OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Board Meeting, Thursday, January 18, 2018
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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BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

OSTEOPATHIC MEDICAL BOARD OF CALIFONIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991
P (916) 928-8390 F (916) 928-8392 | www.ombc.ca.gov

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

BOARD MEETING AND TELECONFERENCE NOTICE AND AGENDA

Date: Thursday, January 18, 2018
Time: 10:00 a.m. – 5:00 p.m. (or until the end of business)

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

TELECONFERENCE LOCATION:

San Diego Public Library Foundation
330 Park Blvd, 4th Floor
Conference Room 443
San Diego CA 92101
(619) 238-6695

AGENDA

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

Open Session

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

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

3. Election of Officers

4. President-elect Report

5. Review and Approval of Minutes of the October 19, 2017 Board meeting

6. Administrative Hearing - 10:30 a.m.

   a) Anthony Benjamin Karam, D.O. (20A 9178) – Petition for Reinstatement of Revoked License
   b) Arsen Nalbandyan, D.O. (20A 9339) – Petition for Early Termination of Probation

7. **Closed Session**

   - The Board will meet in closed session pursuant to Government Code Section 11126(c)(3) to discuss disciplinary matters including the above petitions, petitions for reconsideration, stipulations, and proposed decisions.

Return to Open Session

8. DCA-Update – Dean R. Grafilo, Director, DCA

9. Budget Update - Mark Ito, DCA Budget Office

10. Naturopathic Medicine Committee Update – David Field, N.D., Chair

11. Regulations Update and Possible Action

   - California Code of Regulations, Title 16, section 1606 - Notice to Consumers
   - California Code of Regulations, Title 16, section 1663 - Disciplinary Guidelines and Uniform Standards – Ryan Marcroft, Deputy Director, Legal Affairs Division

12. Discussion Regarding Guidelines for the Recommendation of Cannabis for Medical Purposes, Medical Board of California

13. Executive Director's Report – Angie Burton

   - Licensing
   - Staffing
   - CURES
   - Business & Professions Code 2454.5 - CME
   - Enforcement Report / Discipline – Corey Sparks

14. Agenda Items for Next Meeting

15. Future Meeting Dates

16. Adjournment

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

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

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

TAB 2

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.
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BOARD MEETING
MINUTES

Thursday, October 19, 2017

BOARD MEMBERS PRESENT: Joseph Zammuto, D.O., President
James Lally, D.O., Vice President
Elizabeth Jensen, D.O., Board Member
Claudia Mercado, Board Member
Andrew Moreno, Board Member
Cheryl Williams, Board Member

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

BOARD MEMBERS ABSENT: Cyrus Buhari, D.O., Secretary Treasurer
Megan Blair, Board Member

The Board meeting of the Osteopathic Medical Board of California (OMBC) was called to order by President, Joseph Zammuto, D.O. at 10:07 a.m. at Department of Consumer Affairs (HQ2) - 1747 North Market Blvd., Sacramento CA 95834.

1. Roll Call

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

Upon Cheryl Williams's arrival Dr. Zammuto administered an oath commencing her reappointment as a board member.

2. Public Comment for Items Not on the Agenda

No Public Comment was received by the Board.

3. Introduction of New Board Member(s) and Legal Counsel

Dr. Zammuto welcomed Andrew Moreno and Sabina Knight, Esq. to the Board and opened the floor to the members for self-introduction; during which time, they provided additional background commentary that had not been included in the Board packet.

4. DCA Update – Christopher Castrillo, Deputy Director, Board & Bureau Services

Christopher Castrillo, Deputy Director, Board & Bureau Services, introduced himself as he was newly appointed to the position under the governance of Dean Grafilo. He explained that the position previously held by Christine Lally had now been separated into three (3) positions to better assist all boards and bureaus under the Department of Consumer Affairs (DCA). Mr. Castrillo will be accompanied by Karen Nelson and Patrick Lee on October 30th when they assume their appointment as Assistant Deputy Directors of Board & Bureau Services.

Deputy Director Castrillo, announced that DCA had also appointed Chris Schultz as Chief Deputy Director of DCA and Natalie Daniel as Deputy Director of Administration who will oversee DCA's Office of Human Resources, Business Services, and Fiscal Operations. Both will commence their appointments on October 30th.

Mr. Castrillo addressed the 2nd director's quarterly meeting that was held in September and noted that DCA will continue to hold its annual board president meeting to ensure lines of communication remain open and allow for board presidents to provide feedback on issues that they feel need to be addressed within the department.

Mr. Castrillo noted that DCA released a new license verification database for consumers on the BreEZe website with the key focus being the user experience performance, flow, and functionality. The link for the enhanced BreEZe verification database is https://search.dca.ca.gov/

The Future Leadership Development Training program was officially launched in May 2017, and recently a kick off meeting was held with program participants and mentors on August 28, 2017. The next meeting for the Future Leadership Development Training program will be held on October 24, 2017, and will feature guest speaker Senator Jerry Hill. The program's goal is to expand on the department's current leadership academy, and assist in the development of the best and brightest among the department's boards and bureaus. The program will include mentoring, customized leadership and training, and project management.

The department has established a pro rata workshop with DCA and board and bureau Executives to discuss potential improvements on how DCA communicates on future

developments. The work group held its first meeting on August 27th, and the second workshop is scheduled to be held on October 31st. The department will also hold a pro rata open house on November 14th.

Budget Report - Mr. Ito provided the Board with an updated analysis of the Board's current budget and gave an in-depth explanation of the budget report and projected expenditures.

Dr. Zammuto inquired on the general expenses line and how the budgeted amount is determined, and inquired on the funds needed to assist in Board staff relocation. He was informed by Mr. Ito that the Fiscal department usually performs bottom line budgeting meaning that the main concern is to ensure that the Board does not overspend more than what was allotted, but stated that he could work alongside Mrs. Burton later to complete a budget realignment to ensure that the Board would have enough funds to suffice. Regarding the relocation funds, the Board requests an Architectural Revolving Fund (ARF) to build a relocation fund line into the budget to ensure that the necessary funds needed to move are available.

5. Administrative Hearing(s)

10:30 a.m.

- Sandra Sands-Solgi, D.O. (20A 11259)– Petition for Early Termination of Probation
- Huongdu Ly, D.O. (20A 11259) – Petition for Early Termination of Probation

The Office of Administrative Hearing (OAH) Administrative Law Judge (ALJ) Heather M. Rowan conducted the above hearings.

6. Closed Session

The Board met in closed session to deliberate on the Petitions for Early Termination of Probation of the licensees listed above pursuant to Government Code section 11126(c)(3).

7. Review and Approval of Minutes

- **Motion to approve the January 20, 2017 Board meeting minutes with no corrections. Motion** – Dr. Lally, **Second** – Ms. Mercado
- Roll Call Vote was taken

    - **Aye** – Dr. Jensen, Dr. Lally, Ms. Mercado, Mr. Moreno, Mrs. Williams, Dr. Zammuto
    - **Nay** – None
    - **Abstention** – None
    - **Absent** – Mrs. Blair, Dr. Buhari
- Motion carried to approve minutes with no corrections.

- **Motion to approve the May 18, 2017 Board meeting minutes with no corrections. Motion** – Dr. Lally, **Second** – Dr. Jensen
- Roll Call Vote was taken
    - **Aye** – Dr. Jensen, Dr. Lally, Ms. Mercado, Mr. Moreno, Mrs. Williams, Dr. Zammuto
    - **Nay** – None
    - **Abstention** – None
    - **Absent** – Mrs. Blair, Dr. Buhari
- Motion carried to approve minutes with no corrections.

- **Motion to approve the June 28, 2017 Teleconference minutes with no corrections. Motion** – Dr. Lally, **Second** – Dr. Jensen
- Roll Call Vote was taken
    - **Aye** – Dr. Jensen, Dr. Lally, Ms. Mercado, Mr. Moreno, Mrs. Williams, Dr. Zammuto
    - **Nay** – None
    - **Abstention** – None
    - **Absent** – Mrs. Blair, Dr. Buhari
- Motion carried to approve minutes with no corrections.

8. President's Report

Dr. Zammuto had nothing to report and decided to defer all comments for discussion of SB 798.

9. Legislation

SB 798: Healing arts: boards (Sunset Bill)

SB 798 was chaptered on October 13, 2017, extending both the legislative review and sunset of the Osteopathic Medical Board of California (OMBC) and Medical Board of California through January 1, 2022. Additionally, at the Board's request, SB 798

modified the CME review cycle of the OMBC from a 3-year cycle to a 2-year cycle which will become effective January 1, 2018. The bill also granted OMBC statutory authority to receive from a local/state agency certified documents for arrests or convictions; probations; and/ or all related documentation needed to complete a licensee investigation, which amended Business and Professions Code (BPC) Section 144.5. SB 798 also included numerous changes to the Medical Practice Act including changes to the postgraduate training requirements for licensure applicants, however it has been delayed until January 1, 2020.

During the May OMBC Board meeting the Board discussed at length and opposed implementation of the postgraduate training requirements, and requested that Board staff contact Senator Hill regarding the changes and requesting to also be excluded from the requirement. OMBC executive staff, Board President Dr. Zammuto, and Vice President Dr. Lally attended a meeting on June 30, 2017, to address their opposition to the verbiage with Senator Hill's consultants and members of MBC staff. The Board addressed not only their concerns but noted that the language pertained only to the MBC as the OMBC does not license foreign graduates. Additionally, they noted that moonlighting was a common practice among those physicians entering the profession and would allow for them to obtain an income while also engaged in a training program.

OMBC noted that there are only 2 states currently that have legislatively implemented a 36-month postgraduate training requirement similar to the one presented, and included that the Federation of State Medical Boards also felt that it was premature to recommend completion of an American Osteopathic Association (AOA) or Accreditation Council for Graduate Medical Education (ACGME) residency as a requirement for licensure. The bill was forwarded on to the Governor without addressing the concerns of the Board and was subsequently chaptered on October 13, 2017. It has been estimated that the Board will need $80,000 to amend the BreEZe database to accommodate the legislative changes and will need to recruit additional staff in enforcement and licensing to accommodate the workload increase. Because the estimated implementation of the bill is not until 2020, the Board will submit a Budget Change Proposal (BCP) request for the 18/19 fiscal year to request the additional staff as necessary. Lastly, Senator Hill's request for probation reporting by licensees of health professions did not move forward and was pulled from SB 798 prior to its chaptering.

Kathleen Creason, Executive Director of the Osteopathic Physicians & Surgeons of California (OPSC), reported that OPSC representatives had met with the legislative consultant about the residency provisions in SB 798. She reported that the consultant felt the language in the bill should not be changed, as any concerns could be addressed prior to the provision's 2020 implementation date. Ms. Creason reported that OPSC had established a task force to address this issue, and would be discussing whether it would be appropriate to introduce legislation in the coming year.

10. MAXIMUS Presentation: *Substance Use Disorder and the Impaired Professional* – Anita Mireles, R.N., B.S.N,

Anita Mireles, R.N., B.S.N., MAXIMUS, presented the Board with a Power Point Presentation regarding the process and procedures of the diversion program and answered all questions from the Board related to the diversion program.

11. Regulations

- Diversion Evaluation Committee Duties and Responsibilities: Title 16, California Code of Regulations, section1661.2
- Disciplinary Guidelines: Title 16, California Code of Regulations, section 1663

Mrs. Burton advised that this was simply a place holder in the event that the Board received any commentary during the 15-day public comment period and hearing held on October 13th for the proposed disciplinary guidelines language and regulatory packet. However, no public comments were received, therefore the Board is preparing the package for OAL submission and review.

12. Future Meeting Dates

- Thursday, January 18, 2018 @ 10:00 am - Sacramento, CA
- Thursday, May 17, 2018 @ 10:00 am - Pomona, CA
- Thursday, September 27, 2018 @ 10:00 am – San Diego, CA
- Thursday, January 17, 2019 @ 10:00 am - Sacramento, CA

13. Agenda Items for Next Board Meeting

- SB 798 – Updates (*Dr. Zammuto*)
- CME Audit – Updates (*Dr. Jensen*)
- CMA Medical Marijuana Bureau (*Ms. Mercado*)
- Telehealth
- Department of Investigation Funding (*Dr. Zammuto*)

14. Executive Director's Report

Angie Burton updated the Board on licensing statistics, staffing, Board budget activity, and diversion program statistics.

Dr. Lally inquired on the status of the implementation of random CME audits and was informed by Mrs. Burton that the Board could not move forward with any changes until the CME cycle changes were implemented as requested in SB 798. The regulatory

language has been drafted and approved, however the Board is waiting on the legislative changes to take effect.

Enforcement/ Discipline - Dr. Zammuto inquired if the Board knew what factors would cause a field investigator to go undercover on a case; and inquired whether investigations are initiated upon board receipt of the case or after some review has been completed by the board's enforcement staff. He was advised by Mr. Sparks that it would depend on the type of case received. If the physician is an over-prescriber who is potentially running a "pill mill" that might prompt the field investigator to go undercover. However, field investigations are expensive, therefore the office would need to be certain that an investigation is necessary to ensure public safety. Another option available to the Board is the CURES database. By running a report of a physician's prescribing habits, the office is able to determine from the report whether or not a physician has in fact been over prescribing medication.

Dr. Zammuto made note that this was a topic of discussion at the Federation of State Medical Boards (FSMB) conference that he recently attended in April, and it was found that most states were not proactively investigating physicians for overprescribing practices. Mrs. Burton noted that the Board may not arbitrarily run a CURES report on a physician, and may only do so once information has been received in the office alleging a physician's potential over prescribing.

Dr. Zammuto asked what was necessary to obtain additional financial resources to complete investigations. He was advised by Mrs. Burton that the Board had submitted a BCP to request additional money to complete investigations, however the BCP was subsequently rejected. The Board's request for an increase in the expert witness fee will be moving forward, however at the end of the year the Board will be meeting with the budgets unit in addition to Division of Investigation to review the Board's options regarding investigations.

15. Adjournment

There being no further business, the meeting was adjourned at 2:37 p.m.

TAB 3

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TAB 4

STATE OF CALIFORNIA

DEPARTMENT OF CONSUMER AFFAIRS

NATUROPATHIC MEDICINE COMMITTEE

Dr. David Field, ND, LAc, Chair
Dr. Dara Thompson, ND, Committee Member
Rebecca Mitchell, Executive Officer

Osteopathic Medical Board of California meeting

January 16, 2018

Topics of Discussion

- What is Naturopathy
- What are Naturopathic Doctors (ND)
- Education of Naturopathic Doctors
- Safety Records
- Malpractice
- Formularies
- Scopes

What is Naturopathy?

- Naturopathic Medicine is a distinct and comprehensive system of primary health care that uses primarily natural methods and substances to support and stimulate the body's self-healing process.

- In 2003, California became the 13th state to recognize the profession and provided licensure to naturopathic doctors.

- Currently 17 states, the District of Columbia, and the US territories of Puerto Rico and the US Virgin Islands have licensing laws for naturopathic physicians.

- In most of the other licensing states and territories, NDs are titled as naturopathic physicians.

Naturopathic Philosophy

- First, Do No Harm
- Identify and Treat the Cause
- Doctor as Teacher
- Treat the Whole Person
- Prevention

What are Naturopathic Doctors (ND)?

Naturopathic Doctors

Naturopathic Doctors are trained in a wide variety of primary care, complementary and alternative therapies, including:

- Conventional Medications and Drugs
- Minor Office Procedures
- Naturopathic Childbirth Attendance
- Hormone Replacement Therapies
- Herbal and Homeopathic Medicines
- Clinical Nutrition and Diet
- Vitamins, Amino Acids, Minerals, Enzymes, and Nutraceuticals
- Physical Medicine such as Massage, Bodywork, Exercise Therapy, and Hydrotherapy
- Counseling and Behavioral Therapies
- Health and Lifestyle Counseling

Education of Naturopathic Doctors

Naturopathic Education

- Bachelor's Degree from a regionally accredited college or university
- ND Degree or diploma of a minimum 4,100 total hrs. in basic and clinical sciences, naturopathic philosophy, naturopathic modalities, and naturopathic medicine.
- Not less than 2,500 hrs. shall consist of instruction.
- Not less than 1,200 hrs. shall consist of supervised clinical training.
- NDs are clinically trained in both natural and conventional approaches to medicine.
- NDs are required to complete at least 72 hrs. of pharmacology course hours in school and must complete a minimum of 20 hours of pharmacotherapeutic training every two years of their continuing education requirement.

Standards of Naturopathic Education

The Counsel of Naturopathic Medical Education (CNME) sets the standards for naturopathic colleges in the areas of finances, faculty education, ethics, program development, education, and clinical competencies.

Standards of Naturopathic Education

Basic & Diagnostic Sciences	Anatomy, neuroanatomy, neurosciences, physiology, histology, pathology, biochemistry, genetics, microbiology, immunology, lab diagnosis, clinical diagnosis, physical diagnosis, medical research, epidemiology, public health, medical ethics, and others.
Clinical Sciences	Family medicine, ENT, cardiology, pulmonary medicine, gastroenterology, rheumatology, neurology, dermatology, urology, infectious disease, pediatrics, geriatrics, obstetrics, gynecology, pharmacology, pharmacognosy, minor surgery, ophthalmology, psychiatry, and others.
Naturopathic Therapeutics	Clinical nutrition, botanical medicine, homeopathy, naturopathic manipulative therapy, hydrotherapy, lifestyle counseling, naturopathic philosophy, naturopathic case management, advanced naturopathic therapies, acupuncture and traditional Chinese medicine, & Ayurvedic medicine.

Source: Handbook of Accreditation for Naturopathic Medicine Programs. *Counsel of Naturopathic Medical Education* April 2016; 34-52

Typical Educational Breakdown by Year:

- **First year** studies include the normal structure and function of the body with solid introduction to naturopathic theory, philosophy, and therapeutics.

- **Second year** focuses on the study of disease and diagnosis while beginning course work in botanical medicine, therapeutic manipulation, clinical nutrition, and homeopathic medicine sequences. To enter into the clinical training of the third year, students must pass all basic science courses and diagnostic courses, as well as a clinic entrance examination.

Typical Educational Breakdown by Year:

- **Third year** continues focusing on the botanical medicine, manipulation, clinical nutrition, and homeopathic medicine sequences, begins the organ systems courses (which emphasize case management), and gives major emphasis to clinical training. Students must pass a clinical primary status exam to proceed in the clinic.

- **Fourth year** continues the organ systems courses. The major focus of the fourth year is practical clinical training, working side by side with licensed physicians caring for patients. A clinic proficiency exam ensures clinical competency prior to graduation.

Comparison of the Basic Science Education

	Naturopathic	Allopathic	Osteopathic
Anatomy (gross &dissection)	350	380	362
Physiology	250	125	126
Biochemistry	125	109	103
Pharmacology	100	114	108
Pathology	125	166	152
Microbiology / Immunology	175	185	125
TOTAL HOURS	**1,125**	**1,079**	**976**

Above is a comparison of the basic science education of naturopathic doctors to that of an allopathic or osteopathic physician and surgeon, according to the Journal of Family Practice.

Naturopathic Physicians Licensing Examination (NPLEX)

California and all other licensing states require naturopathic physicians to pass Parts I and II of the NPLEX. The NPLEX is a rigorous, nationally standardized licensing exam implemented in 1986, replacing individual state exams.

- **NPLEX Part I**: Biomedical Science Examination is an integrated, case-based examination that covers the topics of anatomy, physiology, biochemistry & genetics, microbiology & immunology, and pathology. This examination is designed to test whether the examinee has the scientific knowledge necessary for successful completion of clinical training.

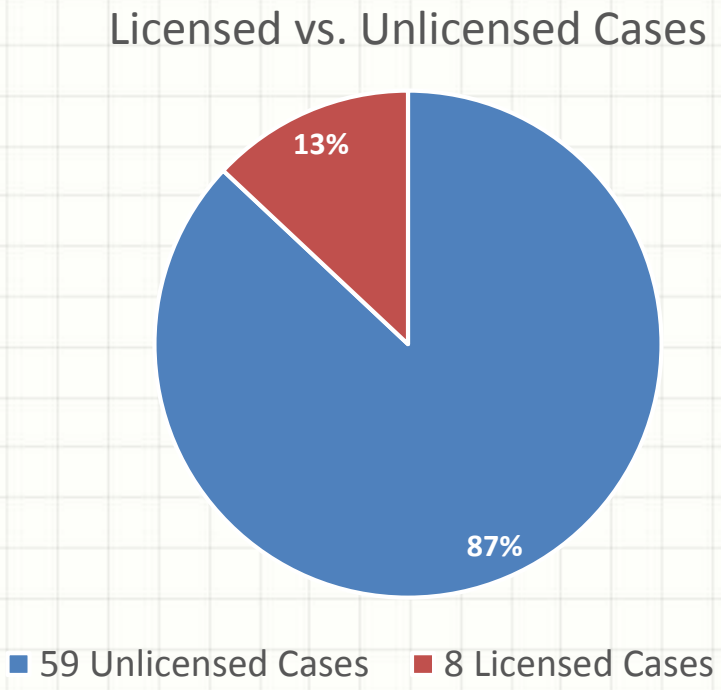
- **NPLEX Part II**: Core Clinical Science Examination is an integrated case-based examination that covers the following topics: diagnosis (using physical & clinical methods, lab tests & imaging studies), materia medica (botanical medicine and homeopathy), nutrition, physical medicine, health psychology, emergency medicine, medical procedures, public health, pharmacology, and research. This examination is designed to test the skills and knowledge that an entry-level naturopathic physician must have in order to practice safely.

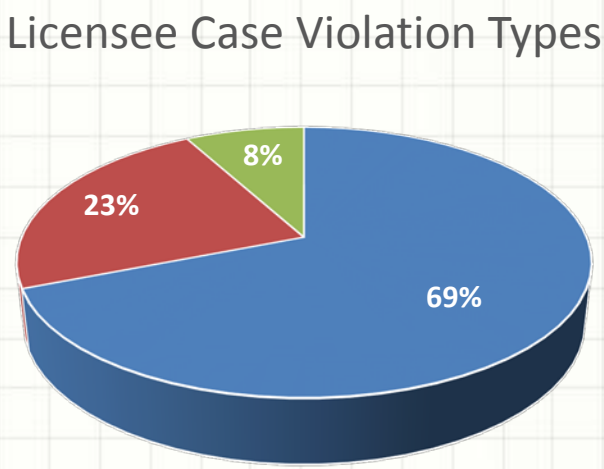
Safety Records

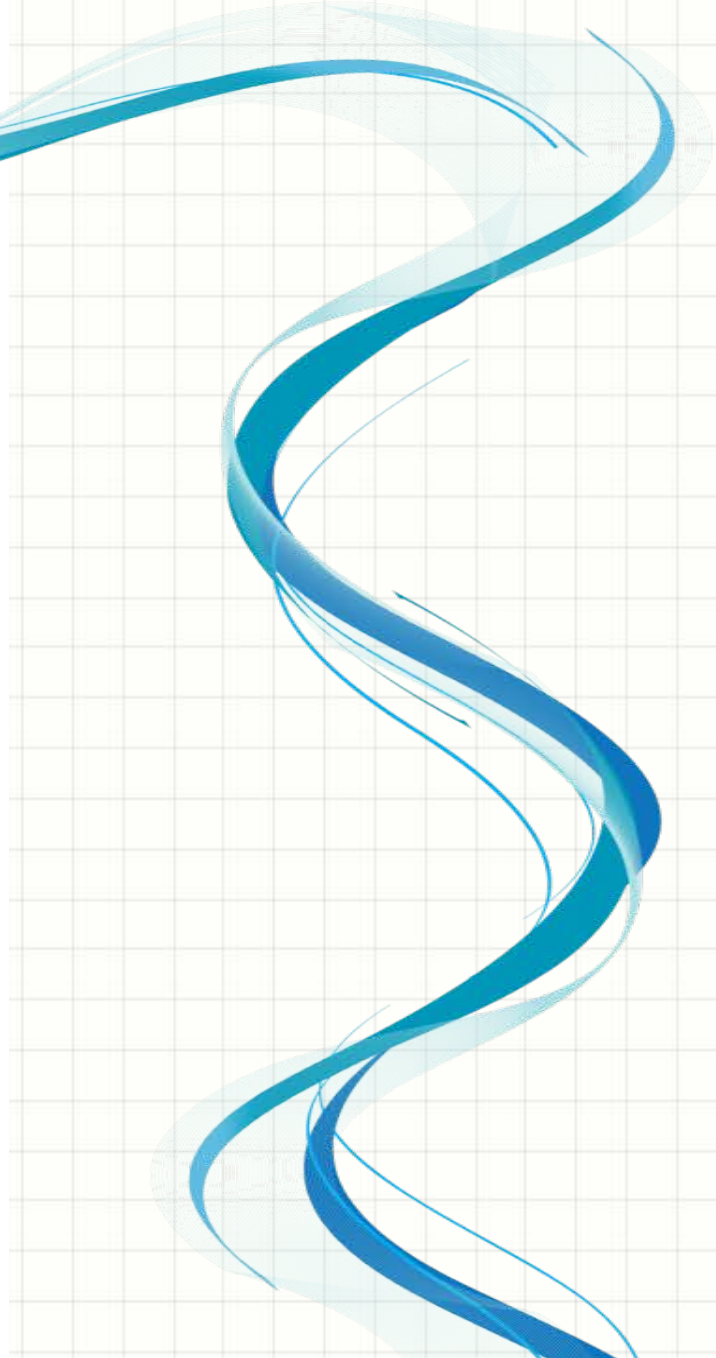
Naturopathic Doctors have the Best Safety Records

- The Naturopathic Medicine Committee rarely receives complaints about licensed naturopathic doctors
- Majority of complaints are for unlicensed practice violations.

Types of Enforcement Cases







Malpractice Insurance

Malpractice Insurance

- Most malpractice companies issue the same policy to NDs vs. other healing arts professionals for half the cost due to low risk factors of naturopathic medicine.
- Malpractice claims are lowest for ND profession across the nation.

Drug Formularies

Drug Formularies for Naturopathic Doctors

- Most ND Regulatory Boards allow Independent Prescribing of:
  - Schedule III through V Controlled Substances
  - All Legend Drugs
  - Hormones (natural and synthetic)
  - Natural Substances
- Formularies
  - Exclusionary

Naturopathic Scopes

Naturopathic Medicine Scope

- In most states includes minor office procedures and independent prescribing rights.

- California is limited in its scope, but the Committee plans to implement the Legislature's original intent to include the minor office procedures and independent prescribing rights by sponsoring a scope bill.

QUESTIONS?

TAB 5

Section 1606 - Notice to Consumers

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

NOTICE TO CONSUMERS PROPOSED LANGUAGE

The Osteopathic Medical Board of California hereby amends its regulations in Division 16 of Title 16 of the California Code of Regulations to read as follows:

1. Adopt Section 1606 of Division 16 of Title 16 of the California Code of Regulations to read as follows:

1606 Notice to Consumers.

(a) A licensee engaged in the practice of medicine shall provide notice to each patient of the fact that the licensee is licensed and regulated by the Board. The notice shall include the following statement and information:

NOTICE TO CONSUMERS
Osteopathic physicians and surgeons (D.O.)
are licensed and regulated
by the Osteopathic Medical Board of California.
(916)928-8390
www.ombc.ca.gov

To check the status of your physician and surgeon's D.O. license online, go to https://search.dca.ca.gov/.

To file a complaint against the physician and surgeon D.O., complete the online complaint form on the Osteopathic Medical Board of California website or email:osteopathic@dca.ca.gov

(b) The notice required by this section shall be provided by one of the following methods:

(1) Prominently posting the notice in an area visible to patients on the premises where the licensee provides the licensed services, in which case the notice shall be in at least 48 point type in Arial font.

(2) Including the notice in a written statement, signed and dated by the patient or the patient's representative and retained in that patient's medical records, stating the patient understands the physician and surgeon D.O. is licensed and regulated by the Board.

(3) Including the notice in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14 point type font.

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p. xciii), Section 1; and Section 3600-1, Section 2018, Business and Professions Code; Reference: Section 138 and 2026, Business and Professions Code.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
1300 National Drive, Suite 150, Sacramento, CA 95834-1991
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MEMORANDUM

DATE	January 18, 2018
TO	Board Members
FROM	Terri Thorfinnson
SUBJECT	Notice to Consumers Proposed Regulatory Language

Policy Issue
Promulgate regulations pursuant to Business and Professions Code (BPC) Sections 138 and 2026, which require the Board to promulgate regulations that require physicians and surgeons to provide a notice to consumers that they are licensed by the Osteopathic Medical Board. This notice must also include the contact information for consumers to contact the Board, let them know they can check the status of the licensee and file a complaint.

Background
Providing notice to consumers has been a concern raised by the Legislature as a consumer protection issue over the years. In 1999, there was a bill that required Boards to promulgate regulations requiring physicians and surgeons to provide specific notice to consumers that the physician and surgeon is licensed by the Board. The purpose of the notice was to provide consumers with the Board's name and contact information and show consumers that physicians and surgeons were licensed in California by the Board. At the January 21, 2016, the Board approved proposed regulatory language that required physicians and surgeon to provide specific notice to consumers.

Effective January 1, 2018, SB 798 created a new statutory requirement requiring the physicians and surgeons provide additional notice to consumers that they can look up the status of their doctor and file complaint. The purpose of this new notice requirement is to make it easy for consumers to check the status of their doctors and inform them that they can files complaints against doctors. Instead of creating two similar regulatory packages, this proposed language adds the newly required language to the existing Board approved regulatory language for BPC Section 138, so the notice is combined.

Discussion
BPC Section 138 requires the Board to promulgate regulations that require physicians and surgeons to provide notice to consumers that informs consumers that the physician and surgeon is licensed by the Osteopathic Medical Board of California and the contact information for the board.

BPC Section 2026 requires that consumers be provided the notice that they can check the status of physicians and surgeons. It also requires that physicians and surgeons provide notice that they can file a complaint against their doctor(s) through the Board internet website or by contacting the Board. Both statutes require the Board to promulgate the regulations that require physicians and surgeons to provide this information to consumers. This proposed language will be added to the Board's regulations as Division 16 of Title 16 California Code of Regulations Section 1606 entitled "Notice to Consumers." This proposed language adds regulatory guidance to physicians and surgeon on how to comply with these notice to consumer requirements; and satisfies the Board's statutory requirement to promulgate these regulations.

Recommendation

Approve the proposed language and approve delegation authority to the Executive Director to promulgate the regulations.

Section 1663 - Disciplinary Guidelines & Uniform Standards

Proposed Language

Changes to the current language are shown by underlining for new text and strikethrough for deleted text.

The Osteopathic Medical Board of California herby amends its regulations in Division 16 of Title 16 of the California Code of Regulations to read as follows:

1. Amend Section 1661.2 of Division 16 of Title 16 of the California Code of Regulations to read as follows:

§ 1661.2 Diversion Evaluation Committee Duties and Responsibilities.

A diversion evaluation committee shall have the following duties and responsibilities in addition to those set forth in Section 2366 of the Code:

To consider recommendations of the program manager and any consultants to the committee;

To set forth in writing for each physician in a program a treatment and rehabilitation plan established for that physician with the requirement for supervision and surveillance.

To use the Uniform Standards Regarding Substance-Abusing Licensees pursuant to Title 16, California Code of Regulations, Section 1663, entitled Disciplinary Guidelines and Uniform Standards Regarding Substance Abusing Licensees (1/19).

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p. xciii), Section 1; and Section 3600-1, Business and Professions Code. Reference: Section 2366, Business and Professions Code.

2. Amend Section 1663 of Division 16 of Title 16 of the California Code of Regulations to read as follows:

§ 1663. Disciplinary Guidelines and Uniform Standards Regarding Substance Abusing Licensees.

In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Osteopathic Medical Board of California shall consider and apply the disciplinary guidelines entitled "Osteopathic Medical Board of California Disciplinary Guidelines and Uniform Standards Regarding Substance Abusing Licensees of 2019 (Rev 1/19)," ~~1996"~~ which are hereby incorporated by reference. Deviation from the guidelines and orders, including the standard terms of probation, is appropriate where the Osteopathic Medical Board of California in its sole discretion determines that the facts of the particular case

warrant such a deviation; –for example: the presence of mitigating or aggravating factors; the age of the case; evidentiary problems.

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p. xciii), Sections 1, 2018, 2451, and 3600-1, Business and Professions Code; Reference: Sections 315 Business and Professions Code; Section 11425.50(e), Government Code.

3. To add Section 1663.1 of Division 16 of Title 16 of the California Code of Regulations to read as follows:

§1663.1 The Uniform Standards Regarding Substance Abusing Licensees.
The Board shall use the "Uniform Standards Regarding Substance Abusing Licensees" incorporated within the Osteopathic Medical Board of California Disciplinary Guidelines and Uniform Standards Regarding Substance Abusing Licensees of 2019 (Rev 1/2019) if the conduct found to be a violation involves the use of drugs, alcohol, or both and the individual is determined to be a substance abusing licensee. The Board shall use the Uniform Standards Regarding Substance Abusing Licensees The terms and conditions that incorporate the Uniform Standards for Substance Abusing Licensees shall apply as written and be used in the order placing the licensee on probation.

(1) If the conduct found to be a violation involves the use of drugs, alcohol, or both, a clinical diagnostic evaluation shall be ordered as a condition of probation in every case to determine whether the licensee is a substance abusing licensee. The clinical diagnostic evaluator's report shall be submitted in its entirety to the Board.

(2) The Board defines a substance abusing licensee as a licensee who undergoes a clinical diagnostic evaluation and is determined by the findings of the clinical diagnostic evaluator to be a substance abusing licensee.

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p. xciii), Sections 1, 2018, 2451, and 3600-1, Business and Professions Code. Reference: Sections 315, Business and Professions Code; Section 11425.50(e), Government Code.

4. Amend Section 1663.2 of Division 16 of Title 16 of the California Code of Regulations to read as follows:

§1663.2 Sexual Exploitation and Sexual Offenses
Notwithstanding the Disciplinary Guidelines, any proposed decision or order issued in accordance with the procedures set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code that contains any finding of fact that the licensee engaged in any act of sexual exploitation with a patient, as defined in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, and Section 2246 of the Business and Professions Code, or any finding that the licensee has committed a sex offense or been

convicted of a sex offense, shall contain an order of revocation. The proposed decision or order shall not contain an order staying the revocation of the license.

(1) As used in this section, the term "sex offense" shall mean any of the following:

(a) Any offense for which registration is required by Section 290 of the Penal Code or a finding that a person committed such an offense.

(b) Any offense defined in Section 261.5, 313.1, 647b, or 647 subdivision (a) or (d) of the Penal Code or a finding that a person committed such an offense.

(c) Any attempt to commit any of the offenses specified in this section.

(d) Any offense committed or attempted in any other state or against the laws of the United State which, if committed or attempted in this state, would be punishable as one or more of the offenses specified in this section.

NOTE: Authority cited: Osteopathic Act (Initiative Measure, Stats. 1923, p. xciii), Sections 1, 2018, 2451, and 3600-1, Business and Professions Code. Reference: Sections 315, 726 and 729, 2246 Business and Professions Code; Section 11425.50(e), Government Code; Sections 261.5, 290, 313.1, 647b, and 647 subdivision (a) or (d), Penal Code.

TAB 6

November 2017

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
November 2017

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. Based on the increasing number of states permitting the recommendation of cannabis in patient care, the U.S. Department of Justice updated its cannabis enforcement policy in August 2013 (James M. Cole, "Guidance Regarding Cannabis Enforcement [Memorandum]," Washington, DC: Department of Justice. (August 19, 2013)). This policy reiterates cannabis's classification as an illegal substance under federal law, but advises states and local governments that authorize cannabis-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 including criminal prosecutions, focused on those harms. In this context, the United States Department of Justice advised that it likely was not an efficient use of federal resources to focus enforcement efforts on seriously ill individuals, or on their individual caregivers. In doing so, the guidance drew a distinction between the seriously ill and their caregivers, on the one hand, and large-scale, for-profit commercial enterprises, on the other, and advised that the latter continued to be appropriate targets for federal enforcement and prosecution.

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;
    - The risk of 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;
    - Risks of using cannabis during pregnancy or breast feeding;
    - 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 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

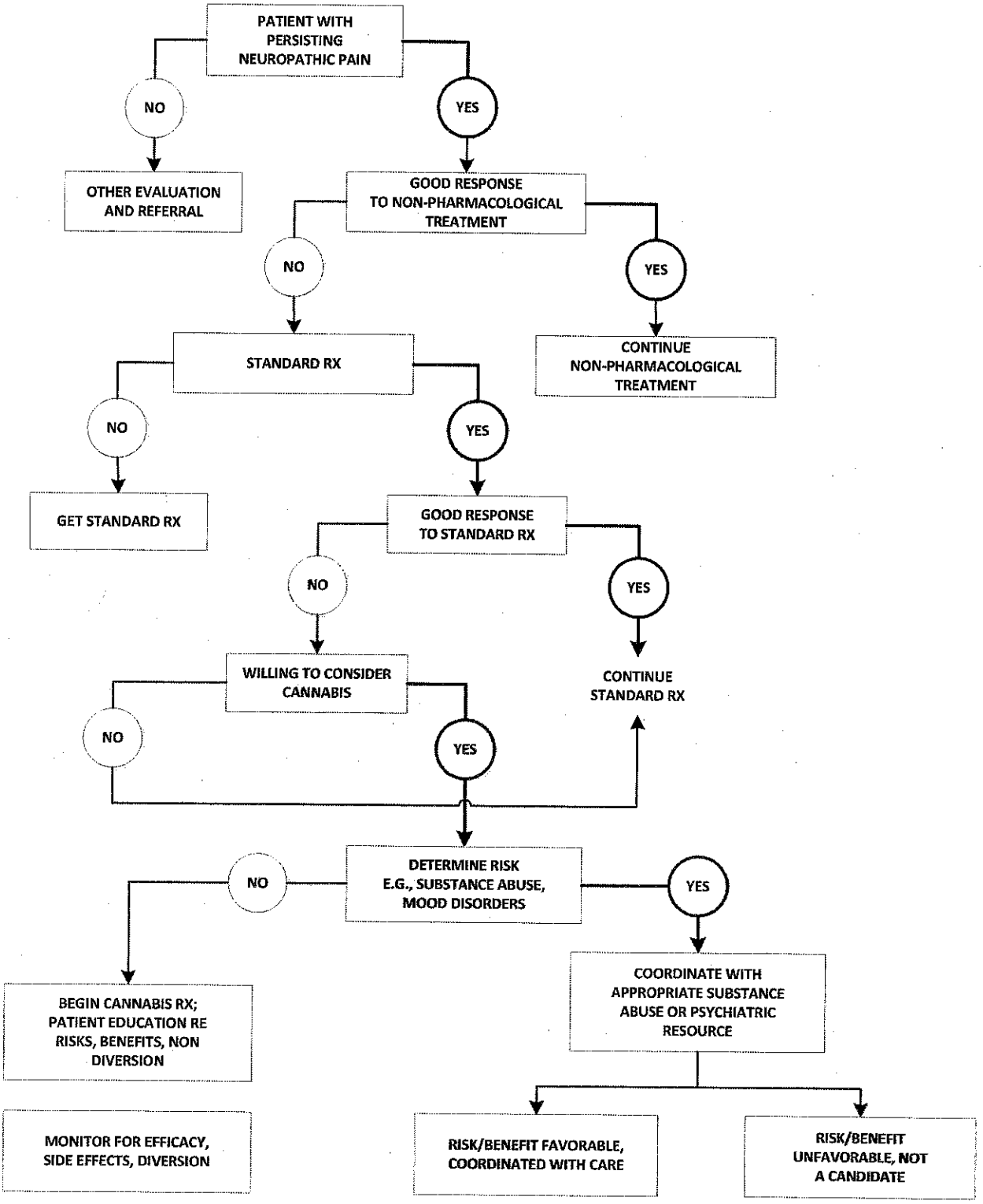
misdemeanor punishable by up to one year in county jail and a fine of up to five thousand dollars or by civil penalties of up to five thousand dollars and constitutes unprofessional conduct.

"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 7

Board Meeting – January 18, 2018

This report is to provide the Board Members with an update on licensing statistics, staffing issues, continuing medical education (CME), CURES, and enforcement functions at the Osteopathic Medical Board of California. No action is needed at this time.

License Statistics

As of December 31, 2017, number of Osteopathic Physicians and Surgeons holding a California license:

Active Status – 8,486
Inactive Status - 592
TOTAL - 9,078
In addition to the above, there are 1,030 licenses in a delinquent status.

In-state licensees – 7,291 Active licenses; 53 inactive licenses

Number of applications received:

From October 1, 2017 through December 31, 2017 - 216

Number of licenses issued:
From October 1, 2017 through December 31, 2017 – 215

Number of days to approve a license application during October 1, 2017 and December 31, 2017 was 41 days. Applications with missing documents took an average of 106 days to complete and approve.

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Staffing

As you know, we lost our Medical Consultant and dear friend, Dr. Krpan. He suddenly and unexpectedly passed away on January 4, 2018. Unfortunately, with a very heavy heart, we must fill our Medical Consultant position in order to continue our mission to protect the consumers of this state. Machiko Chong has submitted paperwork requesting authorization to fill this position. This has been approved. Once we obtain a pool of qualified candidates, the Board will conduct interviews and hire the best candidate for this position.

Board Office - DCA facilities has been meeting with the property managers of our current location. Discussions on the renovation to our current suite to provide space for additional cubicles have been taking place. It is anticipated that this project will commence around July of this year.

OMBC had requested additional funding for our Expert Consultants fees in a Budget Change Proposal (BCP)l in 2017. Unfortunately, this BCP was denied. Therefore, there will be no additional funding for our enforcement budget in the upcoming fiscal year.

Controlled Substance Utilization Review and Evaluation System (CURES)

California Department of Justice CURES program provides a quarterly report of some statistics involving CURES 2.0.

Below are the CURES statistics for the last quarter of 2017.

Total Number of Registered Users of CURES 2.0:

Total Registered Users	***176,562***	***176,786***	***177,398***
License Types	**October 2017**	**November 2017**	**December 2017**
Doctor of Podiatric Medicine	1,139	1,141	1,147
Nurse Practitioner/Nurse Midwife	11,028	11,080	11,505
Medical Doctor	93,419	93,439	93,805
Naturopathic Doctor	160	164	169
Osteopathic Doctor	5,630	5,669	5,713
Physician Assistant	7,631	7,696	7,843
Doctor of Optometry	575	576	583
Pharmacists	37,330	37,507	39,878
Dental Surgeons/ Dental Medicine	8,111	8,141	8,370
Doctor of Veterinary Med	2,408	2,439	2,582
Other (Non-specified license)	6,132	5,915	2,793
Sub Total	**173,563**	**173,767**	**174,388**

Other Roles	**October 2017**	**November 2017**	**December 2017**
LEA's	1,227	1,230	1,233
Delegates	1,645	1,661	1,648
DOJ Admin	12	13	13
DOJ Analyst	32	31	31
Regulatory Boards	83	84	85
Sub Total	**2,999**	**3,019**	**3,010**

Total number of Physician Activity Report's (PAR):

Total PARs Ran	*1,100,447*	*1,080,716*	*1,065,918*
License Types	**October 2017**	**November 2017**	**December 2017**
Doctor of Podiatric Medicine	743	682	222
Nurse Practitioner/Nurse Midwife	63,235	60,468	56,550
Medical Doctor	289,941	281,970	269,223
Naturopathic Doctor	2	11	3
Osteopathic Doctor	36,724	33,215	30,905
Physician Assistant	73,879	71,196	66,252
Doctor of Optometry	1	0	0
Pharmacists	627,687	626,983	635,731
Dental Surgeons/ Dental Medicine	1,148	1,051	1,071
Doctor of Veterinary Med	40	22	31
Other (Non-specified license)	2,319	1,968	2,059
Sub Total	**1,095,719**	**1,077,566**	**1,062,047**

Other Roles	**October 2017**	**November 2017**	**December 2017**
LEA's	161	189	193
Delegates	2,524	2,129	2,199
DOJ Admin	79	45	103
DOJ Analysts	402	56	177
Regulatory Boards	1,562	731	1,199
Sub Total	**4,728**	**3,150**	**3,871**

Total Times System was Accessed:

Total Times System was Accessed	*472,829*	*442,059*	*430,085*
License Types	**October 2017**	**November 2017**	**December 2017**
Doctor of Podiatric Medicine	253	298	197
Nurse Practitioner/Nurse Midwife	27,050	24,902	23,694
Medical Doctor	118,392	109,517	104,456
Naturopathic Doctor	19	10	10
Osteopathic Doctor	14,940	13,874	13,469
Physician Assistant	27,393	25,579	23,687
Doctor of Optometry	32	39	29
Pharmacists	279,441	262,992	259,937
Dental Surgeons/ Dental Medicine	1,016	1,044	1,012
Doctor of Veterinary Med	137	121	143
Other (Non-specified license)	1,009	886	807
Sub Total	**469,682**	**439,427,441**	**427,441**

Other Roles	**October 2017**	**November 2017**	**December 2017**
LEA's	416	333	285
Delegates	1,476	1,420	1,426
DOJ Admin	301	293	205
DOJ Analysts	605	496	479
Regulatory Boards	349	275	249
Sub Total	**3,147**	**2,817**	**2,644**

Number of Prescriptions Filled by Schedule:

	October 2017	**November 2017**	**December 2017**
Schedule II	1,683,105	1,569,711	1,648,465
Schedule III	292,437	282,263	292,352
Schedule IV	1,706,695	1,604,165	1,652,414
Schedule V	86,648	84,042	84,222
R	13,784	12,024	12,107
Unknown	29,587	37,082	39,845
Total	**3,812,256**	**3,589,287**	**3,729,405**

NOTE:
1. R = Not classified under the Controlled Substances Act; includes all other prescription drugs
2. Unknown = Over the counter product

CURES Survey

You will recall at our previous Board Meeting, we reported that a CURES 2.0 survey was conducted by the California Department of Public Health and the University of California Davis. Medical Board of California, California Board of Pharmacy and the Osteopathic Medical Board of California participated in this survey. Due to the time constraints and cost effectiveness, we chose the osteopathic physicians who were renewing their license in December 2016 to participate in this survey. The invitation to participate was included in their renewal notice. Approximately 500 physicians were invited to participate. Included in this agenda packet is the final report provided by the authors of the report.

Business and Professions Code Section 2454.5 (Continuing Medical Education)

Business and Professions Code section 2454.5 was amended to change the CME reporting period from a three-year cycle to a two-year cycle to match the two year license renewals. Because the prior CME cycle was not aligned with the license renewals, the board staff were receiving numerous phone calls from licensees who were confused as to what year CME's needed to be reported in order to renew their license.

This new two-year CME reporting requirement became effective January 1, 2018. Because Senate Bill 798 was not signed by the Governor until October 13, 2017, there was a very short amount of time to notify licensees of this change. Board staff sent out emails to all licensees who had an email address on file and put notification of this change on our website. Both the hard copy and on-line renewal forms were changed to reflect this new CME requirement. Staff received numerous phone calls from licensees who were concerned that they would not have enough CME to be eligible to renew their license as they thought they would have 2018 to complete the three-year CME cycle. Majority of licensees spread their 150 hours evenly over three years, which meant they would have completed an average of 50 hours per year. Those licensees who did so would have no difficulty in complying with the new 100 hours every two years requirement. However, those licensees who chose to complete the majority of the 150 hours in their third year, which would have been the year 2018, will not be able to meet the 100 hours which could have been completed in 2016 and 2017. Because of the short notice, board staff will work with those licensees who may have a deficiency during this first year of implementation of this new statute.

Enforcement Report

Corey Sparks, Lead Enforcement Analyst, will present the enclosed enforcement report.

Enforcement Report

OMBC Enforcement Report

January 18, 2018

The following OMBC Enforcement Report covers a 12-month period starting from the 1st Quarter 2017 though 4th Quarter 2017. The OMBC Enforcement Report is divided into five sections; Intake, Investigations, Enforcement, Performance Measures, and Probation. The data is reproduced from the Breeze Enforcement Reports.

COMPLAINT INTAKE

	1Q 2017			2Q 2017			3Q 2017			4Q 2017			
COMPLAINTS	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
Received	32	39	28	58	47	40	49	55	43	35	28	27	481
Assigned	30	40	26	29	71	33	42	41	42	54	41	42	491
Aging	29	16	17	16	27	24	28	27	28	34	25	26	25
	1Q 2017			2Q 2017			3Q 2017			4Q 2017			
CONV/ARRESTS	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
Received	4	1	6	7	1	4	1	0	2	1	3	1	31
Assigned	5	1	5	7	2	4	1	0	1	2	2	2	32
Aging	7	3	4	3	23	4	3	0	7	3	9	13	7
	1Q 2017			2Q 2017			3Q 2017			4Q 2017			
TOTAL INTAKE	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
Received	36	40	34	65	48	44	50	55	45	36	31	28	512
Assigned	35	41	31	36	73	37	43	41	43	56	43	44	523
Aging	26	15	15	13	27	22	27	27	28	32	25	26	24
Pending	21	46	24	24	23	26	55	30	37	44	32	12	12

Data Table 1: Complaint Intake with Convictions/Arrests

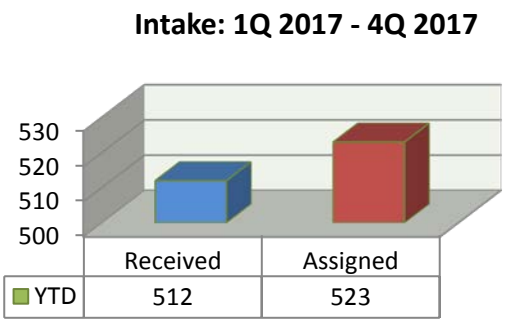


Figure 1.1: Intake Totals

In Data Table 1 above, under TOTAL INTAKE, OMBC received 512 complaints. 31 of these cases were convictions/arrests. During this period, 523 cases were assigned for investigations and the average number of days to assign a case was 24. In Figure 1.2 below we see the intake totals for each month. In April 2017, there was a substantial increase in received complaints while assigned complaints peaked at 73 in May. Received and Pending cases decreased in December and this is due to cases not yet imputed into the system.

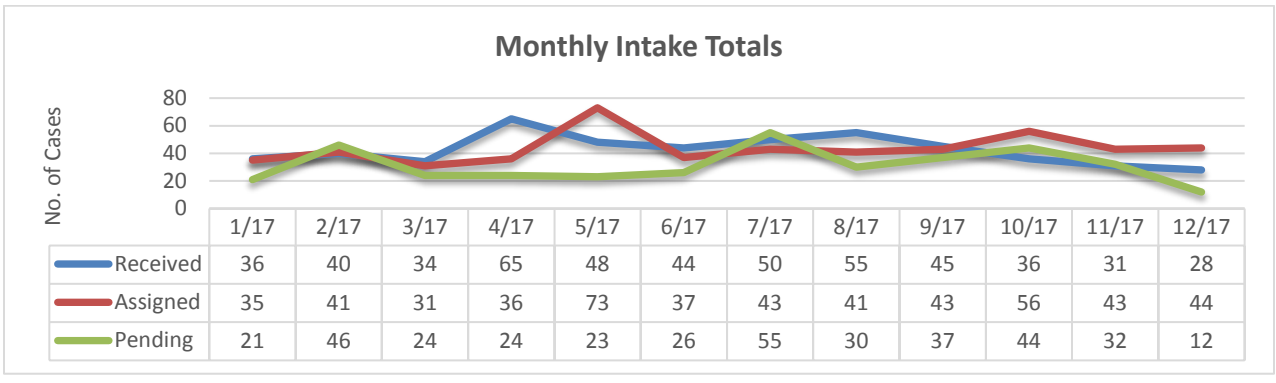


Figure 1.2: Intake Monthly Totals

In Figure 1.3 below, the bar graph illustrates the monthly average number of days to assign or close a complaint. The aging measures the period from the time the complaint is received in the office (the date stamp) to the time the complaint is assigned to investigations. The performance target for intake is 30 days. The Board met the performance target for the last 12 months with one exception, the month of October which averaged 32 days. The overall average for the last 12 months was 24 days.

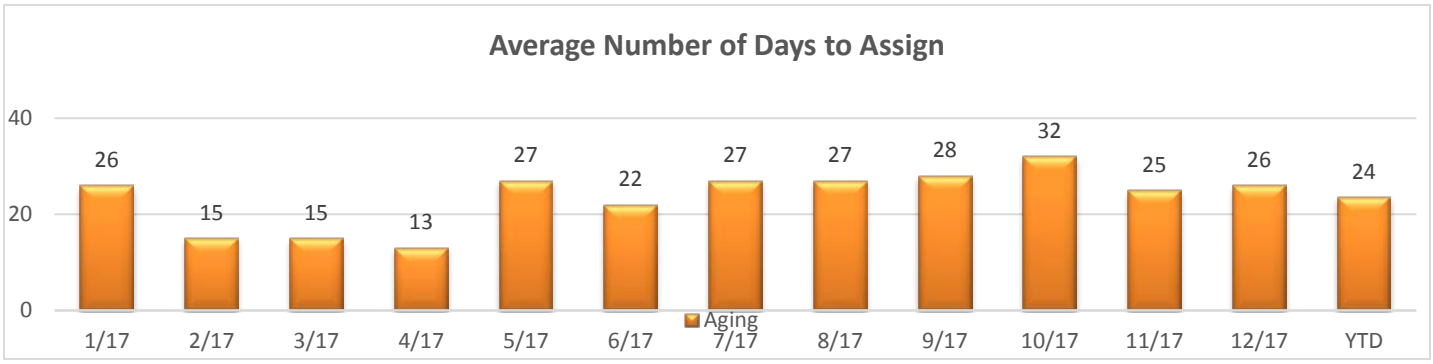


Figure 1.3: Aging for Case Assignment

INVESTIGATIONS

Desk (internal) Investigations

	1Q 2017			2Q 2017			3Q 2017			4Q 2017			
Desk Inv.	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
Assigned	35	41	31	36	73	37	43	41	43	56	43	45	524
Completed	51	29	37	37	29	42	54	30	60	37	47	41	494
Aging	85	105	108	100	67	61	106	116	70	72	115	75	90
Pending	112	125	119	119	164	159	148	160	143	163	159	164	164

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 totaled of 524 desk investigations were assigned, 494 were completed, and 164 cases were pending. The average number of days to complete a desk investigation was 90 days.

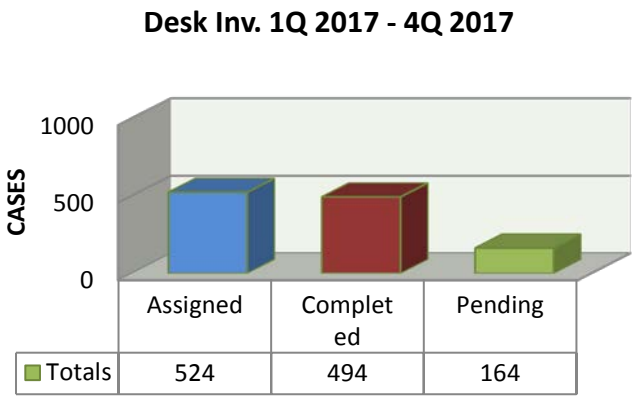


Figure 2.1: Desk Inv. Totals

In Figure 2.2 below, the assigned and completed caseload averaged a little below 50 cases per month except for May in which Assigned cases peaked at 73 and Completed cases peaked at 60 in September. Pending cases averaged a little above 100 until the month of May when the caseload increased at roughly 150 for the rest of the period.

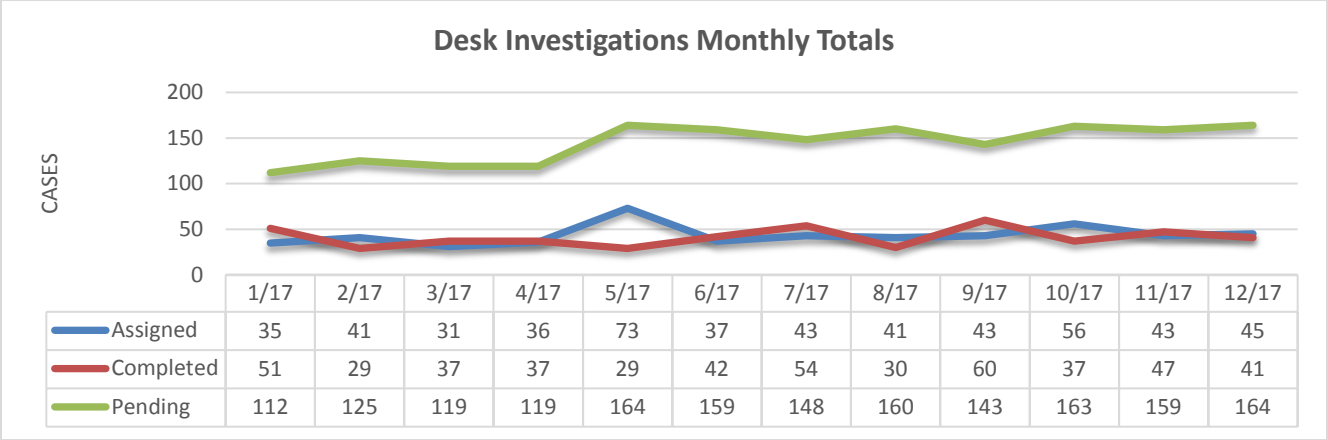


Figure 2.2: Desk Investigations

Field (Sworn) Investigations

	1Q 2017			2Q 2017			3Q 2017			4Q 2017			
Field Inv.	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
Assigned	1	0	0	0	1	2	1	1	5	0	4	3	18
Completed	1	1	3	3	1	2	4	1	1	4	5	5	31
Aging	163	460	381	336	573	362	562	401	985	540	536	440	478
Pending	40	40	38	35	35	35	32	32	36	32	32	30	30

Data Table 3: Field Investigations

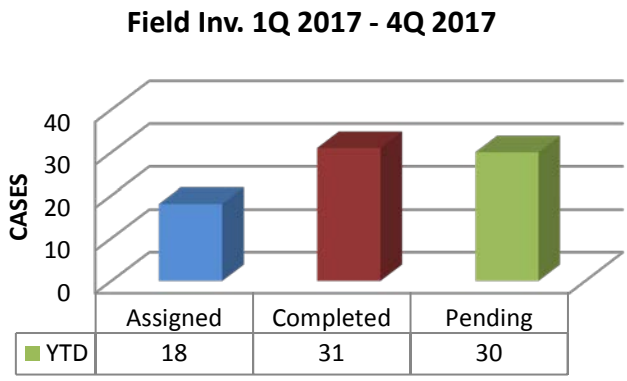
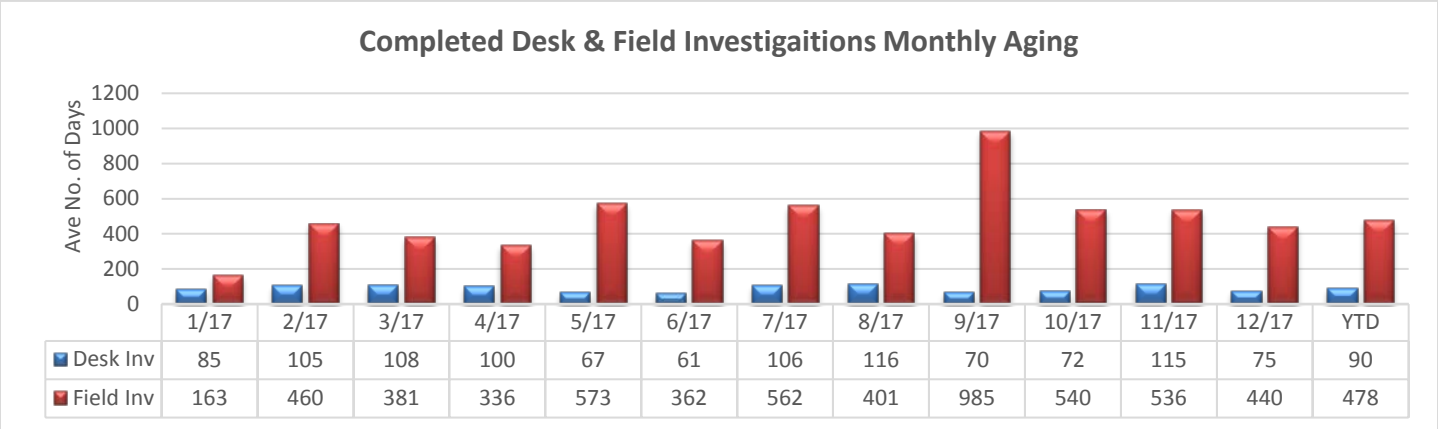


Figure 3.1: Field Inv. Totals

Data Table 3 above breaks down the monthly totals for field investigations 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, 18 cases were assigned to field investigations; 26 were completed; and 30 cases were pending and the end of December 2017.

Figure 3.2 below compares the aging of completed Desk and Field Investigations per month. The aging is the average number of days to complete an investigation starting from the complaint received date to the date that the investigation is completed. The YTD average to complete a desk (internal) investigation is a respectable 90 days (three months). The YTD average for Field Investigations was 478 (an increase from 420 from the last report). In September 2017, there was a single case that was closed with an aging of 985.



	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
Desk Inv	85	105	108	100	67	61	106	116	70	72	115	75	90
Field Inv	163	460	381	336	573	362	562	401	985	540	536	440	478

Figure 3.2: Completed Investigations Monthly Aging

Aging for Desk and Field Investigations

	1Q 2017			2Q 2017			3Q 2017			4Q 2017			
All Inv Aging	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
90 days	26	16	25	23	21	31	26	11	33	17	23	28	280
91-180 days	19	7	6	9	4	9	8	13	22	18	13	8	136
181-1 yr	3	5	6	2	3	3	17	5	1	0	6	3	54
1 yr-2 yrs	0	2	1	3	1	1	1	2	1	1	4	3	20
2 yrs-3 yrs	0	0	0	1	0	0	1	0	1	1	1	1	6
over 3 yrs	0	0	1	0	0	1	0	0	0	0	0	0	2
Totals	48	30	39	38	29	45	53	31	58	37	47	43	498

Data Table 4: All Investigations Aging

In Data Table 4 and Figure 4.1 we see the aging matrix for the number of investigations that were closed per month within a specific time-period. 280 cases (56%) were completed within 90 days; 136 cases (27%) were completed between 91-180 days; 54 cases (11%) were completed between 181-365 days; 20 cases (4%) were completed between 1 – 2 years; 6 cases (1%) were completed between 2-3 years; and 2 cases (less than 1%) were completed after 3 years. The majority of the investigations (83%) were completed within 6 months; and 94% were completed within a year.

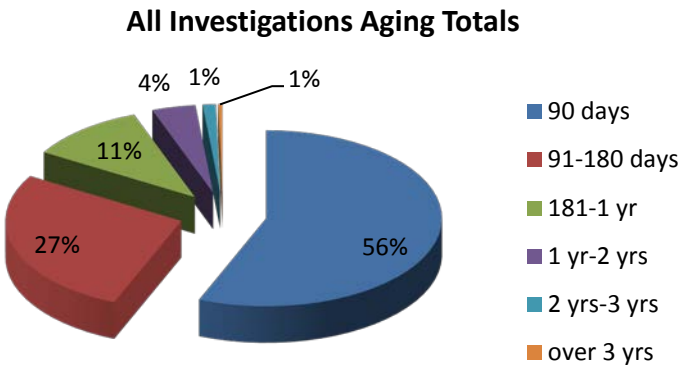


Figure 4.1 All Investigations Aging

ENFORCEMENT ACTIONS

	1Q 2017			2Q 2017			3Q 2017			4Q 2017			
	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
AG Cases Initiated	1	3	1	0	0	0	1	3	5	2	1	1	18
Acc/SOI Filed	3	2	0	1	1	0	0	1	0	3	2	2	15
Final Discplinary Order	1	0	2	3	3	0	0	2	2	2	2	1	18
Acc Withdrawn	0	0	0	0	0	0	0	0	0	0	0	0	0
Closed w/out Disc Acti	0	0	2	1	0	0	0	0	0	0	0	2	5
Citations	0	0	1	0	0	1	1	0	1	1	0	0	5
Suspension Orders	0	0	1	0	0	0	0	2	0	1	0	0	4
AG Cases Pending	25	28	25	21	18	18	19	21	24	24	23	21	21

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, 18 cases were transmitted to the Attorney General's Office for disciplinary actions; 15 Accusations and Statement of Issues were filed; 18 Final Disciplinary Orders were filed; 5 cases were closed without disciplinary action; 5 citations issued; and 4 Suspension Orders were filed. At the end of 3Q 2017 there were 21 AG cases pending.

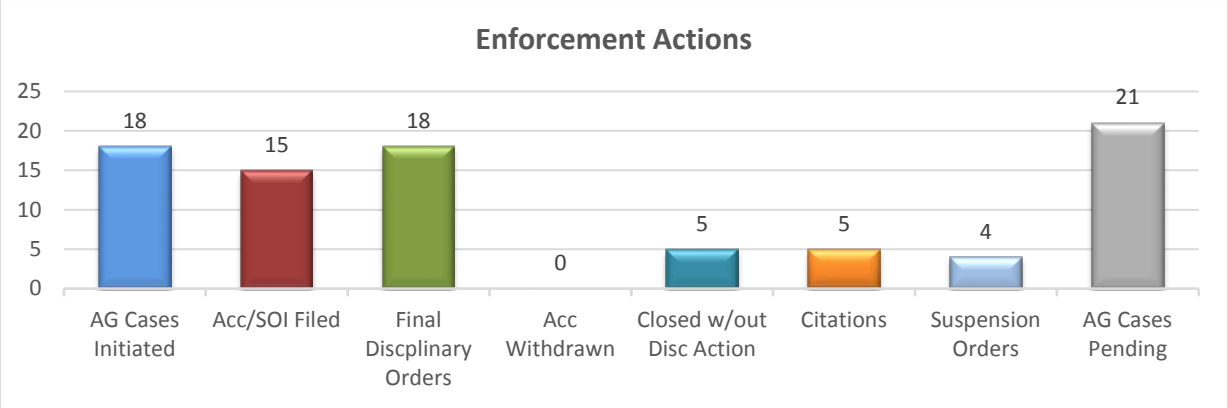


Figure 5.1: Enforcement Actions Totals

Final Disciplinary Orders Aging

	1Q 2017			2Q 2017			3Q 2017			4Q 2017			
Total Orders Aging	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
90 Days	0	0	0	0	0	0	0	0	0	1	0	0	1
91-180 Days	0	0	0	0	1	0	0	0	0	0	0	0	1
181 - 1 Yr	0	0	1	1	0	0	0	0	0	0	0	0	2
1 - 2 Yrs	0	0	0	1	1	0	0	1	0	1	0	0	4
2 - 3 Yrs	0	0	0	1	0	1	0	0	0	0	0	1	3
3-4 Yrs	0	0	0	0	1	0	0	0	1	0	0	0	2
4 yrs	0	0	0	1	0	0	1	1	1	0	1	0	5
Totals	0	0	1	4	3	1	1	2	2	2	1	1	18

Data Table 6: Final Orders Aging Matrix

In Data Table 6 (previous page) and Figure 6.1 we see the aging matrix of the 18 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 18 final disciplinary orders, 1 cases (5%) was completed in 90 days; 1 case (6%) was completed within 180 days; 2 cases (11%) within 181-365 days; 4 cases (21%) within 1-2 years; 3 cases (17%) within 2-3 years; 2 cases (11%) within 3-4 years, and 5 cases (28%) over 4 years. Of the 18 Disciplinary Orders imposed (Figure 6.2), there were 6 probationary orders; 4 revocations; 3 surrenders; 4 reprimands; and 1 statement of issues denied.

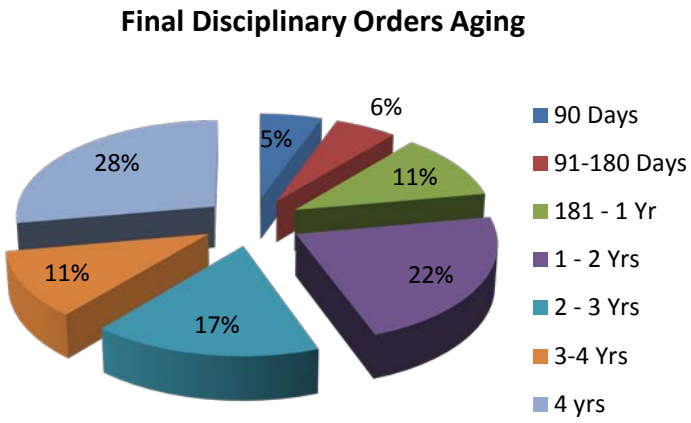


Figure 6.1: Final Orders Aging

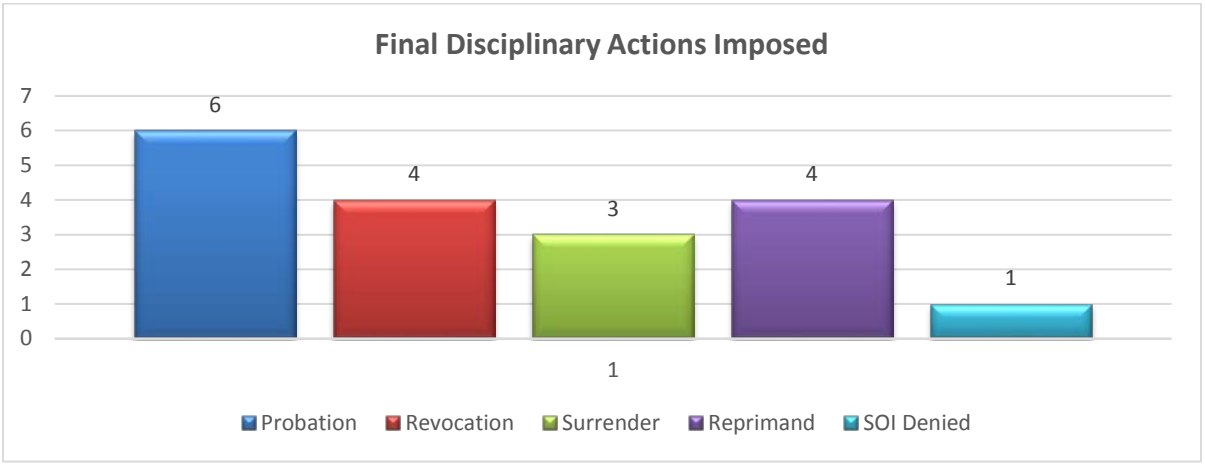
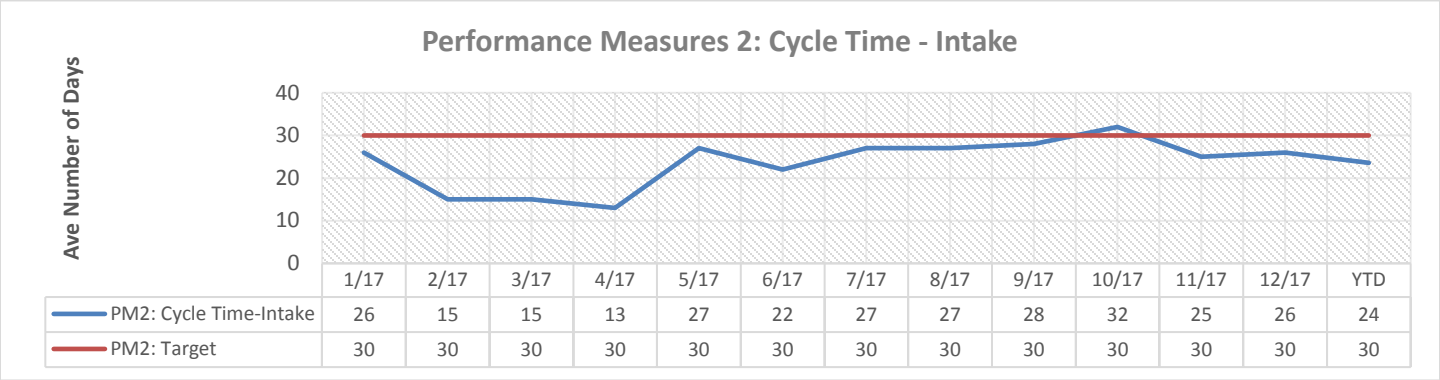


Figure 6.2: Final Disciplinary Actions

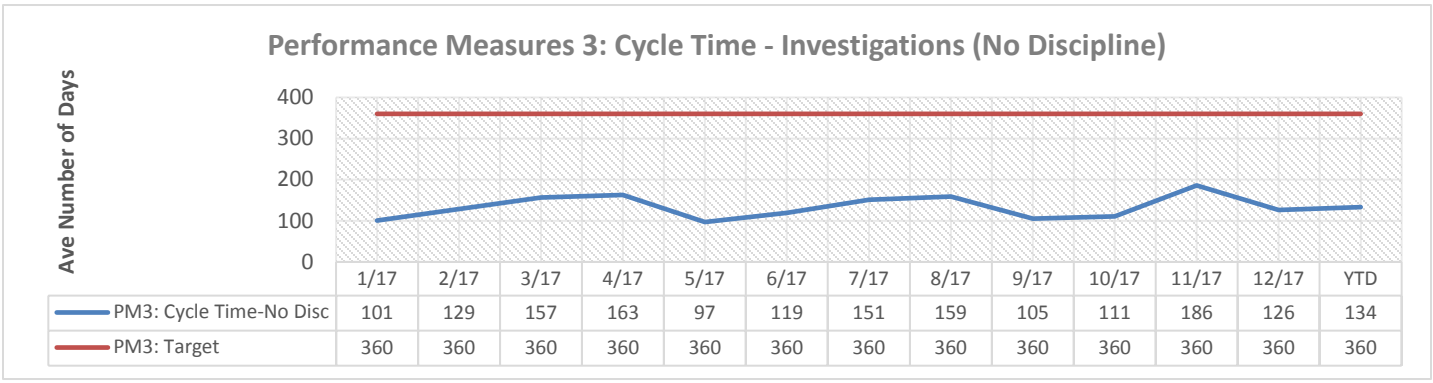
PERFORMANCE MEASURES

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



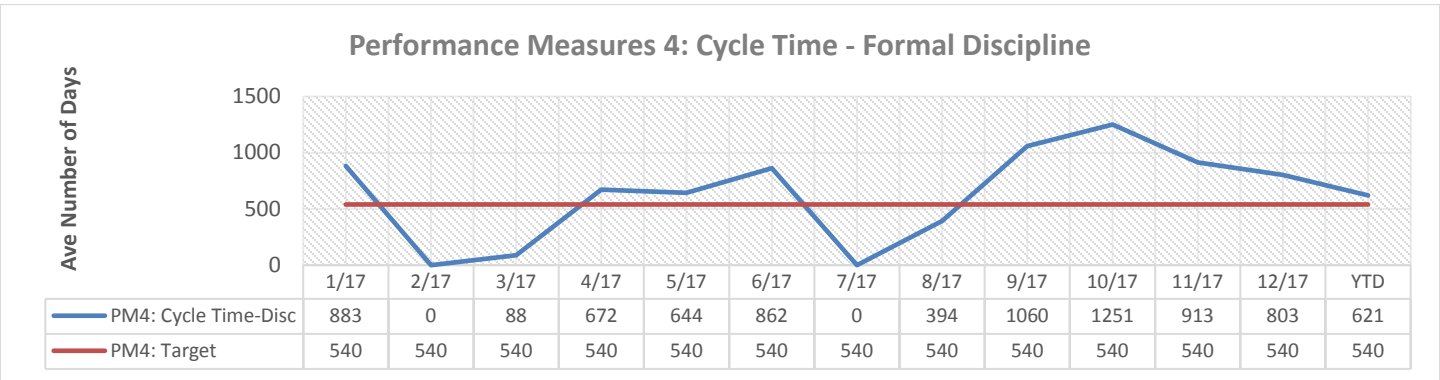
	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
PM2: Cycle Time-Intake	26	15	15	13	27	22	27	27	28	32	25	26	24
PM2: Target	30	30	30	30	30	30	30	30	30	30	30	30	30

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)



	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
PM3: Cycle Time-No Disc	101	129	157	163	97	119	151	159	105	111	186	126	134
PM3: Target	360	360	360	360	360	360	360	360	360	360	360	360	360

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)

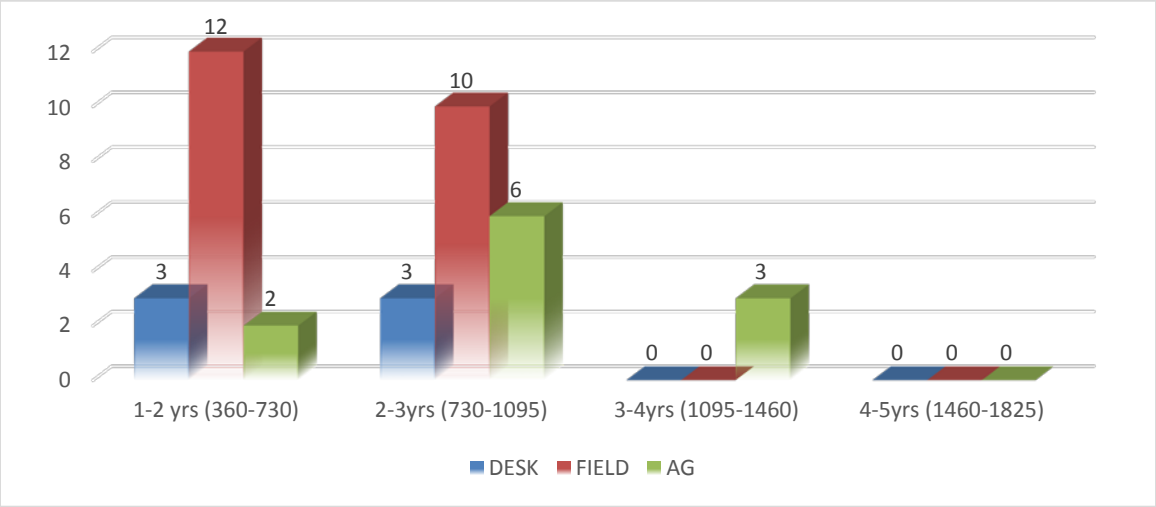


	1/17	2/17	3/17	4/17	5/17	6/17	7/17	8/17	9/17	10/17	11/17	12/17	YTD
PM4: Cycle Time-Disc	883	0	88	672	644	862	0	394	1060	1251	913	803	621
PM4: Target	540	540	540	540	540	540	540	540	540	540	540	540	540

PENDING CASES EXCEEDING PERFORMANCE TARGETS

For all current pending cases exceeding the Performance Targets, there are 6 desk investigations cases, 22 field investigations cases and 11 Attorney General cases.

	Case Disposition	Target	1-2 yrs (360-730)	2-3yrs (730-1095)	3-4yrs (1095-1460)	4-5yrs (1460-1825)	Totals	Highest aging value
PM3	DESK	360 days	3	3	0	0	6	880 days
PM3	FIELD	360 days	12	10	0	0	22	1069 days
PM4	AG	540 days	2	6	3	0	11	1419 days



PROBATION

There are currently 41 probation cases, of which 34 cases have a cost recovery order totaling $364,287.44. As of January 12, 2018, $220,482.74 has been paid leaving a balance of $143,804.70.

California's Controlled Substance Utilization Review and Evaluation System

CURES 2.0

Survey of California Physicians' and Pharmacists' Experience with and Attitudes about CURES 2.0

September 2017

California's Controlled Substance Utilization Review and Evaluation System (CURES 2.0)

Survey of California Physicians' and Pharmacists' Experience with and Attitudes about CURES 2.0

September 2017

This survey was funded by cooperative agreement 2015-PM-BX-K001, awarded to the California Department of Justice by the United States Bureau of Justice Assistance and by cooperative agreement 1U17CE002747, awarded to the California Department of Public Health by the Centers for Disease Control and Prevention. This report is solely the responsibility of the authors and does not necessarily reflect official views of the Centers for Disease Control and Prevention, the Department of Health and Human Services, or the United States Department of Justice.

The authors gratefully acknowledge the advice, cooperation and in-kind support provided by staff from the California State Board of Pharmacy, the Medical Board of California, and the Osteopathic Medical Board of California, without which this survey would not have been possible.

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EXECUTIVE SUMMARY

In 2013, California enacted a new law that provided dedicated funding for California's Controlled Substance Utilization, Review and Evaluation System (CURES), authorized an update and expansion of the CURES database and functionality, and mandated CURES registration for pharmacists and controlled substance prescribers. As part of a comprehensive evaluation of these updates (collectively known as "CURES 2.0"), a statewide, representative survey of California physicians and pharmacists was conducted to assess attitudes and beliefs about CURES and controlled substance use, and to identify areas for further improvement of CURES.

The survey was conducted with cooperation from the California State Board of Pharmacy, the Medical Board of California, and the Osteopathic Medical Board of California. The overall survey response rate was 24% (n = 1904). Comparison of aggregate data on responders and non-responders indicated that responders appear to be representative of California physicians and pharmacists.

Response patterns were broadly similar for pharmacists and physicians. Compared to physicians, pharmacists generally expressed more positive attitudes about CURES, were more likely to register for and use CURES, were more concerned about prescription drug abuse, and expressed a greater sense of professional obligation to use CURES. Pharmacists reported near perfect compliance with mandatory CURES registration (which took effect a few months prior to survey deployment), compared to approximately 82% compliance among DEA-licensed physicians. An additional 12% of physicians reported that they planned to register within the next 3 months. Physicians most frequently cited the time required to register and lack of importance as reasons for not registering; technical problems with CURES were rarely cited as a reason for not registering.

Thirty-one percent of physicians and 20% of pharmacists reported a recent decrease in the number of controlled substances they prescribed and dispensed, respectively. Survey data indicated that access to data from CURES, increased professional awareness of controlled substance risks and benefits, and new clinical guidelines all played major roles in decreasing prescribing and dispensing.

Twenty-eight percent of physicians indicated that they check CURES for least 50% of the patients to whom they prescribe controlled substances. Thirty-six percent of pharmacists indicated that they check CURES for at least 50% of the controlled substance prescriptions they dispense. Sixty percent of physicians and 80% of pharmacists agreed that CURES was helpful. Thirty-two percent of physicians and 59% of pharmacists agreed that CURES was easy to use. Among physicians and prescribers who had used both CURES 1.0 and CURES 2.0, more than 90% rated CURES 2.0 as the same or better than CURES 1.0 across all categories. Forty-seven percent of physicians and 40% of pharmacists reported a need for additional training on how to

use CURES. The most commonly identified needs for additional training related to the new advanced features of CURES 2.0, such as peer-to-peer messaging.

A substantial majority of physicians (81%) and pharmacists (91%) felt that their peers should check CURES when prescribing or dispensing a controlled substance, respectively. Nineteen percent of physicians and 36% of pharmacists felt that their peers ought to be using CURES 100% of the time when prescribing or dispensing controlled substances. In contrast, only 23% of physicians felt that physicians should be required to check CURES when prescribing. The corresponding value for pharmacists was 39%, indicating that nearly two-fifths of pharmacists supported mandatory CURES use for pharmacists. Over two-thirds of pharmacists (69%) agreed that checking CURES was considered standard of care, compared to 40% of physicians.

When asked to give open-ended suggestions or comments, many physicians and pharmacists felt that CURES was not relevant to their practice, particularly those who did not practice in California. Some physicians who rarely prescribed controlled substances and pharmacists who worked in hospital settings also felt that CURES was not relevant to their practice. Finally, several pharmacists recommended improving the accuracy and timeliness of CURES data, including adding data from federal pharmacies in California.

INTRODUCTION AND BACKGROUND

Prescription Drug Monitoring Programs (PDMPs) are considered an important, but under used, tool for combating the ongoing epidemic of prescription opioid abuse and overdose.[1,2] Preliminary evidence suggests that PDMP use may be associated with changes in prescribing behaviors;[3-5] however, important knowledge gaps remain around PDMPs. Each state has a separate PDMP, so the administration, technical details, strengths, and weakness of PDMPs vary widely across states. Thus, to a large extent, the strengths, weaknesses, and effectiveness of PDMPs must be evaluated on a state-by-state basis, because suggestions for improving PDMPs in one state may not be applicable to PDMPs in other states.

On the other hand, all PDMPs share the same general characteristics and so findings related to general PDMP attributes (e.g., ease of registration and use, data accuracy and timeliness) do likely generalize across states. In addition, social and professional norms (i.e., physicians' and pharmacists' beliefs and attitudes about PDMPs) are also likely to be an important determinant of PDMP use and effectiveness, but these concepts have so far been relatively unexplored. Most prior research on barriers to PDMP use has focused on state-specific technical and logistical barriers (e.g., website design, registration processes, etc).[6-9]

California has the nation's oldest prescription drug monitoring program. CURES was established in 1939. An electronic interface that prescribers and pharmacists could search in real time was implemented in 2009, but the CURES program was de-funded in 2011 due to state budget cuts. In September 2013, California enacted a new law to update CURES. This law (SB-809) provided a dedicated funding source for CURES. It also required CURES to streamline the registration process and mandated registration for dispensers and DEA-licensed prescribers. The bill did not specifically define all of the features that needed to be part of the CURES upgrade. Nevertheless, as part of the upgrade, CURES personnel added the following new features: streamlined electronic registration process, automatic alerts for certain high risk prescribing practices, ability to send peer-to-peer messages within CURES, ability to flag patient-provider agreements in CURES, and ability for CURES users to identify delegates who can initiate CURES patient reports. The bundle of upgrades authorized by SB-809 is collectively referred to as "CURES 2.0." The current CURES home page can be accessed at the following web address: https://oag.ca.gov/cures.

To evaluate the impacts of CURES 2.0, a representative, statewide survey of California physicians and pharmacists was conducted by University of California, Davis researchers in collaboration with the California Department of Public Health. The survey focused on physicians and pharmacists because these two professions comprise over 80% of all CURES users and because they represent the two primary categories of CURES users, prescribers and dispensers. Surveys were completed between August 2016 and January 2017. Data collection started after California implemented mandatory CURES registration (July 1, 2016), in order to ensure that all

respondents had a chance to register for CURES prior to the survey. The primary survey goals were as follows:

- To assess attitudes and beliefs about controlled substance misuse and abuse among California physicians and pharmacists
- To assess compliance with mandatory CURES registration
- To evaluate the impact of changes made as part of CURES 2.0
- To evaluate beliefs, attitudes, and social and professional norms related to using CURES
- To elicit suggestions and identify priority areas for further improvement of CURES

This report provides a detailed account of the survey methodology and a descriptive account of survey results. More detailed analysis of predictors of intent to use CURES and of the responses to an open-ended survey question will be published separately. The intended audience for this report includes the California Departments of Justice and Public Health, California state licensing and regulatory boards, California physicians and pharmacists, as well as researchers and public health officials in other states.

FUNDING AND ACKNOWLDGEMENTS

This survey was funded by the Harold Rogers Prescription Drug Monitoring Program (BJA cooperative agreement 2015-PM-BX-K001 awarded to the California Department of Justice) and the Prevention for States program (CDC cooperative agreement 1U17CE002747 awarded to the California Department of Public Health). Neither funding agency had any input into the design or conduct of this survey, or into the analysis of results. The final decision about what to publish in this report rested solely with the listed report authors.

The authors gratefully acknowledge the advice, cooperation and in-kind support provided by staff from the California State Board of Pharmacy, the Medical Board of California, and the Osteopathic Medical Board of California, without which this survey would not have been possible.

METHODS

Survey development

This survey was developed and conducted by the University of California Davis in collaboration with the California Department of Public Health, and with cooperation from the California State Board of Pharmacy, the Medical Board of California (MBC), and the Osteopathic Medical Board of California (OMBC).

Survey questions assessed the following topics: demographics and prescribing / dispensing practice patterns, concern about prescription drug misuse and abuse, beliefs about CURES effectiveness, CURES registration status, barriers to CURES registration and use, beliefs about professional norms, social norms, and moral obligations regarding CURES, questions about

specific features of CURES 2.0, need for additional training on how to use CURES, and comparing CURES 2.0 versus CURES 1.0. Survey questions were informed in part by reviewing previously published PDMP surveys.[6-9] Questions for allopathic and osteopathic physicians were identical; questions for pharmacists were very similar to questions for physicians, but asked about dispensing or managing rather than prescribing controlled substances. In order to reduce respondent fatigue, skip logic was used so that, to the extent possible, prescribers only answered questions relevant to their practice. For example, physicians who reported not having a DEA license (and so were not eligible to register for CURES) did not answer questions about CURES, and physicians who reported not being registered for CURES did not answer questions about how often they checked CURES. An open-ended question asking "Is there anything else you would like to tell us about CURES? (e.g., problems, recommendations)" was also included. The survey was web-based and was hosted by Qualtrics (Provo, UT), an online survey program. The complete physician and pharmacist surveys are shown in Appendix A and B, respectively.

Survey questions were reviewed by the study team and approved by the 3 regulatory boards. Community physicians and pharmacists not related to the study pilot tested the survey to identify any ambiguous questions and technical problems with the web interface. This project was reviewed by the University of California Davis Institutional Review Board and deemed to be program evaluation rather than human subjects research.

Sampling strategy

The survey sample was all pharmacists and allopathic physicians with licenses expiring on November 30, 2016 and all osteopathic physicians with licenses expiring on December 31, 2016. Licenses in California must be renewed every 2 years and expire at the end of the licensee's birth month; for osteopathic physicians, licenses must be renewed every 2 years and expire 6 times a year based on licensee birth month. Therefore, the sample comprised a quasi-random sample of one-twenty-fourth of all California pharmacists (n = 1626) and allopathic physicians (n = 5701) and one-twelfth of all California osteopathic physicians (n = 577).

Initial survey invitations were mailed from each regulatory board between August and October, 2016 and were included in the same envelope as the licensee's license renewal paperwork. One or two additional reminders were sent by mail from the survey team; an additional reminder letter was mailed from each regulatory board using envelopes showing that board's return address. Allopathic physicians also received several email reminders. The OMBC and the State Board of Pharmacy do not maintain licensee email addresses and so could not send out email reminders. All survey materials included the logos of both the University of California Davis and the applicable regulatory board. A detailed timeline of the survey reminder schedule for each survey is shown in Appendix C. All surveys were closed on January 31, 2017. Licensees were advised that participation was voluntary and that their individual responses would not be shared with the regulatory boards. All surveys were completed on the web. Respondents could access the survey by typing in a short web address, scanning a QR code on their cell phone, or clicking on a survey link on the appropriate regulatory board's web page. Licensees were required to type

in their license number before starting the survey. This approach prevented licensees from taking the survey multiple times, restricted respondents to licensees in the sample, and allowed us to keep track of respondents in order to avoid sending reminders to licensees who had already completed the survey.

Statistical analysis

All surveys opened with 2 items assessing respondents' concern about prescription drug misuse and abuse. Because physicians without a DEA license were screened out after these 2 items, physicians who completed these 2 survey items were considered responders for purposes of calculating overall survey response rate. To assess for response bias, the demographic and training characteristics of responders and non-responders were compared using aggregate data obtained from each regulatory board. Descriptive statistics (means and standard deviations for continuous measures, proportions for ordinal and Likert-type items) were calculated for each survey item. Responses from allopathic and osteopathic physicians were combined for all analyses; differences between allopathic and osteopathic physicians were not investigated.

Path analysis

A subset of items was also used to conduct a *path analysis* to identify factors associated with physicians' and pharmacists' intent to use CURES during the next 3 months. Path analysis is a statistical method for modeling and evaluating causal associations between variables.[10] Full details of this analysis will be published elsewhere, and so are not repeated in this report.

Qualitative analysis

Responses to the open-ended survey question were analyzed using content analysis followed by thematic analysis. For the content analysis, two investigators independently reviewed responses to identify content categories that emerged from the data. Investigators met weekly to discuss provisional categories, refine definitions, and discuss challenging cases. Codes were developed and reviewed jointly to ensure coding consistency while minimizing investigator bias. Disagreements were resolved by discussion, resulting in a final list of 18 codes. Both investigators independently coded responses using the final list of codes and compared results until they could apply codes reliably with high levels of agreement on a 5% sample of all open-ended responses. The remaining responses were each coded by one investigator; both investigators reviewed all comments where coding was considered ambiguous. The prevalence of each content category was assessed separately for physicians and pharmacists; the final list of codes was identical for both groups of respondents. Open-ended responses varied in length from a few words to a few paragraphs; therefore, coding categories were exhaustive but not mutually exclusive. For example, if a single response mentioned three different categories, that response was assigned to all three categories.

For the thematic analysis, investigators reviewed responses for each code to identify categories and themes that occurred within the responses. Crosscutting categories and themes were identified and discussed. Based on this analysis, codes were collapsed into larger themes.

RESULTS AND DISCUSSION

Response rate and sample representativeness

The survey received 1904 responses, for an overall response rate of 24%. As shown in Table 1, the response rate for pharmacists was substantially higher than rates for physicians. Detailed comparison of survey responders versus non-responders is shown in Table 2. Overall, characteristics for responders and non-responders were similar. Compared to non-responders, responders were older and more likely to be white or Asian / Pacific Islander. Physician responders were more likely to report psychiatry or emergency medicine as their primary specialty and to have a California address of record. Pharmacist responders were more likely to have a BS degree than a PharmD degree; this difference likely reflects the age difference between responders and non-responders, because PharmD became the required entry-level pharmacist degree in 2003.

Table 1. Survey response rates

Item	Pharmacists	MBC	OMBC	All physicians	Total
Responses	498	1289	117	1406	1904
Invitees[a]	1626	5701	577	6278	7904
Response rate (%)	30.6	22.6	20.3	22.4	24.1

[a]Pharmacy and MBC samples included licensees with out of state addresses. OMBC sample included only licensees with California addresses.

A major strength of this survey was collaboration with and support from the State Board of Pharmacy, OMBC, and MBC. Cooperation from these boards made it possible to survey a representative, statewide sample of physicians and pharmacists, to achieve a higher response rate than prior web-based surveys of prescription drug monitoring programs,[8,11] and to compare characteristics of responders and non-responders to assess sample representativeness and possibility of response bias. As shown in Table 2, physician responders were slightly more likely to report specialties that commonly prescribe controlled substances (e.g., emergency medicine, psychiatry, internal medicine, family medicine, and anesthesiology). However, responders and non-responders were otherwise similar, suggesting that the sample is likely to be representative of California pharmacists and physicians despite a response rate that is lower than traditional paper surveys delivered by U.S. mail.

Table 2. Comparison of responder and non-responder characteristics.

	Physicians					Pharmacists[f]			
	Responders		Non-Responders			Responders		Non-Responders	
Item Response	n = 1406		n = 4872			n = 497		n = 1119	
Gender (n, %)[a]					Gender (n, %)				
Male	908	64.6	3152	64.7	Male	207	41.7	439	39.2
Female	498	35.4	1719	35.3	Female	290	58.4	680	60.8
Mean age, Years (SD)[b]	56.7	(13.0)	52.7	(14.1)	Mean age, Years (SD)	48.9	(13.6)	44.8	(13.8)
Foreign medical graduate (n,%)[c]	289	22.4	1065	24.1					
Race and ethnicity (n, %)[d]					Degree type (n, %)[g]				
White	672	47.8	1843	37.8	PharmD	332	66.8	868	77.6
Black	40	2.8	126	2.6	BS	165	33.2	251	22.4
Asian/Pacific Islander	389	27.7	1571	32.2					
Hispanic	40	2.8	226	4.6	Pharmacy school (n, %)				
Other	16	1.1	26	0.5	Foreign school	61	12.3	89	8.0
Decline to state	198	14.1	764	15.7	US school	436	87.7	1030	92.1
Missing	51	3.6	316	6.5	California school	251	50.5	644	57.6
Primary specialty (n, %)[e]									
Internal medicine	186	13.2	589	12.1					
Family medicine	175	12.4	503	10.3					
Psychiatry	116	8.3	250	5.1					
Emergency medicine	93	6.6	185	3.8					
Anesthesiology	78	5.5	228	4.7					
OBGYN	55	3.9	207	4.2					
Pediatrics	84	6.0	295	6.1					
Pain medicine	10	0.7	23	0.5					
Radiology	53	3.8	241	4.9					
Current license	1390	98.9	4450	91.3					
California address[c]	1123	87.1	3419	77.5	California address	444	89.2	974	86.4

[a]1 missing value; [b]weighted average of osteopathic and allopathic physician data; [c] Reported for allopathic physicians only (1,289 responders; 4,412 non-responders); [d] Categories not mutually exclusive; [e] Categories are mutually exclusive; only results for the most common specialty categories are shown; [f] Data missing for 10 pharmacists; [g] PharmD became the required entry-level degree in 2003.

Respondent characteristics

All California pharmacists were required to register for CURES by July 1, 2016. According to California's mandatory CURES registration law (SB-809), only physicians authorized to prescribe controlled substances (i.e., physicians who are licensed in California and who have a DEA license assigned to a California address) are required to register for CURES. Of the physicians surveyed, 91% (n = 1275) reported having a DEA license to prescribe controlled substances, and 78% (n = 995) of physicians with a DEA license reported currently prescribing controlled substances in their practice. Physicians who self-reported not having a DEA license did not answer any further survey questions, because they are not eligible to register for or use CURES. The survey did not prompt physicians to specify whether their DEA license was assigned to an address in California. Thus, it is not possible to determine exactly how many physician respondents had DEA licenses associated with a California address and so were required to register for CURES under SB-809.

Analysis of answers to the open-ended survey question indicated that a large proportion of the 22% of physicians who reported not prescribing controlled substances were retired or not in active clinical practice. Nineteen percent of all physician respondents commented that that they felt CURES was not relevant to their practice, and about half of these responses indicated that this lack of relevance was due to the physician being retired or working outside of California.

Table 3 shows respondent demographics (excluding physicians who reported not having a DEA license to prescribe controlled substances). Physician respondents were predominantly male and white; pharmacist respondents were predominantly female. Pharmacists were 47% Asian and 42% white. Physicians were slightly older than pharmacists.

Table 3. Respondent demographics

	Physicians n = 1275[a]		Pharmacists n = 482	
Item Response	n	%	n	%
Gender				
Male	734	63.9	193	43.3
Female	407	35.4	251	56.3
Other	8	0.7	2	0.4
Did not respond	126		36	
Ethnicity				
Not Hispanic or Latino	1034	93.0	421	97.7
Hispanic or Latino	78	7.0	10	2.3
Did not respond	163		51	
Race and Ethnicity				
American Indian or Alaskan Native	6	0.5	4	0.9
Asian	272	24.6	206	47.1
Black or African American	34	3.1	9	2.1
Hawaiian or Pacific Islander	14	1.3	5	1.1
White	694	62.7	184	42.1
Other	86	7.8	29	6.6
Did not respond	169		45	
	Mean	SD	Mean	SD
Respondent age (years)	55	12.9	49	13.4
Did not respond (n)	152		45	
Years in practice	23	13.2	21	13.7
Did not respond (n)	139		37	

[a]Physicians who reported having a DEA license

Table 4 shows physician-reported specialty and pharmacist-reported practice location. The most common physician specialties were adult primary care (i.e., internal medicine and family medicine) and surgical specialties. The most common pharmacist practice location was chain pharmacy (31%), followed by hospital (26%). Nine percent of pharmacists reported not being involved in patient care. Twelve percent of pharmacists noted in the open-ended survey question that CURES was not relevant to their practice, and many of these specified that CURES was not relevant to their practice because they only dispensed controlled substances in the hospital setting.

Table 4. Practice specialties and dispensing sites of survey respondents

	Physicians n = 1275[a]		Pharmacists n = 482	
Item Response	n	%	n	%
Specialty				
Anesthesiology and pain medicine	81	7.2		
Emergency medicine	98	8.7		
Pediatrics	94	8.3		
Adult primary care	454	40.1		
Psychiatry	110	9.7		
Surgical specialty	166	14.7		
Other	128	11.3		
Did not respond	144			
Dispensing Site				
Chain pharmacy			137	30.8
Hospital			116	26.1
Independent pharmacy			67	15.1
Mass merchandiser			3	0.7
Supermarket			21	4.7
Other patient care practice			60	13.5
Other non-patient care			41	9.2
Did not respond			37	

[a]Demographic counts available for physicians who reported having a DEA license

Prescribing and dispensing practices

The survey included several items designed to gauge how often respondents prescribed or dispensed controlled substances. Based on respondents' description of their clinical practice patterns, physicians who reported prescribing any controlled substances were estimated to prescribe to a mean of 55 patients per month (median=35, interquartile range 22-65). Pharmacists were estimated to dispense or manage a mean of 760 controlled substance prescriptions per month (median=522, IQR 196-1044).

Respondents were also asked about changes in their prescribing and dispensing practices over the past 3 months. As shown in Table 5, 31% of physicians and 20% of pharmacists reported prescribing / dispensing fewer controlled substances, respectively. Very few respondents indicated that they had prescribed / dispensed more controlled substances over the past 3 months.

Table 5. How have your prescribing / dispensing practices changed in the last 3 months?

	Physicians n = 1275[a]		Pharmacists n = 482	
Item Response	n	%	n	%
Prescribe (dispense) far fewer controlled substances	137	11.6	24	5.4
Prescribe (dispense) fewer controlled substances	231	19.6	65	14.7
No change	800	68.0	321	72.5
Prescribe (dispense) more controlled substances	8	0.7	31	7.0
Prescribe (dispense) far more controlled substances	0	0.0	2	0.5
Did not respond	99		39	

[a]Physicians who reported having a DEA license.

Respondents who reported any change in practice were then asked about the reasons for this change (Table 6). For physicians, increased professional awareness of risks and benefits was by far the most commonly cited reason for changes in prescribing, and was endorsed by 65% of physicians who reported a recent change in their prescribing practices. Other common reasons cited by physicians were new clinical guidelines (47%) and increased patient awareness of risks and benefits (37%). The majority of pharmacists (55%) also cited increased professional awareness. For pharmacists, information from CURES was the most common reason endorsed for changes in their dispensing practices (63%); only 25% of physicians endorsed this factor. Other commonly cited reasons pharmacists endorsed for changing dispensing habits were increased professional awareness of risks and benefits (55%) and new clinical guidelines (35%). Among physicians who endorsed "other" reasons, most cited either increased concern about opioid risks or working in a setting that did not involve controlled substance prescribing. *These results suggest that access to CURES has a major effect on pharmacist dispensing practices, and that increased professional awareness of risks and benefits plays a major role in decreased prescribing /dispensing for both physicians and pharmacists.*

Table 6. What factors led you to change your prescribing / dispensing practices [Check all that apply]?

	Physicians n = 376[a]		Pharmacists n = 122[a]	
Item Response	n	%	n	%
Change in practice location or patient mix	90	24.1	36	28.8
Increased professional awareness of risks, benefits, and other solutions	243	65.2	67	54.9
New clinical guidelines and recommendations	175	46.9	43	35.2
CURES providing greater access to patient prescription drug history	94	25.2	77	63.1
Increased patient awareness of risks and benefits	136	36.5	38	31.1
Medico-legal ramifications	103	27.6	14	11.5
Other	55	14.8	14	11.5

[a]Respondents who reported a change in their prescribing or dispensing habits were eligible to answer this question.

Attitudes about use, misuse, and abuse of controlled substances

The first two survey items assessed respondents' attitudes about prescription drug misuse and abuse. Table 7 shows that 87% of physicians and 93% of pharmacists reported being at least moderately concerned about prescription drug misuse and abuse in California; 44% of physicians and 62% of pharmacists were extremely concerned about prescription drug misuse and abuse in California. Overall, respondents were slightly less concerned about prescription drug misuse in their local community compared to the state overall, and pharmacists were substantially more concerned about prescription drug misuse and abuse than physicians.

Table 7. How concerned are you about prescription drug misuse and abuse among patients in:

	Physicians n = 1401[a]				Pharmacists n = 482[a]			
	California		Practice Community		California		Practice Community	
Item Response	n	%	n	%	n	%	n	%
Not concerned at all	42	3.0	65	4.7	2	0.4	9	1.9
Slightly concerned	137	9.8	230	16.5	34	7.1	60	12.6
Moderately concerned	603	43.4	570	41.0	148	30.8	147	30.9
Extremely concerned	609	43.8	525	37.8	296	61.7	260	54.6
Did not respond	10		11		2		6	

[a]All respondents were eligible to answer these items, including physicians who reported that they did not have a DEA license.

The survey also included items about the perceived benefits and risks of controlled substances in California (Figures 1 and 2). Physicians and pharmacists provided similar estimates about perceived benefits and risks for California overall. Based on the responses shown in Figures 1 and 2, the mean estimate for both physicians and pharmacists was that about one-third of patients taking controlled substances in California misused or abused them, whereas fewer than 60% of patients taking controlled substances in California benefited from them

Figure 1. Percent of California patients perceived to misuse or abuse controlled substance medications

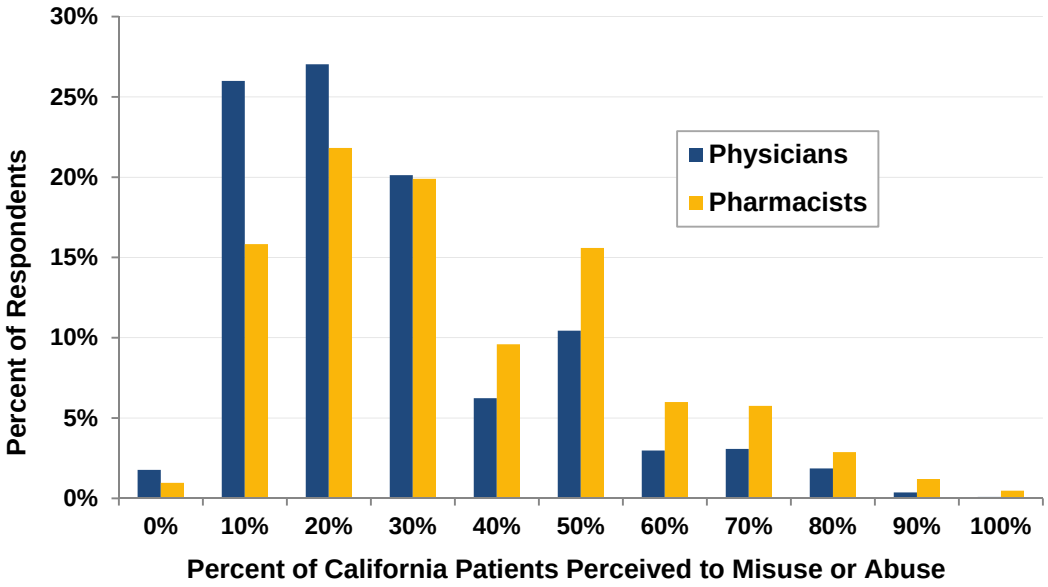
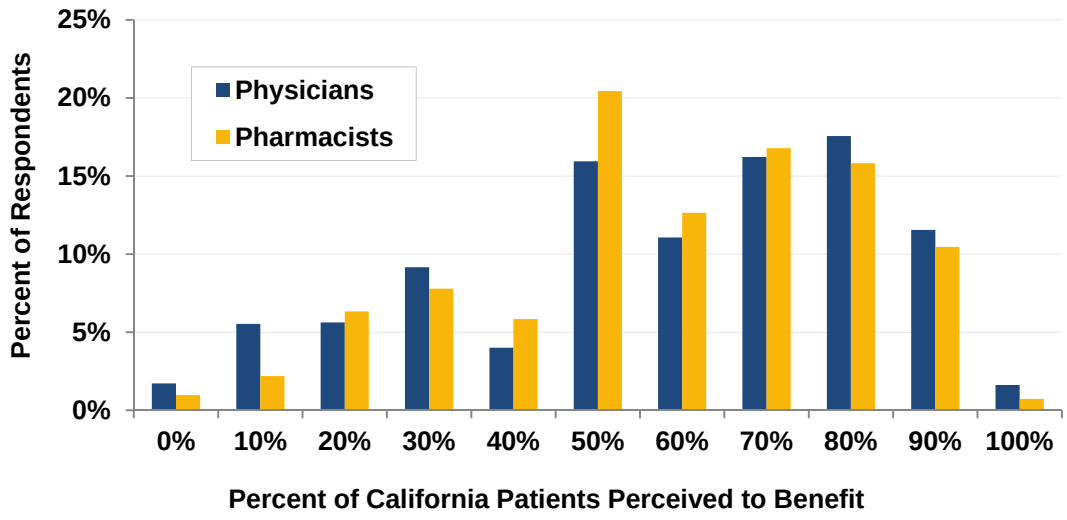


Figure 2. Percent of California patients perceived to benefit from controlled substance medications



Respondents were then asked these same questions specifically about their own patients. Both physicians and pharmacists estimated that the rate of misuse and abuse was substantially lower among their patients compared to all California patients (Figures 3 and 4). This difference may indicate that respondents think their own patients have lower risk of misuse or abuse, or that respondents consider themselves to have safer or more cautious prescribing habits than typical physicians and pharmacists in California.

Figure 3. Physicians: What percent of your own patients (compared with California patients) taking controlled substance medications do you feel misuse or abuse them?

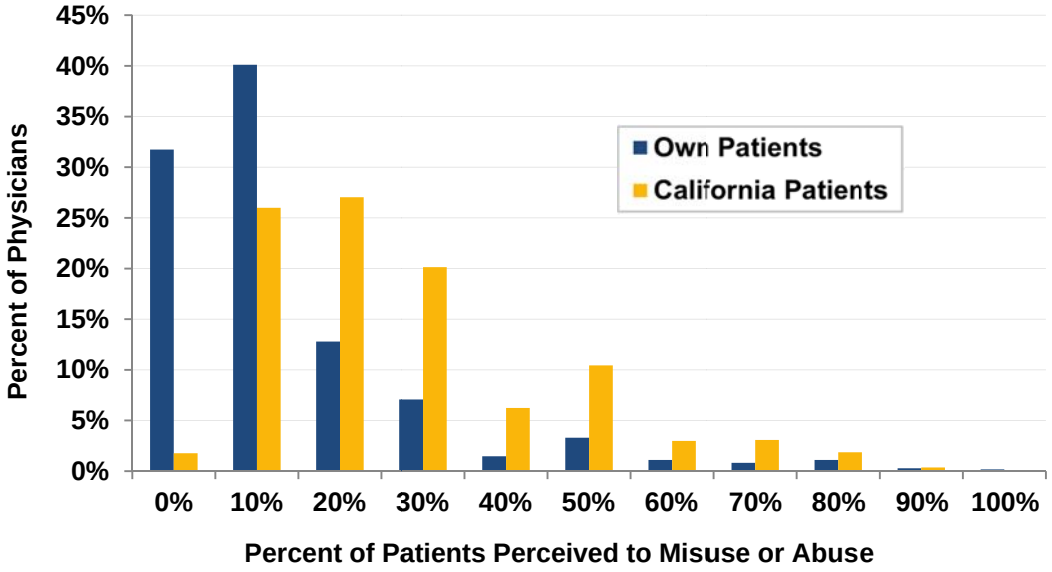
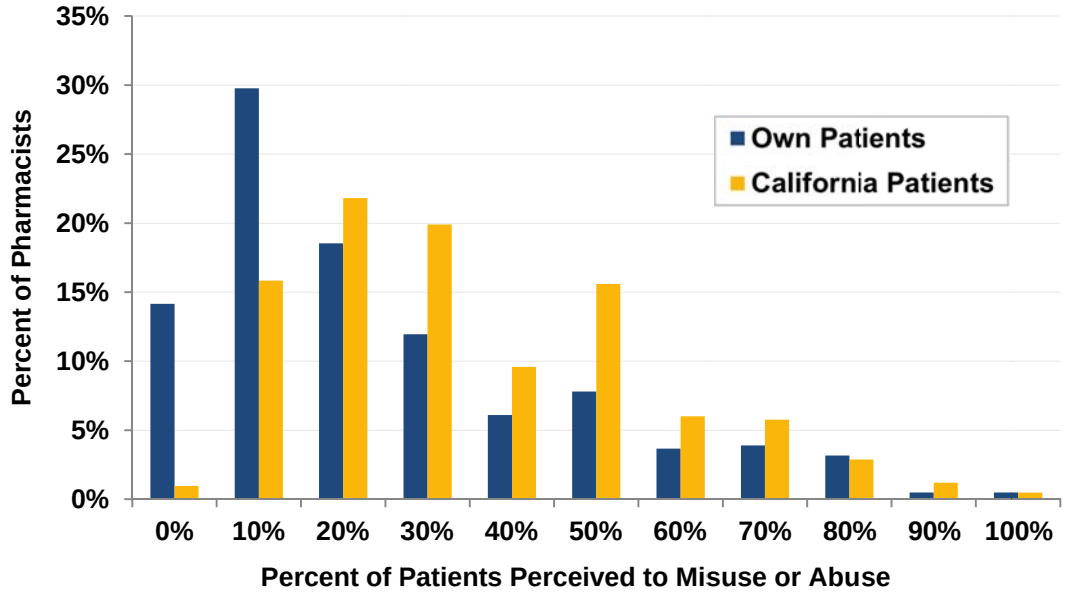
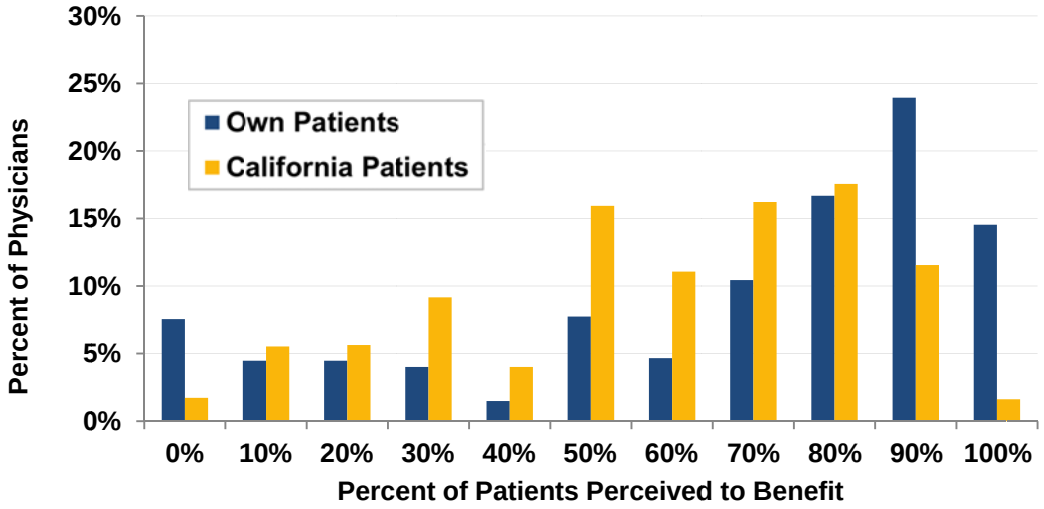


Figure 4. Pharmacists: What percent of your own patients (compared with California patients) taking controlled substance medications do you feel misuse or abuse them?



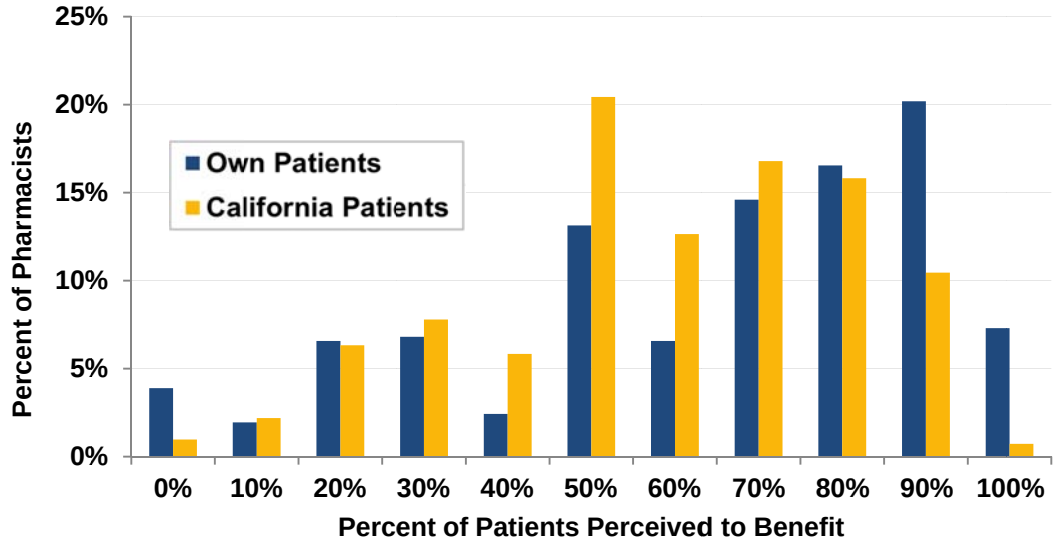
When asked about patient benefit, physicians estimated that a higher proportion of their patients benefited from controlled substances compared to the state average (Figure 5).

Figure 5. Physicians: What percent of your own patients (compared with California patients) taking controlled substance medications do you feel benefit from them?



In contrast, pharmacists estimated that a lower proportion of their patients benefited compared to the state average (Figure 6). This difference between pharmacists and physicians may be due to the fact that physicians have more detailed clinical information on their patients (compared to pharmacists) or that physicians are more inclined to presume that prescriptions they write are helping their patients.

Figure 6. Pharmacists: What percent of your own patients (compared with California patients) taking controlled substance medications do you feel benefit from them?



Awareness of CURES and CURES registration requirement

Tables 8 and 9 show rates of awareness of CURES and CURES registration status, respectively. Nearly all pharmacists and 92% of physicians reported that they had heard of CURES. Among respondents who were required to register for CURES, 82% of physicians and 96% of pharmacists reported that they were either registered or in the process of registering for CURES. Only 18 pharmacists were not registered or in the process of registering, and 16 of these reported that they were likely or very likely to register for CURES in the next 3 months. Of the 231 physicians who were not registered, 70% reported that they were likely or very likely to register for CURES in the next 3 months. *These results indicate that pharmacists have near perfect compliance with mandatory CURES registration. In contrast, only about 82% of DEA-licensed physicians reported compliance with mandatory CURES registration*, though 94% of physicians were either registered or indicated that they were likely to register in the next 3 months.

Table 8. Have you heard of CURES?

	Physicians n = 1275[a]		Pharmacists n = 482	
Heard of CURES?	n	%	n	%
Yes	1156	92.0	464	98.5
No	101	8.0	7	1.5
Did not respond	18		11	

[a]Physicians who reported having a DEA license.

Table 9. Are you registered for CURES?

	Physicians n = 1275[a]		Pharmacists n = 482	
CURES Registration	n	%	n	%
Yes	988	78.7	445	94.7
No	128	10.2	11	2.3
Registration in process	37	2.9	7	1.5
Do not know	103	8.2	7	1.5
Did not respond	19		12	

[a]Physicians who reported having a DEA license.

Tables 10 and 11 show additional information for respondents who had not yet registered for CURES, or who did not know their registration status. Among non-registered physicians, the majority (71%) were not aware that CURES registration was mandatory for DEA-licensed physicians. Separately, 71% of non-registered physicians reported that they were likely to register for CURES in the next 3 months. Among DEA-licensed physicians who were not registered and who reported being unlikely or very unlikely to register for CURES in the next 3

months, nearly half had addresses outside of California (46%; n = 31 of 68). Many physicians with addresses outside California likely also have DEA licenses with non-California addresses, and so are not covered by the mandatory CURES registration requirement.

Table 10. Are you aware that registering for CURES is mandatory for…?

	Physicians[a] n = 231		Pharmacists[a] n = 18	
CURES Registration	n	%	n	%
Yes	65	28.8	8	52.9
No	161	71.2	9	47.1
Did not respond	5		1	

[a]Respondents who reported they had not registered, or did not know if they were registered, were eligible to answer this item.

Table 11. How likely are you to register for CURES within the following month?

	Physicians[a] n = 231		Pharmacists[a] n = 18	
Item Response	n	%	n	%
Extremely unlikely	35	15.5	1	6.3
Unlikely	33	14.6	1	6.3
Likely	76	33.6	5	31.3
Extremely likely	82	36.3	9	56.3
Did not respond	5		2	

[a]Respondents who reported they had not registered, or did not know if they were registered, were eligible to answer this item.

Past and future CURES use

Table 12 shows how long respondents reported having used CURES. Based on the timing of survey administration, those who had been using CURES for 7 months or more likely registered at least a few months prior to implementation of mandatory registration on July 1, 2016. Overall, pharmacists reported having used CURES for longer than physicians. Over half (54%) of pharmacists reported using CURES for more than a year, and 70% reported using CURES for 7 months or more. In contrast, only 33% of physicians reported using CURES for more than a year, and 49% of physicians reported using CURES for 7 months or more. Forty percent of physicians indicated they had been using CURES for 6 months or less, suggesting that physicians were more likely to register at or near the mandatory registration deadline. *These results indicate that pharmacists have been using CURES longer than physicians and were more likely to have registered for CURES before mandatory registration went into effect.*

Table 12. How long have you been using CURES?

	Physicians[a] n = 988		Pharmacists[a] n = 445	
Item Response	n	%	n	%
Less than 3 months	287	29.4	70	15.8
4 to 6 months	210	21.5	61	13.7
7 months to 1 year	158	16.2	75	16.9
More than 1 year	321	32.9	238	53.6
Did not respond	12		1	

[a]Respondents who reported they had registered were eligible to answer this item.

Table 13 indicates respondents' expected likelihood of using CURES at least once in the next 3 months. Overall, pharmacists were much more likely than physicians to report planned use of CURES in the next 3 months. Some of this difference may be due to physicians' and pharmacists' different roles regarding controlled substances.

Table 13. How likely are you to use CURES at least once in the next 3 months?

	Physicians[a] n = 1025		Pharmacists[a] n = 452	
Item Response	n	%[b]	n	%
Extremely unlikely	233	23.1	93	20.7
Unlikely	238	23.6	76	16.9
Likely	240	23.8	75	16.7
Extremely likely	296	29.4	205	45.7
Did not respond	18		3	

[a]Respondents who reported they had registered, or were in process, were eligible to answer this item.

Barriers to CURES registration and use

Table 14 describes barriers to registration among physicians and pharmacists who were not already registered for CURES. Most physicians reported that they knew how to register for CURES; however, 29% indicated that they had more important things to do than registering for CURES and only 19% reported that the registration process takes little time, indicating *that lack of importance and time required for registration were the most commonly reported barriers to registration for physicians.* In contrast, only 13% of physicians reported encountering technical problems when trying to register. Given the small number of pharmacists not registered for CURES, it is difficult to draw meaningful conclusions about barriers to registration among pharmacists.

Table 14. Please indicate the extent to which you agree with the following:

	Physicians[a] n = 231		Pharmacists[a] n = 18	
Item Response	n	%[b]	n	%[b]
I have other problems that are more important than registering for CURES	65	29.4	7	43.8
I know how to go about registering for CURES	123	55.1	7	43.8
Every time I try to register for CURES, something goes wrong	29	13.2	6	37.6
Registering for CURES takes little time	41	18.7	4	35.1
I don't have access to a computer or the internet where I practice	10	4.4	2	12.5

[a]Respondents who reported they had not registered, or did not know if they were registered, were eligible to answer this item.
[b]Percent of respondents indicating they 'somewhat agree' or 'strongly agree' with item.

For respondents who reported being registered for CURES, the survey included several items related to the logistics of accessing and checking CURES. Table 15 shows results for items related to accessing CURES. Overall, physicians reported more difficulty accessing CURES than did pharmacists. For example, 43% of physicians rated registering for CURES as "difficult" or "very difficult" compared to 32% of pharmacists. Other than CURES registration, pharmacist and physicians indicated that remembering security questions was the most common barrier to accessing CURES, with 31% of physicians and 29% of pharmacists indicating that remembering passwords was difficult or very difficult. In the open-ended question, 7% of all physician respondents and 5% of all pharmacist respondents commented on barriers to accessing CURES, such as difficulties with registration and the time required to access CURES.

Table 15. How difficult are the following in CURES?

	Physicians n = 1025[a]		Pharmacists n = 452[a]	
Item Response	n	%[b]	n	%[b]
Registering for CURES	427	42.8	145	32.3
Logging in to CURES	275	28.3	55	12.53
Resetting your password	291	30.4	105	23.92
Remembering security questions	301	31.4	128	28.96

[a]Respondents who reported they had registered, or were in process, were eligible to answer this item.
[b]Percent of respondents indicating item was 'difficult' or 'very difficult'.

Table 16 shows results of items designed to assess non-logistical barriers to using CURES. One quarter (25%) of pharmacists and nearly one-third (32%) of physicians agreed or strongly agreed that CURES was not relevant to their practice. Pharmacists who were practicing in a hospital, a non-clinical setting, or some "other patient care practice" (see Table 4 above) were more likely to agree or strongly agree that CURES was not relevant to their practice than pharmacists working in retail settings (i.e., chain, supermarket, independent or mass merchandiser). Compared to pharmacists, physicians were more likely to agree that CURES was not easy to use, and to agree that they did not know how to use CURES. Very few physicians (9%) and pharmacists (2%) agreed that CURES is not helpful.

Table 16. Please indicate the extent to which you agree with the following:

	Physicians n = 988[a]		Pharmacists n = 445[a]	
Item Response	n	%[b]	n	%[b]
CURES is helpful	594	60.1	356	80.0
CURES is not relevant to my practice	302	30.6	108	24.2
CURES is easy to use	320	32.4	264	59.3
I don't know how to use CURES	194	19.7	31	6.9
CURES is checked by someone else in the office	107	10.8	60	13.5
I have limited or no access to CURES while I practice	112	11.3	45	10.1

[a]Respondents who reported they had registered for CURES were eligible to answer this item.
[b]Percent of respondents indicating they 'agree' or 'strongly agree' with item.

Patterns of CURES use

Table 17 shows frequency of CURES use reported by respondents. Pharmacists reported using CURES more often than physicians. Only 30% reported that they had never used CURES during the past 3 months, and 48% indicated that they used CURES at least daily. In comparison, 44% of physicians reported that they never used CURES, and only 14% reported using CURES at least

daily. These results are consistent with the general finding that pharmacists are more likely to register and use CURES than are physicians.

Table 17. On a typical day when you prescribe (dispense or manage) medications, how many times do you use CURES to look up a patient's controlled substance medication history?

	Physicians n = 1025[a]		Pharmacists n = 452[a]	
Item Response	n	%	n	%
Never	431	44.5	129	29.6
Less than once a day	398	41.1	98	22.5
1-2 times a day	104	10.7	120	27.5
3-5 times a day	24	2.5	36	8.3
6+ times a day	11	1.1	53	12.2
Did not respond	57		16	

[a]Respondents who reported they had registered for CURES, or that their registration was in process, were eligible to answer this item.

The survey included several items asking respondents the percentage of time they checked CURES when prescribing or dispensing a controlled substance, for those who report checking CURES at least once in the last 3 months. Figure 7 shows these results graphically for physicians and pharmacists. For physicians, 28% indicated that they check CURES for least 50% of the *patients* to whom they prescribe controlled substances. For pharmacists, 36% indicated that they check CURES for at least 50% of the controlled substance *prescriptions* they dispense or manage. Although the question did not distinguish between short-term and long-term opioid use, the pattern of CURES use reported by physicians is likely below what would be observed when CURES use becomes mandatory for prescribers in 2018.

Figure 7. When a controlled substance was prescribed, for what percentage of patient visits (physicians) or prescription fills (pharmacists) did you review CURES information (last 3 months)?

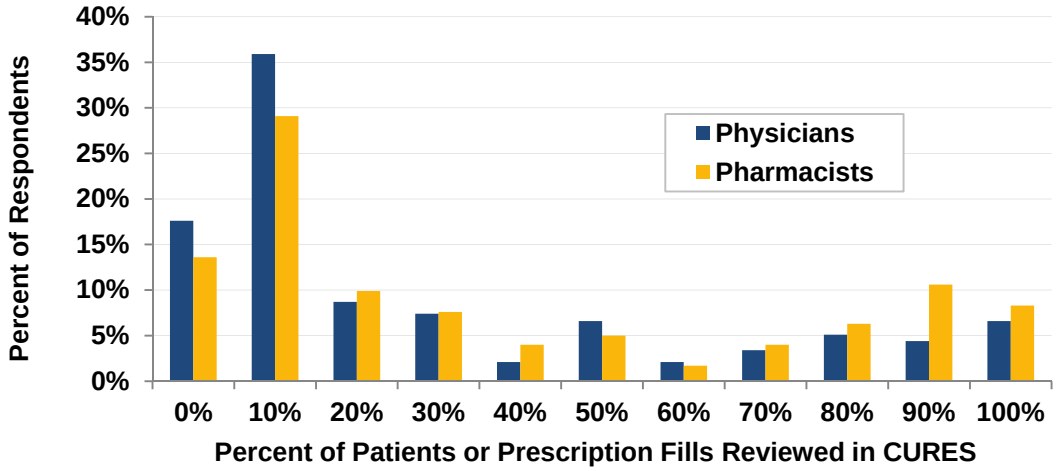
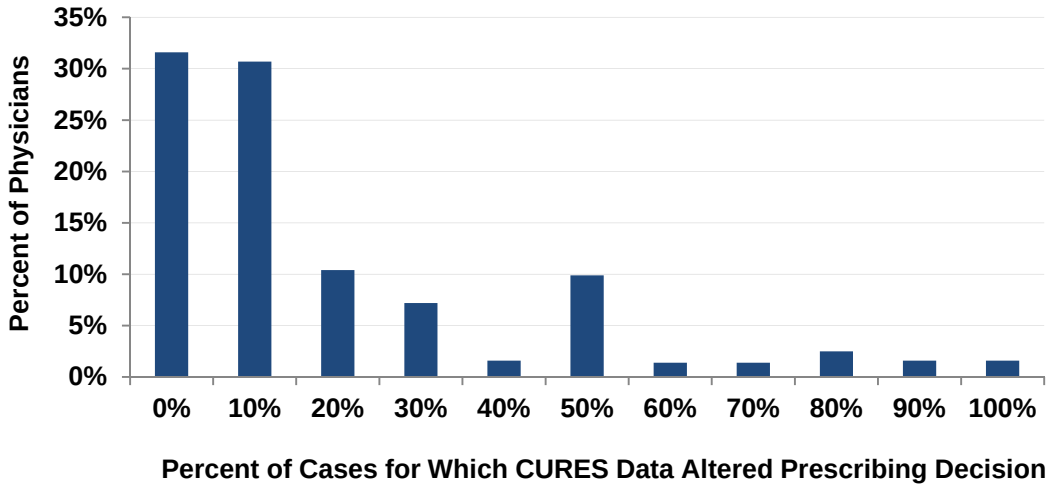


Figure 8 shows physician responses to items asking them to indicate the proportion of time that checking CURES altered their prescribing decision.

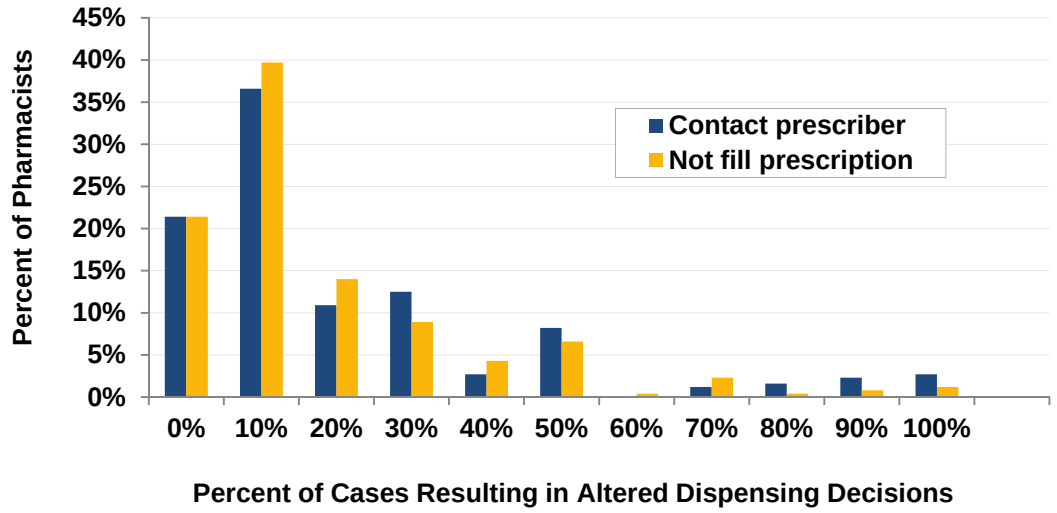
Figure 8. What percent of the time did the information you obtained from CURES alter your prescribing decision (during the past 3 months)?



Overall, results suggest that checking CURES regularly but infrequently caused physicians to change their prescribing decisions. Two-thirds (68%) of physicians reported changing a prescribing decision at least once during the past 3 months based on information they obtained from CURES; however, 63% of physicians reported that checking CURES only affected their prescribing decision in 10% or fewer of the times when they checked CURES. On the other hand, 18% indicated that information obtained from CURES affected their prescribing decision at least 50% of the time that they checked CURES. Of note, these responses do not account for how often physicians checked CURES. In the open-ended response item at the end of the survey, 4% of physicians indicated that CURES should be checked based on physician or pharmacist judgement about the patient. Thus, some physicians likely checked CURES only when they did not know a patient or when they suspected prescription drug misuse or observed unusual patient behavior. It is likely that physicians who reported changing prescribing decisions 50% or more of the time did not check CURES for every patient to whom they prescribed controlled substances, and only checked CURES when they already had a high suspicion for prescription drug misuse.

Figure 9 shows analogous survey results for pharmacists, who were asked to estimate the proportion of time that checking CURES caused them to either contact the prescriber for more information, or to refuse to dispense a controlled substance.

Figure 9. Percent of cases for which pharmacists reviewed patient information in CURES (past 3 months) and altered dispensing decisions.



Response patterns were qualitatively similar to physician responses; 86% and 79% of pharmacists reported that checking CURES caused them to contact the prescriber or refuse to dispense a prescription, respectively, at least once in the prior 3 months. On the other hand, 42% of physicians and 61% of pharmacists reported that checking CURES caused them to contact the prescriber or refuse to dispense, respectively, in 10% or fewer of the times when they checked CURES. As with the physicians, these responses do not account for how often pharmacists checked CURES, so pharmacists who reported contacting the prescriber in most of the cases likely checked CURES only when they had a high suspicion for prescription drug misuse.

Attitudes about the usefulness of CURES

Table 18 lists the reasons that respondents cited for checking CURES. More than three-quarters of physicians and pharmacists endorsed checking CURES prior to prescribing or dispensing a controlled substance in order to look for "doctor shopping." Many respondents also reported checking CURES in order to monitor patients on controlled substances or to improve their communication with patients. Respondents who answered "other" were given the opportunity to type in additional reasons. Many respondents used this open-ended response to note that they do not practice in California or that they work only in inpatient settings. Other reasons provided by respondents included checking on new patients who request controlled substances, evaluating the status of supposedly missing or unfilled prescriptions, helping patients who cannot remember their medications, and to review the fill dates of prior prescriptions.

Table 18. What are your reasons for checking CURES? [Check all that apply]

	Physicians n = 988[a]		Pharmacists n = 445[a]	
Item Response	n	%	n	%
To check on patients prior to dispensing or managing a controlled substance	418	78.0	277	89.4
To look for evidence of "drug seeking"	465	86.9	257	82.9
To monitor patients on controlled substances	365	68.1	246	79.4
To improve my communication with patients regarding controlled substances	258	48.1	187	60.3
Other	35	3.5	28	9.0

[a]Respondents who reported they had registered for CURES were eligible to answer this item.

The survey included multiple items related to respondents' attitudes and beliefs about CURES. Table 19 shows items about the usefulness of CURES for various functions. Overall, pharmacists were more likely to report that CURES was useful or very useful than were physicians. Nearly 90% of pharmacy respondents indicated that CURES was useful or very useful for informing clinical decisions, for identifying "doctor shopping" or "pharmacy shopping," and for identifying patients who misuse or abuse prescriptions drugs. Physician responses in these categories ranged from 62% to 76%. A majority of pharmacists indicated that CURES was useful or very useful for helping manage patients with pain and for building trust with patients. In comparison, 46% of physicians felt that CURES was useful or very useful for helping them to manage patients with pain, and 37% felt that CURES was useful or very useful for helping them to build trust with patients. In the open-ended item at the end of the survey, 7% of all physician respondents and 4% of all pharmacist respondents noted that CURES was a useful or valuable tool. In contrast, 2% of physician respondents and 0.4% of pharmacist respondents used the open-ended item to convey skepticism that CURES was useful for curbing prescription drug abuse.

Table 19. How useful to you is CURES for the following:

	Physicians n = 1025[a]		Pharmacists n = 452[a]	
Item Response	n	%[b]	n	%[b]
Helping manage patients with pain	412	45.5	271	64.5
Helping build trust with patients	333	36.7	243	58.0
Informing decisions to prescribe, dispense, or manage controlled substances	556	61.6	363	86.4
Identifying patients filling prescriptions from multiple doctors and/or pharmacies	685	75.5	374	88.6
Identifying patients who misuse or abuse controlled prescription drugs	672	74.1	370	87.7

[a]Respondents who reported they had registered for CURES, or that their registration was in process, were eligible to answer this item.
[b]Percent of respondents indicating they 'useful' or 'very useful' with item.

Feedback on CURES 2.0

An important survey goal was to get feedback about changes made as part of CURES 2.0, in order to identify what is working well and to identify areas for further improvement. Respondents who reported having used the prior version of CURES were asked to compare CURES 2.0 to the prior version. *As shown in Table 20, more than 90% of respondents rated CURES 2.0 as the same or better across all categories.* For overall ease of use, 43% of physicians and 47% of pharmacists rated CURES 2.0 as an improvement over the prior system. For patient activity reports, 36% of physicians and 52% of pharmacists reported that CURES 2.0 was an improvement over the prior system.

Table 20. Compared to the old website, how would you rate the CURES website on the following characteristics:

	Physicians[a] n = 276						Pharmacists[a] n = 216					
Item Response	Worse		About the same		Better		Worse		About the same		Better	
	n	%	n	%	n	%	n	%	n	%	n	%
Overall ease of use	25	9.1	132	47.8	119	43.1	12	5.6	102	47.2	102	47.2
Login process	16	5.8	163	58.8	98	35.4	8	3.7	125	57.6	84	38.7
Patient activity reports	27	9.8	151	54.7	98	35.5	10	4.6	94	43.3	113	52.1
Help desk support	19	7.3	181	69.1	62	23.7	11	5.2	141	66.8	59	28.0

[a]Respondents who reported they had used the previous version of CURES were eligible to answer this item.

Respondents were also asked about several specific features that were new to CURES 2.0: the ability to send secure peer to peer messages within CURES, the ability to designate delegates to access CURES on one's behalf, automatic alerts for high risk patients, and the ability to flag patients with whom a physician has signed a controlled substance agreement ("compact"). As shown in Table 21, most respondents had never heard of these new features. Only 3% of pharmacists reported having used each of these new features at least once. Similarly, very few physicians reported having used the messaging function (2%), the ability to flag controlled substance agreements (3%), the delegate function (5%), or the automatic alerts (5%) at least once.

Table 21. Are you aware of the following new features in CURES?

	Physicians n = 988[a]		Pharmacists n = 452[a]	
Item Response	n	%[b]	n	%[b]
Sending secure peer-to-peer messages about specific patients	755	77.7	308	70.6
Giving delegates the ability to access to CURES on your behalf	665	68.5	331	76.3
Automatic alerts for high risk patients	721	74.3	319	73.3
The ability to flag patients who have patient-provider agreements	671	69.1	Not Applicable	

[a]Respondents who reported they had registered for CURES were eligible to answer this item.
[b]Percent of respondents indicating they never heard of the feature.

When asked whether they felt they needed additional training or education about CURES, 47% of physicians and 40% of pharmacists responded affirmatively. The most commonly identified need for additional training related to the new advanced features of CURES 2.0. As shown in Table 22, physicians most commonly indicated needing additional training or education about flagging patients with controlled substance agreements (63%), sending secure messages (54%), and running patient activity reports (57%). Pharmacists most commonly indicated needing additional training about how automatic reports are generated (68%), sending secure messages (76%), and using the delegate feature (55%).

Table 22. What would you like additional training on? [Check all that apply]

	Physicians n = 949[a]		Pharmacists n = 205[a]	
Item Response	n	%[b]	n	%[b]
Registering for CURES	158	24.7	29	13.2
CURES passwords and security questions	134	20.9	33	15.0
Running patient activity reports	362	56.6	108	49.1
Identifying and using CURES delegates from my account	301	47.0	121	55.0
Sending secure messages	345	53.9	167	75.9
How automatic reports are generated	317	49.5	149	67.7
Flagging patients who have patient-provider agreements	400	62.5	Not Applicable	
Other topics	58	9.1	15	6.8

[a]Respondents who indicated a need for additional training or education about CURES (or skipped the item) were eligible to answer this item.
[b]Percent of respondents identifying the topic as needed.

Professional attitudes and beliefs related to CURES

Respondents who reported being registered for CURES had similar responses related to social norms, or respondents' beliefs about their colleagues' use of CURES. Both physicians (Figure 10) and pharmacists (Figure 11) tended to think that the proportion of their colleagues using CURES at least weekly was lower than the proportion of their colleagues who *ought* to be using CURES weekly. In other words, respondents felt that some of their colleagues who should be using CURES regularly were not doing so.

Figure 10. Physicians: What percentage of your colleagues do you feel are (or ought to be) using CURES at least weekly?

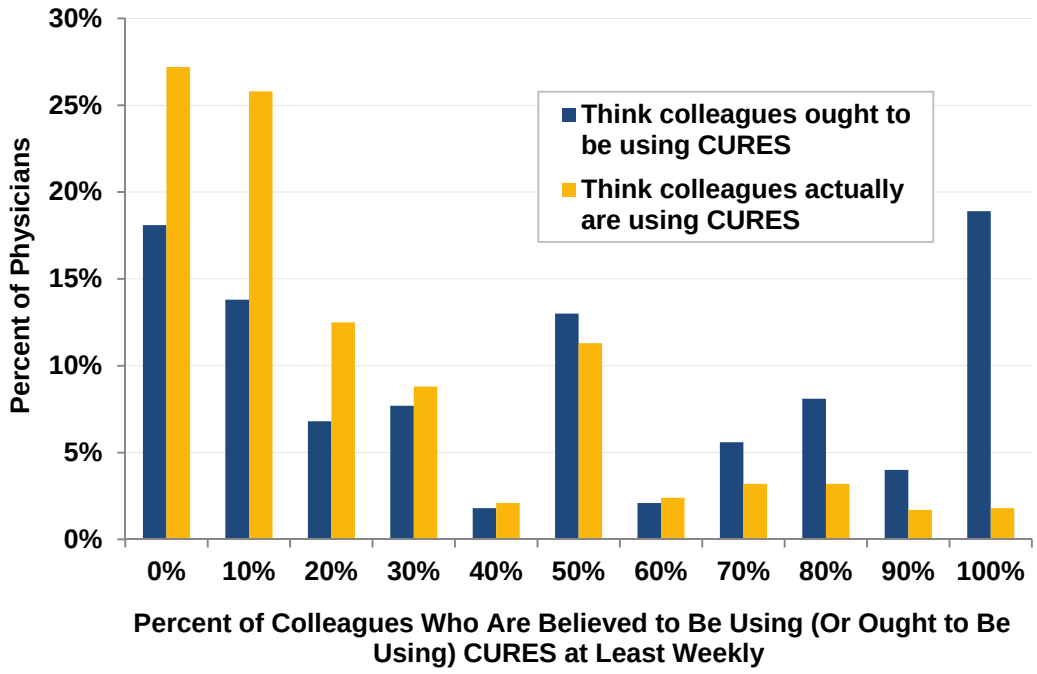


Figure 11. Pharmacists: What percentage of your colleagues do you feel are (or ought to be) using CURES at least weekly

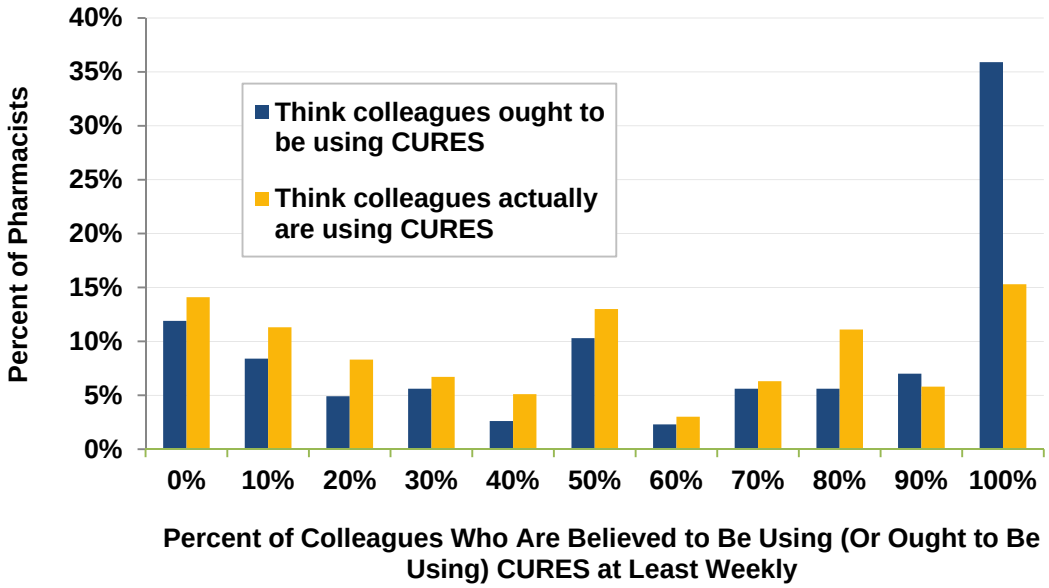


Table 23 summarizes information from Figures 8 and 9 and shows that, on average, pharmacists' estimates of the proportion of their colleagues *using* CURES were higher than physicians' estimates (means = 49% and 24%, respectively). Similarly, pharmacists had higher estimates than physicians for proportion of their colleagues who *ought* to be using CURES (means = 62% and 47%, respectively). As shown in Figures 8 and 9, 19% of physicians and 36% of pharmacists felt that their colleagues ought to be using CURES 100% of the time when prescribing or dispensing controlled substances.

Table 23. What percent of your colleagues do you feel… ?

	Physicians n =1275[a]		Pharmacists n = 482[b]	
	Mean	SD	Mean	SD
Item Response	%	%	%	%
Use CURES at least weekly	23.8	25.9	48.9	35.3
Ought to be using CURES at least weekly	46.5	37.3	61.6	38.1

[a]Of 1275 total DEA-licensed physicians eligible to answer this question, question 1 (n = 1100) and question 2 (n = 1088).
[b]Of 482 total pharmacists, question 1 (n = 432) and question 2 (n = 429).

The questions in Table 24 relate to beliefs about CURES use and regulation. *A substantial majority of physicians (81%) and pharmacists (91%) agreed that their colleagues should check CURES when prescribing or dispensing a controlled substance, respectively. In contrast, only 23% of physicians felt that physicians should be required to check CURES when prescribing. The corresponding value for pharmacists was 39%, indicating that about two-fifths of pharmacists supported mandatory CURES use*

for their colleagues. The survey did not directly ask pharmacists about requirements for physicians (or vice versa). In the open-ended question, 3% of pharmacists commented that prescribers should use CURES more often.

Table 24. Should physicians / pharmacists…

	Physicians n = 1275[a]		Pharmacists n = 482[a]	
Item Response	n	%[b]	n	%[b]
Check CURES when prescribing / dispensing a controlled substance?	728	80.6	367	91.3
Be *required* to check CURES when prescribing / dispensing a controlled substance	218	22.6	152	39.2

[a]Total DEA-licensed physicians and pharmacists eligible to answer.
[b]Percent of respondents who answered "yes" to this item

While the survey was being administered, California passed a new law that, when implemented, will require physicians (and other prescribers) to use CURES when prescribing controlled substances (SB-482). Some survey reminders to physicians mentioned this new law in order to increase physician survey response rates. To evaluate whether passage of the new law (or the survey reminders mentioning the new law) affected results, we analyzed survey responses to the items in Table 24 based on the date that physician respondents took their survey. Seventy-six percent of physicians who took the survey before the Governor signed SB-482 agreed that physicians should check CURES prior to prescribing a controlled substance, compared to 83% of physicians who took the survey after the Governor signed SB-482. Only 19% of physicians who took the survey before the new law was signed agreed that physicians should be required to check CURES prior to prescribing a controlled substance, compared to 25% of physicians who took the survey after the new law was signed. Thus, we found no evidence of a "backlash" by physicians in response to SB-482. In contrast, physicians who took the survey after the new law was signed were more likely to agree that physicians should be required to check CURES before prescribing controlled substances.

Table 25 shows results for survey items relating to respondents' professional and moral obligations to use CURES. Pharmacists indicated greater obligations to use CURES than did physicians, though a majority of physicians did agree that they had a professional responsibility to check CURES and that checking CURES when prescribing controlled substances is the right thing to do. *Over two-thirds of pharmacists (69%) agreed that checking CURES was considered standard of care, compared to 40% of physicians.* In contrast relatively few respondents agreed with negatively worded items on this topic.

Table 25. Please indicate the extent to which you agree with the following…[a]

Item Response	Physicians n = 1275[a]		Pharmacists n =482[a]	
	n	%[b]	n	%[b]
I have a professional responsibility to check CURES when prescribing /dispensing controlled substances	623	52.6	353	77.6
Checking CURES when prescribing / dispensing controlled substances is the right thing to do	710	60.0	368	80.7
Using CURES when prescribing / dispensing controlled substances is considered standard of care	446	37.9	310	68.7
Prescribing / dispensing controlled substances without checking CURES would be morally wrong	190	16.2	142	31.5
Checking CURES when prescribing /dispensing controlled substances is NOT a necessary part of my job	290	24.7	59	13.1

[a]Physicians who reported having a DEA license (valid denominator n per item ranged from 1171-1184) and pharmacist respondents (valid denominator n per item ranged from 451-456) were eligible to answer this item.
[b]Percent of respondents indicating they "agree" or "strongly agree" with item.

Content analysis of responses to the open-ended survey question

Table 26 shows results of the content analysis performed on a single open-ended survey question, "Is there anything else you would like to tell us about CURES (e.g., problems, recommendations)?" Sixty-three percent (n = 597 of 1275) of DEA-licensed physicians and 56% (n = 270 of 482) of pharmacists provided responses to the question. Thus, responses were received from approximately half (49%, n=867 of 1757) of all survey respondents who were eligible to answer the open-ended question.

For both physicians and pharmacists, the most common response category was "relevance," indicating that respondents felt that CURES was not relevant to their practice. Many of the comments in this category indicated that the respondent was retired or no longer working in California. However, many other respondents indicated that they felt CURES was not relevant to them because they rarely prescribed controlled substances or because the respondents were confident that none of their patients were "doctor shopping" or misusing controlled substances. Several physicians commented that they only checked CURES for new patients. After "relevance," the second most common category for pharmacists was "data." Thirty-four pharmacists (7% of all pharmacist respondents) complained about the quality and accuracy of CURES data, with several indicating that they felt CURES data accuracy should be improved and/or that the time lag between dispensing prescriptions and data showing up in CURES reports was too long. This category of responses also included comments about the lack of Veterans Health Administration or out of state prescriptions in CURES. Pharmacists typically dispense many more controlled substances than physicians, which likely explains why pharmacists were more attuned to the need for improved CURES data quality than were

physicians. For physicians, the second most common categories included difficulty accessing (7%) or using (8%) CURES, along with positive statements indicating that CURES had value or was useful to physicians (7%). Comments about difficulty using CURES most often related to the amount of time needed to access CURES and run patient reports while working in clinic.

Table 26. Definitions and frequency of content codes derived from the open-ended survey question[a]

Code	Definition	Physicians n =1275[b]		Pharmacists n =482	
		n	%	n	%
Access	Problems with registration, login, password or security questions, help desk, customer service	85	6.7	27	5.4
Difficulty	Difficulty using CURES, including time consuming, website not user friendly, difficult to generate reports,	99	7.8	14	2.8
Regulation	Loss of physician autonomy, micromanaging patient care, social control by state/ medical board / DOJ, red tape	39	3.1	5	1.0
Relevance	CURES not relevant to respondent due to various reasons, including out of state, retired, specialty, practice patterns, or patient population	240	18.8	61	12.1
Data	Limitations related to CURES data, including timeliness of data, absence of out of state prescriptions, other data quality problems	32	2.5	34	6.8
Laws	Comments about whether CURES should or should not be legally required, either laws for mandatory CURES registration or mandatory CURES use	47	3.7	8	1.6
Value	Positive statements about CURES indicating that it is valuable, helpful, or useful in some way	87	6.8	22	4.4
Skepticism	Statements that CURES is not effective or not useful for curbing drug abuse	19	1.5	2	0.4
Training	Statements about needing training or help to use CURES or better use CURES	21	1.6	8	1.6
Misinform	Statements that are factually incorrect	2	0.2	1	0.2
Suggestion	Concrete suggestions for making CURES better not covered in other categories	51	4.0	31	6.2
Care	Comments that CURES impacts quality of care or patient care	27	2.1	2	0.4
Pharmacist	Comments about how pharmacists should use CURES (physicians only)	11	0.9	0	n/a
Prescriber	Comments about how prescribers / physicians should use CURES (pharmacists only)	0	n/a	16	3.2
Judgment	Comments that using CURES should be based on physician/pharmacist judgment	55	4.3	5	1.0
Aware	Comments that person is not aware of CURES or doesn't know how to use it	21	1.6	3	0.6
Cost	Cost of CURES license fee; productivity costs that mention money	3	0.2	4	0.8
Misc	Any response that does not fit in any of the above categories	58	4.5	46	9.1
None	Respondent left question blank	671	52.6	270	53.7

[a]Responses could be counted in multiple categories.
[b]Physicians who reported having a DEA license were eligible to answer this question

Qualitative analysis of responses to the open-ended survey question

Forty-nine percent (n=867) of sample respondents (n=1757) answered the open-ended question, "Is there anything else you would like to tell us about CURES? (e.g., problems, recommendations)." A qualitative analysis of responses revealed four major themes illustrating attitudes and perceptions of CURES among physicians and pharmacists: (1) cost of using CURES (2) interference with professionalism (3) shifting responsibility and (4) benefits and future direction of CURES. These four major themes are explained in detail in the sections below. Overall, responses from physicians and pharmacists were similar with some exceptions. Pharmacists expressed more positive perceptions of CURES, but were more likely than physicians to report limitations including timeliness and accuracy of data as well as lack of inclusion of data from federal pharmacies in California, such as Veterans Health Administration pharmacies. The qualitative analysis also collected general and specific recommendations that respondents gave for increasing the use and utility of CURES among California physicians and pharmacists.

Cost of using CURES

Costs of using CURES comprise the time required to routinely access and enter patient information as well as the actual monetary cost associated with registration. Both groups of participants expressed that using CURES requires a significant amount of time which reduces the quality of the patient/customer interaction and thus negatively impacts the quality of care provided. A few physicians also expressed a decreased willingness to prescribe opioids due perceived barriers.

> *"…checking CURES has to fit efficiently into a busy primary care workflow, or else providers will burn out and choose not to prescribe opioids to anyone, even if indicated. The decision to prescribe opioids to patients is already a challenging process."* (Physician)

> *"I strongly disagree that pharmacists be required legally to check CURES before dispensing because it is a legal burden. Pharmacists should be encouraged and fully trained without a fee to use CURES, but not required."* (Pharmacist)

> *"CURES is a great resource, but too much CURES will interfere with clinical care. Time should be spent with the patient, not with the database."* (Physician)

Interference with professionalism

While physicians were slightly more likely to express lack of autonomy, professional judgement, and relevance as reasons for not mandating the use of CURES, pharmacists also shared concerns about relevance; some pharmacists who worked in hospital settings indicated that CURES was not relevant to their daily work. Many physicians reported that CURES was irrelevant to their

practice for a variety of reasons including: prescribing patterns, trust and established relationship with patients, medical specialty, pharmacy practice location, and the fact that they use professional judgement. Physicians who rarely, if ever, prescribe controlled substances believed that they should be exempt from using CURES along with pharmacists who work outside of retail settings.

> "*I work in an inpatient setting. CURES, for the most part, is irrelevant to my practice. Perhaps I need further training on how it applies to my work*." (Pharmacist)

> "*An astute physician knows when to check with CURES or prior colleagues treating his patients…*" (Physician)

> "*As it is I generally only use it CURES when someone is demonstrating drug seeking behavior.*" (Physician)

Shifting responsibility

Perceptions of who should be responsible for consulting CURES were contingent on one's role in health care. Many physicians hold pharmacists accountable for using CURES because pharmacists dispense medications. At the same time, some pharmacists shifted responsibility to physicians, noting that physicians have the prescription writing privileges and so have greater responsibility for preventing prescription drug misuse.

> *"I think all prescribers of controlled substances should be required to check CURES before they write prescriptions. The sole responsibility of should not be with pharmacists."* (Pharmacist)

> "*Pharmacists should check on all patients and send notice to us [physicians*]." (Physician)

> "*Unless MDs are forced to buy in you are making me the policeman…unless there are consequences for the MD by the Medical Association nothing will ever change."* (Pharmacist)

> *"Pharmacy involvement should be greater in monitoring patients that reflect misuse."* (Physician)

Benefits of CURES and future directions

While both groups reported various concerns regarding CURES, they also expressed many benefits and suggestions for improving the process. An appreciation for the underlying philosophy of CURES was evident in the open-ended responses.

> *"CURES is a wonderful contribution to help identify patients who are 'doctor shopping' for opioids (Physician).*

> *"CURES is very helpful in ensuring honesty from patients in the patient-pharmacist relationship." (Pharmacist)*

A variety of recommendations was suggested by both physicians and pharmacists and includes: increased training and advertisement around CURES, data updates in real time, and expansion to include out-of-state patient information. Some of these recommendations (e.g., the ability to save commonly-used patient searches) actually already exist in CURES 2.0, while others (e.g., including out-of-state prescriptions and decreasing data lag time) would require new state legislation.

> *"*CURES *should be part of a network like insurance DUR system, so without logging in pharmacists get prompted about prescriptions filled at other places."* (Pharmacist)

> *"Great program. Needs to be promoted more along with further training. Would be good if there were an incentive for less than conscience physicians to use the program."* (Physician)

> *"Some of the chains [pharmacies] have firewalls when it comes to resetting passwords and when trying to reset on a mobile device it does not work. Fixing this problem would be very helpful."* (Pharmacist)

General recommendations made in open-ended responses

- Offer incentives to encourage physicians and pharmacists to use CURES
- Promote CURES to increase awareness and visibility
- Provide additional CURES training
- Improve usability of CURES (including use on mobile devices)

Specific recommendations made in open-ended responses:

- Provide access to out-of-state prescription information
- Store patient names in memory bank to save time on repeat patient searches
- Alert pharmacists when patients get prescriptions filled at other pharmacies
- Update data in real time (currently CURES has a 1-week submission lag time).
- Track and report over-prescribers
- Link registered aliases and legal name changes
- Track identify theft and fraud in conjunction with prescriptions drugs

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Appendix A CURES MBC survey

Q52 How concerned are you about prescription drug misuse and abuse among:

	Not concerned at all (0)	Slightly concerned (1)	Moderately concerned (2)	Extremely concerned (3)
Patients in California (1)	❍	❍	❍	❍
Patients in the community where you practice (2)	❍	❍	❍	❍

Q2 Do you currently have a DEA license to prescribe controlled substances?
- ❍ Yes (1)
- ❍ No (0)

If No Is Selected, Then Skip To End of Survey

Q4 Do you currently prescribe controlled substances in your practice?
- ❍ Yes (1)
- ❍ No (0)

Q8 Now we would like you to think about the last 3 months.

Q9 On average, how many days a week do you see patients?

Q10 On average, how many patients do you see per day?

Display This Question:
If Do you currently prescribe controlled substances in your practice? Yes Is Selected

Q11 On average, for how many of the patients that you see per day do you prescribe a controlled substance?

Q5 Now we'd like to ask you some questions about California's Controlled Substance Utilization Review and Evaluation System (CURES). CURES is California's online, computer-based system for monitoring the prescribing of all Schedule II, III and IV controlled substances dispensed in California. Have you heard of CURES?
- ❍ Yes (1)
- ❍ No (0)

Q7 Are you registered for CURES?
- ❍ Yes (1)
- ❍ No (2)
- ❍ Registration in process (3)
- ❍ Do not know (4)

Q12 Are you aware that registering for CURES is mandatory for DEA-licensed physicians?
- ❍ Yes (1)
- ❍ No (0)

Q13 How likely are you to register for CURES within the following month?
- ❍ Extremely unlikely (1)
- ❍ Unlikely (2)
- ❍ Likely (3)
- ❍ Extremely likely (4)

Q14 Please indicate the extent to which you agree with the following:

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I have other problems that are more important than registering for CURES. (2)	❍	❍	❍	❍	❍
I know how to go about registering for CURES. (3)	❍	❍	❍	❍	❍
Every time I try to register for CURES, something goes wrong. (5)	❍	❍	❍	❍	❍
Registering for CURES takes little time. (4)	❍	❍	❍	❍	❍
I don't have access to a computer or the internet where I practice. (6)	❍	❍	❍	❍	❍

Display This Question:
If Are you registered for CURES? Yes Is Selected

Q34 How long have you been using CURES?
- ❍ Less than 3 months (1)
- ❍ 4 to 6 months (2)
- ❍ 7 months to 1 year (3)
- ❍ More than 1 year (4)

Q17 How likely are you to use CURES at least once in the next 3 months?
- ❍ Extremely unlikely (1)
- ❍ Unlikely (2)
- ❍ Likely (3)
- ❍ Extremely likely (4)

Q15 How difficult are the following in CURES?

	Very difficult (5)	Difficult (4)	Average (3)	Easy (2)	Very easy (1)
Registering for CURES (1)	❍	❍	❍	❍	❍
Logging in to CURES (2)	❍	❍	❍	❍	❍
Resetting your password (3)	❍	❍	❍	❍	❍
Remembering security questions (4)	❍	❍	❍	❍	❍

Display This Question:
If Are you registered for CURES? Yes Is Selected

Q16 Now we would like you to think about the last 3 months.On a typical day when you see patients, how many times do you use CURES to look up a patient's controlled substance medication history?
- ❍ Never (1)
- ❍ Less than once a day (5)
- ❍ 1-2 times a day (2)
- ❍ 3-5 times a day (3)
- ❍ 6+ times a day (4)

Q18 Please indicate the extent to which you agree with the following:

	Strongly disagree (1)	Disagree (2)	Neither agree nor disagree (3)	Agree (4)	Strongly Agree (5)
CURES is helpful (2)	❍	❍	❍	❍	❍
CURES is not relevant to my practice (3)	❍	❍	❍	❍	❍
CURES is easy to use (4)	❍	❍	❍	❍	❍
I don't know how to use CURES (5)	❍	❍	❍	❍	❍
CURES is checked by someone else in the office (6)	❍	❍	❍	❍	❍
I have limited or no access to CURES while I practice (7)	❍	❍	❍	❍	❍

Display This Question:
If We would like you to think about the last 3 months. On a typical day when you see patients, how m... Never Is Not Selected
And Are you registered for CURES? Yes Is Selected

Q19 What are your reasons for checking CURES? [Check all that apply]
- ❑ To check on patients prior to prescribing a controlled substance. (1)
- ❑ To look for evidence of “drug seeking.” (5)
- ❑ To monitor patients on controlled substances. (2)
- ❑ To improve my communication with patients regarding controlled substances. (7)
- ❑ Other (6) _____

Display This Question:
If We would like you to think about the last 3 months. On a typical day when you see patients, how m... Never Is Not Selected
And Are you registered for CURES? Yes Is Selected

Q20 Thinking about the past 3 months, for what percentage of patient visits that resulted in a prescription for controlled substances did you review CURES information?
- ❍ 0% (0)
- ❍ 10% (1)
- ❍ 20% (2)
- ❍ 30% (3)
- ❍ 40% (4)
- ❍ 50% (5)
- ❍ 60% (6)
- ❍ 70% (7)
- ❍ 80% (8)
- ❍ 90% (9)
- ❍ 100% (10)

Display This Question:
If Thinking about the past 3 months, for what percentage of patient visits that resulted in a prescr... 0% Is Not Selected
And We would like you to think about the last 3 months. On a typical day when you see patients, how m... Never Is Not Selected
And Are you registered for CURES? Yes Is Selected

Q21 Consider the patient visits for which you have reviewed CURES in the past 3 month period. For what percent of these cases did the information you obtained from CURES alter your prescribing decision?
- ❍ 0% (0)
- ❍ 10% (1)
- ❍ 20% (2)
- ❍ 30% (3)
- ❍ 40% (4)
- ❍ 50% (5)
- ❍ 60% (6)
- ❍ 70% (7)
- ❍ 80% (8)
- ❍ 90% (9)
- ❍ 100% (10)

Display This Question:
If Are you registered for CURES? Yes Is Selected

Q28 How useful to you is CURES for the following:

	Very Useful (4)	Useful (3)	A little useful (2)	Not useful at all (1)
Helping manage patients with pain (1)	❍	❍	❍	❍
Helping build trust with patients (2)	❍	❍	❍	❍
Informing decisions to prescribe controlled substances. (4)	❍	❍	❍	❍
Identifying patients filling prescriptions from multiple doctors and/or pharmacies (5)	❍	❍	❍	❍
Identifying patients who misuse or abuse controlled prescription drugs (6)	❍	❍	❍	❍

Q27 Are you aware of the following new features in CURES?

	Never heard of it (0)	Heard of it, but never use it (1)	Used it at least once (2)
Sending secure peer-to-peer messages about specific patients (2)	❍	❍	❍
Giving delegates the ability to access to CURES on your behalf (4)	❍	❍	❍
The ability to flag patients who have patient-provider agreements (3)	❍	❍	❍
Automatic alerts for high risk patients (5)	❍	❍	❍

Display This Question:
If Are you registered for CURES? Yes Is Selected

Q31 Did you use the previous version of CURES in your practice?

❍ Yes (1)
❍ No (0)

Display This Question:
If Did you use the previous version of CURES in your practice? Yes Is Selected
And Are you registered for CURES? Yes Is Selected

Q32 Compared to the old website, how would you rate the new CURES website on the following characteristics?

	Much worse (-2)	Somewhat worse (-1)	About the same (0)	Somewhat better (1)	Much better (2)
Overall ease of use (1)	❍	❍	❍	❍	❍
Login process (2)	❍	❍	❍	❍	❍
Patient Activity Reports (3)	❍	❍	❍	❍	❍
Help Desk support (4)	❍	❍	❍	❍	❍

Q29 Do you feel that you need additional training or education about CURES?
- ❍ Yes (1)
- ❍ No (0)
- ❍ Don't know (2)

Display This Question:
If Do you feel that you need additional training or education about CURES? Yes Is Selected
Or Do you feel that you need additional training or education about CURES? Don't know Is Selected

Q30 What would you like additional training on? [Check all that apply]
- ❑ Registering for CURES (1)
- ❑ CURES passwords and security questions (2)
- ❑ Running patient activity reports (3)
- ❑ Identifying and using CURES delegates from my account (4)
- ❑ Sending secure messages (5)
- ❑ How automatic reports are generated (6)
- ❑ Flagging patients who have patient-provider agreements (7)
- ❑ Other topics (8) _____

Q33 Now we would like to ask you some general questions about monitoring patient's controlled substance medications using systems such as CURES.

Q54 Should physicians check CURES prior to writing a prescription for a controlled substance?
- ❍ Yes (1)
- ❍ No (0)
- ❍ Don't know (2)

Q55 Should physicians be required to check CURES prior to writing a prescription for a controlled substance?
- ❍ Yes (1)
- ❍ No (0)
- ❍ Don't know (2)

Q56 What percentage of your colleagues do you think use CURES at least weekly?
- ❍ 0% (1)
- ❍ 10% (2)
- ❍ 20% (3)
- ❍ 30% (4)
- ❍ 40% (5)
- ❍ 50% (6)
- ❍ 60% (7)
- ❍ 70% (8)
- ❍ 80% (9)
- ❍ 90% (10)
- ❍ 100% (11)

Q57 What percentage of your colleagues do you feel ought to be using CURES at least weekly?
- ❍ 0% (1)
- ❍ 10% (2)
- ❍ 20% (3)
- ❍ 30% (4)
- ❍ 40% (5)
- ❍ 50% (6)
- ❍ 60% (7)
- ❍ 70% (8)
- ❍ 80% (9)
- ❍ 90% (10)
- ❍ 100% (11)

Q35 I have a professional responsibility to check CURES when prescribing controlled substances.
- ❍ Strongly agree (5)
- ❍ Agree (4)
- ❍ Neither agree nor disagree (3)
- ❍ Disagree (2)
- ❍ Strongly disagree (1)

Q36 Checking CURES when prescribing controlled substances is the right thing to do.
- ❍ Strongly agree (5)
- ❍ Agree (4)
- ❍ Neither agree nor disagree (3)
- ❍ Disagree (2)
- ❍ Strongly disagree (1)

Q37 Using CURES when prescribing controlled substances is considered standard of care.
- ❍ Strongly agree (5)
- ❍ Agree (4)
- ❍ Neither agree nor disagree (3)
- ❍ Disagree (2)
- ❍ Strongly disagree (1)

Q38 Prescribing controlled substances without checking CURES would be morally wrong.
- ❍ Strongly agree (5)
- ❍ Agree (4)
- ❍ Neither agree nor disagree (3)
- ❍ Disagree (2)
- ❍ Strongly disagree (1)

Q39 Checking CURES when prescribing controlled substances is NOT a necessary part of my job.
- ❍ Strongly agree (1)
- ❍ Agree (2)
- ❍ Neither agree nor disagree (3)
- ❍ Disagree (4)
- ❍ Strongly disagree (5)

Q40 Now we would like to ask you some questions regarding your prescribing practices more generally.

Q41 How have your prescribing practices changed in the last 3 months?
- ❍ I prescribe FAR FEWER controlled substances (-2)
- ❍ I prescribe FEWER controlled substances (-1)
- ❍ No change (0)
- ❍ I prescribe MORE controlled substances (1)
- ❍ I prescribe FAR MORE controlled substances (2)

If No change Is Selected, Then Skip To End of Block

Q42 What factors led you to change your prescribing practices? [Check all that apply]
- ❑ Change in practice location or patient mix (1)
- ❑ Increased professional awareness of risks, benefits, and other solutions (3)
- ❑ New clinical guidelines and recommendations (4)
- ❑ CURES providing greater access to patient prescription drug history (6)
- ❑ Increased patient awareness of risks and benefits (7)
- ❑ Medico-legal ramifications (8)
- ❑ Other reason (10) _____

Q44 What percent of patients in California taking controlled substance medications do you feel:

	0% (1)	10% (2)	20% (3)	30% (4)	40% (5)	50% (6)	60% (7)	70% (8)	80% (9)	90% (10)	100% (11)
Misuse/Abuse them (1)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Benefit from them (2)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Q43 What percent of your patients taking controlled substance medications do you feel:

	0% (1)	10% (2)	20% (3)	30% (4)	40% (5)	50% (6)	60% (7)	70% (8)	80% (9)	90% (10)	100% (11)
Misuse/Abuse them (1)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Benefit from them (2)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Q45 Is there anything else you would like to tell us about CURES? (e.g., problems, recommendations)

Q46 Which gender do you identify with?
- ❍ Male (0)
- ❍ Female (1)
- ❍ Other (2) _____

Q47 Please indicate your age in years:

Q51 Please indicate whether you consider yourself
- ❍ Hispanic or Latino (1)
- ❍ Not Hispanic or Latino (2)

Q48 Which one of the following groups do you most identify with?
- ❍ American Indian or Alaskan Native (1)
- ❍ Asian (2)
- ❍ Black or African American (3)
- ❍ Native Hawaiian or Other Pacific Islander (4)
- ❍ White (5)
- ❍ Other (please specify) (6) _____

Q49 How long have you been practicing in years:

Q50 Please choose the specialty that best describes your current practice:

- ❍ Allergy and Immunology (24)
- ❍ Anesthesiology (1)
- ❍ Colon and Rectal Surgery (2)
- ❍ Dermatology (3)
- ❍ Emergency Medicine (4)
- ❍ Family Medicine (5)
- ❍ Internal Medicine (general) (6)
- ❍ Internal Medicine (subspecialty) (7)
- ❍ Medical Genetics (25)
- ❍ Neurology (8)
- ❍ Neurosurgery (26)
- ❍ Nuclear Medicine (27)
- ❍ Obstetrics and Gynecology (9)
- ❍ Ophthalmology (10)
- ❍ Orthopaedic Surgery (17)
- ❍ Otolaryngology (28)
- ❍ Pathology (29)
- ❍ Pain Medicine (11)
- ❍ Pediatrics (general) (12)
- ❍ Pediatrics (subspecialty) (30)
- ❍ Physical Medicine and Rehabilitation (31)
- ❍ Plastic Surgery (14)
- ❍ Preventive Medicine (32)
- ❍ Psychiatry (15)
- ❍ Radiology (13)
- ❍ Surgery (general) (34)
- ❍ Surgery (subspecialty) (35)
- ❍ Thoracic and Cardiac Surgery (33)
- ❍ Urology (16)

Q51 As part of the effort to understand prescribing practice and CURES usage, some of your colleagues have volunteered to participate in a follow up survey. May we contact you in the future regarding your prescribing practices and usage of CURES?

- ❍ Yes (1)
- ❍ No (0)

If No Is Selected, Then Skip To End of Survey

Q58 Thank you for your participation. Please provide your email address so we may contact you at a later date.

Appendix B CURES pharmacist survey

Q52 How concerned are you about prescription drug misuse and abuse among:

	Not concerned at all (0)	Slightly concerned (1)	Moderately concerned (2)	Extremely concerned (3)
Patients in California (1)	❍	❍	❍	❍
Patients in the community where you practice (2)	❍	❍	❍	❍

Q8 Now we would like you to think about the last 3 months.

Q9 On average, how many days a week do you dispense or manage medications?

Q10 On average, how many prescriptions do you dispense or manage per day?

Q11 On average, how many controlled substance substance prescriptions do you dispense or manage per day?

Q5 Now we'd like to ask you some questions about California's Controlled Substance Utilization Review and Evaluation System (CURES). CURES is California's online, computer-based system for monitoring the dispensing of all Schedule II, III and IV controlled substances dispensed in California. Have you heard of CURES?

❍ Yes (1)
❍ No (0)

Q7 Are you registered for CURES?

❍ Yes (1)
❍ No (2)
❍ Registration is in process (3)
❍ Don't know (4)

Q12 Are you aware that registering for CURES is mandatory for pharmacists?

❍ Yes (1)
❍ No (0)

Q13 How likely are you to register for CURES within the following month?

❍ Extremely unlikely (1)
❍ Unlikely (2)
❍ Likely (3)
❍ Extremely likely (4)

Q14 Please indicate the extent to which you agree with the following:

	Strongly disagree (1)	Somewhat disagree (2)	Neither agree nor disagree (3)	Somewhat agree (4)	Strongly agree (5)
I have other problems that are more important than registering for CURES. (2)	❍	❍	❍	❍	❍
I know how to go about registering for CURES. (3)	❍	❍	❍	❍	❍
Every time I try to register for CURES, something goes wrong. (5)	❍	❍	❍	❍	❍
Registering for CURES takes little time. (4)	❍	❍	❍	❍	❍
I don't have access to a computer or the internet where I practice. (6)	❍	❍	❍	❍	❍

Display This Question:
If Are you registered for CURES? Yes Is Selected

Q34 How long have you been using CURES?

- ❍ Less than 3 months (1)
- ❍ 4 to 6 months (2)
- ❍ 7 months to 1 year (3)
- ❍ More than 1 year (4)

Q17 How likely are you to use CURES at least once in the next 3 months?

- ❍ Extremely unlikely (1)
- ❍ Unlikely (2)
- ❍ Likely (3)
- ❍ Extremely likely (4)

Q15 How difficult are the following in CURES?

	Very difficult (5)	Difficult (4)	Average (3)	Easy (2)	Very easy (1)
Registering for CURES (1)	❍	❍	❍	❍	❍
Logging in to CURES (2)	❍	❍	❍	❍	❍
Resetting your password (3)	❍	❍	❍	❍	❍
Remembering security questions (4)	❍	❍	❍	❍	❍

Display This Question:
If Are you registered for CURES? Yes Is Selected

Q16 Now we would like you to think about the last 3 months.On a typical day when you dispense or manage medications, how many times do you use CURES to look up a patient's controlled substance medication history?

- ❍ Never (1)
- ❍ Less than once a day (5)
- ❍ 1-5 times a day (2)
- ❍ 6-9 times a day (3)
- ❍ 10+ times a day (4)

Q18 Please indicate the extent to which you agree with the following:

	Strongly disagree (1)	Disagree (2)	Neither agree nor disagree (3)	Agree (4)	Strongly Agree (5)
CURES is helpful (2)	❍	❍	❍	❍	❍
CURES is not relevant to my practice (3)	❍	❍	❍	❍	❍
CURES is easy to use (4)	❍	❍	❍	❍	❍
I don't know how to use CURES (5)	❍	❍	❍	❍	❍
CURES is checked by someone else in the office (6)	❍	❍	❍	❍	❍
I have limited or no access to CURES while I practice (7)	❍	❍	❍	❍	❍

Display This Question:
If On a typical day when you dispense or manage medications, how many times do you use CURES to look... Never Is Not Selected
And Are you registered for CURES? Yes Is Selected

Q19 What are your reasons for checking CURES? [Check all that apply]

- ❑ To check on patients prior to dispensing or managing a controlled substance. (1)
- ❑ To look for evidence of “drug seeking.” (5)
- ❑ To monitor patients on controlled substances. (2)
- ❑ To improve my communication with patients regarding controlled substances. (7)
- ❑ Other (6) _____

Display This Question:
If On a typical day when you dispense or manage medications, how many times do you use CURES to look... Never Is Not Selected
And Are you registered for CURES? Yes Is Selected

Q20 Thinking about the past 3 months, for what percentage of controlled substance fills did you review CURES information?

- ❍ 0% (6)
- ❍ 10% (7)
- ❍ 20% (8)
- ❍ 30% (9)
- ❍ 40% (10)
- ❍ 50% (11)
- ❍ 60% (12)
- ❍ 70% (13)
- ❍ 80% (14)
- ❍ 90% (15)
- ❍ 100% (16)

Display This Question:
If On a typical day when you dispense or manage medications, how many times do you use CURES to look... Never Is Not Selected
And Thinking about the past 3 months, for what percentage of controlled substance fills did you revie... 0% Is Not Selected
And Are you registered for CURES? Yes Is Selected

Q21 Consider the prescriptions for which you have reviewed CURES in the past 3 month period. For what percent of these prescriptions did the information you obtained from CURES prompt you to...

	0% (1)	10% (2)	20% (3)	30% (4)	40% (5)	50% (6)	60% (7)	70% (8)	80% (9)	90% (10)	100% (11)
contact the prescriber for more information? (2)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
not to fill the prescription? (3)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Display This Question:
If Are you registered for CURES? Yes Is Selected

Q28 How useful to you is CURES for the following

	Very Useful (4)	Useful (3)	A little useful (2)	Not useful at all (1)
Helping manage patients with pain (1)	❍	❍	❍	❍
Helping build trust with patients (2)	❍	❍	❍	❍
Informing decisions to dispense or manage controlled substances (4)	❍	❍	❍	❍
Identifying patients filling prescriptions from multiple doctors and/or pharmacies (8)	❍	❍	❍	❍
Identifying patients who misuse or abuse controlled prescription drugs (6)	❍	❍	❍	❍

Q27 Are you aware of the following new features in CURES?

	Never heard of it (0)	Heard of it, but never use it (1)	Used it at least once (2)
Sending secure peer-to-peer messages about specific patients (2)	❍	❍	❍
Giving delegates the ability to access CURES on your behalf (4)	❍	❍	❍
Automatic alerts for high-risk patients (5)	❍	❍	❍

Display This Question:
If Are you registered for CURES? Yes Is Selected

Q31 Did you use the previous version of CURES in your practice?
- ❍ Yes (1)
- ❍ No (0)

Display This Question:
If Did you use the previous version of CURES in your practice? Yes Is Selected
And Are you registered for CURES? Yes Is Selected

Q32 Compared to the old website, how would you rate the new CURES website on the following characteristics?

	Much worse (-2)	Somewhat worse (-1)	About the same (0)	Somewhat better (1)	Much better (2)
Overall ease of use (1)	❍	❍	❍	❍	❍
Login process (2)	❍	❍	❍	❍	❍
Patient Activity Reports (3)	❍	❍	❍	❍	❍
Help Desk support (4)	❍	❍	❍	❍	❍

Q29 Do you feel that you need additional training or education about CURES?
- ❍ Yes (1)
- ❍ No (0)
- ❍ Don't know (2)

Display This Question:
If Do you feel that you need additional training or education about CURES? Yes Is Selected
Or Do you feel that you need additional training or education about CURES? Don't know Is Selected

Q30 What would you like additional training on? [Check all that apply]
- ❑ Registering for CURES (1)
- ❑ CURES passwords and security questions (2)
- ❑ Running patient activity reports (3)
- ❑ Identifying and using CURES delegates from my account (4)
- ❑ Sending secure messages (5)
- ❑ How automatic reports are generated (6)
- ❑ Other topics (8) _____

Q33 Now we would like to ask you some general questions about monitoring patient's controlled substance medications using systems such as CURES.

Q51 Should pharmacists check CURES prior to dispensing or managing a controlled substance?
- ❍ Yes (1)
- ❍ No (0)
- ❍ Don't know (2)

Q52 Should pharmacists be required to check CURES prior to dispensing or managing a controlled substance?
- ❍ Yes (1)
- ❍ No (0)
- ❍ Don't know (2)

Q54 What percentage of your colleagues do you think use CURES at least weekly?
- ❍ 0% (1)
- ❍ 10% (2)
- ❍ 20% (3)
- ❍ 30% (4)
- ❍ 40% (5)
- ❍ 50% (6)
- ❍ 60% (7)
- ❍ 70% (8)
- ❍ 80% (9)
- ❍ 90% (10)
- ❍ 100% (11)

Q56 What percentage of your colleagues do you feel ought to be using CURES at least weekly?
- ❍ 0% (1)
- ❍ 10% (2)
- ❍ 20% (3)
- ❍ 30% (4)
- ❍ 40% (5)
- ❍ 50% (6)
- ❍ 60% (7)
- ❍ 70% (8)
- ❍ 80% (9)
- ❍ 90% (10)
- ❍ 100% (11)

Q35 I have a professional responsibility to check CURES when dispensing or managing controlled substances.
- ❍ Strongly agree (5)
- ❍ Agree (4)
- ❍ Neither agree nor disagree (3)
- ❍ Disagree (2)
- ❍ Strongly disagree (1)

Q36 Checking CURES when dispensing or managing controlled substances is the right thing to do.
- ❍ Strongly agree (5)
- ❍ Agree (4)
- ❍ Neither agree nor disagree (3)
- ❍ Disagree (2)
- ❍ Strongly disagree (1)

Q37 Using CURES when dispensing or managing controlled substances is considered standard of care.
- ❍ Strongly agree (5)
- ❍ Agree (4)
- ❍ Neither agree nor disagree (3)
- ❍ Disagree (2)
- ❍ Strongly disagree (1)

Q38 Dispensing or managing controlled substances without checking CURES would be morally wrong.
- ❍ Strongly agree (5)
- ❍ Agree (4)
- ❍ Neither agree nor disagree (3)
- ❍ Disagree (2)
- ❍ Strongly disagree (1)

Q39 Checking CURES when dispensing or managing controlled substances is NOT a necessary part of my job.
- ❍ Strongly agree (1)
- ❍ Agree (2)
- ❍ Neither agree nor disagree (3)
- ❍ Disagree (4)
- ❍ Strongly disagree (5)

Q40 Now we would like to ask you some questions regarding your dispensing and managing practices more generally.

Q41 How have your dispensing or managing practices changed in the last 3 months?
- ❍ I dispense/manage FAR FEWER controlled substances (-2)
- ❍ I dispense/manage FEWER controlled substances (-1)
- ❍ No change (0)
- ❍ I dispense/manage MORE controlled substances (1)
- ❍ I dispense/manage FAR MORE controlled substances (2)

If No change Is Selected, Then Skip To End of Block

Q42 What factors led you to change your prescribing practices? [Check all that apply]
- ❑ Change in practice location or patient mix (1)
- ❑ New professional standards and protocols where I practice (2)
- ❑ Increased professional awareness of risks, benefits, and other solutions (3)
- ❑ New clinical guidelines and recommendations (4)
- ❑ Increased law enforcement activity (5)
- ❑ CURES providing greater access to patient prescription drug history (6)
- ❑ Increased patient awareness of risks and benefits (7)
- ❑ Medico-legal ramifications (8)
- ❑ Other reason (10) _____

Q43 What percent of patients in California taking controlled substance medications do you feel:

	0% (1)	10% (2)	20% (3)	30% (4)	40% (5)	50% (6)	60% (7)	70% (8)	80% (9)	90% (10)	100% (11)
Misuse/Abuse them (1)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Benefit from them (2)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Q44 What percent of your patients taking controlled substance medications do you feel:

	0% (1)	10% (2)	20% (3)	30% (12)	40% (13)	50% (14)	60% (15)	70% (16)	80% (17)	90% (18)	100% (19)
Misuse/Abuse them (1)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍
Benefit from them (2)	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍	❍

Q45 Is there anything else you would like to tell us about CURES? (e.g. problems, recommendations)

Q46 Which gender do you identify with?
- Male (0)
- Female (1)
- Other (2) _____

Q47 Please indicate your age in years:

Q50 Please indicate whether you consider yourself
- Hispanic or Latino (1)
- Not Hispanic or Latino (2)

Q48 Which one of the following groups do you most identify with?
- American Indian or Alaskan Native (1)
- Asian (2)
- Black or African American (3)
- Native Hawaiian or Other Pacific Islander (4)
- White (5)
- Other (please specify) (6) _____

Q49 How long have you been practicing in years:

Q50 Please identify the choice that best describes your primary practice site?
- Independent pharmacy (1)
- Chain pharmacy (2)
- Hospital (3)
- Supermarket (4)
- Mass merchandiser (5)
- Other patient care practice (6)
- Other (non patient care) (7)

Q51 As part of the effort to understand clinical practice and CURES usage, some of your colleagues have volunteered to participate in a follow up survey. May we contact you in the future regarding your clinical practice and usage of CURES?
- Yes (1)
- No (0)

If No Is Selected, Then Skip To End of Survey

Q57 Thank you for your participation. Please provide your email address so we may contact you at a later date.

Appendix C. Timeline of survey deployment and reminders

	Medical Board	Pharmacy Board[a]	Osteopathic Board[a]
Initial fliers mailed	8/10/2016	9/6/2016	10/6/2016
Email #1 sent	8/23/2016	--	--
Post card #1 mailed	8/27/2016	9/26/2016	--
SB-482 signed[b]		9/27/2016	
Tri-fold reminder #1	--	--	10/19/2016
Email #2 sent	10/18/2016	--	--
Reminder letter mailed from Board of Pharmacy	--	10/12/2016**	--
Postcard #2 mailed	--	--	12/5/2016
Email #3 sent	11/9/2016	--	--
Email #4 sent	11/16/2016	--	--
Email #5 sent	11/30/2016	--	--
Reminder letter mailed from MBC	11/21/2016	--	--
Reminder letter mailed from OMBC	--	--	12/19/2016
Survey closed	1/31/2017	1/31/2017	1/31/2017

[a]Email reminders were not possible for Pharmacy Board and OMBC.

[b]SB-482, a state law mandating eventual CURES use by prescribers, was signed during the survey period. Some physician reminders sent out after this date mentioned SB-482 in order to encourage participation.

Attorney General's Annual Report

Attorney General's Annual Report

on

Accusations Prosecuted for Department of Consumer Affairs Client Agencies

Business and Professions Code Section 312.2

January 1, 2018

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Attorney General's Annual Report on Accusations Prosecuted for Department of Consumer Affairs Client Agencies

January 1, 2018

EXECUTIVE SUMMARY

This is the first annual report by the Office of the Attorney General required under Business and Professions Code section 312.2, which became effective on January 1, 2016, and requires the first report to be filed by January 1, 2018. The report is based on information from Fiscal Year 2016-17. It provides a baseline concerning accusation referrals received and adjudicated accusations for each Department of Consumer Affairs client agency of the Licensing Section and Health Quality Enforcement Section of the Attorney General's Office.

Each client agency is unique and not comparable to each other, yet some general observations can be made from the data collected to compile this report. In Fiscal Year 2016-17, approximately 40 percent of the legal work performed by the Licensing Section and Health Quality Enforcement Section was for the prosecution of accusation matters, which are the focus of this report. During the year, 3,097 accusation referrals were received from our Department of Consumer Affairs client agencies. Less than 2.7 percent of accusation referrals to the Attorney General's Office were rejected, and 10 percent of accusation referrals required further investigation.

The Office of the Attorney General adjudicated 3,384 accusations during the year. The matters adjudicated were transmitted to this office in Fiscal Year 2016-17 or in a prior fiscal year. Multiple adjudications can occur when more than one licensee is included within one matter, each with different adjudication dates and types, or a client agency exercises its discretion to reject an initial adjudication. Close to 60 percent of the total adjudications were by stipulated settlement, approximately 25 percent by default, and 12 percent by administrative hearing.

We have provided individual reports of the information requested in Business and Professions Code section 312.2 for each Department of Consumer Affairs client agency represented by the Licensing Section and Health Quality Enforcement Section of the Attorney General's Office.

BACKGROUND

Licensing Section and Health Quality Enforcement Section

The Licensing Section and Health Quality Enforcement Section of the Office of the Attorney General's Civil Law Division specialize in licensing law in California. These sections represent 38 Department of Consumer Affairs agencies that issue multiple types of professional and vocational licenses. They provide legal representation to these agencies in many kinds of licensing matters to protect California consumers. Liaison deputies also regularly consult with agency clients and advise them on jurisdictional, legal, and programmatic issues. Deputy Attorneys General also frequently train Division of Investigation and agency investigators, agency staff, and expert witnesses.

Both sections prosecute licensing matters, including accusations (license discipline), which comprise about forty percent of their combined caseload. The balance of prosecution matters consist of statements of issues (appeal hearing when a license application has been denied), interim suspension

petitions (hearing before the Office of Administrative Hearings for immediate suspension of a license), injunction proceedings (brought in superior court to stop unlicensed practice), post-discipline matters (when a licensee petitions for reduction of penalty, or reinstatement of a revoked license), citations (appeal hearing when a citation has been issued), Penal Code section 23 petitions (seeking a license restriction during the pendency of a criminal proceeding), subpoena enforcement actions (to obtain records needed for the investigation of complaints), judicial review proceedings (superior court review of final administrative decisions), appeals (usually from superior court review proceedings), and civil litigation related to license discipline (defending agencies in civil lawsuits brought in state or federal courts).

Of these many types of legal actions, Business and Professions Code section 312.2 requests statistics only for the prosecution of accusation matters. Accusations are the primary component of the enforcement program for each licensing agency. The legal services in other types of licensing matters handled by the Licensing Section and Health Quality Enforcement Section are not included in this report, except where accusations are combined with petitions to revoke probation.

Department of Consumer Affairs Client Agencies

The 38 Department of Consumer Affairs agencies represented by the Licensing and Health Quality Enforcement Sections each have different licensing programs and processes unique to their practice areas. A few agencies issue only one type of license, but most issue multiple license types. Agencies also differ in how they refer accusation matters to the Attorney General's Office; some referring one matter for each licensee, while others refer multiple licensees involved in the same or related acts for which discipline is sought as a single matter to be included in one accusation. They may also refer additional investigations to the Attorney General's Office while an initial accusation matter is pending. Depending on the circumstances, subsequent investigations may or may not be counted as additional *accusation referrals* in this report. Some agencies have higher default rates than others, perhaps because some licensees have invested less time and money to obtain their license than others, just as the respondents for some agencies are almost always represented by counsel, while others have a mix of represented respondents and those who represent themselves. Client agencies also differ in their applicable burdens of evidentiary proof, and some are not subject to a statute of limitations. Most agencies are entitled to recover their costs of investigation and prosecution from respondents. The statistics included in this report are consistent with each client's licensing programs and practices to the extent possible, but as a result of the wide variances among the many agencies, often are not comparable to each other in any meaningful way.

Investigation Process

Agencies also differ in how they investigate their cases. They generally assign investigation of their cases in four ways with an aim to balance quality and efficiency, and avoid insufficiency of evidence, which causes delay while further investigation is done to gather supplemental evidence. First and most commonly, agencies investigate their cases using their own staff, including inspectors, sworn and unsworn investigators, investigator assistants, or analysts. Second, certain kinds of cases are required to be referred to the Department of Consumer Affairs Division of Investigation for investigation consistent with Complaint Prioritization Guidelines developed pursuant to Business and Professions Code section 328. Medical Board cases are excluded from the requirements of section 328 and instead, since 2006, their cases have been investigated under a third model known as Vertical Enforcement and Prosecution, pursuant to Government Code section 12529.6. The Vertical Enforcement model requires a deputy attorney general, who will be responsible for prosecuting the case if the investigation results in the filing of an accusation, to be jointly assigned to the investigation with a Division of Investigation investigator from the Health Quality Investigation Unit. Some agencies represented by the Health Quality Enforcement Section of the Office of the Attorney General opt to

have some or all of their cases investigated under the Vertical Enforcement model. Lastly, all Division of Investigation investigators, agency investigators, and agency staff have the option of consulting with a liaison deputy assigned to each client agency by the Office of the Attorney General to provide counsel with respect to any investigation.

Administrative Adjudication Process

If the investigation reveals evidence that a licensee of an agency has violated the agency's practice act, the agency refers the matter to the Office of the Attorney General to initiate a legal proceeding to revoke, suspend, limit, or condition the license, which is called an *accusation*. (Gov. Code, § 11503.)

Upon receipt, the assigned deputy attorney general reviews the transmitted evidence to determine its sufficiency to meet the requisite burden of proof and for any jurisdictional issues. If the evidence is insufficient and circumstances suggest additional avenues for evidentiary development, the deputy may request further investigation from the agency. In such cases, in the Licensing Section, the file remains open pending receipt of supplemental investigation, and the file is documented to indicate the further investigation request. In the Health Quality Enforcement Section, the file will be returned to the client agency and will be rereferred to the Office of the Attorney General if further evidence is developed. When evidence is insufficient and further investigation is not recommended, or legal issues prevent prosecution, the Office of the Attorney General declines prosecution, and the case is rejected, or reviewed and returned to the agency.

Based upon sufficient evidentiary support, the Attorney General's Office prepares an accusation to initiate the agency's adjudicative proceeding. The accusation pleading is sent to the agency for signature by the executive director, executive officer, or other designated *complainant* for the agency. The accusation is *filed* when the complainant signs it, and it is then served by the agency, or returned to the Office of the Attorney General for service on the licensee, known in the accusation proceeding as the *respondent*. When charged in an accusation, a respondent has a right to an adjudicative hearing under the California Administrative Procedure Act (Gov. Code, tit. 2, div. 3, ch. 5, commencing with §11500.) A deputy attorney general is assigned to prosecute the case and bring it to hearing. Once served with an accusation, the respondent must file a notice of defense within fifteen days, or is in default. Once the notice of defense has been received, a hearing is scheduled with the Office of Administrative Hearings. If no notice of defense is received, then a default is prepared for presentation to the client agency for its ultimate decision.

The deputy attorney general prosecutes the accusation case before the Office of Administrative Hearings. Upon conclusion of the hearing, the case is submitted to the administrative law judge who presides over the hearing, issues a proposed decision, and sends it to the agency for its ultimate decision. Of course, settlement can occur at any time and is the most common method of adjudication of accusation matters.

Each licensing agency makes the final decision in each accusation case. The agency can accept or reject a settlement, and if rejected, the proceedings will continue. After an administrative hearing, the agency can accept the proposed decision issued by the administrative law judge, in which case it becomes the final decision. However, the agency may opt to reduce the penalty, or reject the proposed decision and call for the transcript. After review of the transcript, it can then adopt the proposed decision or issue its own decision. Most cases are resolved when the agency accepts a settlement or proposed decision, but if not, additional proceedings ensue, which take more time.

Even after an agency's decision is issued it may not be final. The respondent may exercise the right to petition for reconsideration, and if granted by the agency, the final decision will be reconsidered.

This can also happen if an agency decides a case based upon the default of the respondent for failure to timely file a notice of defense, or failure to appear at a duly noticed hearing. Upon petition by the respondent, the agency can vacate the default decision, and additional proceedings are conducted to ultimately decide the case. Each of these types of *post-submission* events will lengthen the processing of a case and require further adjudication.

Business and Professions Code section 312.2, subdivision (a)(7), and subdivision (b)(1) – (6) request the number of matters adjudicated by the Office of the Attorney General, and average number of days for various components of the adjudication process. *Adjudication* means the work of the Office of the Attorney General is complete to bring the matter back before the agency for issuance of its decision. Adjudication occurs in four different ways:

1. Default. If a respondent does not timely submit a Notice of Defense, or fails to appear at a duly noticed hearing on the accusation, a default is provided to the agency for its ultimate decision, or the deputy attorney general conducts the hearing without the presence of the respondent.

2. Settlement. The complainant may authorize settlement of an accusation on terms that are sufficient to protect the public, which will be presented to the agency for its ultimate decision.

3. Hearing Submitted. Upon completion of the adjudicative hearing, the matter is submitted to the administrative law judge, who prepares a proposed decision and sends it to the agency for its ultimate decision.

4. Withdrawal of Accusation. Under certain conditions, an accusation that has been filed may be withdrawn by the complainant of the agency as recommended by the Office of the Attorney General, and the matter is closed.

Multiple adjudications may be reported in a single accusation matter in one or more fiscal years because more than one licensee is included in one matter, each with different adjudication dates and types, or a client agency exercises its discretion to reject a proposed settlement, non-adopt a proposed decision, or grant a petition for reconsideration.

MEASURES REPORTED

The following measures are reported, as required by Business and Professions Code section 312.2, which states:

> (a) The Attorney General shall submit a report to the department, the Governor, and the appropriate policy committees of the Legislature on or before January 1, 2018, and on or before January 1 of each subsequent year that includes, at a minimum, all of the following for the previous fiscal year for each constituent entity within the department represented by the Licensing Section and Health Quality Enforcement Section of the Office of the Attorney General:
>
> (1) The number of accusation matters referred to the Attorney General.
>
> (2) The number of accusation matters rejected for filing by the Attorney General.
>
> (3) The number of accusation matters for which further investigation was requested by the Attorney General.

(4) The number of accusation matters for which further investigation was received by the Attorney General.

(5) The number of accusations filed by each constituent entity.

(6) The number of accusations a constituent entity withdraws.

(7) The number of accusation matters adjudicated by the Attorney General.

(b) The Attorney General shall also report all of the following for accusation matters adjudicated within the previous fiscal year for each constituent entity of the department represented by the Licensing Section and Health Quality Enforcement Section:

(1) The average number of days from the Attorney General receiving an accusation referral to when an accusation is filed by the constituent entity.

(2) The average number of days to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received by the Attorney General from a constituent entity or the Division of Investigation.

(3) The average number of days from an agency filing an accusation to the Attorney General transmitting a stipulated settlement to the constituent entity.

(4) The average number of days from an agency filing an accusation to the Attorney General transmitting a default decision to the constituent entity.

(5) The average number of days from an agency filing an accusation to the Attorney General requesting a hearing date from the Office of Administrative Hearings.

(6) The average number of days from the Attorney General's receipt of a hearing date from the Office of Administrative Hearings to the commencement of a hearing.

METHODOLOGY

Case Management System

This report is based on data entered by legal professionals into the case management system of the Office of the Attorney General. Each matter received by the Licensing and Health Quality Enforcement Sections from a client is opened in this system. Rules for the entry of data have been created by the sections, and are managed by the Case Management Section of the Office of the Attorney General, which dictate the definitions, dating, entry, and documentation for each data point. Section-specific protocols, business processes, and uniform standards across all professionals responsible for data entry ensure the consistency, veracity, and quality of the reported data. The data entered has been verified to comply with established standards. The data markers in administrative cases have been used to generate the counts and averages in this report. Every effort has been undertaken to report data in a transparent, accurate, and verifiable manner. The Office of the Attorney

General continues to improve its technology, systems and protocols, and integrates them into its business routines and operations.

Data Presentation

The statistical information required by Business and Professions Code section 312.2 has been organized on a separate page for each constituent entity in the Department of Consumer Affairs represented by the Licensing and Health Quality Enforcement Sections of the Office of the Attorney General. Each page includes the number of licenses and types of licenses issued by the agency, which were taken from the Fiscal Year 2015-16 Sunset Review Reports of individual boards or the 2016 Annual Report of the California Department of Consumer Affairs, containing data from Fiscal Year 2015-16. This report can be found on line at: http://www.dca.ca.gov/publications/2016_annrpt.pdf. Further information concerning Department of Consumer Affairs agencies can be found through the links at: http://www.dca.ca.gov/about_dca/entities.shtml.

Table 1 on the page for each agency provides the counts for various aspects of accusation matters, as requested under subdivision (a) of section 312.2, such as the number of accusation referrals received and the number of accusations filed (subd. (a)(1) and (5)). Table 2 provides the averages requested under subdivision (b) of section 312.2, which are based on the accusation matters adjudicated during the year, as reported under section 312.2, subdivision (a)(7). The word *average* in subdivision (b), is a general word that expresses the central or typical value in a set of data, which is most commonly thought of as the arithmetic mean. The mean is the result obtained by adding together several values, and then dividing this total by the number of values. The central value in an ordered set of data is known as the median. The standard deviation (SD) for a data set provides context for averages. A low standard deviation indicates that the data points tend to be close to the mean (also called the expected value) of the set, while a high standard deviation indicates that the data points are spread out over a wider range of values. In Table 2, we have included the mean, median, and standard deviation, along with the number of values in the data set from which the averages were determined. The averages reported in Table 2 for section 312.2, subdivision (b)(2), were calculated from the date matters were received at the Office of the Attorney General until pleadings were sent to the agency, and include the time during which matters were reinvestigated and rereferred by the client back to the Office of the Attorney General. The pleadings filed reported in subdivision (b)(1) include the matters reported in subdivision (b)(2), that required further investigation before pleadings were sent to the agency for filing.

The individual client agency pages that follow have been organized in alphabetical order for convenience.

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California Board of Accountancy

The California Board of Accountancy regulated 100,736 licenses in Fiscal Year 2015-16 with five different license types. Most complaints received by the Board are investigated by the Board's own investigators, who are certified public accountants themselves. The Board investigations are often assisted by the Office of Attorney General and the Board's Enforcement Advisory Committee through the taking of testimony under oath of licensees under investigation. There were multiple respondents in about 10 percent of the Board's accusation matters adjudicated by the Attorney General, reported in subdivisions (a)(7) and (b), below. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	73
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	4
(4) accusation matters for which further investigation was received by the Attorney General.	1
(5) accusations filed.	98
(6) accusations withdrawn.	5
(7) accusation matters adjudicated by the Attorney General.	98

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	196	161	123	94
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	194	163	91	3
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	145	108	93	72
(4) from the filing of an accusation to when a default decision is sent to the agency.	53	53	19	15
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	97	71	66	21
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	168	144	68	5

California Acupuncture Board

The California Acupuncture Board regulated 16,126 licenses in Fiscal Year 2015-2016 with one license type. Complaints received by the Board are investigated by the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	10
(2) accusation matters rejected for filing by the Attorney General.	1
(3) accusation matters for which further investigation was requested by the Attorney General.	0
(4) accusation matters for which further investigation was received by the Attorney General.	0
(5) accusations filed.	14
(6) accusations withdrawn.	1
(7) accusation matters adjudicated by the Attorney General.	19

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	92	77	68	18
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	0	0	0	0
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	220	223	96	15
(4) from the filing of an accusation to when a default decision is sent to the agency.	52	52	0	1
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	66	49	40	5
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	142	142	44	2

California Architects Board

The California Architects Board regulated 20,914 licenses in Fiscal Year 2015-16 with only one license type, licensed architect. Most complaints received by the Board are investigated by the Board's own staff and architect consultants, and when appropriate referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	2
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	2
(4) accusation matters for which further investigation was received by the Attorney General.	0
(5) accusations filed.	2
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	4

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	150	124	40	3
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	0	0	0	0
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	353	353	0	1
(4) from the filing of an accusation to when a default decision is sent to the agency.	60	60	0	1
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	259	259	0	1
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	154	131	34	3

California State Athletic Commission

The California State Athletic Commission regulated 3,550 licenses in Fiscal Year 2015-16 with eight different license types. The Commission referred eight arbitration matters to the Office of the Attorney General in Fiscal Year 2016-17, but did not refer any accusation matters.

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Bureau of Automotive Repair

The Bureau of Automotive Repair regulated 75,042 registrations, licenses and permits in Fiscal Year 2015-16 with 11 different license types. Most complaints received by the Bureau are investigated by the Bureau's own program representatives. When appropriate, cases may also be referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit. There were multiple respondents in about 40 percent of the Bureau's accusation matters adjudicated by the Attorney General, reported in subdivisions (a)(7) and (b), below. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	271
(2) accusation matters rejected for filing by the Attorney General.	1
(3) accusation matters for which further investigation was requested by the Attorney General.	12
(4) accusation matters for which further investigation was received by the Attorney General.	9
(5) accusations filed.	164
(6) accusations withdrawn.	1
(7) accusation matters adjudicated by the Attorney General.	225

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	164	134	132	182
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	272	292	112	5
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	275	238	203	112
(4) from the filing of an accusation to when a default decision is sent to the agency.	120	73	100	62
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	111	75	123	61
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	152	110	136	44

Board of Barbering and Cosmetology

The Board of Barbering and Cosmetology regulated 602,637 licenses in Fiscal Year 2015-16 with ten different license types. The Board receives consumer complaints and routinely inspects establishments for health and safety. The Board's cases are investigated by the Board's own inspectors or other staff, and when appropriate, may also be referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	58
(2) accusation matters rejected for filing by the Attorney General.	2
(3) accusation matters for which further investigation was requested by the Attorney General.	3
(4) accusation matters for which further investigation was received by the Attorney General.	3
(5) accusations filed.	103
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	96

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	142	133	92	91
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	139	139	0	1
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	177	168	85	40
(4) from the filing of an accusation to when a default decision is sent to the agency.	81	61	73	44
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	97	58	94	33
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	74	80	36	5

Board of Behavioral Sciences

The Board of Behavioral Sciences regulated 105,613 licenses in Fiscal Year 2015-16 with eight different license types. Most complaints received by the Board are investigated by the Board's own investigators or staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	88
(2) accusation matters rejected for filing by the Attorney General.	1
(3) accusation matters for which further investigation was requested by the Attorney General.	13
(4) accusation matters for which further investigation was received by the Attorney General.	7
(5) accusations filed.	90
(6) accusations withdrawn.	6
(7) accusation matters adjudicated by the Attorney General.	103

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	138	120	84	96
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	160	108	101	3
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	230	210	136	69
(4) from the filing of an accusation to when a default decision is sent to the agency.	114	97	78	11
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	115	83	84	37
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	191	203	48	11

Cemetery and Funeral Bureau

The Cemetery and Funeral Bureau regulated 12,761 licenses in Fiscal Year 2015-16 with eleven different license types. Most complaints received by the Bureau are investigated by the Bureau's own investigators or staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. There were multiple respondents in only one percent of the Bureau's accusation matters adjudicated by the Attorney General, reported in subdivisions (a)(7) and (b), below. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	9
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	1
(4) accusation matters for which further investigation was received by the Attorney General.	1
(5) accusations filed.	6
(6) accusations withdrawn.	2
(7) accusation matters adjudicated by the Attorney General.	8

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	101	65	81	8
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	264	264	0	1
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	315	243	168	3
(4) from the filing of an accusation to when a default decision is sent to the agency.	52	52	0	1
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	60	60	0	1
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	131	131	0	1

Board of Chiropractic Examiners

The Board of Chiropractic Examiners regulated 18,619 licenses in Fiscal Year 2015-16 with four different license types. Most complaints received by the Board are investigated by the Board's own investigators or staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	33
(2) accusation matters rejected for filing by the Attorney General.	3
(3) accusation matters for which further investigation was requested by the Attorney General.	9
(4) accusation matters for which further investigation was received by the Attorney General.	8
(5) accusations filed.	36
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	35

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	159	92	201	32
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	419	269	335	3
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	190	165	127	18
(4) from the filing of an accusation to when a default decision is sent to the agency.	84	69	55	6
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	113	74	101	10
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	165	136	65	10

Contractors' State License Board

The Contractors' State License Board regulated 302,123 licenses in Fiscal Year 2015-16 with two license types and many classifications, including general contractor. Most complaints received by the Board are investigated by the Board's own enforcement representatives, some of whom are sworn investigators. There were multiple respondents in about 13 percent of the Board's accusation matters adjudicated by the Attorney General, reported in subdivisions (a)(7) and (b), below. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	310
(2) accusation matters rejected for filing by the Attorney General.	4
(3) accusation matters for which further investigation was requested by the Attorney General.	27
(4) accusation matters for which further investigation was received by the Attorney General.	28
(5) accusations filed.	269
(6) accusations withdrawn.	9
(7) accusation matters adjudicated by the Attorney General.	279

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	194	169	137	259
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	340	330	181	13
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	277	248	146	104
(4) from the filing of an accusation to when a default decision is sent to the agency.	73	46	90	108
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	144	109	114	65
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	171	133	136	39

Court Reporters Board of California

The Court Reporters Board of California regulated 6,842 licenses in Fiscal Year 2015-16 with only one license type. Most complaints received by the Board are investigated by the Board's own staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	0
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	0
(4) accusation matters for which further investigation was received by the Attorney General.	0
(5) accusations filed.	5
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	6

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	163	166	68	6
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	0	0	0	0
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	218	119	157	5
(4) from the filing of an accusation to when a default decision is sent to the agency.	0	0	0	0
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	47	41	20	3
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	0	0	0	0

Dental Board of California

The Dental Board of California regulated 97,139 licenses and 17,380 permits in Fiscal Year 2015-16 with 16 license and permit types. Most complaints received by the Board are investigated by the Board's own investigators or staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	83
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	12
(4) accusation matters for which further investigation was received by the Attorney General.	10
(5) accusations filed.	93
(6) accusations withdrawn.	6
(7) accusation matters adjudicated by the Attorney General.	113

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	153	139	105	105
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	228	219	67	7
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	363	307	248	80
(4) from the filing of an accusation to when a default decision is sent to the agency.	116	68	99	13
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	182	132	157	32
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	295	198	255	8

Dental Hygiene Committee of California

The Dental Hygiene Committee of California regulated 24,205 licenses and 477 permits in Fiscal Year 2015-16 with four license and permit types. Most complaints received by the Committee are investigated by the Dental Board's own investigators or staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	13
(2) accusation matters rejected for filing by the Attorney General.	1
(3) accusation matters for which further investigation was requested by the Attorney General.	0
(4) accusation matters for which further investigation was received by the Attorney General.	0
(5) accusations filed.	9
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	8

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	92	86	46	8
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	0	0	0	0
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	132	129	77	8
(4) from the filing of an accusation to when a default decision is sent to the agency.	0	0	0	0
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	124	124	25	2
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	0	0	0	0

Bureau of Electronic & Appliance Repair, Home Furnishings & Thermal Insulation

The Bureau regulated 42,352 licenses, certificates, and permits in Fiscal Year 2015-16 with 15 types. Most complaints received by the Bureau are investigated by the Bureau's own investigators or staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate.

In Fiscal Year 2016-17, the Bureau referred one accusation matter to the Office of the Attorney General, which was received on April 7, 2017. There was no request for further investigation, nor was the matter rejected. The accusation was filed on July 25, 2017, and therefore will be reported on further in the next annual report.

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State Board of Guide Dogs for the Blind

The State Board of Guide Dogs for the Blind regulated 116 licenses and 12 approvals in Fiscal Year 2015-16. The Board did not refer any accusation matters to the Office of the Attorney General in Fiscal Year 2016-17.

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Landscape Architects Technical Committee

The Landscape Architects Technical Committee regulated 3,593 licenses in Fiscal Year 2015-16. The Committee's cases are investigated by the California Architects Board's staff and architect consultants, and when appropriate referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit.

In Fiscal Year 2016-17, the Committee referred two judicial review matters to the Office of the Attorney General, but did not refer any accusation matters.

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Licensed Midwives Program (Medical Board of California)

The Medical Board of California regulated 429 Licensed Midwife licenses in Fiscal Year 2015-2016. Complaints received by the Midwives Program are investigated by the Department of Consumer Affairs Division of Investigation, Health Quality Investigation Unit. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	0
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	0
(4) accusation matters for which further investigation was received by the Attorney General.	0
(5) accusations filed.	1
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	1

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	75	75	0	1
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	0	0	0	0
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	33	33	0	1
(4) from the filing of an accusation to when a default decision is sent to the agency.	0	0	0	0
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	21	21	0	1
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	0	0	0	0

Medical Board of California

The Medical Board of California regulated 187,875 licenses in Fiscal Year 2015-2016, with six types of license and registration. Physicians and Surgeons, Research Psychoanalysts, and Polysomnographic Program data is consolidated below. Data for the Licensed Midwives Program is set forth on the preceding page. Complaints received by the Board are investigated by its in-house Complaint Investigation Office and by the Department of Consumer Affairs Division of Investigation, Health Quality Investigation Unit. The Board uses vertical enforcement in investigations referred to the Health Quality Investigation Unit. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	412
(2) accusation matters rejected for filing by the Attorney General.	8
(3) accusation matters for which further investigation was requested by the Attorney General.	16
(4) accusation matters for which further investigation was received by the Attorney General.	31
(5) accusations filed.	384
(6) accusations withdrawn.	4
(7) accusation matters adjudicated by the Attorney General.	433

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	86	64	82	411
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	192	210	111	19
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	300	266	203	301
(4) from the filing of an accusation to when a default decision is sent to the agency.	173	93	190	41
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	129	56	171	163
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	182	147	113	83

Naturopathic Medicine Committee

The Naturopathic Medicine Committee regulated 927 licenses in Fiscal Year 2015-2016, with one type of license. Complaints received by the Board are investigated by the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	0
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	0
(4) accusation matters for which further investigation was received by the Attorney General.	0
(5) accusations filed.	0
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	1

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	553	553	0	1
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	549	549	0	1
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	246	246	0	1
(4) from the filing of an accusation to when a default decision is sent to the agency.	0	0	0	0
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	63	63	0	1
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	0	0	0	0

California Board of Occupational Therapy

The Board of Occupational Therapy regulated 15,553 licenses in Fiscal Year 2015-16 with two license types. Most complaints received by the Board are investigated by the Board's own investigators or staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	14
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	2
(4) accusation matters for which further investigation was received by the Attorney General.	1
(5) accusations filed.	6
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	13

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	112	115	53	12
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	108	108	0	1
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	154	136	89	6
(4) from the filing of an accusation to when a default decision is sent to the agency.	69	61	34	5
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	5	5	0	1
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	90	90	44	2

California State Board of Optometry

The Board of Optometry includes the Dispensing Optician Committee. The Board regulated 17,082 licenses in Fiscal Year 2015-16 with 12 types of licenses, including optometrists and opticians. Most complaints received by the Board are investigated by the Board's own staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The Board does not employ its own investigators. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	13
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	1
(4) accusation matters for which further investigation was received by the Attorney General.	1
(5) accusations filed.	9
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	8

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	198	189	123	8
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	0	0	0	0
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	286	286	193	2
(4) from the filing of an accusation to when a default decision is sent to the agency.	198	115	155	3
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	64	64	4	2
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	378	378	0	1

Osteopathic Medical Board of California

The Osteopathic Medical Board of California regulated 9,582 licenses in Fiscal Year 2015-2016, with one type of license. Complaints received by the Board were formerly investigated by the Department of Consumer Affairs Division of Investigation, Health Quality Investigation Unit. In 2015, the Board's investigations were transferred in the Division of Investigation to the Investigation and Enforcement Unit. The Board uses vertical enforcement in select investigations. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	13
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	1
(4) accusation matters for which further investigation was received by the Attorney General.	1
(5) accusations filed.	16
(6) accusations withdrawn.	1
(7) accusation matters adjudicated by the Attorney General.	14

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	42	23	34	14
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	113	113	0	1
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	266	210	211	9
(4) from the filing of an accusation to when a default decision is sent to the agency.	599	599	0	1
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	134	112	108	6
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	162	161	35	5

California State Board of Pharmacy

The Board of Pharmacy regulated 138,444 licenses in Fiscal Year 2015-16 with 20 different license types. The Board receives consumer complaints and routinely inspects pharmacies for compliance. Most complaints received by the Board are investigated by the Board's own inspectors, who are licensed pharmacists themselves, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. There were multiple respondents in about 26 percent of the Board's accusation matters adjudicated by the Attorney General, reported in subdivisions (a)(7) and (b), below. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	258
(2) accusation matters rejected for filing by the Attorney General.	2
(3) accusation matters for which further investigation was requested by the Attorney General.	36
(4) accusation matters for which further investigation was received by the Attorney General.	23
(5) accusations filed.	238
(6) accusations withdrawn.	5
(7) accusation matters adjudicated by the Attorney General.	302

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	228	178	224	254
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	457	408	319	14
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	308	249	227	143
(4) from the filing of an accusation to when a default decision is sent to the agency.	120	74	136	97
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	127	118	103	85
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	167	143	112	44

Physical Therapy Board of California

The Physical Therapy Board of California regulated 37,051 licenses of two types in Fiscal Year 2015-2016. Complaints received by the Board are investigated by the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	33
(2) accusation matters rejected for filing by the Attorney General.	1
(3) accusation matters for which further investigation was requested by the Attorney General.	6
(4) accusation matters for which further investigation was received by the Attorney General.	2
(5) accusations filed.	24
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	20

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	98	72	65	20
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	128	128	78	2
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	176	169	93	17
(4) from the filing of an accusation to when a default decision is sent to the agency.	169	169	18	2
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	60	62	29	11
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	190	190	0	1

Physician Assistant Board

The Physician Assistant Board regulated 10,764 licenses of one type in Fiscal Year 2015-2016. Complaints received by the Board are investigated by the Department of Consumer Affairs Division of Investigation, Health Quality Investigation Unit. The Board uses vertical enforcement in select investigations. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	27
(2) accusation matters rejected for filing by the Attorney General.	1
(3) accusation matters for which further investigation was requested by the Attorney General.	4
(4) accusation matters for which further investigation was received by the Attorney General.	5
(5) accusations filed.	32
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	16

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	94	80	62	16
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	64	64	0	1
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	235	214	122	15
(4) from the filing of an accusation to when a default decision is sent to the agency.	454	454	0	1
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	100	45	156	8
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	0	0	0	0

California Board of Podiatric Medicine

The California Board of Podiatric Medicine regulated 2,333 licenses in Fiscal Year 2016-2017. The Board issues two types of licenses. Complaints received by the Board are investigated by the Department of Consumer Affairs Division of Investigation, Health Quality Investigation Unit. The Board uses vertical enforcement in all of its investigations. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	6
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	0
(4) accusation matters for which further investigation was received by the Attorney General.	1
(5) accusations filed.	9
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	5

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	68	71	43	5
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	0	0	0	0
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	335	335	106	4
(4) from the filing of an accusation to when a default decision is sent to the agency.	0	0	0	0
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	131	131	92	2
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	163	163	126	2

Bureau for Private Postsecondary Education

The Bureau for Private Postsecondary Education issues only one type of approval, which authorizes private postsecondary institutions to operate. It regulated 1,137 approvals in Fiscal Year 2015-16. The Bureau does not employ investigators and most complaints are investigated by the Board's own staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	10
(2) accusation matters rejected for filing by the Attorney General.	1
(3) accusation matters for which further investigation was requested by the Attorney General.	4
(4) accusation matters for which further investigation was received by the Attorney General.	0
(5) accusations filed.	10
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	9

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	106	133	59	9
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	0	0	0	0
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	238	202	134	5
(4) from the filing of an accusation to when a default decision is sent to the agency.	154	164	85	3
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	116	116	66	2
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	138	138	0	1

Board for Professional Engineers, Land Surveyors, and Geologists

The Board for Professional Engineers, Land Surveyors, and Geologists regulated 106,692 licenses in Fiscal Year 2015-16 with 28 different license types. The Board does not employ investigators and most complaints are investigated by the Board's own staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	24
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	4
(4) accusation matters for which further investigation was received by the Attorney General.	0
(5) accusations filed.	15
(6) accusations withdrawn.	2
(7) accusation matters adjudicated by the Attorney General.	25

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	329	319	197	24
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	288	288	0	1
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	364	338	249	17
(4) from the filing of an accusation to when a default decision is sent to the agency.	176	134	142	5
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	197	177	105	8
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	62	62	0	1

Professional Fiduciaries Bureau

The Professional Fiduciaries Bureau regulated 712 licenses in Fiscal Year 2015-16 with only one license type. Complaints received by the Bureau are investigated by the Bureau's own staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	3
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	0
(4) accusation matters for which further investigation was received by the Attorney General.	0
(5) accusations filed.	0
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	1

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	55	55	0	1
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	0	0	0	0
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	595	595	0	1
(4) from the filing of an accusation to when a default decision is sent to the agency.	0	0	0	0
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	0	0	0	0
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	0	0	0	0

California Board of Psychology

The California Board of Psychology regulated 22,079 licenses in Fiscal Year 2015-2016 with three types of license. Complaints received by the Board were formerly investigated by the Department of Consumer Affairs Division of Investigation, Health Quality Investigation Unit. In 2015, the Board's investigations were transferred in the Division of Investigation to the Investigation and Enforcement Unit. The Board uses vertical enforcement in select investigations. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	36
(2) accusation matters rejected for filing by the Attorney General.	2
(3) accusation matters for which further investigation was requested by the Attorney General.	5
(4) accusation matters for which further investigation was received by the Attorney General.	4
(5) accusations filed.	33
(6) accusations withdrawn.	2
(7) accusation matters adjudicated by the Attorney General.	38

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	99	57	138	37
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	305	80	328	3
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	239	206	178	29
(4) from the filing of an accusation to when a default decision is sent to the agency.	56	57	26	4
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	124	39	171	14
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	245	246	111	4

Bureau of Real Estate Appraisers

The Bureau of real Estate Appraisers regulated 10,886 licenses in Fiscal Year 2015-16 with five different license types. Most complaints received by the Bureau involved violations of the Uniform Standards of Appraisal Practice and are investigated by the Bureau's own staff or investigators, who are licensed appraisers, themselves. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	11
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	1
(4) accusation matters for which further investigation was received by the Attorney General.	1
(5) accusations filed.	12
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	9

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	65	64	42	9
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	0	0	0	0
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	103	76	65	5
(4) from the filing of an accusation to when a default decision is sent to the agency.	41	41	0	1
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	50	44	16	4
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	136	136	44	2

Board of Registered Nursing

The Board of Registered Nursing regulated 528,198 licenses in Fiscal Year 2015-16 with 11 different license types. Most complaints received by the Board are investigated by the Board's own staff or investigators, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	860
(2) accusation matters rejected for filing by the Attorney General.	43
(3) accusation matters for which further investigation was requested by the Attorney General.	98
(4) accusation matters for which further investigation was received by the Attorney General.	64
(5) accusations filed.	822
(6) accusations withdrawn.	21
(7) accusation matters adjudicated by the Attorney General.	930

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	140	108	141	891
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	368	252	270	31
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	214	190	147	606
(4) from the filing of an accusation to when a default decision is sent to the agency.	77	28	129	213
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	112	87	98	248
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	138	112	89	68

Respiratory Care Board of California

The Respiratory Care Board of California regulated 23,215 licenses in Fiscal Year 2015-2016 with one type of license. Complaints received by the Board are investigated by Board staff. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	49
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	6
(4) accusation matters for which further investigation was received by the Attorney General.	5
(5) accusations filed.	55
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	52

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	92	59	100	52
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	367	367	0	1
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	181	154	125	29
(4) from the filing of an accusation to when a default decision is sent to the agency.	68	50	36	19
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	54	31	63	18
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	105	82	70	6

Bureau of Security and Investigative Services

The Bureau of Security and Investigative Services regulated 367,957 licenses in Fiscal Year 2015-16 with 22 different license types. Most complaints received by the Bureau are investigated by the Bureau's own staff, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. There were multiple respondents in about three percent of the Bureau's accusation matters adjudicated by the Attorney General, reported in subdivisions (a)(7) and (b), below. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	58
(2) accusation matters rejected for filing by the Attorney General.	4
(3) accusation matters for which further investigation was requested by the Attorney General.	10
(4) accusation matters for which further investigation was received by the Attorney General.	5
(5) accusations filed.	44
(6) accusations withdrawn.	2
(7) accusation matters adjudicated by the Attorney General.	47

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	215	121	288	44
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	886	1,114	394	4
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	166	162	100	9
(4) from the filing of an accusation to when a default decision is sent to the agency.	90	69	68	16
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	92	99	51	17
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	128	122	77	18

Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board

The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board regulated 28,335 licenses in Fiscal Year 2015-2016 with 14 types. Complaints received by the Board are investigated by the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	7
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	0
(4) accusation matters for which further investigation was received by the Attorney General.	0
(5) accusations filed.	7
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	18

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	272	156	304	18
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	524	524	0	1
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	335	306	191	14
(4) from the filing of an accusation to when a default decision is sent to the agency.	62	62	0	1
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	116	78	93	12
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	166	171	62	3

Structural Pest Control Board

The Structural Pest control Board regulated 26,391 licenses in Fiscal Year 2015-16 with five different license types. Most complaints received by the Board are investigated by the Board's own staff or investigators, or referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. There were multiple respondents in about four percent of the Board's accusation matters adjudicated by the Attorney General, reported in subdivisions (a)(7) and (b), below. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	46
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	6
(4) accusation matters for which further investigation was received by the Attorney General.	6
(5) accusations filed.	50
(6) accusations withdrawn.	0
(7) accusation matters adjudicated by the Attorney General.	64

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	73	63	49	63
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	74	74	0	1
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	254	212	192	21
(4) from the filing of an accusation to when a default decision is sent to the agency.	156	108	132	39
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	115	125	65	11
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	114	93	64	6

Veterinary Medical Board

The Veterinary Medical Board regulated 25,799 licenses in Fiscal Year 2015-16 with five different license types. The Board receives consumer complaints and routinely inspects veterinary hospital premises for compliance. The Board's cases are investigated by the Board's own inspectors or other staff, and when appropriate, may also be referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit. There were multiple respondents in about 1 percent of the Board's accusation matters adjudicated by the Attorney General, reported in subdivisions (a)(7) and (b), below. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	33
(2) accusation matters rejected for filing by the Attorney General.	0
(3) accusation matters for which further investigation was requested by the Attorney General.	7
(4) accusation matters for which further investigation was received by the Attorney General.	6
(5) accusations filed.	30
(6) accusations withdrawn.	1
(7) accusation matters adjudicated by the Attorney General.	44

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	200	177	150	44
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	237	237	85	2
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	267	266	166	31
(4) from the filing of an accusation to when a default decision is sent to the agency.	68	52	34	4
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	128	133	72	15
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	192	165	48	5

Board of Vocational Nursing and Psychiatric Technicians

The Board of Vocational Nursing and Psychiatric Technicians regulated 134,410 licenses in Fiscal Year 2015-16 with two different license types, vocational nurse and psychiatric technician. Most complaints received by the Board are investigated by the Board's own staff or investigators, and referred to the Department of Consumer Affairs Division of Investigation, Investigations and Enforcement Unit, when appropriate. The tables below show data for Fiscal Year 2016-17.

Table 1 – Business and Professions Code Section 312.2, Subdivision (a)	
Number of –	Count
(1) accusation matters referred to the Attorney General.	285
(2) accusation matters rejected for filing by the Attorney General.	7
(3) accusation matters for which further investigation was requested by the Attorney General.	23
(4) accusation matters for which further investigation was received by the Attorney General.	18
(5) accusations filed.	319
(6) accusations withdrawn.	1
(7) accusation matters adjudicated by the Attorney General.	339

The statistics reported in Table 2 are based on the adjudicated accusation matters reported under Business and Professions Code section 312.2, subdivision (a)(7) in Table 1.

Table 2 – Business and Professions Code Section 312.2, Subdivision (b)				
Average number of days for adjudicated accusation matters –	Mean	Median	SD	Count
(1) from receipt of referral by the Attorney General to when an accusation is filed.	130	111	114	335
(2) to prepare an accusation for a case that is rereferred to the Attorney General after further investigation is received.	326	284	207	16
(3) from the filing of an accusation to when a stipulated settlement is sent to the agency.	201	182	136	180
(4) from the filing of an accusation to when a default decision is sent to the agency.	84	58	77	129
(5) from the filing of an accusation to the Attorney General requesting a hearing date.	107	91	74	95
(6) from the Attorney General's receipt of a hearing date to the commencement of a hearing.	112	87	63	32

CONCLUSION

This first report is for the data in Fiscal Year 2016-17, and establishes a baseline to build on for future reports. This data collection and report will assist the Office of the Attorney General to derive insights related to performance, productivity, and public protection enhancements that will assist in making strategic and operational decisions. The report will allow for statistical and predictive modeling techniques to identify trends and correlations to drive beneficial changes in business processes. The insights and value derived from this data will also provide the basis for the Office of the Attorney General to support the acquisition of additional resources and data knowledge tools. We will endeavor to identify any performance gaps as additional relevant data is generated and case delivery mechanisms are examined. We anticipate that this report will create collaboration among the Office of the Attorney General, Office of Administrative Hearings, and Department of Consumer Affairs, all of which join in responsibility for protection of the public through efficiency in adjudicating accusation matters.

This Attorney General's Annual Report on Accusations Prosecuted for Department of Consumer Affairs Client Agencies is also available on the Attorney General's website at http://oag.ca.gov/publications.

If you have any questions regarding this report, or if you would like additional information, please contact Sirat Attapit, Director of Legislative Affairs, at (916) 210-6192.

TAB 8

Osteopathic Medical Board

Future Agenda Items

Agenda Item	Requestor

TAB 9

Osteopathic Medical Board

Future Meeting Dates

Date	Place	Time
Thursday May 17, 2018	Chino, CA	10:00 am
Thursday September 27, 2018	San Diego, CA	10:00 am
Thursday January 17, 2019	Sacramento, 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.*