OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Board Meeting, Thursday, January 16, 2020
10:00 a.m.

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

OMBC Phone (916) 928-8390

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Tab 1

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 | F (916) 928-8392 | www.ombc.ca.gov

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
BOARD MEETING NOTICE AND AGENDA

Thursday, January 16, 2020
10:00 a.m. to 5:00 p.m.
(or until the conclusion of business)

Meeting Location:
Department of Consumer Affairs
Headquarters Building 2 (HQ2)
1747 North Market Blvd.
Hearing Room
Sacramento, CA 95834

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 on Items Not on the Agenda
   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. Election of Officers

4. President's Report

5. Review and Possible Approval of Minutes

   - November 21, 2019 Teleconference

6. Petition for Early Termination of Probation, Ed Shapiro, D.O., 20A 4201.

7. Petition for Early Termination of Probation, Peter Hugh, D.O., 20A 6005

CLOSED SESSION

Pursuant to Government Code section 11126, subdivision (c)(3), the Board will meet in closed session for discussion and to deliberate on a decision to be reached in the above Petitions.

RECONVENE OPEN SESSION

8. Budget Update – Sara Hinkle, DCA Budget Office

9. Executive Director's Report – Mark Ito
   - Licensing
   - Staffing
   - Regulations
   - CURES
   - Enforcement Report / Discipline

10. Strategic Plan Update

11. Discussion and Approval of Guidelines for the Recommendation of Cannabis for Medical Purposes

12. Future Agenda Items

13. Future Meeting Dates

14. Adjournment

For further information about this meeting, please contact Machiko Chong at 916-928-7636 or in writing at 1300 National Drive, Suite 150, Sacramento, CA 95834. This notice and agenda, as well as any available Board meeting materials, can be accessed on the Board's website at www.ombc.ca.gov

Discussion and action may be taken on any item on the agenda. The time and order of agenda items are approximate and subject to change at the discretion of the Board President to facilitate the effective transaction of business.

In accordance with the Bagley-Keene Open Meeting Act, all meetings of the Board, including the teleconference sites, are open to the public. 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, at his or her discretion, may 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. (Government Code sections 11125, 11125.7(a).)

Board meetings are held in barrier free facilities that are accessible to those with physical disabilities in accordance with the Americans with Disabilities Act (ADA). If you are a person with a disability requiring disability-related modifications or accommodations to participate in the meeting, including auxiliary aids or services, please contact Machiko Chong, ADA Liaison, at (916) 928-7636 or e-mail at Machiko.Chong@dca.ca.gov or 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. Requests should be made as soon as possible, but at least five (5) working days prior to the scheduled meeting. You may also dial a voice TTY/TDD Communications Assistant at (800) 322-1700 or 7-1-1.

Tab 2

Communicating with Patients

Guidelines from the Maine Board of Licensure in Medicine

Why Are These Guidelines Important?

Refined skills in communicating with patients have been shown in many studies to produce therapeutic benefits for patients.

It is likewise true that patients who experience satisfaction with their clinicians' sincere attempts at meaningful communication also express greater satisfaction with their medical care over-all.

A practical consequence of this attitude is the likely preclusion of complaints to the Board, and to the courts via lawsuits. A majority of Board complaints about clinicians are related to issues of communication, rather than clinical competence.[*]

The Board intends these Guidelines to enhance the artful practice of the science of medicine, as shown by this analogy to musical performance: "To become a musician . . . you need to acquire all the technical skills . . . the notes, the chords, the scales. This is the *science* of music. But when you *play* music, especially when you improvise, this is the art of music."[†]

Goals of These Guidelines

A primary goal of these Guidelines is to facilitate an increase in comfort and confidence for clinicians and patients, which then can lead to more satisfactory outcomes in terms of diagnosis and readiness to act in accordance with treatment plans.

A second goal is to increase efficiency in office visits by obtaining a good history that adds *meaning* to the information given (more on this below).

A third goal is to emphasize that, like any skill, effective communication requires practice, reflection, and refinement.

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[*] Competent clinical decision-making is not, by itself, enough. Interpersonal and communications skills are one of the six areas in which clinicians-in-training need to demonstrate competence as identified by the Accreditation Council for Graduate Medical Education (ACGME).

[†] Danielle Ofri, MD. *What Patients Say, What Doctors Hear*. Beacon Press, 2017.

The Setting

The most effective position to assume while communicating with a patient is to sit down at the same level as the patient, in an unhurried posture, showing emotional comfort, while making easy and sustained eye contact.

Sitting in this way is itself powerful non-verbal communication.[‡] It leads to a *perception* of added time with the patient (but not actual time). It also conveys an impression of caring, connection, and respect. When this impression is sincere, there is a very good chance the patient will be pleased, even gratified with the visit.

The desk, the computer, and the chair can either be aids or impediments to good communication. In general, it is better not to use a desk to separate yourself from the patient. Likewise, looking at the computer screen while talking with a patient can convey an impression of indifference to the patient *as a person*, rather than as a clinical portrait.

If necessary, given that electronic medical records are ubiquitous, place the computer such that it and the patient are in the same line of sight. This way, shifting focus from the patient to the screen can be done by simply raising and lowering the eyes.

Kinds of Questions

"Everyone nodded, nobody agreed."[§] This outcome is to be avoided at all cost.

Typically when patients encounter their clinician they want to "begin the story" of their problem, their illness, their suffering. This can be facilitated with an *open question* such as "What's happening; what's going on?" Some patients may be reluctant at first and will need gentle prodding; don't be in a hurry. Once the story has been told, the clinician can ask, "How can I help?"

On the other hand, clinicians often want to hear "the chief complaint," and fear the patient's story will take too long to tell. Research shows this fear, in almost all cases, is unfounded. On average, telling the story takes approximately 150 seconds (two and a half minutes). However, given the

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[‡] Nonverbal communication (e.g., body language and facial expressions) occurs throughout a patient encounter. Clinicians are trained to observe and evaluate patients' nonverbal cues. A clinician's nonverbal cues can convey *to the patient* a sense of attention or caring or a sense of impatience and indifference.

[§] Ian McEwan. *Amsterdam*. Doubleday, 1999.

pressure of time (and perhaps a reluctance to give up control), there is an urge to interrupt the patient with a question, which can leave the patient feeling cut-off and that the clinician is not really interested in the background and context of the problem, which might prove to be essential for a correct diagnosis.

How a question is framed will affect the answer offered.

Sometimes starting a question with "Why . . . ?" can sound critical or inquisitorial, and therefore should be avoided. Patients can be expected to *describe* rather than to interpret, or explain. The latter is the clinician's job.

Likewise, *closed questions* that require a specific answer (a Q & A list of symptoms aimed at Yes or No answers) leave little room for qualification or explanation, and when asked in rapid succession can be so taxing as to preclude precision in response. This is especially important to keep in mind when the patient is feeling vulnerable due to anxiety or pain.

Leading questions: "Did you then take the pills as prescribed?" is a leading question. This form can introduce bias and be misleading. Objectivity (accuracy and precision) is compromised by leading questions.

After discussing a medical situation, asking a patient "Do you understand?" can actually be threatening. Admitting a lack of understanding can feel like exposing ignorance – nobody wants to do that. So, that form of question might well elicit a nod of agreement, when there is no agreement.

With all these caveats, what is left? Open questions (i.e., "What did you do then?") that allow the patient to tell the story of the problem, followed by requests for clarification and elaboration, followed by the "teach back" technique; that is, asking the patient to express a personal understanding of the conversation, along with desires, and expectations. This form of question does not carry the same threat potential that comes with "Do you understand?"

Kinds of Listening

Consider this anecdote from an astute physician: A wise senior partner told me when I was starting, "You will know the diagnosis within a minute of entering the room. Restrain yourself from triumphantly announcing it. Instead, sit down and listen to the story. Even examine him/her whether you need to or not. He/she has come less for the diagnosis than to be seen and heard. And who knows, you might find out that your first impression was wrong."

There is a useful distinction between two kinds of listening:

1) Keenly focused attention with regard to the technical/medical concerns of the listener: like recording post-surgical details. This is related to a closed Q & A list of questions.

2) Empathetic attention with the aim of assuming the speaker's perspective: like identifying with a character in a novel or a movie. This is related to the open narrative type of question.

In the first kind of listening, if what is heard does not fit within what is already known and familiar, it may sometimes be discounted or ignored.

The second kind of listening is deliberately drawn to anomaly, to the descriptive details and explanations that make the speaker unique as a person who is also a patient, or make the situation unique because *this* person is in it. (The anecdote above is about this kind of listening.)

Failure to recognize the anomalous (unique) patient can usually be traced to the clinician's skills and style of listening. Luckily, the skills of empathetic understanding can be improved simply and without cost (except in terms of time set aside for the purpose). Start by engaging a partner who is willing to sit with you and explain something of personal importance. Attend to what is offered and do not interrupt except to clarify your understanding of a word or expression. At certain junctures, ask to paraphrase in your own words what you believe you have heard. Repeat until the speaker can certify your understanding by saying something like "Yes; that is what I mean. You understand."

This exercise takes time because first impressions or first interpretations are often only partially correct. They need refinement to capture subtlety; that is, to become accurate and precise. Accuracy and precision in understanding what a patient is saying can be more than helpful in diagnostics and treatment planning.

If a good scientific clinician is one who seeks, acquires, interprets, and understands all data relevant to diagnosing and treating a given condition, and if empathetic understanding offers access to more of these data that would otherwise be unavailable, then the clinician who has developed skills of empathetic understanding is a better *scientific* clinician, as well as a more adaptable one. Just as important, the clinician who listens empathetically conveys that she/he cares about the patient.

Kinds of Explanation

It is important to distinguish between two useful but distinct kinds of explanation. The first is *scientific* explanation, which is making a case for

why certain events are the way they are and for predicting future events. The second is *semantic* explanation, which by contrast is making the meaning of something clear to the listener. Semantic explanation is like translation or paraphrase, using different words and terms until the intended meaning is revealed and understood.

An explanation can be *satisfactory* (to the clinician) from a formal (scientific) point of view, while at the same time failing to be *satisfying* from the patient's point of view. Another way to put this point is that while a medical explanation of risks and benefits associated with treatment options can be scientifically sound, the listener may find it to be unintelligible, and therefore not useful as information upon which to grant or withhold consent, or even to comprehend what to expect, or what to do.

Self-Evaluation

Be aware of the "Lake Wobegon Effect": a town where "all the children are above average."

There is a common tendency for clinicians to overestimate their communicative effectiveness. It is helpful to be aware of one's personal style and when it may not be working. "Inappropriate humor" can be particularly damaging to relations with patients and their families.

Self-review of interpersonal behavior, often with the help of a colleague (especially including nurses) takes a bit of humility, but it can be enormously helpful. Nurses have more frequent incidental interaction with patients who might reveal to them misunderstandings, particular needs, and reactions. Nurses can be a rich source of information about how to communicate with individual patients, and to interpret their non-verbal signs.

Extension to Other Persons and Situations

While these Guidelines have been focused on clinician-patient interactions, they can with similar benefit be applied to conversations with colleagues, nurses, other staff members, patients' families and advocates, and even, should it come to that, with Board members.

Plenty of research shows that a higher quality of communication skills and effort leads to higher quality in patient outcomes, and interpersonal relations generally.

Tab 3

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
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Osteopathic Medical Board of California

Teleconference Minutes

November 21, 2019

MEMBERS PRESENT:	Joseph Zammuto, D.O., President Cheryl Williams, Vice President Cyrus Buhari, D.O., Secretary Treasurer Claudia Mercado, Board Member Gor Adamyan, Board Member Andrew Moreno, Board Member
MEMBERS ABSENT:	Elizabeth Jensen, D.O., Board Member
STAFF PRESENT:	Mark Ito, Executive Director Machiko Chong, Executive Analyst Frederic Chan-You, Esq., Legal Counsel, DCA
MEMBERS OF THE AUDIENCE:	

Agenda Item 1 Call to Order/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:

- **Gor Adamyan,** Avia Billing & Consulting, 4640 Lankershim Blvd., Ste. 105, Toluca Lake CA 91602, (650) 992-4000; No member of the public was present at this location
- **Cyrus Buhari, D.O.,** Osteopathic Medical Board of California, 1300 National Drive, Suite 150, Sacramento, CA 95202, (209) 937-8221; No member of the public was present at this location
- **Andrew Moreno**, The Moreno Law Group, 1505 North Wishon Ave., Fresno CA 93728, (559) 449-0400; No member of the public was present at this location
- **Claudia Mercado**, 501 23rd Avenue, Conference Room, Oakland CA 94606, (510) 735-5999; No member of the public was present at this location

- **Cheryl Williams**, 1636 50th Street, San Diego CA 92102, (619) 254-5064; No member of the public was present at this location

Agenda Item 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)]

There were no public comments as upon inquiry, there were no members of the public present at any of the locations listed above.

Agenda Item 3 Review and Approval of Minutes

Dr. Zammuto called for a motion for approval of the Board meeting minutes of the May 16, 2019 Board Meeting.

Motion to approve May 16, 2019 Board Meeting minutes with no corrections. Motion – C. Buhari **Second** – Dr. Zammuto

- Roll Call Vote was taken
  - **Aye** – Mr. Adamyan, Dr. Buhari, Ms. Mercado, Mr. Moreno, Mrs. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – None
  - **Absent** – Dr. Jensen
- Motion carried to approve Mat 16, 2019 minutes with no corrections.

*****

Dr. Zammuto called for a motion for approval of the Board meeting minutes of the June 17, 2019 Board Meeting.

Correction to future meeting dates: Amend January 2020 meeting date to reflect January 16, 2020.

Motion to approve June 17, 2019 Board Meeting minutes with correction to future meeting dates. Motion – Dr. Zammuto **Second** – A. Moreno

- Roll Call Vote was taken
  - **Aye** – Mr. Adamyan, Dr. Buhari, Ms. Mercado, Mr. Moreno, Mrs. Williams, Dr. Zammuto
  - **Nay** – None
  - **Abstention** – None

- **Absent** – Dr. Jensen
- Motion carried to approve June 17, 2019 minutes with corrections to future meeting dates.

Agenda Item 4 Discussion and Possible Action Regarding Comments Received Regarding Proposed Rulemaking to Implement the Post Graduate Training License (Title 16, California Code of Regulations, Section 1690)

Mr. Ito informed the Board that a hearing was held for the Post Graduate Training License rulemaking packet on November 20, 2019 and noted that there were no members of the public present nor any commentary submitted opposing any portion of the proposed regulatory changes.

Agenda Item 5 Agenda Items for Next Meeting

- Follow up on the Post Graduate Training License issuance

Agenda Item 6 Future Meeting Dates

- Thursday, January 16, 2020 @ 10:00 am – Sacramento, CA
- Thursday, May 7, 2020 @ 10:00 am – Pomona, CA
- Thursday, September 10, 2020 @ 10:00 – San Diego, CA

Agenda Item 7 Adjournment

There being no further business or public comment, Dr. Zammuto adjourned the meeting adjourned at 3:36 p.m.

Tab 4

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Tab 5

OSTEOPATHIC MEDICAL BOARD
BUDGET REPORT
FY 2019-20 EXPENDITURE PROJECTION

FM 5 - Based on 12/24 Activity Log

OBJECT DESCRIPTION	FY 2016-17 ACTUAL EXPENDITURES (FM12)	FY 2017-18 ACTUAL EXPENDITURES (Prelim FM12)	FY 2018-19* PRIOR YEAR EXPENDITURES (Prelim FM12)	FY 2019-20 GOVERNOR'S BUDGET 2019-20	CURRENT YEAR EXPENDITURES (12/24 Activity Log)	PERCENT SPENT	PROJECTIONS TO YEAR END	UNENCUMBERED BALANCE
Salary & Wages (Staff)	635,329	625,584	650,583	**853,000**	299,051	35%	**763,892**	89,108
Temp Help	17,143	500	500	**0**	500	0%	**1,000**	(1,000)
Statutory Exempt (EO)	89,949	96,621	93,865	**76,000**	37,960	50%	**91,104**	(15,104)
Board Member Per Diem	1,200	3,100	3,500	**3,000**	0	0%	**3,000**	0
Overtime/Retirement Payout	1,214	23,043	58,759	**0**	0		**0**	0
Staff Benefits	367,521	384,409	404,335	**569,000**	186,925	33%	**475,000**	94,000
TOTALS, PERSONNEL SVC	**1,112,356**	**1,133,257**	**1,211,542**	**1,501,000**	**524,436**	**35%**	**1,333,996**	167,004
OPERATING EXPENSE AND EQUIPMENT								
General Expense	50,722	41,529	62,889	**140,000**	21,612	15%	**52,000**	88,000
Printing	8,881	17,633	13,894	**8,000**	3,383	42%	**13,000**	(5,000)
Communication	5,923	5,738	3,636	**19,000**	1,233	6%	**5,000**	14,000
Postage	7,506	10,510	7,371	**7,000**	0	0%	**8,000**	(1,000)
Insurance	11	3,361	3,971	**0**	29	0%	**4,000**	(4,000)
Travel In State	10,942	5,666	12,594	**14,000**	2,619	19%	**10,000**	4,000
Training	457	-	1,040	**6,000**	385	6%	**1,000**	5,000
Facilities Operations	62,144	138,801	63,297	**110,000**	26,166	24%	**63,000**	47,000
C & P Services - Interdept.	-	45	48	**101,000**	0	0%	**0**	101,000
Attorney General	291,561	177,478	184,066	**582,000**	82,985	14%	**249,000**	333,000
Office of Adminstrative Hearings	95,131	19,240	20,590	**102,000**	1,200	1%	**5,000**	97,000
C & P Services - External	137,167	148,181	86,695	**159,000**	28,438	18%	**124,000**	35,000
DCA Pro Rata	302,873	347,000	350,833	**434,000**	180,833	42%	**434,000**	0
DOI - Investigations - IEU	90,570	115,342	67,112	**0**	0		**0**	0
DOI - Investigations - HQIU	25,630	13,221	25,589	**0**	24,613		**74,000**	(74,000)
Interagency Services	1,458	1,222	1,211	**0**	218		**2,000**	(2,000)
Consolidated Data Center	18,852	3,479	1,745	**2,000**	0	0%	**3,000**	(1,000)
Information Technology	1,218	398	4,071	**4,000**	993	25%	**2,000**	2,000
Equipment	1,352	12,099	43,925	**16,000**	0	0%	**16,000**	0
Other Items of Expense	-	12,112	-	**0**	0		**0**	0
TOTALS, OE&E	1,112,398	1,073,055	954,577	**1,704,000**	374,707	22%	**1,065,000**	639,000
TOTAL EXPENSE	2,224,754	2,206,312	2,166,119	**3,205,000**	899,143	28%	**2,398,996**	806,004
Distributed - From Naturopathic				**(14,000)**	(14,000)		**(14,000)**	0
Sched. Reimb. - Fingerprints	(42,434)	(41,699)	(25,000)	**(25,000)**	(25,000)	100%	**(25,000)**	0
Sched. Reimb. - Other	(3,055)	(3,055)	(28,000)	**(28,000)**	(28,000)	100%	**(28,000)**	0
Unsched. Reimb. - Other	(82,666)	(64,493)		**0**		0%	**0**	0
NET APPROPRIATION	2,096,599	2,097,065	2,113,119	**3,138,000**	832,143	27%	**2,331,996**	**806,004**
							SURPLUS/(DEFICIT):	**25.7%**

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

Prepared 12.23.19

(Dollars in Thousands)

2020-21 Governor's Budget

	PY 2018-19	Governor's Budget CY 2019-20	BY 2020-21	BY+1 2021-22	BY+2 2022-23
BEGINNING BALANCE	$ 2,837	$ 3,372	$ 3,899	$ 3,217	$ 2,443
Prior Year Adjustment	$ 224		$ -	$ -	$ -
Adjusted Beginning Balance	$ 3,061	$ 3,372	$ 3,899	$ 3,217	$ 2,443
REVENUES AND TRANSFERS					
Revenues:					
4121200 Delinquent fees	$ 14	$ 15	$ 15	$ 15	$ 15
4127400 Renewal fees	$ 2,044	$ 1,724	$ 1,939	$ 1,939	$ 1,939
4129200 Other regulatory fees	$ 40	$ 31	$ 31	$ 31	$ 31
4129400 Other regulatory licenses and permits	$ 406	$ 584	$ 584	$ 584	$ 584
4163000 Income from surplus money investments	$ 50	$ 24	$ 35	$ 36	$ 23
Totals, Revenues	$ 2,554	$ 2,378	$ 2,604	$ 2,605	$ 2,592
Transfers from Other Funds					
F00001 GF loan repayment per Item 1485-011-0264, BA of 2002	$ -	$ 1,500	$ -	$ -	
Totals, Revenues and Transfers	$ 2,554	$ 3,878	$ 2,604	$ 2,605	$ 2,592
Totals, Resources	$ 5,615	$ 7,250	$ 6,503	$ 5,822	$ 5,035
EXPENDITURES					
Disbursements:					
1111 Department of Consumer Affairs Program Expenditures (State Operations)	$ 2,057	$ 3,138	$ 3,085	$ 3,178	$ 3,273
9892 Supplemental Pension Payments (State Operations)	$ 25	$ 53	$ 53	$ 53	$ 53
9900 Statewide General Administrative Expenditures (Pro Rata) (State Operations)	$ 161	$ 160	$ 148	$ 148	$ 148
Total Disbursements	$ 2,243	$ 3,351	$ 3,286	$ 3,379	$ 3,474
FUND BALANCE					
Reserve for economic uncertainties	$ 3,372	$ 3,899	$ 3,217	$ 2,443	$ 1,562
Months in Reserve	12.1	14.2	11.4	8.4	5.4

NOTES:

A. ASSUMES WORKLOAD AND REVENUE PROJECTIONS ARE REALIZED FOR BY+1 AND ON-GOING.

B. ASSUMES APPROPRIATION GROWTH OF 3% PER YEAR IN BY+1 AND ON-GOING..

C. ASSUMES INTEREST RATE OF 1.5%

Tab 6

EXECUTIVE DIRECTOR’S REPORT

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834
Phone (916) 928-8390 | Fax (916) 928-8392 | www.ombc.ca.gov

MEMORANDUM

DATE	January 8, 2020
TO	Board Members
FROM	Mark Ito Executive Director
SUBJECT	**Executive Director's Report – Agenda Item 9**

This report provides the Board Members with information on the following topics:

- Licensing Statistics
- Staffing
- Regulations
- CURES
- Enforcement Report/Discipline

Licensing Statistics:

The table below shows the OMBC's total licensee count as of January 6, 2020. The table shows the number of licensees practicing or residing in California, and the total number of licensees under the OMBC's jurisdiction. The total number of licensees under the OMBC's jurisdiction is 11,608.

License Status	Practicing/Residing in CA	Total Licensees
Active/Current	9,418	9,774
Inactive/Current	304	568
Delinquent	[redacted]	1,266
Total:	9,722	11,608*

* Total licensees under the OMBC's jurisdiction

The table below shows the Licensing Unit's workload for 2018-19 and 2019-20. The workload for 2019-20 is from July 1, 2019 – December 31, 2019. The licensing workload for the OMBC continues to increase and we are looking into different ways to increase efficiency in the Licensing Unit. Creating efficiencies will allow the OMBC to process this increasing workload within our existing resources.

Licensing Workload				
	Fiscal Year 2018-19		Fiscal Year 2019-20*	
	Total	Monthly Average	Total	Monthly Average
Applications Received	999	83	637	106
Applications Approved	804	67	644	107
Certificates Issued	773	64	599	100
Licenses Renewed	5,038	420	2,201	367
Fictitious Name Permits Received	137	11	66	11
Fictitious Name Permits Approved	94	8	46	8
Fictitious Name Permits Renewed	670	56	531	89

* Fiscal Year 2019-20 data is from July 1, 2019 – December 31, 2019

The number of days to approve a license application during the current fiscal year is 90 days. Applications with missing documents took an average of 146 days to complete and approve.

Staffing:

The Board is in the process of hiring one Administrative Governmental Program Analyst (AGPA) and one Staff Services Analyst (SSA) position to process the workload associated with the implementation of the Postgraduate Training License (PTL). The SSA will process the licensing workload and the AGPA will process the enforcement workload associated with the PTL.

Regulations:

Continuing Medical Education and Audit

Currently, the Board verifies a licensee's CMEs at the time of renewal. This regulatory proposal would adjust this process. This proposal would create a post-renewal audit for CMEs. This is advantageous to the Board and its licensees because it would make the renewal process more efficient. It would reduce workload for Board staff and alleviate a significant amount of phone calls and correspondence from licensees checking on the status of their license renewal. Board staff and DCA are working collaboratively to finalize this proposal.

Substantial Relationship and Rehabilitation Criteria

This regulatory proposal would implement the provisions of Assembly Bill 2138. This proposal would increase opportunities for those with prior convictions or disciplinary action to obtain licensure if evidence points to rehabilitation. This proposal is being reviewed by DCA and the Board plans on noticing the proposal in the coming months.

Postgraduate Training License

This regulatory proposal would create the Postgraduate Training License Fee. The Board is unable to charge a fee for the Postgraduate Training License fee until this regulatory proposal is approved. The Board is working collaboratively with DCA to expeditiously get this proposal approved by the Office of Administrative Law.

CURES:

The CURES November 2019 Statistics report is attached to this report. As of November 2019, there are 7,354 osteopathic physicians registered as CURES users. Osteopathic physicians ran 81,720 separate patient activity reports while accessing the system 42,492 times.

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

November 2019 Statistics

Registered Users			
			November
Total Registered Users			
Clinical Roles			
	Prescribers		166,683
	Pharmacists		44,262
		Sub-Total A	**210,945**
	License Type		
		Doctor of Dental Surgery/Dental Medicine	15,539
		Doctor of Optometry	684
		Doctor of Podiatric Medicine	1,462
		Doctor of Veterinary Medicine	3,153
		Medical Doctor	110,551
		Naturopathic Doctor	371
		Osteopathic Doctor	7,354
		Physician Assistant	10,435
		Registered Nurse Practitioner/Nurse Midwife	16,543
		(Out of State) Prescribers	591
		Pharmacists	43,744
		(Out of State) Pharmacists	518
		Sub-Total B	**210,945**
Other Roles			
	LEAs		1,454
	Delegates		4,654
	DOJ Administrators		17
	DOJ Analysts		75
	Regulatory Board		175
		Sub-Total C	**6,375**

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

November 2019 Statistics

Number of PARs Ran				
				November
Total PARs Search Counts				
Clinical Roles				
		App PAR Searches	IEWS PAR Searches*	TOTALS
Prescribers		1,021,367	889,228	1,910,595
Pharmacists		813,206	531	813,737
	Sub-Total A	**1,834,573**	**889,759**	**2,724,332**
License Type				
	Doctor of Dental Surgery/Dental Medicine	5,247	468	5,715
	Doctor of Optometry	0	1,461	1,461
	Doctor of Podiatric Medicine	4,791	4,106	8,897
	Doctor of Veterinary Medicine	86	0	86
	Medical Doctor	670,013	742,646	1,412,659
	Naturopathic Doctor	1,034	1	1,035
	Osteopathic Doctor	81,720	57,602	139,322
	Physician Assistant	112,872	35,998	148,870
	Registered Nurse Practitioner/Nurse Midwife	143,943	46,936	190,879
	(Out of State) Prescribers	1,661	10	1,671
	Pharmacists	810,660	531	811,191
	(Out of State) Pharmacists	2,546	0	2,546
	Sub-Total B	**1,834,573**	**889,759**	**2,724,332**
Other Roles				
LEAs		259	0	259
DOJ Administrators		169	0	169
DOJ Analysts		249	0	249
Regulatory Board		1,017	0	1,017
	Sub-Total C	**1,694**	**0**	**1,694**
Delegate Initiated Searches				
Delegates		**29,200**	**0**	**29,200**

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

*****The Monthly Report will now include the Information Exchange Web Service (IEWS) counts.*

November 2019 Statistics

Times System was Accessed			
			November
Total Times System was Accessed			**906,525**
Clinical Roles			
	Prescribers		531,946
	Pharmacists		347,579
		Sub-Total A	**879,525**
	License Type		
		Doctor of Dental Surgery/Dental Medicine	4179
		Doctor of Optometry	48
		Doctor of Podiatric Medicine	1,432
		Doctor of Veterinary Medicine	225
		Medical Doctor	363,866
		Naturopathic Doctor	469
		Osteopathic Doctor	42,492
		Physician Assistant	51,315
		Registered Nurse Practitioner/Nurse Midwife	66,800
		(Out of State) Prescribers	1,120
		Pharmacists	372,969
		(Out of State) Pharmacists	1,610
		Sub-Total B	**906,525**
Other Roles			
	LEAs		383
	Delegates		11,133
	DOJ Administrators		149
	DOJ Analysts		595
	Regulatory Board		314
		Sub-Total C	**12,574**

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

November 2019 Statistics

Number of CURES Help Desk Requests				
				November
Emails [Note: Email requests are not included in the breakdown below]				**1,730**
Total Phone Calls				**2,410**
Clinical Roles				
Prescribers				1,898
Pharmacists				512
Sub-Total A				**2,410**
License Type				
Doctor of Dental Surgery/Dental Medicine				124
Doctor of Optometry				1
Doctor of Podiatric Medicine				20
Doctor of Veterinary Medicine				47
Medical Doctor				1,190
Naturopathic Doctor				2
Osteopathic Doctor				90
Physician Assistant				157
Registered Nurse Practitioner/Nurse Midwife				267
Pharmacists				512
Other (Non-Specific License Type)				0
Sub-Total B				**2,410**
Other Roles				
LEAs				8
Delegates				40
DOJ Administrators				0
DOJ Analysts				0
Regulatory Board				13
Sub-Total C				**61**

NOTE:

1. Subtotal A = Subtotal B

2. Subtotal A + Subtotal C = Total Help Desk Phone Calls

November 2019 Statistics

			November
Number of Distinct Prescriptions			**2,497,753**
Number of Prescriptions Filled by Schedule			
Schedule II			1,112,643
Schedule III			218,314
Schedule IV			1,076,125
Schedule V			58,662
R			10,922
Over-the-counter product			21,766
TOTAL			**2,498,432**

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

2. R = Not classified under the Controlled Substances Act; includes all other prescription drugs

3. Over-the-counter product

ENFORCEMENT REPORT

OMBC Enforcement Report

January 16, 2020

The following OMBC Enforcement Report covers a 12-month period starting from January 1, 2019 through December 31, 2019. The OMBC Enforcement Report is divided into five sections; Intake, Investigations, Enforcement, Performance Measures, and Probation. The data is collected from the Breeze Enforcement Reports and DCA QBIRT (IBM Cognos Analytics).

COMPLAINT INTAKE

	1Q 2019			2Q 2019			3Q 2019			4Q 2019			
TOTAL INTAKE	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Totals
Received	43	35	56	108	49	30	51	82	45	53	19	12	583
Assigned	30	52	30	42	50	30	98	50	59	67	33	47	588
Aging	28	24	24	19	32	60	69	40	34	41	50	43	39
Pending	93	114	42	61	91	79	39	13	27	40	23	41	

Data Table 1: Complaint Intake with Convictions/Arrests

In Data Table 1 above, under TOTAL INTAKE, OMBC received 583 complaints (18 convictions/arrests). 588 cases were assigned 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 assigned. In Figure 1.1 below we see pending complaints peak in February and May; a spike in received complaints in April and August; and a spike in assigned complaints in July. The complaint levels appear decrease in November and December, however, not call complaints have been entered into the system from this period.

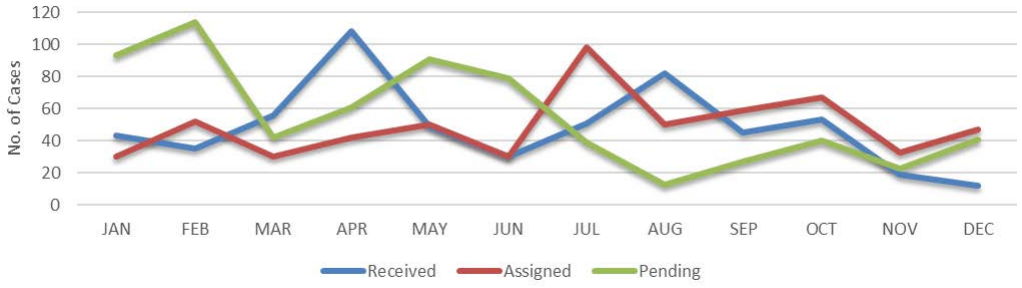


Figure 1.1: Intake Totals Per Month

INVESTIGATIONS

Desk (internal) Investigations

	1Q 2019			2Q 2019			3Q 2019			4Q 2019			
Desk Inv.	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Totals
Assigned	30	52	30	42	50	30	98	50	59	68	33	47	589
Completed	46	47	61	48	25	37	54	57	47	64	43	53	582
Aging	74	77	87	123	64	143	56	94	51	71	78	114	86
Pending	157	162	132	125	157	147	193	186	200	205	196	190	132

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 589 cases were assigned to desk investigations and 582 were completed. The average number of days to complete a desk investigation was 86 days. In Figure 2.2 (page 2), the assigned and completed caseloads averaged around 50 per month except for the month of July as assignments peaked around 100. Pending desk investigations increased in July from an average 150 to 200 through the end of the fourth quarter 2019.

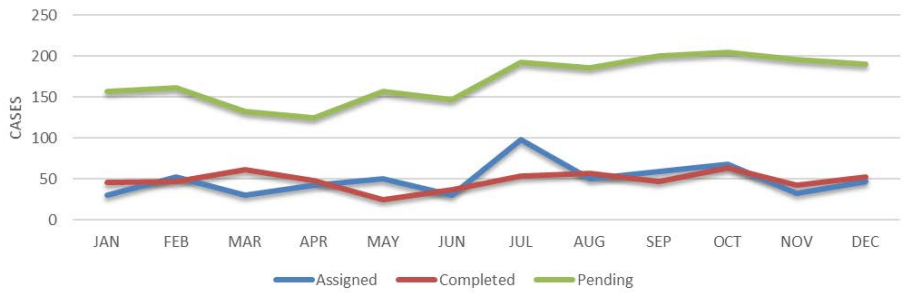


Figure 2.1: Desk Investigations Monthly Totals

Division of Investigation (DOI) Field Investigations

	1Q 2019			2Q 2019			3Q 2019			4Q 2019			
Field Inv.	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Totals
Assigned	0	5	5	6	4	0	2	2	4	5	4	2	39
Completed	3	0	1	2	6	2	1	9	2	5	4	2	37
Aging	242	0	209	530	463	372	107	376	363	408	115	149	278
Pending	30	36	41	46	45	42	45	43	45	47	48	48	48

Data Table 3: Field Investigations

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, 39 cases were assigned to field investigations; 37 were completed; and 48 cases were pending at the end of 14Q 2019. The average number of days to complete a field investigation was 278 (down from 316 from last report).

The case complexity is the breakdown of the specific allegations. In Figure 3.1, for all competed field investigations (37 cases), there were 15 excessive prescribing cases (40%); 6 Unprofessional conduct (16%); 2 sexual misconduct cases (5%); 1 Criminal (3%); 3 fraud cases (8%); 1 Impairment (3%); 4 negligent/injury cases (11%); 4 substance abuse cases (11%); and 1 Unlicensed practice (3%).

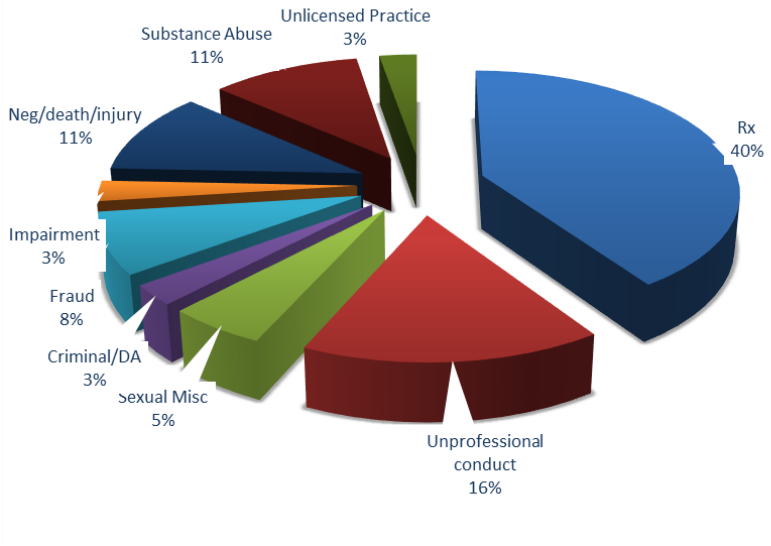


Figure 3.1 Complexity for completed Field Investigations

Aging for Desk and Field Investigations

	1Q 2019			2Q 2019			3Q 2019			4Q 2019			
All Inv Aging	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Totals
90 days	35	25	28	29	18	15	44	37	39	49	25	27	371
91-180 days	5	14	18	6	2	16	3	6	2	7	8	21	108
181-1 yr	6	6	6	5	4	3	5	2	1	5	2	3	48
1 yr-2 yrs	1	0	0	3	3	3	0	3	0	3	2	1	19
2 yrs-3 yrs	0	0	0	1	0	1	1	3	0	0	3	2	11
Totals	**47**	**45**	**52**	**44**	**27**	**38**	**53**	**51**	**42**	**64**	**40**	**54**	**557**

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. 371 cases (67%) were completed within 90 days; 108 cases (19%) were completed between 91-180 days; 48 cases (9%) were completed between 181-365 days; 19 cases (3%) were completed between 1 – 2 years; and 11 cases (2%) were completed between 2-3 years. 86% of the investigations were completed within 6 months; and 95% were completed within a year.

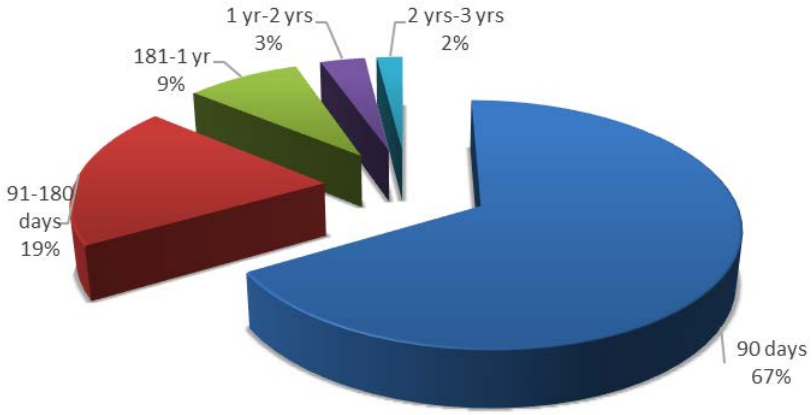


Figure 4.1 All Investigations Aging

ENFORCEMENT ACTIONS

	1Q 2019			2Q 2019			3Q 2019			4Q 2019			
	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Totals
AG Cases Initiated	0	0	1	4	2	5	0	2	1	2	2	1	20
Acc/SOI Filed	1	2	0	0	1	2	0	3	2	0	1	1	13
Final Discplinary Order	1	2	2	1	1	0	0	0	2	1	3	0	13
Acc W/drawn/declined	0	0	0	0	0	0	0	0	1	0	0	0	1
Closed w/out Disc Acti	0	1	1	1	0	0	0	0	1	0	0	0	4
Citations	2	0	0	1	0	0	0	0	0	0	1	0	4
Suspension Orders	0	0	0	0	0	0	0	0	1	0	0	0	1
AG Cases Pending	27	27	29	28	25	24	23	21	19	18	16	15	15

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, 20 cases were transmitted to the Attorney General's Office for disciplinary actions; 13 Accusations were filed; 13 Final Disciplinary Orders were filed; 1 accusation withdrawn; 4 cases were closed without disciplinary action; 4 citations issued; and 1 Suspension Order was filed. Currently 15 AG cases are pending.

Aging for Final Disciplinary Orders

	1Q 2019			2Q 2019			3Q 2019			4Q 2019			
Total Orders Aging	JAN	FEB	MAR	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	Totals
90 Days	0	0	0	0	0	0	0	0	0	0	0	0	0
91-180 Days	0	1	0	0	0	0	0	0	0	0	0	0	1
181 - 1 Yr	0	1	0	0	0	0	0	0	0	0	1	0	2
1 - 2 Yrs	0	0	0	0	0	0	0	0	0	0	0	0	0
2 - 3 Yrs	0	0	0	0	0	0	0	0	0	0	1	0	1
3-4 Yrs	1	0	2	1	1	0	0	0	2	1	1	0	9
4 yrs	0	0	0	0	0	0	0	0	0	0	0	0	0
Totals	1	2	2	1	1	0	0	0	2	1	3	0	13

Data Table 6: Final Orders Aging Matrix

In Data Table 6 and Figure 6.1 we see the aging matrix of the 13 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 13 final disciplinary orders, 1 case (8%) within 91-180 days; 2 cases (15%) within 181-365 days; 1 case (8%) within 2-3 years; 9 cases (69%) within 3-4 years. Of the 13 Disciplinary Orders imposed (Figure 6.2 below), there were 8 probationary orders; 1 revocation; 1 surrenders; 3 reprimands; and 2 Pre-accusation public reprimand.

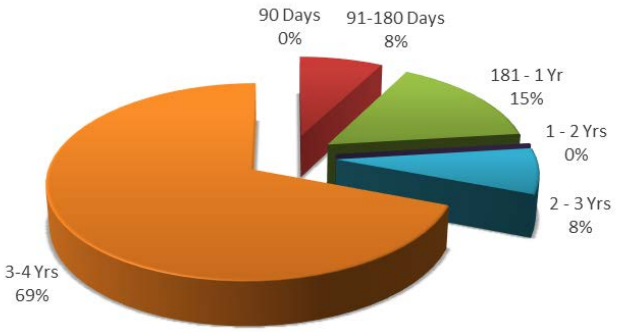


Figure 6.1: Final Orders Aging

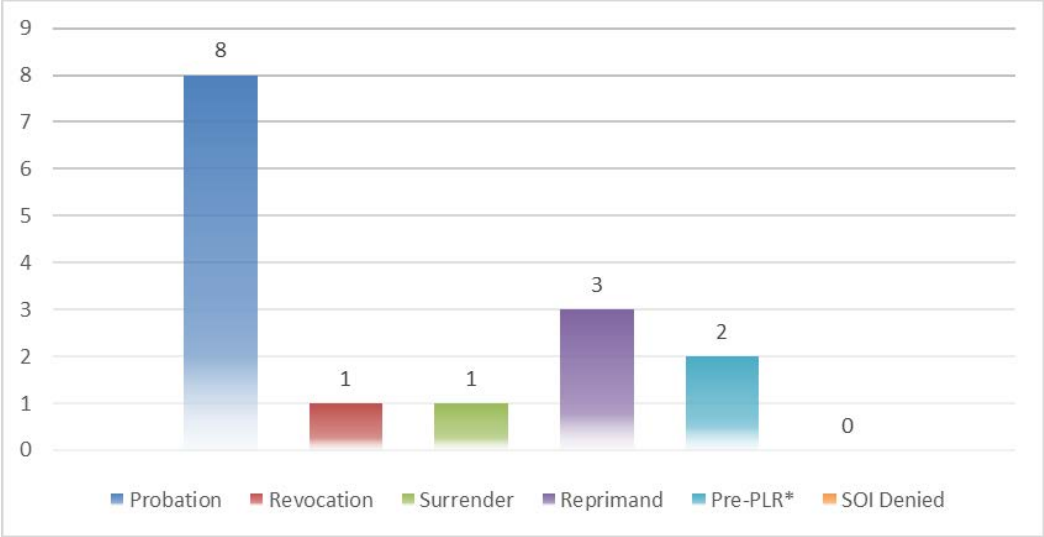
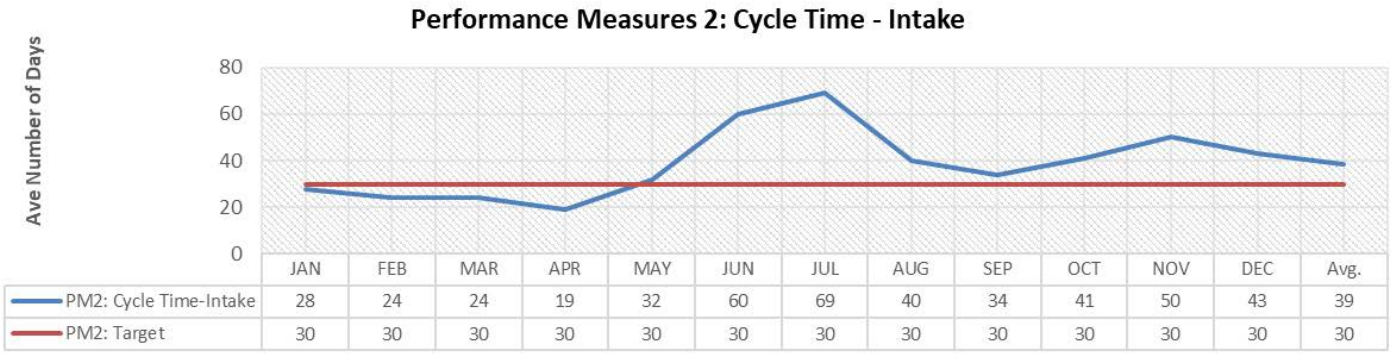


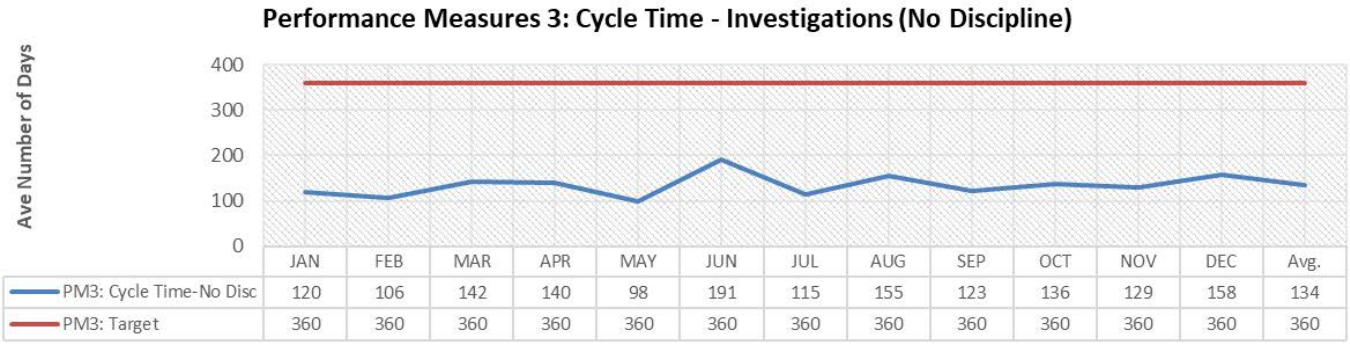
Figure 6.2: Final Disciplinary Actions Imposed
* Pre-accusation public letter for reprimand

PERFORMANCE MEASURES

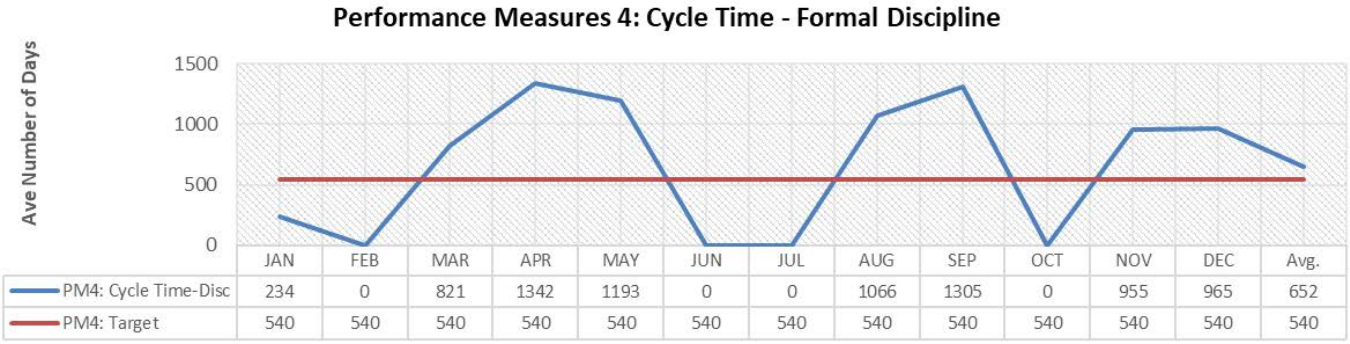
PM2: CYCLE TIME-INTAKE: Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



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)

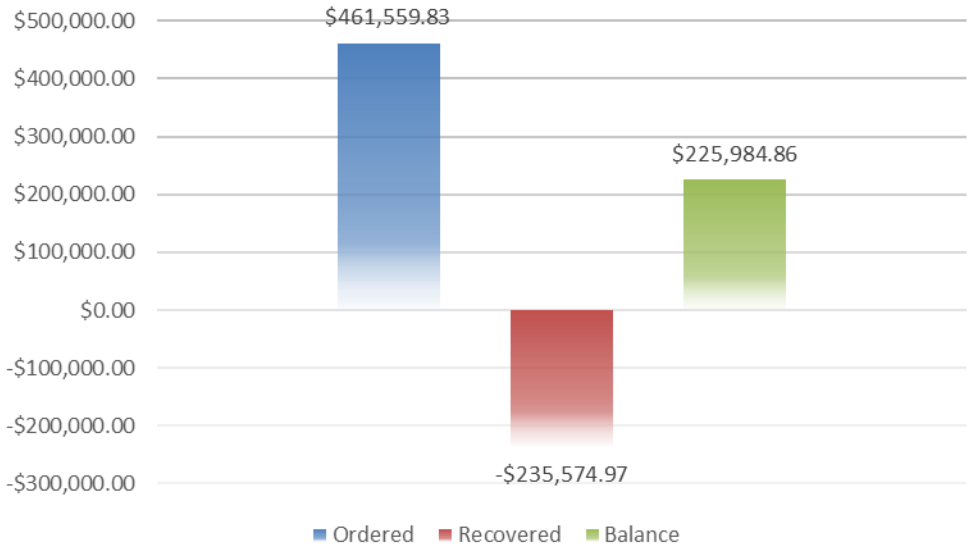


PM4: CYCLE TIME – FORMAL DISCIPLNE: Average number of days to complete the entire enforcement process for cases transmitted to the Attorney General for formal discipline. (Includes intake, investigation, and transmittal outcome)



PROBATION

There are currently 40 probation cases; of which 9 cases are tolled. During this period 9 probationary cases were closed; 7 by completion and 2 by petition; and 9 cases opened. The total cost recovery ordered is currently $461,559.83. As of January 10, 2020, $235,574.97 has been recovered; leaving a balance of $225,984.86.



Tab 7

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834
Phone (916) 928-8390 | Fax (916) 928-8392 | www.ombc.ca.gov

MEMORANDUM

DATE	January 10, 2020
TO	Board Members
FROM	Mark Ito Executive Director
SUBJECT	**Strategic Plan Update – Agenda Item 10**

The Osteopathic Medical Board of California (Board) convened for Strategic Planning on April 30, 2019, and the Strategic Plan was subsequently approved by the Board on May 16, 2019. On October 17, 2019, the Board's Executive Director and Executive Analyst met with SOLID's Strategic Planning and Facilitation staff to develop an action plan to ensure that the Board meets all the goals and objectives set forth in the new Strategic Plan.

Attached is the Board's Action Plan. The following goals are scheduled to be completed by the end of fiscal year 2019-20:

<u>Fiscal Year 2019-20: Quarter 3 (January – March)</u>

- **Goal 3.7** – Audit the website and develop content to keep it up-to-date, innovative, and informative, and to drive stakeholders to the website.

- **Goal 5.5** – Update procedural manuals to onboard new employees and prepare for succession planning.

<u>Fiscal Year 2019-20: Quarter 4 (April – June)</u>

- **Goal 1.1** – Investigate the options to implement the Interstate Medical Licensure Compact to streamline the licensing process.

- **Goal 3.3** – Create a quarterly newsletter as a way for stakeholders to get to know the Board and promote the Board's listserv and website so that important issues are disseminating to all interested parties.

- **Goal 4.3** – Collaborate and build relationships with law makers and staffers in order to have a stronger voice and represent the Board.

- **Goal 5.1** – Research options available to collaborate and utilize SOLID to assist in creating a more cohesive team.

STRATEGIC PLAN

OSTEOPATHIC MEDICAL BOARD ACTION PLAN

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Acronyms 5
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Outreach 10
Regulations and Legislation 13
Board Administration 15

About the Board

The Osteopathic Medical Board of California

The Osteopathic Medical Board of California (OMBC) was established in 1922 when the Osteopathic Initiative Act was passed by electorate. Initially, the Board was comprised of five Osteopathic Physicians appointed by the Governor to staggered three year terms. In 1991 two Public members were added to the Board, also serving three year terms.

In 2002, the Board volunteered to be included under the umbrella of the California Department of Consumer Affairs (DCA). The affiliation with the DCA and access to its resources has strengthened the OMBC.

The OMBC is charged with a mission of public protection as defined in the Medical Practice Act. This charge is met through Board functions of Licensing and Enforcement

Mission, Vision, and Values

Mission

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

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.

Values

- Collaborative
- Health
- Inclusion
- Proactive
- Diversity
- Innovation
- Professional

Strategic Goal Areas

Goal 1: LICENSURE
The OMBC requires that only qualified individuals are licensed as osteopathic doctors.

Goal 2: ENFORCEMENT
Protect the health and safety of consumers through the enforcement of the laws and regulations.

Goal 3: OUTREACH AND COMMUNICATION
Consumers and licensees are able to make informed decisions regarding the safe practice of osteopathic medical services.

Goal 4: REGULATIONS AND LEGISLATION
Monitor and uphold the law and participate in the regulatory and legislative process.

Goal 5: BOARD ADMINISTRATION
Build an excellent organization through proper Board governance, effective leadership, and responsible management.

Acronyms

AEO - Assistant Executive Officer

AGPA - Associate Government Program Analyst

BCP - Budget Change Proposal

DCA - Department of Consumer Affairs

DOI - Division of Investigation

EA - Executive Assistant

EO - Executive Officer

MC - Medical Consultant

OIS - Office of Information Services

OMBC - Osteopathic Medical Board of California

PDE - Publications, Design, and Editing

SOLID - Strategic Organizational Leadership and Individual Development

SSA - Staff Services Analyst

TBD - To Be Determined

Goal 1: Licensure

1.1 Investigate the options to implement the Interstate Medical Licensure Compact to streamline the licensing process.

Start Date: Q3 2019*	End Date: Q4 2019	
Success Measure: Gathered data has been analyzed.		
Major Tasks	**Responsible Party**	**Completion Date**
Contact Federation of State Medical Boards to gather information (revenue impacts, effects on processes, impact on consumer protection)	EO	Q3 2019
Analyze information gathered	EO, Board Members	Q4 2019
Promulgate regulations if necessary	EO, Legal Counsel	TBD
BreEZe updates if necessary	AEO, OIS	TBD

*Quarters represent fiscal year quarters

1.2 Investigate the options available through BreEZe to reduce barriers to entry and improve functionality.

Start Date: Q3 2019	End Date: Q3 2020	
Success Measure: All options investigated and final determinations made.		
Major Tasks	**Responsible Party**	**Completion Date**
Reach out to other BreEZe users for best practices	EA	Q3 2019
Work with OIS to implement BreEZe changes	AEO	Q3 2020

1.3 Develop an online portal for documentation submissions to streamline the process and reduce time for licensees.

Start Date: Q3 2019	End Date: Q3 2020/TBD	
Success Measure: Online portal developed.		
Major Tasks	**Responsible Party**	**Completion Date**
Reach out to other BreEZe users for best practices of online portal	EO	Q3 2019
Work with OIS to implement online portal	AEO	Q3 2020
Work with Legal Affairs to determine if regs are necessary	EO	Q3 2019
Promulgate regs if necessary	EO, Legal Counsel	TBD

1.4 Align continuing education audits with the renewal process to reduce confusion among licensees.

Start Date: Q3 2016	End Date: Q2 2020	
Success Measure: CE audits aligned with renewal process**.**		
Major Tasks	**Responsible Party**	**Completion Date**
Promulgate regulations	EO	Q1 2020
Work with OIS to make adjustments in BreEZe	AEO	Q2 2020
Change renewal forms	AEO	Q2 2020
Update website with information about changes	EA	Q2 2020
Create outreach campaign	EO, Public Affairs	Q2 2020

1.5 Collaborate with the Office of Information Services (OIS) to schedule a demonstration of BreEZe to view the licensee point of view and better understand how the system operates.

Start Date: Q3 2019	End Date: TBD	
Success Measure: Demonstration is scheduled.		
Major Tasks	**Responsible Party**	**Completion Date**
Contact OIS to schedule BreEZe demonstration	EO	Q2 2019
Demonstration is scheduled	EO	TBD

1.6 Research the feasibility of hiring additional staff to improve office efficiencies.

Start Date: Q4 2021	End Date: TBD	
Success Measure: Need for additional staff determined.		
Major Tasks	**Responsible Party**	**Completion Date**
Determine need for additional staff	EO	Q4 2021
Conduct cost benefit analysis	EO	TBD

1.7 Implement a board meeting in-office training to improve board member understanding of office processes.

Start Date: Q2 2019	End Date: TBD	
Success Measure: Training implemented if necessary.		
Major Tasks	**Responsible Party**	**Completion Date**
Determine interest in training	EA	Q2 2019
Schedule in office training	EA	TBD
Create training agenda and materials	EO, AEO, EA, AGPA, SSA	TBD

Goal 2: Enforcement

2.1 Create efficiencies with the Board's internal investigations to reduce case aging.

Start Date: Q2 2020	**End Date: Q1 2021**	
Success Measure: Case aging reduced.		
Major Tasks	**Responsible Party**	**Completion Date**
Obtain outside perspective via other DCA programs	EO	Q2 2020
Work with DCA's DOI to ensure that we are working cases in the most efficient way possible	EO	Q2 2020
Have enforcement staff attend applicable enforcement academy classes	EO, AEO, EA, AGPA	Ongoing
Identify opportunities for greater efficiency	EO, MC	Q3 2020
Implement new processes to create the efficiencies	EO, MC	Q1 2021

2.2 Research the concept of the chaperone and set parameters around who can be a chaperone to protect patients and determine best practices.

Start Date: Q3 2019	**End Date: TBD**	
Success Measure: All options considered and if applicable, parameters were established.		
Major Tasks	**Responsible Party**	**Completion Date**
Recruit Ethics Committee members from Board	EO, Board President	Q3 2019
Committee conducts research	Ethics Committee, EO	TBD
Committee reports research and makes recommendations to the Board	Ethics Committee, EA	TBD
Board members vote on recommendations	Ethics Committee	TBD
Work with Legal Affairs to determine if regulations are necessary	EO, Legal Counsel	TBD
Promulgate regulations if necessary	EO, Legal Counsel	TBD
Implement recommendations	EO	TBD

2.3 Implement cross-training with enforcement staff to improve morale and continuity of work.

Start Date: Q1 2019	End Date: Q1 2020 and Ongoing	
Success Measure: Enforcement staff is cross-trained on all enforcement tasks.		
Major Tasks	**Responsible Party**	**Completion Date**
Enforcement staff attends Enforcement Academy classes	EO, AEO	Ongoing
Enforcement staff participates in SOLID team building courses	AGPA	Q2 2019
Implement weekly case review between enforcement staff	EO, AEO, AGPA, MC	Q1 2019 and ongoing
Create a cross-training plan and schedule	EO, AEO	Q1 2020

2.4 Research technological opportunities to improve workflow, efficiency, and communication between staff.

Start Date: Q2 2020	End Date: Q2 2020	
Success Measure: Best business process identified.		
Major Tasks	**Responsible Party**	**Completion Date**
Investigate the full scope of BreEZe's capabilities in regards to enforcement	EO, AEO, AGPA	Q2 2020
Reach out to other Boards for best practices	EO	Q2 2020
Attend BreEZe enforcement user groups	EO, AEO, AGPA	Ongoing

Goal 3: Outreach

3.1 Educate licensees on personal responsibilities regarding licensure and ongoing to set expectations.

Start Date: Q3 2018	End Date: Q1 2020	
Success Measure: Active online presence established.		
Major Tasks	**Responsible Party**	**Completion Date**
Collaborate with Public Affairs to get social media up and running	EO, AEO, EA	Ongoing
Update Board's website as needed	EO, AEO, EA	Q2 2019 and ongoing
Brainstorm with office staff	Board	Ongoing
Determine appropriate staffing levels to implement and maintain social media presence	EO, AEO	Q1 2020

3.2 Develop presentations and informational videos (e.g., for out-of-state doctors and residents who are considering applying for licensure in California) to explain the application process and provide statistics on the resident population.

Start Date: Q2 2019	End Date: Ongoing	
Success Measure: Informational videos and presentations are launched.		
Major Tasks	**Responsible Party**	**Completion Date**
Brainstorm with staff and consult Board	Board	Ongoing
Collaborate with Public Affairs to develop materials and videos; find actors	EO, AEO, Public Affairs	Ongoing
Gather data about content to include in presentations and videos	EO, AEO, EA	Q2 2019 and ongoing

3.3 Create a quarterly newsletter as a way for stakeholders to get to know the Board and promote the Board's Listserv and website so that important issues are disseminating to all interested parties.

Start Date: Q2 2019	**End Date: Q4 2019 and ongoing**	
Success Measure: Quarterly newsletter distributed.		
Major Tasks	**Responsible Party**	**Completion Date**
Gather information that could be included in newsletter (link roundup from e-Clips, board meeting information)	EO, AEO, EA	Q2 2019 and ongoing
Designate staff who will be responsible for producing newsletter	EO, AEO	Q3 2019
Consult with Public Affairs about template and potential content	EO	Q3 2019
Create and distribute newsletter	EA	Q4 2019 and ongoing

3.4 Recreate the branding and logo of the Board to better market and educate stakeholders.

Start Date: Q4 2018	**End Date: Q4 2018**	
Success Measure: Logo and branding ae updated.		
Major Tasks	Responsible Party	Completion Date
Done!		Q4 2018

3.5 Collaborate with the Office of Public Affairs to develop a marketing plan to improve awareness of the Board, create interest for potential licensees, and allow them to be more engaged with the Board and the community.

Start Date: Q2 2019	**End Date: Q1 2020**	
Success Measure: Marketing plan developed.		
Major Tasks	**Responsible Party**	**Completion Date**
Collaborate with Public Affairs to get social media up and running	EO, AEO, EA	Ongoing
Collaborate with Public Affairs to get social media up and running	EO, AEO, EA	Q2 2019 and ongoing
Brainstorm with office staff	Board	Ongoing
Determine appropriate staffing levels to implement the plan	EO, AEO	Q1 2020

3.6 Attend schools, conventions (e.g., medical association events), and other outreach events to be proactive in informing the public and potential licensees about the Board.

Start Date: Q4 2017	End Date: Ongoing	
Success Measure: Increased presence at schools, conventions, other outreach events.		
Major Tasks	**Responsible Party**	**Completion Date**
Reach out to schools and associations to gauge interest in presentations	EO, EA	Ongoing
Create travel plans and manage logistics	EA	Ongoing
Create materials and/or presentations for specific events	EO, AEO, EA	Ongoing
Collaborate with associations	EO, EA	Ongoing

3.7 Audit the website and develop content to keep it up-to-date, innovative, and informative, and to drive stakeholders to the website.

Start Date: Q1 2019	End Date: Q3 2019	
Success Measure: Updated website is launched.		
Major Tasks	**Responsible Party**	**Completion Date**
Conduct website audit	Publications, Design, and Editing (PDE)	Q1 2019
Develop content	EO, AEO, EA, PDE	Q1 2019
Work with OIS to launch	EO, OIS	Q3 2019

3.8 Create a budget change proposal (BCP) for additional staff who would manage content for the website and update regulations and legislation.

Start Date: Q2 2021	End Date: Q3 2021	
Success Measure: BCP is approved.		
Major Tasks	**Responsible Party**	**Completion Date**
Conduct cost benefit analysis	EO	Q2 2021
Determine if additional staffing is necessary	EO	TBD
Create a BCP if necessary	EO, EA	TBD

Goal 4: Regulations and Legislation

4.1 Research the feasibility of developing a statute for including anti-discrimination language to allow the Board to take action when complaints arise.

Start Date: Q3 2021	**End Date: TBD**	
Success Measure: Research completed.		
Major Tasks	**Responsible Party**	**Completion Date**
Review current anti-discrimination statutes	Legal Counsel, EO	Q3 2021
If necessary, recruit Ethics Committee members from Board	EO, Board President	Q4 2021
If necessary, committee conducts research	Ethics Committee, EO	TBD
If necessary, committee reports research and makes recommendations to the Board	Ethics Committee, EA	TBD
If necessary, Board members vote on recommendations	Ethics Committee	TBD
Work with Legal Affairs to determine if regulations are necessary	EO, Legal Counsel	TBD
Promulgate regulations if necessary	EO, Legal Counsel	TBD

4.2 Explore hiring a consultant or pursuing a dedicated staff person to better track regulations and legislation.

Start Date: Q2 2021	**End Date: TBD**	
Success Measure: BCP approved.		
Major Tasks	**Responsible Party**	**Completion Date**
Conduct cost benefit analysis	EO	Q2 2021
Determine if additional staffing is necessary	EO	TBD
Create a BCP if necessary	EO, EA	TBD

4.3 Collaborate and build relationships with law makers and staffers in order to have a stronger voice and represent the Board.

Start Date: Q3 2019	**End Date: Q4 2019**	
Success Measure: Relationships with law makers and staffers are established.		
Major Tasks	**Responsible Party**	**Completion Date**
Identify law makers and staffers of interest	EO	Q3 2019
Conduct network mapping	EO	Q4 2019 and ongoing
Develop a cultivation plan	EO	Q4 2019 and ongoing
Execute the plan	EO	Q4 2019 and ongoing

4.4 Research innovative approaches to disease/medication and create advisory guidelines for legislation and regulations to support best practices.

Start Date: Q3 2021	**End Date: TBD**	
Success Measure: Updated advisory guidelines have been established.		
Major Tasks	**Responsible Party**	**Completion Date**
Review current approaches to disease/medication	Legal Counsel, EO	Q3 2021
If necessary, recruit Ethics Committee members from Board	EO, Board President	Q4 2021
If necessary, committee conducts research	Ethics Committee, EO	TBD
If necessary, committee reports research and makes recommendations to the Board	Ethics Committee, EA	TBD
If necessary, Board members vote on recommendations	Ethics Committee	TBD
Work with Legal Affairs to determine if regulations are necessary and work with Leg Reg to see if legislation necessary	EO, Legal Counsel	TBD
If Legislation is necessary, work with Leg Reg, and/or legislators, and/or associations to find author	EO, Legal Counsel	TBD
If necessary, promulgate regulations	EO, Legal Counsel	TBD

Goal 5: Board Administration

5.1 Research options available to collaborate and utilize SOLID to assist in creating a more cohesive team.

Start Date: Q2 2019	**End Date: Q4 2019**	
Success Measure: All options are considered, and a plan is established.		
Major Tasks	**Responsible Party**	**Completion Date**
Board staff participates in SOLID team building courses	Board	Q2 2019
Work with SOLID to identify appropriate measures to achieve a more cohesive team	EO, AEO	Q2 2019
Develop plan to carry out recommendations	EO, AEO	Q4 2019

5.2 Implement cross-training with staff for business continuity and efficiency.

Start Date: Q2 2019	**End Date: Q1 2020**	
Success Measure: Staff are cross-trained.		
Major Tasks	**Responsible Party**	**Completion Date**
Board staff participates in SOLID team building courses	Board	Q2 2019
Update procedure manuals	Board	Q3 2019
Create a cross-training plan and schedule	EO, AEO	Q1 2020

5.3 Improve communication using available technology to promote office efficiencies and provide better customer service.

Start Date: Q2 2020	**End Date: Q3 2021**	
Success Measure: Best business practices implemented.		
Major Tasks	**Responsible Party**	**Completion Date**
Investigate the full scope of BreEZe's capabilities in regards to communication	EO, AEO, AGPA	Q2 2020
Reach out to other Boards for best practices	EO	Q2 2020
Attend appropriate BreEZe user groups	Board	Ongoing
Attend appropriate BreEZe classes if necessary	Board	Ongoing
Implement action plan once information is analyzed	EO	Q3 2021

5.4 Create a schedule for staff to attend board meetings to foster a greater understanding of Board processes.

Start Date: Q2 2019	**End Date: Q2 2019**	
Success Measure: More staff attending board meetings.		
Major Tasks	**Responsible Party**	**Completion Date**
Identify staff interested in attending board meetings	EO	Q2 2019
Develop schedule for staff to attend board meetings	EO	Q2 2019

5.5 Update procedure manuals to onboard new employees and prepare for succession planning.

Start Date: Q4 2018	**End Date: Q3 2019**	
Success Measure: Procedure manuals are updated/created and signed off on by Internal Audits.		
Major Tasks	Responsible Party	Completion Date
Review current mapping to identify needed procedure manuals	EO, AEO	Q3 2019
Have staff attend "How to Build a Procedure Manual"	Board	Q4 2018
Update and/or create procedure manuals	Board	Q3 2019
Procedure manuals approved by Internal Audits	EO	Q3 2019

5.6 Develop Board informational materials to provide to DCA staff and help when onboarding new employees.

Start Date: Q1 2022	**End Date: Q2 2022**	
Success Measure: Onboarding materials developed.		
Major Tasks	**Responsible Party**	**Completion Date**
Identify information needed by new staff	EO, AEO, EA	Q1 2022
Compile and/or create onboarding materials	EA	Q2 2022

5.7 Schedule a legal training for the Board to assist members in the decision-making process.

Start Date: Q3 2019	End Date: Q1 2020	
Success Measure: Legal training provided to Board members.		
Major Tasks	**Responsible Party**	**Completion Date**
Identify board members interested in legal training	EO, EA	Q3 2019
Survey board members for desired content of training	EA	Q3 2019
Reach out to Legal Affairs to see what training they can do	EO	Q4 2019
Schedule legal training as needed	EO, EA	Q1 2020

5.8 Develop a Board member orientation packet to provide to new Board members during onboarding.

Start Date: Q4 2021	End Date: Q1 2022	
Success Measure: Board member orientation packet is updated.		
Major Tasks	**Responsible Party**	**Completion Date**
Talk with DCA discover their board member orientation information	EO	Q4 2021
Talk with other Boards regarding board member orientation practices	EO	Q4 2021
Review current board member orientation packets and update/create if needed	EO,AEO, EA	Q1 2022

Tab 8

FSMB - GUIDELINES

FEDERATION OF STATE MEDICAL BOARDS

Model Guidelines for the Recommendation of Marijuana in Patient Care

Report of the FSMB Workgroup on Marijuana and Medical Regulation

Adopted as policy by the Federation of State Medical Boards
April 2016

INTRODUCTION

Over the past two decades, the attitudes and laws in the United States have become more tolerant towards marijuana, with the proportion of adults using the substance doubling between 2001 and 2013. Due to the increasing number of state governments authorizing the use of marijuana and marijuana infused product for "medicinal purposes," state medical and osteopathic boards now have the added responsibility for the regulatory oversight of physicians choosing to incorporate the recommendation of marijuana in patient care and management.

The Federation of State Medical Boards (FSMB) Chair, J. Daniel Gifford, MD, FACP, appointed the Workgroup on Marijuana and Medical Regulation to develop model policy guidelines regarding the recommendation of marijuana in patient care, including conditions, diseases, or indications for which marijuana may be recommended. The Workgroup was further tasked with the development of a position statement or white paper regarding the regulation of licensees who use marijuana, which will be addressed in a separate document.

In order to accomplish this charge, the Workgroup reviewed existing laws and medical and osteopathic board rules, regulations and policies related to marijuana; reviewed current literature and policies related to the incorporation of marijuana by health care professionals in their professional practice and related research; and reviewed cases of board disciplinary actions related to the recommendation of marijuana in patient care and/or use and abuse of marijuana by licensees.

This policy document is intended as a resource to state medical boards in regulating physicians and physician assistants (or other licensees regulated by the board) with a full and unrestricted license participating in marijuana programs and may also be valuable in educating licensees as to the board's expectations when recommending marijuana to a patient for a particular medical condition. The guidelines should in no way be construed as encouraging or endorsing physicians to recommend marijuana as a part of patient care.

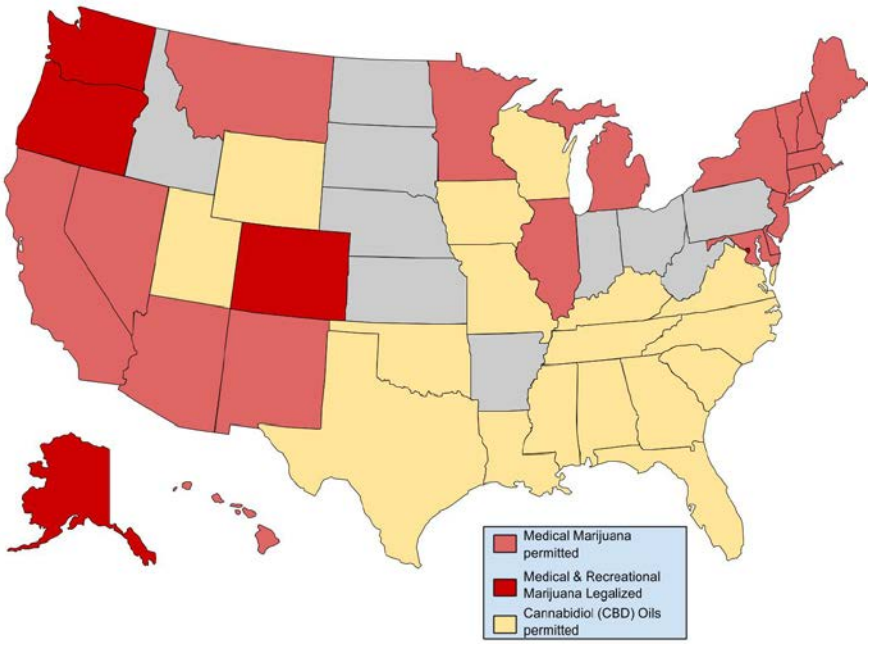
In developing the model guidelines that follow, the Workgroup conducted a comprehensive review of marijuana statutes, rules, and state medical board policies currently enacted across the country, and considered research reports, peer-reviewed articles, and policy statements regarding the recommendation of marijuana in patient care. In addition, a survey of FSMB member boards was conducted to determine which issues related to marijuana and medical regulation are of high priority to state boards. Fifty-one out of 70 state boards completed the survey, yielding a 72.9% response rate. Many boards reported several issues being most important to their board about

marijuana and medical regulation, including guidance on handling recreational use by physicians (31.4%), guidance on handling marijuana for medical use by physicians (47.1%), and model guidelines for recommending marijuana for medical purposes to patients (49.0%).

Section One. Background.

Marijuana has been suggested for alleviating symptoms of a range of debilitating medical conditions, such as cancer, HIV/AIDS, multiple sclerosis, Alzheimer's Disease, post-traumatic stress disorder (PTSD), epilepsy, Crohn's Disease, and glaucoma, as well as an alternative to narcotic painkillers. Accordingly, marijuana use in patient care has increased in popularity nationwide since 1996 when California voters passed Proposition 215, making it the first state to allow marijuana to be recommended in patient care. Since then, 22 other states, in addition to the District of Columbia and Guam, have enacted laws or passed ballot initiatives establishing comprehensive "medical marijuana programs," authorizing marijuana for medical purposes.[1] Moreover, 17 states have enacted laws to permit limited use of cannabidiol (CBD) oils for the treatment of specific illnesses and symptoms.[2] See Figure 1.

Figure 1: State Map of Marijuana and Cannabidiol Oils Laws



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[1] The states and territories that have enacted comprehensive marijuana programs are: Alaska (AS 17.37.070), Arizona (A.R.S. § 36-2801), California (Cal. Health & Safety Code § 11362.7 et seq.), Colorado (Colo. Rev. Stat. § 25-1.5-106), Connecticut (Conn. Gen. Stat. §420f-21a-408), Delaware (Del. Code tit. 16 § 4901A et seq.), District of Columbia (D.C. Code § 7-1671.01 et seq.), Guam (10 Guam Code Ann. § 122501 et seq.), Hawaii (Haw. Rev. Stat. § 329-121), Illinois (410 Ill. Comp. Stat. § 130/10), Maine (Me. Stat. tit. 22, § 2422 et seq.), Maryland (Md. Code, Health Gen. § 13-3301 et seq.), Massachusetts (105 Code of Mass. Regs. 725.000), Michigan (Mich. Comp. Laws § 333.26423), Minnesota (Minn. Stat. § 152.21 et seq.), Montana (Mont. Code Ann. § 50-46-301 et seq.), Nevada (NRS 453A), New Hampshire RSA 126-X), New Jersey (N.J.S.A. C.24:6I-3), New Mexico (N.M. Stat. § 26-2B-1 et seq.), New York (NY Pub Health Law § 3360), Oregon (Or. Rev. Stat. § 475.300 et seq.), Rhode Island (R.I. Gen. Laws § 21-28.6-3), Vermont (18 V.S.A. § 4472 et seq.), and Washington (RCS 69.51A).
Recreational Marijuana Ballot Initiatives: Alaska (2014); Colorado (2012); District of Columbia (2014); Oregon (2014); Washington (2012).

[2] The states that have enacted laws permitting limited use of cannabidiol oils are: Alabama, Florida, Georgia, Iowa, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

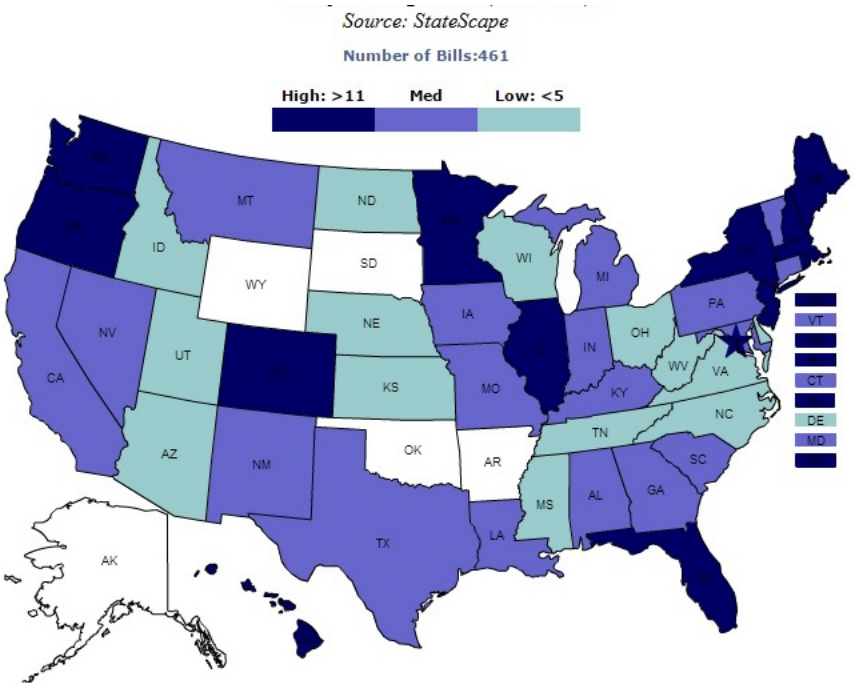
Although states have enacted laws permitting the use of both medical and recreational marijuana, the prescribing of marijuana remains illegal under federal law, as marijuana has not been subject to the U.S. Food and Drug Administration's evaluation and approval process. Marijuana is classified in federal law as a Schedule 1 substance under the Controlled Substance Act.[3] As a Schedule 1 substance, the federal government classifies marijuana as a substance with high potential for dependency or addiction, with no accepted medical use. Federal law prohibits knowingly or intentionally distributing, dispensing, or possessing marijuana.[4] Additionally, a person who aids and abets another in violating federal law or engages in a conspiracy to purchase, cultivate, or possess marijuana may be punished to the same extent as the individual who commits the crime.[5]

Providers and state regulators should continue to monitor usage and adverse effects of marijuana. See Figure 2. Based on the increasing number of states permitting the recommendation of marijuana in patient care, the U.S. Department of Justice updated its marijuana enforcement policy in August 2013. The updated policy reiterates marijuana's classification as an illegal substance under federal law, but advises states and local governments that authorize marijuana-related conduct to implement strong and effective regulatory and enforcement systems to address any threat state laws could pose to public safety, public health, and other interests. Should these state efforts be insufficient, the federal government may seek to challenge the regulatory structure itself and bring forward individual enforcement actions.[6]

The Guidelines that follow are designed to communicate to state medical board licensees that if marijuana is recommended, these recommendations should be consistent with accepted professional and ethical practices.

[3] 21 U.S.C. §812.
[4] 21 U.S.C. §841-44.
[5] 18 U.S.C. §2; 21 U.S.C. §846.
[6] James M. Cole, "Guidance Regarding Marijuana Enforcement [Memorandum]," Washington, DC: Department of Justice. (August 19, 2013).

Figure 2: Marijuana Legislation (2013-2015)



AL 5	AZ 4	CA 11	CO 14	CT 5	DC 27	DE 3	FL 20	GA 6	HI 50
IA 11	ID 1	IL 21	IN 5	KS 3	KY 5	LA 6	MA 18	MD 8	ME 17
MI 10	MN 14	MO 9	MS 3	MT 8	NC 3	ND 2	NE 4	NH 15	NJ 19
NM 5	NV 8	NY 15	OH 1	OR 15	PA 8	RI 21	SC 10	TN 3	TX 5
US 1	UT 1	VA 4	VT 6	WA 26	WI 1	WV 4			

Section Two. Definitions.

For the purposes of these guidelines, the following definitions apply:

"Marijuana" means the leaves, stems, flowers, and seeds of all species of the plant genus cannabis, whether growing or not. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture or preparation of the mature stalks, fiber, oil or cake or sterilized seed of the plant which is incapable of germination.

"Medical Marijuana Program" is the term used in some state statutes, rules, and regulations that provide for the medical use, cultivation and dispensing of marijuana for medical purposes, which may or may not include specific medical conditions for which a physician (or other licensed health care provider) may issue a recommendation, attestation, or authorization for a patient to obtain and use marijuana.

"Cannabidiol (CBD) Oil" means processed cannabis plant extract, oil, or resin that contains a high percentage of cannabidiol, but a low percentage of tetrahydrocannabinol.

"Tetrahydrocannabinol (THC)" means the primary psychoactive compound in cannabis, delta-9-tetrahydrocannabinol (THC), which is a partial agonist at cannabinoid receptors in the body.

Section Three. Guidelines.

The [Name of Board] has adopted the following guidelines for the recommendation of marijuana in patient care:

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 must have documented that an appropriate physician-patient relationship has been established,[7] prior to providing a recommendation, attestation, or authorization for marijuana to the patient. Consistent with the prevailing standard of care, physicians should not recommend, attest, or otherwise authorize marijuana for themselves or family member.

Patient Evaluation: A documented in-person medical evaluation 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 marijuana for medical use. At minimum, the evaluation 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 or mental illness/ psychotic disorders, physical exam, documentation of therapies with inadequate response, and diagnosis requiring the marijuana recommendation.

Informed and Shared Decision Making: The decision to recommend marijuana should be a shared decision between the physician and the patient. The physician should discuss the risks and benefits of the use of marijuana with the patient. Patients should be advised of the variability and lack of standardization of marijuana preparations and the effect of marijuana. Patients should be reminded not to drive or operate heavy machinery while under the influence of marijuana. If the patient is a minor or without decision-making capacity, the physician should ensure that the patient's parent, guardian or surrogate is involved in the treatment plan and consents to the patient's use of marijuana.

[7] The health and well-being of patients depends upon a collaborative effort between the physician and patient. The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient. FSMB *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* (HOD 2014).

Treatment Agreement: A health care professional should document a written treatment plan that includes:

- Review of other measures attempted to ease the suffering caused by the terminal or debilitating medical condition that do not involve the recommendation of marijuana.
- Advice about other options for managing the terminal or debilitating medical condition.
- Determination that the patient with a terminal or debilitating medical condition may benefit from the recommendation of marijuana.
- Advice about the potential risks of the medical use of marijuana to include:
    - The variability of quality and concentration of marijuana;
    - The risk of cannabis use disorder;
    - Exacerbation of psychotic disorders and adverse cognitive effects for children and young adults;
    - Adverse events, exacerbation of psychotic disorder, adverse cognitive effects for children and young adults, and other risks, including falls or fractures;
    - Use of marijuana during pregnancy or breast feeding;
    - The need to safeguard all marijuana and marijuana-infused products from children and pets or domestic animals; and
    - The need to notify the patient that the marijuana is for the patient's use only and the marijuana should not be donated or otherwise supplied to another individual.
- Additional diagnostic evaluations or other planned treatments.
- A specific duration for the marijuana 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 paucity of evidence for the efficacy of marijuana in treating certain medical conditions. Recommending marijuana for certain medical conditions 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 marijuana.

Ongoing Monitoring and Adapting the Treatment Plan: Where available, the physician recommending marijuana should register with the appropriate oversight agency and provide the registry with information each time a recommendation, attestation, authorization, or reauthorization is issued [see Appendix 1]. Where available, the physician recommending marijuana should check the state Prescription Drug Monitoring Program (PDMP) each time a recommendation, attestation, authorization, or reauthorization is issued.

The physician should regularly assess the patient's response to the use of marijuana and overall health and level of function. This assessment should include the efficacy of the treatment to the patient, the goals of the treatment, and the progress of those goals.

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, psychiatric, addiction or mental health specialist, as needed.

Medical Records: The physician should keep accurate and complete medical records. Information that should appear in the medical record includes, but is not necessarily limited to the following:

- The patient's medical history, including a review of prior medical records as appropriate;
- Results of the physical examination, patient evaluation, diagnostic, therapeutic, and laboratory results;
- Other treatments and prescribed medications;
- Authorization, attestation or recommendation for marijuana, 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 marijuana;
- A copy of the signed Treatment Agreement, including instructions on safekeeping and instructions on not sharing.

Physician Conflicts of Interest: A physician who recommends marijuana 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.

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Appendix 1: Registration

Many states that permit the recommendation of marijuana to patients for the treatment of serious medical conditions have laws establishing a registry to track and monitor the utilization of marijuana in patient care.[8]

In these states, physicians recommending marijuana to patients for the treatment of conditions are required to register with the regulatory agency overseeing the marijuana program, and must provide the registry with information each time a recommendation is issued.

The state's registry is required by law to regularly perform analyses of the number of recommendations issued. With the statistical review of physician recommendations, the regulating agency periodically determines whether a physician should be referred to the state medical or osteopathic board for review and possible sanction.

The following are common factors oversight agencies rely on in referring physicians to the state board for possible abuse of marijuana recommendations:

1. Physician caseload as determined by the number of patients for whom marijuana is recommended. A high caseload is calculated as 3,521 or more patient recommendations in one year for a general practitioner. This reflects the recommendation of patients equal to or greater than the national average of patient visits per year for a generalist physician as reported by the Centers for Disease Control and Prevention (Co. Registry Policy # 2014-04_001);
2. The plant and ounce recommendations by the physician. Physicians recommending an amount of marijuana above the standard set within a state's statutes will be referred to the state medical board for review;
3. Age demographics of the patient caseload. According to the CDC, older adults have a significantly higher prevalence of chronic conditions than younger adults. Physicians for whom more than one-third of the patient caseload is under the age of 30 may be recommended for referral; and
4. Other circumstances determined by the overseeing agency. The oversight agency may also refer physicians to the state medical board if there is evidence of potential violation of the constitution, statutes, state medical board regulations or any violation of the Medical Practice Act.

If evidence supports a referral, the overseeing agency will issue a formal referral to the state medical board with the physician's identifying information, the reason for the referral, and any statistical data supporting the referral. Once the referral is received, the state medical board typically reviews the documentation and conducts an investigation as deemed appropriate.

[8] *See e.g.* Colorado Medical Marijuana Registry; *See e.g.* Minnesota Medical Cannabis Registry

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MBC - GUIDELINES

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.

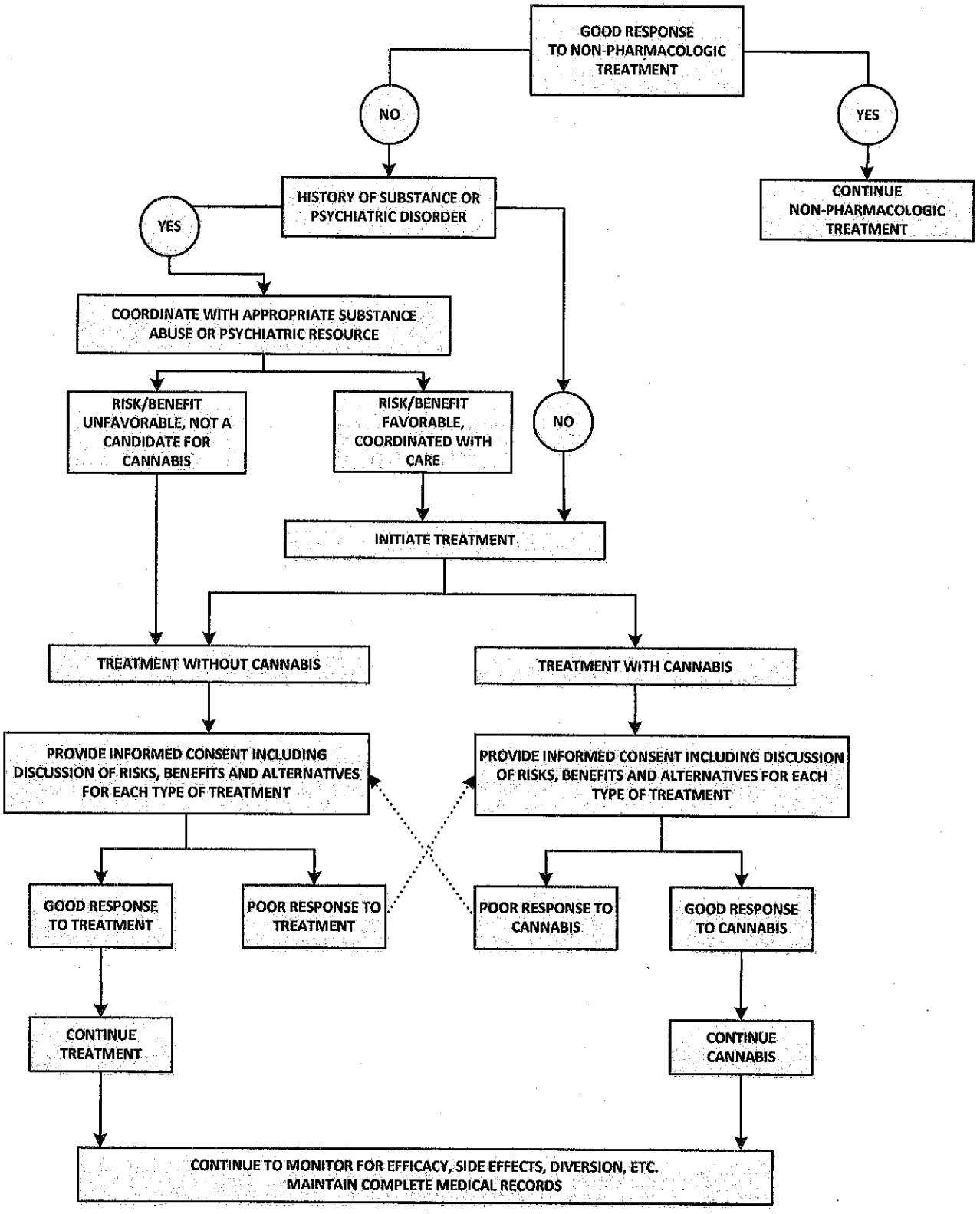
"Financial Interest" includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and

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



Tab 9

Osteopathic Medical Board

Future Meeting Dates

Date	Place	Time
Thursday May 7, 2020	Pomona, CA	10:00 am
Thursday September 10, 2020	San Diego, CA	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.*

Tab 10

Osteopathic Medical Board

Future Agenda Items

Agenda Item	Requestor