cases were closed without disciplinary action; 4 citations issued; and 3 Suspension Orders were filed. At the end of 4Q 2018 there were 19 AG cases pending (Figure 5.1).

Figure 5.1: Enforcement Actions Totals

Final Disciplinary Orders Aging

	1Q 2018			2Q 2018			3Q 2018			4Q 2018			
Total Orders Aging	01/18	02/18	03/18	04/18	05/18	06/18	07/18	08/18	09/18	10/18	11/18	12/18	Totals
90 Days	0	0	0	0	1	0	0	0	0	0	0	0	1
91-180 Days	0	0	0	0	0	0	1	0	0	0	0	0	1
181 - 1 Yr	0	1	0	0	2	0	0	1	1	0	1	1	7
1 - 2 Yrs	0	0	0	0	0	0	0	1	1	0	0	0	2
2 - 3 Yrs	0	0	0	0	0	0	1	0	0	1	1	0	3
3-4 Yrs	1	0	1	0	0	0	0	1	0	2	0	0	5
4 yrs	0	0	0	0	0	0	1	0	0	0	0	0	1
Totals	1	1	1	0	3	0	3	3	2	3	2	1	20

Data Table 6: Final Orders Aging Matrix

In Data Table 6 (previous page) and Figure 6.1 we see the aging matrix of the 20 Final Disciplinary Orders that were completed during this 12-month period. The chart shows the percentage of cases distributed within each aging period. Of the 20 final disciplinary orders, 1 case (5%) completed in 90 days; 1 case (5%) completed within 180 days; 7 cases (35%) completed within 181-365 days; 2 cases (10%) completed within 1-2 years; 3 cases (15%) completed within 2-3 years; 5 cases (25%) completed within 3-4 years, and 1 case (5%) completed over 4 years. Of the 20 Disciplinary Orders imposed (Figure 6.2 below), there were 7 probationary orders; 2 revocations; 8 surrenders; 3 reprimands; and 1 license denial (SOI Denied).

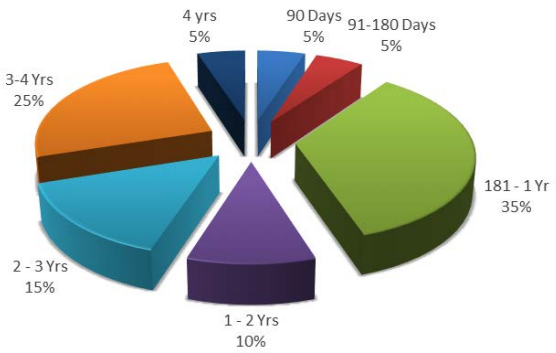


Figure 6.1: Final Orders Aging

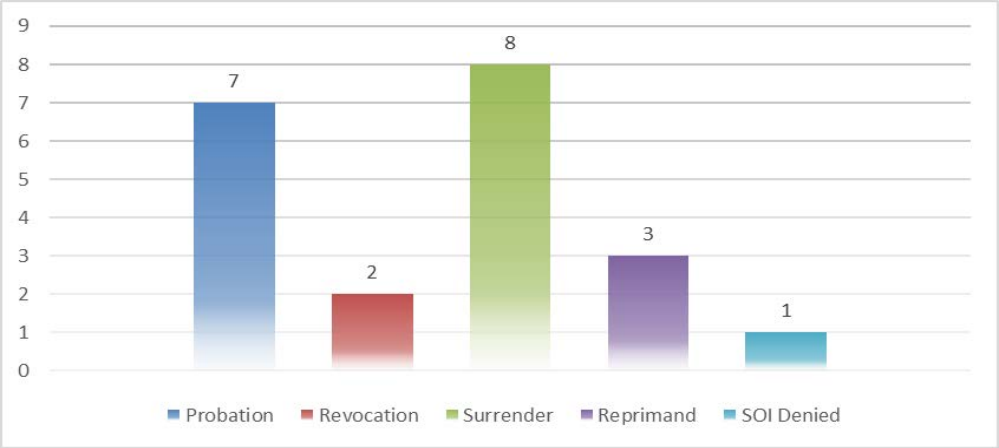
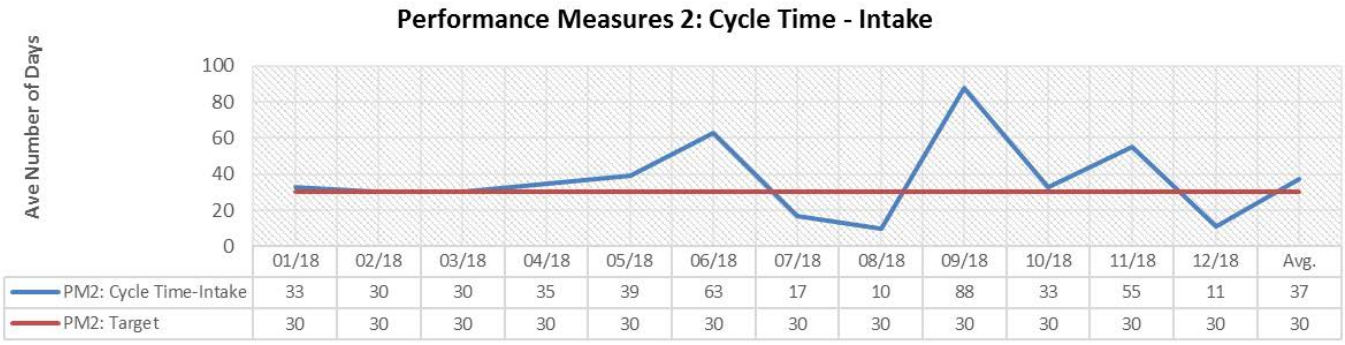


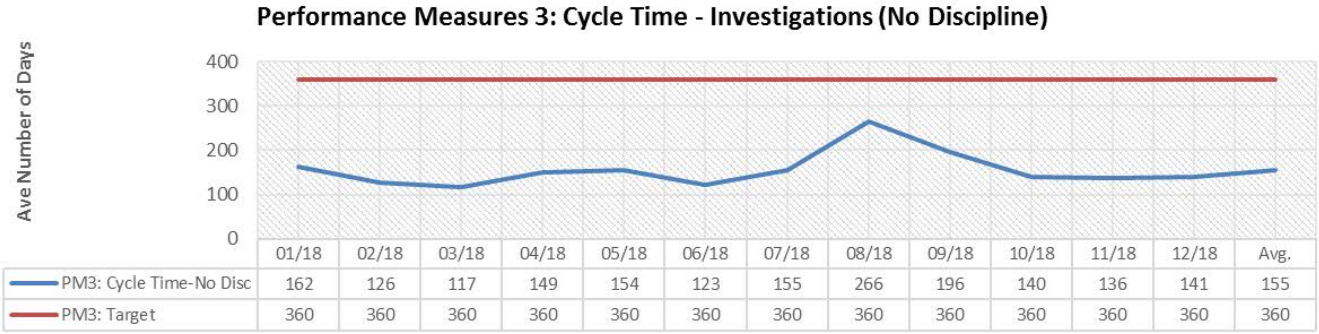
Figure 6.2: Final Disciplinary Actions Imposed

PERFORMANCE MEASURES

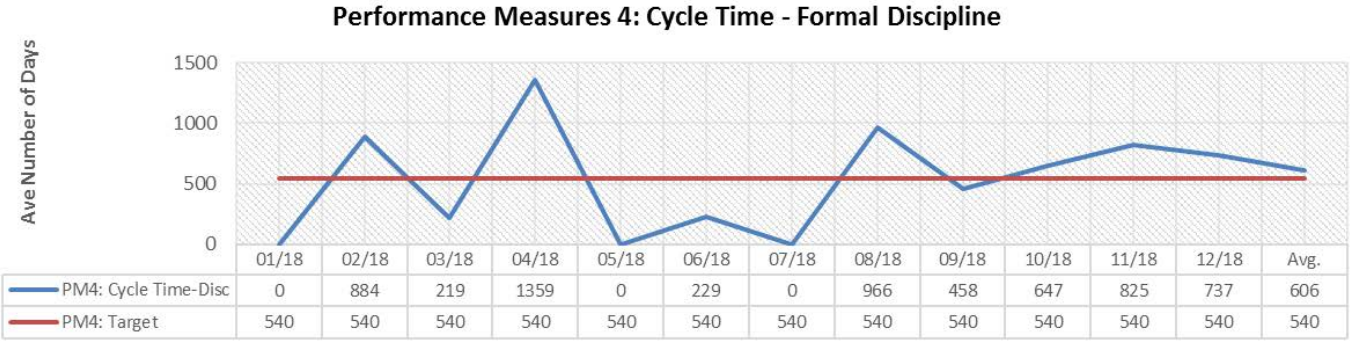
PM2: CYCLE TIME-INTAKE: Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



PM3: CYCLE TIME – INTAKE & INVESTIGATION: Average number of days to complete the entire enforcement process for cases not transmitted to the Attorney General. (Includes intake and Investigation)



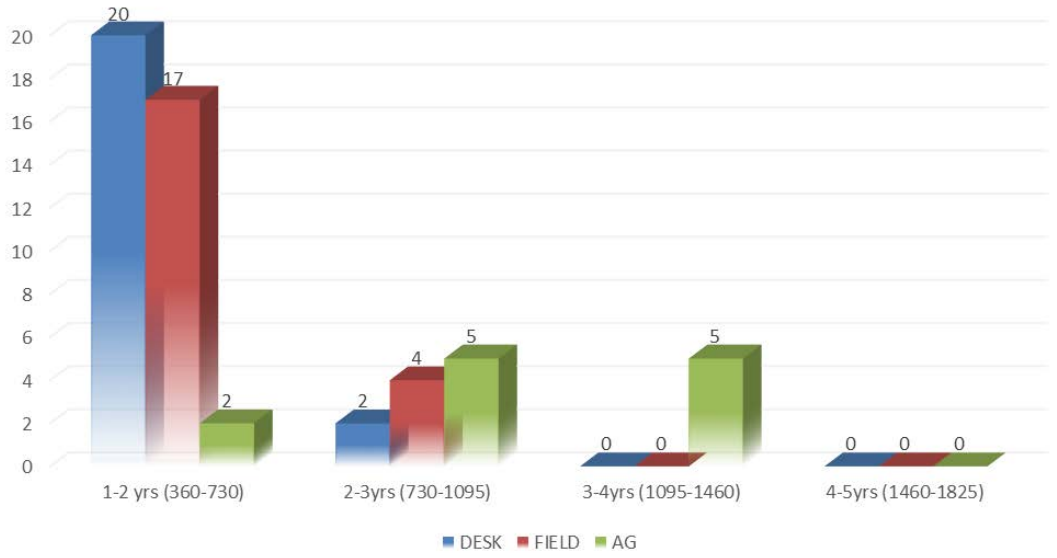
PM4: CYCLE TIME – FORMAL DISCIPLNE: Average number of days to complete the entire enforcement process for cases transmitted to the Attorney General for formal discipline. (Includes intake, investigation, and transmittal outcome)



PENDING CASES EXCEEDING PERFORMANCE TARGETS

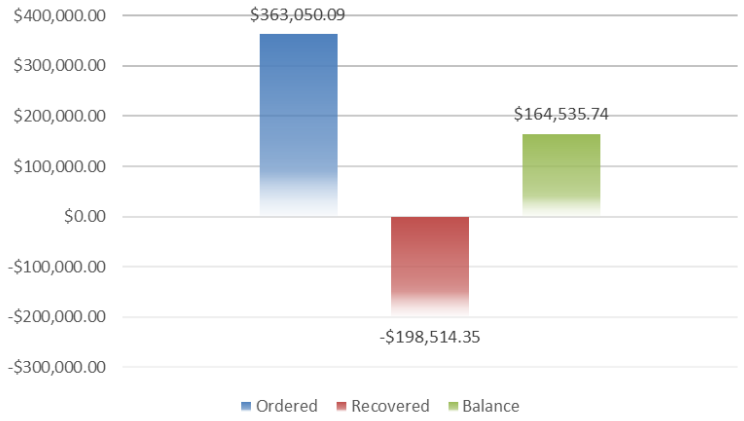
For all current pending cases exceeding the Performance Targets, there are 22 desk investigations cases, 21 field investigations cases and 12 Attorney General cases.

	Case Disposition	Target	1-2 yrs (360-730)	2-3yrs (730-1095)	3-4yrs (1095-1460)	4-5yrs (1460-1825)	Totals	Highest aging value
PM3	DESK	360 days	20	2	0	0	22	832 days
PM3	FIELD	360 days	17	4	0	0	21	1090 days
PM4	AG	540 days	2	5	5	0	12	1233 days



PROBATION

There are currently 42 probation cases; of which 9 cases are tolled. The total cost recovery ordered is $363,050.09. As of January 10, 2019, $198,514.35 has been paid leaving a balance of $164,535.74.



Tab 9

Osteopathic Medical Board

Future Agenda Items

Agenda Item	Requestor

Tab 10

Osteopathic Medical Board

Future Meeting Dates

Date	Place	Time
Thursday May 16, 2019	Chino Police Department Chino, CA 91710	10:00 am
Thursday September 5, 2019	TBD	10:00 am

**Please note that all meetings should be held in the best interest of the Board. Meetings in resorts or vacation areas should not be made. Using Conference areas that do not require contracts and or payment is the best option for the Board. No overnight travel. If an employee chooses a mode of transportation which is more costly than another mode, a Cost Comparison form must be completed. Reimbursement by the State will be made at the lesser of the two costs. Taxi Service should be used for trips within but not over a 10-mile radius. Receipts are required for taxi expenses of $10.00 and over. Tips are not reimbursable.*