OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Teleconference, Thursday, May 13, 2021
10:00 a.m.

Osteopathic Medical Board of California
1300 National Drive, Suite 150
Sacramento, CA 95834-1991

OMBC Phone (916) 928-8390

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- **AB 1386 (*Cunningham*) License Fees: military partners and spouses**
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Tab 1

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

TELECONFERENCE BOARD MEETING NOTICE AND AGENDA

Date: Thursday, May 13, 2021
Time: 10:00 a.m. to 5:00 p.m. (or until the conclusion of business)

NOTE: Pursuant to the provisions of Governor Gavin Newsom's Executive Order N-29-20, dated March 17, 2020, neither Board member locations nor a public meeting location are provided. Public participation may be through the WebEx link as provided below. If you have trouble getting on the call to listen or participate, please call 916-928-8390.

The Osteopathic Medical Board of California will hold a public meeting via WebEx Events. To participate in the WebEx Events meeting, please log on to this website on the day of the meeting:

https://dca-meetings.webex.com/dca-meetings/onstage/g.php?MTID=e49b1c673ac4e05c4e52f670bfa59aa35

Instructions to connect to the meeting can be found at the end of this agenda. Members of the public may but are not obligated to provide their names or personal information as a condition of observing or participating in the meeting. When signing into the WebEx platform, participants may be asked for their name and email address. Participants who choose not to provide their names will need to provide a unique identifier such as their initials or another alternative, so that the meeting moderator can identify individuals who wish to make public comment; participants who choose not to provide their email address may utilize a fictitious email address like in the following sample format: XXXXX@mailinator.com.

AGENDA

Discussion and possible action may be taken on any items listed on the agenda, and items may be taken out of order to facilitate the effective transaction of business.

OPEN SESSION

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

2. Public Comment on Items Not on the Agenda

The Board may not discuss or take action on any matter raised during this public comment section except to decide whether to place the matter on the agenda of a future meeting. (Government Code sections 11125, 11125.7(a).)

3. Review and Possible Approval of January 14, 2021 Teleconference Board Meeting Minutes

4. Petition for Reinstatement of Revoked License, Keith Ky Ly, D.O., 20A 7355

CLOSED SESSION

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

RECONVENE IN OPEN SESSION

5. Budget Update – Paul McDermott, DCA Budget Office

6. Presentation and Update on the COMLEX USA Level 2 Performance Evaluation Exam and Alternative Pathways by the National Board of Osteopathic Medical Examiners (NBOME) – John R. Gimpel, D.O., MED – President and CEO, Douglas Murray, Esq, General Counsel and Geraldine O'Shea, D.O., Board Chair

7. Discussion, Review, and Possible Approval of the Board's Final Responses to the Sunset Review Background Paper Issues

8. Executive Director's Report – Mark Ito

   - Licensing
   - Staffing
   - Regulations
   - Examinations
   - COVID-19 Update
   - Enforcement Report – Corey Sparks

9. Discussion and Possible Action on Pending Legislation:

   - AB 2 (Fong) Regulations: legislative review: regulatory reform
   - AB 29 (Cooper) State bodies: meetings
   - AB 107 (Salas) Licensure: veterans and military spouses
   - AB 225 (Gray) Department of Consumer Affairs: boards: veterans: military spouses: licenses
   - AB 305 (Maienschein) Veteran services: notice
   - AB 339 (Lee) State and local government: open meetings
   - AB 356 (Chen) Fluoroscopy: temporary permit
   - AB 359 (Cooper) Physicians and surgeons: licensure: examination
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   - SB 48 (Limon) Dementia and Alzheimer's disease
   - SB 731 (Durazo) Criminal records: relief
   - SB 772 (Ochoa Bogh) Professions and vocations: citations: minor violations

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

11. Future Agenda Items

12. Future Meeting Dates

13. Adjournment

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

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

Board meetings are held in barrier free facilities that are accessible to those with physical disabilities in accordance with the Americans with Disabilities Act (ADA). If you are a person with a disability requiring disability-related modifications or accommodations to participate in the meeting, including auxiliary aids or services, please contact Machiko Chong, ADA Liaison, at (916) 928-7636 or e-mail at Machiko.Chong@dca.ca.gov or send a written request to the Board's office at 1300 National Drive, Suite 150, Sacramento, CA 95834-1991. Providing your request at least five (5) business days before the meeting will help to ensure availability of the requested accommodation. Requests should be made as soon as possible, but at least five (5) working days prior to the scheduled meeting. You may also dial a voice TTY/TDD Communications Assistant at (800) 322-1700 or 7-1-1.

Tab 2

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY • GAVIN NEWSOM, GOVERNOR
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Osteopathic Medical Board of California

Teleconference Minutes

January 14, 2021

MEMBERS PRESENT:	Cheryl Williams, President Cyrus Buhari, D.O., Secretary Treasurer Gor Adamyan Elizabeth Jensen, D.O. Claudia Mercado Andrew Moreno Hemesh Patel, D.O.
MEMBERS ABSENT:	None
STAFF PRESENT:	Sabina Knight, Esq., Legal Counsel, DCA Mark Ito, Executive Director Terri Thorfinnson, Assistant Executive Director Machiko Chong, Executive Analyst James Lally, D.O., Medical Consultant Corey Sparks, Enforcement Analyst
MEMBERS OF THE AUDIENCE:	Carrie Holmes, Board and Bureau Relations Nick Birtcil, Osteopathic Physicians & Surgeons of California Joseph Zammuto, D.O. Rebecca Mitchell, Naturopathic Medicine Committee Angie Burton Students, A.T. Still University – Visalia Campus

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

The Board Meeting of the Osteopathic Medical Board of California (OMBC) was called to order by President, Cheryl Williams at 10:03 a.m. Mark Ito called roll and determined a quorum was present. Due notice was provided to all interested parties.

Board Meeting Minutes – January 14, 2021

Agenda Item 2 Public Comment for Items not on the Agenda

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

Mark Ito presented former Board President, Joseph Zammuto, D.O. with a plaque to thank him for all of the work that he performed on behalf of the Board during his term. The floor was subsequently opened for public comment so that members of the public were able to offer further praise and acknowledgment of Dr. Zammuto.

Agenda Item 3 Election of Officers

President

Mr. Ito called for a nomination/motion for election of Board President.

Cyrus Buhari, D.O., was nominated for President by Andrew Moreno.
Elizabeth Jensen, D.O., was nominated for President by Claudia Mercado.

Dr. Jensen thanked Ms. Mercado for her consideration for nomination/motion of Board President, however she declined and chose to second the nomination/motion of Dr. Buhari for election of Board President.

Motion – Mr. Moreno **Second** – Dr. Jensen

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

- Motion carried to unanimously elect Dr. Buhari as Board President.

Vice President

Mr. Ito called for a nomination/motion for election of Board Vice President.

Elizabeth Jensen, D.O., was nominated for Vice President

Motion – Dr. Patel **Second** – Dr. Buhari

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

- **Absent** – None

- Motion carried to unanimously elect Dr. Jensen as Board Vice President.

Secretary/Treasurer

Mr. Ito called for a nomination/motion for election of Board Secretary/Treasurer.

Andrew Moreno was nominated for Secretary/Treasurer

Motion – Ms. Williams **Second** – Dr. Jensen

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

- Motion carried to unanimously elect Mr. Moreno as Board Secretary/Treasurer.

Agenda Item 4 Review and Possible Approval of Minutes

Ms. Williams called for a motion for approval of the meeting minutes of the September 10, 2020 and December 4, 2020 Teleconference Board Meetings.

Motion to approve the September 10, 2020 and December 4, 2020 Teleconference Board Meeting minutes with no corrections.

Motion – Dr. Buhari **Second** – Mr. Moreno

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

- Motion carried to approve the September 10, 2020 and December 4, 2020 Teleconference Board Meeting minutes with no corrections.

Agenda Item 5 Petition for Early Termination of Probation, James Paul Maganito, D.O., 20A 11964

The Office of Administrative Hearing (OAH) Administrative Law Judge (ALJ) Julie Cox conducted the above hearing.

CLOSED SESSION

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

RECONVENE IN OPEN SESSION

Agenda Item 6 Department of Consumer Affairs (DCA) Update – Carrie Holmes, Deputy Director of Board and Bureau Relations, DCA

Deputy Director Holmes Introduced herself, thanked the Board for allowing her to participate, and congratulated Dr. Buhari, Dr. Jensen, and Mr. Moreno on being elected to Board President, Vice-President, and Secretary/Treasurer.

Deputy Director Holmes informed the Board that DCA has conducted three brown bag trainings in the past six months, to better equip Executive Officers with best practices on topics such as: appointments, managing staff remotely, and providing ADA compliant meeting materials to members of the public. She stated that DCA has partnered with SOLID to offer virtual Board Member Orientation Trainings for newly and reappointed Board members and will be preparing to execute its first Board President training.

Deputy Director Holmes provided an update on the measures that DCA has taken to ensure the health and safety of both staff and members of the public considering the current climate due to COVID-19.

Agenda Item 7 Budget Report – Carl Beermann

Carl Beermann, DCA Budget Analyst, provided the Board with a detailed overview of the Board's budget for this fiscal year. Mr. Beermann indicated that the OMBC has a healthy fund condition and is anticipated to spend within their appropriation.

Mr. Ito inquired if the difference in appropriation for fiscal year 2020-21 and 2021-22 of the program expenditures was due in part to the five percent reduction in staff salary. He was informed by Mr. Beermann that the five percent reduction was not included in the 2021-22 projection at the time the report was generated, however the report did include the implementation of the Personal Leave Program (PLP) in the current year.

Agenda Item 8 Discussion and Possible Action to Initiate Rulemakings to Amend Board Regulations – Mark Ito

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

Mr. Ito provided the Board members with background information regarding the regulatory packet being presented and notified them of the changes that were needed in order to move the process forward. He informed the Board members that there was duplicative language found within the law and the proposed language. Currently, the amount of CME required is already identified in Business and Professions Code (BPC) section 2454.5 so it is redundant and unnecessary to include the required hours in CCR section 1635. Mr. Ito also advised the Board of the revisions made to the CME reporting period. He stated that the language has been amended to reflect the CME reporting period is the "2 years immediately preceding the expiration date." The revision should alleviate any confusion over the CME reporting dates.

Dr. Patel thanked Mr. Ito for requesting amendment and approval of the proposed language adding that the CME cycle has always been confusing not only for him but fellow physicians as well.

Motion to approve the proposed text for a 45 day public comment period and delegate to the Executive Director the authority to adopt the proposed regulatory changes if there are no adverse comments received during the public comment period, to follow established procedures and processes in doing so, and also delegate to the Executive Director the authority to make any technical and non-substantive changes that may be required in completing the rulemaking file.

Motion – Dr. Jensen **Second** – Dr. Buhari

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

- Motion carried to approve the proposed text for a 45 day public comment period and delegate to the Executive Director the authority to adopt the proposed regulatory changes if there are no adverse comments received during the public comment period, to follow established procedures and processes in doing so, and also delegate to the Executive Director the authority to make any technical and non-substantive changes that may be required in completing the rulemaking file.

Agenda Item 9 Discussion and Possible Adoption of the Osteopathic Medical Board of California's Administrative Manual – Sabina Knight

Ms. Knight advised the Board of the final amendments that had been to the OMBC'S Administrative Manual. The Board previously met in December 2020 to delegate the ability to make non-substantive changes to the Executive Director, and also voted to

approve all minor changes to the document for inclusion in the OMBC'S 2020 Oversight Report.

Additionally, Ms. Knight noted that the manual included a proposed provision for how many votes the Board would need to hold a closed session item for discussion. The Board would have the ability to discuss the topic at the next available board meeting in closed session pending two (2) Board members vote to add it as a closed session item.

Dr. Patel inquired if it would be easier moving forward to create a committee to assist with revisions to the Manual annually and alleviate some of the strain on Board staff regarding revision completion. Ms. Knight advised that it is something that the Board members could consider if they liked. However, it may not be necessary considering the major revisions that have been made and the only changes that would be needed moving forward would be any laws that have been revised.

Motion to adopt the Osteopathic Medical Board of California's Administrative Manual, as well as delegate to the Executive Director the ability to continue to make non-substantive changes to the OMBC's Administrative Manual.

Motion – Ms. Mercado **Second** – Dr. Jensen

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

- Motion carried to adopt the Osteopathic Medical Board of California's Administrative Manual, as well as delegate to the Executive Director the ability to continue to make non-substantive changes to the OMBC's Administrative Manual.

Agenda Item 10 Executive Director's Report – Mark Ito

Mr. Ito updated the Board on licensing statistics, staffing, regulations, and COVID-19 updates, which were included in the Board packet.

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

Agenda Item 11 Discussion and Possible Approval of Guidelines for the Recommendation of Cannabis for Medical Purposes

Ms. Knight informed the Board that the Cannabis Prescribing Guidelines Committee opted to table the discussion until the next Board meeting. She stated that she has been

working alongside the Board's committee to finalize the proposed language of the Guidelines for the Recommendation of Cannabis.

Ms. Mercado inquired if any of the professional members would be willing to read over the Guidelines and provide additional input. Dr. Jensen stated that she would be more than willing to and would provide her commentary on any items that she felt may need revision. Ms. Knight stated that any of the Board members could review and provide their feedback to Board staff once the document is disseminated if they would like.

Agenda Item 12 Future Agenda Items

- Review of Guidelines for the Recommendation of Cannabis for Medical Purposes (*Proposed Language*)
- Future Committees for Board related matters (*i.e. Telehealth, Outreach, etc.*)

Agenda Item 13 Future Meeting Dates

Mr. Ito suggested that the Board consider having additional meetings monthly to facilitate petitioner hearings as the Board had not completed any in the latter part of 2020. He stated that the Board need not make an immediate decision, however he recommended that they could revisit the topic at the next Board meeting.

Dr. Jensen inquired if Board staff could be provided a figure of petitioners that are awaiting to be heard and was informed by Mr. Ito that he would make that number available so that they could make an advised decision.

- Thursday, May 13, 2021 @ 10:00 am – *TBD*
- Thursday, September 23, 2021 @ 10:00 am – *TBD*

Agenda Item 14 Adjournment

There being no further business or public comment, Ms. Williams adjourned the meeting at 3:15 p.m.

Tab 3

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Tab 4

Department of Consumer Affairs

Expenditure Projection Report

Osteopathic Medical Board
Reporting Structure(s): 11112600 Support
Fiscal Month: 9
Fiscal Year: 2020 - 2021
Run Date: 5/7/2021

PERSONAL SERVICES

Fiscal Code	PY FM13	Budget	Current Month	YTD	Projections to Year End	Balance
5100 PERMANENT POSITIONS	$811,356	$866,000	$69,287	$555,719	$723,645	
5100 TEMPORARY POSITIONS	$500	$0	$0	$500	$667	
5105-5108 PER DIEM, OVERTIME, & LUMP SUM	$2,100	$3,000	$400	$1,809	$2,412	
5150 STAFF BENEFITS	$471,611	$532,000	$38,626	$327,048	$425,874	
PERSONAL SERVICES	**$1,285,567**	**$1,401,000**	**$108,312**	**$885,076**	**$1,152,597**	**$248,403**

OPERATING EXPENSES & EQUIPMENT

Fiscal Code	PY FM13	Budget	Current Month	YTD	Projections to Year End	Balance
5301 GENERAL EXPENSE	$67,445	$140,000	$138	$23,706	$32,584	
5302 PRINTING	$17,350	$8,000	$2,393	$8,480	$18,822	
5304 COMMUNICATIONS	$4,328	$19,000	$350	$3,793	$5,058	
5306 POSTAGE	$0	$7,000	$278	$278	$370	
5308 INSURANCE	$29	$0	$0	$0	$29	
53202-204 IN STATE TRAVEL	$25,835	$14,000	$0	$0	$0	
5322 TRAINING	$385	$6,000	$0	$0	$385	
5324 FACILITIES	$60,746	$110,000	$5,154	$40,593	$54,124	
53402-53403 C/P SERVICES (INTERNAL)	$296,000	$696,000	$35,316	$253,681	$487,161	
53404-53405 C/P SERVICES (EXTERNAL)	$156,846	$195,000	$21,969	$66,626	$156,825	
5342 DEPARTMENT PRORATA	$489,711	$423,000	$7,928	$377,620	$492,493	
5342 DEPARTMENTAL SERVICES	$1,173	$0	$31	$593	$791	
5344 CONSOLIDATED DATA CENTERS	$2,325	$2,000	$0	$0	$2,325	
5346 INFORMATION TECHNOLOGY	$8,294	$4,000	$250	$2,604	$3,472	
5362-5368 EQUIPMENT	$17,970	$0	$0	$1,811	$2,415	
54 SPECIAL ITEMS OF EXPENSE	$1,059	$0	$0	$0	$1,059	
OPERATING EXPENSES & EQUIPMENT	**$1,149,495**	**$1,624,000**	**$73,833**	**$779,812**	**$1,257,913**	**$366,087**

OVERALL TOTALS	**$2,435,062**	**$3,025,000**	**$182,145**	**$1,664,888**	**$2,410,511**	**$614,489**

20.3%

Osteopathic Medical Board of California
(Dollars in Thousands)
2021-22 Governor's Budget with FM 09 Projections

	2019-20	CY 2020-21	BY 2021-22	BY+1 2022-23
BEGINNING BALANCE	$3,344	$5,025	$5,157	$4,038
Prior Year Adjustment	-$37	$0	$0	$0
Adjusted Beginning Balance	$3,307	$5,025	$4,719	$4,038
REVENUES, TRANSFERS AND OTHER ADJUSTMENTS				
Revenues				
4121200 - Delinquent fees	$14	$18	$15	$15
4127400 - Renewal fees	$1,770	$2,284	$1,755	$1,755
4129200 - Other regulatory fees	$29	$27	$31	$31
4129400 - Other regulatory licenses and permits	$488	$484	$985	$985
4150500 - Interest from interfund loans	$45	$0	$0	$0
4163000 - Income from surplus money investments	$95	$22	$52	$52
4171400 - Escheat of unclaimed checks and warrants	$3	$1	$0	$0
4172500 - Miscellaneous revenues	$268	$74	$0	$0
Totals, Revenues	$2,712	$2,910	$2,838	$2,838
General Fund Transfers and Other Adjustments	$1,500	-$166	$0	$0
TOTALS, REVENUES, TRANSFERS AND OTHER ADJUSTMENTS	$4,212	$2,744	$2,838	$2,838
TOTAL RESOURCES	$7,519	$7,769	$7,557	$6,876

EXPENDITURES AND EXPENDITURE ADJUSTMENTS	2019-20	CY 2020-21	BY 2021-22	BY+1 2022-23
Expenditures:				
1111 Program Expenditures (State Operations)	$2,281	$2,411	$3,239	$3,336
9892 Supplemental Pension Payments (State Operations)	$53	$53	$53	$53
9900 Statewide Pro Rata	$160	$148	$227	$227
TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS	$2,494	$2,612	$3,519	$3,616
FUND BALANCE				
Reserve for economic uncertainties	$5,025	$5,157	$4,038	$3,260
Months in Reserve	23.1	17.6	13.4	10.8

NOTES:
Assumes workload and revenue projections are realized in BY +1 and ongoing.
Expenditure growth projected at 3% beginning BY +1.
CY revenue and expenditures are projections.

Tab 5

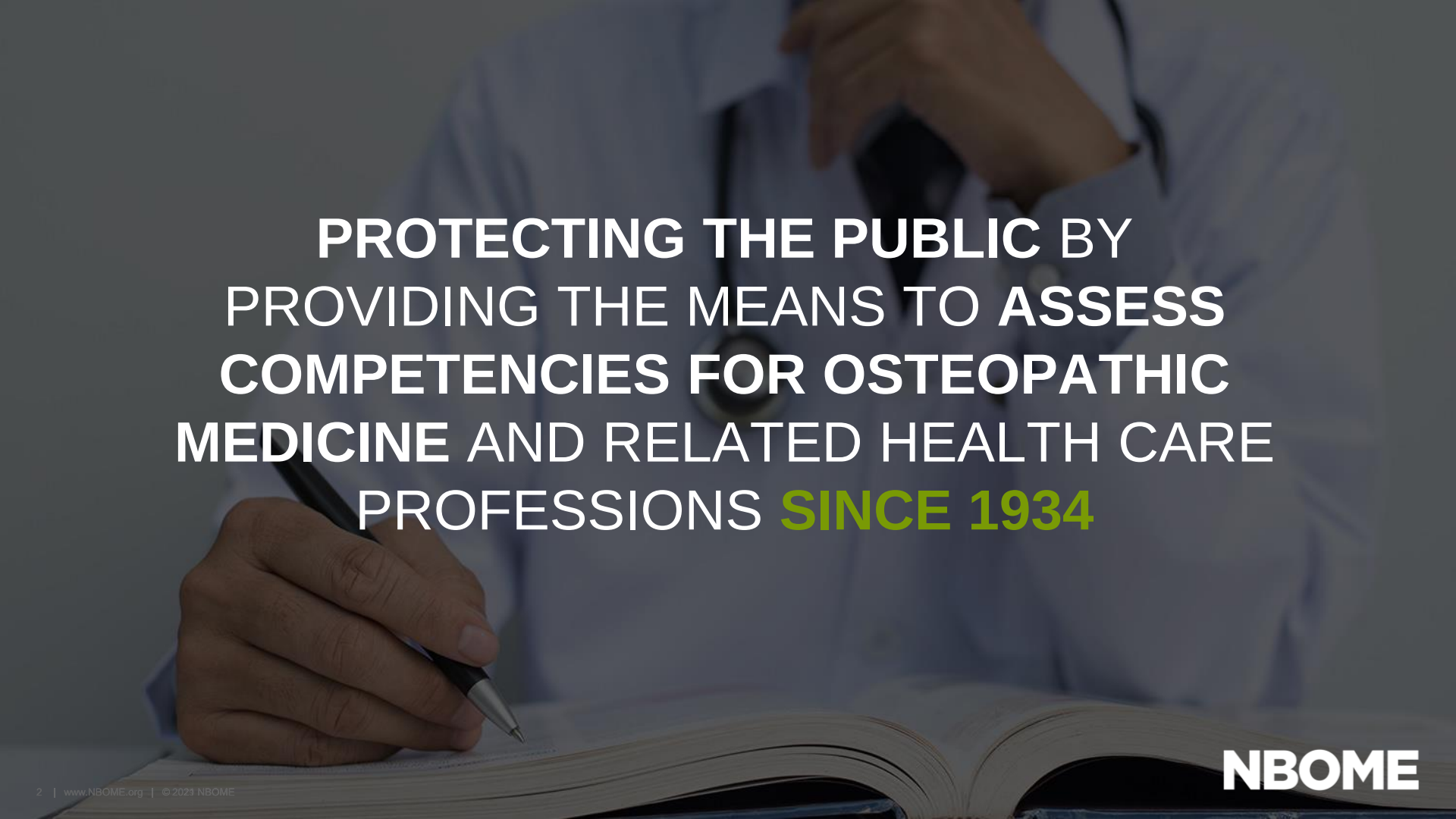
NBOME Update:
Osteopathic Medical Board of California

John Gimpel, DO, MEd

Douglas Murray, Esq.
General Counsel

May 13, 2021

NBOME
NATIONAL BOARD OF OSTEOPATHIC MEDICAL EXAMINERS



NBOME

NBOME CONTINUITY
THROUGH THE PANDEMIC

AGILITY IN DELIVERING SAFE TESTING

WEEKLY MONITORING OF TESTING CAPACITY

- Increased testing dates (incl. Saturdays and Sundays) and longer testing hours at many Prometric centers
- Procured “seat holds” for COMLEX USA candidates from Prometric
- Weekly reports directly to contact at COMs informing them of their COM statistics (96% satisfaction rating from participating COMs)
- Expanded our CS team to increase available representatives and provide person to person contact to assist test takers

SATELLITE TESTING CENTER PARTNERSHIPS for CBT examinations July-September 2020

- Reduced urgent needs for testing seats
- UNTHSC TCOM and MSU COM

RESULTS OF EFFORTS

- Over 30,000 administrations completed by since reopening of Prometric sites on 5/4/20
    - Over 96% of the Class of 2022 took Level 1
    - Over 98% of the Class of 2021 took Level 2 CE
    - Over 13,000 Level 3 administrations

NBOME

LEVEL 2-PE AND SPECIAL COMMISSION

COMLEX-USA Level 2-PE is postponed indefinitely

- **Due to continuing pandemic conditions and related restrictions**

SPECIAL COMMISSION ON OSTEOPATHIC MEDICAL LICENSURE ASSESSMENT

- Comprised of 19 groups representing individuals from across the UME to GME to practice continuum for osteopathic medicine, including licensure and patient/public representation
- Stakeholder surveys, public commentary periods, we want to hear from you

NBOME

REPRESENTATION

COMMISSION REPRESENTATION
*Accreditation Council on Graduate Medical Education (ACGME)
American Association of Colleges of Osteopathic Medicine (AACOM) Board of Deans
American Association of Osteopathic Examiners (AAOE) / licensure
American Osteopathic Association (AOA)
AOA-Bureau of Emerging Leaders (BEL) / (student or resident)
AOA-Student Osteopathic Medical Association (SOMA) / (student)
Assembly of Osteopathic Graduate Medical Educators (AOGME)
Commission on Osteopathic College Accreditation (COCA)
Council of Osteopathic Student Government Presidents (COSGP) / (student)
Educational Council on Osteopathic Principles (ECOP)
National Board of Osteopathic Medical Examiners (NBOME) Board of Directors & National Faculty
Organization of Program Director Associations (OPDA)
Patient/Public Representative

COMLEX-USA

SPECIAL COMMISSION ON OSTEOPATHIC MEDICAL LICENSURE ASSESSMENT

PHASE 1: February 22-April 30, 2021

- Focus on obtaining feedback regarding the verification, documentation, and assessment of fundamental clinical skills for the pathway for licensure in the context of the indefinite suspension of COMLEX-USA Level 2-PE due to the pandemic
- Position statements from over 20 organizations (including state boards and AAOE) as well as 5600 individual survey respondents reviewed
- Temporary Level 3 pathway for Classes of 2020-21 announced March 11, 2021
- Temporary Level 3 pathways for Classes of 2022 and beyond announced April 29, 2021

NBOME

COMLEX-USA

SPECIAL COMMISSION ON OSTEOPATHIC MEDICAL LICENSURE ASSESSMENT

PHASE 2: May 2021-April 2022

- Focus on long-term solutions to assess competencies for osteopathic medicine in the COMLEX-USA program, with an eye on our collective duty to ensure quality care for the public and our patients.
- Phase 2 will review the COMLEX-USA program in its entirety, including the competency domains for the practice of osteopathic medicine, ongoing initiatives in assessment delivery innovations and technologies, adding content related to practice tasks such as telemedicine and caring for patients with COVID-19, and imperatives related to diversity, equity and inclusion.

NBOME

SPECIAL COMMISSION ON OSTEOPATHIC MEDICAL LICENSURE ASSESSMENT

TEMPORARY ELIGIBILITY PATHWAYS FOR COMLEX USA LEVEL 3 CLASSES OF 2020 AND 2021

PATHWAY 1: Classes of 2020 and 2021

(Passed COMLEX USA Level 2 PE)

- Passing of both COMLEX-USA Level 2-CE and Level 2-PE
- Graduation from an accredited COM with DO degree
- Attestation of Program Director that you are in good academic and professional standing
- Recommended 6 months of GME completion

PATHWAY 2: Class of 2021

(Never Took COMLEX USA Level 2 PE)

- Attestation by COM Dean that you have graduated and have demonstrated the fundamental osteopathic clinical skills necessary for graduation
- Attestation of Program Director that you are in good academic and professional standing
- Recommended 6 months of GME completion

PATHWAY 3: Classes of 2020 and 2021

(Unsuccessful Attempt of COMLEX USA Level 2 PE)

- Attestation by COM Dean that you have graduated and have demonstrated the fundamental osteopathic clinical skills necessary for graduation
- Attestation of Program Director that you are in good academic and professional standing
- Required 6 months of GME completion

NBOME

TEMPORARY ELIGIBILITY PATHWAYS FOR COMLEX USA LEVEL 3 CLASSES OF 2022 AND 2023 AND BEYOND

Class of 2022

- Enhanced attestation by COM Dean that you have graduated and have demonstrated the fundamental osteopathic clinical skills necessary for graduation
- Attestation of Program Director that you are in good academic and professional standing
- Recommended 6 months of GME completion
- Details to be announced by June 30, 2021

Class of 2023 and Beyond

NBOME will continue to explore means to assess and/or verify fundamental osteopathic clinical skills via options that may include, but would not be limited to, COM clinical skills program certification, COM based clinical skills assessment, and virtual clinical skills assessment.

NBOME

ORGANIZATIONAL FEEDBACK

1. Which clinical skills remain important to assess for osteopathic physician licensure
    - Physician patient communication
    - Interpersonal skills
    - Professionalism
    - Medical interviewing (data gathering/history taking)
    - Performing a physical examination
    - Osteopathic palpatory diagnosis
    - Performing OMT
    - Electronic documentation of a patient encounter
    - Clinical problem solving
    - Integrated differential diagnosis, including OPP/OMT where appropriate
    - Formulation of diagnostic and treatment plan

2. Recommendations your organization has regarding assessing these skills in the absence of the Level 2 PE?

3. Submit feedback to COMLEXCommission@nbome.org

NBOME

THANK YOU!

#DOProud | #NBOME | #COMLEX-USA / #RoadToDOLicensure

NBOME

Tab 6

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

MEMORANDUM

DATE	May 5, 2021
TO	Board Members
FROM	*Mark M. Ito* Mark Ito Executive Director
SUBJECT	**Final Responses to the Sunset Review Background Paper Issues – Agenda Item 7**

On April 9, 2021, the Assembly Committee on Business and Professions and Senate Committee on Business, Professions and Economic Development (Joint Committee) convened a Sunset Review Hearing for the Osteopathic Medical Board of California (Board). The Board was represented by Cyrus Buhari, D.O., Board President and Mark Ito, Executive Director. The Joint Committee published a Background Paper, which among other things, posed issues and questions for the Board.

Attached to this memo are the questions posed to the Board by the Joint Committee and proposed answers to the questions for your review and approval.

Action Requested: Staff recommends the Board move to approve the responses as written and delegate to the Executive Director the authority to make technical and non-substantive changes that may be required to submit the responses to the Background Paper.

CURRENT SUNSET REVIEW ISSUES

The following are unresolved issues pertaining to the Osteopathic Medical Board of California or areas of concern that should be considered, along with background information for each issue. There are also recommendations Committee staff have made regarding particular issues or problem areas OMBC needs to address. OMBC and other interested parties have been provided with this Background Paper and OMBC will respond to the issues presented and the recommendations of staff.

BOARD ADMINISTRATION AND BUDGET ISSUES

ISSUE #1: (BOARD COMPOSITION.) The Committees have been concerned about the impact the decision in *North Carolina State Board of Dental Examiners v. FTC* would have on California professional regulatory boards. Prior legislative efforts would have protected board members by establishing active supervision through independent review of board decisions and by ensuring members who serve on boards like OMBC are not personally liable in the event they are sued in an antitrust matter related to their board service. Does OMBC's composition need to be updated to include members of the public?

Background: In 2010, the Federal Trade Commission (FTC) brought an administrative complaint against the North Carolina State Board of Dental Examiners (Board) for exclusion of non-dentists from the practice of teeth whitening. The FTC alleged that the Board's decision was an uncompetitive and unfair method of competition under the Federal Trade Commission Act. This opened the Board to lawsuits and substantial damages from affected parties.

The Board was composed of 6 licensed, practicing dentists and 2 public members. The practice of teeth whitening was not addressed in the statutes comprising the Dental Practice Act. Instead of initiating a rulemaking effort to clarify the appropriate practice of teeth whitening, the Board sent cease-and-desist letters to non-dentists in the state offering teeth whitening services. The Board argued that the FTC's complaint was invalid because the Board was acting as an agent of North Carolina, and according to state-action immunity, one cannot sue the state acting in its sovereign capacity for anticompetitive conduct. A federal appeals court sided with the FTC, and the Board appealed to the United States Supreme Court (Court).

In February 2015, the Court agreed with the FTC and determined that the Board was not acting as a state agent and could be sued for its actions. The Court ruled, "Because a controlling number of the Board's decision-makers are active participants in the occupation the Board regulates, the Board can invoke state-action antitrust immunity only if it was subject to active supervision by the State, and here that requirement is not met."

The Court was not specific about what may constitute "active participants" or "active supervision." However, the Court did say that "active supervision" requires "that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy," and that "the supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it."

In October 2015, the FTC released a staff guidance, *Active Supervision of State Regulatory Boards Controlled by Market Participants* in order to better explain when active supervision of a state

regulatory board would be required, in order for a board to invoke the state action defense. The guidance also aimed to highlight what factors are relevant when determining if the active supervision requirement has been satisfied. The FTC states that active supervision includes the ability of a state supervisor to review the substance of the anticompetitive decision and have the power to veto or modify a decision. The state supervisor may not be an active market participant. In addition, the FTC states that active supervision must precede the implementation of the alleged anticompetitive restraint.

The FTC states that the guidance addresses only the active supervision requirement of the state action defense, and antitrust analysis is fact-specific and context-dependent. This means that although a state action defense might not be applicable in a certain case, this does not mean that the conduct of a regulatory board necessarily violates federal antitrust laws.

On October 22, 2015, the Committees held a joint informational hearing to explore the implications of the Court decision on the DCA's professional regulatory boards and consider recommendations.

In response to the Court's decision, State Senator Jerry Hill requested an opinion from the Office of Attorney General Kamala Harris (AG). The AG released the following:

> "North Carolina Dental has brought both the composition of licensing boards and the concept of active state supervision into the public spotlight, but the standard it imposes is flexible and context-specific. This leaves the state with many variables to consider in deciding how to responds.
>
> Whatever the chosen response may be, the state can be assured that North Carolina Dental's 'active state supervision' requirement is satisfied when a non-market-participant state official has and exercises the power to substantively review a board's action and determines whether the action effectuates the state's regulatory policies.

Boards like OMBC are semiautonomous bodies whose members are appointed by the Governor and the Legislature. Although a most of the non-healing arts boards have statutory authority for a public majority allotment in their makeup, most healing arts and non-healing arts boards are comprised of a majority of members representing the profession.

North Carolina State Board of Dental Examiners v. FTC placed limitations on the immunity of regulatory boards controlled by active market participants. This is because individuals who are directly affected by their own rulemaking may not be able to detect their biases, purposefully or inadvertently placing their benefit over those of the public. Or, as the Supreme Court stated, "Dual allegiances are not always apparent to an actor."

Although the boards are tied to the state through various structural and statutory oversights, it is presently unclear whether current laws and practices are sufficient to ensure that the boards are state actors and, thus, immune from legal action. Changing the Board's composition to a public member may decrease OMBC's risk of exposure to lawsuits and have the added value of creating a more patient centric program.

Staff Recommendation: ***The Committees may wish to amend the Act to add two additional members of the public to OMBC, one appointed by the Senate Committee on Rules, and one appointed by the Speaker of the Assembly, to establish a public majority membership.***

Board Response: **The OMBC is comprised of nine members, five D.O.s and four public members. The OMBC currently has two member vacancies, which are both professional members. The OMBC has not had any issues with its current composition. The OMBC does not believe that its composition needs to be changed but is open to discuss this issue further. The Board is under the umbrella of the Department of Consumer Affairs and is actively supervised by DCA, Agency and the Legislature.**

ISSUE #2: (REGULATIONS.) OMBC indicates that is has a number of pending regulatory packages, including efforts to implement recent legislation and enhance Board operations. What is the status of OMBC regulations and what has OMBC's experience with the DCA Regulations Unit been? Have timeframes decreased and are regulations approved more swiftly than they were previously?

Background: Promulgating regulations is at the heart of OMBC's work to implement the law and establish a framework for consumer protection. According to the Office of Administrative Law (OAL), a "regulation" is any rule, regulation, order or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it. When adopting regulations, every department, division, office, officer, bureau, board or commission in the executive branch of the California state government must follow the rulemaking procedures in the Administrative Procedure Act (APA) (Government Code section 11340 et seq.) and regulations adopted by OAL, unless expressly exempted by statute from some or all of these requirements. The APA requirements are designed to provide the public with a meaningful opportunity to participate in the adoption of regulations or rules that have the force of law by California state agencies and to ensure the creation of an adequate record for the OAL and judicial review."

The rulemaking process does provide some discretion to agencies. While each agency must comply with timeframe requirements and must produce the same uniform documents supporting rulemaking efforts to submit to OAL, there are not the same standards for how regulation packages are determined, written, and produced.

Prior to 2016, boards and bureaus like OMBC that are organized within DCA filed rulemaking packages directly with OAL. Boards and bureaus were not required to submit rulemaking packages to DCA or the overseeing agency for review and approval prior to submission for publication in the Notice Register. OAL reported that this process was unusual within state government: most programs must submit regulations packages to their respective agency for approval. As a result, in September 2016, the Secretary of the Business, Consumer Services and Housing Agency (BCSH) changed the procedures: boards and bureaus were now required to submit rulemaking packages to the department and BCSH for review prior to filing with OAL. BCSH stated that the reason for the decision was an increase in the number of regulations disapproved by OAL for failing to meet their statutory requirements.

According to a 2019 DCA report to the Legislature, *Internal Review of Regulation Procedures*, "the resulting enhanced scrutiny from Agency and DCA's Legal Affairs Division successfully reduced the number of disapproved regulation packages, with the number of disapprovals falling from nine in 2016 to only one in 2018." The report also found that "while disapproval rates plummeted, a consequence was lengthened timelines to adopt regulations. Several boards and bureaus raised objections to the lengthened review time and reported difficulty obtaining timely updates about regulation packages under review." The "pre-review" process required regulations to go through DCA's entire review

process prior to the package being submitted for public comment. DCA established a formal Regulations Unit designed to "minimize the length of time it currently takes to review regulatory packages; allow board and bureau attorneys to focus on the increased workload of non-regulatory work; respond to the demand of regulation packages under review and the increase of regulation packages from Chapter 995, Statutes of 2018 (AB 2138); avoid the habitual carry-over of regulation packages; and, enhance the level of regulation training provided to boards and bureaus to improve the quality of regulations and create efficiencies by having better quality packages submitted for review."

In its 2020 Sunset Report to the Legislature, OMBC indicated that the Board approved the following regulation changes:

- Disciplinary Guidelines – This regulatory package proposes to add specified uniformed standards related to substance abuse and updates the OMBC's existing standards and optional terms of probation. OMBC advised that the package was rejected by OAL on December 9, 2016 and a request to resubmit was granted by OAL on March 17, 2017. The revised regulatory language has been approved by OMBC and the revised regulatory package is being drafted.

- Substantial Relationship and Rehabilitation Criteria (AB 2138) – This regulatory package amends existing regulations consistent with AB 2138 (Low, Chapter 995, Statutes of 2018) and to accurately reflect the OMBC's authority to consider denials or discipline and petitions for reinstatement or modification of penalty. AB 2138 is further discussed in Issue #___ below. This package was filed with OAL on November 20, 2020 and is waiting for final approval.

- Postgraduate Fee – This regulatory package implemented an application and processing fee for the PTL. This package was approved by OAL on June 16, 2020.

- Notice to Consumers – This package creates regulations that outline the requirements for licensees to provide notice to consumers that D.O.s are licensed by the OMBC, patients can check the status of a D.O., and how patients can file a complaint against a D.O., stemming from changes implemented through SB 798 which took effect in 2018. This package is currently under review by DCA.

- CME – This regulatory package amends the renewal process to allow for self-certification of CME and to create a post-renewal audit process. The revised regulatory language has been approved by OMBC and the full regulatory package is being drafted.

- Fee Increase – This regulatory package would increase the application fee for a D.O. The OMBC's fund is currently structurally balanced so the need for a fee increase has been alleviated. If its fund balance begins to decrease, the OMBC will submit this regulatory proposal in the future.

It would be helpful for the Committees to have a better understanding of why certain regulation packages are delayed, the status of necessary OMBC regulations, the timeframe for regulations to be processed and complete, and what efficiencies OMBC has realized since the creation of the DCA Regulations Unit.

Staff Recommendation: ***OMBC should provide the Committees with an update on pending regulations and timeframes for regulatory packages, and advise on efficiencies in promulgating regulations OMBC has experienced in recent years, if any.***

Board Response: **The OMBC's Postgraduate Training License regulation was approved in 2020. The Notice to Consumers and AB 2138 regulation packages are currently under review by the Office of Administrative Law. The Disciplinary Guidelines and CME regulatory packages are currently with the OMBC and will be submitted later this calendar year.**

The OMBC has observed efficiencies in the services we have received from the DCA's Regulations Unit. Specifically, in the expeditious review of applicable documents and the Economic and Fiscal Impact Statement (Form 399).

ISSUE #3: (MENTAL HEALTH SERVICES FOR COVID-19 PROVIDERS.) Under ordinary circumstances, frontline healthcare providers and first responders often face difficult situations that are mentally and emotionally challenging. Are there new issues arising from, or ongoing issues being worsened by, the extreme conditions of the COVID-19 pandemic?

Background: Throughout the COVID-19 pandemic, frontline healthcare workers and first responders, such as D.O.s, M.D.s, nurses, respiratory care therapists, paramedics, and more, have been caring for COVID-19 patients through multiple deadly surges, including a record-shattering death toll surge in December of 2020.

The Centers for Disease Control notes that "[p]roviding care to others during the COVID-19 pandemic can lead to stress, anxiety, fear, and other strong emotions…. Experiencing or witnessing life-threatening or traumatic events impacts everyone differently. In some circumstances, the distress can be managed successfully to reduce associated negative health and behavioral outcomes. In other cases, some people may experience clinically significant distress or impairment, such as acute stress disorder, post-traumatic stress disorder (PTSD), or secondary traumatic stress (also known as vicarious traumatization). Compassion fatigue and burnout may also result from chronic workplace stress and exposure to traumatic events during the COVID-19 pandemic."

Frontline healthcare workers are essential to the state of California. Given the length and the unique conditions of the COVID-19 pandemic, it may be beneficial to track trends and identify potential challenges and solutions in delivering mental health care and support for frontline healthcare workers who have been under extreme physical and mental pressure since the start of the coronavirus pandemic.

Staff Recommendation: ***OMBC should discuss any findings related to the mental and behavioral healthcare needs of frontline healthcare providers arising from the COVID-19 pandemic.***

Board Response: **The Board has not done any studies at the Board level. The Board is aware that studies have been done at the national level that have focused on this topic. The Board collaborated with UC Davis on a Physician Suicide Study and anticipates that this will be included in their study.**

OMBC BUDGET ISSUES

ISSUE #4: (DAG FEE INCREASE.) Will the abrupt increase in the Attorney General's client billing rate for hours spent representing the Board in disciplinary matters result in cost pressures for the Board's special fund?

Background: In July of 2019, the California Department of Justice announced that it was utilizing language included in the Governor's Budget authorizing it to increase the amount it billed to client agencies for legal services. The change was substantial: the attorney rate increased by nearly 30% from $170 to $220, the paralegal rate increased over 70% from $120 to $205, and the analyst rate increased 97% from $99 to $195. While justification was provided for why an adjustment to the rates was needed, the rate hike occurred almost immediately and without any meaningful notice to any client agencies.

For special funded entities such as OMBC, unexpected cost pressures can be very impactful. OMBC has indicated that it estimates added costs of $70,000 in 2020-21 solely as a result of the Attorney General's rate increase.

Staff Recommendation: ***OMBC should inform the Committees about the impact of the Attorney General's rate increase and whether any action is needed by the Administration or the Legislature to safeguard the health of its special fund.***

Board Response: The Board's appropriation was adjusted to accommodate for the increase. The Board is closely monitoring its fund and doesn't appear to need a fee increase for the foreseeable future.

OMBC LICENSING ISSUES

ISSUE #5: (CME.) During the prior sunset review for OMBC, changes were made to CME that are still pending implementation. OMBC is requesting to decrease the amount of mandatory CME to sync its requirements to those MBC requires for its licensees. What is the rationale for this change, particularly given the CME changes are currently underway?

Background: OMBC's currently requires D.O.s to complete 100 hours of CME every two years, with 40 of those hours being AOA Category 1, the highest credit quality as defined by the AOA which is generally obtained by attending a CME conference in-person.

During its prior review, OMBC requested changes impacting CME and renewal cycles. OMBC approved a regulatory package that creates a self-certification system for licensees that would replace the time-consuming review of CMEs at the time of renewal. Additionally, the regulations create an audit system for the OMBC to audit the self-certifications of CME for all renewals. OMBC indicates that it was hesitant to create an audit system that weakened the OMBC's oversight of CME compliance for licensure in the interest of protecting public safety. Once approved, OMBC states that this new renewal system will streamline renewals for both licensees and OMBC staff while still protecting public safety. This regulatory package is being drafted by the OMBC and will be noticed in early 2021.

In its sunset report to the Legislature, OMBC now recommends amending the law to adjust CME requirements for D.O.s in California to 50 hours of CME every two years, with 20 of those hours being

American Osteopathic Association (AOA) Category 1 credit. In justifying the request, OMBC states that "California's CME requirements for D.O.s are double than the CME requirement for their M.D. colleagues. The OMBC believes that the current difference between CME requirements for M.D.s under the Medical Board of California and D.O.s under the OMBC does not line up with the parity of skill between the two types of medical degrees."

OMBC adds that most physicians maintain board certification in one medical specialty with many carrying one or more certifications in subspecialties and that these certifications require stand-alone CME requirements to measure and ensure competency in the specialties. OMBC states that the current 100-hour CME requirement, in addition to any specialty and subspecialty board maintenance of certification requirements, represents an additional barrier for D.O.s that their M.D. colleagues do not experience and further creates a disincentive for out-of-state residents and physicians to practice in California.

Given OMBC's reporting that California has the highest population of licensed D.O.s in the state and that applications received are at an all-time high, it would be helpful to understand what impact CME has on potential applicants.

Staff Recommendation: ***OMBC should update the Committees on the rationale for this request, in light of changes made recently to update CME cycles. OMBC should inform the Committees of the impacts any changes would have on OMBC's current ability to receive CME completion documentation directly and how this change will impact patients, the public, and licensees.***

Board Response: The OMBC's CME regulation package will be submitted to DCA for pre-review no later than June 30, 2021. There have been changes to the proposed language that required a vote by the full Board. The OMBC is currently finalizing the regulatory package with the changes.

The OMBC does not believe that requesting the reduction of CME hours and submitted a regulatory change will be an issue if done concurrently. Making the changes concurrently may create less confusion and streamline the process as the OMBC can do one outreach effort to notify its applicants, licensees and stakeholders of the changes.

The CME requirement should be reduced because it creates an unnecessary burden on DOs that have specialties or subspecialties and have specific CMEs to complete for the specialties. Additionally, DOs and MDs train side by side in residency so the CME standards should be consistent. The CME requirement for the Osteopathic Medical Board of 100 hours every two years is not the standard for the medical profession in the state of California and throughout the country so patient safety would not be compromised.

ISSUE #6: (AB 2138.) What is the status of OMBC's implementation of Assembly Bill 2138 (Chiu/Low) and are any statutory changes needed to enable the Board to better carry out the intent of the Fair Chance Licensing Act?

Background: In 2018, Assembly Bill 2138 (Chiu/Low, Chapter 995, Statutes of 2018) was signed into law, making substantial reforms to the license application process for individuals with criminal records. Under AB 2138, an application may only be denied on the basis of prior misconduct if the applicant was formally convicted of a substantially related crime or was subject to formal discipline by a licensing board. Further, prior conviction and discipline histories are ineligible for disqualification of

applications after seven years, with the exception of serious and registerable felonies, as well as financial crimes for certain boards. Among other provisions, the bill additionally requires each board to report data on license denials, publish its criteria on determining if a prior offense is substantially related to licensure, and provide denied applicants with information about how to appeal the decision and how to request a copy of their conviction history.

Because AB 2138 significantly modifies current practice for boards in their review of applications for licensure, it was presumed that its implementation will require changes to current regulations for every board impacted by the bill. It is also likely that OMBC may identify potential changes to the law that it believes may be advisable to better enable it to protect consumers from license applicants who pose a substantial risk to the public.

Staff Recommendation: ***OMBC should provide an update on its implementation of the Fair Chance Licensing Act, as well as relay any recommendations it has for statutory changes.***

Board Response: The AB 2138 regulation package was submitted to the Office of Administrative Law on December 2, 2020 for final approval. The Board has removed the conviction attestation from its applications and has increased functionality within BreEZe for tracking purposes. The Board does not anticipate needing statutory changes to carry out the intent of the Fair Chance Licensing Act.

ISSUE #7: (POSTGRADUATE TRAINING LICENSE.) OMBC now requires physicians to complete three years postgraduate training in order to be licensed. Concerns have been raised by PTL holders, echoing those OMBC raised during the original discussions about the new requirement to complete a residency program.

Background: Beginning January 1, 2020, D.O.s must satisfactorily complete a minimum of 36 months of approved postgraduate training. Three years comes from the industry-recognized standard of three years of training required for board certification by American Board of Medical Specialty boards in specialties like family medicine, internal medicine, pediatrics, and others. Stemming from OMBC's prior sunset review, the law changed previous authority for a D.O. to have full licensure after only one year of postgraduate training.

As noted previously, the PTL has posed challenges for OMBC in processing license and in meeting workload demands.

The PTL is intended to be an unrestricted licenses and specifies that a resident possessing this category of recognition from OMBC may engage in the practice of medicine in connection with their duties as an intern or resident physician, including its affiliated sites, or under those conditions as are approved in writing and maintained in the postgraduate training licensee's file by the director of his or her program. These D.O.s are authorized to diagnose and treat patients; prescribe medications without a cosigner, including prescriptions for controlled substances, if the individual has the appropriate Drug Enforcement Agency registration or permit and is registered with CURES; sign birth certificates without a cosigner; and sign death certificates without a cosigner. While law is clear on PTL authority, some agencies have policies or statutes that only authorize an unrestricted medical license holder to engage in certain activities, thus have directed residents holding a PTL that they are not fully authorized the same as licensees who have completed their three-year residency.

Concerns have been raised that:

- A PTL may not be deemed equivalent to an unrestricted medical license for purposes of Medi-Cal billing. Questions arose as to whether the PTL would impact billing for the Medi-Cal Payment Prospective System (PPS) in Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs). The Department of Health Care Services advised that there were not hindrances but later issued guidance that a PTL is not an unrestricted license, and an unrestricted license is required for an individual to enroll as a Medi-Cal Fee-For-Service (FFS) or Managed Care provider in order to work outside of a residency program, known as moonlighting. It appears that residents with a PTL who moonlight may not be able to bill Medi-Cal. Stakeholders have advised that prior to the transition to the PTL, residents could enroll as a Medi-Cal FFS or Managed Care provider and bill health plans for moonlighting services and are concerned that private health plans are following a similar direction by prohibiting payment for moonlighting services provided by residents with a PTL. This has led several health delivery systems, including FQHCs, Tribal & Rural Indian Health Centers, and private practices, are not allowing residents to moonlight. Primary care clinic representatives and family physician advocates are concerned that the inability to bill for moonlighting services decreases the number of providers available to serve patients and heavily impacts rural regions with primary care provider shortages, a demand which has only grown in light of the COVID-19 pandemic. Moonlighting also allows residents to work outside of their residency training and earn additional income to pay off their educational loans so decreased opportunities to moonlight affect patients, residents, and healthcare delivery systems. Stakeholders argue that individuals applying for residency programs are less incentivized to apply in California because they are not able to bill for services conducted while moonlighting and are concerned that, with fewer applicants, the state will have a smaller pool of medical graduates to choose and recruit which will negatively impact heath centers, communities, and patients reliant on resident care and worsen the provider shortage.

  The law specifies that the holder of a PTL may engage in the practice of medicine only in connection with his or her duties as a resident in an accredited postgraduate training program in California, including its affiliated sites, or under those conditions as approved in writing and maintained in the file by the director of his or her program. Accordingly, a holder of a PTL may moonlight with written authorization from the program director. The ability to moonlight does not equate to the ability to bill health plans for the reasons cited above and is further complicated by the CMS guidelines for residents. In terms of moonlighting, the resident is required to be "Fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State where the services are performed". DHCS concluded that the inability to bill health plans for moonlighting services rendered by residents with a PTL cannot be fixed administratively and requires policy revisions.

- Residents with a PTL may not be able to obtain Substance Abuse and Mental Health Services Administration (SAMHSA) DEA X-waivers in order to prescribe buprenorphine and practice medication-assisted treatment. Under the Drug Addiction Treatment Act of 2000 (DATA 2000), physicians complete a mandatory eight-hour training course and obtain a DEA-X waiver to administer and/or prescribe buprenorphine medication-assisted therapy to treat opioid use disorder. DEA-X waiver protocol requires physicians to first notify the SAMHSA Center for Substance Abuse Treatment (CSAT) of their intent. To verify waiver eligibility, physicians provide their DEA number, state medical license number, and training certificate details.

Stakeholders cite several recent cases of denied DEA X-waiver applications to say that SAMSHA does not recognize the PTL as a license, despite MBC confirming, as stated in FAQs, "that a resident can apply and be issued a controlled substance permit once he or she has obtained a postgraduate training license." PTL holders with DEA prescribing authority should be able to receive a DEA X-waiver to administer and or prescribe necessary treatment for opioid use issues.

- Residents with a PTL may not be able to sign birth certificates, death certificates, and disability forms. While the law states these are authorized activities, other agencies may require statutory or policy updates to ensure a PTL holder is able to do what they are trained and intended to do. Stakeholders note that residency programs have cited cases where residents with a PTL are not accepted as authorized signatories for essential documents. The California Department of Public Health Vital Records Registration Branch mentioned in response to a death certificate signed by a resident with a PTL that "Per H&SC 102795, the medical and health section data and the time of death shall be completed and attested to by the physician and surgeon last in attendance. The board's definition of PTL is neither a licensed physician or surgeon." Stakeholders say that for similar reasons, the California Employment Development Department prohibits medical graduates from signing disability forms.

Concerns have also been raised about provisions that limit a PTL holder's practice to the facility where they are training which some argue has empowered residency directors to deny residents the ability to gain practice experience by moonlighting at other facilities.

Staff Recommendation: ***OMBC should advise the Committees on recent discussions with other agencies that impact the ability of PTL holders to fully practice. The Committees may wish to make changes to the Act in order to create efficiencies in the PTL licensing process. OMBC should provide an update on discussions with stakeholders about continued barriers to practicing, allegations of program directors rejecting PTL holders' requests to practice at different facilities, and what steps need to be taken to ensure California patients receive access to quality care provided by residency program participants holding a PTL.***

Board Response: The OMBC had concerns with the bill during the initial implementation, but we fully support the consumer protection intention of the bill requiring 36 months of residency to obtain an unrestricted license.

The OMBC has been made aware of the impact that this bill has created, but also understands that any change may undermine consumer protection.

OMBC ENFORCEMENT ISSUES

ISSUE #8: (ENFORCEMENT DISCLOSURES.) OMBC licensees are required to disclose probationary status to patients and OMBC makes this available public on its website and through other means. How has the implementation of the Patient's Right to Know Act enhanced consumer awareness with OMBC and licensees? Has OMBC seen any changes in its disciplinary proceedings stemming from the disclosure requirement?

Background: Access to timely, accurate information about OMBC licensees is a fundamental means by which patients and the public are informed about medical services provided to them. OMBC posts

information on its website and has improved these efforts. When a licensee is placed on probation, generally they continue to practice and interact with patients, often under restricted conditions. As such, increasing the ability of patients and the public to obtain information about health care professionals they interact with has also been the subject of various Legislative and regulatory actions. Information posted to a licensee's profile and provided to the public is specifically set forth in statute. In 2018, the Legislature passed the Patient's Right to Know Act (SB 1448, Hill, Chapter 570, Statutes of 2018) which required physicians ordered on probation to proactively notify patients of their status and required OMBC to add a probation summary to the profile pages of physicians on probation for acts of serious misconduct.

As of July 1, 2019, D.O.s are required to provide a patient or the patient's guardian or healthcare surrogate with a disclosure prior to the patient's first visit if the licensee is on probation that contains the licensee's probationary status, the length of the probation and the end date, all practice restrictions placed on the D.O. by OMBC, the board's phone number, and an explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the OMBC's online license information site.

Physicians and surgeons licensed by OMBC and MBC have to comply with probation notification requirements under more narrow circumstances, only if there is a final adjudication by OMBC or MBC following an administrative hearing, or the physician and surgeon stipulates in a settlement to any of the following:

- The commission of any act of sexual abuse, misconduct or relations with a patient or client;
- Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely;
- Criminal conviction involving harm to patient safety or health;
- Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

Staff Recommendation: ***OMBC should advise the Committees whether the implementation of the Patient's Right to Know Act has enhanced consumer awareness about OMBC and its licensees? OMBC should update the Committees about any changes to its disciplinary proceedings stemming from the disclosure requirement.***

Board Response: The Board has implemented SB 1448. The Board posted information to its website and sent out the information to its applicants, licensees and stakeholders through its listserv messaging. The Board is in the process of implementing a system to ensure that DOs on probation are notifying their patients of their probationary status.

ISSUE #9: (DIVERSION AND UNIFORM STANDARDS FOR SUBSTANCE ABUSE.) OMBC has a diversion program and Diversion Evaluation Committee that recommends treatment for substance abusing D.O.s. What is the status of the program?

Background: OMBC maintains a diversion program to, as OMBC notes, monitor and treat D.O.s who are impaired by the use of alcohol and or drugs. OMBC utilizes a Diversion Evaluation

Committee (DEC), comprised of three D.O. members with expertise in substance abuse and psychosocial disorders, which, as OMBC notes, "provides the diversion program with the needed understanding of impaired D.O.s that could not be obtained by non-physician staff. Face to face meetings with these experts, ensures OMBC staff that the participants are receiving excellent guidance and monitoring in their sobriety, which, in turn, provides consumer safety. When and if there is a need, the DEC may remove a participant from practicing medicine until such time the DEC feels the participant is ready to resume practice." OMBC's Diversion program requires all licensees that are disciplined for substance abuse to enter the Diversion Program as a condition of probation. OMBC believes that the combination of requiring successful completion of the Diversion Program for all substance abusing licensee that is managed by trained case workers ensures the greatest protection of public safety and greatest chance for licensees to successfully recover from their addiction.

In response to concerns about the different approaches to deal with substance abusing healing arts licensees, SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) required the DCA to develop uniform and specific standards to be used by each healing arts board in dealing with substance-abusing licensees in 16 specified areas, including requirements and standards for: (1) clinical and diagnostic evaluation of the licensee; (2) temporary removal of the licensee from practice; (3) communication with licensee's employer about licensee status and condition; (4) testing and frequency of testing while participating in a diversion program or while on probation; (5) group meeting attendance and qualifications for facilitators; (6) determining what type of treatment is necessary; (7) worksite monitoring; (8) procedures to be followed if a licensee tests positive for a banned substance; (9) procedures to be followed when a licensee is confirmed to have ingested a banned substance; (10) consequences for major violations and minor violations of the standards and requirements; (11) return to practice on a full-time basis; (12) reinstatement of a health practitioner's license; (13) use and reliance on a private-sector vendor that provides diversion services; (14) the extent to which participation in a diversion program shall be kept confidential; (15) audits of a private-sector vendor's performance and adherence to the uniform standards and requirements; and (16) measurable criteria and standards to determine how effective diversion programs are in protecting patients and in assisting licensees in recovering from substance abuse in the long term. The Uniform Substance Abuse Standards (Uniform Standards) were finally adopted in early 2010, with the exception of the frequency of drug testing which was finalized in March 2011.

The DCA currently manages a master contract with MAXIMUS, Inc. (MAXIMUS), a publicly traded corporation for the healing arts boards that have a diversion program, including OMBC. Under this model, the individual boards oversee the programs, but services are provided by MAXIMUS. The services for licensees recovering from substance abuse or addiction under Maximus include managing both testing but also referrals for outpatient and inpatient treatment.

Health practitioners with substance abuse issues may be referred in lieu of discipline or self-refer into the programs to receive help with rehabilitation. After an initial evaluation, individuals accept a participation agreement and are regularly monitored in various ways, including random drug testing, to ensure compliance. Licensees are managed and monitored by case workers trained in substance abuse recovery. OMBC states that no other wellness program offers this high-level quality of case workers who work closely with licensees. OMBC believes that licensees have the highest chance of recovery if they are in a program that offers both treatment and testing, not just testing for abstinence. According to OMBC, many boards only test licensees but do not offer treatment services to assist in their successful recovery. OMBC is satisfied that its Diversion Program with Maximus managing it offers the best recovery options for D.O.s suffering from substance abuse or addiction.

Staff Recommendation: ***OMBC should update the Committees on the work of the DEC and diversion program and advise the Committees on the status of OMBC's adoption of the Uniform Standards. OMBC should advise the Committees whether it plans to utilize MBC's Physician Health and Wellness Program, in the event such a program is implemented at MBC, as the statute creating the program notes the need for "physicians and surgeons", which D.O.s are, and given the multiple other sections of BPC related to "physicians and surgeons" that OMBC follows in its regulatory efforts.***

Board Response: The Board is very satisfied with its current diversion program and with Maximus managing the program. The Board believes that the diversion program has played a key role in ensuring that public safety is met. The program continues to create success stories for substance abusing licensees to rehabilitate and rejoin the work force. The diversion program under Maximus has a very low relapse rate, which the Board considers a success. For this reason, the Board prefers to continue to utilize its existing diversion program and be excluded from the Physician Health and Wellness Program.

ISSUE #10: (OVERPRESCRIBING AND THE OPIOID CRISIS.) Growing efforts to combat the opioid crisis from a public health approach have brought attention to the important role D.O.s and other prescribers play in identifying patients who pose a risk for abusing or diverting controlled substances. How has OMBC furthered these efforts through its role as a regulator of D.O.s?

Background: In October of 2017, the White House declared the opioid crisis a public health emergency, formally recognizing what had long been understood to be a growing epidemic responsible for devastation in communities across the country. According to the Centers for Disease Control and Prevention (CDC), as many as 50,000 Americans died of an opioid overdose in 2016, representing a 28 percent increase over the previous year. Additionally, the number of Americans who died of an overdose of fentanyl and other opioids more than doubled during that time with nearly 20,000 deaths. These death rates compare to, and potentially exceed, those at the height of the AIDS epidemic.

Opioids are a class of drugs prescribed and administered by health professionals to manage pain. Modern use of the term "opioid" typically describes both naturally occurring opiates derived from the opium poppy as well as their manufactured synthetics. Common examples of prescription opioids include oxycodone (OxyContin, Percocet); hydrocodone (Vicodin, Norco, Lorcet); codeine; morphine; and fentanyl. Heroin is also an opioid.

In addition to providing pain relief, opioids can be used as a cough suppressant, an antidiarrheal, a method of sedation, and a treatment for shortness of breath. The majority of pharmaceutical opioids are Schedule II drugs under the federal Controlled Substances Act, considered by the federal Drug Enforcement Agency (DEA) to have a high potential for abuse that may lead to severe psychological or physical dependence. However, combination drugs containing lower doses of opioids combined with other active ingredients are typically less restricted; for example, cough syrups containing low doses of codeine are frequently classified Schedule V medications.

The abuse of prescription drugs was historically viewed as a criminal concern analogous to street narcotics cases regularly investigated by law enforcement. In recent years, however, an expert consensus has evolved around the opinion that the opioid crisis must be addressed through the lens of public health policy. This belief is supported by research demonstrating how health professionals may

have inadvertently contributed to the origins of the crisis. It is widely accepted that health professionals will play a critical role in any meaningful solutions.

In reviewing the effectiveness of nonpharmacological therapies, the CDC concluded that "nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. Clinicians should consider opioid therapy only if expected benefits for both pain and function are anticipated to outweigh risks to the patient. If opioids are used, they should be combined with nonpharmacologic therapy and nonopioid pharmacologic therapy, as appropriate." While efforts have not been successful to require D.O.s to refer patients to nonopioid pain management treatment options, OMBC may still consider steps to encourage or require its licensees to incorporate nonopioid treatments as part of the standard of care.

Prescribers are advised to regularly consult the state's prescription drug monitoring program (PDMP), known as CURES. CURES was first established in 1996 as a "technologically sophisticated" database containing prescription records collected through California's Triplicate Prescription Program, which provided the DOJ with copies of all Schedule II drug prescriptions. Subsequent legislation made CURES the state's sole prescription record repository and added Schedule III and IV drugs to the database. In 2008, CURES was upgraded to function as a PDMP, allowing health professionals, regulators, and law enforcement to conduct web-based searches of the system to inform prescribing practices and support investigations.

Every dispenser of controlled substances and every health practitioner authorized by the DEA to prescribe controlled substances is required to obtain a login for access to CURES. For each dispensed Schedule II, III, IV, or V drug, pharmacists are required to report basic information about the patient and their prescription. This information is then made available to other system users in a variety of possible contexts. For example, D.O.s may query a patient's prescription history prior to writing a new prescription; pharmacists can check the system before agreeing to fill a prescription for a controlled substance; regulators may review a licensee's prescribing practices as part of a disciplinary investigation; and law enforcement can incorporate a search of the system into a potential criminal case of drug diversion.

As of October 2018, health practitioners are required to consult the CURES database prior to writing a prescription for a Schedule II, III, or IV drug for the first time, and then at least once every four months as long as the prescription continues to be renewed. Other recently enacted statutes require the DOJ to facilitate interoperability between health information technology systems and the CURES database, subject to a memorandum of understanding setting minimum security and privacy requirements. As attention to the opioid crisis continues to grow, CURES and other PDMPs are regularly mentioned as powerful tools for curbing the abuse of prescription drugs.

OMBC is required to enforce the CURES query mandate as part of its oversight functions. OMBC may also use CURES as part of its own investigations into prescribing practices among licensees. As efforts to address the overprescribing epidemic persist, OMBC should continue to identify ways to utilize the system in its efforts to prevent opioid abuse and overdose deaths.

Staff Recommendation: ***OMBC should provide the Committees with insight into how it has helped to combat the opioid crisis through its oversight of D.O.s and whether it believes any further statutory change would better enable CURES to function principally as a public health tool.***

Board Response: **The Board has focused enforcement efforts on overprescribing. The Board utilizes its resources to enforce D.O.s that overprescribe. This is a high priority for the Board. The Board focuses on settling cases at or above the Disciplinary Guidelines when it comes to overprescribing cases. The Board reviews the CURES system when reviewing cases to focus on overprescribing DOs and patients utilizing multiple DOs as their supply chain.**

COVID-19

ISSUE #11: (WHAT EFFECT HAS THE COVID-19 PANDEMIC HAD ON OMBC.) Since March 2020, there have been a number of waivers issued through Executive Order which impact licensees and future licensees alike. Do any of these waivers warrant an extension or statutory changes? What is OMBC doing to address the pandemic?

Background: In response to the COVID-19 pandemic, a number of actions were taken by the Governor in 2020, including the issuance of numerous executive orders in order to address the immediate crisis. Many executive orders directly impact the state's healthcare workforce. For example, on, March 4, 2020, the Governor issued a State of Emergency declaration, as defined in Government Code § 8558, which immediately authorized the Director of the Emergency Medical Services Authority (EMSA) to allow licensed healthcare professionals from outside of California to practice in California without a California license. Under BPC § 900, licensed professionals are authorized to practice in California during a state of emergency declaration as long as they are licensed and have been deployed by the Director of EMSA. Following that executive order, on March 30, 2020, the Governor issued Executive Order N-39-20 authorizing the Director of DCA to waive any statutory or regulatory professional licensing relating to healing arts during the duration of the COVID-19 pandemic – including rules relating to examination, education, experience, and training. Many of the waivers, which affect the OMB, also affected other healing arts licensees under the DCA.

The OMB noted that pursuant to the Governor's Executive Orders N-40-20 and N-75-20, the OMBC worked on additional waiver with the DCA to address immediate impacts of the COVID-19 pandemic.

The OMBC worked on the following waiver requests with the Department:

- OMBC requested a waiver for licensees changing their license status from inactive to active. California Code of Regulations § 1646 (b) requires inactive licensees complete 20 hours of Category 1A (in-person) CME to be eligible for an active license. The requested waiver would allow inactive licensees to complete Category 1B (online) CME to be eligible for an active license.

  DCA Waiver 20-57 was issued on September 17, 2020. This waiver superseded DCA Waiver 20-02 that was issued on March 31, 2020. This waiver, among other things, waives any statutory or regulatory requirement that an individual seeking to reinstate or restore their license complete or demonstrate compliance with any CME requirements. A license reactivated or restored pursuant to this waiver if valid until January 1, 2021, or when the State of Emergency ceases to exist, whichever is sooner.

- DCA Waiver 20-69 was issued on October 22, 2020. This waiver superseded previous related waivers dated March 31, 2020, July 1, 2020, and August 27, 2020. This waiver, for active licensees expiring between March 31, 2020 and December 31, 2020, waives any statutory or

regulatory requirement to complete or demonstrate compliance with any CME requirements in order to renew a license.

- DCA Waiver 20-76 was issued on October 22, 2020. This waiver superseded previous related waivers dated May 6, 2020 and August 27, 2020. This waiver extends the date that an individual enrolled in an approved postgraduate training program in California must obtain a postgraduate training license from June 30, 2020 to December 31, 2020.

OMBC reports that is has not had any waiver requests denied through the DCA, nor does it have any waiver requests pending. Information about available waivers for DCA licensees is clearly accessible on the DCA's general website; however, information about waiver's impacting OMBC licensees is not as easy to identify for stakeholders who are inquiring about waiver availability.

Staff Recommendation: ***OMBC should advise the Committees on its COVID-19 waiver requests and whether or not any of the waivers be permanent or for a set time, or if any waivers are no longer necessary. OMB should update the Committees on the impact of COVID-19 to licensees and patients stemming from the pandemic and potential challenges for future D.O.s.***

Board Response: On March 19, 2020, Governor Newsom issued Executive Order N-33-20. This Executive Order provided a stay at home order for the citizens of California, except as needed to maintain continuity of operations. Board management determined that all Board staff are considered essential at this time considering the nature of the profession. Board management set up a telework schedule for staff that ensures that operational needs are met. Staff are required to intermittently work from the office while maintaining the appropriate social distancing guidelines.

On March 30, 2020, Governor Newsom issued Executive Order N-39-20. This Executive Order authorized the Director of the Department of Consumer Affairs (DCA) to waive any of the professional licensing requirements and amend scopes of practice in Division 2 of the Business and Professions Code and regulations. The following waivers have been issued during the pandemic:

- **DCA 21-134 Continuing Education – Active licensees that expire between March 31, 2020 and May 31, 2021 are temporarily exempt from completing or demonstrating compliance with any continuing education requirements in order to renew a license. These licensees must satisfy any waived renewal requirements within six months of the waiver, which was issued on March 30, 2021. Additionally, these waivers do not apply to any continuing education required pursuant to a disciplinary order against a license.**

- **DCA 20-02 Reinstatement of Licensure – Inactive licensees who are seeking to reactivate their license are temporarily exempt from completing or demonstrating compliance with any continuing education requirements. Additionally, these licensees do not need to pay any fees in order to reactivate their license. These licenses are valid for a maximum of six months, or when the State of Emergency ceases to exist, whichever is sooner. Additionally, licenses that were surrendered or revoked pursuant to disciplinary proceedings or any licensee who entered an inactive status following an initiation of a disciplinary proceeding are not eligible for this waiver.**

- **DCA 21-128 Postgraduate Training License (Initially enrolled June 1, 2020 – July 31, 2020) – Individuals who were initially enrolled in an approved postgraduate training program in**

California between June 1, 2020 and July 31, 2020, and who are required to obtain a postgraduate training license within 180 days of their enrollment, this waiver extends the time to obtain the postgraduate training license to June 30, 2021.

- **DCA 21-129 Postgraduate Training License (Enrolled January 1, 2020) – Individuals who were enrolled in an approved postgraduate training program in California on January 1, 2020, and who are required to obtain a postgraduate training license by June 30, 2020, this waiver extends the time to obtain the postgraduate training license to June 30, 2021**

CONTINUED REGULATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS BY THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

ISSUE #12: (CONTINUED REGULATION BY OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA.) Should the licensing and regulation of osteopathic physicians and surgeons be continued and be regulated by the current OMBC membership?

Background: Patients and the public are best protected by a strong regulatory board with oversight Primary care practitioners like D.O.s remain a highly trusted profession and millions of Californians receive quality care from OMBC licensees every day. OMBC remains a separate and distinct entity, despite trends and changes to further align D.O.s with M.D.s, and should continue taking steps to ensure patient protection is prioritized.

Staff Recommendation: ***The OMBC should be continued, to be reviewed again on a future date to be determined.***

Board Response: The OMBC is in support of the continued licensing and regulation by the current OMBC membership. The OMBC is a growing profession with a different approach to medicine than their M.D. counterparts. Additionally, as an initiative created board with specific laws that both establish and govern the Board, the OMBC has sole authority to regulate D.O.s in California. Considering the growing profession and the different approach to medicine, D.O.s should be licensed and regulated by the OMBC.

Tab 7

EXECUTIVE DIRECTOR'S REPORT

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

MEMORANDUM

DATE	May 3, 2021
TO	Board Members
FROM	Mark Ito Executive Director
SUBJECT	**Executive Director's Report – Agenda Item 7**

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

- Licensing
- Staffing
- Regulations
- Examinations
- COVID-19 Update
- Enforcement Report/Discipline

Licensing Statistics:

The table below shows the OMBC's total licensee count as of April 28, 2021. The table shows the number of licensees practicing or residing in California, and the total number of licensees under the OMBC's jurisdiction. The total number of licensees under the OMBC's jurisdiction is 12,253.

License Status	Practicing/Residing in CA	Total Licensees
Active/Current	8,814	10,324
Inactive/Current	66	540
Delinquent	588	1,389
Total:	9,468	12,253

* Total licensees under the OMBC's jurisdiction

The table below shows the Licensing Unit's workload for 2019-20 and 2020-21. The workload for 2020-21 is from July 1, 2020 – March 31, 2021. The number of days to approve a license application during the current fiscal year is 89 days. Applications with missing documents took an average of 127 days to complete and approve. The licensing workload for the OMBC continues to increase and we are looking into different ways to increase efficiency in the Licensing Unit. Creating efficiencies will allow the OMBC to process this increasing workload within our existing resources.

Licensing Workload		
	Fiscal Year 2019-20	Fiscal Year 2020-21*
	Total	Total
DO Apps Received	987	519
DO Apps Approved	1,020	422
DO Certificates Issued	997	396
PTL Apps Received	634	304
PTL Apps Approved	232	615
Licenses Renewed	4,456	4,342
Fictitious Name Permits Received	119	90
Fictitious Name Permits Approved	112	83
Fictitious Name Permits Renewed	678	666

* Fiscal Year 2020-21 data is from July 1, 2020 – March 31, 2021

Staffing:

The Board has 13.4 authorized positions with 11.4 of those positions currently filled.

On February 16, 2021, Beth Dutchler was hired as an Associate Governmental Program Analyst in the Board's Enforcement Unit. Ms. Dutchler will process all of the enforcement workload associated with the Postgraduate Training License. Currently, the Board has redirected Ms. Dutchler to assist with opening and processing initial complaints.

On April 9, 2021, the Board's cashier, Patrice Powe, separated from her employment with the Board.

The Board currently has the following two vacancies that are in various stages of the recruitment process:

- Staff Services Analyst to process physician and surgeon applications
- Office Technician to process all cashiering functions

Regulations

- Notice to Consumers – This regulatory proposal would adopt California Code of Regulations section 1606, which would require osteopathic physicians and surgeons to notify consumers of their licensure with the Board, that consumers can check the status of a license and file a complaint against a licensee. This regulatory package was submitted to the Office of Administrative Law on December 23, 2020 for final approval.

- AB 2138 – This regulatory proposal would amend regulations consistent with the provisions of Assembly Bill 2138 to more accurately reflect the Board's authority to consider denials and discipline. This regulatory proposal was submitted to the Office of Administrative Law on December 2, 2020 for final approval.

- Continuing Medical Education – This regulatory proposal would amend regulations to create a post-renewal audit, make exemptions to CME requirements and change the CME reporting period. The full board approved the proposed text at the January 14, 2021 Board Meeting. The Board anticipates submitting the regulatory proposal to the department for pre-review by the end of the fiscal year.

- Disciplinary Guidelines This regulatory proposal would add specified uniform standards related to substance abuse by incorporating them by reference. This proposal would also update the existing standards and optional terms of probation. The Board anticipates submitting the regulatory proposal by the end of the calendar year.

Examinations

California Code of Regulations (CCR) section 1620 states, "A successfully completed written examination is required for all applicants. The written examination may be:

(a) The National Board of Osteopathic Medical Examiners (National Boards) Parts I, II, and III;

The Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) is a three-level national standardized licensure examination designed for licensure for the practice of osteopathic medicine. The COMLEX-USA examination series follows a progressive sequence broken into three levels. The required examinations are listed below:

- COMLEX-USA Level 1 – Computer based, application of osteopathic medical knowledge concepts related to foundational sciences, patient presentations and physician tasks

- COMLEX-USA Level 2-CE – Computer based, application of osteopathic medical knowledge concepts related to clinical sciences, patient presentations and physician tasks

- COMLEX-USA Level 2-PE – Standardized patient-based assessment of fundamental clinical skills essential for osteopathic patient care

- COMLEX-USA Level 3 – Two-day computer based, application of osteopathic medical knowledge concepts related to clinic sciences, patient safety and independent practice, foundational competency domains and clinical presentations

On February 11, 2021, the National Board of Osteopathic Medical Examiners (NBOME) indefinitely postponed the COMLEX-USA Level 2-PE. The NBOME created alternative pathways for the class of 2020 and 2021 to be eligible for the COMLEX-USA Level 3. Eligibility to take COMLEX-USA Level 3 will be based on an attestation of their fundamental skills from Deans and Residency Program Directors.

COVID-19 Update:

On March 19, 2020, Governor Newsom issued Executive Order N-33-20. This Executive Order provided a stay at home order for the citizens of California, except as needed to maintain continuity of operations. Board management determined that all Board staff are considered essential at this time considering the nature of the profession. Board management set up a telework schedule for staff that ensures that operational needs are met. Staff are required to intermittently work from the office while maintaining the appropriate social distancing guidelines.

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- **DCA 20-02 Reinstatement of Licensure** – Inactive licensees who are seeking to reactivate their license are temporarily exempt from completing or demonstrating compliance with any continuing education requirements. Additionally, these licensees do not need to pay any fees in order to reactivate their license. These licenses are valid for a maximum of six months, or when the State

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ENFORCEMENT REPORT

The following OMBC Enforcement Report covers a 12-month period starting from April 1, 2020 to March 31, 2021. The OMBC Enforcement Report is divided into four sections: Intake, Investigations, Enforcement, and Probation. The data is collected from the DCA Enforcement Reports and ad hoc reports created in IBM Cognos Analytics.

COMPLAINT INTAKE

	2Q 2020			3Q 2020			4Q 2020			1Q 2021			
TOTAL INTAKE	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Totals
Received	70	51	44	52	46	57	51	54	35	49	34	62	605
Assigned/Closed	46	17	25	108	53	29	156	24	35	72	22	45	632
Aging	31	36	77	86	61	41	48	18	25	41	23	20	42
Pending	110	144	163	107	100	128	23	53	53	30	42	59	

Data Table 1: Complaint Intake with Convictions/Arrests

In Data Table 1 above, under TOTAL INTAKE, OMBC received 605 complaints (34 convictions/arrests). 632 complaints were either assigned or closed and the average aging for this period was 42 days. (The aging for intake measures the period from the date the complaint was received to the date the complaint was assigned). In Figure 1.1 below we see pending complaints drop significantly starting in October 2020 which was a result of the Board addressing the backlog of complaints during 2Q and 3Q 2020.

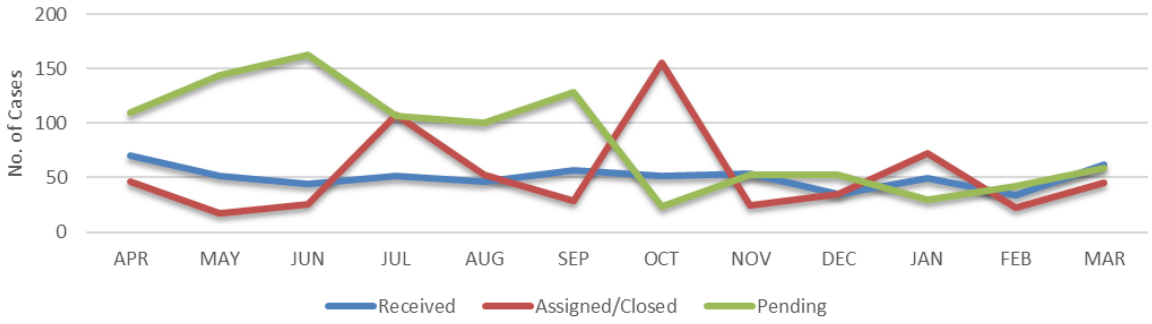


Figure 1.1: Intake Totals Per Month

INVESTIGATIONS

Desk (internal) Investigations

	2Q 2020			3Q 2020			4Q 2020			1Q 2021			
Desk Inv.	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Totals
Assigned	46	17	25	108	53	29	156	24	34	72	22	45	631
Completed	35	35	28	32	24	33	97	52	75	54	38	52	555
Aging	43	88	76	21	68	72	133	145	177	88	222	109	104
Pending	205	188	187	263	292	289	349	325	285	303	287	283	193

Data Table 2: Desk Investigations

For all desk investigations during this period, Data Table 2 above breaks down the monthly totals for how many complaints were assigned and completed; the monthly aging and cases pending. During this period, a total of 631 cases were assigned to desk investigations and 555 cases were completed. The average number of days to complete a desk investigation was 104 days. In Figure 2.1 on the following page, the assigned and completed caseloads averaged around 52 and 46 per month respectively. Pending desk investigations increased from 200 to 350 from 2Q 2020 to 4Q 2020 and leveled off to around 300 during 1Q 2021.

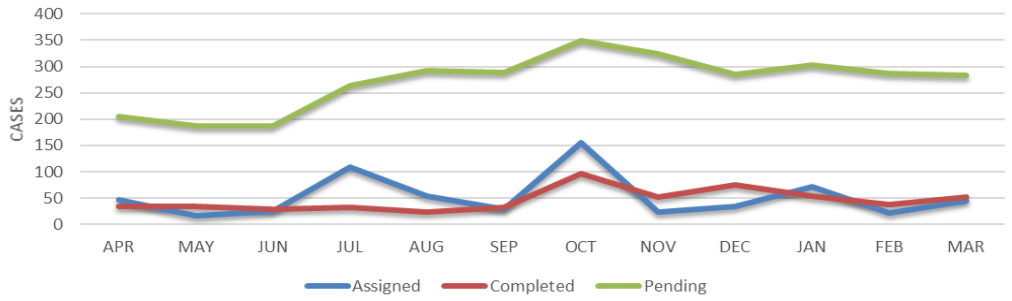


Figure 2.1: Desk Investigations Monthly Totals

Division of Investigation (DOI) Field Investigations

	2Q 2020			3Q 2020			4Q 2020			1Q 2021			
Field Inv.	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Totals
Assigned	5	2	0	1	1	1	5	2	5	5	4	3	34
Completed	1	0	2	1	3	5	2	2	2	4	2	4	28
Aging	366	0	82	962	365	536	591	814	602	871	665	565	523
Pending	52	54	52	52	50	47	50	51	54	55	57	57	

Data Table 3: Field Investigations

Data Table 3 above breaks down the monthly totals for cases assigned to the Division of Investigations. Completed cases are either closed with insufficient evidence or referred to the Attorney General's office for disciplinary action. During this 12-month period, 34 cases were assigned to field investigations; 28 were completed; and 57 cases were pending at the end of 1Q 2021. The average number of days to complete a field investigation was 523

The case complexity is the breakdown of the specific allegations. In Figure 3.1, for all 28 competed field investigations, there were 7 excessive prescribing cases (25%); 7 Unprofessional conduct (25%); 5 sexual misconduct cases (18%); 3 Criminal (11%); 1 negligent/injury cases (3%); 3 substance abuse cases (11%); and 2 Unlicensed practice (7%).

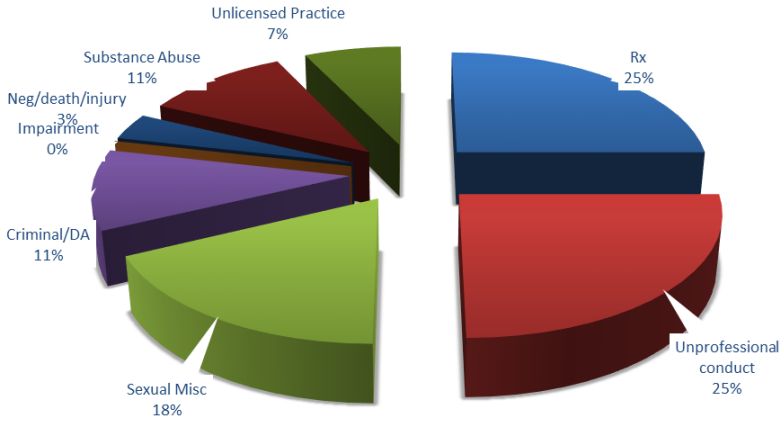


Figure 3.1 Complexity for completed Field Investigations

Aging for All Investigations

	2Q 2020			3Q 2020			4Q 2020			1Q 2021			
All Inv Aging	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Totals
90 days	32	18	17	28	16	22	47	23	27	26	5	24	285
91-180 days	0	11	6	3	3	1	14	16	17	16	7	17	111
181-1 yr	2	4	5	0	5	9	24	7	24	8	15	6	109
1 yr-2 yrs	1	0	1	0	2	3	9	3	5	1	5	1	31
2 yrs-3 yrs	1	1	0	1	0	1	1	3	2	3	2	2	17
Totals	**36**	**34**	**29**	**32**	**26**	**36**	**95**	**52**	**75**	**54**	**34**	**50**	**553**

Data Table 4: All Investigations Aging

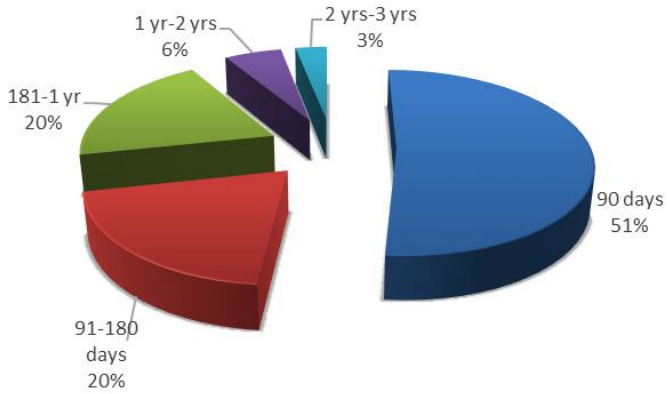


Figure 4.1: All Investigation Aging

In Data Table 4 and Figure 4.1 we see the aging matrix for the number of all investigations that were closed per month during this period. 285 cases (51%) were completed within 90 days; 111 cases (20%) were completed between 91-180 days; 109 cases (20%) were completed between 181-365 days; 31 cases (6%) were completed between 1 – 2 years; and 17 cases (3%) were completed between 2-3 years. 396 (71%) investigations were completed within 6 months; and 505 (91%) were completed within a year.

ENFORCEMENT ACTIONS

	2Q 2020			3Q 2020			4Q 2020			1Q 2021			
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Totals
AG Cases Initiated	5	1	1	0	1	2	2	2	1	3	1	0	19
Acc/SOI Filed	3	1	0	0	1	1	0	1	1	0	1	1	10
Final Discplinary Order	2	0	0	1	0	5	0	2	1	1	1	0	13
Acc W/drawn/declined	0	0	0	0	0	0	0	0	0	0	0	0	0
Closed w/out Disc Acti	0	1	0	0	0	2	0	1	0	1	0	0	5
Citations	0	0	0	2	1	0	0	0	0	0	0	0	3
Suspension Orders	0	0	0	0	1	1	0	0	0	0	0	1	3
AG Cases Pending	25	25	26	25	26	19	21	20	21	20	21	23	

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, 19 cases were transmitted to the Attorney General's Office for disciplinary actions; 10 Accusations/SOI were filed; 13 Final Disciplinary Orders were filed; 0 accusation withdrawn; 5 cases were closed without disciplinary action; 3 citations issued; and 3 Suspension Order was filed. 23 AG cases pending at the end of 1Q 2021.

Aging for Final Disciplinary Orders

	2Q 2020			3Q 2020			4Q 2020			1Q 2021			
Total Orders Aging	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Totals
90 Days	0	0	0	0	0	0	0	0	0	0	0	0	0
91-180 Days	0	0	0	0	0	1	0	0	0	0	0	0	1
181 - 1 Yr	1	0	0	0	0	0	0	0	0	0	0	0	1
1 - 2 Yrs	0	0	0	0	0	1	0	0	1	0	0	0	2
2 - 3 Yrs	0	0	0	0	0	0	0	1	0	0	0	0	1
3-4 Yrs	0	0	0	1	0	2	0	1	0	1	1	0	6
4 yrs	1	0	0	0	0	1	0	0	0	0	0	0	2
Totals	2	0	0	1	0	5	0	2	1	1	1	0	13

Data Table 6: Final Orders Aging Matrix

In Data Table 6 and Figure 6.1 we see the aging matrix of the 13 Final Disciplinary Orders that were completed during this 12-month period. The chart displays the percentage of cases distributed within each aging period: 1 case completed (8%) within 91-181 days; 1 cases completed (8%) within 181-365 days; 2 cases (15%) within 1-2 years; 1 case (8%) within 2-3 years; 6 cases (46%) within 3-4 years; and 2 cases (10%) after 4 years. Of the 13 Disciplinary Orders imposed (Figure 6.2 below), there were 8 probationary orders; 1 revocation; 2 surrenders; and 2 public reprimands.

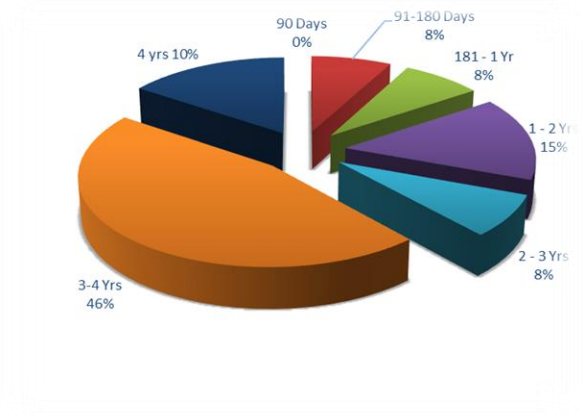


Figure 6.1: Final Orders Aging

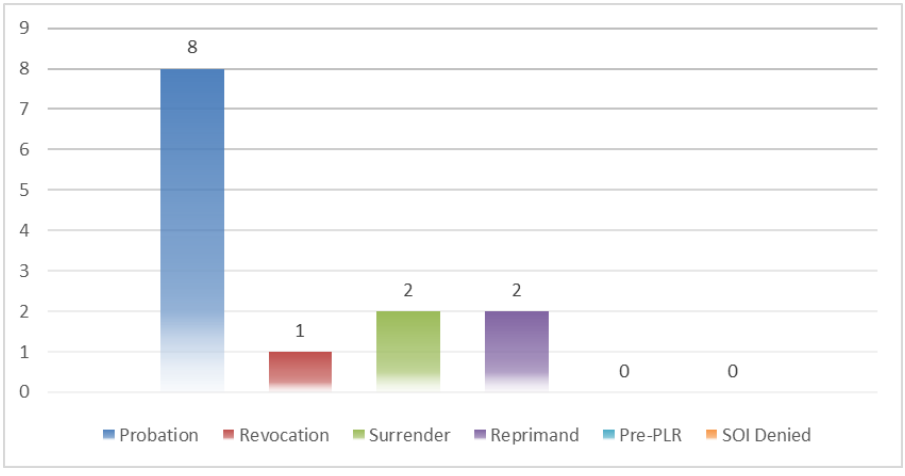
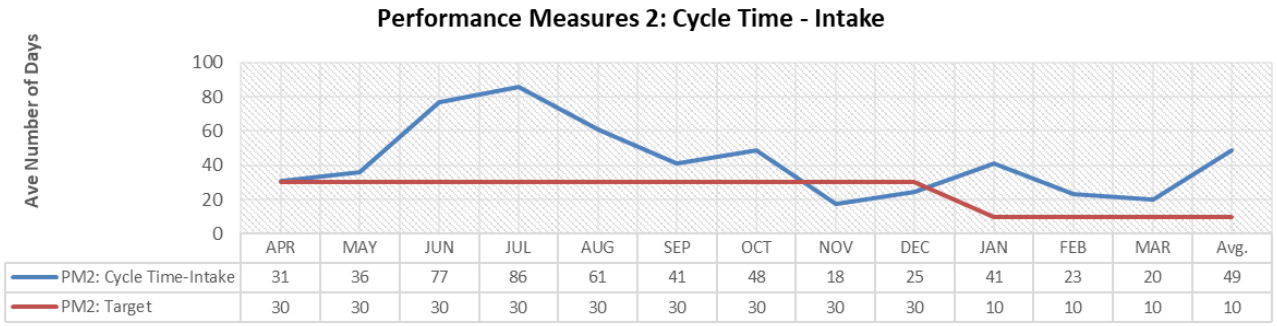


Figure 6.2: Final Disciplinary Actions Imposed
* Pre-accusation public letter for reprimand

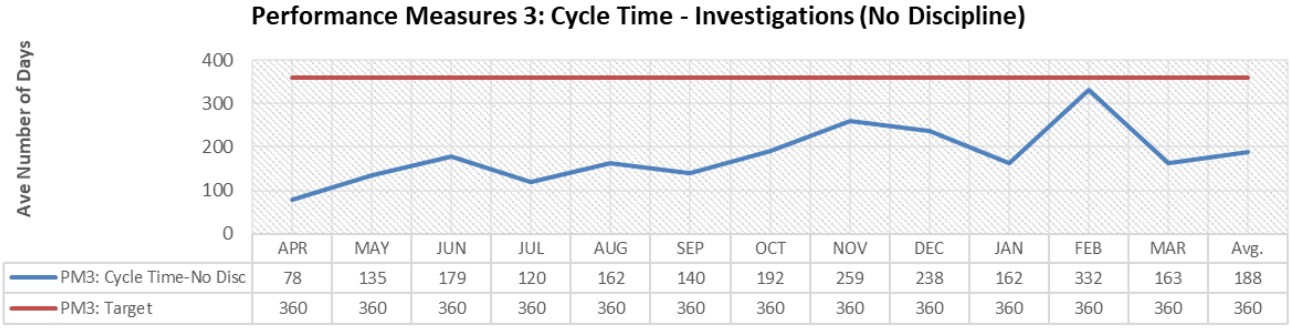
PERFORMANCE MEASURES

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



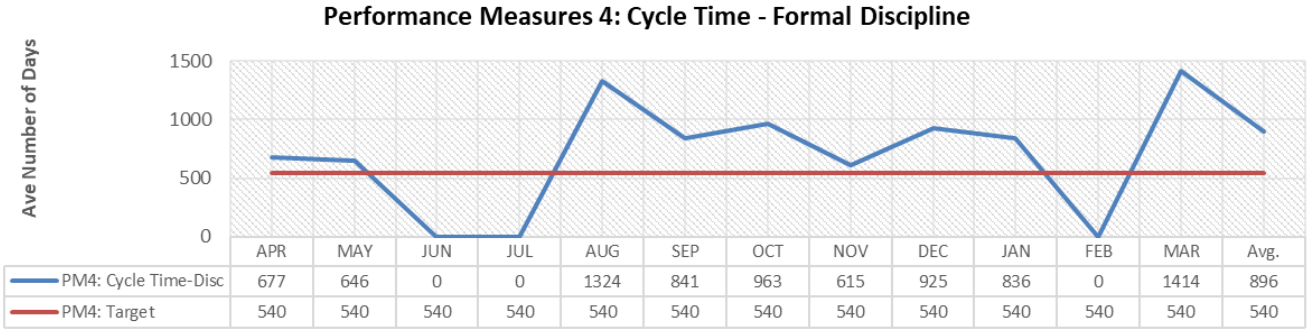
	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Avg.
PM2: Cycle Time-Intake	31	36	77	86	61	41	48	18	25	41	23	20	49
PM2: Target	30	30	30	30	30	30	30	30	30	10	10	10	10

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)



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Avg.
PM3: Cycle Time-No Disc	78	135	179	120	162	140	192	259	238	162	332	163	188
PM3: Target	360	360	360	360	360	360	360	360	360	360	360	360	360

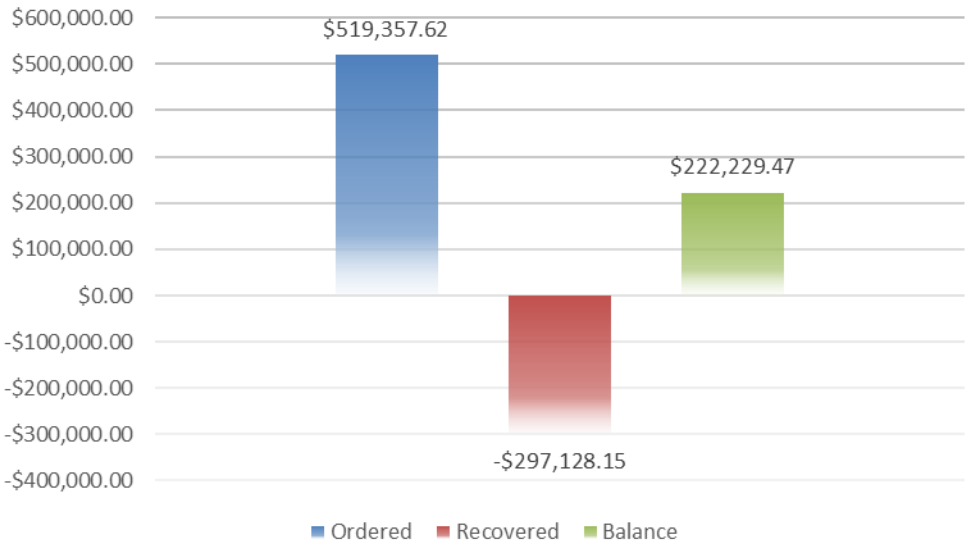
PM4: CYCLE TIME – FORMAL DISCIPLNE: Average number of days to complete the entire enforcement process for cases transmitted to the Attorney General for formal discipline. (Includes intake, investigation, and transmittal outcome)



	APR	MAY	JUN	JUL	AUG	SEP	OCT	NOV	DEC	JAN	FEB	MAR	Avg.
PM4: Cycle Time-Disc	677	646	0	0	1324	841	963	615	925	836	0	1414	896
PM4: Target	540	540	540	540	540	540	540	540	540	540	540	540	540

PROBATION

There are currently 40 probation cases; of which 12 cases are tolled. During this period 7 probationary cases were closed, and 8 cases opened. The total cost recovery ordered is currently $516,020.49. To date, $308, 172.80 has been paid, leaving a balance of $207,847.69.



Tab 8

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

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

MEMORANDUM

DATE	May 3, 2021
TO	Board Members
FROM	Mark Ito Executive Director
SUBJECT	**Pending Legislation – Agenda Item 8**

Listed below are the key bills that the Board has been following:

AB 2	Regulations: legislative review: regulatory reform Fong (R)

SUMMARY: This bill would require each state agency to, on or before January 1, 2023, review that agency's regulations, identify any regulations that are duplicative, overlapping, inconsistent, or out of date, to revise those identified regulations; and report those regulatory revisions to the Legislature and Governor.

INTRODUCED:	December 7, 2020
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Accountability and Administrative Review
STATUS:	January 11, 2021 – Referred to the Assembly Committee on Accountability and Administrative Review

AB 29	State Bodies: meetings Cooper (D)

SUMMARY: This bill would require a state body's notice to include all writings or materials. The bill would require those writings or materials to be made available on the state body's internet website, and to any person who requests the writings or materials in writing, on the same day as the dissemination of the writings and materials to members of the state body or at least 72 hours in advance of the meeting, whichever is earlier. The bill would prohibit a state body from discussing those writings or materials, or from taking action on an item to which those writings or materials pertain, at a meeting of the state body unless the state body has complied with these provisions.

INTRODUCED:	December 7, 2020
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Appropriations
STATUS:	April 21, 2021- Set for the first hearing. Referred to Suspense File

AB 107	Licensure: veterans and military spouses Salas (D)

SUMMARY: This bill would require all boards and bureaus within the Department of Consumer Affairs to issue temporary licenses to military spouses meeting specified criteria; require those temporary licenses to be issued within 30 days of receiving an application if the results of a criminal background check do not show grounds for denial; and require any regulations need to implement this bill be submitted to the Department by June 15, 2022. The Department would also be required to submit an annual report to the Legislature on licensure of military members, veterans and spouses.

INTRODUCED:	December 16, 2020
LAST AMENDED:	April 20, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Military and Veteran Affairs
STATUS:	April 21, 2021 – Re-referred to the Assembly Committee on Military and Veteran Affairs

AB 225	Department of Consumer Affairs: boards: veterans: military spouses: licenses Gray (R), Patterson (R) and Gallagher (R)

SUMMARY: This bill would extend the duration that temporary licenses issued to military spouses by specified boards and bureaus are active from 12 to 18 months after issuance. The bill would also require all boards and bureaus that do not issue temporary licenses to issue reciprocal licenses to honorably discharged veterans and military spouses that hold a professional license in another state if the spouse or veteran meets California's minimum requirements for license.

INTRODUCED:	January 11, 2021
LAST AMENDED:	April 11, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Military and Veteran Affairs
STATUS:	April 21, 2021 – Re-referred to the Assembly Committee on Military and Veteran Affairs

AB 305	Veteran Services: notice Maienschein (D)

SUMMARY: This bill would eliminate the requirement that state agencies inquire about veteran status and replace it with a requirement that state agencies inquire about veteran status on application forms and request permission to transmit the applicant's information to the Department of Veteran Affairs.

INTRODUCED:	January 25, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Military and Veteran Affairs
STATUS:	February 12, 2021 – Referred to the Assembly Committee on Military and Veteran Affairs

AB 339	Local government: open and public meetings Arambula (D), Cooley (D), and Rivas (D)

SUMMARY: This bill would require all meetings to have a call-in or interest-based service option that provides closed captioning provided to the public.

INTRODUCED:	January 28, 2021
LAST AMENDED:	April 15, 2021
DISPOSITION:	Pending

LOCATION: Assembly Committee on Local Government
STATUS: April 19, 2021 – Re-referred to the Assembly Committee on Local Government

AB 356	Fluoroscopy: temporary permit Flora (R) and Santiago (D)

SUMMARY: This bill would authorize the Department of Public Health to issue a physician and surgeon or a doctor of podiatric medicine a one-time, nonrenewable, temporary fluoroscopic permit. The temporary permit would be valid for up to 12 months form the date of the issue.

INTRODUCED: February 1, 2021
DISPOSITION: Pending
LOCATION: Assembly Committee on Business, Professions and Consumer Protection
STATUS: April 7, 2021 – Re-referred to Committee on Business, Professions and Consumer Protection

AB 359	Physicians and surgeons: licensure: examination Cooper (D)

SUMMARY: This bill would allow physicians and surgeons to be eligible for a California medical license even if they required more than four attempts to pass Step 3 of the USMLE examination as long as they are licensed in another state and meet other requirements. This bill would also expand the scope of topics allowed for continuing medical education to include certain administrative issues.

INTRODUCED: February 1, 2021
LAST AMENDED: March 22, 2021
DISPOSITION: Pending
LOCATION: Senate Committee on Rules
STATUS: April 26, 2021 – To Senate Committee on Rules for assignment

AB 562	Frontline COVID-19 Provider Mental Health Resiliency Act of 2021: health care providers: mental health services Flora (R)

SUMMARY: This bill would require the Department of Consumer Affairs, in consultation with the relevant boards, to establish a mental health resiliency program to provide mental health services to licensed health care providers who provide or have provided consistent in-person healthcare services to COVID-19 patients. The relevant boards would have to notify their licensees and solicit applications for access to the program.

INTRODUCED: February 11, 2021
LAST AMENDED: April 8, 2021
DISPOSITION: Pending
LOCATION: Assembly Committee on Appropriations
STATUS: April 15, 2021 – Re-referred to the Assembly Committee on Appropriations

AB 646	Department of Consumer Affairs: boards: expunged convictions Low (D), Cunningham (R), and Gipson (D)

SUMMARY: This bill would require a board within the department that has posted on its internet website that a person's license was revoked because the person was convicted of a crime, within 90 days of receiving an expungement order for the underlying offense from the person, if the person reapplies for licensure or is relicensed, to post notification of the expungement order and the date thereof on the board's internet website. The bill would require the board, on receiving an expungement order, if the person is not currently licensed and does not reapply for licensure, to remove within the same period the initial posting on its internet website that the person's license was revoked and information previously posted regarding arrests, charges, and convictions. The

bill would authorize the board to charge a fee to the person not to exceed the cost of administering the bill's provisions.

INTRODUCED:	February 12, 2021
LAST AMENDED:	April 14, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Appropriations
STATUS:	April 21, 2021 – Referred to Suspense File

AB 657	State civil service system: personal services contracts: professionals Cooper (D)

SUMMARY: This bill would prohibit a state agency from contracting with an outside professional for a period of no more than 365 consecutive days, or 365 nonconsecutive days in a 24-month period. The bill defines "professional" to include, among others, a physician and surgeon, dentist and clinical psychologist.

INTRODUCED:	February 12, 2021
LAST AMENDED:	April 21, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Public Employment and Retirement
STATUS:	April 22, 2021 – Re-referred to the Committee on Public Employment and Retirement

AB 705	Health care: facilities: medical privileges Kamlager (D)

SUMMARY: This bill would prohibit a health facility from placing limits on physicians from providing medical treatments that fall within the scope of their privileges. The bill would prohibit a health facility from limiting or otherwise exercising control over the independent professional judgment of a physician or surgeon concerning the practice of medicine or the diagnosis or treatment of disease, if the physician or surgeon, exercising their independent professional judgment, determines that a particular medical service or treatment.

INTRODUCED:	February 16, 2021
LAST AMENDED:	March 30, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Health
STATUS:	April 5, 2021 – Re-referred to the Committee on Health

AB 830	Department of Consumer Affairs: vacancies Flora (R)

SUMMARY: This bill would require the Department of Consumer Affairs to notify appropriate policy committees of the Legislature when the chief or executive officer position of any board or bureau becomes vacant.

INTRODUCED:	February 17, 2021
LAST AMENDED:	April 19, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Business and Professions
STATUS:	April 20, 2021 – Re-referred to the Committee on Business and Professions

AB 885	Bagley-Keene Open Meeting Act: teleconferencing Quirk (D)

SUMMARY: This bill would require a state body that elects to conduct a meeting or proceeding by teleconference to make the portion that is required to be open to the public both audibly and visually observable. The would also require a state body that elects to conduct a meeting or proceeding by

teleconference to post an agenda at the designated primary physical meeting location in the notice of the meeting where members of the public may physically attend the meeting and participate.

INTRODUCED:	February 17, 2021
LAST AMENDED:	March 24, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Governmental Organization
STATUS:	March 25, 2021 – Re-referred to the Assembly Committee on Governmental Organization

AB 1278	Physicians and surgeons: payment or transfer of value: disclosure: notice Nazarian (D)

SUMMARY: This bill would require a physician and surgeon who receives a payment or transfer of value from a drug or device company, to disclose the source of the payment or transfer of value in writing to each patient or patient representative prior to the intended use of the device or drug. Physicians and surgeons would have to post a notice about the CMS Open Payments database on their website and in their practice location.

INTRODUCED:	February 19, 2021
LAST AMENDED:	April 15, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Appropriations
STATUS:	April 19, 2021 – Re-referred to the Assembly Committee on Appropriations

AB 1386	License fees: military partners and spouses Cunningham (R)

SUMMARY: This bill would require boards and bureaus to waive initial license fees for military spouses.

INTRODUCED:	February 19, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Business and Professions
STATUS:	March 11, 2021 – Re-referred to the Assembly Committee on Business and Professions

AB 1477	Maternal mental health Cervantes (D)

SUMMARY: This bill would require a health care practitioners, who practice prenatal and postpartum care to offer mothers a mental health screening at least once during pregnancy and once postpartum.

INTRODUCED:	February 19, 2021
LAST AMENDED:	April 19, 2021
DISPOSITION:	Pending
LOCATION:	Assembly Committee on Health
STATUS:	April 20, 2021 – Re-referred to the Assembly Committee on Health

SB 48	Dementia and Alzheimer's disease Limon (D)

SUMMARY: This bill would require all general internists and family physicians to complete at least four hours mandatory continuing education on the special care needs of patients with dementia.

INTRODUCED:	December 7, 2020
LAST AMENDED:	March 9, 2021
DISPOSITION:	Pending

LOCATION: Senate Committee on Appropriations
STATUS: March 23, 2021 – Ordered to third reading

SB 731 Criminal Records: relief
Durazo (D) and Bradford (D)

SUMMARY: This bill would expand upon recent criminal justice reforms by creating further mechanisms for conviction dismissal. Felony conviction records would be automatically sealed for individuals who have completed their sentence and have gone two years without new criminal convictions.

INTRODUCED: February 19, 2021
LAST AMENDED: April 20, 2021
DISPOSITION: Pending
LOCATION: Senate Committee on Appropriations
STATUS: April 20, 2021 – Re-referred to the Senate Committee on Appropriations

SB 772 Professions and vocations: citations: minor violations
Ochoa Bogh (R)

SUMMARY: This bill would prohibit the assessment of an administrative fine for a minor violation, and would specify that a violation shall be considered minor if it meets specified conditions, including that the violation did not pose a serious health or safety threat and there is no evidence that the violation was willful.

INTRODUCED: February 19, 2021
DISPOSITION: Pending
LOCATION: Senate Committee on Business and Professions
STATUS: April 19, 2021 – Second hearing cancelled at the request of the author

Tab 9

OMBC

Osteopathic Medical Board of California

Guidelines for the Recommendation of Cannabis for Medical Purposes

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

Gavin Newsom, Governor of California
Cyrus Buhari, D.O., President, Osteopathic Medical Board
Mark M. Ito, Executive Director, Osteopathic Medical Board

Osteopathic Medical Board of California's
Guidelines for the Recommendation of Cannabis for Medical Purposes
May 2021

PREAMBLE

The Osteopathic Medical Board of California [Hereinafter referred to as "the Board"] developed these guidelines as cannabis, under qualifying circumstances, is a permissible treatment modality in California. The Board wants to assure physicians, who are licensed by this Board, who choose to recommend cannabis for medical purposes to their patients, will not be subject to investigation or disciplinary action 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 or disciplinary action 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. The Board recognizes that 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. *See California Business and Professions Code § 2525.3*.

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 statutory language of the Act states, in part, that the purpose of the Act is:

> "To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that 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 marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief." *See California Health and Safety Code § 11362.5(b)(1)(A).*

The Act also states that the purpose of the Act is to, "To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction." *See California Health and Safety Code § 11362.5(b)(1)(B)*

The Act also states, "Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes." *See California Health and Safety Code § 11362.5(c).*

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

Although the Act allows the use of cannabis for medical purposes by a patient upon the recommendation of a physician, California physicians should bear in mind that cannabis is listed in Schedule I of the federal Controlled Substances Act.

The use and recommendation of cannabis is an evolving issue and physicians should be aware of any applicable federal statutes or policies..

GUIDELINES

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

Physician-Patient Relationship: Pursuant to California 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 "an individual who possesses a license in good standing to practice medicine, podiatry, or osteopathy issued by the Medical Board of California, the California Board of Podiatric Medicine, or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient and who has conducted a medical examination of that 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 medical use of cannabis is appropriate."

H&S Code 11362.7(h) states, "'Serious medical condition' means all of the following medical conditions: (1) Acquired immune deficiency syndrome (AIDS); (2) Anorexia; (3) Arthritis; (4) Cachexia; (5) Cancer; (6) Chronic pain; (7) Glaucoma; (8) Migraine; (9) Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis; (10) Seizures, including, but not limited to, seizures associated with epilepsy; (11) Severe nausea; (12) Any other chronic or persistent medical symptom that either: (A) Substantially limits the ability of the person to conduct one or more major life activities as defined in the federal Americans with Disabilities Act of 1990 (Public Law 101-336) or (B) If not alleviated, may cause serious harm to the patient's safety or physical or mental health.

The Board recognizes that 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.

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. Recommending cannabis for any medical conditions 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." The Judicial Council of California Civil Jury Instructions (CACI), for 2020, writes that a physician "is negligent if they fail to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful physicians would use in the same or similar circumstances. This level of skill, knowledge, and care is sometimes referred to as 'the standard of care'." *See CACI No. 501, Standard of Care for Healthcare Professionals.*

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 made aware 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. Patients should be advised to only obtain cannabis products from licensed California retailers, of the possible effects based on dose levels, variances in cannabis extraction methods, added

ingredients and application methods.

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 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, concentration of cannabis levels, risk and benefits of application methods;
    - Cannabis use disorder;
    - Potential adverse events, such as exacerbation of psychotic disorder, adverse cognitive effects for children and young adults, falls or fractures, and other risks;
    - Using cannabis during pregnancy or breastfeeding[1];
    - The need to safeguard all cannabis and cannabis-infused products from children, pets, or domestic animals; and
    - The reminder that the cannabis is for the patient's use only and the cannabis must not be sold, donated, or otherwise supplied to another individual.
- Advice about the potential risks of the medical use of cannabis and reminders to safeguard the cannabis, including but not limited to, the following:
- Additional diagnostic evaluations or other planned treatments.
- A specific duration for the cannabis authorization as determined for a period of twelve months at a time, as needed.
- A specific ongoing treatment plan as medically appropriate.

Qualifying 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

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

state laws, rules and regulations which specify qualifying conditions for which a patient may qualify for cannabis for medical purposes.

The 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 their 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 of 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, and understand the levels of cannabis consumed by the patient and types of products used.

Consultation and Referral: A patient who has a history of substance use disorder, a co- occurring mental health disorder, or cardiovascular conditions 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 dose levels, risks and benefits, side effects and variable effects;
- Results of ongoing assessment and monitoring of patient's response to the use of cannabis based on dose levels and cannabis products used;
- A copy of a signed treatment agreement, including instructions on safekeeping and instructions on not sharing cannabis.

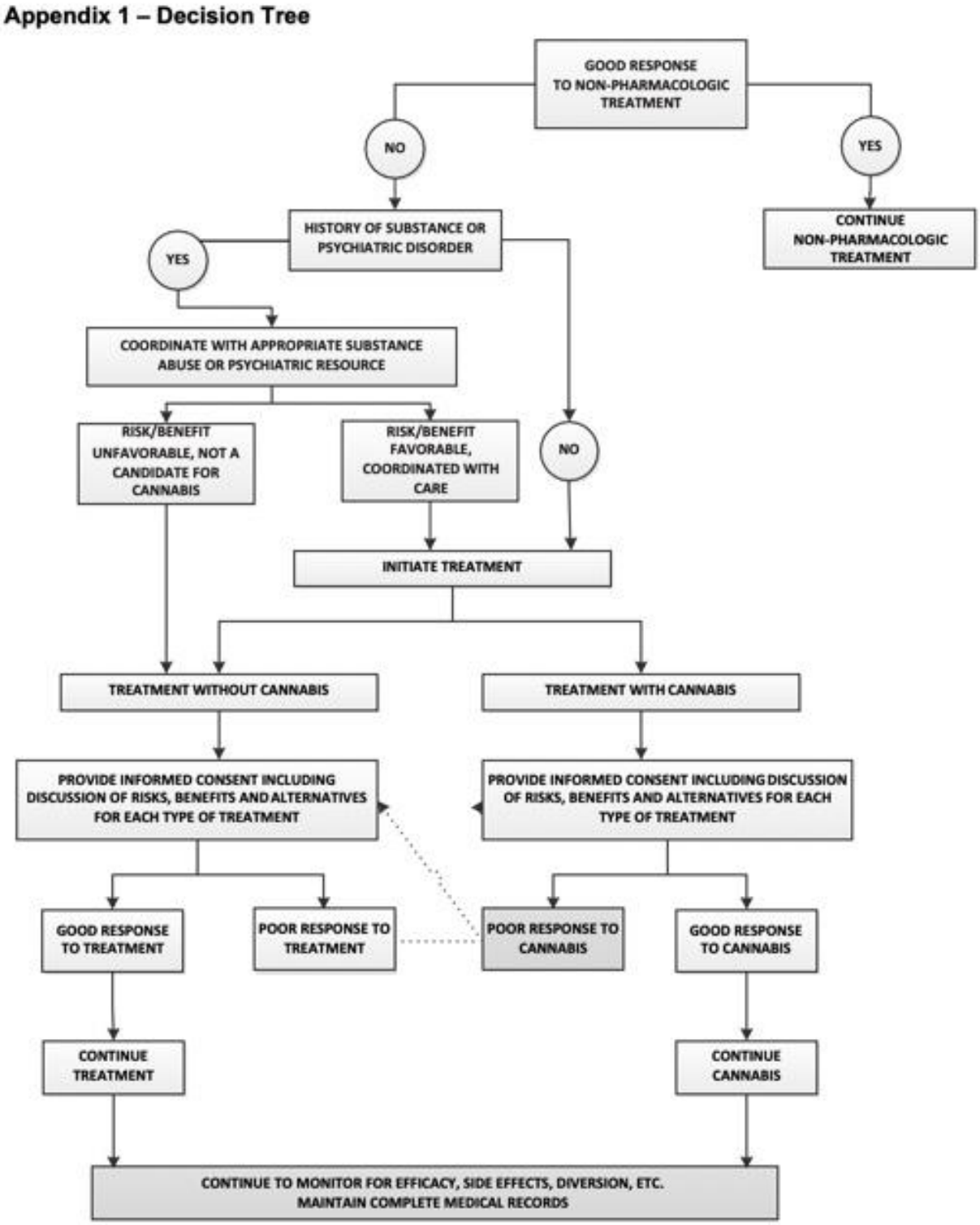
Physician Conflicts of Interest: B&P Code section 2525 includes a provision that makes it unlawful for a physician who recommends cannabis for a medical purpose to accept, solicit, or offer any form of remuneration from or to a facility, as defined, if the physician or their immediate family have a financial interest in that facility. Per Section 2525, 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. Physicians are encouraged to confer with the appropriate statute to confirm the statute/regulation has not changed.

"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 10

Osteopathic Medical Board

Future Agenda Items

Agenda Item	Requestor

Tab 11

Osteopathic Medical Board

Future Meeting Dates

Date	Place	Time
Thursday September 23, 2021	Teleconference	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.*