DRAFT

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

SUNSET REVIEW REPORT 2027

PRESENTED TO THE ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS AND SENATE COMMITTEE ON BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT



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Adopted on January 22, 2026

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OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM
As of January 1, 2027

Section 1
Background and Description of the Board and Regulated Profession

Provide a short explanation of the history and function of the Board.[1] Describe the occupations/professions that are licensed and/or regulated by the Board (Practice Acts vs. Title Acts).[2]

History/Origins of Osteopathic Medicine

Osteopathic medicine was founded by Andrew Taylor Still, M.D., D.O., in 1874. The first osteopathic medical school opened in Kirksville, Missouri, in 1892, and Vermont became the first state to license D.O.s in 1896. The American Osteopathic Association (AOA) was established in 1897, followed by the National Board of Osteopathic Medical Examiners (NBOME) in 1934.

Osteopathic physicians, or Doctors of Osteopathic Medicine (D.O.), are fully licensed to prescribe medication and practice in all medical and surgical specialties. Their training emphasizes whole-person care and includes hands-on techniques for diagnosing and treating patients.

Establishment of the Board

The Osteopathic Medical Board of California (Board) was established by an Initiative Act in 1922. Amendments to this Act in 1962 were partially overturned by the California Supreme Court in 1974, which restored Section 2 of the original Act (reinstating the Board's licensing authority).

Early Licensing and Governance

The Board's predecessor, the Board of Osteopathic Examiners of California (BOEC), was formed by "The Osteopathic Act" in November 1922 to license osteopathic physicians and surgeons. Prior to this, licensing was the responsibility of the Board of Medical Examiners. D.O.s took the same licensing exam as M.D.s until 1919, after which they were excluded. The California Osteopathic Association sponsored the 1922 Initiative to preserve the osteopathic profession in California.

1962 Amendments and Professional Integration

The Osteopathic Act was amended in 1962 to facilitate the merging of D.O. and M.D. professions. Major provisions included:

[1] The term "board" in this document refers to the Osteopathic Medical Board.
[2] The term "license" in this document includes a license, certificate, permit or registration.

- That D.O.s could choose to be licensed as M.D.s and fall under the Board of Medical Examiners.
- BOEC was prohibited from issuing new D.O. licenses but retained authority over existing D.O.s who did not convert to M.D.s.
- The State Legislature was permitted to amend the Osteopathic Act.

Legal Challenges and Restoration of Authority

The 1962 referendum, which allowed for M.D. election and legislative amendments, was upheld by the courts in 1974 and 1975. However, the removal of BOEC's licensing authority was contested by out-of-state D.O.s. The California Supreme Court reinstated BOEC's licensing authority in 1974, making it once again the sole agency responsible for licensing D.O.s in California.

Subsequent Amendments

The Act underwent further amendments in 1969, 1971, and 1982. Significant changes included:

- The licensing body was renamed the Osteopathic Medical Board of California.
- Board members were limited to two full terms.
- Two public members were added to the Board.

Recent Legal Developments

The authority of the Board has remained largely unchanged since the original Act, aside from the 1962 amendments and subsequent restoration of licensing authority by the California Supreme Court. A significant legal decision occurred in 1996, The Court of Appeal ruled that no formal hearing is required before distributing a report on peer review actions taken against a doctor, establishing a precedent for all California health care licensing boards.

Historical Facts on the Make Up of the Board

The Board had a major change in 2009 when the Legislature placed the Naturopathic Committee within the Board. The Board was increased at that time from seven (five professional and two public) to nine members. The added members were both Naturopathic Doctors and were considered public members. These appointments were in violation of Business and Professions Code (BPC) Section 3600 1.5 which states, "public members shall not be a licensee of any board in Division 2 commencing with BPC Section 500 nor of any initiative act referred to in that section." In response, the Osteopathic Physicians and Surgeons of California (OPSC) sponsored SB 1050, supported by the Board and the Naturopathic Committee. Passage of SB 1050 made the Naturopathic Committee independent and resulted in the removal of the two naturopathic practitioners from the Board and in their replacement by two public members, one appointed by the Speaker of the Assembly and one by the Senate Pro Tempore.

Current Make Up of the Board

The Board consists of nine members: five D.O.s and four public members. All five D.O.s and two public members are appointed by the Governor, one public member is appointed by the Speaker of the Assembly, and one by the Senate Pro Tempore. D.O. members must be California citizens, actively practicing for at least five years before appointment, graduates of osteopathic medical

schools, and hold valid California licenses; no one living or practicing outside California can serve. Public members cannot be licensees of any Division 2 Healing Arts board or initiative act. Members serve four-year terms, with a maximum of two consecutive full terms, not including time spent filling unexpired terms. There are currently no vacancies on the Board. In the past four years, the Board has met at least three times annually, and the nine-member board is considered adequate for handling its workload.

Function of the Board

The Board protects the public from the incompetent, negligent, unprofessional, and fraudulent practice of medicine. It is a fully functioning regulatory Board within the Department of Consumer Affairs (DCA). The Board's mission is "To protect the public by requiring competency, accountability, and integrity in the safe practice of medicine by osteopathic physicians and surgeons." To carry out its mission, the Board:

- Verifies that applicants demonstrate the required education, examination, and experience qualifications before licensure is granted;
- Requires licensees to maintain licensure by complying with continuing medical education requirements;
- Informs consumers of their rights and how complaints may be filed with the Board;
- Investigates consumer complaints thoroughly and efficiently to protect the public;
- Imposes appropriate disciplinary action on licensees found in violation of the Osteopathic and Medical Practice Act; and
- Enforces laws and regulations that uphold the Board's mandate, mission, and vision

The Board enforces its specific initiative laws within the Business and Professions (BPC) Code 3600 Section (Osteopathic Initiative Act) and the California Code of Regulations (CCR) Title 16, as well as the Medical Practice Act within BPC Chapter 5. Professional and Vocational Regulations, Division 16., Section 1600 Et. Seq., authorizes the Board to license qualified D.O.s to practice osteopathic medicine, and to effectuate the enforcement of laws and regulations governing their practice (BPC Chapter 5, Medical Practice Act). The act requires the Board to ensure that consumer protection is their highest priority in exercising its licensing, regulatory, and disciplinary functions.

Profession of Osteopathic Physicians and Surgeons

D.O.s are similar to M.D.'s in that both are considered to be "complete physicians," in other words, one who has taken the prescribed amount of premedical training, graduated from an undergraduate college (typical emphasis on science courses) and received four years of training in medical school. With the new changes to California's licensure requirements and the creating of a postgraduate training license, D.O.s must complete 36 months of residency training of which 24 months must be in the same training program before they are eligible to apply for full licensure. Additionally, a postgraduate resident must obtain a postgraduate training license in order to practice medicine within their residency or fellowship unless otherwise eligible for licensure.

The integration of residency training programs for medical and osteopathic professions has now been fully implemented. Since 2020, the American Osteopathic Association (AOA) and the Accreditation Council for Graduate Medical Education (ACGME) have operated a unified accreditation system for all residency programs. As a result, M.D. and D.O. residents train together in the same programs, and

all new physicians are eligible to apply for both osteopathic and non-osteopathic residencies in any specialty. This single accreditation system ensures that M.D.s and D.O.s meet identical training standards, eliminating previous restrictions that prevented M.D.s from obtaining osteopathic training.

D.O.'s utilize all scientifically accepted methods of diagnosis and treatment, including the use of drugs and surgery. D.O.s are licensed in all fifty states to perform surgery and prescribe medication. D.O.s practice in fully accredited and licensed hospitals and medical centers. BPC Section 2453 states that it "is the policy of this State that holders of M.D. degrees and D.O. degrees shall be accorded equal professional status and privileges as licensed physicians and surgeons."

A D.O. may refer to themselves as a "Doctor" or "Dr." but in doing so, must clearly state that they are a D.O. or osteopathic physician and surgeon. They may not state or imply that they are an M.D. while being licensed in California as a D.O.

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

According to the most recent 2026 Osteopathic Medical Profession (OMP) Report from the American Osteopathic Association (AOA)[3], there are 177,000 D.O.s actively practicing across the United States. Of these, 17,152 D.O.s are licensed to practice in California, which represents 9.6% of the nation's active D.O. population. D.O.s are the fastest-growing segment of U.S. physician population today.

AOA also reports that most D.O.s practice in just a few states. The AOA data show that half of all D.O.s in the U.S. are concentrated in the following eight states:

1. California
2. Florida
3. Pennsylvania
4. New York
5. Texas
6. Michigan
7. Ohio
8. New Jersey

[3] American Osteopathic Association, 2026 Osteopathic Medical Profession (OMP) Report

Occupations Licensed by the Board

The Board issues two licenses and one permit: the physician and surgeon license, the postgraduate training license, and a fictitious name permit for clinical office locations.

A licensed D.O. may use an aide to help with osteopathic manipulative treatment, but the aide must always work under direct supervision of the D.O. and cannot practice medicine or work independently. Aides are not licensed by the Board.

Physician and Surgeon License

This is the main license required to independently practice medicine as a D.O. in California. Applicants must meet educational and examination requirements, including graduation from an accredited osteopathic medical school, completion of postgraduate training, and passing national board exams.

Postgraduate Training License

Effective January 1, 2020, this license is mandatory for all medical residents and fellows participating in California-based residency or fellowship programs. Previously, only one year of postgraduate training was required for full licensure, but the new law increased the requirement to 36 months. Residents must secure this license before they are allowed to practice medicine within their training program, ensuring compliance with Board regulations. The Board has the authority to oversee and enforce discipline among residents throughout their training, addressing issues such as unprofessional conduct, medical errors, or violations of state regulations.

The introduction of the postgraduate training license has streamlined oversight and improved accountability for medical trainees, granting the Board broader enforcement powers.

Fictitious Name Permit

This permit is required for clinical practices that operate under a name other than the legal name of the licensee or group. For example, if a physician wishes to open a practice under a brand or trade name, they must obtain this permit from the Board to ensure transparency and proper identification of responsible practitioners.

These credential types are designed to protect public health and safety, ensure high standards of practice, and clarify the responsibilities of physicians and trainees in California.

1. **Describe the make-up and functions of each of the Board's committees (cf., section 1, Attachment B).**

Board members play a critical role in policy and decision-making related to licensing requirements, disciplinary matters, contracts, budget issues, legislation and regulatory proposals and consumer and public outreach.

The following tables provide details regarding Board meeting dates and members attendance of current and past Board members:

Table 1a. Board Meeting Attendance

Table 1a. Board Meeting Attendance																			
	01/20/2022 - Webex	04/14/2022 - Webex	08/10/2022 - Webex	01/19/2023 - Sacramento	05/11/2023 - Sacramento	08/17/2023 - Pomona	01/18/2024 - Sacramento	05/16/2024 - Vallejo	08/15/2024 - Clovis	11/14/2024 - Sacramento	02/13/2025 - Sacramento	05/15/2025 - Sacramento	08/14/2025- Vallejo	11/13/2025 - Sacramento	01/22/2026 - Sacramento	04/23/2026 - Pomona	08/25/2026 - Sacramento	11/05/2026 - Clovis
BOARD MEMBER	FY 2021/22			FY 2022-23			FY 2023/24				FY 2024/25				FY 2025/26			
Gor Adamyan ***																		
Cyrus Buhari, D.O.*																		
John Cummins, J.D.**																		
Elizabeth, Jensen-Blumberg, D.O. *																		
Michael Kim, D.O. *																		
Brett Lockman, D.O.*																		
Michael Luszczak, D.O. *																		
Claudia Mercado **																		
Negeen Mirreghabie, Esq.*																		
Andrew Moreno, Esq.*																		
Hemesh Patel, D.O. *																		
Denise Pines, MBA*																		
Faisal Qazi, D.O. *																		
Matthew Swain, D.O. *																		
Shannon Walsh, D.O. *																		
Table Legend		Attended			Absent			Not Appointed			Vacant							
* Governor Appointment **Pres. Pro Tempore ***Assembly Appointment																		

Table 1b. Board/Member Roster

Refer to Attachment B for the current organizational chart of the Board's committees

Table 1b. Board Member Roster					
Member Name (Include any vacancies and a brief member biography)	**Date First Appointed**	**Date Re-appointed**	**Date Term Expires**	**Appointing Authority**	**Type (public or professional)**
Denise Pines, MBA (President)	04/21/2021	12/30/2025	01/01/2029	Governor	Public
Hemesh Patel, D.O. (Vice President)	01/23/2020	05/30/2024	06/01/2027	Governor	Professional
Gor Adamyan (Secretary)	12/14/2018	11/22/2021	06/01/2027	Speaker	Public
John M. Cummins, J.D.	06/12/2024	06/11/2025	06/01/2028	Senate	Public
Brett Lockman, D.O.	08/07/2024	N/A	06/01/2028	Governor	Professional
Negeen Mirreghabie, Esq.	10/30/2025	N/A	01/01/2029	Governor	Public
Matthew Swain, D.O.	07/23/2024	N/A	06/01/2027	Governor	Professional
Faisal Qazi, D.O.	03/20/2026	NA	06/01/2027	Governor	Professional
Shannon Walsh, D.O.	08/14/2026	N/A	06/01/2027	Governor	Professional

Committees of the Board

Committees are a crucial part of the Board. Committees help address specific issues referred by the public, the Legislature, DCA, or are established by the recommendation of staff to help steer Board projects and goals. Typically, committees consist of at least two Board members who gather public input, explore alternatives, and make recommendation to the full Board. Although the Board by statute is only required to form a Diversion Evaluation Committee (DEC), the Board President may appoint task forces and advisory committees as needed.

Currently, the Board has five functioning committees in addition to its Diversion Evaluation Committee (DEC), an executive, legislative, licensing, enforcement, and education/and outreach committee.

Diversion Evaluation Committee (Established September 22, 1989)

The DEC is composed of California licensed D.O.s who are appointed by the Board and who serve at the pleasure of the Board. The D.O.s so appointed must have experience in the diagnosis and treatment of drug or alcohol abuse.

The DEC not only has the responsibility to accept, deny or terminate a participant, they also prescribe in writing for each participant a treatment and rehabilitation plan including requirements for supervision and surveillance. The DEC is currently comprised of three D.O.s qualified to the position.

Executive Committee (Established November 14, 2024)

The purpose of this committee is to handle urgent, day-to-day operations, make interim decisions between full board meetings and assist the Executive Director in preparing items for the full board's review.

Legislative Committee (Established November 14, 2024)

The purpose of this committee is to review legislation that impacts the Board, licensees, and consumers, and to make recommendations to the Board regarding potential positions on proposed legislation.

Licensing Committee (Established November 14, 2024)

The purpose of this committee is to review and make decisions on license applications, set professional standards, handle practice-related issues, and advise the main board on policies, all to protect the public by ensuring only qualified osteopathic physicians and surgeons are practicing medicine.

Enforcement Committee (Established November 14, 2024)

The purpose of this committee is to act as an advisory body to enhance consumer protection by improving the Board's enforcement program and educating the public and board members on enforcement processes, ensuring that the Board is meeting its consumer protection mandate.

Education/Outreach Committee (Established November 14, 2024)

The purpose of this committee is to examine education and workforce issues related to osteopathic physicians and surgeons and help address the healthcare needs of California consumers.

2. In the past four years, was the board unable to hold any meetings due to lack of quorum? If so, please describe. Why? When? How did it impact operations?

We are pleased to report that the Board has not encountered any challenges with quorum in the past four years. This has allowed for uninterrupted operations.

3. Describe any major changes to the Board since the last Sunset Review, including, but not limited to:

- **Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)**

Executive and Management Team

- **Erika Calderon** became Executive Director of the Board on November 1, 2022. Director Calderon previously managed the enforcement program at the Physical Therapy Board of California, held leadership roles at the Medical Board of California from 2014 to 2022, and was an analyst at the Veterinary Medical Board of California from 2010 to 2014.
- **Machiko Chong** became the Board's Licensing Program Manager on February 1, 2023, and now oversees licensing operations.
- **Cristy Livramento** became the Board's Enforcement Program Manager on May 21, 2025, and now oversees the enforcement program's operations.
- **Terri Thorfinnson** became the Board's Legislative and Regulations Specialist on March 3, 2025, and now manages legislation and assists the Executive Director with drafting regulations.

Board Reorganization

The Board has undergone an office restructuring to establish distinct program areas. These include an Administrative/Licensing Program, an Enforcement Program, and a Probation and Investigation unit. Each of the programs will operate under managerial oversight to ensure effective program operations.

Office Improvements

In 2024, during lease renewal, the Board upgraded office security by adding key card readers and purchasing a safe.

License Program Enhancements

The Board has implemented several substantial improvements to its licensing program over time. These enhancements are designed to expedite application processing, increase the efficiency of licensure and related transactions, and streamline overall operations, all while upholding the rigorous standard of ensuring only qualified individuals receive osteopathic physician and surgeon licenses.

In partnership with the DCA Office of Information Services (OIS), the Board has upgraded the BreEZe system. This modification now enables licensees to submit all licensure applications and payments, as well as request and remit payments for license verifications and fictitious name permits. This initiative has not only shortened mail and cashiering processing times but has also markedly improved overall processing efficiency. While the Board strongly advocates for electronic submissions for all application-related transactions, it recognizes the importance of retaining a paper-based option to ensure accessibility for all stakeholders.

Furthermore, with OIS's support, the Board has established a secure electronic file transfer portal for the submission of primary source application documents. This portal, accessible via the Board's website, facilitates a more rapid transmittal of application materials, thereby reducing application processing timelines.

The Board has also modified BreEZe to allow licensees to print their own pocket licenses directly from their online BreEZe accounts. This enhancement provides convenience, cost savings, and immediate access, while also contributing to the Board's environmental sustainability goals by reducing paper consumption.

Enforcement Program Enhancements

The Board's Enforcement program has been significantly enhanced to improve efficiency, streamline processes, and strengthen consumer protection.

In collaboration with the DCA's OIS, the Board has updated its BreEZe system to enhance the enforcement program. These modifications include expansions to class and complexity codes, allegations, violations, activities, compliance, and discipline codes. Additionally, the online complaint submission portal has been improved to align with the paper complaint and allow for submission of the Board's medical release forms.

The Board revised its consumer complaint form to expedite intake processing and ensure the collection of more comprehensive information upfront. This allows for more robust desk investigations. The updated form now includes an option for complainants to indicate if they have filed a complaint with another jurisdiction. This facilitates the retrieval of findings from that jurisdiction for the Board's consideration. Furthermore, the consumer complaint form has been translated into Spanish and is accessible on the Board's website.

To reduce the number of non-jurisdictional complaints and improve processing times for both agencies, the Board partnered with the Medical Board of California (MBC). This collaboration involves redirecting consumers to file complaints with the appropriate board. Both boards have implemented links on their websites, under the consumer tab, to guide stakeholders to their respective boards.

New enforcement procedures have been established for intake, desk investigations, citations, and discipline. The Board has also developed a suite of template letters, including those for analyst introductions, desk investigation status updates (with the option for impact statements), subject educational letters, citations, public reprimands, case closures, and disciplinary and probation documents. These updates have led to improved enforcement processing times and a reduction in errors.

The Board eliminated its in-house medical consultant position. The allocated funds have been redirected to enhance other key positions within the Board, such as program manager positions, and to establish an intake analyst position that can help triage consumer complaints. Currently, the Board contracts with over 136 medical consultants and experts across various specialties to review quality-of-care consumer complaints.

Monthly analyst pending reports have been developed to monitor all open enforcement cases. These reports identify high-priority cases, those with short statutes of limitations, and aged cases requiring immediate attention.

To further enhance operational efficiency, consumer protection, and cost savings, the Board created a limited 24-month term, non-sworn Special Investigator position. The Board has identified several case types that can be investigated and referred for prosecution without the involvement of sworn investigators such as;

- Subsequent arrest notifications that do not require a suspension-Penal Code Section 23 (PC23) action or interim suspension order (ISO)
- Failure to release records, recordkeeping violations, contract violations
- False/misleading advertising – not unlicensed/not criminal
- Continuing education violations
- Some probation violations
- Non-jurisdictional issues
- General unprofessional conduct, negligence, incompetence resulting in minor/potential harm
- General work/quality complaints, offensive behavior/conduct/speech (non-criminal)
- Practicing with a delinquent license/not requiring an in-person undercover operation
- Patient abandonment with no/minimal consumer harm (non-criminal, minor/potential consumer harm, no major financial loss, minor/potential patient harm)

Reassigning these cases to non-sworn personnel will streamline processes and reduce costs. Non-sworn investigators can effectively perform many investigative tasks, including detecting and verifying violations, interviewing witnesses, gathering information, analyzing testimony, serving legal documents, and serving as expert witnesses. The Board will continue to utilize DCA's Division of Investigation Health Quality Investigation Unit (HQIU) for criminal investigations that necessitate the expertise of a sworn peace officer.

In terms of inter-agency communication, monthly meetings with DOI's HQIU have been established. These meetings, held on the last Thursday of each month, facilitate open communication between the Board and investigative staff. Discussions focus on enforcement-related matters impacting both departments, such as case aging and urgent or high-profile cases, to ensure efficient and effective progression.

Lastly, recent regulatory changes have expanded the Board's citation authority. This expansion significantly broadens the Board's ability to issue citations, fines, and abatement orders for a wide range of violations under its jurisdiction, not limited to a specific list. The Board's enforcement program is now able to issue a citation for a violation of any provision in the Osteopathic Act or Medical Practice Act, any regulation adopted by the Board, and any other statute or regulation upon which the Board may base a disciplinary action, in addition to certain specified statutes and regulations. These amendments will help keep the list of citable offenses current, as statutes and regulations are added, repealed, and modified. In addition, the Board will be updating its unlicensed activity citations to ensure greater compliance with the laws under the Board's jurisdiction and the enforcement of provisions prohibiting the unlicensed practice of medicine.

This enhancement strengthens consumer protection and enforcement by addressing CME compliance and unlicensed activity, including practice under delinquent licenses or fictitious-name permits. It reflects a more proactive, comprehensive enforcement approach.

Disciplinary Guidelines

The Board has been diligently engaged in the process of revising its disciplinary guidelines, which have not been updated since 1996. Board staff have worked tirelessly in collaboration with the DCA regulatory unit to ensure these guidelines reflect current practices and address evolving needs. The Board anticipates presenting a newly revised version of its disciplinary guidelines by the end of the 2026 calendar year or the beginning of next year (2027).

Continuing Medical Education

Effective October 1, 2025, the Board enacted a new policy regarding continuing medical education (CME) requirements for licensure renewal through regulation. CME compliance rates were found to be consistently high. Therefore, this policy transitions from a manual system, where staff reviewed and approved all CMEs prior to renewal, to an automated certification system for licensees, supplemented by a post-renewal audit process conducted by the Board. The objective of this revised policy is to expedite the renewal process while upholding compliance with CME mandates.

This updated renewal process is designed to streamline operations and mitigate delays previously incurred by staff reviewing CME documentation at the time of renewal. The comprehensive review of CME compliance documentation will now be conducted after renewal through random audits, allowing Board staff to manage this task within a more efficient timeframe without negatively impacting licensees or patient care. Licensees will experience a more efficient renewal process, enabling them to certify their compliance and renew without delay. Concurrently, the Board retains the authority to conduct random audits to verify compliance.

By eliminating the need to review CME completion documentation during the renewal period, processing delays and potential disruptions to patient care, such as practice suspension, will be averted. The Board's enhanced authority to conduct random audits, which may result in citations and fines for non-compliance, serves to strengthen public protection. Individuals who do not successfully pass an audit will be ineligible for subsequent renewal until they have fulfilled their outstanding CME requirements. The fundamental requirement of completing the prescribed number of CMEs for renewal remains in effect.

Communications and Outreach

During the current Sunset Review period, the Board has engaged in a variety of consumer-focused outreach efforts aimed at: (1) educating and protecting the public, including making community presentations that encourage patients to verify physician licenses, understand their rights, and report concerns; (2) running public education campaigns explaining how to file complaints and what types of issues the Board investigates; (3) organizing presentations at schools and educational institutions; (4) holding Interested Parties Meetings to gather public input on consumer protection and Board operations; (5) establishing open public board meetings that encourage stakeholder participation; and, (6) conducting ongoing outreach through consumer guides, licensing lookup tools, email subscriber communications, and other educational resources designed to increase transparency and help Californians make informed healthcare decisions.

During the first fiscal quarter of 2023, the Board initiated its social media engagement by launching official accounts on Facebook and X (formerly known as Twitter). These platforms, alongside the Board's website and Listserv, are instrumental in the dissemination of all board-related information. Content disseminated includes, but is not limited to, timely reminders of upcoming board meetings,

pertinent information regarding the osteopathic profession, CURES updates, details pertaining to waivers issued by the Director of the DCA, notifications of disciplinary actions taken against licensees, proposed regulations and revisions, and employment announcements.

As a component of its continuous outreach endeavors, the Board, in partnership with DCA's Office of Publications, Design, and Editing, published the first Issue of its newsletter, the Winter 2023 edition of "Osteoscope." This publication, along with subsequent issues, is readily available on the Board's website and social media channels. The newsletter functions as a vital communication channel, facilitating the provision of critical information and Board updates to applicants, licensees, and consumers, while simultaneously fostering greater utilization of the Board's online services.

In April 2026, the Board introduced its first educational enforcement video. This resource offers consumers a detailed, step-by-step tutorial on the process of filing a formal complaint. The video provides explicit instructions and support regarding the required documentation for a complaint and the methodology for submission. These efforts are strategically implemented to enhance the consumer experience and augment the overall efficiency of the complaint process.

Branding

In 2023, the Board partnered with the DCA Office of Publications, Design, and Editing to develop and approve its new logo. The updated design incorporates the Board's establishment year, enhancing awareness of its century-long service to Californians.

Website Enhancements

In November 2023, the Board unveiled its redesigned website, prioritizing enhanced user experience and improved accessibility. This updated platform offers significantly improved functionality to better serve its visitors. A key enhancement is the introduction of a more intuitive interface designed for streamlined communication with specific board programs. The Board has meticulously developed the website's layout, navigation, and design elements to ensure users can efficiently locate the information they require. This redesign underscores the Board's dedication to providing valuable resources and maintaining responsiveness to constituent needs.

Strategic Plan

The Board formally adopted its Strategic Plan for the 2024-2028 period on January 18, 2024. This comprehensive plan outlines a revised mission statement, core values, and specific objectives aligned with five key strategic goal areas: Board Administration, Regulations and Legislation, Enforcement, Licensure, and Outreach and Communication. A significant element of this plan is the integration of Diversity, Equity, and Inclusion principles to ensure that board initiatives and policies are equitable and effectively serve the diverse communities represented.

Subsequent to the initial adoption, the Board approved minor amendments to its 2024-2028 Strategic Plan on January 22, 2026. These revisions incorporated additional objectives within several goal areas, reflecting the substantial progress achieved by the Board in its first year of implementation. During this inaugural year, the Board demonstrated notable success, achieving 100% completion for Administrative Objectives and Enforcement Objectives. Furthermore, significant progress was made in Regulations and Legislative Objectives (67%), Licensure Objectives (74%), and Outreach and Communication Objectives (56%).

Refer to Attachment C for the amended Board's 2024-2028 Strategic Plan.

- **All legislation sponsored by the Board and affecting the Board since the last sunset review.**

The Board has not sponsored any legislation since the last Sunset Review. The major legislation that affected the Board is listed below:

Statutes of 2026

- **AB 1703 (Hart, Chapter 543, Statutes of 2026)** strengthens California's statutory framework governing osteopathic medicine by closing long-standing gaps in title protection and unlicensed practice enforcement. The bill clarifies that osteopathic titles and Osteopathic Manipulative Treatment (OMT) are reserved exclusively for individuals licensed by the Osteopathic Medical Board of California (OMBC). This ensures that only practitioners who have met the state's education, training, fingerprinting, and vetting requirements may present themselves as osteopathic physicians or provide physician-level osteopathic treatment.

- **SB 849 (Weber-Pierson, Chapter 654, Statutes of 2026)** prohibits a person from petitioning the Board for reinstatement or renewal of a certificate when the certificate was automatically revoked under specified circumstances involving sexual misconduct or sexual offenses. It also expands these restrictions to include certificate surrenders that occur while an enforcement case is pending.

- **AB 1637 (Coloza, Chapter 536, Statutes of 2026)** establishes that a physician or surgeon is solely responsible for their patient notes, including after-visit summaries and diagnosis or treatment plan documentation. The law prohibits these notes from being altered, modified, or edited by anyone other than the authoring physician, unless the physician has expressly authorized specific individuals to make updates under defined circumstances.

- **AB 2311 (Schiavo, Chapter 299, Statutes of 2026)** creates a temporary exemption, effective until January 1, 2037, that allows health care districts and nonprofit corporations they exclusively control, which own or operate a general acute care hospital, to employ physicians and surgeons and bill for their services. To use this authority, entities must meet specified safeguards, including prohibiting any interference with a physician's independent medical judgment. They must also publish an annual public report with data on physician recruitment and retention at their hospitals.

- **AB 1979 (Bonta, Chapter 854, Statutes of 2026)** restricts health facilities (including doctor's offices) from using AI to guide unlicensed personnel in performing any functions that require licensure.

- **AB 1811 (Rogers, Chapter 549, Statutes of 2026)** establishes a state definition of Health Professional Shortage Areas (HPSAs) and significantly expands California's workforce data collection requirements for healing arts licensees, aiming to improve statewide health workforce planning and access to care. The bill allows HPSAs to be defined by federal designation or by the Department of Health Care Access and Information (HCAI), which is also

authorized to revoke state-level shortage designations. To support more accurate assessments of provider supply and service patterns, the bill requires licensees and registrants to report workforce data at initial licensure and at least biennially thereafter, and mandates that boards submit this data to HCAI monthly. New required data elements include primary and secondary practice specialties, hours worked across inpatient and outpatient settings, provision of direct primary care services, and whether a clinician accepts Medicaid or offers a sliding fee scale. These changes respond to longstanding concerns identified in legislative analyses about inconsistent data limiting policymakers' ability to evaluate prior workforce initiatives, understand regional shortages, and design evidence-based interventions.

- **SB 164 (Menopause Trailer bill, Chapter, Chapter 27, Statutes of 2026)** a budget implementation measure that builds on concepts from prior menopause-related legislation by allowing double CME credit hours for qualifying educational courses without imposing a CME mandate, while also requiring commercial health insurers—but not Medi-Cal managed care or Medicare—to cover medically necessary evaluations and treatments for perimenopause and menopause. It directs insurers to annually review FDA-approved treatment options and notify providers of available therapies, with all coverage subject to standard utilization review requirements, and establishes July 1, 2027, as the effective date for these provisions.

Statutes of 2025

- **AB 460 (Chen, Chapter 435, Statutes of 2025)** allows radiologic technologists to be supervised remotely by a physician, if the physician is available immediately via audio and video communication with access to the patient's medical imaging records and has the ability to intervene by directing other onsite personnel. Health facilities will need to have safety protocols and personnel onsite who have the appropriate license to respond to adverse events at the physician's direction.

Statutes of 2024

- **AB 2164 (Berman, Chapter 952, Statutes of 2024)** prohibits the Board from requiring physician licensure applicants to disclose conditions or disorders that do not impair the applicant's ability to practice medicine safely. This includes conditions for which applicants are receiving appropriate treatment. The bill also requires the Board to provide applicants who disclose conditions that impair their ability to practice medicine with information on the availability of probationary or limited practice licenses.

- **AB 3030 (Calderon, Chapter 848, Statutes of 2024)** requires health facilities, clinics, and physician's offices that use generative artificial intelligence to generate written or verbal patient communications pertaining to patient clinical information to provide a disclaimer and clear instructions describing how a patient may contact a human. The bill specifies the types of disclaimers needed for written, audio, and video communications. Exceptions apply for communications that are read and reviewed by a human licensed or certified health care provider.

- **SB 233 (Skinner, Chapter 11, Statutes of 2024)** was an urgency bill that allows physicians licensed in Arizona to perform abortion services in California on Arizona residents, through November 30, 2024, after registering with the Board. Upon receiving a completed application,

which does not include a fee, the Boards would register the physician within five business days. The Board has the authority to deny or revoke a registration that does not meet specified requirements.

- **SB 1451 (Ashby, Chapter 481, Statutes of 2024),** among other things, eases licensing restrictions by allowing physicians still in residency to initially renew their licenses even if they have not completed 36 months of postgraduate training, if specified requirements are met. It also adds additional title protections for D.O.s.

Statutes of 2023

- **AB 242 (Wood, Chapter 641, Statutes of 2023)** eliminates the January 1, 2024, sunset date and makes permanent a pilot program that authorizes federally certified critical access hospitals to employ medical professionals and charge for professional services rendered by those medical professionals. The bill makes no other changes to the pilot program, critical access hospitals will still be prohibited from directing or interfering with the professional judgment of a physician, and medical staff will still be required to concur by an affirmative vote prior to employment.

- **AB 834 (Irwin, Chapter 166, Statutes of 2023)** authorizes podiatrists to own an equal or majority interest in a professional partnership with physicians. Physicians and podiatrists combined will still need to have majority control in partnerships that include other individuals. This bill prohibits partners who are not physicians from voting on matters related to the practice of medicine that are outside of their scope of practice.

- **AB 1130 (Berman, Chapter 21, Statutes of 2023)** replaces the term “addict” with “person with substance use disorder” in several sections of the Business and Professions and Health and Safety Codes.

- **AB 1369 (Bauer-Kahan, Chapter 837, Statutes of 2023)** allows out-of-state physicians, who are not licensed in California, to practice medicine in California via telehealth when treating certain eligible patients who suffer from immediately life-threatening conditions. These physicals do not need to be registered with the Board.

- **AB 1646 (Nguyen, Stephanie, Chapter 257, Statutes of 2023)** allows a graduate of a medical school approved by the Board, who is participating in an out-of-state postgraduate training program, to engage in guest rotations in California for up to 90 days without obtaining a license.

- **SB 815 (Roth, Chapter 294, Statutes of 2023)** was the sunset bill for the Board, which extends Board operations until January 1, 2028. Additionally, this bill makes several changes to the Medical Practice Act, such as amending postgraduate training license requirements and making several changes to the Board’s enforcement processes.

Statutes of 2022

- **AB 1278 (Nazarian, Chapter 750, Statutes of 2022)** requires physicians to provide each patient, at their initial office visit, a written or electronic notice of the Open Payments database. The disclosure, which must include a link to the database website, must be signed by the

patient and kept in their records. The bill also requires physicians to conspicuously post an open payments database notice in each location where they practice and, beginning January 1, 2024, on their internet website.

- **AB 1636 (Weber, Chapter 453, Statutes of 2022)** prohibits the Board from reinstating the license of a physician that had their license revoked or surrendered because they committed certain sex offenses or sexual misconduct with a patient. It expands current automatic revocation requirements to also include certain out-of-state convictions for sex offenses. This bill also allows the Board to deny a license to an applicant who was disciplined by another licensing board for sexual misconduct with a patient regardless of when the discipline occurred, removing the current seven-year limitation.

- **AB 1954 (Quirk, Chapter 232, Statutes of 2022)** prohibits physicians from automatically denying treatment or medication to a qualified patient based solely on a positive drug screen for tetrahydrocannabinol or report of medical cannabis use without first completing a case-by-case evaluation of the patient. Physicians could not be punished, or denied any right or privilege, for administering treatment or medication consistent with the standard of care to such patients.

- **AB 2098 (Low, Chapter 938, Statutes of 2022)** specifies that the dissemination of misinformation or disinformation related to COVID-19, from physicians to their patients, constitutes unprofessional conduct.

- **SB 923 (Wiener, Chapter 822, Statutes of 2022)** among other things, updates cultural competency requirements for physicians to recommend more detailed topics related to transgender, gender diverse, and intersex patients.

- **All regulation changes approved by the Board since the last Sunset Review. Include the status of each regulatory change approved by the Board.**

Substantial Relationship and Rehabilitation Criteria (AB 2138) – This regulatory package amends existing regulations consistent with Chapter 995, Statutes of 2018 (AB 2138) and to accurately reflect the Board's authority to consider denials or discipline and petitions for reinstatement or modification of penalty.

This package was approved by OAL on May 17, 2021, with an effective date of May 17, 2021.

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 Board, patients can check the status of a D.O., and how patients can file a complaint against a D.O.

This package was approved by OAL on June 8, 2021, with an effective date of October 1, 2021.

Continuing Medical Education and Citations and Fines – This regulatory package amends the renewal process to allow for self-certification of CME and a post-renewal audit process and expanded citation and fine authority.

This package was approved by OAL on July 10, 2025, with an effective date of October 1, 2025.

Retired License, Petitions, Fees – This regulatory package establishes a retired license status, and fees for petitions, and it brings all existing fees to its statutory caps.

This package is in the process of getting filed with OAL.

Disciplinary Guidelines – This regulatory package proposes to add specified uniformed standards related to substance abuse and updates the Board's existing standards and optional terms of probation.

This package was previously rejected by Office of Administrative Law (OAL) on December 9, 2016 and a request to resubmit was granted by OAL on March 17, 2017. Over the past three years, Board staff has been diligently engaged in the process of revising its disciplinary guidelines, which have not been updated since 1996. Board staff have worked tirelessly in collaboration with the DCA regulatory unit to ensure these guidelines reflect current practices and address evolving needs. The Board anticipates presenting a newly revised version of its disciplinary guidelines by the end of this calendar year or the beginning of next year.

4. Describe any major studies conducted by the Board (cf. section 12, Attachment C).

Since the last Sunset Report, the Board has not conducted any major studies. The Board relies on the national American Osteopathic Association Osteopathic Medical Profession Reports, Office of State Health Planning and Development studies, and other University of California research projects.

5. List the status of all national associations to which the Board belongs.

As a dues-paying member of the Federation of State Medical Boards (FSMB), the Board benefits from engagement with this national organization. Since the last sunset review, Board staff were able to attend two FSMB annual meetings: May 4-6, 2023, in Minneapolis, MN, and April 24-26, 2025, in Seattle, WA. While state limitations on out-of-state travel for board members and staff restricted attendance at other meetings, President Pines, serving on the FSMB Board of Directors, was able to represent the federation at each event. The FSMB unites medical boards from across the U.S. and its territories, fostering dialogue on vital issues. These annual gatherings address critical topics such as opioid overprescribing, the Interstate Licensing Compact, telemedicine, the role of AI in medicine, enforcement, credentialing, and the needs of underserved populations. The Board's annual FSMB dues of $2,400 ensure access to all relevant publications and activity reports, supporting the Board's ongoing efforts and informed decision-making.

As a dues-paying member of the International Association of Medical Regulatory Authorities (IMRA), the Board benefits from engagement with this international organization. Since the last sunset review, Board staff was unable to attend any of the Annual conferences due to limitations on out-of-state travel for board members and staff. IMRA unites medical boards internationally, fostering dialogue on vital issues. The conferences focus on the regulation of the medical and other health professions and regulatory best practice in areas including registration and licensure; complaints management and resolution; quality assurance of physicians' practice; professional standards; global movement of the health workforce; and medical education and assessment. The Board's annual IMRA dues of $1,500 ensure access to all relevant publications and activity reports, supporting the Board's ongoing efforts and informed decision-making.

- **Does the board's membership include voting privileges?**

The Board's membership includes voting privileges. The current voting delegate for the Board is the Executive Director.

- **List committees, workshops, working groups, task forces, etc., on which board participates.**

Board President Denise Pines, MBA, is a current Board Member Fellow of the FSMB and works as an ambassador between the Board and FSMB.

Board member Mathew Swain, D.O., is a current member of the Board of Directors of the Osteopathic Physician & Surgeons of California (OPSC).

Board member Shannon Walsh, D.O., is a current member of the Board of Directors of OPSC.

- **How many meetings did board representative(s) attend? When and where?**

The Board strives to work collaboratively with the FSMB and attend their annual meetings, while at the same time, adhering to the DCA's directive limiting out-of-state travel. The Board attended the following FSMB meetings:

- Cyrus Buhari, D.O., past Board President, Denise Pines, MBA, current Board President, and Erika Calderon, Executive Director, and Machiko Chong, Licensing Program Manager attended FSMB's Annual Meeting on May 4-6, 2023, in Minneapolis, MN.

- Denise Pines, MBA, current Board President, Hemesh Patel, D.O., current Vice President, and Erika Calderon, Executive Director attended FSMB's Annual Meeting on April 24-26, 2025, in Seattle, WA.

- Denise Pines, MBA, current Board President and Erika Calderon, Executive Director attended FSMB's Annual Meeting on April 30-May 2, 2026, in Baltimore, MD.

- **If the Board is using a national exam, how is the Board involved in its development, scoring, analysis, and administration?**

The Board does rely on a national examination. That examination is generated and administered by the NBOME. The examination, the NBOME COMLEX-USA is the recognized national evaluative instrument for osteopathic students and graduates, and successful completion is required for osteopathic licensure in California. Statistics are reported in Table 8. The examination is comprised of Level I, Level 2 Cognitive Evaluation (CE), Level 2 Performance Evaluation (PE), and Level 3 and is given at all colleges of osteopathic medicine. Level 1 is taken by students on completion of the first two years of osteopathic education, and covers subjects generally considered to be the basic sciences including, but not limited to, anatomy, biochemistry, and microbiology. Level 2 CE and PE are taken during the third and fourth years of osteopathic medical school and measures the student's knowledge of the clinical sciences including, but not limited to surgery, pediatrics, osteopathic manipulative medicine, general medicine and therapeutics. Level 3 is taken during the first post graduate year. Statistics are reported in Table 8.

Section 2
Fiscal and Staff

Fiscal Issues

6. Is the board's fund continuously appropriated? If yes, please cite the statute outlining this continuous appropriation.

No. The Board's fund is not continuously appropriated. The Board's budget is developed on an annual basis and remains subject to legislative approval through the state's budget process.

7. Using Table 2, *Fund Condition*, describe the board's current reserve level, spending, and if a statutory reserve level exists.

Table 2. Fund Condition (list dollars in thousands)

(Dollars in Thousands)	FY 2022-23	FY 2023-24	FY 2024-25	FY 2025-26	FY 2026-27**	FY 2027-28**
Beginning Balance[1]	$4,472	$4,622	$5,098	$4,922	$4,139	$3,764
Revenues and Transfers	$3,734	$3,940	$4,119	$4,132	$4,564	$4,851
Total Resources	$8,206	$8,562	$9,217	$9,054	$8,703	$8,615
Budget Authority	$3,655	$3,593	$4,156	$5,011	$4,556	$4,693
Expenditures[2]	$3,625	$3,512	$4,274	$4,915	$4,939	$5,076
Loans to General Fund	$0	$0	$0	$0	$0	$0
Accrued Interest, Loans to General Fund	$0	$0	$0	$0	$0	$0
Loans Repaid From General Fund	$0	$0	$0	$0	$0	$0
Fund Balance	$4,581	$5,050	$4,943	$4,139	$3,764	$3,539
Months in Reserve	15.7	14.2	12.1	10.1	8.9	8.1

[1]Actuals include prior year adjustments

[2]Expenditures include reimbursements and direct draws to the fund

*Includes EO transfer to GF (AB 84)

**Estimate

The Board has no statutory reserve requirement and maintains a reserve level of 10.1 months as of FY 2025–26. In recent years, Investigations, Attorney General (AG), and Office of Administrative Hearings (OAH) expenses exceeded projections because of increased consumer complaints. In addition, the Board saw higher legal and hearing fees.

To manage these pressures, the Board redirected operating funds and secured additional resources for AG and investigation costs. The Board will monitor expenditures and seek relief through the Budget Change Proposal process as needed.

Expenditure trends show steady growth, increasing from $3.62 million in FY 2022–23 to a projected

$4.91 million in FY 2025–26, while the reserve level decreased from 15.7 months in FY 2021–22 to 10.1 months in FY 2024–25. If current expenditure trends persist, projections indicate the reserve level will decline further to approximately 8.1 months by FY 2027–28.

Although the Board's reserve remains sufficient to support its operations, it currently falls below the Department of Consumer Affairs' (DCA) recommended reserve level of 12–15 months. Maintaining a reserve within this recommended range is critical to absorbing rising enforcement and pro rata costs, ensuring fiscal stability, and protecting the Board's ability to meet its highest priority, which is public protection.

8. Describe if/when a deficit is projected to occur and if/when a fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the Board.

The Board is funded through revenues received from applicants and licensees, including initial licensure, license renewal, endorsements (license verifications), and administrative actions such as citations, cost recovery, and probation monitoring.

During the current Sunset Review period, the Board identified a structural fund imbalance beginning in FY 2024–25, when operational costs began exceeding fee revenues. This trend is projected to continue through FY 2025–26, FY 2026–27, and FY 2027-28. Although the Board's reserve remains stable in the near term, fund condition projections indicate that current fees will not sustain ongoing program operations beyond FY 2031–32.

Reserves are expected to decline steadily, reaching approximately 8.1 months in FY 2027–28. This is well below the DCA's recommended reserve level of 12–15 months. Without corrective action, a structural deficit is projected by FY 2031–32.

The Board is actively working on a regulatory package to increase all of its fees to the statutory caps.

Given these fiscal pressures, the Board is seeking legislative authority to adjust statutory fee limits during this review period to ensure revenue levels adequately support ongoing operations and may need to pursue a fee increase within the four years to preserve solvency and ensure the continued delivery of its consumer protection mission.

Historically, the Board has demonstrated strong fiscal stewardship, managing resources responsibly by redirecting funds, obtaining expenditure augmentations when necessary to address workload increases, and maintaining essential operations despite rising legal and enforcement costs. Any future fee adjustment would reflect a measured and necessary response to preserve the Board's financial stability and ability to protect California consumers.

9. Using table 2, *Fund Condition*, describe year over year expenditure fluctuations and the cause for the fluctuations.

In FY 2022-23, Board expenditures were $3.62 million, decreasing slightly to $3.51 million in FY 2023-24, a slight decrease of $110,000 (3%). The slight decrease in FY 2023-24 can be attributed, in part, to a leadership transition that resulted in temporary savings from staff vacancies, and the postponement of certain initiatives and operational activities while organizational priorities were reassessed under new leadership.

In FY 2023-24, expenditures increased from $3.51 million to $4.27 million in FY 2024-25, an increase of $760,000 (22%). The increase in expenditures can be attributed to the extensive program overhaul that the Board performed on its enforcement program, an increase in AG and OAH rate escalations, along with cost-of-living adjustments and expanded enforcement activity with an increase in investigations resulting from an increase in complaints received, were key contributors to this growth.

In FY 2024-25, expenditures rose from $4.27 million to $4.91 million in FY 2025-26, an increase of $640,000 (15%). By this time, AG and OAH costs had become a significant factor in over-expenditures, compounded by higher case volume and enforcement complexity. To address these mandated enforcement obligations, the Board was required to redirect resources and obtain augmentations to sustain operations. In addition, the Board sought the recruitment of a Special Investigator on a limited term basis to cover lower-level investigations to help with investigative costs.

The Board projects rising expenditures from $4.91 million in FY 2025-26 to $4.93 million in FY 2026-27 (.4%), and from $4.93 million in FY 2026-27 to $5.07 million in FY 2027-28 (2.8%). Again, these increases are expected to be driven by multiple factors, including AG and OAH costs, investigations, personnel expenses tied to collective bargaining agreements, new staffing to meet program needs, and general inflationary pressures.

Overall, while many elements contribute to expenditure fluctuations, AG, OAH and investigative service and rate increases since FY 2022-23 remain a significant reason for upward cost trends alongside staffing, regulatory implementation, and operational needs.

10. **Using Table 3, *Expenditures by Program Component*, describe the amounts and percentages of expenditures by program component, including the cause of fluctuations aside from increasing personnel costs. Provide a breakdown of the expenditures by the Board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.**

Table 3. Expenditures by Program Component (list dollars in thousands)

	FY 2022 23		FY 2023 24		FY 2024 25		FY 2025 26	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	$405	$1,259	$454	$1,188	$708	$1,454	$737	$1,740
Examination	$ -	$1	$ -	$ -	$ -	$77	$0	$179
Licensing	$726	$90	$814	$15	$480	$10	$500	-$2
Administration[1]	$405	$38	$458	$6	$840	$15	$875	-$3
DCA Pro Rata	$ -	$428	$ -	$338	$ -	$473	$0	$648
Diversion	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
(if applicable)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
TOTALS	**$1,536**	**$1,816**	**$1,726**	**$1,547**	**$2,028**	**$2,029**	**$2,112**	**$2,562**

[1]*Administration includes costs for executive staff, board, administrative support, and fiscal services.*

During the current Sunset Review period, total Board expenditures increased from $3.25 million in FY 2022–23 to a projected $4.67 million in FY 2025–26. This steady growth reflects statewide cost adjustments, personnel allocations, and rising DCA Pro Rata assessments.

Expenditure Distribution and Trends

- Personnel Services increased from $1.54 million in FY 2022–23 to $2.11 million in FY 2025–26, representing approximately 63 percent of total expenditures on average over the four-year period. Growth was primarily driven by statewide salary and benefit adjustments and personnel allocations supporting the Board's core programs.

- Operating Expenses and Equipment (OE&E) increased from $1.816 million in FY 2022–23 to $2.562 million in FY 2025–26, accounting for approximately 37 percent of total expenditures on average. OE&E growth was largely attributable to increased enforcement-related legal costs and rising shared-service assessments.

- Enforcement expenditures increased from $1.664 million in FY 2022–23 to $2.477 million in FY 2025–26, an increase of approximately 49 percent. The growth was primarily driven by higher Attorney General and Office of Administrative Hearings costs, as well as increased personnel expenditures.

- Licensing expenditures declined from $816 thousand in FY 2022–23 to $498 thousand in FY 2025–26, reflecting fluctuations in staffing allocations and operating costs during the review period.

- Administration expenditures increased from $443 thousand in FY 2022–23 to $872 thousand in FY 2025–26, an increase of approximately 97 percent, primarily due to increased personnel costs associated with executive, administrative support, and fiscal services.

- DCA Pro Rata costs increased from $428 thousand in FY 2022–23 to $648 thousand in FY 2025–26, representing approximately 13 percent of total expenditures on average during the review period. These costs support department-wide administrative and shared services.

- Examination expenditures were minimal throughout the review period, consisting primarily of OE&E costs. Expenditures increased from $1 thousand in FY 2022–23 to $179 thousand in FY 2025–26, reflecting examination-related contractual and program support activities.

Overall, the Board's expenditures increased from $3.35 million in FY 2022–23 to a projected $4.67 million in FY 2025–26, an increase of approximately 39 percent. Growth during the Sunset Review period was primarily driven by increased personnel costs, rising enforcement-related expenses, and higher DCA Pro Rata assessments. Despite these increases, expenditures continued to support the Board's licensing, enforcement, examination, and administrative functions in furtherance of its consumer protection mission.

11. Describe the amount the board has spent on business modernization, including contributions to the BreEZe program, which should be described separately?

The chart below provides the BreEZe maintenance costs for the current Sunset Review reporting period:

BreEZe Maintenance Costs

FY 22/23	FY 23/24	FY 24/25	FY 25/26	FYs 2022-2026
Actual	Actual	Actual	Actual	Total
$34,000	$31,000	$54,000	$53.000	$172,000

For other non-BreEZe business needs, the Board is currently piloting the utilization of existing Microsoft programs for communication, collaboration, process routing, tracking status, record keeping, and collecting workload data. By leveraging tools such as Microsoft Teams, SharePoint, and Copilot, the Board aims to streamline processes, enhance productivity, and increase data collection opportunities. For example, Microsoft Teams is used for efficient communication and collaboration among team members, while SharePoint serves as a central repository for document management and sharing. This initiative has already improved operational efficiency and provided better insight into workload volume and status at no additional cost beyond the existing software licenses.

12. Describe license renewal cycles and history of fee changes in the last 10 years. Give the fee authority (Business and Professions Code and California Code of Regulations citations) for each fee charged by the board.

Table 4. Fee Schedule and Revenue (list revenue dollars in thousands)

Fee	Current Fee Amount	Statutory Limit	FY 2022 23 Revenue	FY 2023 24 Revenue	FY 2024 25 Revenue	FY 2025 26 Revenue	% of Total Revenue
Delinq Tax & Reg Fee	$100	Varies	$15	$18	$17	$20	0.4%
Delinq Inact Ren Fee	$75	Varies	$3	$4	$4	$5	0.1%
Phys/Surg Cite & Fine	Varies	Varies	$11	$15	$4	$28	0.4%
Dup Cert Fee	$25	$25	$5	$3	$3	$3	0.1%
Endorsement Fee	$25	$25	$34	$25	$19	$20	0.6%
Lic Stat Change Fee	Varies	Varies	$3	$4	$2	$3	0.1%
Name Change Fee	$25	$25	$0	$0	$1	$2	0.0%
Phys/Surg Orig App	$200	$400	$271	$336	$239	$286	7.1%
Phys/Surg Lic Fee	$400	$400	$564	$720	$478	$573	14.7%
Fict Name Perm App	$100	$100	$18	$14	$22	$46	0.6%
Phys/Surg Train App Fee	$491	No cap	$318	$348	$355	$378	8.8%
Misc Serv To Public General	Varies	Varies	$0	$0	$0	$0	0.0%
Biennial Active License Renewal	$400	$400	$2,238	$2,108	$2,588	$2,423	58.8%
Bien Inact Cert Fee	`	$399	$86	$70	$78	$66	1.9%
Ann Ren Fict Name Prmt	$50	$100	$36	$41	$51	$51	1.1%
Oshp Osteopathic	$25	$25	$17	$14	$20	$18	0.4%
Misc Revenue	Varies	Varies	$115	$220	$238	$210	4.9%
Total Revenue			**$3,734**	**$3,940**	**$4,119**	**$4,132**	**$15,925**

Licensing Renewal Cycles

Osteopathic physician and surgeon licenses are renewed on a biennial (every two years) basis (BPC Section 2454.5).

The Board's fee regulation establishes a biennial renewal fee and biennial inactive license fee.

The Board's renewal application instructions state that:

- Active licenses must be renewed every two years and require compliance with continuing medical education (CME) requirements.
- Inactive licenses are also renewed biennially but do not require CME.
- Licenses become delinquent if a renewal is not completed by the expiration date.
- A license that remains delinquent for more than five years is canceled and requires reapplication.

Fees and Authority

The Board's fees are established in California Code of Regulations, Title 16, Division 16, Section 1690 (Fees). The Board's authority for this regulation is derived from Section 1 of the Osteopathic Act and BPC Sections 2018, 2064.5, 2456.1, and 3600-1. The regulation references BPC Sections 2064.5, 2451, and 2455.

- Physician and surgeon original certificate application fee $200 16 CCR Section1690(a)
- Reciprocity certificate application fee $200 16 CCR Section1690(b)
- Postgraduate training license application and processing fee $491 16 CCR Section1690(c)
- Duplicate certificate / name change / certification endorsement fee $25 16 CCR Section1690(d)
- Biennial renewal fee (active license) $400 16 CCR Section1690(e)
- Biennial inactive certificate fee $300 16 CCR Section1690(f)
- Delinquent renewal fee $100 16 CCR Section1690(g)
- Fictitious name permit application fee $100 16 CCR Section1690(h)
- Fictitious name permit renewal fee $50 16 CCR Section1690(h)

Additional charges being collected at renewal include:

- Steven M-Thompson Physician Corps Loan Repayment Program Fee $25 (B&P Code Section 2436.5)
- CURES Fee Currently $15 annually; because osteopathic licenses renew biennially, licensees will pay $30 during renewal.

Fee Changes During the Last 10 Years

Postgraduate Training License Fee

In 2020, the Board amended Section1690 to add a postgraduate training license non-refundable application and processing fee of $491. The regulation history specifically notes the creation of new subsection (c) in 2020.
CURES Fee

The Board announced that the CURES assessment increased from $9 to $15 annually, effective for licenses expiring on and after July 1, 2025.

Pending Fee Rulemaking

Board materials from 2025-2026 indicate that the Board is pursuing a rulemaking package titled Retired License, Petitions and Fees, which includes additional fee increases and new fees. However, the proposal had not yet been finalized in the materials reviewed.

13. Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

Table 5. Budget Change Proposals (BCPs)*in thousands

BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	$ Requested	$ Approved	$ Requested	$ Approved
1111-027-BCP-2024-GB	2024-25	The Osteopathic Medical Board of California requests an increase in expenditure authority to address increased costs for Attorney General services.	0	0	$0	$0	$347,000	$347,000
1111-032-BCP-2026-GB	2026-27	The Osteopathic Medical Board of California requests an increase in expenditure authority to support investigative services provided by the Division of Investigation's Health Quality Investigation Unit.	0	0	$0	$0	$338,000	$338,000

Over the past several fiscal years, the Board has submitted a limited number of Budget Change Proposals (BCPs), demonstrating fiscal prudence and a commitment to requesting additional resources only when necessary to fulfill its mission. Most recently, the Board received approval for two expenditure authority augmentations that did not include additional staffing.

In FY 2024-25, BCP 1111-027-BCP-2024-GB provided an augmentation of $347,000 in Operating Expenses and Equipment (OE&E) to address increased costs for Attorney General services.

In FY 2026-27, BCP 1111-032-BCP-2026-GB provided an augmentation of $336,000 in OE&E to support investigative services provided by the Division of Investigation's Health Quality Investigation Unit.

Both proposals were approved at the full amount requested and did not include position authority or personnel services funding. These augmentations ensure the Board has sufficient resources to

support its enforcement and consumer protection responsibilities while maintaining effective oversight of the osteopathic medical profession in California.

Staffing Issues

14. Describe any board staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.

Erika Calderon assumed the role of Executive Director for the Board in November 2022, following the departure of the previous Executive Director to a new position within DCA. The Board boasts a strong record of employee retention, particularly within highly specialized roles that necessitate substantial subject matter expertise, institutional knowledge, and familiarity with established processes. Filling vacancies in these positions can pose significant operational challenges due to the specialized skills and experience required, which are not easily or quickly replicated.

To mitigate these operational vulnerabilities, the Board has proactively implemented strategies focused on enhancing organizational resilience. These initiatives include the comprehensive documentation of workflows, the facilitation of targeted cross-training programs, and the promotion of increased knowledge sharing across all units. These efforts aim to prevent the over-concentration of critical responsibilities within single individuals. While these mitigation measures do not entirely eliminate the inherent difficulties in recruiting and training personnel for these specialized positions, they have demonstrably strengthened the Board's ability to maintain continuity in essential functions and adapt to personnel changes.

The Board received authorization for two additional positions via Senate Bill 815 (2023). These positions are designated to enhance patient safety through enforcement outreach efforts, strengthen enforcement activities, and facilitate mandatory complaint interviews. Concurrently, the Board has experienced a substantial growth in its licensee population and a marked increase in consumer complaints, with the latter nearly doubling over the past four fiscal years. This escalation in operational duties necessitates additional staff resources.

In response, the Board has taken steps to reduce costs and at the same time improve operational efficiency and consumer protection through temporary help using its blanket authority. It established a non-sworn special investigator position on a limited 24-month term. This position is designed to handle specific cases that do not require sworn resources, streamlining processes and lowering expenses. The Board aims to make this position permanent through a future Budget Change Proposal.

15. Describe the board's staff development efforts and total spend annually on staff development (cf., section 12, Attachment D).

The Board recognizes staff development as a critical element for achieving organizational effectiveness and fulfilling its public protection mandate. The Board is committed to fostering a culture of continuous learning by encouraging staff participation in both internal and external training programs. These opportunities are designed to cultivate essential leadership, analytical, and technical proficiencies necessary for robust regulatory oversight.

Staff training and development are facilitated through various channels, including programs offered by DCA such as Strategic Organization, Leadership and Individual Development (SOLID) Training Solutions, and the Federation of State Medical Boards (FSMB). Participation in these programs

exposes staff to the best national practices in areas including complaint resolution, administrative law, investigative methodologies, data management, and the professional standards governing medical regulation. Furthermore, the Board leverages internal DCA resources for mandatory statewide training on crucial topics such as Ethics, Information Security, and Sexual Harassment Prevention.

In parallel with external professional development, the Board prioritizes organizational modernization through ongoing internal training and the provision of digital learning resources. These initiatives are aimed at familiarizing staff with new systems and digital tools. Regular training sessions are conducted on platforms such as Microsoft Teams, SharePoint, BreEZe, and other workflow automation systems. This ensures staff competency in modern technologies that enhance efficiency, collaboration, and transparency. The costs associated with these training initiatives are integrated into the Board's Pro Rata assessment. This assessment represents the allocation of shared administrative and programmatic expenses for services provided by the DCA to all constituent boards and bureaus, encompassing personnel development and leadership training. The annual allocation for this purpose is $9,000.

The Board's 2024–28 Strategic Plan underscores staff development as a core priority within its Board Administration goal. The plan mandates investment in professional growth opportunities, the enhancement of internal communication systems, and continuous assessment of technological requirements to improve customer service. These strategic efforts are designed to ensure that the Board's workforce remains knowledgeable, adaptable, and proficient in addressing evolving regulatory demands, while upholding the highest standards of performance and accountability.

Collectively, these comprehensive initiatives foster a highly skilled and forward-thinking workforce, enabling the Board to effectively fulfill its mission of protecting the public and delivering high-quality, efficient services to consumers, applicants, and licensees.

Section 3
Licensing Program

Table 6. Licensee Population

		FY 2022/23	FY 2023/24	FY 2024/25	FY 2025/26
Osteopathic Physician & Surgeon	Active[4]	12,135	13,495	14,375	15420
	Out of State	1673	2111	2465	2808
	Out of Country	7	5	9	10
	Delinquent/Expired	1,708	1,755	1,948	1,918
	Retired[5]	0	0	0	0
	Inactive	502	467	421	431
	Other	0	2	2	1
Postgraduate Training License	Active	1185	906	1,214	1,545
	Out of State	8	5	7	11
	Out of Country	0	0	0	0
	Delinquent/Expired	2	4	4	4
	Retired	0	0	0	0
	Inactive	0	0	0	0
	Other	0	0	0	0
Fictitious Name Permit	Active	838	876	1,013	1,271
	Out of State	9	7	20	21
	Out of Country	0	0	0	0
	Delinquent/Expired	422	429	277	303
	Other	0	0	0	0

Note: "Out of State" and "Out of Country" are two mutually exclusive categories. A licensee should not be counted in both.

16. What are the board's performance targets/expectations for its licensing[6] program? Is the board meeting those expectations? If not, what is the Board doing to improve performance?

Since the last sunset report, the Board has successfully transitioned all its applications and transactions to the BreEZe platform. The Board maintains a standard of sixty (60) days for the initial review of submitted applications, including payment, and to notify applicants in writing of any deficiencies. This target has been consistently met with dedicated licensing staff. The Board has two staff members that process applications for the osteopathic physician and surgeon certificate, and one staff member who processes postgraduate training license (PTL) applications and fictitious name permits (FNP). However, as the osteopathic physician and surgeon licensee population in California continues to expand, so will application volume, indicating a future need for additional licensing staffing.

In pursuit of continuous improvement, the Board has implemented several process enhancements. These include the revision and simplification of application instructions, advancements in document tracking within the BreEZe system, and the utilization of electronic verification methods to streamline the submission of required materials and reduce the administrative burden on applicants. These initiatives have fostered a more efficient and applicant-centered licensing process.

[4] Active status is defined as able to practice. This includes licensees that are renewed, current, and active.
[5] Retired status is intended for individuals who are no longer practicing. While the Board does not currently offer a retired license status, it is actively pursuing the establishment of this status through the regulatory process.
[6] The term "license" in this document includes a license certificate or registration.

Furthermore, the Board has bolstered its operational infrastructure by filling critical staffing positions, such as the Licensing Program Manager, and by cross-training team members to enhance operational flexibility and program resilience. Consistent outreach to educational programs is ongoing to inform graduating students about the licensing process, thereby enabling them to submit timely and accurate applications.

Through these consolidated efforts, the Board reaffirms its dedication to timely licensure, facilitating workforce access, and safeguarding the public by ensuring that only qualified individuals are authorized to practice medicine in California.

17. Using Table 7a, *Licensing Data by Type*, describe any increase or decrease in the Board's average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done by the Board to address them? What are the performance barriers and what improvement plans are in place? What has the Board done and what is the Board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?

Table 7a. (1) Licensing Data by Type – Physician and Surgeon

					Pending Applications			Application Process Times		
		Received	App(roved /Issued	Closed	Complete (within Board control)*	Incomplete (outside Board control)*	Total (Close of FY)	Complete Apps*	Incomplete Apps*	Total (Close of FY)
FY 22/23	(License)	1,348	1,499	58	-	-	245	85	152	113
	(Renewal)	5,793	5,793	231	-	-	3,437	26	-	26
FY 23/24	(License)	1,707	1,658	136	-	-	320	40	58	49
	(Renewal)	5,511	5,511	292	-	-	2,826	23	-	2
FY 24/25	(License)	1,196	1,259	62	-	-	208	37	65	63
	(Renewal)	6,502	6,502	237	-	-	4,239	24	-	24
FY 25/26	(License)	1,449	1,394	40	-	-	241	16	54	52
	(Renewal)	7,204	7,204	350	-	-	3,411	16	-	16

* Optional. List if tracked by the Board.

Table 7a. (2) Licensing Data by Type – Postgraduate License

					Pending Applications			Application Process Times		
		Received	Approved /Issued	Closed	Complete (within Board control)*	Incomplete (outside Board control)*	Total (Close of FY)	Complete Apps*	Incomplete Apps*	Total (Close of FY)
FY 22/23	(License)	652	576	87	-	-	280	83	101	83
	(Renewal)	-	-	-	-	-	-	-	-	-
FY 23/24	(License)	723	583	34	-	-	401	26	-	26
	(Renewal)	-	-	-	-	-	-	-	-	-
FY 24/25	(License)	710	700	10	-	-	428	67	61	65
	(Renewal)	-	-	-	-	-	-	-	-	-
FY 25/26	(License)	796	721	14	-	-	439	15	56	56
	(Renewal)	-	-	-	-	-	-	-	-	-

* Optional. List if tracked by the Board.

Table 7a. (3) Licensing Data by Type – Fictitious Name Permit

					Pending Applications			Application Process Times		
		Received	Approved /Issued	Closed	Complete (within Board control)*	Incomplete (outside Board control)*	Total (Close of FY)	Complete Apps*	Incomplete Apps*	Total (Close of FY)
FY 22/23	(License)	177	171	39	-	-	37	87	186	88
	(Renewal)	698	698	64	-	-	443	7	-	7
FY 23/24	(License)	146	142	30	-	-	12	20	-	20
	(Renewal)	802	802	75	-	-	460	4	-	4
FY 24/25	(License)	217	162	3	-	-	5	26	-	26
	(Renewal)**	904	904	82	-	-	393	4	-	4
FY 25/26	(License)	464	398	18	-	-	23	18	17	18
	(Renewal)	979	979	72	-	-	388	2	-	2

* Optional. List if tracked by the Board.
** FNP Audit program begun in 2024-25

Table 7b. License Denial

	FY 22/23	FY 23/24	FY 24/25	FY 25/26
License Applications Denied (no hearing requested)	0	0	0	1
Initial Probationary License offered	0	0	0	1
SOIs Filed	0	0	0	1
Average Days to File SOI (from request for hearing to SOI filed)	0	0	0	223
SOIs Declined	0	0	0	0
SOIs Withdrawn	0	0	0	1
SOIs Dismissed (license granted)	0	0	0	0
License Issued with Probation / Probationary License Issued	0	0	0	0
Average Days to Complete (from SOI filing to outcome)	0	0	0	152
License Denied After Appeal	0	0	0	0

During this current Sunset Review period, the Board has demonstrated consistent performance in processing applications and issuing licenses, with only slight year-to-year variation. The number of initial applications received each year has remained steady and even increased slightly in the most recent fiscal year. In 2023-2024 the Board experienced a slight backlog due to the Board's transition of all its applications from paper to electronic. This indicates that the Board has successfully kept pace with demand and has not experienced a growth in pending applications that exceeded completions. Board's performance target for the D.O. license application process is 60 days from the receipt of the application until the issuance of the license. Currently the Board is issuing applications within 12 days for those applications that have no deficiencies. In instances where the Board has notified the applicant that the Board might still be waiting on primary source documents such as osteopathic college transcripts, national exam scores, and postgraduate training certifications applications are taking up to 56 days to approve, still under the 60-day performance target.

D.O.s are one of the fastest growing segments of health care professionals in the United States with California leading as the largest D.O. population nationally. The Board regularly assesses the procedures for handling license applications. One of the recent revisions includes leveraging current capabilities to enhance oversight of applications throughout each phase of the process.

To enhance processing efficiency and support long-term performance, the Board has implemented several key strategies:

- Streamlined Verification: The Board leveraged electronic submission processes for verifying educational completion, reducing manual steps and increasing accuracy and timeliness.
- Process Flexibility: Internally, staff are cross-trained to assist across high-demand areas during peak periods, enabling adaptive responses to shifting workloads.
- Applicant Education: Outreach efforts to osteopathic colleges/universities and residency programs have been expanded, equipping future applicants with guidance that helps reduce submission errors and incomplete applications.
- Regulatory Improvements: The Board has actively pursued regulatory updates to support clearer standards.
- Planning for Growth: As new postgraduate training licensee programs launch across California, the Board continues to monitor trends and adjust internal operations to maintain licensing timelines as the applicant pool expands.

Looking forward, the Board remains committed to continuous improvement of its licensing processes and will continue evaluating and refining systems to ensure timely and effective service to applicants and licensees while maintaining the Board's highest priority of public protection.

18. How many licenses or registrations has the board denied over the past four years based on criminal history that is determined to be substantially related to the qualifications, functions, or duties of the profession, pursuant to BPC Section 480? Please provide a breakdown of each instance of denial and the acts the Board determined were substantially related.

The Board denied one license over the past four years based on criminal history substantially related to the qualifications, functions, or duties of the profession, pursuant to BPC Section 480.

19. How does the Board verify information provided by the applicant?

- **What process does the Board use to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant? Has the Board denied any licenses over the last four years based on the applicant's failure to disclose information on the application, including failure to self-disclose criminal history? If so, how many times and for what types of crimes (please be specific)?**

During this current Sunset Review period, the Board has continued its commitment to public protection through a robust applicant screening process designed to identify criminal history and prior disciplinary actions. The Board utilizes fingerprint-based background checks through the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI).

Applicants are required to submit fingerprints via Live Scan or hard card submission, which allows the Board to receive both California and federal criminal history information.

In alignment with statutory changes implemented in response to AB 2138 and amendments to BPC Section 480, effective January 1, 2023, the Board no longer requires that applicants self-disclose criminal convictions on the application. However, applicants must still disclose prior professional license discipline from other states or jurisdictions. For applicants applying via endorsement, licensing staff verify licensure history and discipline using the Federation Credentials Verification Service (FCVS). This database includes nationwide disciplinary actions reported by member jurisdictions.

Denial decisions are made when the conduct itself is substantially related to the qualifications, functions, or duties of a licensee and met denial criteria under BPC Sections 480 and 3600. The Board as stated above denied one application pursuant to BPC Sections 480 and 3600.

The Board remains committed to improving the clarity of the application process and ensuring applicants are aware of all disclosure requirements and the implications of failing to comply with these requirements. Staff also participate in outreach presentations at osteopathic colleges/universities to educate prospective applicants about these expectations.

- **Does the Board fingerprint all applicants?**

Yes, the Board requires all applicants to submit fingerprints. All applicants are required to submit fingerprints either through Live Scan (in-state) or hard card (out-of-state), which enables the Board to receive state and federal criminal history information from the DOJ and FBI. This process is mandated by BPC Section 144 and ensures that the Board conducts a thorough background check on every applicant to protect the public. Additionally, the Board requires a Physician Data Center (PDC) report generated by the Federation of State Medical Boards (FSMB) which reveals licenses held by the applicant in any other state in order to determine whether any prior or current disciplinary actions have been taken against the applicant by another board.

- **Have all current licensees been fingerprinted? If not, explain.**

Yes, all current licensees have been fingerprinted. While all applicants are required to undergo fingerprinting prior to initial licensure, the Board does not require licensees to be re-fingerprinted after licensure or during the renewal process, unless the license was revoked and that the individual wishes to petition the Board for reinstatement of their license.

- **Is there a national databank relating to disciplinary actions? Does the Board check the national databank prior to issuing a license? Renewing a license?**

The Board uses information obtained by the FSMB to determine if any disciplinary actions have been taken by any other state licensing board prior to the issuance of an initial license. When information is received by the Board that other state boards may have taken disciplinary action against the applicant, the Board then uses the National Practitioner Data Bank (NPDB) to obtain further disciplinary information. Staff will also obtain certified documents from the other state(s) involved. The NPDB is also used to obtain information on malpractice cases filed against the applicant/licensee. The Board reports all disciplinary actions to both FSMB and NPDB.

However, the Board does not routinely check FSMB or NPDB records at the time of license renewal, as current law does not require these reviews during the renewal process. If concerns arise or additional information is brought to the Board's attention such as through a complaint or report, the Board may access these resources as part of its investigation process.

- **Does the board require primary source documentation?**

Yes, the Board requires primary source verification, but not from the applicant directly. While applicants are required to disclose all licenses held in other jurisdictions, the Board does not require

hard copies of those licenses. Instead, the Board staff independently verify the status and history of each license through online primary sources, such as official state licensing websites and the FSMB and if needed may request a state to provide a license verification. This approach ensures the accuracy and authenticity of licensure information without placing the burden on the applicant to provide physical documentation.

- **Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.**

Yes, the Board sends No Longer Interested (NLI) notifications to DOJ on a regular and ongoing basis. This process is automated through the BreEZe licensing system and is triggered by changes in license status for individuals over whom the Board no longer has jurisdiction. NLI requests are transmitted electronically to DOJ, and there is no current backlog.

On May 5, 2026, Board staff were contacted by DOJ and notified that the Board had been selected for an audit. Staff participated in the audit and the final finding was that the Board "was found to be compliant in all areas assessed."

20. Describe the Board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.

The Board requires that all applicants, both in-state and out-of-state, graduate from an accredited college of osteopathic medicine, complete 12 months of postgraduate training, and successfully complete all levels of the COMLEX-USA exam before applying for licensure. The licensee will then have to demonstrate completion of 36 months of postgraduate training typically by their first renewal. The Board does not accept foreign graduates from out of the country.

21. Describe the board's process, if any, for considering military education, training, and experience for purposes of licensing or credentialing requirements, including college credit equivalency.

During the current Sunset Review period, the Board has implemented an internal process to support military service members, veterans, and military spouses seeking licensure. This process complies with BPC Sections 35, 114.3, 115.4, 115.5, and 115.6, while ensuring continued consumer protection.

Internal Process for Considering Military Education, Training, and Experience

- **Military Application Identification**
  Upon receipt of an application, Board staff screen for any indication that the applicant may qualify for military-related considerations. This includes self-identification as an active- duty service member, veteran, or military spouse. These applications are flagged for expedited handling.
- **Expedited Review and Processing Time**
  Military applications are given priority review/processing and placed in color coded folders for easy identification by licensing staff. The Board has established a performance target of 14

days to process complete military applications, which is significantly shorter than the standard timeframes for other application types.

- **Evaluation of Military Education and Training**
  If documentation of military education, training, or experience is submitted, Board staff evaluate it for alignment with the statutory and regulatory requirements for licensure as an osteopathic physician and surgeon. Evaluation may include academic coursework, clinical training, or job functions performed in the military.
- **Verification and Documentation**
  Military applicants must still meet all applicable licensure requirements. The Board verifies all credentials and qualifying experience using primary source documentation.
- **License Fee Waivers and Temporary Licensure**
  In accordance with BPC Sections 115.4 and 115.5, the Board offers application fee waivers and temporary licenses for qualified military spouses and honorably discharged veterans. Board staff are trained to recognize and apply these provisions during the application process.
- **Ongoing Support and Communication**
  The licensing analyst assigned to the expedited application provides direct support to military applicants throughout the application lifecycle and post-licensing. This includes assisting with document submission, clarifying requirements, and ensuring that applicants are guided through the process without unnecessary delay.
- **Legislative and Policy Compliance**
  The Board monitors and incorporates legislative changes related to military licensure pathways, such as AB 107 (Salas, Chapter 693, Statutes of 2021) and SB 1237 (Newman, Chapter 386, Statutes of 2022), for continued compliance with statewide military licensure policy.

This streamlined internal process reflects the Board's commitment to honoring military service while maintaining rigorous licensing standards that protect the public.

- **How many applicants offered military education, training or experience towards meeting licensing or credentialing requirements, and how many applicants had such education, training or experience accepted by the board?**

For current Sunset Review period, the Board received zero applications for individuals who qualified with military education, training or experience.

	FY 22/23	FY 23/24	FY 24/25	FY 25/26
Applications received	0 application	0 applications	0 applications	0 applications

- **How many licensees has the board waived fees or requirements for pursuant to BPC Section 114.3, and what has the impact been on board revenues?**

Since FY 2022/23, the Board has waived renewal requirements pursuant to BPC Section 114.3 for 25 licensees with no significant impact to Board revenues.

Typically, the Board receives significantly more requests for waiver of fees, but the vast majority of requests are rescinded when the licensees find out from their commanding officer that they need a full license not a restricted military license that restricts their practice to military bases and facilities.

The military license that comes with the fee waiver does not allow practice at non-military civilian facilities. So, the number of those military applicants who really want the military license amounts to approximately six per year. Over the past four years, the Board has waived six military application fees each year for the past four years for a total of 24 (24 X $400 = $9,600 in lost revenue).

- **How many applications has the Board expedited pursuant to BPC Section 115.5?**

	FY 22/23	FY 23/24	FY 24/25	FY 25/26	TOTAL
Physician and Surgeon	5	37	36	34	**112**
Postgraduate Training License	3	5	2	5	**15**
TOTAL	8	42	38	39	**127**

Examinations

22. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required? Are examinations offered in a language other than English? Are interpreters or translation services permitted?

The Board does not administer examinations but relies on national examinations that is generated and administered by NBOME. The NBOME Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) is the recognized national evaluative instrument for osteopathic students and graduates, and successful completion is required for osteopathic licensure in California.

COMLEX Level 1 is a one-day examination, computer-based assessment, that integrates the foundational biomedical sciences and osteopathic principles with clinical knowledge and other physician competencies relevant to addressing clinical presentations and promoting health in supervised patient care settings.

COMLEX Level 2 Cognitive Evaluation (CE) is a one-day examination, computer-based assessment that integrates application of knowledge in clinical and foundational biomedical sciences and osteopathic principles with other physician competencies related to the clinical care of patients and promoting health in supervised patient care settings. These competency domains include application of osteopathic medical knowledge, osteopathic patient care, osteopathic principles and practice, communication skills, systems-based practice, practice-based learning and improvement, professionalism, and ethics.

COMLEX-USA Level 2-Performance Evaluation (Level 2-PE) was a clinical skills exam which was indefinitely suspended in March 2020 and formally discontinued in June 2022.

COMLEX Level 3 is a two-day computer-based examination assessing competence in the foundational competency domains required for generalist physicians to deliver safe and effective osteopathic medical care and promote health in unsupervised clinical settings. Competency domains assessed include application of osteopathic medical knowledge, osteopathic patient care, osteopathic principles and practice, communication skills, systems-based practice, practice-based learning and improvement, professionalism, and ethics. Competency assessment occurs in the context of clinical and patient presentations and systems-based practice as required for entry in the unsupervised

practice of osteopathic medicine as an independently practicing osteopathic generalist physician and for readiness for lifelong learning and practice-based learning and improvement.

The COMLEX-USA is only offered in the English language.

NBOME also offers the **Comprehensive Osteopathic Medical Variable-Purpose Examination (COMVEX)** which is an assessment of osteopathic physicians who hold or have held a valid license to re-enter the practice of osteopathic medicine in the United States or where an assessment of an osteopathic physician's current medical knowledge is otherwise requested by a state medical or osteopathic medical licensing board.

The purpose of COMVEX is to assist state licensing boards by providing an evaluation examination for candidates required or sponsored by a state licensing board to demonstrate current osteopathic medical knowledge and released competencies under standardized conditions.

23. What are pass rates for first time vs. retakes in the past 4 fiscal years? Please include pass rates for all examination offered, including examinations offered in a language other than English. Include a separate data table for each language offered.

The Board does not administer examinations but does rely on a national examination that is generated and administered by the NBOME. The NBOME COMLEX-USA is the recognized national evaluative instrument for osteopathic students and graduates, and successful completion is required for osteopathic licensure in California. It is only administered in English.

Table 8(a). National Examination				
California Examination (include multiple language) if any:				
License Type		**Physician and Surgeon**		
Exam Title		**COMLEX 1**	**COMLEX 2**	**COMLEX 3**
FY 2022/23	# of 1st Time Candidates	7,604	7,816	7,604
	Pass %	90.6%	94.5%	96.3%
FY 2023/24	# of 1st Time Candidates	9,222	8,598	7,559
	Pass %	93.0%	92.5%	94.7%
FY 2024/25	# of 1st Time Candidates	9,381	8,924	7,986
	Pass %	90.3%	91.3%	96.8%
FY 2025/26	# of 1st Time Candidates	9,678	9,096	8,596
	Pass %	90.2%	92.5%	97.1%
Date of Last Occupational Analysis		2026	2026	2026
Name of Occupational Analysis Developer		FOMCD 2026/NBOME	FOMCD 2026/NBOME	FOMCD 2026/NBOME
Target Occupational Analysis Date		TBD	TBD	TBD

Source: https://www.nbome.org/assessments/comlex-usa/examination

COMLEX-USA Attempt Limits

- Four attempt limit for all COMLEX-USA Levels
- Exception: NBOME permits candidates one additional attempt per COMLEX-USA Level if an individual state Board requests
    - Requires candidates seeking the additional attempt has reasonable nexus with state requesting the additional attempt (e.g. resident or native of state, attended medical school or residency in state, intends to practice in state, etc.).
- Limited to one additional attempt
- "Petition for Exception to COMLEX-USA Attempt Limit Policy" form for board to submit is available on NBOME's website.

COMLEX-USA Scoring & Reporting

	REPORTING	PASSING
LEVEL 1	PASS/FAIL	Passing Standard: 400 Includes a formulative performance profile showing relative strengths and weakness
LEVEL 2-CE	3-Digit Score + PASS/FAIL	Passing Score: 400 Includes a performance profile for blueprint content and clinical disciplines
LEVEL 3	3-Digit Score + PASS/FAIL	Passing Score: 350 Includes a performance profile for blueprint content and clinical disciplines

COMVEX- Attempt Limits

- Four attempt limit
- Exception: NBOME permits candidates one additional attempt per COMVEX Level if an individual state Board requests
- Content:
    - Dimension 1: includes seven competency domains, which comprise foundational abilities representing the required elements and outcomes that define knowledge, skills, experience, attitudes, values, behaviors, and established professional standards.
    - Dimension 2: includes ten clinical presentations, which represent the manner in which a particular patient, group of patients, or community present for osteopathic medical care.

COMVEX Scoring & Reporting

	REPORTING	PASSING
COMVEX	3-Digit Score +PASS/FAIL	Passing Score: 350 designed to evaluate whether an osteopathic physician or surgeon demonstrates current medical knowledge and competence at a level appropriate for safe, independent practice. It is typically required when a state medical board requests an updated assessment of a physician's knowledge.

24. Is the board using computer-based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?

The COMLEX exam is delivered by computer at approximately 300 Pearson test centers throughout the U.S.

They are offered during published exam windows which are available on NBOME's website.

COMLEX-USA Testing Windows & Score Release Dates - NBOME

Test accommodations are available upon submission of an application accompanied by appropriate medical, psychological, or psychiatric documentation following the Americans with Disabilities Act (ADA).

25. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe. Has the board approved any amendments, or is the board considering amendments to address the hindrances presented by these statutes?

There are no existing statutes that hinder the efficient and effective processing of applications. The Board does not administer examinations.

26. When did the board last conduct an occupational analysis that validated the requirements for a California-specific examination? When does the board plan to revisit this issue? Has the Board identified any reason to update, review, or eliminate its current California-specific examination?

California Business & Professions Code Section 139 directs the DCA to establish a policy for examination development and validation and for review of state and national examinations. This is the statutory basis that allows boards to use national exams when they meet psychometric standards.

The Board's laws and regulations (found in Title 16, Division 16; Articles covering Applications and Examinations) implement licensing requirements within the Medical Practice Act framework.

The Board uses NBOME a multi-layered, nationally recognized assessment-development process that is competency-based, evidence-driven, and aligned with professional psychometric standards, which is accepted by all 50 U.S. licensing jurisdictions, is recognized by the International Association of Medical Regulatory Authorities (IAMRA), and uses standardized, evidence-based design recognized by national bodies such as ACGME, AMA, and FSMB.

School Approvals

27. Describe legal requirements regarding school approval. Who approves your schools? What role does BPPE (Bureau for Private and Post-Secondary Education) have in approving schools? How does the board work with BPPE in the school approval process?

All osteopathic colleges are approved by the Commission on Osteopathic College Accreditation (COCA) utilizing COM Accreditation Standards and Procedures, and are recognized by the U.S.

Department of Education. Neither the BPPE nor the Board, working independently or in conjunction, have a role in the accreditation of any osteopathic college(s). Schools of Osteopathic Medicine are reviewed by the COCA on a scheduled basis and must satisfactorily meet all markers on the stringent accreditation timetable to obtain provisional and/or permanent accreditation. Schools strive to obtain full accreditation status through the COCA and once approved are granted a seven-year certification, which will need to be reassessed at the end of the seventh year or prior, if otherwise directed by the COCA. The Board has no role in approval of international schools as there are no colleges outside of the United States which have curricula commensurate with the American model.

28. How many schools are approved by the board? How often are approved schools reviewed? Can the board remove its approval of a school?

The Board does not have a role in the approval process of schools.

29. What are the board's legal requirements regarding approval of international schools?

The Board has no role in approval of international schools as there are no colleges outside of the United States which have curricula commensurate with the American model.

Continuing Education/Competency Requirements

30. Describe the board's continuing education/competency requirements, if any. Describe any changes made by the board since the last review.

The Board requires all active Osteopathic Physicians and Surgeons to demonstrate completion, within a two-year cycle, of 50 hours of continuing medical education (CME), including 20 hours of AOA Category 1A or 1B coursework, along with at least one hour of training related to addiction or opioid prescribing. CME may include accredited seminars, conferences, teaching, independent study, or reading medical journals, and physicians must retain documentation for a minimum of six years for audit purposes, as the Board conducts routine CME audits and may issue citations, fines, or renewal delays for non-compliance. Applicants restoring a license to active status must attest to 50 hours of CME completed within the previous two years in accordance with Article 9 of Title 16 of the California Code of Regulations.

- **How does the board verify CE or other competency requirements? Has the Board worked with the Department to receive primary source verification of CE completion through the Department's cloud?**

At the time of renewal, licensees must certify under penalty of perjury that they have complied with the Board's CME requirements, pursuant to BPC Section 2454.5. Licensees are required to maintain proof of each CME activity for six years and must provide supporting documentation upon the Board's request (Title 16, CCR Section 1636).

The Board does not currently use the DCA's "cloud" solution for licensee CME requirement submission. Instead, the Board has found email communication to be an efficient and effective method for obtaining documentation and corresponding with licensees. When audited, licensees must submit their CME records and attest that all information submitted is true and correct.

If verification is needed, Board staff will follow up with the recognized CME entity that approved the course. For alternate pathway activities (e.g., academic coursework, research, or pro bono service), staff will contact the appropriate entity to verify the submitted documentation.

- **Does the board conduct CE audits of licensees? Describe the board's policy on CE audits.**

Yes. The Board conducts random post-renewal CME audits. The audit selection percentage is set at 10% of its annual renewing population.

A licensee passes the audit if they demonstrate sufficient compliance with the CME requirements. Reasons for failure include not providing acceptable proof of hours, submitting hours from non-compliant activities, or failing to respond to the CME audit request.

- **What are consequences for failing a CE audit?**

Consequences vary depending on the degree of noncompliance:

  - **Citation with order of abatement** – requiring the licensee to complete deficient continuing competency hours within a specified timeframe.
  - **Warning letter** – for minor, first-time documentation issues.
  - **Formal discipline** – for severe or repeated noncompliance or failure to comply with an abatement order.

- **How many CE audits were conducted in the past four fiscal years? How many fails? What is the percentage of CE failure?**

The Office of Administrative Law (OAL) approved the Board's CME audit regulations on July 10, 2025, with an effective date of October 1, 2025. The Board updated BreEZe to enable audits on July 15, 2026, and has since conducted 39 audits, with zero failures. So far, the Board has had three licensees that have failed to respond to the audit and will be receiving an Administrative Citation.

- **Who approves CE courses? What is the board's course approval policy?**

The Board accepts all CME courses which are pre-approved by the AOA and/or American Medical Association (AMA).

- **Who approves CE providers? If the board approves them, what is the board application review process?**

The Board does not approve CME providers or courses. The Board accepts all CME courses which are pre-approved by the AOA and/or AMA.

- **How many applications for CE providers and CE courses were received? How many were approved?**

The Board does not approve CME providers or courses.

- **Does the Board audit CE providers? If so, describe the Board's policy and process.**

The Board does not approve CME providers or courses. The Board accepts all CME courses which are pre-approved by the AOA and/or AMA.

- **Describe the board's effort, if any, to review its CE policy for purpose of moving toward performance-based assessments of the licensee's continuing competence.**

The Board has not formally revised its policy to adopt a performance-based model. However, the Board continues to monitor national developments through the American Osteopathic Association (AOA) and has engaged in preliminary discussions about how performance-based elements might be incorporated into the existing CME framework without compromising consumer protection.

Section 4
Enforcement Program

31. What are the board's performance targets/expectations for its enforcement program? Is the Board meeting those expectations? If not, what is the Board doing to improve performance?

In July 2009, Governor Schwarzenegger directed the State and Consumer Services Agency (SCSA) to conduct an internal review of the Division of Investigation and health care boards' enforcement programs within DCA. Based on SCSA's findings, Governor Schwarzenegger charged then DCA Director, Brian Stiger, with reforming the enforcement process for health care boards in California.

The DCA reviewed existing enforcement processes and identified systemic problems that were barriers limiting the health care boards' abilities to investigate and act on cases in a timely manner. The barriers identified ranged from legal and procedural challenges to inadequate resources, such as funding and staff shortages. In response, the DCA launched the Consumer Protection Enforcement Initiative (CPEI). As part of the CPEI, enforcement performance measures were developed to monitor and assist in determining the effectiveness of efforts to streamline enforcement processes, reduce backlogs, and achieve the overall goal to process complaints within 12-18 months. In July 2010, the DCA began collecting data on its new enforcement measures.

Although the Board had an ongoing process to evaluate and improve its enforcement program, the Board also implemented CPEI with the expectation of reducing the average enforcement completion time. The Board's program included a review, comparison, and evaluation of best practices within the DCA and incorporated the DCA's established targets for the enforcement program.

CPEI Performance Measures

The enforcement process is monitored by the assigned Board analyst at all phases and intervals of the process. The targets serve as a tool to improve case management at each interval. The Board's performance targets are reflected in the tables below by quarter and fiscal year. Included after each table below are comments on the Board performance for these targets.

Performance Measures One: Complaints and Convictions/Arrest Received

Performance Measure (PM) one measures the total number of complaints and convictions received, which do not have target and performance standards. It is important to note that the number of complaints received has doubled in the past four years.

Complaints and Convictions and Arrest Received by Fiscal Year	
	Received
FY 22/23	669
FY 23/24	889
FY 24/25	1041
FY 25/26	1379

Performance Measures Two: Intake

PM two measures the time from complaint receipt until the complaint is assigned to an analyst to begin the investigation. Complaints are received by telephone, mail, email, fax, or by filing a complaint via the Board website and through the BreEZe Licensing and Enforcement System (BreEZe).

Target: The Board initially set the performance target for PM two at 30 days; however later its target decreased to ten days to conform with CPEI recommendations and allow for greater consumer protection.

Comment: The target was not met in quarter one of FY 22/23 but was met every other quarter. In FY 22/23, the Board established an intake analyst position to help meet this target going forward.

Intake Process Target Performance			
FY 22/23	Average Days	Target # of Days	Target Met
Quarter 1	13	10	No
Quarter 2	3	10	Yes
Quarter 3	6	10	Yes
Quarter 4	3	10	Yes
Intake Process Target Performance			
FY 23/24	Average Days	Target # of Days	Target Met
Quarter 1	3	10	Yes
Quarter 2	4	10	Yes
Quarter 3	3	10	Yes
Quarter 4	2	10	Yes
Intake Process Target Performance			
FY 24/25	Average Days	Target # of Days	Target Met
Quarter 1	5	10	Yes
Quarter 2	4	10	Yes
Quarter 3	4	10	Yes
Quarter 4	6	10	Yes
Intake Process Target Performance			
FY 25/26	Average Days	Target # of Days	Target Met
Quarter 1	4	10	Yes
Quarter 2	5	10	Yes
Quarter 3	6	10	Yes
Quarter 4	5	10	Yes

Performance Measures Three: Intake and Investigation

PM three measures the average time from complaint receipt to closure of the investigation process. The investigative process includes desk investigations conducted by the Board analysts, and formal investigations conducted by the DCA, Division of Investigation (DOI) Health Quality Investigation Unit (HQIU). Cases resulting in formal discipline forwarded to the Attorney General (AG) are not included in this measure.

Target: The Board set the performance target for PM three at 365 days.

FY 22/23

Intake and Investigation Target Performance			
FY 22/23	**Average Days**	**Target # of Days**	**Target Met**
Quarter 1	204	365	Yes
Quarter 2	224	365	Yes
Quarter 3	466	365	No
Quarter 4	246	365	Yes

- 248 cases were closed within 90 days
- 72 cases were closed within 91 days-180 days
- 136 cases were closed within 181 days-one year
- 130 cases were closed within one-two years
- 78 cases were closed within two-three years

Comment: The Board met the target in three of the four quarters in fiscal year 22/23. A total of 37% of cases were completed within 90 days, 11% of cases were completed within 91-180 days, 20% of the cases were completed within 181-365 days, and only 32% were completed outside of the Board's target.

FY 23/24

Intake and Investigation Target Performance			
FY 23/24	**Average Days**	**Target # of Days**	**Target Met**
Quarter 1	227	365	Yes
Quarter 2	218	365	Yes
Quarter 3	248	365	Yes
Quarter 4	187	365	Yes

- 352 cases were closed within 90 days
- 110 cases were closed within 91 days-180 days
- 140 cases were closed within 181 days-one year
- 135 cases were closed within one-two years
- 35 cases were closed within two-three years

Comment: The Board met the target for all four quarters in fiscal year 23/24. A total of 46% of cases were completed within 90 days, 14% of cases were completed within 91-180 days, 18% of the cases were completed within 181-365 days, and only 22% were completed outside of the Board's target.

FY 24/25

Intake and Investigation Target Performance			
FY 24/25	**Average Days**	**Target # of Days**	**Target Met**
Quarter 1	165	365	Yes
Quarter 2	198	365	Yes
Quarter 3	212	365	Yes
Quarter 4	183	365	Yes

- 474 cases were closed within 90 days
- 129 cases were closed within 91 days-180 days
- 141 cases were closed within 181 days-one year
- 145 cases were closed within one-two years
- 32 cases were closed within 2-3 years

Comment: The Board met the target for all four quarters in fiscal year 24/25. A total of 51% of cases were completed within 90 days, 14% of cases were completed within 91-180 days, 15% of the cases were completed within 181-365 days, and only 19% were completed outside of the Board's target. [6]

FY 25/26

Intake and Investigation Target Performance			
FY 25/26	**Average Days**	**Target # of Days**	**Target Met**
Quarter 1	230	365	Yes
Quarter 2	215	365	Yes
Quarter 3	227	365	Yes
Quarter 4	188	365	Yes

- 447 cases were closed within 90 days
- 214 cases were closed within 91 days-180 days
- 277 cases were closed within 181 days-one year
- 190 cases were closed within one-two years
- 49 cases were closed within two-three years

Comment: The Board met the target for all four quarters in fiscal year 25/26. A total of 38% of cases were completed within 90 days, 18% of cases were completed within 91-180 days, 24% of the cases were completed within 181-365 days, and only 20% were completed outside of the Board's target.

[7] Please note that total percentage was rounded to 99%.

Performance Measures Four: Formal Discipline

PM four identifies the average number of days to complete the entire enforcement process for cases resulting in formal discipline. This includes intake, investigation by the Board analysts and DOI, and prosecution by the AG.

Target: The Board set the performance target for PM four at 540 days.

FY 22/23

Formal Discipline Target Performance			
FY 22/23	Average Days	Target # of Days	Target Met
Quarter 1	1268	540	No
Quarter 2	1065	540	No
Quarter 3	807	540	No
Quarter 4	677	540	No

- Two cases were completed within one year
- One case was completed within one year-540 days
- Three cases were completed within 540 days-two years
- Four cases were completed within two-three years
- Five cases were completed within three-four years
- Five cases were completed over four years

Comment: In FY 2022/23, 15% of cases were completed within the performance target of 540 days.

FY 23/24

Formal Discipline Target Performance			
FY 23/24	Average Days	Target # of Days	Target Met
Quarter 1	1376	540	No
Quarter 2	1315	540	No
Quarter 3	763	540	No
Quarter 4	801	540	No

- Zero cases were completed within one year
- One case was completed within one year-540 days
- Three cases were completed within 540 days-two years
- Seven cases were completed within two-three years
- Nine cases were completed within three-four years
- Eight cases were completed in over four years

Comment: In FY 2023/24, 4% of cases were completed within the performance target of 540 days.

FY 24/25

Formal Discipline Target Performance			
FY 24/25	Average Days	Target # of Days	Target Met
Quarter 1	980	540	No
Quarter 2	809	540	No
Quarter 3	735	540	No
Quarter 4	1029	540	No

- Zero cases were completed within one year
- Three cases were completed within one year-540 days
- Three cases were completed within 540 days-two years
- Six cases were completed within two-three years
- Ten cases were completed within three-four years
- Four cases were completed over four years

Comment: In FY 2024/25, 12% of cases were completed within the performance target of 540 days.

FY 25/26

Formal Discipline Target Performance			
FY 25/26	Average Days	Target # of Days	Target Met
Quarter 1	727	540	No
Quarter 2	669	540	No
Quarter 3	735	540	No
Quarter 4	494	540	Yes

- 15 cases were completed within one year
- Three cases were completed within one year-540 days
- Six cases were completed within 540 days-two years
- Eight cases were completed within two-three years
- Five cases were completed within three-four years
- One case was completed over four years

Comment: In FY 2025/26, 48% of cases were completed within the performance target of 540 days.

Performance Measures Seven: Probation Intake

PM seven identifies the average number of days from probation monitor assignment to the date the probation monitor makes first contact with the probationer by phone or letter.

Target: The Board set the performance target for PM seven at ten days.

Probation Intake			
	Average Days	Target # of Days	Target Met
FY 22/23	3	10	Yes
FY 23/24	3	10	Yes
FY 24/25	1	10	Yes
FY 25/26	1	10	Yes

In each of the fiscal years under review in this Sunset Report, the Board Probation Monitor has met this target, averaging 2 days to make first contact with the probationer over the past four years.

The Board currently has one probation monitor who has monitored an average of 31 licensees per year throughout California during the fiscal years under review in this report. The probation monitor conducts interviews with all incoming probationers and conducts quarterly meetings with each probationer either remotely, by phone, or face-to-face. Video conferencing has been successful and still allows the probation monitor to see the probationers. These meetings are documented in reports detailing discussions related to each probation condition.

In addition to scheduled contacts, the probation monitor also conducted multiple unscheduled and unannounced visits and reviews. These spontaneous check-ins help ensure compliance and allow for a more thorough assessment of probationer activities.

Performance Measures Eight: Probation Violation Response

PM eight identifies the average number of days from the date a violation of probation is reported, to the date the probation monitor initiates action.

Target: The Board set the performance target for PM eight at 10 days. The Board has consistently met its target for this performance measure.

Probation Violation				
	# of Violations	Average Days	Target # of Days	Target Met
FY 22/23	1	3	10	Yes
FY 23 24	3	1	10	Yes
FY 24 25	2	1	10	Yes
FY 25 26	1	6	10	Yes

32. Referring to table 9., *Enforcement Statistics*, explain trends in enforcement data and the Board's efforts to address any increase in volume, timeframes, ratio of closure to pending cases, or other challenges. What are the performance barriers? What improvement plans are in place? What has the Board done and what is the Board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

Table 9. Enforcement Statistics				
	FY 22/23	FY 23/24	FY 24/25	FY 25/26
COMPLAINTS				
Intake				
Received	632	863	1012	1339
Closed without Referral for Investigation	0	0	0	0
Referred to INV	633	882	1000	1339
Pending (close of FY)	3	7	12	18
Conviction / Arrest				
CONV Received	37	26	29	40
CONV Closed Without Referral for Investigation	1	0	0	0
CONV Referred to INV	37	25	29	40
CONV Pending (close of FY)	1	1	0	0
Source of Complaint[7]				
Public	446	547	520	678
Licensee/Professional Groups	41	92	129	197
Governmental Agency Referral	79	106	231	240
Internal	3	3	16	93
Other	57	37	66	81
Anonymous	43	104	79	90
Average Time to Refer for Investigation (from receipt of complaint / conviction to referral for investigation)	7	3	4	5
Average Time to Closure (from receipt of complaint / conviction to closure at intake)	281	223	199	222
Average Time at Intake (from receipt of complaint / conviction to closure or referral for investigation)	288	227	202	226
INVESTIGATION				
Desk Investigations				
Opened	659	870	1014	1295
Closed	632	725	854	1076
Average days to close (from assignment to investigation closure)	290	197	163	191
Pending (close of FY)	455	411	669	658
Non-Sworn Investigation[8]				
Opened	20	20	14	72
Closed	0	11	14	30
Average days to close (from assignment to investigation closure)	N/A	274	383	105
Pending (close of FY)	16	14	4	40

[7] The total number of complaints and convictions should correspond to the overall count for the source of complaint. The increase in complaints categorized under "Licensee" is due to the increase in tracking of self-disclosure of a criminal conviction during the license renewal process. The increase in internal cases is due to the Board's newly implemented annual expired fictitious name permit audit and Continuing Medical Education audit. "Other" includes mandatory reports.

[8] The Board refers cases to the DCA's Division of Investigation office which is made up of non-sworn and sworn investigators. Starting in FY 25/26 the Board also hired its own internal non-sworn investigator and those numbers are merged with DOI's non-sworn numbers and timeframes

Sworn Investigation[9]				
Opened	28	43	65	67
Closed	45	42	34	89
Average days to close (from assignment to investigation closure)	599	501	499	449
Pending (close of FY)	43	52	70	99
All investigations				
Opened	670	882	1029	1379
Closed	381	786	944	1214
Average days for all investigation outcomes (from start investigation to investigation closure or referral for prosecution)	298	223	199	222
Average days for investigation closures (from start investigation to investigation closure)	279	208	177	211
Average days for investigation when referring for prosecution (from start investigation to referral for prosecution)	716	766	458	486
Average days from receipt of complaint to investigation closure	311	227	202	226
Pending (close of FY)	455	540	655	875
DIVISION OF INVESTIGATION				
Average Days to Refer to Division of Investigations (from complaint receipt to referral for investigation)	244	208	196	195
Average Days for Division of Investigation to Complete (from DOI receipt to return to program of referral)	599	454	503	430
Average Days from Return to Referral to AG (from DOI investigation to AG referral)	16	9	9	15
CITATION AND FINE				
Citations Issued	11	7	3	30
Average Days to Complete (from complaint receipt / inspection conducted to citation issued)	706	739	331	506
Amount of Fines Assessed	$15,500	$15,250	$6,500	$56,500
Amount of Fines Reduced, Withdrawn, Dismissed	$1,000	$0	$0	$23,250
Amount Collected	$9,500	$14,750	$4,000	$28,450
CRIMINAL ACTION				
Referred for Criminal Prosecution	0	2	0	0
ACCUSATION				
Accusations Filed	16	14	13	21
Accusations Declined	0	0	0	0
Accusations Withdrawn	2	0	1	1
Accusations Dismissed	0	0	0	0
Average Days from Referral to Accusations Filed (from AG referral to Accusation filed)	91	106	103	66

[9] Refer to prior notation.

INTERIM ACTION				
ISO & TRO Issued	1	0	7	1
PC 23 Orders Issued	1	0	0	0
Other Suspension/Restriction Orders Issued (ASO)	1	1	0	1
Referred for Diversion	N/A	N/A	N/A	N/A
Petition to Compel Examination Ordered	4	3	3	1
DISCIPLINE				
AG Cases Initiated (cases referred to the AG in that year)	33	27	26	49
AG Cases Pending Pre-Accusation (close of FY)	9	12	9	10
AG Cases Pending Post-Accusation (close of FY)	18	21	16	21
DISCIPLINARY OUTCOMES				
Revocation	4	2	3	3
Surrender	3	1	2	5
Suspension only	0	0	0	0
Probation with Suspension	1	0	1	0
Probation only	5	11	9	6
Public Reprimand / Public Reproval / Public Letter of Reprimand	1	12	4	5
Other	0	1	0	0
DISCIPLINARY ACTIONS				
Proposed Decision	2	2	2	1
Default Decision	3	2	2	3
Stipulations	9	23	15	15
Average Days to Complete After Accusation (from Accusation filed to imposing formal discipline)	324	374	359	186
Average Days from Closure of Investigation to Imposing Formal Discipline	363	347	376	259
Average Days to Impose Discipline (from complaint receipt to imposing formal discipline)	1026	1168	902	743
PROBATION				
Probations Completed	2	4	5	8
Probationers Pending (close of FY)	33	35	34	30
Probationers Tolled *	9	6	4	5
Petitions to Revoke Probation / Accusation and Petition to Revoke Probation Filed	0	1	1	1
SUBSEQUENT DISCIPLINE[10]				
Probations Revoked	1	0	0	0
Probationers License Surrendered	0	0	0	0
Additional Probation Only	0	0	1	0
Suspension Only Added (Cease Practice Order)	0	0	0	0
Other Conditions Added Only	0	0	0	0
Other Probation Outcome	0	0	0	0

[10] Do not include these numbers in the Disciplinary Outcomes section above.

SUBSTANCE ABUSING LICENSEES				
Probationers Subject to Drug Testing	3	6	7	12
Drug Tests Ordered	517	391	467	448
Positive Drug Tests	0	0	0	0
PETITIONS				
Petition for Termination or Modification Granted	0	1	1	1
Petition for Termination or Modification Denied	0	0	0	3
Petition for Reinstatement Granted	0	0	0	0
Petition for Reinstatement Denied	0	0	0	0
DIVERSION				
New Participants	2	4	1	1
Successful Completions	2	1	5	1
Participants (close of FY) Including Self Referrals	14	14	13	15
Terminations	0	0	0	0
Terminations for Public Threat	1	0	0	0
Withdrawn	1	1	1	0
Drug Tests Ordered	517	391	467	448
Positive Drug Tests	0	0	0	2

Table 10. Enforcement Aging

	FY 22/23	FY 23/24	FY 24/25	FY 25/26	Cases Closed	Average %
Investigations (Average %)						
Closed Within:						
90 Days	170	350	477	442	1439	43%
91 - 180 Days	46	115	131	225	517	16%
181 - 1 Year	73	137	149	290	649	20%
1 - 2 Years	55	141	146	201	543	16%
2 - 3 Years	21	37	36	56	150	5%
Over 3 Years	16	6	5	0	27	1%
Total Investigation Cases Closed	**381**	**786**	**944**	**1214**	**3325**	**N/A**
Attorney General Cases (Average %)						
Closed Within:						
0 - 1 Year	2	16	16	28	62	53%
1 - 2 Years	5	12	9	8	34	29%
2 - 3 Years	5	2	4	1	12	10%
3 - 4 Years	8	0	0	0	8	7%
Over 4 Years	0	0	0	0	0	0%
Total Attorney General Cases Closed	**20**	**30**	**29**	**37**	**116**	**N/A**

Enforcement Trends

During the current Sunset Review period, the number of complaints received by the Board has steadily increased each year. This upward trend is likely attributed to heightened public awareness of the Board's complaint process, the increase in licensee population, expanded consumer access to healthcare services, and proactive outreach and monitoring efforts.

Complaint processing timeframes have fluctuated slightly during the Sunset Review period; however, these changes are directly related to case complexity, volume surges, and factors outside of the Board's control, such as criminal or civil proceedings, rather than any operational slowdowns. Matters involving complex issues, formal discipline and coordination with multiple jurisdictions naturally extend investigative timelines. Despite these challenges, the Board has maintained a strong closure-to- pending case ratio, reflecting sustained productivity and efficient case management.

Performance Barriers

- **Case Complexity and External Dependencies** – Cases involving multiple agencies, criminal investigations, or specialized expert review require extended timeframes.
- **Legislative Changes** – Amendments to BPC (BPC) Section 480 and related statutes have required procedural adjustments to align with revised denial and disciplinary criteria.
- **Resource Constraints** – Increased complaint volumes and the need for specialized investigations have placed continued demands on existing personnel and budget allocations. Increased enforcement procedures such as complainant interviews for quality-of-care complaints and the requirement to have a complaint liaison unit, which duties are being handled by existing staff, also constrain resources.
- **Interagency Coordination** – Timelines are occasionally impacted by the workload and priorities of external partners such as other DCA Boards, DOI, AG's Office, and other law enforcement entities.

Improvement Plan

The Board continues to take proactive steps to address challenges and maintain timely, high-quality enforcement outcomes:

- **Enhanced Interagency Collaboration** – Regular meetings with DOI liaisons and AG's Office representatives to review caseloads, address obstacles and prioritize high-risk matters. Interagency MOU agreements with BRN to address MedSpa concerns.
- **Strengthened Legal Coordination** – Ongoing engagement with the Board's legal counsel to expedite legal review and ensure consistency with statutory and regulatory updates.
- **Expert Consultant Development** – Recruitment, onboarding and continuous training of expert consultants to ensure timely and high-quality evaluations.
- **Special Investigator Recruitment** – Onboarding of the Board's Special Investigator to provide more expeditious investigations and reviews.
- **Technology and Data Enhancements** – BreEZe system updates and procedure refinements to improve data accuracy, automate case tracking and streamline workflows.
- **DCA Enforcement User Group Participation** – Active participation to share best practices, troubleshoot common challenges and advocate for process improvements.

- **Consumer Outreach and Transparency** – Clear, accessible information on the Board's website, newsletter, and in acknowledgment letters and status update letters to complainants to set expectations and build public trust.
- **Staff Ongoing Training and Development** – Created monthly pending reports for enforcement staff to utilize to keep track of pending enforcement matters. Staff participated in DCA's Enforcement Academy, which is a weeklong academy focused on the entire enforcement process.

Legislative and Regulatory Efforts

- **BPC 480 Amendments** – Implemented procedural changes to align with updated conviction and denial criteria, ensuring that only substantially related conduct meeting statutory thresholds results in discipline.
- **SB 815** – Implemented complaint liaison unit to enhance enforcement and public engagement. Implemented quality of care complaint interviews and outreach efforts for enforcement program.
- **Regulatory Packages** – The Board updated its citation regulations to expand its authority to issue citations. The Board is pursuing a rulemaking to update the Board's disciplinary guidelines.
- **Budget Change Proposal (BCP)** – Submitted to secure additional Enforcement Program resources to support increased case volumes.

33. What do overall statistics show as to increases or decreases in disciplinary action since last review?

- **Please explain any challenges contributing to unmet performance targets, such as outlier cases, procedural barriers, difficulties in obtaining evidence, etc.**

During the current Sunset Review period, overall statistics indicate a modest increase in certain disciplinary actions compared to the prior Sunset Review period, and a significant increase in administrative citations with the implementation of the CME audit process and the expansion in authority to issue citations.

Key trends include:

- **Complaints Received** – Annual complaint volume has nearly doubled over the period, consistent with trends in other DCA Boards and possibly influenced by increased public awareness and post-pandemic resumption of full clinical operations.
- **Accusations Filed** – The number of formal accusations has shown an increase since the last review, reflecting both the higher volume of complaints and improvements in case processing efficiency that allow cases to advance more quickly to the formal discipline stage.
- **Revocations and Surrenders** – The number of revocations and surrenders has shown an increase since the last review, indicating the Board is focusing on the most serious violations where public protection requires removal from practice.
- **Probationary Orders and Probationary Licenses Issued** – Have increased modestly, reflecting the Board's commitment to rehabilitation where appropriate while maintaining oversight to ensure public safety.

- **Citations and Fines** – With the expansion in citation authority the Board has seen a significant increase, indicating the Board is focusing on utilizing its administrative citation authority to fine for minor violations of the medical practice act not requiring disciplinary action.

Since the last review, the Board has:

- Strengthened collaboration with the DOI and the AG's Office to streamline investigative and prosecutorial timelines.
- Expanded training for medical consultants/experts to ensure consistent, high-quality case evaluations.
- Increased use of data tracking tools to monitor case progress and identify bottlenecks, leading to more timely investigations.
- Maintained a consistent closure-to-pending case ratio, ensuring that enforcement staff's pending caseloads remain manageable while prioritizing public safety.

Overall, while the volume of certain disciplinary actions has increased, the Board's emphasis on timely resolution, targeted discipline, and rehabilitation demonstrates its continued effectiveness in protecting the public. The Board remains committed to refining enforcement processes, leveraging data analytics, and ensuring due process while addressing violations of the Medical Practice Act.

34. How are cases prioritized? What is the board's complaint prioritization policy?

- **Please provide a brief summary of the board's formal discipline.**

The Board has prioritized cases using a structured framework pursuant to BCP Section 2220.05 (relevant language is excerpted below) to ensure timely action on the most serious threats to public safety. Upon receipt, each complaint is reviewed by the enforcement program and assigned one of five priority levels:

BCP Section 2220.05

(a) In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California and the California Board of Podiatric Medicine shall prioritize their investigative and prosecutorial resources to ensure that physicians and surgeons and doctors of podiatric medicine representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon or the doctor of podiatric medicine represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon or a doctor of podiatric medicine involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing, including, but not limited to, Sections 725,

2241.5, and 2241.6 of this code and Sections 11159.2 and 124961 of the Health and Safety Code, be prosecuted for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation.

(5) Sexual misconduct with one or more patients during a course of treatment or an examination.

(6) Practicing medicine while under the influence of drugs or alcohol.

(7) Repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor.

(b) The Board may by regulation prioritize cases involving an allegation of conduct that is not described in subdivision (a). Those cases prioritized by regulation shall not be assigned a priority equal to or higher than the priorities established in subdivision (a).

(c) The Medical Board of California shall indicate in its annual report mandated by Section 2312 the number of temporary restraining orders, interim suspension orders, and disciplinary actions that are taken in each priority category specified in subdivisions (a) and (b).

35. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report to the Board actions taken against a licensee. Are there problems with the Board receiving the required reports? If so, what could be done to correct the problems?

BPC Section 801, Section 801.1, Section 802 requires insurers providing professional liability insurance to a licensee, to report malpractice settlements over $30,000 to the Board.

BPC Code Section 803 requires the clerk of the court to report a physician and surgeon who has committed a crime or is liable for any death or personal injury resulting in a judgment of any amount caused by his/her negligence or incompetence.

BPC Section 802.5 requires Coroners to report to the Board, any death that may be the result of a physician's gross negligence or incompetence.

BPC Section 803.5 requires the district attorney, city attorney or other prosecuting agency to notify the Board and the clerk of the court in which the charges have been filed, of any filings against a licensee of the Board charging a felony. The clerk of the court in which a licensee of the Board is convicted of a crime shall, within 48 hours after the conviction, transmit a certified copy of the record of conviction to the Board.

BPC Section 805 requires any peer review body of health care facilities, hospitals, clinics or other setting providing medical services, to report to the Board, any action taken with regards to staff privileges. These include, but are not limited to denial or termination of staff privileges or employment, and/or restrictions imposed on staff privileges.

The Board has not experienced any problems in receiving these mandated reports.

- **What is the dollar threshold for settlement reports received by the board?**

BPC Section 801, Section 801.1, Section 802 requires insurers providing professional liability insurance to a licensee, to report malpractice settlements over $30,000 to the Board.

- **What is the average dollar amount of settlements reported to the board?**

Board public reports do not include this metric; however, internal data for the current Sunset Review period indicate an average value of approximately $639,646, derived from a total of 154 reports received during the review period.

36. Describe settlements the board, and Office of the Attorney General on behalf of the board, enter into with licensees.

A Stipulated Settlement offer can be made to the licensee and/or their legal counsel and can include probation, a stipulated surrender or stipulated revocation. Once a settlement is reached, the Deputy Attorney General (DAG) will prepare a Stipulated Settlement and Disciplinary Order, which is signed by both the respondent, his/her legal counsel, if applicable, and the DAG. The document is then submitted to the Board members for their vote. If the Board members vote to adopt the settlement, then the Stipulated Settlement and Disciplinary Order are filed.

The Board follows their Disciplinary Guidelines to ensure that the terms and conditions of the probation fit the violations committed by the licensee. The probationary period, on an average, runs five years. If the violation includes negligence or incompetence, the probationary term may include a comprehensive Physician Assessment and Clinical Evaluation course, a supervised structured practice, or a practice monitor. The Board will require the licensee take courses, such as recordkeeping, prescribing course, ethics course and other courses which would fit the violations committed by the licensee. If the violation includes drug and/or alcohol impairment, the licensee may be required to enter and participate in the Board's diversion program until such time the program feels the licensee is rehabilitated and no longer in need of monitoring. The Board also collects cost recovery of investigative and prosecuting costs.

- **What is the number of cases, pre-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?**

The Board does not settle cases prior to the filing of a formal accusation. However, in lieu of prosecuting a formal accusation against a licensee, the Executive Director has authority, pursuant to BPC Section 495 and BPC Section 2233, to issue a Public Letter of Reprimand (PLR) after the Board has conducted an investigation. The delegation to the Executive Director without Board member involvement provides for better use of resources for those cases that do not warrant full discipline, such as probation. The Board may use a PLR for minor violations that warrant a higher level of action than a citation but not necessarily probation.

The PLR under this authority does not require transmittal to the AG's Office since it is an agreement between the licensee and the Executive Director; however, if the licensee does not agree to the PLR, the PLR does not get issued, the Board proceeds with filing an accusation. PLRs are considered discipline and are disclosed to the public. The Board issued fifteen PLRs within the last four fiscal years.

- **What is the number of cases, post-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?**

Decision Type Outcome	Case Count from 7/1/2022 to 6/30/2026
Stipulations Post-Accusation/SOI	50
Hearing Decisions	5
Default Decisions*	10

*Default decisions are included as they represent another potential method through which a disciplinary action can be taken.

- **What is the overall percentage of cases for the past four years that have been settled rather than resulted in a hearing?**

Overall, 91 percent of the Board's disciplinary cases over the past four fiscal years have been resolved through settlement rather than proceeding to a full administrative hearing.

This high settlement rate reflects the Board's continued emphasis on timely, consumer protective case resolution. Settlements allow the Board to impose appropriate and enforceable disciplinary terms more quickly, reduce delays inherent in the hearing process, and ensure that remedial actions can be implemented without unnecessary administrative burden. In all cases, the Board ensures that disciplinary terms are consistent with the Disciplinary Guidelines. While hearings remain an essential tool for the most egregious or contested cases, the Board's ability to successfully negotiate case resolutions underscores its effectiveness in working with the AG's Office, expert consultants, and respondents to achieve outcomes that protect the public while maintaining due process.

37. Does the board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases have been lost due to statute of limitations? If not, what is the Board's policy on statute of limitations?

BPC Section 2230.5 sets forth that an accusation against a licensee pursuant to Government Code Section 11503 shall be filed within three years after the Board discovers the act or omission alleged as the grounds for disciplinary action, or within seven years after the act or omission alleged as the grounds for disciplinary action occurs, whichever occurs first.

Exceptions to this law include an accusation alleging the procurement of a license by fraud or misrepresentation, in which case there is no statute of limitation, or if it is proven that the licensee intentionally concealed from discovery their incompetence, gross negligence or repeated negligent acts which would be the basis for filing an accusation. For allegations of sexual misconduct, the accusation shall be filed within three years of when the Board discovers the act or omission or within 10 years after the act or omission occurs, whichever occurs first. If the alleged act or omission involves a minor, the seven-year statute of limitations period provided for and the 10-year limitations period provided for regarding sexual misconduct allegations shall be tolled until the minor reaches the age of majority.

The numbers below identify the number of complaints filed with the Board after the statute of limitations had elapsed or would elapse before the investigation could be completed. The Board maintains these complaints consistent with its retention schedule as a part of the physician's

complaint history and advises the complainant that administrative action against the physician cannot be pursued because the statute of limitations has passed.

FY 22/23 Physicians and Surgeons: 16
FY 23/24 Physicians and Surgeons: 13
FY 24/25 Physicians and Surgeons: 8
FY 25/26 Physicians and Surgeons: 11

38. Describe the board's efforts to address unlicensed activity and the underground economy.

During the current Sunset Review period the Board has continued to take a multi-pronged approach to address unlicensed activity and combat the underground economy, with consumer protection as the highest priority.

Efforts to Address Unlicensed Activity and the Underground Economy

- Complaint Intake and Investigation – The Board actively investigates cases alleging the unlicensed practice of medicine or the aiding and abetting of the unlicensed practice of medicine received from consumers, licensees, law enforcement, and other regulatory bodies. Allegations are prioritized according to the CPEI guidelines, with unlicensed activity cases being elevated in priority when there is a clear and immediate threat to patient safety.
- Collaboration with DOI – Board partners with DOI investigators for complex unlicensed practice cases, including those involving repeat offenders, fraudulent advertising, or large-scale underground operations. These partnerships help expedite field investigations and improve evidence gathering for administrative or criminal action.
- Cease and Desist Orders and Citations – The Board issues cease and desist letters to unlicensed individuals or businesses and can impose administrative fines under BPC Section 125.9. These actions both stop illegal practice and deter future violations.
- Public Education and Outreach – Board engages in targeted outreach to educate consumers about the risks of receiving medical care from unlicensed individuals. Efforts include:
    - Website resources with license verification tools and guidance on reporting suspected unlicensed practice.
    - Social media campaigns highlighting consumer rights and the importance of licensed care.
    - Presentations to professional associations and schools to raise awareness among students and practitioners about unlicensed activity risks and reporting obligations.
    - Referrals to Other Agencies – When unlicensed activity overlaps with broader underground economy concerns, such as workers' compensation fraud, insurance fraud, or tax evasion, Board refers cases to local law enforcement, district attorneys, or other relevant state entities for appropriate action.
    - Use of Technology in Complaint Cases – When a complaint regarding potential unlicensed practice is received, Board uses its licensing database to verify licensure status and identify related entities or individuals who may be engaged in unlicensed activity. This tool supports investigations but is not used for proactive sweeps.
    - Follow-up and Monitoring – When unlicensed activity is confirmed, the Board ensures follow-up to verify compliance with cease and desist orders and pursues further action if violations continue.

Board effectively addresses immediate threats, deters future unlicensed practice, and addresses underground economy concerns by combining investigations, enforcement action, referrals, outreach, and strategic use of investigative tools.

Cite and Fine

39. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes from last review and describe the last time regulations were updated and any changes that were made. Has the Board increased its maximum fines to the $5,000 statutory limit? Does the board have authority to issue fines greater than $5,000? If so, under what circumstances?

During the review period, the Board continued to utilize its citation and fine authority as a targeted enforcement mechanism designed to promote compliance with the Medical Practice Act while reserving formal discipline for violations that warrant more significant action. This authority is established under the Osteopathic Act and implemented through Title 16, CCR(CCR) Sections 1659.30–1659.35, which govern the structure, issuance, and administration of citations and fines.

Use of Citation and Fine Authority

The Board applies cite-and-fine authority when violations are minor, technical, or unlikely to require formal disciplinary measures. Under CCR Section 1659.30, the Executive Director or designee issues citations that may include administrative fines, orders of abatement, or both, with detailed documentation of the violation and service by certified or regular mail, depending on licensure status.

This authority is used for lower-level violations such as continuing medical education (CME) compliance issues, documentation failures, minor advertising violations, delinquent-license practice, and certain unlicensed-practice scenarios.

This approach aligns with the Board's broader enforcement process, in which minor violations are resolved through education, corrective action, and administrative fines rather than formal accusations.

Fine Structure and Determination

Consistent with BPC Section 125.9, the Board evaluates fine amounts based on the gravity of the violation, the licensee's good faith, willfulness, prior history, and efforts to mitigate harm. Most administrative fines fall within the regulatory range of $100 to $2,500, unless otherwise specified for particular BPC Sections identified in CCR Section 1659.31.

For unlicensed-practice matters under CCR Section 1659.33, the Board may issue citations, including orders of abatement, and levy fines consistent with BPC Section 125.9, particularly when individuals practice with a delinquent license or before receiving a license.

Changes Since the Last Sunset Review

The Board completed significant regulatory updates to its citation and fine regulations during the current review cycle. On July 10, 2025, the Office of Administrative Law approved revisions to CCR Sections 1659.30–1659.35, with an effective date of October 1, 2025. These updates were part of the Board's broader CME and Cite-and-Fine regulatory package and included procedural clarifications,

updated CME requirements, refined abatement and contesting processes, and records-retention rules (ten-year retention for resolved citations; immediate purge for withdrawn/dismissed citations).

Although regulatory text was revised, these amendments did not expand or increase the maximum administrative fine authority available to the Board.

Maximum Fine Authority

Under California Business and Professions Code Section 125.9, the Board's administrative citation program may not assess an administrative fine exceeding $5,000 per investigation related to a violation, or $5,000 per violation or count in cases involving fraudulent billing submitted to an insurance company, Medi-Cal, or Medicare. The Board has adopted this statutory maximum in its citation regulations and does not have authority to impose administrative citation fines exceeding the limits established by Section 125.9.

Authority to Issue Fines Greater Than $5,000

The Board does not have authority to issue fines above $5,000 through its citation and fine program. However, the Board possesses separate statutory authority under BPC Section 805(k), which permits fines up to $100,000 per violation for the willful failure to file an 805 report. This authority may be exercised only through formal administrative action, not through a citation. As confirmed in enterprise correspondence, such fines must be pursued via administrative proceedings and are not part of the citation system.

Overall, the Board continues to employ its citation and fine authority effectively as a flexible, proportionate response to minor violations, emphasizing corrective action and public protection. Regulatory updates finalized in 2025 improved clarity and operational consistency but did not expand fine authority. The Board's administrative fine maximum remains $5,000 under BPC Section 125.9, with higher fines available only through formal administrative processes for statutorily prescribed violations.

40. How is cite and fine used? What types of violations are the basis for citation and fine?

The Board uses cite and fine as a proportionate enforcement tool to address minor violations that do not warrant formal disciplinary action such as probation or revocation. This approach allows the Board to uphold public protection while efficiently resolving lower-level violations and conserving resources for more serious cases.

How Cite and Fine is Used

- Applied when a violation is established but does not rise to the level of formal discipline.
- Provides an opportunity for corrective action and education of the licensee while still holding them accountable.
- Serves as a deterrent by documenting the violation in the licensee's enforcement history.
- Promotes public awareness and transparency, since citation and fine records are publicly available for up to 10 years, allowing consumers to make informed choices when seeking medical care.

Types of Violations that Typically Result in Citation and Fine

- Documentation issues – incomplete or inaccurate patient records.
- Supervision violations – failure to comply with supervision requirements of mid-level staff.
- Minor or first-time criminal convictions – when related to the profession but not of a severity requiring formal discipline.
- Discipline by another jurisdiction – where an out-of-state board has taken action, but the conduct is not severe enough for formal California discipline.
- CME or renewal requirement violations – such as failure to meet CME requirements.
- Other practice-related technical violations – where public risk is limited, but correction is necessary.

Citations issued for these violations often result in fines between $500 and $2,500, depending on the specifics of the case. While fines may be higher for more serious matters, most Board citations address isolated or lower-level compliance issues that can be effectively corrected through this mechanism.

Through this measured use of cite and fine, the Board maintains a balanced approach to enforcement while protecting consumers, encouraging compliance, increasing public awareness and reserving formal discipline for the most serious violations.

The list of citable offenses is listed in the Board's regulations Title 16, CCR Section 1659.31. It is not considered a disciplinary action under California law but is an administrative action. Payment of the fine amount and compliance with an abatement order represents satisfactory resolution of the matter.

41. How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals of a citation or fine in the last 4 fiscal years?

Informal Conferences and Administrative Hearings Requested and Held				
	FY 22/23	FY 23/24	FY 24/25	FY 25/26
Informal Conferences requested	0	1	0	7
Informal Conferences held	0	1	0	7
Administrative Hearings requested	0	1	0	7
Administrative Hearings held	0	0	0	0

Most administrative hearing requests were submitted concurrently with the informal conference request. In nearly all cases, the matter was resolved at the informal conference, and the licensee either withdrew their request for an administrative hearing or the citation was modified or withdrawn.

The high rate of resolution at the informal conference stage highlights the Board's effectiveness in providing timely due process for licensees while protecting consumers and conserving State resources.

42. What are the five most common violations for which citations are issued?

The most common violations for which a cite and fine is utilized are:

- Criminal Convictions (First Offense)-First time convictions of crimes substantially related to the practice of medicine, where the violation does not directly threaten patient safety or warrant formal discipline.
- Practice-Related Violations-Isolated or lower-level practice issues such as incomplete or inaccurate documentation, failure to meet supervision requirements for mid-level staff, or aiding and abetting unlicensed activity in violation of the Medical Practice Act.
- Discipline by Another State Board-Cases in which a licensee was disciplined by another state and the underlying violation is also a citable offense under California law.
- CME Violations-Failure to provide proof of completion of required CME hours during an audit, or false attestation at renewal (signed under penalty of perjury) that requirements were completed.
- Fictitious Name Permit Violations-Operating with an expired fictitious name permit, or use of fictitious business name without valid fictitious name permit

43. What is average fine pre- and post- appeal?

The average fine, pre- and post- appeal is $750.

44. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines. If the Board does not use Franchise Tax Board intercepts, describe the rational behind that decision and steps the Board has taken to increase its collection rate.

During the current Sunset Review period, the Board has effectively utilized the Franchise Tax Board (FTB) Intercept Program as a tool to collect unpaid fines resulting from both citations and disciplinary orders.

- When a licensee fails to pay a citation fine or a fine imposed as part of an administrative order within the required timeframe, the Board initiates a structured collection process. A series of three written notices are sent reminding the licensee of their obligation to pay and providing the opportunity to voluntarily resolve the matter.
- If the licensee still does not comply, the Board refers their information to the FTB for intercept. Under this program, unpaid fines can be withheld from state tax refunds, lottery winnings, and other eligible state disbursements until the balance is satisfied.
- This process strengthens accountability and reinforces Board's consumer protection mandate by ensuring licensees comply with both citations and disciplinary orders.

The Board's participation in the FTB Intercept Program has proven to be an effective deterrent and enforcement mechanism. It prevents licensees from avoiding their financial obligations, conserves staff resources that would otherwise be spent on manual collection efforts and promotes fairness by applying consistent collection standards across all cases.

In addition, the Board continues to monitor its collection practices to ensure timely referral of unpaid fines to FTB, maximizing collection rates while maintaining due process protections for licensees.

Cost Recovery and Restitution

45. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.

Pursuant to BPC Section 125.3 and BPC Section 2661.5, the Board has authority to obtain cost recovery in disciplinary proceedings. The Board may request that the ALJ order the licensee to pay all or part of the reasonable and actual costs of investigation and prosecution, which typically include DOI costs, subject matter expert fees, and AG prosecution expenses.

Efforts to Obtain Cost Recovery

- In all formal disciplinary matters, the Board pursues cost recovery unless extraordinary circumstances exist.
- Cost recovery is considered during settlement negotiations, allowing the EO to reach agreements that balance consumer protection with fairness to licensees.
- The Board may reduce costs when licensees demonstrate financial hardship, provided they comply with agreed-upon repayment schedules. If a licensee defaults, the full amount immediately becomes due.
- Licensees are required to remain on probation until all cost recovery obligations have been paid in full, ensuring that repayment is completed before probation can be successfully terminated.
- The Board monitors unpaid cost recovery through its probation monitoring program and refers delinquent debts to the FTB's Intercept Program when appropriate.

Changes Since the Last Sunset Review (2020)

- There have been no statutory changes to Board's cost recovery authority since the prior review.
- The Board has also coordinated more closely with the DCA's DOI and the AG's Office to ensure that cost recovery requests reflect accurate, documented expenses and are consistently pursued.
- Annual enforcement reports confirm that cost recovery continues to be a standard condition of discipline, reinforcing the principle that violators should bear the costs of enforcement. Since the last Sunset Review in 2020, the Board's process has remained stable and effective, consistently applying cost recovery to promote accountability while ensuring that enforcement costs are not solely borne by the licensee population.

46. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.

There is no specific amount of cost recovery ordered for revocations, surrenders, or probationers. Cost recovery typically includes DOI costs, subject matter expert fees, and AG prosecution expenses. The amount ordered may be reduced through a stipulated agreement if payment is made within a defined period, and if the reduced amount is not paid in full during that time, the full cost recovery balance becomes due. This structured incentive has resulted in greater compliance and improved cost recovery outcomes for the Board.

Cost recovery amounts are generally considered uncollectable in revocation and surrender cases, as the orders commonly include language specifying that payment is only due when a new or reinstated license is issued.

47. Are there cases for which the board does not seek cost recovery? Why?

Yes. In cases of extreme financial hardship where pursuing cost recovery would create a significant barrier to settlement negotiations, the Board may choose to waive or, more commonly, reduce cost recovery amounts. In practice, full waiver of costs is rare; the Board typically seeks at least partial recovery to uphold accountability while allowing flexibility in settlement negotiations. This approach enables the Board to expedite a Stipulated Decision, which is often the most efficient means of securing terms that protect the public. The decision to waive or reduce cost recovery is made on a case-by-case basis and is guided by the principle of consumer protection. In these circumstances, prioritizing timely discipline and ensuring that appropriate probationary conditions or restrictions are imposed takes precedence over financial recovery.

48. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery. If the board does not use Franchise Tax Board intercepts, describe methods the Board uses to collect cost recovery.

The Board utilizes the FTB Intercept Program as a tool to collect unpaid cost recovery orders. When a licensee fails to make payment, the balance may be referred to the FTB for interception through tax refunds or wage garnishments.

In addition, cost recovery is tied directly to probation compliance. Licensees on probation are required to remain current on cost recovery payments; failure to do so constitutes a violation of probation, which can result in additional disciplinary action or an extension of probation until payment is satisfied.

By combining the FTB Intercept Program with probation enforcement, the Board ensures that outstanding cost recovery obligations are actively pursued, reinforcing the Board's consumer protection mandate.

Table 11. Cost Recovery (list dollars in thousands)

	FY 2022/23	FY 2023/24	FY 2024/25	FY 2025/26
Total Enforcement Expenditures	$1,664	$1,642	$2,162	$2,477
Potential Cases for Recovery *	14	26	19	19
Cases Recovery Ordered	13	26	16	16
Amount of Cost Recovery Ordered	$94	$365	$402	$861
Amount Collected	$26	$278	$184	$488

* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.

49. Describe the board's efforts to obtain restitution for individual consumers, any formal or informal board restitution policy, and the types of restitution that the Board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the board may seek restitution from the licensee to a harmed consumer.

The Board does not have statutory authority to order or collect restitution for individual consumers. Unlike fines, citations, or cost recovery, which are authorized by statute and directed toward enforcement and disciplinary purposes, restitution is a remedy that must be pursued through the civil court system.

When consumer harm arises, the Board's role is to investigate and take disciplinary or administrative action to ensure public protection, which may include license suspension, probation with conditions, or revocation. These actions safeguard the public but do not extend to providing monetary or service-based restitution to an individual consumer.

Table 12. Restitution (list dollars in thousands)

	FY 2022/23	FY 2023/24	FY 2024/25	FY 2025/26
Amount Ordered	0	0	0	0
Amount Collected	0	0	0	0

Section 5
Public Information Policies

50. How does the board use the internet to keep the public informed of board activities? Does the board post board meeting materials online? When are they posted? How long do they remain on the Board's website? When are draft meeting minutes posted online? When does the Board post final meeting minutes? How long do meeting minutes remain available online?

During the current Sunset Review period, the Board has expanded its use of digital platforms to keep the public informed and engaged with Board activities.

Use of the Internet to Inform the Public

The Board disseminates information through a variety of online platforms, including:

- Official Website: www.OMBC.ca.gov
- Social Media: Facebook, X (Twitter), Instagram, LinkedIn
- Listserv: An email notification system for stakeholders
- YouTube

In November 2023, the Board launched a redesigned website focused on improving user experience and navigation. This enhancement enables the public to find timely and relevant information more efficiently, aligning with Board's mission to protect the public through transparency and outreach.

Board Meeting Materials

The Board posts all public meeting materials online in accordance with Bagley-Keene Open Meeting Act requirements:

- Agendas are posted at least 10 days prior to the meeting date, and a notification is distributed via Listserv.
- Meeting materials (agenda packets or Board books) are published prior to the meeting to allow the public and stakeholders time to review the items.
- Meeting minutes follow this schedule:
    - Draft minutes are posted online within the next Board meeting materials to be approved.
    - Final minutes are posted after Board approval, typically at the next scheduled meeting.

Retention of Online Materials

- Board meeting agendas, materials, and approved minutes are retained on the Board's website for a minimum of 10 years and then transferred to California State Archives.
- Currently, Board maintains meeting materials from 2015 to present available on its website.

This approach ensures consistent, transparent communication with the public and fosters trust in Board's regulatory responsibilities.

51. Does the board webcast its meetings? What is the board's plan to webcast future board and committee meetings? How long will archived webcast meetings remain available online?

All Board meetings are webcasted and subsequently posted on both the Board website and YouTube channel. The Board intends to continue using webcasts for all future meetings. Webcasts remain available on the Board website for a minimum of 10 years and are not removed from YouTube by the Board. Currently, meetings from 2015 to present are available on the Board website. To facilitate remote access, the Board uses Webex, allowing individuals to join meetings via computer, mobile device, telephone, or video system and participate in public comment. Access links to Webex are provided in the meeting agenda, which is posted on the Board website.

52. Does the board establish an annual meeting calendar and post it on the board's web site?

Yes, the Board does establish an annual meeting calendar and posts it on its website.
Each November, the Board adopts the meeting calendar for the upcoming year during its public Board meeting. Once the calendar is approved, it is promptly posted online for public access, while the prior year's calendar is archived. If additional meetings are later scheduled, the updated calendar is also posted in accordance with the Bagley-Keene Open Meeting Act and the Administrative Procedure Act.

Currently, meeting calendars from 2015 to the present remain publicly available on the Board website.

53. Is the board's complaint disclosure policy consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure*?

Yes, the Board's complaint disclosure policy is consistent with DCA's Recommended Minimum Standards for Consumer Complaint Disclosure.

- **Does the board post accusations and disciplinary actions consistent with BPC 27, if applicable?**

Yes, the Board posts accusations and disciplinary actions consistent with BPC Section 27.

- **Does the board post complaint data on its website? If so, please provide a brief description of each data point reported on the website along with any statutory or regulatory authorization.**

During the current Sunset Review period, the Board makes complaint and disciplinary information publicly available through its website in accordance with BPC Section 27, which requires licensing entities under the DCA to disclose specified enforcement actions to the public.

The Board does not publish aggregate complaint data; however, it provides public access to individual disciplinary and enforcement actions that contain complaint-related information. Specifically, the Board posts:

- **Accusation Documents** - Formal charging documents that initiate disciplinary proceedings against a licensee and outline the alleged violations of the Medical Practice Act.
- **Final Disciplinary Decisions** - Decisions and orders that impose discipline such as revocation, suspension, or probation.
- **Public Letters of Reprimand** - Issued in lieu of filing a formal accusation when a violation has occurred but does not warrant more severe discipline.
- **Citations and Fines** - An enforcement tool used to address relatively minor violations of the Practice Act that do not rise to the level of formal discipline. Citation and fine orders are not disciplinary actions but are matters of public record.

These documents are accessible through the Board's License Search feature and the DCA's centralized License Lookup system, ensuring consumers have access to accurate and timely enforcement information.

- **Does the board post citations for unlicensed practice on its website?**

Yes. The Board posts citations issued for unlicensed practice on its website. These citation and fine orders are matters of public record and are available through the Board's License Search feature and the DCA' centralized License Lookup system.

54. What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

Information posted to a licensee's profile and provided to the public is specifically set forth in statute (BPC Sections 803.1 and 2027). In 2018, the Legislature passed the Patient's Right to Know Act, which required the Board to add a probation summary to the profile pages of physicians on probation. The information posted on the licensee's profile page gives a quick summary of the probationary terms and informs the public about the discipline.

In addition to the DCA recommendations in its minimum standards for disclosure, the Board's website provides the following information:

- If a physician has been disciplined or formally accused of wrongdoing by the Board (public reprimands and public letters of reprimand are only available for 10 years on the website).
- If a physician's practice has been temporarily restricted or suspended pursuant to a court order.
- If a physician has been disciplined by a medical board of another state or federal government agency.
- If a physician has been convicted of a felony reported to the Board after January 3, 1991.
- If a physician has been convicted of a misdemeanor after January 1, 2007, that results in a disciplinary action or an accusation being filed by the Board, and the accusation is not subsequently withdrawn or dismissed.
- If a physician has been issued a citation (that has not been withdrawn or dismissed) for a minor violation of the law by the Board within the last 10 years.

- If a physician has been issued a public letter of reprimand at the time of licensure within the last 10 years.
- If a physician has been placed on probation, the licensee's probation status, the length of the probation, the probation end date, and all practice restrictions placed on the licensee by the Board pursuant to BPC Section 2228.1(d).
- Any hospital disciplinary actions that resulted in the termination or revocation of the physician's privileges to provide healthcare services at a healthcare facility for a medical disciplinary cause or reason reported to the Board after January 1, 1995.
- All malpractice judgments and arbitration awards reported to the Board after January 1, 1998 (between January 1, 1993, and January 1, 1998, only those malpractice judgments and arbitration awards more than $30,000 were required to be reported to the Board).
- All malpractice settlements over $30,000 reported to the Board after January 1, 2003, that meet the following criteria:
    - Four or more qualifying malpractice settlements in a five-year period if the physician practices in a high-risk specialty (obstetrics, orthopedic surgery, plastic surgery and neurological surgery).
    - Three or more qualifying malpractice settlements in a five-year period if the physician practices in a low-risk specialty (all other specialties).

In addition to the information above regarding public record actions, the Board discloses the following information regarding past and current licensees/registrants: license/registration number; type; name; address/county of record; status; original issue date; expiration date; school name; and year graduated. The Board also posts denied licensee applications on its website that users can view. The Board provides the following voluntary survey information if supplied by the physician licensee: retired status; activities in medicine; patient care practice location; telemedicine primary and secondary practice location zip code; training status; board certifications; primary practice area(s); secondary practice area(s); post graduate training years; cultural background; foreign language(s); and gender.

Unless prohibited by law, the Board provides the actual documents on the website for the following: accusation/petition to revoke or amended accusation; public letter of reprimand; citation and fine; suspension/restriction order; and administrative/disciplinary decision.
Through the Board's newsletter, Osteoscope, the Board publishes information about newly licensed physicians and post graduate trainees, as well as citations and disciplinary actions taken during the reporting period. This helps the public stay informed of enforcement outcomes and overall regulatory activity.

When requested in writing, the Board provides a licensee's address of record.

The Board also engages in public outreach events where staff emphasize the importance of verifying a license through BreEZe. Social media platforms, including Facebook, Instagram, X (formerly Twitter), LinkedIn, and YouTube are used to amplify messages regarding enforcement actions, application updates, and public protection tips.

By offering multiple access points to licensing and enforcement information, the Board ensures the public can make informed decisions when seeking medical care in California.

55. What methods are used by the board to provide consumer outreach and education?

The Board utilizes a comprehensive, multi-channel approach to consumer outreach and education with the goal of informing the public and protecting Californians through transparent, accessible information.

Participation in Community and Educational Events

Board staff actively participated in career fairs, community events, college presentations, and conferences to educate the public and prospective licensees. These events provided opportunities to distribute educational brochures and offer in-person guidance on how to:

- Verify a license using the DCA BreEZe system
- File a complaint
- Understand laws and regulations governing the practice of medicine
- Recognize the qualifications and responsibilities of licensees

The Board's engagement with future licensees and consumers helps establish a strong understanding of professional standards, laws, and ethical expectations early on. This support creates a smoother path to licensure while reinforcing the Board's role in protecting consumers and promoting accountability. By fostering trust and encouraging lifelong learning, the Board strengthens both the profession and public confidence in the practice of medicine.

Website & Redesigned Online Resources

In November 2023, the Board launched a fully redesigned website, significantly improving accessibility and user experience. The site includes dedicated sections for consumers, with information on:

- License verification
- Filing complaints
- Patient rights
- Citations and disciplinary actions
- Meeting materials and public notices

Social Media and Digital Campaigns

The Board maintains a strong presence across multiple social media platforms, including:

- Facebook
- Instagram
- LinkedIn
- X (formerly Twitter)

These platforms are used to share educational content, infographics, consumer protection tips, and updates about new laws, Board activities, and public health messaging. Content is crafted to be accessible and engaging to a wide audience.

Email Outreach and Publications

The Board uses a Listserv email system to send timely updates, regulatory changes, and consumer alerts directly to subscribers. The Board also publishes its newsletter and distributes it to stakeholders and is available online. Each issue includes:

- Articles on the practice of Osteopathic Medicine
- Consumer protection updates
- Citation and disciplinary action summaries
- Information on laws, policies, and Board actions

Brochures and Publications

The Board has made the following brochures and publications available on the Board's website (for downloading and printing locally) and provided at community outreach events. These publications include:

- Don't Wait, File a Complaint!
- A Consumer's Guide to the Complaint Process (English and Spanish)
- Most Asked Questions About Medical Consultants
- Questions and Answers About Investigations
- Newsletter
- Expert Reviewer Brochure
- Strategic Plan
- Sunset Review Report

FAQs on Website

The Board also includes FAQs on numerous topics for both the public and licensees. Some of these FAQs include:

- Fictitious Name Permit
- Applicants
    - Application Timeframes
    - Fingerprints
- Consumers
    - Complaints/Investigations
    - General Office Practices/Protocols
    - Internet Prescribing
    - Medical Records
    - Physician Credentials/Practice Specialties
    - Public Disclosure
    - Complaint Review Process
- Controlled Substance and Utilization Review Systems (CURES)
- Mandatory Reporting

- Licensee
    - Address of Record/Email Address
    - Continuing Medical Education (CME)
    - Cosmetic Treatments
    - Criminal Convictions
    - Financial Interest Statement
    - Inactive License
    - Name Change
    - Physician Assistants

Board Meetings & Public Engagement

In accordance with BPC Section 3600, the Board hosts public meetings at least three times per year, including meetings held in both Northern and Southern California, often at university campuses. This promotes student and faculty engagement, allowing the Board to directly communicate with future licensees and consumers.

All meeting agendas, materials, and minutes from 2015 to present are posted publicly online, reinforcing transparency. Webcast access is made available when possible, enhancing statewide participation.

Multilingual Resources

To further support California's linguistically diverse communities, the Board provides:

- Translated brochures and outreach materials
- Staff presentations sensitive to community-specific needs

The Board is committed to ensuring its consumer outreach and educational efforts are fully accessible to individuals with disabilities. Board provides materials in formats compatible with screen readers, offers captioning and transcripts for video content, and designs its website and publications in compliance with ADA accessibility standards. These efforts ensure that individuals who are visually or hearing impaired have equal access to important information and resources that promote consumer protection and awareness.

Through these initiatives, the Board demonstrates a strong, proactive commitment to public protection and education. By meeting the public where they are, the Board ensures consumers are informed, empowered, and protected.

Section 6
Online Practice Issues

56. Discuss the prevalence of online practice and whether there are issues with unlicensed activity.

In recent years, the field has expanded significantly due to advances in telemedicine, growing demand for remote care, and the integration of artificial intelligence (AI) into clinical settings. These developments create both opportunities and challenges for regulators, particularly in overseeing healthcare practitioners and AI-enabled platforms and addressing the risks associated with unlicensed practice.

Online medical practice has become a mainstream option, with telemedicine platforms facilitating patient access to care across geographic boundaries. The COVID-19 pandemic accelerated adoption, making virtual consultations and remote monitoring standard in many specialties. Despite these advances, certain restrictions remain, especially regarding physical examinations, which are still required for specific diagnoses and treatments. Clinical guidelines have evolved cautiously, balancing innovation with patient safety, but the profession continues to emphasize the importance of in-person evaluation when necessary.

- **How does the Board regulate online/internet practice?**

The Board regulates online practice under the same standards as traditional in-office care. All practitioners serving California-based patients must hold a valid state license, regardless of whether care is delivered in person or virtually. This requirement remains the cornerstone of consumer protection and quality assurance. With the rise of AI-powered diagnostic and consultation tools, the Board has begun to assess the need for specific guidelines addressing the use of AI in clinical decision-making. Oversight efforts now include monitoring compliance with privacy, security, and ethical standards for AI-driven platforms.

- **How does the board regulate online/internet business practices outside of California?**

The Board's jurisdiction extends to practitioners offering care to California residents, even if the provider is located elsewhere. Interstate telemedicine presents regulatory complexities, particularly with AI-enabled platforms that may automate portions of patient care. While the Board collaborates with other states to address cross-border practice, challenges remain in tracking and enforcing licensing requirements when AI or remote services are involved.

- **Does the board need statutory authority or statutory clarification to more effectively regulate online practice, if applicable?**

As online practice and AI technologies continue to evolve, statutory clarification may be necessary to ensure robust regulation. Current statutes do not explicitly address AI-enabled medical services, leaving potential gaps in oversight. The Board recommends legislative review to define the scope of

permissible AI use, clarify provider responsibilities, and strengthen protections against unlicensed or automated practice.

Unlicensed Activity: Risks and Emerging Challenges

Unlicensed activity remains a concern, particularly as online platforms and AI tools lower barriers to entry for non-credentialed individuals. Although current enforcement mechanisms are effective, the rapid expansion of telemedicine and AI introduces new risks, such as automated diagnosis or treatment recommendations provided without valid licensure. The Board maintains ongoing surveillance and encourages reporting of suspected unlicensed activity, recognizing the need for increased vigilance as technology advances.

AI in Medicine: Impact on Guidelines, Licensing, and Consumer Protection

Artificial intelligence is transforming clinical practice, offering enhanced diagnostic capabilities and personalized care. However, its integration raises questions about provider accountability, patient safety, and the adequacy of existing licensing frameworks. The Board is actively reviewing clinical guidelines to address the use of AI, ensuring that practitioners remain responsible for all aspects of patient care, regardless of technological assistance. Consumer protection remains paramount, with efforts focused on transparency, informed consent, and the prevention of unlicensed or inappropriate AI use.

Future Outlook and Recommendations

The Board anticipates continued growth in online medical practice and AI-driven platforms, especially in underserved areas and among populations with limited mobility. To safeguard the public, the Board recommends legislative updates, enhanced monitoring of technology-enabled services, and ongoing education for practitioners and consumers regarding the risks and benefits of online and AI-assisted care. Maintaining high standards for licensure and oversight will be critical as the landscape evolves.

Section 7
Workforce Development and Job Creation

57. What actions has the board taken in terms of workforce development?

Workforce Development

The Board has taken significant actions to support workforce development in the practice of medicine, always with public protection as the highest priority. The Board does not directly expand the workforce, but it plays a critical role in monitoring trends, informing policymakers, and facilitating licensure entry.

Key Accomplishments

- Education Pipeline Awareness – The Board conducts outreach to most graduating Osteopathic students, informing them about licensure, consumer protection, and professional obligations.

- Licensure Pathways and Expedited Application Process: The Board offers a reciprocity licensure process and expedited licensure process to the following:

    - Military veteran – honorably discharged
    - Active-duty military – spouses or partners
    - Refugee, asylee, or special immigrant visa holder
    - Intent to provide abortion services
    - Skillbridge Program

- Diversity, Equity, and Inclusion (DEI) Support – Board collaborates with Department of Healthcare Access and Information (HCAI) by contributing licensure and renewal survey data. At the time of initial licensure and renewal of a physician license, the Board collects $25, which is transferred to HCAI to help fund the Steven M. Thompson California Physician Corps Loan Repayment Program administrated by HCAI. The program encourages recently, licensed physicians to practice in medically underserved areas in California, by authorizing a student loan repayment plan in exchange for a minimum of three years of service. There is a requirement that most participants be selected from the specialty areas of family practice, internal medicine, pediatrics, and obstetrics/gynecology. However, up to 20 percent of the participants may be selected from other specialty areas. In addition, physicians and surgeons at the time of initial licensure or renewal may contribute money to provide training for family physicians and other primary-care providers who will serve in medically underserved areas. The funds the Board collects for the family physician training program is transferred to HCAI.

- Professional and Legislative Engagement – Maintained active partnerships with Federation of State Medical Boards (FSMB), the Osteopathic Physicians and Surgeons of California Association (OPSC), and academic institutions to align California's workforce readiness with national and state standards.
- The Board has collaborated with various University of California workforce research projects providing data only.

58. Describe any assessment the board has conducted on the impact of licensing delays.

The Board has transitioned all applications and licensee transactions to an online platform, resulting in significantly decreased application processing times since the last sunset review. This shift has streamlined the workflow for applicants and staff, reducing delays and improving overall efficiency. By adopting digital solutions, the Board has made the licensing process more accessible and responsive to the needs of applicants while decreasing the workload for Board staff. Additionally, the Board created a secure document upload portal on its website, enabling the direct submission of application documents from primary sources. This portal enhances security and promotes timely processing by ensuring that required materials are received and verified quickly and efficiently.

Furthermore, the Board partnered with NBOME, FSMB, and FCVS to expedite access to examination results.

The Board has not conducted an assessment on how licensing delays affect job creation. However, the Board closely monitors application processing times against established performance targets to ensure timely licensure and minimize potential impacts. The Board continues to explore new outreach methods and develop new professional relationships with entities that can reach a large number of training programs and residents to provide information on the application process and how to most efficiently submit required application documents to the Board.

59. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

During the current Sunset Review period, the Board has made extensive efforts to ensure students are well informed about the licensure process and professional requirements prior to entering the workforce.

- The Board regularly attends OPCS annual conference, providing an opportunity to interact directly with potential and future licensees, answer questions, and promote awareness of consumer protection responsibilities.
- Board personnel participate in school fairs and outreach initiatives organized by residential programs.
- When Board meetings are hosted by universities with osteopathic physician and surgeon programs, the Board conducts Q&A sessions with students, creating opportunities for students to engage directly with Board members and staff on topics such as ethics, licensing pathways, and professional accountability.
- The Board works closely with OPSC to get out critical information about the change in licensure requirements.

Through these efforts, the Board ensures that students and future applicants enter the profession with a clear understanding of the requirements to achieve licensure, the standards expected of licensees, and the Board's public protection mission.

60. Describe any barriers to licensure and/or employment the Board believes exist.

The Board does not believe there are any barriers to licensure and/or employment for D.O.s.

61. Provide any workforce development data collected by the board, such as:

a. **Workforce shortages**
b. **Successful training programs.**

The Board collects data but does not have the resources to evaluate the information gathered. Instead, it provides assistance and resources to other agencies and/or official research groups, such as the HCAI, California Health Care Foundation (CHCF), and the University of California, San Francisco, that study workforce issues relative to physicians in California. This assistance includes providing statistics and staff assistance to survey California licensed physicians for workforce data collection.

The CHCF and the University of California's Program on Access to Care provided support to UC, San Francisco staff as they analyzed the data. Multiple reports have been written using information obtained by the Board's survey data in conjunction with other data the Board has assisted in obtaining.

The Board also collects and publishes certain information for each licensee. This is performed through an extensive survey that may be voluntarily completed by physicians when they are initially licensed and updated each renewal period as part of the renewal process. The information requested from physicians includes data on years of postgraduate training; time spent in teaching, research, patient care, telemedicine, and administration; practice locations; areas of practice; and board certification. In addition, the survey requests information on race/ethnicity, foreign language, and gender. Even though these questions are optional, they are an important part of the efforts to examine physician demographics.

62. What actions has the Board taken to help reduce or eliminate inequities experienced by vulnerable communities, including low-and moderate-income communities, communities of color, and other marginalized communities, or otherwise avoid harming those communities?

During the current Sunset Review period, the Board has strengthened its efforts to protect vulnerable consumers and ensure all patients receive safe, ethical, and respectful care.

- **Consumer-Focused Education** - The Board has created several patient/consumer centered publications about its complaint process including a YouTube video.
- **Outreach** - The Board has participated in outreach events in the central valley in cities such as Selma and Bakersfield.
- **Equity in Enforcement** – The Board emphasizes fairness in its disciplinary processes by focusing on cases that involve direct consumer harm such as elder abuse, unlicensed practice, and sexual misconduct while also supporting rehabilitation where appropriate. This balanced approach ensures that the Board's actions protect vulnerable patients, particularly those from low, and moderate, income communities who may have fewer care options, without creating unnecessarily punitive barriers that could further limit access to safe medical care.
- **Accessibility and ADA Compliance** – The Board ensures that consumer-facing resources are accessible to all Californians including its Notice to Consumer so consumers can understand their rights and how to file a complaint. In addition, the Board meeting materials and disciplinary action documents are published in accessible formats.
- **Accessible Public Participation** – The Board ensures its meetings are webcast, held in publicly accessible locations (including universities with diverse student bodies), and open to

individuals with disabilities. This transparency lowers geographic, financial, and physical barriers to participation for consumers across the state.

- **Collaboration with Health Equity Initiatives** - Through data collection and reporting, the Board contributes licensure and workforce data to HCAI. These data help identify geographic and demographic disparities in access to care, supporting broader state efforts to reduce inequities in the health workforce.

By ensuring patients are informed of their rights, maintaining ADA-accessible resources, prioritizing enforcement actions that protect the most vulnerable, and collaborating with partners to expand equity-focused initiatives, the Board demonstrates its commitment to reducing inequities and avoiding harm to marginalized communities. The Board will continue to strengthen these efforts moving forward to uphold its highest mandate: protecting the public.

Section 8
Current Issues

63. Describe how the board is participating in development of online application and payment capacity and any other secondary IT issues affecting the board?

- **Is the board utilizing BreEZe? What Release was the board included in? What is the status of the board's change requests?**

The Board was part of Release 1 for the new BreEZe data system. Release 1 was implemented in October 2013.

Since the initial launch of BreEZe, Board staff has continued to work with the DCA BreEZe team and the vendor to develop and enhance reports for licensing and enforcement purposes. Staff attend regular meetings with users of the license and enforcement system from other boards to continuously compare and learn about the use of the many functions offered in BreEZe. Additionally, Board staff continues its work to identify issues in the data system and to submit a request for change, when needed.

- **If the board is not utilizing BreEZe, what is the board's plan for future IT needs? What discussion has the board had with DCA about IT needs and options? Is the board currently using a bridge or workaround system?**

While the Board is utilizing BreEZe, as it looks to the future, the Board will continue to monitor the following key issues that are emerging:

- Excessive customizations have undermined fundamental/core features
- Limited opportunity for growth to align with internal and external stakeholder needs and expectations
- Lacking visual appeal and intuitiveness

Section 9
Board Action and Response to Prior Sunset Issues

Include the following;

- **Background information concerning the issue as it pertains to the board.**
- **Short discussion of recommendations made by the Committees during prior Sunset Review.**
- **What action the board took in response to the recommendations or findings made under prior Sunset Review.**
- **Any recommendations the board has for dealing with the issue, if appropriate.**

Board Administration 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 the Board are not personally liable in the event they are sued in an antitrust matter related to their board service. Does the Board'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 are semiautonomous bodies whose members are appointed by the Governor and the Legislature. Although 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 the Board'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 the Board, one appointed by the Senate Committee on Rules, and one appointed by the Speaker of the Assembly, to establish a public majority membership.

Prior Board Response: The Board is comprised of nine members, five D.O.s and four public members. The Board currently has two member vacancies, which are both professional members. The Board has not had any issues with its current composition and 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.

Board Updated Response: The Board continues to be composed of nine members, consisting of five D.O.s and four public members. All board positions are currently filled, supporting continuity in governance and decision-making.

The Board has operated within DCA since 2002, when the Board voluntarily sought inclusion under the Department. The affiliation with DCA and access to its resources have strengthened the Board's operations. The Board is a self-governing entity that establishes its own policies and priorities, while receiving administrative support from the Department.

As a constituent entity within DCA, the Board continues to receive administrative support, oversight, and guidance from DCA, as well as legislative oversight through the Legislature. This governance structure promotes accountability, transparency, and compliance with applicable laws and regulations while enabling the Board to carry out its statutory responsibilities and regulatory mission.

ISSUE #2: (REGULATIONS.) The Board indicates that it has a number of pending regulatory packages, including efforts to implement recent legislation and enhance Board operations. What is the status of the Boards regulations and what has the Board'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 the Board'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, these are not the same standards for how regulation packages are determined, written, and produced.

Prior to 2016, boards and bureaus 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, the Board 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 Board's existing standards and optional terms of probation. The Board 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 the Board 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 Board'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 Board, 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 the Board and the full regulatory package is being drafted.
- Fee Increase – This regulatory package would increase the application fee for a D.O. The Board's fund is currently structurally balanced so the need for a fee increase has been alleviated. If its fund balance begins to decrease, the Board 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 Board regulations, the timeframe for regulations to be processed and complete, and what efficiencies Board has realized since the creation of the DCA Regulations Unit.

Staff Recommendation: The Board 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.

Prior Board Response: The Board'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 Board and will be submitted later this calendar year.

The Board 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).

Board Updated Response: The Board has established a dedicated position for a legislation and regulation specialist to enhance oversight and expedite the regulatory process. This specialist is responsible for tracking, coordinating, and advancing regulatory packages to ensure compliance with legislative requirements and timely implementation.

Substantial Relationship and Rehabilitation Criteria (AB 2138) – This regulatory package amends existing regulations consistent with Chapter 995, Statutes of 2018 (AB 2138) and to accurately reflect the Board's authority to consider denials or discipline and petitions for reinstatement or modification of penalty.

This package was approved by OAL on May 17, 2021, with an effective date of May 17, 2021.

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 Board, patients can check the status of a D.O., and how patients can file a complaint against a D.O.

This package was approved by OAL on June 8, 2021, with an effective date of October 1, 2021.

Continuing Medical Education and Citations and Fines – This regulatory package amends the renewal process to allow for self-certification of CME and a post-renewal audit process and expanded citation and fine authority.

This package was approved by OAL on July 10, 2025, with an effective date of October 1, 2025.

Retired License, Petitions, Fees – This regulatory package establishes a retired license status, and fees for petitions, and it brings all existing fees to its statutory caps.

This package is in the process of getting filed with OAL.

Disciplinary Guidelines – This regulatory package proposes to add specified uniformed standards related to substance abuse and updates the Board's existing standards and optional terms of probation.

This package was previously rejected by Office of Administrative Law (OAL) on December 9, 2016 and a request to resubmit was granted by OAL on March 17, 2017. Board staff has been diligently engaged in the process of revising its disciplinary guidelines, which have not been updated since 1996. Board staff have worked tirelessly in collaboration with the DCA regulation unit to ensure these guidelines reflect current practices and address evolving needs. The Board anticipates presenting a newly revised version of its disciplinary guidelines by the end of this calendar year or the beginning of next year.

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: The Board should discuss any findings related to the mental and behavioral healthcare needs of frontline healthcare providers arising from the COVID-19 pandemic.

Prior 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.

Board Updated Response: In response to ongoing concerns, the Board has continued to monitor developments related to the mental health needs of frontline healthcare workers. Recent feedback from stakeholders and preliminary data from ongoing studies suggest that rates of burnout, anxiety, and symptoms of PTSD remain elevated among providers, especially those who worked through the most intense phases of the pandemic. Efforts are underway to expand access to mental health resources, including peer support programs and confidential counseling services, with several hospitals and clinics reporting increased utilization of these offerings.

Additionally, the Board is actively reviewing best practices and recommendations from national organizations and intends to collaborate further with academic institutions on research initiatives. The findings from the UC Davis Physician Suicide Study are expected to inform future strategies, with a focus on addressing both immediate and long-term behavioral health needs for providers impacted by COVID-19. The Board will continue to prioritize this issue and provide updates as more information becomes available.

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 the Board, 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: The Board 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.

Prior 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.

Board Updated Response: In FY 2024-25 the Board sought a permanent Attorney General budget change proposal. With this approved Budget Change Proposal, the Osteopathic Medical Board of California permanently increased its expenditure authority by $347,000 beginning in FY 2024-25 to align its budget with the consistently rising costs of Attorney General (AG) services, which have surged due to rapid growth in the state's licensed osteopathic physician population and corresponding enforcement workload. Over recent years, AG-referred cases, hours, and costs have

climbed sharply, forcing the Board to rely on temporary midyear spending augmentations that were not sustainable. The approved augmentation ensures the Board can fully support essential enforcement activities including investigation, prosecution, and emergency actions without delays that could compromise consumer protection, especially for vulnerable Californians with limited access to licensed providers. The Board is closely monitoring this expenditure and actively seeking a fee increase.

Licensing Issues

ISSUE #5: (CME.) During the prior sunset review for the Board, changes were made to CME that are still pending implementation. The Board 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: The Board 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, the Board requested changes impacting CME and renewal cycles. The Board 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 Board to audit the self-certifications of CME for all renewals. The Board indicates that it was hesitant to create an audit system that weakened the Board's oversight of CME compliance for licensure in the interest of protecting public safety. Once approved, the Board states that this new renewal system will streamline renewals for both licensees and Board staff while still protecting public safety. This regulatory package is being drafted by the Board and will be noticed in early 2021.

In its sunset report to the Legislature, the Board 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, the Board states that "California's CME requirements for D.O.s are double the CME requirement for their M.D. colleagues. The Board believes that the current difference between CME requirements for M.D.s under the Medical Board of California and D.O.s under the Board does not line up with the parity of skill between the two types of medical degrees."

The Board 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. The Board 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 the Board'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: The Board should update the Committees on the rationale for this request, in light of changes made recently to update CME cycles. The Board should inform the Committees of

the impacts any changes would have on the Board's current ability to receive CME completion documentation directly and how this change will impact patients, the public, and licensees.

Prior Board Response: The Board'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 Board is currently finalizing the regulatory package with the changes.

The Board does not believe that requesting the reduction of CME hours and submitting a regulatory change will be an issue if done concurrently. Making the changes concurrently may create less confusion and streamline the process as the Board 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 D.O.s that have specialties or subspecialties and have specific CMEs to complete for the specialties. Additionally, D.O.s and M.D.s 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.

Board Updated Response: The Board reduced its continuing medical education (CME) requirement to 50 hours per two-year cycle effective January 1, 2022. This change was made through Senate Bill 806 (SB 806, Chapter 649, Statutes of 2021), which amended BPC Section 2454.5 and required OMBC to revise its regulations accordingly.

Effective October 1, 2025, the Board amended its regulations to implement a (CME) audit system that aligns CME cycles with license renewal periods. Under these new rules, licensees will self-certify completion of CME requirements at renewal, eliminating the need for detailed CME review each renewal cycle of all licensees. If a licensee is selected for audit, however, the Board will conduct a thorough review of their CME documentation to ensure compliance. Although the Board initially expressed concerns that relying on audits might reduce oversight and impact public safety, it now believes the streamlined renewal process will benefit both licensees and staff while maintaining safety standards through the random audit selection process.

ISSUE #6: (AB 2138.) What is the status of the Board'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 the Board 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: The Board should provide an update on its implementation of the Fair Chance Licensing Act, as well as relay any recommendations it has for statutory changes.

Prior 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.

Board Updated Response: The Board completed its AB 2138 regulatory updates in 2020, filing its Substantial Relationship and Rehabilitation Criteria regulatory package with the Office of Administrative Law on November 20, 2020. These updates amended Title 16 CCR Section 1654, 1655, and 1657 to incorporate AB 2138's mandatory factors nature and gravity of the offense, time elapsed, and relevance to the profession and modernized the Board's rehabilitation criteria and licensing-denial procedures to align with its statutory requirements. The Board also updated its website and licensing materials to meet AB 2138's public-information posting requirements. The Board continues to be in full compliance with AB 2138 to date.

ISSUE #7: (Postgraduate training license) The Board now requires physicians to complete three years postgraduate training in order to be licensed. Concerns have been raised by PTL holders, echoing those raised by the Board 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 the Board'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 the Board 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 the Board 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 no 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, to not allow 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: The Board 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. The Board 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.

Prior Board Response: The Board 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 Board has been made aware of the impact that this bill has created but also understands that any change may undermine consumer protection.

Board Updated Response: The Board remains in full compliance with verifying that all Osteopathic Physicians and Surgeons have successfully completed their 36-month postgraduate training program requirement. Requiring physicians to complete a full 36-month postgraduate training program is essential to ensuring that every doctor practicing in California has gained the depth, continuity, and hands-on experience needed to provide safe, high-quality care. These three years of supervised training allow new physicians to develop clinical judgment, refine technical skills, and learn to respond effectively to complex, real-world medical situations before practicing independently. Maintaining this 36-month requirement helps protect patients by ensuring that all physicians entering the workforce have completed a rigorous, standardized training pathway that supports competence, accountability, and public trust.

Enforcement Issues

ISSUE #8: (ENFORCEMENT DISCLOSURES.) The Board's licensees are required to disclose probationary status to patients and the Board 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 the Board and licensees? Has the Board seen any changes in its disciplinary proceedings stemming from the disclosure requirement?

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

The Board 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 the Board 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 the Board, 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 Board's online license information site.

Physicians and surgeons licensed by the Board and MBC have to comply with probation notification requirements under more narrow circumstances, only if there is a final adjudication by the Board 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: The Board 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.

Prior 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 D.O.s on probation are notifying their patients of their probationary status.

Board Updated Response: Implementation of the Patient's Right to Know Act has significantly enhanced consumer awareness of the Board's probationary licensees through greater transparency, expanded online disclosures, and mandatory patient notification. The Board has not observed substantive changes in its disciplinary outcomes stemming from the disclosure requirements.

However, the Act has driven operational improvements in probation compliance verification, public-facing information management, and consistency in disciplinary guidelines work.

The Board remains committed to maintaining transparency, protecting patients through robust enforcement practices, and ensuring that probation information is clear, accurate, and readily accessible to the public and verified on a quarterly basis by probation staff.

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: The Board maintains a diversion program to, as the Board notes, monitor and treat D.O.s who are impaired by the use of alcohol and or drugs. The Board utilizes a Diversion Evaluation Committee (DEC), comprised of three D.O. members with expertise in substance abuse and psychosocial disorders, which, as the Board 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 Board 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." The Board's Diversion program requires all licensees that are disciplined for substance abuse to enter the Diversion Program as a condition of probation. The Board 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 the Board. 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. The Board states that no other wellness program offers this high-level quality of case workers who work closely with licensees. The Board 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 the Board, many boards only test licensees but do not offer treatment services to assist in their successful recovery. The Board 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: The Board should update the Committees on the work of the DEC and diversion program and advise the Committees on the status of the Board's adoption of the Uniform Standards. The Board 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 the Board follows in its regulatory efforts.

Prior 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.

Updated Board Response: Since the last sunset review, the Board is now contracting its diversion program services with a new company, Premier Health. The Board continues to be extremely satisfied with the quality and effectiveness of the diversion program and, for this reason, maintains its position to be excluded from the Physician Health and Wellness Program, for which the MBC is actively seeking legislative approval. Additionally, the Board is actively collaborating with Premier Health and DCA's communication team to conduct outreach efforts, encouraging more physicians and surgeon D.O.s to utilize the diversion program as early intervention before enforcement actions may necessitate probation.

The Board is also actively working on revising its disciplinary guidelines to formally adopt the Uniform Standards through regulation, ensuring continued alignment with best practices and regulatory requirements.

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, the Board 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.

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

Staff Recommendation: The Board 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.

Prior 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 D.O.s and patients utilizing multiple D.O.s as their supply chain.

Board Updated Response: Addressing overprescribing, under prescribing, and unsafe opioid combinations remains a top priority. The Board uses the CURES database and its regulatory tools to monitor prescribing practices during desk and field investigations.

The Board's executive director, Ms. Erika Calderon, previously led the Medical Board of California's prescription review program. She has also recruited experts experienced in evaluating prescribing practices, patient activity reports (PARs), and physician profile reports (PPRs) in CURES, strengthening the Board's ability to address overprescribing and protect public health.

COVID 19 Issues

ISSUE #11: (WHAT EFFECT HAS THE COVID-19 PANDEMIC HAD ON THE BOARD.) 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 the Board 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 Section 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 Section 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 Board, also affected other healing arts licensees under the DCA.

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

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

- The Board requested a waiver for licensees changing their license status from inactive to active. CCR Section 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.

The Board reports that it 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 the Board licensees is not as easy to identify for stakeholders who are inquiring about waiver availability.

Staff Recommendation: The Board 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. The Board 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.

Prior 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 BPC 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.

Updated Board Response: Board staff returned to the office on July 1, 2026, under a hybrid work model that requires four days in the office and one day of telework. This arrangement supports continued collaboration, timely access to Board operations, and reliable service to licensees, applicants, patients, and other stakeholders while retaining limited flexibility when circumstances warrant. The Board remains committed to addressing issues promptly during ongoing or future public health emergencies and to maintaining continuity of essential regulatory functions. It continues to respond to requests and waivers issued by the Governor or the Director of the Department of Consumer Affairs (DCA), evaluate the effect of those actions on licensees and patients, and provide appropriate support as circumstances evolve. The Board also remains focused on clear communication, consistent implementation of applicable requirements, and compliance with all relevant laws, regulations, and executive directives. These efforts help ensure that emergency measures do not compromise the Board's responsibility to protect the public, maintain professional standards, and promote safe patient care. The Board has no issues to report regarding the waivers it previously executed. Based on its experience during the COVID-19 pandemic, the Board will continue monitoring changes in public health conditions and statewide direction, coordinating with the DCA as appropriate, and adjusting its operational practices when necessary to preserve effective oversight and uninterrupted service.

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 Board 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 Board licensees every day. The Board 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 Board should be continued, to be reviewed again on a future date to be determined.

Prior Board Response: The Board is in support of the continued licensing and regulation by the current Board membership. The Board 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 Board 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 Osteopathic Medical Board of California.

Update Board Response: The Board supports the ongoing licensing and regulation of osteopathic physicians and surgeons by its current Board membership. It remains committed to collaborating with the Medical Board of California (MBC) to align processes and standards where appropriate, fostering a unified approach to regulatory oversight that enhances public safety and patient care. At the same time, the Board maintains its distinct operational structure and authority, ensuring that the unique needs and perspectives of osteopathic practitioners are represented and protected. This dual

approach allows the Board to uphold its mission, adapt to evolving healthcare environments, and remain responsive to licensees and the public, while still preserving its independence and specialized focus as a separate regulatory entity.

Section 10
New Issues

This is the opportunity for the board to inform the Committees of solutions to issues identified by the board and by the Committees. Provide a short discussion of each of the outstanding issues, and the board's recommendation for action that could be taken by the board, by DCA or by the Legislature to resolve these issues (i.e., policy direction, budget changes, and legislative changes) for each of the following:

- **Issues raised under prior Sunset Review that have not been addressed.**
- **New issues identified by the board in this report.**
- **New issues not previously discussed in this report.**
- **New issues raised by the Committees.**

Issue #1: Updating Fee Statute

The Board conducted a comprehensive fee study to evaluate its existing fee structure, projected operational needs over the next four years, and the statutory fee caps necessary to maintain fiscal sustainability. Based on this analysis, the Board is seeking legislative approval to increase the statutory caps for several fees under Business and Professions Code (BPC) Section 2455, as shown in the chart below, and to eliminate the statutory caps on delinquency fees. Establishing fee ranges in statute would authorize future adjustments as necessary.

A central justification for the proposed changes is that the Board has not increased its fees since 1996. During the nearly three decades since the last fee increase, the number of licensees, the Board's workload, and its operational responsibilities have grown substantially, resulting in increased expenditures. These demands necessitate adjustments to the statutory fee caps to ensure the Board can continue fulfilling its statutory obligations and serving licensees and consumers effectively. Additionally, the Board is actively working on a regulatory package to increase its existing fees to the current statutory caps.

Osteopathic Medical Board of California
Proposed Fees

Statutory Authority	Fee Type	Current Fee	Statutory Cap	Audit Finding Total Costs	Proposed Cap Amount
BPC 2455(a)	Original or Reciprocity Certificate Application	$200	$400	$777	$750
BPC 2455(b)	Initial License	$400	$400	$755	$750
BPC 2455(b)	License Renewal	$400	$400	$755	$750

In addition, the Board requests clean-up and the addition of more accurate terminology regarding the fee for an initial license to BPC Section 2455 to address an ambiguity created by prior amendments to BPC Section 2455. BPC Section 2455 was amended by Senate Bill (SB) 1549 (Stats. 2004, ch.

691) to add the “biennial license fee” terminology and repeal references to the “tax and registration fee” (first enacted in 1994 by Assembly Bill 3732 (Stats.1994, ch. 895). However, the removal of the reference to the “registration fee” and the addition of the reference only to a “biennial license” fee has created an ambiguity regarding whether an initial licensing fee is required of all applicants to receive their initial physicians and surgeons’ certificate with the Board.

To resolve these terminology issues, the Board proposes to add language that would clarify that applicants must pay an “initial certificate fee” equal to the biennial renewal fee once eligibility is established and remove references to a “biennial license” fee. Since the renewal and initial certificate fee are both intended to cover enforcement oversight by the Board for two years, the initial certificate fee would be equal to the biennial renewal fee. These changes are consistent with other boards’ fee and licensing processes in the Department of Consumer Affairs, see e.g., BPC Sections 1724(d), 2983, 4938 and 7072.

The proposed increases in the statutory caps and clarifications regarding the initial licensing fee authority are essential for the Board to maintain financial health and continue providing high-quality services to osteopathic physicians and surgeons in California. The Board respectfully requests legislative approval for these adjustments to ensure that it can meet its operational needs and regulatory responsibilities effectively.

Proposed Language Amending Business and Professions Code Section 2455

BPC 2455 The amount of fees and refunds is that established by the following schedule for any certificate issued by the Osteopathic Medical Board of California. All other fees and refunds for any certificate issued by the Osteopathic Medical Board of California which are not prescribed in this schedule, are prescribed in Sections 2455.1 and 2456. Any and all fees received by the Osteopathic Medical Board of California shall be for the sole purpose of the operation of the board and shall not be used for any other purpose, except as specified in Section 2455.1.

(a) Each applicant for an original or reciprocity Physicians and Surgeons Certificate shall pay an application fee in a sum ~~not to exceed~~of at least four hundred dollars ($400) which may be increased to not more than seven hundred and fifty dollars ($750) at the time his or her application is filed.

(b) Each applicant who qualifies for an original or reciprocity Physicians and Surgeons Certificate shall pay, as a condition precedent to its issuance and in addition to other fees required, the initial certificate fee. The initial certificate fee shall be set at the same amount as the biennial renewal fee described in subdivision (c).

(~~b~~c) The biennial ~~license~~ renewal fee, unless otherwise provided, shall be set by the board ~~on or before November 1 of each year for the ensuing calendar year~~ at a sum as the board determines necessary to defray the expenses of administering this chapter, under the Osteopathic Act, relating to the issuance of certificates to those applicants, subject to the limitations in this section. ~~Which sum, however, shall not exceed~~ The renewal fee is set at four hundred dollars ($400) which may be increased to not more than seven hundred and fifty dollars ($750) ~~nor be less than twenty-five dollars ($25)~~.

(~~c~~d) The board shall set a biennial inactive certificate ~~license~~ renewal fee in an amount less than that levied pursuant to subdivision (b) that shall be paid by any applicant who indicates to the board in

writing that he or she does not intend to practice under the Osteopathic Act during the current renewal period.

(~~d~~e) The fee for failure to pay the biennial ~~license~~ renewal fee shall be 50 percent of the renewal fee ~~but not more than two hundred dollars ($200)~~.

(Amended by Stats. 2009, Ch. 600, Sec. 2. (SB 606) Effective January 1, 2010.)

Proposed Language Amending Business and Professions Code Section 2455.1

BPC 2455.1 (a) In addition to the fees charged pursuant to Section 2455, and at the time those fees are charged, the board shall charge each applicant for an original or reciprocity certificate or for a biennial ~~license~~ renewal of their certificate an additional twenty-five-dollar ($25) fee for the purposes of this section. This twenty-five-dollar ($25) fee shall be due and payable along with the fee for the original or reciprocity certificate or the biennial license.

(b) ~~On or before July 1, 2015, t~~The board shall develop a mechanism for an osteopathic physician and surgeon to pay a voluntary contribution, at the time of initial application for licensure or biennial renewal, for the purposes of this section.

(c) The board shall transfer all funds collected pursuant to this section, on a monthly basis, to the Medically Underserved Account for Physicians created by Section 128555 of the Health and Safety Code for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Notwithstanding Section 128555 of the Health and Safety Code, these funds shall not be used to provide funding for the Physician Volunteer Program.

(Amended by Stats. 2014, Ch. 439, Sec. 2. (SB 1116) Effective January 1, 2015.)

Issue #2: Osteopathic Medicine: Representation

The Board proposes a clarifying statutory provision detailing the professional titles that Osteopathic Physicians and Surgeons licensed by the Osteopathic Medical Board of California may use.

Historically, the Board and the profession have been around for approximately 104 years. Despite this time frame, little is known about the profession. Additionally, there have been misunderstandings about the Board and the profession, such as what is a D.O. and what they do exactly. Adding this amendment would increase understanding and accurately represent osteopathic medicine credentials and use consistent professional designations. It would also help prevent the misuse or misinterpretation of professional titles, support regulatory enforcement, and promote public confidence in the osteopathic profession. Comparable provisions include Section 2633 of the Physical Therapy Board Act and Business and Professions Code Section 2570.18 `applicable to occupational therapy, as represented by the Occupational Therapy Board.

Amendment #1: Amend to Add Business and Professions Code Section 2451.1: Representation as follows:

2451.1 Representation

(a) Unless licensed as an osteopathic physician and surgeon under this chapter and pursuant to the Osteopathic Act, a person may not use the professional abbreviations or title "D.O." or "Osteopath" or "Doctor of Osteopathy," or refer to themselves as an "osteopathic physician and surgeon or doctor", or use any other words, letters, symbols, manner, or means with the intent to represent that the person practices or is authorized to practice as an osteopathic-trained physician and surgeon, osteopathic physician and surgeon or doctor of osteopathy or osteopath in California or is authorized to practice osteopathic medicine in California.

(b) A violation of subsection (a) constitutes an unfair business practice and false and misleading advertising under Business and Professions Code Sections 17200 and 17500, respectively.

Issue # 3: Continuing Medical Education- Chapter 5 Medical Practice Act Shared Statutes Alignment

Article 10 of Chapter 5 of the Business and Professions Code governs continuing medical education (CME) under the Medical Practice Act and applies to both the Medical Board of California and the Osteopathic Medical Board of California. However, amendments under Article 21 of the Osteopathic Act have created duplicative or inconsistent requirements, resulting in different standards for the two boards.

Because the Osteopathic Medical Board's CME regulations are based on Article 10, the duplicative provisions in Article 21 should be repealed. This would prevent conflicting or more restrictive requirements and preserve exemptions provided under Article 10.

The Board's enforcement authority also does not always align with its current practices. In particular, Sections 2190.5 and 2454.5 contain conflicting requirements concerning pain management and the addiction risks of Schedule II drugs. The proposed amendments would resolve this conflict and align the statutory requirements with the Board's regulations and enforcement practices.

Amendment # 1: Amend Business and Professions Code Section 2454.5 as follows:

In order to ensure the continuing competence of licensed osteopathic physicians and surgeons, the board shall adopt and administer standards for the continuing education of those licensees. The board shall require each licensed osteopathic physician and surgeon to demonstrate satisfaction of the continuing education requirements as a condition for the renewal of a license at intervals of not less than one year nor more than two years. The board shall require each licensed osteopathic physician and surgeon to complete a minimum of 50 hours of American Osteopathic Association continuing education hours during each two-year cycle, of which 20 hours shall be completed in American Osteopathic Association Category 1 continuing education hours and the remaining 30 hours shall be either American Osteopathic Association or American Medical Association accredited as a condition for renewal of an active license. ~~Licensed osteopathic physicians and surgeons shall complete a course on the risks of addiction associated with the use of Schedule II drugs.~~

For purposes of this section, “American Osteopathic Association Category 1” means continuing education activities and programs approved for Category 1 credit by the Committee on Continuing Medical Education of the American Osteopathic Association.

(Amended by Stats. 2021, Ch. 649, Sec. 25. (SB 806) Effective January 1, 2022.)

Note: BPC 2190.5 already applies to the Board so the sentence in 2454.5 regarding risks of addiction associated with the use of Schedule II drugs is duplicative and should be repealed. Section 2190.5 is a more comprehensive version that specifies exemptions that the wording in 2454.5 lacks. This duplicative provision takes up statutory space in Article 21.

2190.5 (a) (1) All physicians and surgeons shall complete a mandatory continuing education course in the subjects of pain management and the treatment of terminally ill and dying patients. For the purposes of this section, this course shall be a one-time requirement of 12 credit hours within the required minimum established by regulation, to be completed by December 31, 2006. All physicians and surgeons licensed on and after January 1, 2002, shall complete this requirement within four years of their initial license or by their second renewal date, whichever occurs first. The board may verify completion of this requirement on the renewal application form.

(2) For physicians and surgeons licensed on or after January 1, 2019, the course described in paragraph (1) shall also include the subject of the risks of addiction associated with the use of Schedule II drugs.

(b) By regulatory action, the board may exempt physicians and surgeons by practice status category from the requirement in subdivision (a) if the physician and surgeon does not engage in direct patient care, does not provide patient consultations, or does not reside in the State of California.

(c) This section shall not apply to physicians and surgeons practicing in pathology or radiology specialty areas.

(Amended by Stats. 2018, Ch. 693, Sec. 3. (SB 1109) Effective January 1, 2019.)

Amendment #2: Repeal Business and Professions Code Section 2454.6 as follows:

~~**2454.6**~~

~~2454.6 In determining its continuing education requirements, the board shall consider including a course in infection-associated chronic conditions, including, but not limited to, long COVID, as defined by the United States Department of Health and Human Services, myalgic encephalomyelitis, and dysautonomia.~~

~~*(Added by Stats. 2024, Ch. 433, Sec. 2. (AB 3119) Effective January 1, 2025.)*~~

Note: Repeal. This requirement is already included in BPC 2191.6 and would apply to the Board once 2454.6 is repealed.

2191.6 In determining its continuing education requirements, the board shall consider including a course in infection-associated chronic conditions, including, but not limited to, long COVID, as

defined by the United States Department of Health and Human Services, myalgic encephalomyelitis, and dysautonomia.

(Added by Stats. 2024, Ch. 433, Sec. 1. (AB 3119) Effective January 1, 2025.)

Amendment #3: Repeal Business and Professions Code Section 2454.7 as follows:

Already required by BPC 2190.4 in Article 10 of Medical Practice Act

Note: This CME requirement (BPC 2454.7) already applies to the Board so this section below in the Osteopathic Act should be repealed.

BPC 2190.4 would require a minor amendment to pave the way for it to be shared by both boards. The minor amendment would be to add the Board's regulatory code Section Title 16, California Code of Regulations (CCR) Section 1635 that defines CME requirements to this section.

In the Board's most recently approved CME regulations, the Board amended Section 1635 to tie the definition of CME requirements to whatever is required in statute due to the frequency of CME bills that would otherwise require regulatory promulgations every year for CME alone.

Amendment #4: Repeal BPC Section 2454.7 as follows:

~~2454.7 (a) Beginning July 1, 2027, a qualifying osteopathic physician and surgeon who completes continuing medical education courses in perimenopause, menopause, and postmenopausal care shall receive two hours of credit for each hour completed of that coursework, for a total earned credit that does not exceed eight course hours, toward the requirement set forth in Section 1635 of Title 16 of the California Code of Regulations.~~

~~(b) For purposes of this section, "qualifying osteopathic physician and surgeon" means a holder of a physician's and surgeon's certificate who is certified by a member board of the American Board of Medical Specialties or the American Osteopathic Association in internal medicine, family medicine, obstetrics and gynecology, neurology, neurological surgery, or psychiatry and whose patient population is composed of adult women under 65 years of age.~~

~~*(Added by Stats. 2026, Ch. 27, Sec. 3. (SB 164) Effective June 29, 2026.)*~~

Amendment #5: amend BPC Section 2190.4 as follows:

2190.4. (Add OMBC regulatory sections related to CMEs) amend as follows:

(a) Beginning July 1, 2027, a qualifying physician and surgeon who completes continuing medical education courses in perimenopause, menopause, and postmenopausal care shall receive two hours of credit for each hour completed of that coursework, for a total earned credit that does not exceed eight course hours, toward the requirement set forth in Sections 1336 and 1635 of Title 16 of the California Code of Regulations.

(b) For purposes of this section, "qualifying physician and surgeon" means a holder of a physician's and surgeon's certificate from the board who is certified by a member board of the American Board of Medical Specialties in internal medicine, family medicine, obstetrics and gynecology, neurology,

neurological surgery, or psychiatry and whose patient population includes adult women under 65 years of age.

Issue # 4: OMBC Reciprocity Application and Licensure

Under existing law, the Osteopathic Medical Board of California shall grant a reciprocity license to an applicant who holds an equivalent unlimited license from another state, passes an approved exam, and who has no disciplinary history or been the subject of adverse judgments or settlements resulting from the practice of medicine that the Board determines constitutes evidence of a pattern of negligence or incompetence.

This proposed amendment clarifies that applicants applying under reciprocity must have no other grounds for denial, submit a completed electronic, online form prescribed by the Board and pay all applicable application and processing fees before being issued a certificate. This ensures consistency, prevents applicants with other disqualifying issues from bypassing scrutiny, improves administrative efficiency by eliminating incomplete or piecemeal submissions, and strengthens the Board's ability to uniformly enforce its licensing requirements.

Amendment #1: Amend Business and Professions Code Section 2153.5 as follows:

Notwithstanding any other provisions of law, the Osteopathic Medical Board of California shall issue an osteopathic physician's and surgeon's certificate on reciprocity to an applicant providing he or she meets the following requirements:

(a) The applicant holds an unlimited license to engage in the practice of osteopathic medicine in another state whose written licensing examination is recognized and approved by the board to be equivalent in content to that administered in California. For the purposes of this section, the board may recognize and approve as equivalent, along with other examinations, an examination prepared by the Federation of State Medical Boards if an applicant had been licensed in another state as a result of the successful completion, prior to December 31, 1993, of that examination. In lieu of a board recognized and approved state written license examination, the board may require the applicant to successfully complete a special examination in general medicine and osteopathic principles prepared by the National Board of Osteopathic Medical Examiners, or the Osteopathic Medical Board of California. The board may also utilize a special purpose examination prepared by the Federation of State Medical Boards.

(b) The board determines that no disciplinary action has been taken against the applicant by any medical licensing authority, ~~and~~ that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of medicine that the board determines constitutes evidence of a pattern of negligence or incompetence or that any other grounds for denial exist pursuant to this chapter or Section 480.

(c) Each applicant applying pursuant to this section shall complete the electronic, online form prescribed by the board and pay all applicable application and processing fees required by Sections 2455 and 2455.1.

(Amended by Stats. 2003, Ch. 789, Sec. 10. Effective January 1, 2004.)

Issue #5: OMBC's Proposed Retired License

The purpose of this amendment is to provide additional details regarding eligibility and ineligibility not currently required by law for a retired license status from this Board. In particular, it requires licenses to be current and in good standing and to meet other eligibility criteria designed to prevent applicants that should not be eligible for retired status due to expiration of their license, disciplinary history, consumer complaints, compliance issues, and failure to meet other retired status eligibility criteria that are not included in the current DCA statute, Business and Professions Code Section 464, which governs the existing retired status authority. The current proposal would borrow existing statutory language from Business and Professions Code Sections 464 and 3521.3, which the Board believes would strengthen its regulatory oversight over this new retired status category of licensees.

Amendment #1: Amend to add Section 2455.3 Business and Professions Code Section Osteopathic Retired License as follows

(a) The board may establish, by regulation, a system for the placement of a license on a retired status, for an osteopathic physician and surgeon who is not actively engaged in practice as an osteopathic physician and surgeon or any activity that requires them to be licensed by the board.

(b) The regulation shall contain the following:

(1) A retired status license may be issued to a person with either an active license or an inactive license in good standing. "Good standing" for the purposes of this section shall mean a current, active and unrestricted license or a current, unrestricted inactive license issued by the board. The following individuals will not be considered eligible and shall not be issued a license in retired status by the board:

(A) individuals whose licenses have expired pursuant to Section 2456.1;
(B) individuals whose licenses have not been renewed within five years after expiration per Section 2456.3 or forfeited per Section 2457;
(C) licensees with pending enforcement investigations, unresolved citation and fine cases, pending disciplinary actions, or pending complaints with the board;
(D) licensees whose licenses have been placed on probation with the board or whose license is otherwise disciplined or punitively restricted by the board;
(E) licensees who have surrendered their license to the board; and,
(F) individuals who have had their licenses revoked by the board.

(2) The holder of a retired status license issued pursuant to this section shall not practice medicine or engage in any activity for which a license is required unless the board, by regulation, specifies the criteria for a retired licensee to practice his or her profession or vocation.

(3) The board shall establish an appropriate application process, and application fee for a retired status license to cover the reasonable regulatory cost of issuing a license in retired status.

(4) An applicant shall meet any other requirements as specified by the board by regulation.

(c) The board may exempt the holder of a retired status license from the renewal requirements in Section 2456.1.

(d) In order for the holder of a retired status license issued pursuant to this section to restore his or her license to an active status, the holder of that license shall meet all the following:

(A) Pay all fees required to renew a license in active status including the biennial renewal fee specified by the board and any fees required by Sections 208 and 2455.1.
(B) Certify, in a manner satisfactory to the board, that he or she has not committed an act or crime constituting grounds for denial of licensure.
(C) Comply with the fingerprint submission requirements established by regulation.
(D) Complete continuing education equivalent to that required for renewal of an active license, unless a different requirement is specified by the board.
(E) Complete any other requirements as specified by the board by regulation.

(e) The board may upon its own determination and shall upon receipt of a complaint from any person, investigate the actions of any licensee, including a person with a license that either restricts or prohibits the practice of that person in his or her profession or vocation, including, but not limited to, a license that is in retired status, inactive, canceled, revoked, or suspended.

Note: Below is the DCA statute that provides the authority for the current retired status regulations.

464 (a) Any of the boards within the department may establish, by regulation, a system for a retired category of licensure for persons who are not actively engaged in the practice of their profession or vocation.

(b) The regulation shall contain the following:

(1) A retired license shall be issued to a person with either an active license or an inactive license that was not placed on inactive status for disciplinary reasons.

(2) The holder of a retired license issued pursuant to this section shall not engage in any activity for which a license is required, unless the board, by regulation, specifies the criteria for a retired licensee to practice his or her profession or vocation.

(3) The holder of a retired license shall not be required to renew that license.

(4) The board shall establish an appropriate application fee for a retired license to cover the reasonable regulatory cost of issuing a retired license.

(5) In order for the holder of a retired license issued pursuant to this section to restore his or her license to an active status, the holder of that license shall meet all the following:

(A) Pay a fee established by statute or regulation.

(B) Certify, in a manner satisfactory to the board, that he or she has not committed an act or crime constituting grounds for denial of licensure.

(C) Comply with the fingerprint submission requirements established by regulation.

(D) If the board requires completion of continuing education for renewal of an active license, complete continuing education equivalent to that required for renewal of an active license, unless a different requirement is specified by the board.

(E) Complete any other requirements as specified by the board by regulation.

(c) A board may upon its own determination, and shall upon receipt of a complaint from any person, investigate the actions of any licensee, including a person with a license that either restricts or prohibits the practice of that person in his or her profession or vocation, including, but not limited to, a license that is retired, inactive, canceled, revoked, or suspended.

(d) Subdivisions (a) and (b) shall not apply to a board that has other statutory authority to establish a retired license.

(Added by Stats. 2016, Ch. 473, Sec. 1. (AB 2859) Effective January 1, 2017.)

Issue # 6: Require Postgraduate Training License Holders, Interns and Residents to Report to the Board When Leaving Their Program

BPC Section 2065(e) requires a postgraduate training program to report to the Board within 30 days when a postgraduate training license (PTL) holder is terminated from, or otherwise leaves, or has completed a one-year contract approved by, the program.

When a PTL holder is no longer enrolled in a California ACGME-accredited postgraduate training program, they are no longer permitted to practice in California, and their license may be cancelled. For holders of a physician and surgeon license the existing law is vague and needs to add similar provisions that anyone holding a physician and surgeon license who has not completed 36 months is unauthorized to continue to practice outside an authorized residency program and must cease practice. This clarification is needed to deal with residents and interns who are terminated from their residency program and seek to practice medicine with the active license even though they are not eligible for renewal at the time of renewal and it occurs months before they are up for renewal. This amendment addresses termination from residency programs that occur between 12 months and 36 months. This amendment is needed to preserve the legislative intent of requiring completion of 36 months of residency training to be renewed. Unchanged, current law does not provide the Board with the authority to require a licensee to cease practice as is required of PTL holders.

To ensure the Board receives complete and timely information, in the furtherance of consumer protection, staff recommend including within the Sunset Report a request to amend this code to add Section BPC Section 2097.1 to require the PTL holder to notify the Board on an appropriate form within 30 days of leaving a program for any reason. This new requirement would only apply to residents and interns with either PTL or physician and surgeon license who have not successfully completed their 36 months of residency required by law as a condition of renewal of their physician and surgeon license. This new

requirement is also intended to prevent residents who have been terminated or left their training programs to continue to practice without authorization and without board knowledge.

The proposed amendment below creates a new section to add the reporting requirements and clarity around the status of a holder of a physician and surgeon license if they leave the program.

Proposed language: Amend to add new Section 2097.1 as follows:

Amend BPC Section 2097.1 as follows:

(a) A postgraduate training licensee, or an intern or resident who has not completed at least 36 months of their postgraduate training in compliance with Section 2097 shall report on a form required by the board, and provide any supporting documents as required by the board, the following actions within 30 days of the action:

(1) The postgraduate training licensee's, intern's or resident's termination or dismissal by the postgraduate training or residency program.
(2) The postgraduate training licensee's, intern's or resident's resignation or withdrawal from the postgraduate training or residency program.
(3) The postgraduate training licensee's, intern's or resident's leave of absence or break for any reason from their postgraduate training or residency program.

(b) Upon receipt of the notice in in this section or upon otherwise receiving notice of the postgraduate training licensee's, intern's or resident's failure to complete their postgraduate training, the board shall notify the postgraduate training licensee, intern, or resident of the following, as applicable:

(1) For a postgraduate training licensee, the individual's failure to be enrolled in a postgraduate training program in accordance with this section and Section 2064.5 requires the individual to cease the practice of medicine on the date they were no longer enrolled in the program.

(2) For an intern or resident, the individual's failure to complete their 36 months of postgraduate training in accordance with Section 2097 will result in their license being placed in a delinquent status until they provide proof satisfactory to the board that they meet the requirements of Section 2097.

(3) Any continued practice thereafter shall constitute the unlicensed practice of medicine.

(c) This section shall only apply to individuals issued a license by the board on or after January 1, 2027.

MBC Issues that OMBC would like to be included

Issue 7: MBC's Sexual Misconduct

Addressing Licensees Who Engage in Sexual Misconduct (MBC)

Sexual misconduct is an egregious violation of the law and a physician's ethical obligation. Currently, the Board has a position of Support, if Amended on SB 849 (Weber Pierson). In addition to the amendments already made to the bill, the Board has requested further enhancements to Business and Professions Code (BPC) Section 2307 that would strengthen the law and further protect the public from licensees who have engaged in sexual misconduct.

Staff recommend that the Sunset Report include a request for any of its outstanding proposals that are not included in SB 849.

Note: OMBC supported MBC's proposed amendments to SB 849 and these proposed amendments.

Amendment #1: Amend Business and Professions Code Sections 2221, 2246, 2307 as follows:

BPC Section 2221. (c) Notwithstanding any other law, the board shall deny a physician's and surgeon's certificate to an applicant who is or has ever been required to register pursuant to Section 290 of the Penal Code or comparable law outside of California, regardless of a dismissal pursuant to Section 1203.4, 1203.4a, 1203.41, 1203.42 or 1203.425 of the Penal Code, or a comparable dismissal or expungement, or who meets the criterial described in the subparagraph (C) of paragraph 1, of subdivision (i) of Section 2307. This subdivision does not apply to an applicant who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

2246. Any proposed decision or decision issued under this article that contains any finding of fact that the licensee violated Section 726 or subdivision (a) of Section 729, ~~engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient~~ shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge.

2307. (i) (1) The board shall not reinstate the certificate of a person under any of the following circumstances:

(A) The person's certificate was surrendered while a board accusation was pending against their license that alleges the person committed an act of sexual abuse, misconduct, or relations with a patient pursuant to Section 726 or sexual exploitation as defined in subdivision (a) of Section 729.

(B) The person's certificate has been revoked based on a finding by the board that the person committed an act of sexual abuse, misconduct, or relations with a patient pursuant to Section 726 or sexual exploitation as defined in subdivision (a) of Section 729.

(C) The person was convicted in a court in or outside of this state of any offense that, if committed or attempted in this state, based on the elements of the convicted offense, would have been punishable as one or more of the offenses described in subdivision (c) of Section

290 of the Penal Code, ~~and the person engaged in the offense with a patient or client, or with a former patient or client if the relationship was terminated primarily for the purpose of committing the offense.~~

(D) Notwithstanding any other law, the person is or has ever been required to register as a sex offender pursuant to the provisions of Section 290 of the Penal Code or comparable law outside California, regardless of whether the conviction has been appealed, and regardless of a dismissal pursuant to Section 1203.4, 1203.4a, 1203.41, 1203.42, or 1203.425 of the Penal Code, or a comparable dismissal or expungement, ~~and the person engaged in the offense with a patient or client, or with a former patient or client if the relationship was terminated primarily for the purpose of committing the offense.~~

(2) A plea or a verdict of guilty or a conviction after a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The record of the conviction shall be conclusive evidence of the fact that the conviction occurred.

(3) This subdivision does not apply to an applicant who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

Issue # 8: Repeal an Obsolete Licensing Code Section

BPC Section 2064.6 contains an obsolete requirement to extend the expiration date of certain postgraduate training licenses to March 31, 2024. Staff recommend that the Sunset Report includes a request to repeal this section.

Note: This section does apply to OMBC and should be included in OMBC proposals.

Amendment #1: Amend as follows:

BPC Section 2064.6 repeal:
~~Notwithstanding subdivision (b) of Section 2064.5, the expiration date for any postgraduate training license that expires after June 1, 2023, and before December 31, 2023, shall be extended to March 31, 2024.~~
(Added by Stats. 2023, Ch. 196, Sec. 3. (SB 143) Effective September 13, 2023.)

Section 11
Attachments

Please provide the following attachments:

A. **Attachment A**
Board's administrative manual

B. **Attachment B**
Current organizational chart showing relationship of committees to the Board and memberships of each committee (cf. section 1, Question 1).

C. **Attachment C**
Board's amended strategic plan 2024-2028 adopted on January 22, 2026

D. **Attachment D**
Year-end organizational charts for last four years. Each chart should include number of staff by classification assigned to each major program area (licensing, enforcement, administration, etc.)

ATTACHMENT A

Board's Administrative Manual





OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

ADMINISTRATIVE MANUAL

1300 National Drive, Suite 150, Sacramento CA 95834-1991

Revised: November 5, 2026

OMBC
EST. 1922
Osteopathic Medical Board of California

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

MEMBERS OF THE BOARD

Denise Pines, MBA, *President*

Hemesh Patel, D.O., *Vice President*

Gor Adamyan, *Secretary-Treasurer*

John M. Cummins, J.D.

Brett Lockman, D.O.

Negeen Mirreghabie, Esq.

Faisal Qazi, D.O.

Matthew Swain, D.O.

Shannon Walsh, D.O.

EXECUTIVE DIRECTOR

Erika Calderon

This Board Administrative Manual serves as an authoritative reference to support Board member decision-making and promote the efficacy and efficiency of Board operations. This manual does so by providing an overview of key laws, regulations, and fundamental Board policies.

The manual may be revised through approval by a majority vote of any current or future Board.

PATHWAY TO LICENSURE IN CALIFORNIA

Graduate from Accredited Osteopathic Medical School

(D.O. degree, COCA accredited)

Post Graduate Training (PTL) License

Must apply for licensure within **180 days** of beginning a postgraduate training program

Required Documents Include:

Postgraduate Training Program Enrollment Form **(OMB.23)** to be completed by the program director or the designated institutional official (DIO)

Postgraduate Training License or Physician and Surgeon's Certificate Attestation & Release of Information Form **(OMB.26)** to be the applicant and include a photograph (passport quality)

Official medical school transcript to be submitted by the school

Copy of medical school diploma to be submitted by the applicant may also be accepted from the school

COMLEX-USA Level **1 & 2** passing scores must come from NBOME

DOJ Fingerprint clearance (Live Scan in California-Fees to be paid by applicant)

Extra photograph (passport quality) to be included with application

Application Fee **$491** (as of 2026)

American Osteopathic Association Commision on Osteopathic College Accreditation (COCA)

or

Accreditation Council for Graduate Medical Education (ACGME)

Must complete at least **12 months** of postgraduate training (PGY 1) in a COCA or ACGME-accredited program

COMLEX-USA Level **3** passing score

To transition into a full and unristricted Physician and Surgeon license

Physician and Surgeon License

Eligible to apply for licensure after completing the **12 months** of postgraduate Training program (PGY 1)

Required documents include:

Official medical school transcript to be submitted by the school may also be accepted from FCVS

Copy of medical school diploma to be submitted by the applicant may also be accepted from the school and FCVS

Postgraduate training verification **(OMB.25)** to be completed by the program director or the designated institutional official (DIO)

Postgraduate Training License or Physician and Surgeon's Certificate Attestation & Release of Information Form **(OMB .26)** to be completed by the applicant and include a photograph (passport quality)

COMLEX-USA Level **1-3** passing score must come from NBOME

DOJ and FBI Fingerprint clearance (Live Scan in California/hard copy fingerprint cards available if residing outside CA-Fees to be paid by applicant)

License verifications from other states (if applicable) must be submitted by respective licensing Board

Extra photograph (passport quality) to be included with application

Application Fee **$625** (as of 2026)

****If previsouly submitted no need to resubmit****

Renewal Requirements

Show completion of **36 months** of postgraduate education at either the first or second renewal, depending on when the 36 months of training is completed **(OMB.29)** to be completed by the program director or the designated institutional official (DIO)

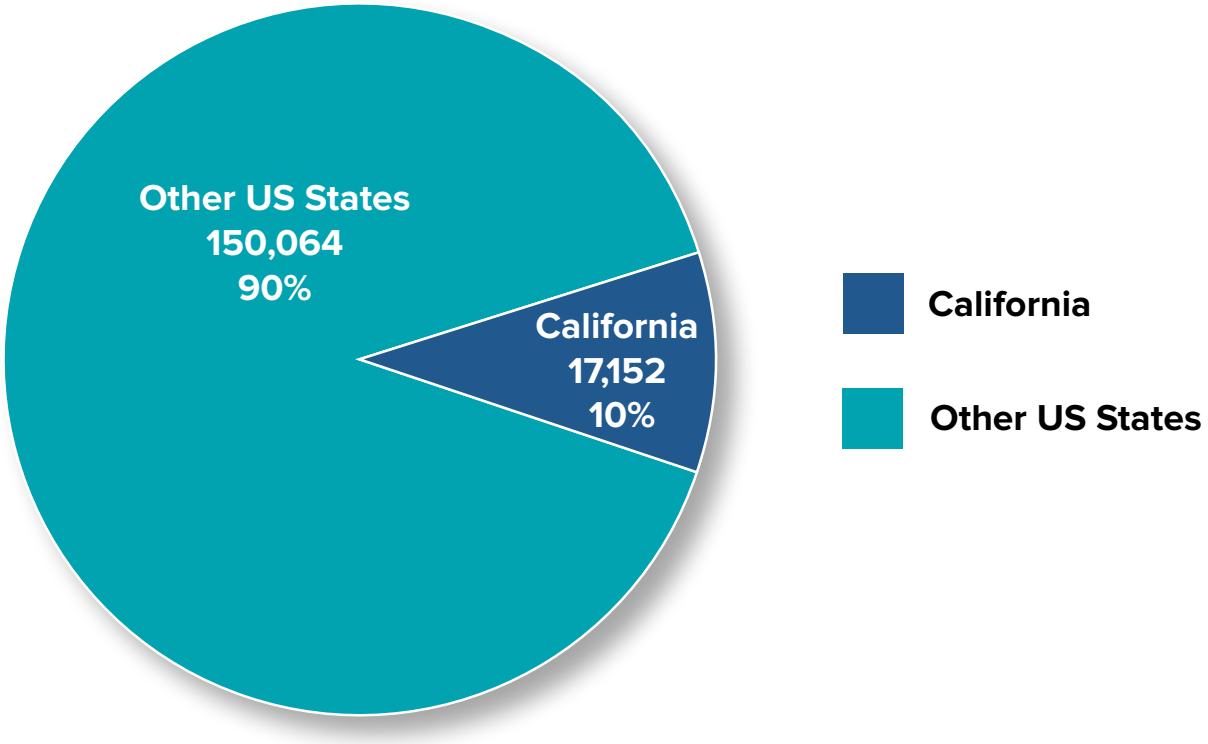
If postgraduate certification form was postdated prior to completion, the licensee must demonstrate completion of 36 months at the time of renewal.

Continuing Medical Education (CME) Requirement (effective October 1, 2025): Each physician must submit satisfactory proof of CME to the Board if randomly selected for an audit.

A physician must complete **50** credit hours earned within the two-year period between the prior expiration date and current expiration dates.

A minimum of twenty (20) hours out of the **50** hours must be American Osteopathic Association (AOA) Category **1A or 1B.**

Active Osteopathic Physician and Surgeon Population



CATEGORY	NUMBER	PERCENTAGE
Licensed in California (May also hold licenses in other states)	17,152	10.3%
Not licensed in California	150,064	89.7%
Total	**167,216**	**100%**

According to the most recent 2025 Osteopathic Medical Profession (OMP) Report from the American Osteopathic Association (AOA), there are 167,216 Doctors of Osteopathic Medicine (D.O.s) actively practicing across the United States. Of these, 17,152 D.O.s are licensed to practice in California, which represents 10.3% of the nation's active D.O. population. It's important to note that D.O.s who are licensed in California may also hold licenses to practice in other states.

AOA also reports that most D.O.s practice in just a few states. The AOA data show that half of all D.O.s in the U.S. are concentrated in the following eight states:

1. California
2. Florida
3. Pennsylvania
4. New York
5. Texas
6. Michigan
7. Ohio
8. New Jersey

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INTRODUCTION

This Board Administrative Manual serves as an authoritative reference to support Board member decision-making and promote the efficacy and efficiency of Board operations. This manual does so by providing an overview of key laws, regulations, and fundamental Board policies.

The Executive Director will coordinate an orientation session with each new Board Member upon their appointment, to assist the new member in learning processes and procedures.

The Board's mission is to protect the public by requiring competency, accountability, and integrity in the safe practice of medicine by osteopathic physicians and surgeons.

The Board envisions all osteopathic physicians and surgeons provide the highest quality of care to all and thereby excel in protecting the public.

To accomplish its mission, the Board: investigates consumer complaints and criminal convictions; responds to emerging changes and trends in the osteopathic healthcare profession legislatively or through regulations; and creates publications for consumers, applicants, registrants, and licensees.

The Board's statutes and regulations require an individual to be licensed before they may engage in the practice of osteopathic medicine. These statutes and regulations set forth the requirements for licensure and provide the Board with the authority to regulate the practice of medicine and take appropriate action against individuals that are practicing medicine without a license.

The highest priority for the Board is protection of the public in exercising its licensing, regulatory, and disciplinary functions. Board members fulfill this mandate through policy decisions and voting on disciplinary actions in which a licensee or registrant has violated the Board's laws and regulations.

BOARD HISTORY

The Board is one of 36 regulatory boards, bureaus, and programs operating within the Department of Consumer Affairs (DCA). The DCA functions under the Business and Consumer Services Agency (BCSA). Its role includes providing educational resources to consumers, equipping them with information necessary to identify and avoid individuals who engage in deceptive, unsafe, or unqualified practices. While the DCA offers administrative oversight and support services to the Board, the Board retains policy autonomy and independently establishes its own policies, procedures, and regulations.

Established in 1922 through the Osteopathic Initiative Act, the Board operates as a fully empowered regulatory entity within the DCA. It holds exclusive responsibility and authority for issuing licenses to Doctors of Osteopathic Medicine (D.O.s), Postgraduate Training licensees, and issues Fictitious Name Permits.

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

1. Ensure licensees comply with statutory and regulatory requirements.
2. Ensure licensees stay competent by mandating approved continuing education.
3. Take appropriate disciplinary action whenever a licensee fails to meet the standard of practice.
4. Determine that osteopathic medical schools and hospitals are following medical education curriculum and post-graduate training requirements.
5. Provide rehabilitation opportunities for licensees whose competency may be impaired.
6. Provide education and outreach.

The Board consists of nine members (five professional and four public members) who are appointed to the Board for four-year terms. Seven members (five professional and two public members) are appointed by the Governor. The Senate Rules Committee and the Speaker of the Assembly each appoint a public member.

GENERAL RULES OF CONDUCT

Whether the Board members are attending a public board meeting or an event/activity unrelated to the Board, their role as a Board Member is continuous. The public perceives the Board members as the "Board" and this perception will not end until their service on the Board is concluded. Therefore, it is important that their actions and conduct are a positive reflection upon the Board, and ultimately the state of California and its Governor.

The following list is intended to assist Board Members in avoiding any situation that has the potential to reflect poorly on the Board.

- Board Members actions must uphold the Board's primary mission to protect the public.
- Board Members must maintain the confidentiality of confidential documents and information.
- Board Members must commit time, actively participate in Board activities, and prepare for Board meetings, which includes reading Board packets and all required legal documentation.
- Board Members must respect and recognize the equal role and responsibilities of all Board Members, whether public or licensee.
- Board Members must act fairly and, in a nonpartisan, impartial, and unbiased manner.
- Board Members must treat all applicants and licensees in a fair and impartial manner.
- Board Members must not use their positions on the Board for political, personal, familial, or financial gain.

DEFINITIONS

OAG	Office of the Attorney General
Agency (BCSA)	Business and Consumer Services Agency
ALJ	Administrative Law Judge
B&P, BP, BPC	Business and Professions Code
BCP	Budget Change Proposal (request for additional staff/funds to Board budget)
BreEZe	Board Database System
CCR	California Code of Regulations
DAG	Deputy Attorney General
DCA/Department	The Department of Consumer Affairs
D.O.	Doctor of Osteopathic Medicine
DOF	Department of Finance
DOI (HQIU)	Division of Investigation (Health Quality Investigation Unit)
OAH	Office of Administrative Hearings
PD	Proposed Decision issued by an ALJ
SAM	State Administrative Manual
Stip	Stipulation – settlement agreement
Uniform Standards	Disciplinary Guidelines for Substance Abusing Licensees



BOARD AND COMMITTEE MEETINGS

Board Meeting Frequency

Business and Professions Code Section 101.7 requires the Board to meet at least two times per calendar year, holding at least one meeting in Northern California and one meeting in Southern California. The Board usually schedules three to four one-day meetings per calendar year.

The meeting dates are coordinated with the Board President and the upcoming legislative calendar. The meeting dates are set during the last meeting of the calendar year.

Committee Meeting Frequency

As needed, ad-hoc committees are established to address specific topic areas. The number of members on an ad-hoc committee ranges from two to three Board Members.

All committee members are appointed by the Board President.

Board Meeting Attendance

Board Members must attend each meeting of the Board and their assigned committee. If a member is unable to attend, they must contact the Board President or the Executive Director and ask to be excused from the meeting for a specific reason.

All meeting minutes will reflect Board Member attendance including when a member is excused or absent from the meeting.

Meeting Quorum

A quorum of the Board or committee must be present to constitute an act and/or decision on behalf of the Board. If a quorum of the Board is not present, the meeting is canceled.

Quorum for a Board meeting is five members. Committee meetings require a majority of the Committee membership. For example, in committees comprised of three members, two members must be present.

Board Meeting Format

Board meetings typically include an open and closed session. The closed session permits the Board to deliberate and render a decision on all disciplinary matters. At all Board meetings, Board Members are provided with a quarterly report regarding the Board's operations, statistics, and budget. All open sessions of the Board meetings are webcast when possible.

Committee Meeting Format

At all committee meetings, the members and the public discuss items on the meeting agenda. The committee members will vote to recommend a position or language to the Board. The recommendation is presented at the next Board Meeting. Alternatively, the committee members may direct Board staff to complete specified tasks and present the findings at the following committee meeting.

Agenda Topics

Any Board Member may suggest items for a future Board meeting agenda to the Executive Director or during the last agenda item of each Board meeting typically titled "Solicitation of Future Agenda Items." The Executive Director sets the agenda at the direction and approval of the Board President.

Meeting Materials

Board staff prepare all materials for Board and Committee meetings. Board meeting materials will be provided electronically two weeks prior to the scheduled meeting.

To engage in a meaningful discussion to determine a recommendation or position, Board and Committee Members must thoroughly review all meeting materials prior to each meeting.

Record of Meeting

Board minutes serve as comprehensive summaries of each Board Meeting rather than verbatim transcripts. The minutes are distributed to the members with the Board meeting materials for upcoming meeting and are subject to approval and adoption as is or as amended at that subsequent meeting. The purpose of this review process is to ensure the accuracy and faithful reflection of the Board's discussions, not to ratify actions taken during the prior meeting. Once approved and adopted, the minutes constitute the official record of the proceedings.

Digital Recording

The public-session portions of a meeting if available will be recorded using Webex, in addition to being webcasted.

MEETING REQUIREMENTS

All Board and Committee meetings are open to the public unless a closed session is specifically authorized. All Board and Committee meetings are subject to the provisions of the **Bagley-Keene Open Meeting Act**.

Definition of a Meeting (*Government Code Section 11122.5*)

A meeting is defined in the Bagley-Keene Open Meeting Act (Open Meeting Act) as including "any congregation of a majority of the members of a state body at the same time and place to hear, discuss, or deliberate upon any item that is within the subject matter jurisdiction of the state body to which it pertains." In this definition, the term "state body" refers to the Board.

The meeting definition also applies to all communication between Board Members (e.g., emails, telephone calls, texts, dining conversations) if the total number of Board Members involved in the communication is a majority of the Board or a Committee.

If Board Members engage in any communication regarding Board business with more than one member, this communication is a violation of the Open Meeting Act. The violating members may be guilty of a misdemeanor (**Government Code Section 11130.7**).

There are some exemptions to the meeting definition. Please refer to the Bagley-Keene Open Meeting Act for clarification. If you are in doubt, contact the Executive Director or the Board's legal counsel.

Please refer to the Guide to the Bagley-Keene Open Meeting Act listed in the Resource Links.

Teleconference Meetings (*Government Code Section 11123*)

The Board may opt to hold a meeting via teleconference. Meetings held via teleconference are also subject to the same notice requirements under the Open Meeting Act. The meeting notice must be published at least ten days in advance and must include the physical location of each teleconference meeting location.

The Board Member must be present at one of the physical locations listed in the meeting notice, and at least one member must be present at each publicly accessible teleconference location. The public is permitted to attend the meeting at any of the locations listed on the meeting notice during an open session of the meeting. Therefore, each Board Member must confirm that the physical location used for the teleconference meeting is ADA accessible. The public is not permitted to attend any part of the meeting that is designated as "closed session."

Teleconference Meetings (**Government Code Section 11123.2**)

The Open Meeting Act offers an additional procedure for boards to hold a teleconference meeting when board members are at different physical locations, including private locations. A board member can attend remotely as long as all requirements of **Government Code Section 11123.2** are met.

The majority (i.e. a quorum) of board members must be present at the same publicly accessible site. Other members, above a majority may then participate in the meeting remotely from private sites without noticing the location (**Government Code Section 11123.2, Subd. (j)(1)**.)

Remote members must visibly appear on camera unless the appearance would be technologically impracticable (e.g., unreliable internet connection or when their images cannot be displayed because of other information, materials, or speakers). If the remote member is not visible due to internet connectivity challenges, they must announce the reason before turning off the camera (**Government Code Section 11123.2, Subd. (k)(1)-(2)**.) The remote member must disclose whether other individuals over the age of 18 are present with them and the general nature of the relationship. (**Government Code Section 11123.2, Subd. (j)(4)**.) Therefore, they must only attend a meeting from a secluded location.

The public must be able to remotely participate in the meeting using the same means of participation as remote board members (**Government Code Section 11123.2, Subd. (d)(1)**.) Finally, if the electronic means of attending the meeting fails, the meeting will need to end or adjourn. (**Government Code Section 11123.2, Subd. (o)**.)

BAGLEY-KEENE OPEN MEETING ACT

Bagley-Keene Open Meeting Act

The Bagley-Keene Open Meeting Act *(**Government Code Section 11120 et seq.**)* directs that the people's business must be conducted openly. Therefore, decisions and actions by a public agency must be conducted openly so that the public may be informed. The Board achieves this legislative mandate by complying with all the requirements specified in the Bagley-Keene Open Meeting Act.

Board Duties Under the Open Meeting Act

The Board has three duties under the Open Meeting Act: provide notice of meetings, provide opportunity for public comments, and conduct public meetings.

Meeting Notice Requirements (*Government Code Section 11125*)

The Board must give adequate notice of meetings to be held. The Board meets this duty at the time the meeting notice is published. The Board must give at least ten calendar days written notice of each Board and Committee meeting. This notice is posted on the Board's website. The meeting notice includes the location(s) where the meeting will be held and the meeting agenda.

The agenda must include all items of business to be conducted or discussed at the meeting. A brief description of the item to be discussed at the meeting is required. The description may not be generalized (e.g., miscellaneous topics or old business) and must provide sufficient information so that the public is aware of the item to be discussed.

The notice must include the name, address, and telephone number of any person who can provide further information prior to the meeting and must contain the website address where the notice can be accessed. Additionally, the notice must contain information that would enable a person with a disability to know how, to whom, and by when a request can be made for any disability-related accommodation, including auxiliary aids or services.

A meeting notice, once posted, may not be revised after the tenth day prior to the meeting date.

Opportunity for Public Comment (*Government Code Section 11125.7*)

The Board meeting must provide an opportunity for public comments. The Board solicits public comments for each topic on the agenda and after a motion is made. Additionally, every Board and Committee meeting agenda contains an agenda item that allows for public comment on items not on the agenda. Members may not act or discuss matters presented by the public under this agenda item. The matter may be suggested for a future agenda item or for follow-up by Board staff.

Public Meetings

The Board must conduct the meetings in an open session except where a closed session is specifically authorized. All Board and Committee meetings, except for a closed session, are open to the public.

Closed session meetings must follow the same meeting notice requirements and are held specifically for matters designated under law, such as discussion of disciplinary cases, pending litigation, and personnel matters.



TRAVEL AND SALARY/PER DIEM

Travel Policies

Board Members will be reimbursed for travel expenses related to all Board and Committee meetings. Reimbursement will be in accordance with current state travel reimbursement policies. Please refer to the DCA's Travel Guide for specific travel guidelines and reimbursement policies.

You can find more details in the DCA's Travel Guide, which is included under Resource Links.

Travel Approval (State Administrative Manual Section 700 et seq.)

Travel related to Board and Committee meetings do not need approval. All other travel related to Board business must be approved by the DCA prior to the event. This includes any out-of-state travel. Under specific circumstances, a Board Member may travel to attend a national federation or association meeting/conference. Please contact the Executive Director for further information.

Travel Arrangements (Department Procedure/Board Procedure)

Board Members must always contact the Board's liaison to make travel arrangements for Board and Committee meetings. The liaison will book flights, hotel, and rental car reservations. A hotel that honors the state Government employee rate will be chosen for all reservations. Rental cars will be reserved for Board Members when a car is needed. To encourage ride sharing, vans or large sedans are reserved. Board Members may also use taxi, ride sharing services, shuttle service, or a personal vehicle for transportation.

To facilitate easier travel planning, all Board Members must provide the Board's liaison with their credit card information and Rewards number. This information will be kept in a secure location and will be kept on file for future travel arrangements.

All travel and transportation arrangements are made in compliance with state travel guidelines. Any expenses incurred by a Board Member, which were not previously approved or within the state travel guidelines, may require written justification. The written justification will be submitted with the travel claim and is subject to the appropriate approvals. The expense may or may not be approved.

Exceptions To Travel Reimbursement Policies

Lodging

State guidelines generally prohibit reimbursement of hotel expenses within 50 miles of an individual's home address or an extra night stay following the conclusion of the Board activity. However, an exception to this guideline may be obtained if the circumstances necessitate an overnight stay. Please contact the Board's liaison for further information.

Airport Parking Reimbursement

State guidelines strongly encourage the use of the least expensive parking available. However, if the Board determines that additional parking costs above the lowest-cost option are in the best interest of the State, a written justification explaining the necessity for the additional cost must be submitted with the travel claim. Please contact the Board's liaison for further information.

Travel Claims (Department Policy)

Rules governing reimbursement of travel and meeting expenses for Board Members are the same as for state management-level staff. All invoices must be submitted to the Board's liaison for processing.

Board Members must submit invoices promptly (preferably electronically) after each trip, no later than 10 days from the last day of travel. It is also necessary to submit original receipts for expenses claimed such as parking, transportation services, bridge tolls, and flight itineraries. Hotel receipts must reflect a zero balance. Receipts for meals are not required for reimbursement.

Salary Per Diem (*Business and Professions Code Section 103)*

Compensation in the form of salary per diem and reimbursement of travel and other related expenses for Board Members is determined by **Business and Professions Code Section 103**.

This section provides for payment of salary per diem for Board Members "for each day actually spent in the discharge of official duties," and provides that the Board Member "must be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

Board Members fill non-salaried positions but are paid $100 per day for each meeting day or 8-hour day spent performing Board business.

SELECTION OF OFFICERS AND COMMITTEES

Board Officers (*Business and Professions Code Section 2012*)

The Board must elect a President, a Vice President, and a Board Secretary-Treasurer, from its membership. Officers must serve terms of one year and may be re-elected to consecutive terms. The election of officers occurs at the January Board meeting.

If for any reason the Board President is unable to continue in their role, the Vice President must immediately assume the duties of the President until the next election of officers.

Committee Appointments (Board Procedure)

Committees are created by and appointed at the discretion of the Board President. The Committee Chair is appointed by the Board President. Board Members who desire to serve on a committee are encouraged to speak to the Board President.

Duties of the Board President

Spokesperson for the Board (may attend legislative hearings and testify on behalf of the Board, may attend meetings with the DCA or Agency, may attend meetings with stakeholders and legislators).

Meets and communicates with the Executive Director on a regular basis.

Communicates with other Board Members for Board business.

Chairs and facilitates Board meetings.

Assigns Board Members to Board Committees, appoints the Chair for committees.

In the absence of the Board President, the Board Vice President will perform the above duties.

BOARD ADMINISTRATION AND BOARD STAFF

Board Administration

Board Members must be concerned primarily with formulating decisions on Board policies rather than making decisions concerning the implementation of such policy. It is inappropriate for Board Members to become involved in the details of program delivery or implementation. Strategies for the day-to-day management of Board programs and Board staff is the sole responsibility of the Executive Director. Board Members must not interfere with day-to-day operations, which are under the authority of the Executive Director.

Executive Director (*Business and Professions Code Section 2020*)

The Executive Director is appointed by and serves at the pleasure of the Board and is exempt from civil service. The Executive Director must exercise the powers and perform the duties delegated by the Board. The Executive Director is responsible for the financial operations and integrity of the Board and is the official custodian of records. Annually, the Board Members will conduct a review of the Executive Director's performance. The Board President will meet with the Executive Director to discuss the performance appraisal.

Board Staff

Employees of the Board, except for the Executive Director, are civil service employees. Their employment, pay, benefits, discipline, termination, and condition of employment are governed by a myriad of civil service laws and regulations, and often by collective bargaining labor agreements. Due to this complexity, it is most appropriate that the Board delegate all authority and responsibility for management of the civil service staff to the Executive Director. Board Members must not intervene or become involved in specific day-to-day personnel transactions.

Rules for Contacting Staff (Board Procedure)

Board Members must only contact the following designated staff:

- Executive Director, Erika Calderon at Erika.Calderon@dca.ca.gov or at (916) 291-4660 regarding all Board matters.
- Legislative and Regulatory Specialist, Terri Thorfinnson, J.D. at Terri.Thorfinnson@dca.ca.gov regarding all legislation and regulation matters.
- Licensing and Administrative Services Program Manager, Machiko Chong (Board liaison) at Machiko.Chong@dca.ca.gov regarding licensing matters. In addition; travel, salary per diem, Board and Committee meeting materials, training, and required personnel/member forms.
- Enforcement Program Manager, Cristy Livramento at Cristy.Livramento@dca.ca.gov regarding enforcement matters.
- Legal Counsel, Yuping Lin at Yuping.Lin@dca.ca.gov regarding disciplinary procedural questions or ethical questions.

Strategic Planning

The Board will conduct periodic strategic planning sessions. Dates for these sessions will be announced well in advance.

Board Member Addresses (The DCA Policy)

Board Member addresses and telephone numbers are confidential and must not be released to the public without expressed authority by the individual Board Member.

A roster of Board Members is maintained for public distribution and is placed on the Board's website, using the Board's physical address and telephone number.

Business Cards

Business cards will be provided for each Board Member with the Board's physical address, telephone and fax number, and website address.

OTHER POLICIES AND PROCEDURES

Public Records Act and Complaint Disclosure

The California Public Records Act (PRA), **Government Code Section 7920.000** et seq., requires public records to be available upon request. The PRA provides specific timelines and general process to respond to a request for public records. Further, the PRA specifies which records are not subject to public disclosure. As a state regulatory board within the DCA, the Board is subject to the requirements for all PRA requests. The Board's response is coordinated with the Board's legal counsel.

Business and Professions Code Section 27 specifies what information, such as enforcement actions and a licensee's address of record, must be available through the Internet (i.e., Board website). Providing this information allows consumers to verify their osteopathic doctor's licensure status as well as determine if there is any disciplinary action.

Immunity from Liability

There are many provisions in state law relating to the liability of public agencies and employees. **Government Code Section 818.4 states**, "A public entity is not liable for an injury caused by the issuance, denial, suspension or revocation of, or by the failure or refusal to issue, deny, suspend or revoke, any permit, license, certificate, approval, order, or similar authorization where the public entity or an employee of the public entity is authorized by enactment to determine whether or not such authorization must be issued, denied, suspended or revoked."

Government Code Section 821.2 states, "A public employee is not liable for an injury caused by their issuance, denial, suspension or revocation of, or by their failure or refusal to issue, deny, suspend or revoke, any permit, license, certificate, approval, order, or similar authorization where they are authorized by enactment to determine whether or not such authorization must be issued, denied, suspended or revoked."

Many other complex provisions relate to defense, payment of a judgment or settlement, and indemnification. Specific questions must be discussed with the Board's legal counsel.

Resignation of Board Members (*Government Code Section 1750*)

If it becomes necessary for a Board Member to resign, a letter must be sent to the appropriate appointing authority (Governor, Senate Rules Committee, or Speaker of the Assembly) with the effective date of the resignation. Written notification is required by state law. A copy of this letter must also be sent to the Director of the DCA, the Board President, and the Executive Director.

The departing Board Member is also required to complete and submit specific paperwork immediately following the effective date of the resignation. The departing Board Member is encouraged to contact the Board's liaison for further information.

Removal of Board Members (*Business and Professions Code Section 106*)

The Governor has the power to remove from office, at any time, any member of any Board appointed by them for continued neglect of duties required by law, or for incompetence, or unprofessional or dishonorable conduct.

Rules for Contact with the Public, a Licensee, an Applicant, or the Media

Occasionally, in the role as Board Member, a member may be contacted by a licensee, colleague, applicant, member of the public, or the media regarding an issue or concern that pertains to Board business or proceedings. Any one of these contacts may compromise the members' position relating to future decisions about policy, disciplinary actions, or other Board business.

To avoid compromising the role as a Board Member, the member must refrain from assisting the individual with their issue. Instead, the member must offer to refer the matter to the Executive Director or give the individual the contact information for the Executive Director. The Board member must refrain from engaging in discussion with the individual and make every effort to end the conversation quickly and politely. The Board member must report to all such contacts to the Executive Director as soon as possible.

Conflict of Interest (*Government Code Section 87100*)

A Board Member may not make, participate in making, or in any way attempt to use their official position to influence a governmental decision in which they know or have reason to know they have financial interest. Any Board Member, who has a financial interest that may be affected by a governmental decision, must disqualify themselves from making or attempting to use their official position to influence the decision. Any Board Member who feels they are entering a situation where there is potential for a conflict of interest must immediately consult the Executive Director or the Board's legal counsel.

Service of Lawsuits

Board Members may receive service of a lawsuit against themselves and the Board pertaining to a specific issue (e.g., a disciplinary matter, a complaint, a legislative matter, etc.). To prevent confrontation, the Board Member must accept service. Upon receipt, the Board Member must notify the Executive Director of the service and indicate the name of the matter that was served, date and time of service, and any other pertinent information. The Board Member must mail and email the entire packet to the Executive Director as soon as possible. The Board's legal counsel will provide instructions to the Board Members on what is required of them once service has been made.

Ex Parte Communications (*Government Code Section 11430.10 et seq.)*

The Government Code contains provisions prohibiting ex parte *communications.* An "ex parte" communication is a communication to the decision-maker made by one party to an enforcement action without participation by the other party.

While there are specified exceptions to the general prohibition, the key provision is found in subdivision (a) of Section 11430.10 which states:

"While the proceeding is pending, there must be no communication, direct or indirect, regarding any issue in the proceeding, to the presiding officer from an employee or representative of an agency that is a party or from an interested person outside the agency, without notice and opportunity for all parties to participate in the communication."

An applicant who is formally being denied licensure, or a licensee/registrant against whom a disciplinary action is being taken, may attempt to directly contact Board Members.

If the communication is written, the member must read only enough to determine the nature of the communication. Once they realize it is from a person against whom an action is pending, the Board Member must reseal the documents and send them to the Executive Director or forward the email.

If the Board Member receives a telephone call from an applicant or licensee/registrant against whom an action is pending, the Board Member must immediately tell the person they cannot speak to the person about the matter. If the person insists on discussing the case, the person must be told that the Board Member will be required to recuse himself or herself from any participation in the matter. Therefore, continued discussion is of no benefit to the licensee/registrant or applicant.

If the Board Member believes they may have received unlawful ex parte communication the Board Member must contact the Board's legal counsel and/or the Executive Director.

BOARD MEMBER REQUIRED TRAINING

Board Members are required to complete specific forms and training at various intervals during their appointment period. To ensure compliance and notification to the requisite agencies, all training certificates and required forms must be sent to the Board's liaison.

The Board's liaison will forward the required documentation to the appropriate agency and maintain a copy in the Board Member's personnel file. It is important that the Board maintain a copy of all required training and documents. This ensures that the Board has an accurate record that the members have satisfied all requirements and are able to provide copies upon request.

Statement of Economic Interest

This form is commonly referred to as Form 700 and is to be completed upon assuming the position, annually, and upon leaving. Under the DCA's Conflict of Interest Code, designated officials are required to complete a Statement of Economic Interests Form 700. Annually, the DCA will send several reminders to complete this form with a link to the electronic filing system.

Failure to complete this form in a timely manner may result in a fine from the Fair Political Practice Commission. All fines are publicly noticed.

https://www.fppc.ca.gov/form-700/efiling-form-700/

Ethics Orientation For State Officials (*Government Code Sections 11146-11146.4*)

California law requires all appointees to take an ethics orientation within the first six months of their appointment and to repeat the ethics orientation every two years throughout their term.

The training includes important information on activities or actions that are inappropriate or illegal. For example, public officials cannot take part in decisions that directly affect their own economic interests. They are prohibited from misusing public funds, accepting free travel and accepting honoraria. There are limits on gifts.

An online, interactive version of the training is available on the Attorney General's website at **https://oag.ca.gov/ethics/course**. An accessible, text-only version of the materials is also available at the Attorney General's website.

Copies of completion certificates must be sent to the Board's liaison to be maintained in the personnel file. Records concerning the attendance of this course must be kept on file for five years.

The DCA Board Member Orientation Training (BPC Section 453)

Business and Professions Code Section 453 requires that every newly appointed member complete a training and orientation program offered by the DCA within one year of assuming office.

The DCA has been advised that this statute also applies to all reappointed Board Members. Therefore, if the member attended the training during their first term and are reappointed, they must attend the training following their reappointment.

The training covers the functions, responsibilities and obligations that come with being a member of the DCA board. To receive credit for the training, Board Members must attend the entire training.

The DCA schedules the Board Member Orientation Training (BMOT) sessions throughout the year. Specific locations are announced several months prior to the orientation. Board Members must register for the training through the Board's liaison.

Sexual Harassment Prevention Training (Government Code Section 12950.1; California Code of Regulations, Title 2, Section 11024)

Section 12950.1 of the Government Code requires an employer having five or more employees to provide at least two hours of classroom or other interactive training and education regarding sexual harassment to all supervisory employees and at least one hour of classroom or other effective interactive training and education regarding sexual harassment to all nonsupervisory employees. The employer must provide sexual harassment training and education to each employee once every two years. New nonsupervisory employees must be provided with training within six months of hire.

California Code of Regulations, Title 2, Section 11024 also specifies requirements of an employer to provide two hours of training mandated by **Government Code Section 12950.1**.

An online, two-hour Sexual Harassment Prevention Tutorial is provided by the DCA. The Board's liaison will provide information and instructions to access the online tutorial.

BOARD MEMBER ROLE – POLICY DECISIONS

Protection of the public is the highest priority for a Board Member. Board Members achieve this mandate by establishing policies that affect the licensing, regulatory, and disciplinary functions. Whenever the protection of the public is inconsistent with other interests sought to be promoted, the protection of the public must be paramount.

Setting Board Policy

There are two types of policy: statutes and regulations. Statutes are created through legislation by the legislature and approved or rejected by the Governor. The legislature is responsible for creating, amending and repealing statutes. The Board's role in protecting public safety includes considering taking positions on proposed legislation that support or oppose expressed policies promoted by specific legislation. For example, the Board may support bills that enhance public protections that may not exist. In addition, the Board may oppose legislation such as a change in scope of practice that the Board believes may endanger public safety.

Regulations set policy by the Board that is authorized by existing statutes or authority provided to the Board by the Osteopathic Act. Regulations are promulgated by the Board. Board staff prepare proposed regulatory language for Board consideration and approval at public board meetings. Board staff draft the remaining documents explaining and justifying the proposed language and shepherd it through the approval process. Regulations are approved or rejected by the Office of Administrative Law.

Legislation

Board staff identify bills each year that may be of interest to the Board to consider either taking a position or simply monitoring as a watch position. The following are the options for taking positions on bills. Formal board approved positions or approval from the executive committee provide staff authority to negotiate bill modifications with the Legislature. Board staff may negotiate "technical modifications" to correct mistakes in the language.

Regulations

The Board is responsible for updating its own regulations. Regulations may need to be updated to reflect new policy, operational changes, or new policies signed into law in statutes each year. Not all newly enacted laws require regulations. The role of regulations related to newly modified or created statutes is to further interpret the statute and provide more detail of how the statute will become operational. For instance, statutes set forth the criteria necessary for licensure, whereas regulations enacted to implement these statutes outline specific documentation procedures. The Board is responsible for verifying credentials to ensure adherence to statutory requirements.

Position/Definition

POSITION	DEFINITION
Support	The Board agrees with the proposal. The Board will send a letter of support to the author and actively participate in the legislative process to get the proposal in law.
Support, if amended	The Board is seeking some changes to the proposal. If the requested changes are made, the Board will move to a support position. If changes are not made, the Board will move to a neutral (silent) position on the proposal.
Oppose	The Board does not agree with the proposal. The Board will send a letter of opposition to the author and actively participate in the legislative process to prevent the bill from becoming law.
Oppose, unless amended	The Board is seeking some changes to the proposal. If the changes are not made, the Board will move to an oppose position. If the changes are made, the Board will move to a neutral (silent) position on the proposal.
Neutral	The Board neither supports nor opposes the proposal. The Board does not participate in the legislative process.

BOARD MEMBER ROLE – DISCIPLINARY PROCESS

Disciplinary Process Overview

Through the enforcement process, each consumer complaint and criminal arrest notification is reviewed to determine if the matter is within the Board's jurisdiction. If the complaint or conviction is determined to be within the Board's jurisdiction, the allegations are investigated to determine if evidence exists to substantiate a violation of the Board's laws and regulations.

All cases in which the evidence substantiates that a violation has occurred are referred to Subject Matter Experts (SMEs). The SME is a licensee of the Board and will review the investigation and evidence to determine if the violation constitutes gross negligence, incompetence, and/or patient harm. For cases in which clear and convincing evidence substantiates a violation of the Board's laws and regulations, appropriate disciplinary action is initiated.

Investigative Outcome Options

The Board has options available at the conclusion of an investigation with merit. In cases in which the violations do not warrant the revocation of a license, the Board can issue an educational letter, a citation and fine, or a pre-Accusation public letter of reprimand. In cases in which the violations are egregious and warrant formal discipline of the license, the Board forwards the matter to the Attorney General's (AG's) office to pursue formal disciplinary action which starts with the filling of an Accusation. Each decision is made in consultation with the Executive Director.

Educational Letters/Citation and Fine/Pre-accusation Public Letters of Reprimand

Educational letters, a citation and fine or a pre-Accusation public letter of reprimand issued to the licensees are not considered formal disciplinary action. However, with the exception of an educational letter, the matters are administrative actions and are subject to public disclosure. A pre-Accusation public letter of reprimand can include cost recovery. The fines set in a citation are set forth in law and range from $100 to a maximum of $2,500 per violation. In specific circumstances (e.g., a violation against a senior citizen or disabled person), a fine up to a maximum of $5,000 may be issued.

All citations and fines issued include an order of abatement in which the cited person must provide information or documentation that the violation has been corrected. The cited person is afforded the opportunity to appeal the issuance of the citation and fine.

The cited person may submit a written request for an administrative hearing or an informal citation conference. All informal citation conferences are conducted by the Executive Director. The citation may be modified, affirmed, or dismissed. If the cited person wishes to contest the affirmed or modified citation, the matter will be referred to an administrative hearing before an Administrative Law Judge (ALJ).

Formal Disciplinary Action

If an investigation and evidence substantiate gross negligence, incompetence, or patient harm, the Enforcement Manager, in consultation with the Executive Director, determine whether the case must be forwarded to the AG's Office for formal disciplinary action.

Filing Formal Charges

Formal charges are almost always filed in cases in which the health and safety of the consumer has been compromised, and in which clear and convincing evidence can be established. The Board's Executive Director determines whether to file formal charges for any violation of the Board's licensing laws. These formal charges are referred to as pleadings. In each pleading, the Executive Director is the complainant. The Deputy Attorney General (DAG) assigned to the matter represents the Board.

Pleadings

There are three types of pleadings. The type of pleading is dependent upon whether the respondent (subject of the case) is licensed with the Board, an applicant for licensure, or is already on probation.

- **Accusation**: A written statement of charges against the holder of a license or privilege, to revoke, suspend or limit the license, specifying the statutes and rules allegedly violated and the acts or omissions comprising the alleged violations.
- **Statement of Issues**: A written statement of the reasons for denial of an application for a license or privilege, specifying the statutes and rules allegedly violated and the acts or omissions comprising the alleged violations.
- **Petition to Revoke Probation:** A written statement to revoke a probationer's license alleging the probationer has violated the terms and conditions of their probation.

In all formal disciplinary actions, the respondent is formally notified of the Board's proposed action, their rights under the law, and a due date to respond to the Board's notification.



ACTIONS PRECEDING AN ADMINISTRATIVE HEARING

Stipulations (Settlements) – Requires Board Member Vote

The licensee/applicant and Board may decide to settle the case at any time during the administrative process. Settlements are negotiated and completed prior to the date of an administrative hearing. Although settlements prior to the scheduled hearing avoid the expense of a hearing; this is not a reason to settle a case. Settlements are considered in cases where the respondent has presented mitigating information/evidence to demonstrate that they may be a good candidate for probation.

The settlement is reduced to a written stipulation and order which sets forth the settlement terms and proposed disciplinary order. The DAG prepares a memo describing the rationale for the proposed settlement. The memo and the written stipulation and order are forwarded to the Board Members for consideration and decision.

If the Board Members reject the proposed settlement, the case will return to the disciplinary process. A new settlement may be submitted to the Board Members later or the case may proceed to an administrative hearing before an ALJ.

Stipulations prior to an administrative hearing also eliminate the six-months to one-year delay that may result from attempting to schedule a mutually agreeable hearing date. The public is often better served because the resolution time is reduced, lengthy appeals are avoided, and the Board and respondent save time and money. Furthermore, a licensee on probation is closely monitored by the Board.

Determining Settlement Terms

Stipulations (settlements) are negotiated by the DAG (in consultation with the Executive Director), the respondent, and the respondent's legal counsel if represented. Stipulation terms are provided to the DAG utilizing the Board's Disciplinary Guidelines and the Uniform Standards for Substance Abusing Licensees. These guidelines provide the parameters for settlement terms for specific violations of law. The Executive Director considers the evidence, the law, witness and subject matter expert testimony, and protection of the public in the decision process.

The following factors are considered when settlement terms are proposed:

- Nature and severity of the act(s), offense(s), or crime(s).
- Actual or potential harm to any consumer or client.
- Prior disciplinary record.
- Number and/or variety of current violations.
- Mitigation evidence.
- Rehabilitation evidence.
- In the case of a criminal conviction, compliance with terms of sentence and/or court-ordered probation.
- Overall criminal record.
- Time elapsed since the act(s) or offense(s) occurred.
- Whether the respondent cooperated with the Board's investigation, other law enforcement or regulatory agencies, and/or the injured parties.
- Recognition by respondent of wrongdoing and demonstration of corrective action to prevent recurrence.

The Board's Disciplinary Guidelines were established to provide consistency in determining settlement terms. Variation from the guidelines may occur when sufficient mitigating information or evidence warrants a deviation in the term(s) and does not compromise consumer protection.

Enforcement staff consider the Disciplinary Guidelines when determining whether to seek revocation, suspension, and/or probation of a license. Board Members use the Disciplinary Guidelines when voting on disciplinary matters and during closed sessions deliberations. The Disciplinary Guidelines are updated when necessary and are distributed to DAGs and ALJs who work on Board cases.

If the parties cannot agree on the proposed settlement terms, the matter will move forward to a hearing held at the Office of Administrative Hearings.

Refer to the Resource Links for the Uniform Standards on Substance Abuse and Disciplinary Guidelines.

Office of Administrative Hearings

The Office of Administrative Hearings (OAH) is a central panel of experienced, highly qualified ALJs who preside as neutral judicial officers at hearings and settlement conferences. The ALJs are fully independent of the agencies whose attorneys appear before them. The ALJs are required to have practiced law for at least five years before being appointed and typically have over ten years of experience.

The administrative hearing process is similar to any other court proceeding. The ALJ presides over the hearing; a DAG represents the Board and presents the case; and the respondent or the respondent's representative/attorney presents its case. Testimony and evidence is presented and there is a transcript of the proceedings.

Upon the conclusion of the administrative hearing, the ALJ will consider all the testimony and evidence and will prepare a Proposed Decision. Once the hearing is finished, the ALJ has 30 days to prepare the Proposed Decision and send it to the Board.

Formal Disciplinary Case Outcomes

The possible outcomes for these cases are denial of the application, revocation, surrender of the license, or probation. If an individual is placed on probation, the individual must comply with the specific terms of the probation during the probation period. Once the individual has successfully completed probation, the license is restored without restrictions. However, discipline will remain part of the individual's record.



Default Decisions

If an Accusation is returned by the post office as unclaimed, then service is not possible because the Board does not know the whereabouts of a respondent. The respondent is considered to be in default. A respondent is also considered to be in default if the respondent fails to file a Notice of Defense upon receipt of the Accusation or Statement of Issues or fails to appear personally or through counsel at the hearing.

Default cases result in revocation of the license or denial of the application. The Board Members have delegated the authority to adopt a Default Decision to the Executive Director. In the event the respondent becomes aware of the decision prior to the effective date, respondent may submit a written request to reconsider the decision. This request is presented to the Board Members to determine if they wish to grant the request.

Probation

Licensees who are placed on probation are monitored by the Board. The average length of probation is five years. Upon successful completion of probation, the license is restored and is unrestricted.

A probationary file is established to monitor an individual's compliance with the probation requirements (e.g., cost recovery payments, remedial education course completion, and quarterly reports). When a probationer violates a term of probation, the Board has the option to revoke probation and impose previously stayed discipline.

Criminal Prosecution

Depending on the nature of a complaint, cases may be referred to local law enforcement entities. All cases in which there is sufficient evidence to file charges against a licensee or person performing unlicensed activity are referred to the appropriate city or district attorney's office. Criminal actions include, but are not limited to, violations of the licensing laws of the Board.

BOARD MEMBER ROLE – DISCIPLINARY CASE REVIEW

Board Review of Stipulations and Proposed Decisions

The Board Members review and vote on each case where the matter is either settled prior to hearing or the ALJ issues a Proposed Decision. In all cases, the Board Member has the option to adopt, reject, or hold for discussion. The decision on each case is based on a majority vote of the Board.

Mail Vote Process

Proposed Decisions (decision from the ALJ) and Proposed Stipulations (negotiated settlements) are sent to the Board via email for their consideration and vote. Mail ballot packet materials are confidential and include the following:

- Memo from enforcement staff listing the cases for review and decision.
- Ballot or instructions to submit the vote electronically using the BreEze portal.
- Legal documents (Proposed Decision or Proposed Stipulation, and Accusation or Statement of Issues).
- Memo from the assigned DAG (Proposed Stipulated Settlement cases only).

Deliberation and decision-making must be done independently and confidentially by each Board Member. The Board Member must only use the information provided to make their determination. Voting members may not communicate with each other and may not contact the DAG, the respondent, anyone representing the respondent, any witnesses, the complainant, the ALJ, or anyone else associated with the case.

Additionally, Board Members must not discuss pending cases with Board staff, except as to questions of procedure or to ask whether additional information is available, and whether the agency may properly consider such information. It is strongly encouraged that these types of questions be directed at the Executive Director or the Board's legal counsel.

If a Board Member has any procedural questions not specific to evidence, or any question specifically related to the cases, the questions must be directed at the Board's legal counsel.

Completed mail ballots are due at the Board office no later than the due date indicated in the mail ballot package. The due dates are established in accordance with the timelines indicated in the Administrative Procedure Act (APA). It may be that a specific member's vote is the deciding vote in the outcome of a case. Therefore, it is critical that Board Members return their votes timely.

Mail ballot materials must be retained until notification by enforcement staff that the cases have been adopted. Once a decision is final, the mail ballot packet materials must be confidentially destroyed.

Mail Ballot Definitions

Each mail ballot will have the following options for each case. Below are the definitions for each option.

- **Adopt/Grant**: A vote to adopt the proposed action means that the members agree with the action as written.
- **Reject/Non-Adopt**: A vote to reject or non-adopt the proposed action means that the members disagree with one or more portions of the proposed action and do not want it adopted as the Board's decision. However, a majority vote to adopt will prevail over a minority vote to not adopt.
- **Hold for Discussion**: A vote to hold for discussion may be made if the member wishes to have some part of the action changed in some way (increase penalty, reduce penalty, etc.). For example, the member may believe an additional or a different term or condition of probation must be added, or that a period of suspension must be longer. At least two votes in this category must be received to stop the process until the Board can consider the case in closed session at the next scheduled Board meeting.

Mail Vote Outcomes

Below are the outcomes for each voting option for either a Stipulation (proposed settlement) or Proposed Decision.

Stipulations–Proposed Settlement

- **Adopt** – If the decision of the Board is to adopt the terms proposed in the Stipulation, the decision becomes effective within 30 days and the respondent is notified.

- **Reject/Non-Adopt** – If the Board decides to reject or non-adopt the stipulation, the respondent is notified, and the matter resumes the process for a formal administrative hearing before an ALJ. Following the hearing, the ALJ will issue a Proposed Decision for the Board Members to consider.
- **Hold for Discussion** – A Board Member may be unable to decide due to concerns or desire further clarification. *(Note: A Board Member may seek procedural clarification from the Board's legal counsel.)* In this situation, the Board Member may choose to hold the case for discussion citing the reasons for this vote. If two or more Board Members vote to hold the case for discussion, the case is discussed in the next available meeting during a closed session. If only one Board Member votes to hold the case for discussion, the case is not held for discussion, and the majority decision of the remaining Board Members prevails.

Proposed Decisions–Decision from the ALJ Following a Formal Hearing

Proposed Decisions (PDs) are subject to a specified timeline pursuant to the APA. The Board has 100 days after receiving the PD to either adopt or not adopt the PD.

- **Adopt** – If the Board Members decide to adopt the Proposed Decision, it becomes effective within 30 days, and the respondent is notified by Board staff.
- **Reject/Non-Adopt** – If the Board Members do not agree with any aspect of the ALJ's Proposed Decision, they may non-adopt the Proposed Decision. In this situation, the respondent is notified. Board staff will order the administrative hearing transcripts and request written arguments from the respondent. Board Members review the transcripts, evidence, and written arguments and meet in a closed session with legal counsel to write their decision. The Board uses the Disciplinary Guidelines and applicable law when making such decisions. The Board's decision is then adopted and issued to the respondent.

Disqualification – May Not Participate in Case Decision

With some limited exception, a Board Member cannot decide a case if that Board Member investigated, prosecuted or advocated in the case or is subject to the authority of someone who investigated, prosecuted or advocated in the case. A Board Member may be disqualified for bias, prejudice or interest in the case. When in doubt Board Members must contact the DCA legal counsel for guidance.

Recusal from Case Decision

If the Board Member knows the respondent and/or is familiar with facts/circumstances regarding the action that lead to the disciplinary matter, such as serving as the SME on the case, the Board Member must consult with legal counsel regarding the Board Member's ability to participate in the case decision.

Ex Parte Communications Definition and Limitations

"Ex Parte" technically means "by or for one party only." In practice, it is a limitation on the types of information and contacts that Board Members may receive or make when considering a case. While a case is pending, there are only limited types of communication with Board Members that are allowed if all parties are not aware of the communication and do not have a chance to reply.

For example, a Board Member can accept advice from a Board staff member who has not been an investigator, prosecutor, or advocate in the case; however, that person/staff cannot add to, subtract from, alter or modify the evidence in the record. Or a Board Member can accept information on a settlement proposal or on a procedural matter.

Most other communications may need to be disclosed to all parties, and an opportunity will be provided for the parties to make a record concerning the communication. Disclosure may also apply to communications about a case received by a person who later becomes a Board Member deciding the case. Receipt of some ex parte communications may be grounds to disqualify a Board Member from that case.

GUIDELINES FOR PETITIONER HEARINGS

Petition Hearing Overview

Board meetings consist of requests from probationers to modify the terms of their probation or from licensees seeking to reinstate their license. These individuals submit a request to the Board and include all documentation to support their request. Board staff will review all documentation to determine if the individual is eligible to make the request. If so, the individual will be scheduled to appear at an upcoming Board meeting.

Prior to the Board meeting, Board staff will prepare the petition package, include all relevant documentation, and mail or email the petition package to the Board Members for their review. Members must review the package thoroughly, noting any questions they may have about the documentation.

The petition hearings are conducted during an open session of the Board Meeting with an ALJ presiding. A court reporter is present to document the testimony. Unless otherwise indicated, all testimony, questions, and comments are part of the record.

The hearing format begins with the ALJ announcing the petitioner's name and case number. The ALJ will explain the hearing process to the petitioner and ascertain if the petitioner has any questions. Once the ALJ is satisfied that the petitioner understands the process, the ALJ begins the hearing.

First, the DAG appears on behalf of the Board and introduces the case. The DAG provides the history of the conduct that resulted in probation or license revocation and introduces the relevant evidence. The DAG will question the petitioner regarding their request, supporting documentation, and rehabilitation efforts. The DAG's questions may occur either before or after the Board Members question the petitioner.

Next, the petitioner is provided with an opportunity to testify in support of their request. The petitioner may or may not be represented by an attorney. The petitioner often reads a prepared statement or speaks freely. The petitioner may, or may not, call witnesses to provide testimony in support of the petitioner's request.

Following the petitioner's testimony, each Board Member is provided with the opportunity to question the petitioner.

Questions For Petitioners

In the members role to protect the public, it is critical to determine the following.

- Will the public be protected without the current restrictions? Will the petitioner deliver services safely to the public?

A decision must be based on the evidence before the members; the petitioner's supporting documentation, petitioner's testimony, witness testimony, and rehabilitation. All questions to the petitioner must be related to documentation in the petitioner's packet and testimony provided by the petitioner.

Board Members may inquire about the following topics:

- Inconsistencies in the documentation.
- Inconsistencies or clarification related to the petitioner's testimony.
- Incidents of non-compliance with probation.
- Efforts related to rehabilitation and support systems.
- Petitioners' efforts to practice self-care and good physical and mental health.
- Petitioner's personal growth while on probation.
- What assurance does the petitioner offer that the incident will not recur.

These types of questions are appropriate and often, the responses aid in determining the petitioner's ability to safely practice.

Board Members must exercise caution to avoid inquiries that are not appropriate, such as:

- Questions that attempt to relitigate the matter that led to the probation or revocation.
- Questions that may compel the petitioner to disclose a medical condition or physical disability.
- Questions that may compel the petitioner to disclose a protected group category (e.g., age, race, religion, sexual orientation).

Deliberations

Following the public evidentiary portion of the hearing, the Board may deliberate in closed session as authorized by law, with the ALJ and legal counsel participating as appropriate.

RESOURCES

Osteopathic Medical Board of California Website
https://www.ombc.ca.gov

The DCA Board Member Resource Center
http://www.dcaboardmembers.ca.gov

California Administrative Procedure Act
The California Administrative Procedure Act is found in the California Government Code starting at Section 11370 and continuing through Section 11529 and title 1 of the California Code of Regulations starting at Section 1000 through Section 1050.
http://leginfo.legislature.ca.gov/faces/codes.xhtml
https://govt.westlaw.com/calregs

Bagley-Keene Open Meeting Act
https://leginfo.legislature.ca.gov/faces/codes_displayText.xhtml?lawCode=GOV&division=3.&title=2.&part=1.&chapter=1.&article=9

California Legislative Information (may search for bills and subscribe to bill updates)
http://leginfo.legislature.ca.gov/faces/home.xhtml

Osteopathic Medical Board of California Disciplinary Guidelines and Uniform Standards
https://www.ombc.ca.gov/forms_pubs/disp_guideline.pdf

The DCA Travel Guide
https://inside.dca.ca.gov/documents/travel_guide.pdf

Professional Associations

Federation of State Medical Board
Federation of State Medical Boards

Osteopathic Physicians and Surgeons of California (OPSC)
Osteopathic Physicians and Surgeons of California

American College of Osteopathic Family Physicians of California
American College of Osteopathic Family Physicians of California

American Osteopathic Association (AOA)
American Osteopathic Association

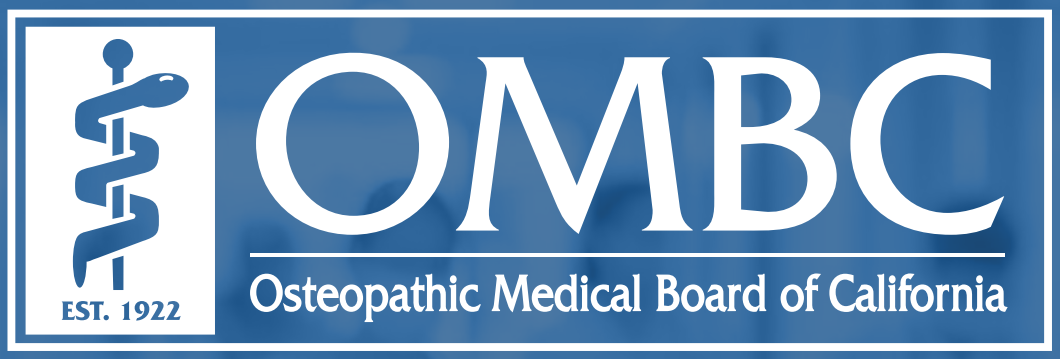
California Medical Association
California Medical Association Home

Osteopathic Medical Board of California Administrative Manual Disclaimer

This Administrative Manual is intended solely as a general reference resource. It does not supersede, replace, or modify any applicable statutes, regulations, executive orders, Department policies, or formal legal advice. In the event of any inconsistency or conflict, controlling law and authoritative legal guidance must prevail.



NOTES



Osteopathic Medical Board of California

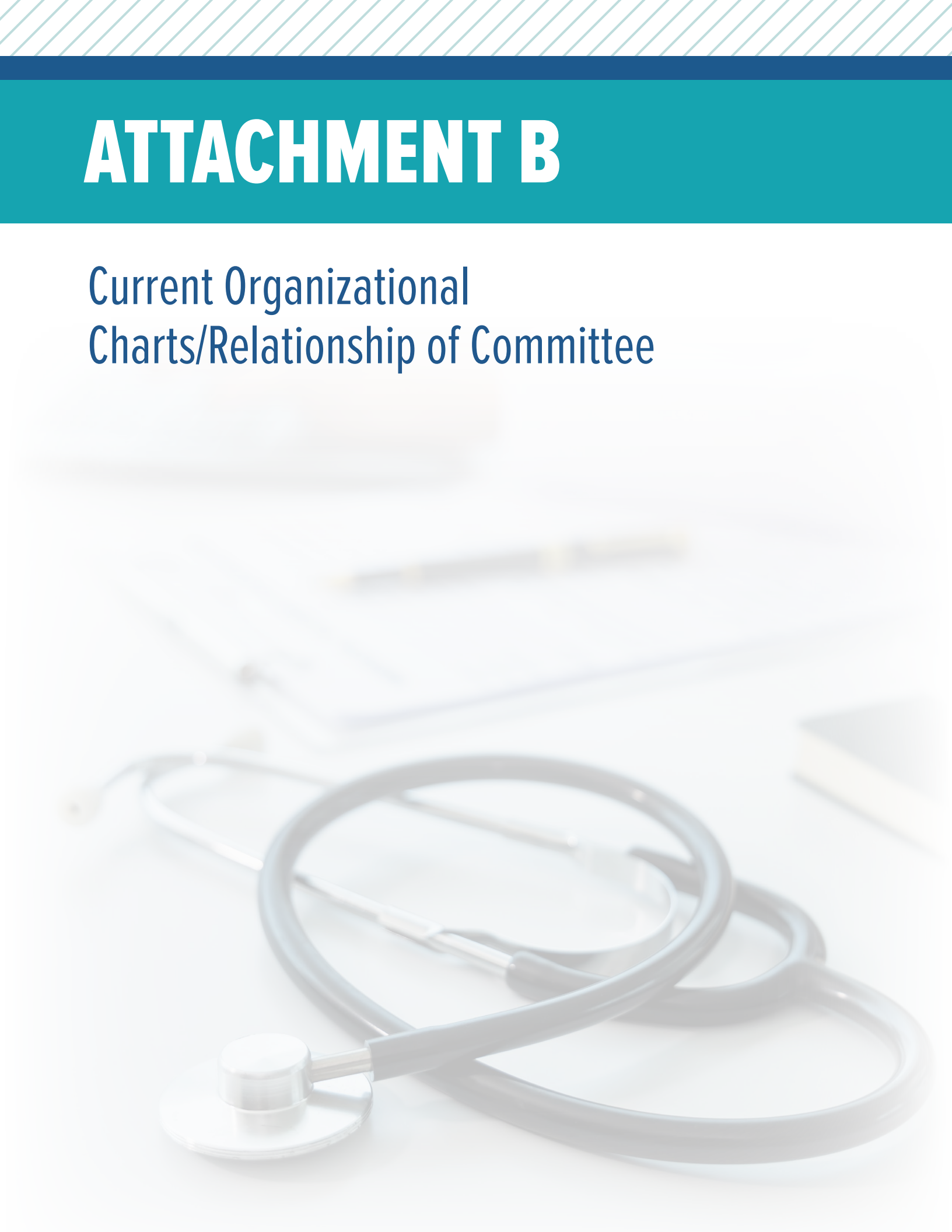
1300 National Drive, Suite 150,

Sacramento CA 95834-1991

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ATTACHMENT B

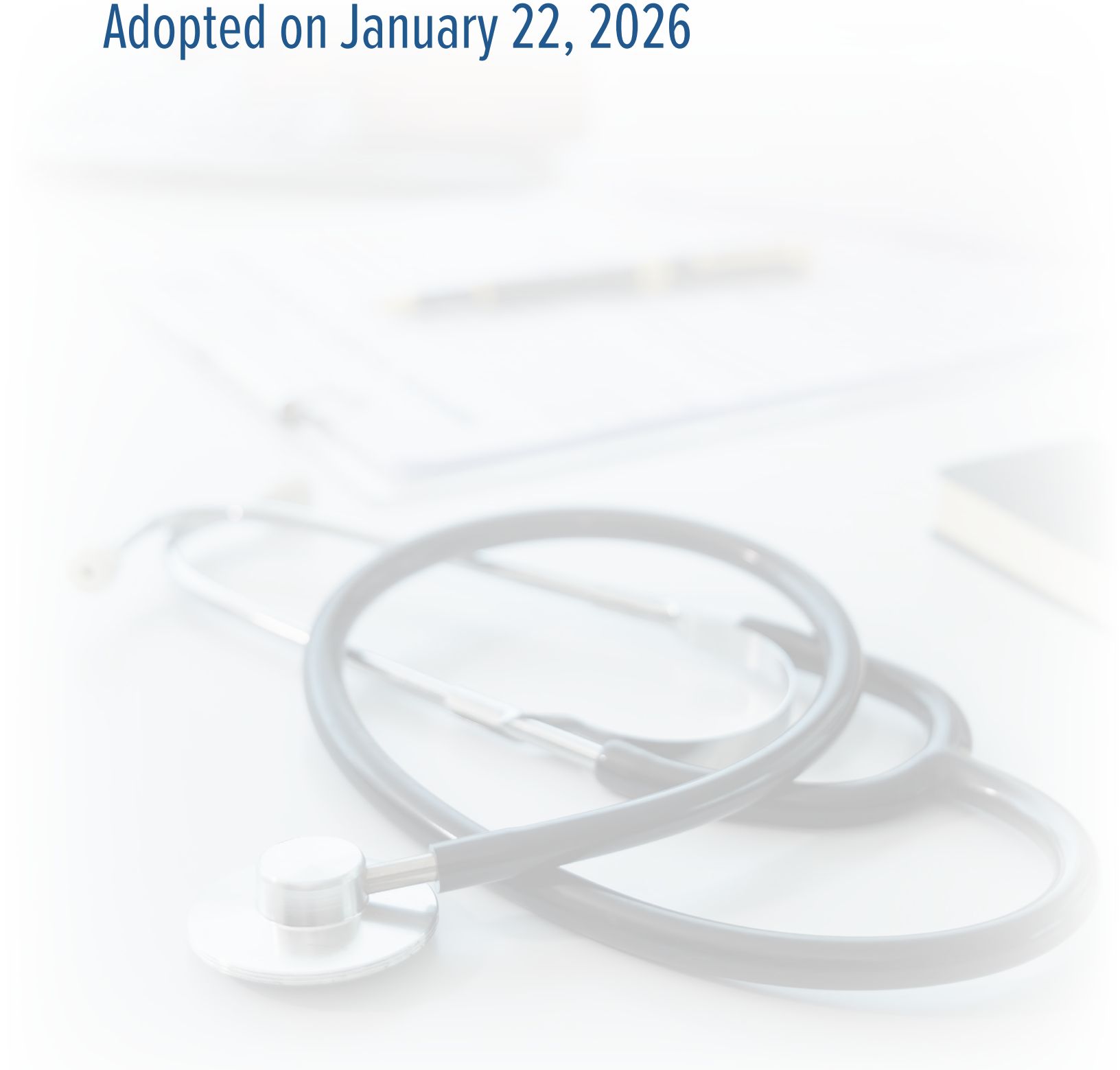
Current Organizational Charts/Relationship of Committee



Committee	Members
Executive Committee	President, Denise Pines, MBA Vice President, Hamesh Patel, D.O.
Legislative Committee	President, Denise Pines, MBA Vice President, Hamesh Patel, D.O.
Licensing Committee	Secretary-Treasurer, Gor Adamyan Matthew Swain, D.O.
Enforcement Committee	John Cummins, J.D. Brett Lockman, D.O.
Education/Outreach Committee	Negeen Mirreghabie, Esq. Shannon Walsh, D.O.
AI Committee	Faisal Qazi, D.O. John Cummins, J.D.
Diversion Committee	George Bifano, D.O. Paul Steier, D.O. Wadsworth Murad, D.O. Matthew Goldenberg, D.O.

ATTACHMENT C

Board's Amended Strategic Plan 2024-2028
Adopted on January 22, 2026





2024–2028 STRATEGIC PLAN

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA



Prepared by: **SOLID Planning Solutions**

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Board Members

Denise Pines, MBA, President, Public Member

Hemesh Patel, D.O., Vice President, Licensed Member

Gor Adamyan, Secretary, Public Member

John M. Cummins, JD, Public Member

Brett Lockman, D.O., Licensed Member

Nageen Mirreghabie, Esq., Public Member

Matthew Swain, D.O., Licensed Member

Gavin Newsom, Governor

Tomiquia Moss, Secretary
Business, Consumer Services and Housing Agency

Christine Lally, Acting Director
Department of Consumer Affairs

Erika Calderon, Executive Director
Osteopathic Medical Board of California

Osteopathic Medical Board of California

About the Board

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

In 2002, the Board volunteered to be included under the umbrella of the California Department of Consumer Affairs (DCA). The affiliation with DCA and access to its resources has strengthened OMBC. To publish the Board's longevity in 2023, the Board added its establishment year to its logo.

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

OMBC is a fully functioning regulatory board within DCA with the responsibility and sole authority to issue licenses to Doctors of Osteopathy (D.O.s) to practice osteopathic medicine as a physician and surgeon or training licenses for residents and fellows in California. OMBC is also responsible for ensuring the enforcement of legal and professional standards to protect California consumers from incompetent, negligent, or unprofessional D.O.s.

D.O.s are fully licensed to prescribe medication and practice in all medical and all surgical specialty areas, just as their M.D. counterparts. D.O.s are trained to consider the health of the whole person and use their hands in an integrated approach to help diagnose and treat their patient.

Message from the President

On behalf of the Osteopathic Medical Board of California (OMBC), it is my sincere pleasure to present the OMBC's amended 2024–2028 Strategic Plan. I want to thank the California Department of Consumer Affairs' SOLID unit for their leadership in the process, all Board members, the executive director, Board managers, Board staff, and the public for putting together this plan.

The primary function of the Board remains consumer protection. The mission of the Board is to protect the public by requiring competency, accountability, and integrity in the safe practice of medicine by osteopathic physicians and surgeons.

The Board's mission is a commitment to California consumers about the practice of osteopathic medicine. The Board stands by our oath to protect the public from hurt or harm through the practice of medicine. It is our duty to uphold principles to ensure that we honor the mission statement. Those principles make sure that there is proper evaluation of applicants when it comes to licensure, enforcing and administering investigations, disciplinary actions when appropriate, and providing consumer outreach by sharing information with all regarding the practice of medicine. Our dedication to protecting consumers from unsafe practices is highly regarded and each Board member takes that responsibility seriously.

Our physicians and surgeons shall give the highest quality of care for all, striving for excellence in public protection.

The Board continually strives to attain meaningful improvement to service our physicians, protect the public, and maintain the highest standards in health care.

The success of this strategic plan depends on an ever-evolving relationship with all the stakeholders in California. The Board is committed to improve its licensure, enforcement, outreach and communication,

Denise Pines, MBA
President, Osteopathic Medical Board of California

MISSION

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

VISION

Our physicians and surgeons give the highest quality of care for all, striving for excellence in public protection.

VALUES

Accountability
Consumer Protection
Collaboration
Competency
Diversity, Equity, Inclusion and Accessibility
Effective Leadership
Innovation

Goal 1: Board Administration

Build an excellent organization through proper Board governance, effective leadership, technology, and responsible management.

1.1 Establish a process for conducting an annual evaluation of the Board's strategic plan and achieved objectives to maintain accountability and effectiveness.

1.2 Establish licensing, education, and outreach advisory committees to support the advancement of the Board's efforts.

1.3 Conduct licensee salary, fee, and growth analyses to inform a regulatory proposal to increase application fees, address licensee population growth, and staffing needs.

1.4 Explore methods to utilize automated emails and maximize BREEZE functionality to increase consistency, timeliness, and accessibility of communication.

1.5 Register staff for customer service training to improve interactions between staff and licensees.

1.6 Update the Board members with a monthly newsletter on office projects.

Goal 2: Regulation and Legislation

Monitors and upholds the law and participates in the regulatory and legislative process.

2.1 Create a dedicated legislation and regulation staff position to effectively track legislation that affects the Board, ensure the Board has a voice in the legislation process, and align regulations with statutory requirements necessary for the Board to carry out its mission.

2.2 Establish an OMBC Legislative Day for board representatives to meet with legislators, highlight the distinct philosophy and contributions of the osteopathic medical profession, and ensure public safety through the Board's active voice in legislation.

2.3 Conduct a comprehensive review of the Board's regulations and ensure they are up to date and communicated, and establish a process for the regular review of legislation impacting the Board on a state and federal level.

Goal 3: Enforcement

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

3.1 Publish disciplinary actions in the Board newsletter to keep the public informed of enforcement actions.

3.2 Create brochures, as well as complaint status letters and newsletter articles, to increase transparency and understanding of the complaint process.

3.3 Fully implement Senate Bill 815, including obtaining additional resources.

3.4 Recruit an additional investigator to improve communication, and allow for more effective enforcement.

3.5 Acquire specialty subject matter experts for the expert review program to improve efficiency and create a robust team of expert reviewers.



Goal 4: Licensure

Requires that only qualified individuals are licensed as osteopathic doctors.

4.1 Communicate online application options to applicants and students to reduce processing times.

4.2 Seek regulatory changes to establish a continuing education self-certification and follow-up audit to decrease license renewal processing times.

4.3 Conduct an annual assessment of staff workload and performance metrics to ensure proper staffing and workload management.

4.4 Pursue legislation that will require licensees to provide an email address to the Board to improve communication and renewal updates.



Goal 5: Outreach and Communication

Consumers and licensees are making informed decisions regarding the safe practice of osteopathic medical services.

5.1 Regularly manage the Board's social media accounts to keep the public informed of Board activities and increase public awareness.

5.2 Attend more school events and promote best practices to increase outreach to students and aid in the accurate completion of applications.

5.3 Create an awareness campaign and partner with other healing arts boards to increase consumer knowledge of osteopathic doctors.

5.4 Partner with other healing arts boards within DCA on common issues facing the healing art professions to encourage collaboration and promote visibility.

5.5 Create a dedicated outreach position to improve outreach to the public.

5.6 Update the Board's logo to include the establishment year to publicize its longevity.



Strategic Planning Process

To understand the environment in which the Board operates as well as identify factors that could impact the Board's success in carrying out its regulatory duties, the DCA's SOLID Planning Unit conducted an environmental scan of the Board's internal and external environments by collecting information through the following methods:

- Interviews with the executive director and Board management in June and July 2023.
- Interviews conducted with Board members in June and July 2023.
- Online surveys were distributed to staff and external stakeholders in June and July 2023.

The most significant themes and trends identified from the environmental scan were discussed by Board members and the executive director, licensing manager, and administrative manager during a strategic planning session facilitated by SOLID on September 28, 2023. This information guided the Board in the development of its strategic objectives outlined in this strategic plan.

OMBC

Osteopathic Medical Board of California

EST. 1922

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

Phone: (916) 928-8390
Hearing-Impaired Persons: 711, or (800) 735-2929 (TTY)
California Relay Service: (800) 735-2922 (Voice)

www.ombc.ca.gov

CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

This strategic plan is based on stakeholder information and discussions facilitated by SOLID for the Osteopathic Medical Board of California on September 28th, 2023. The Board's 2024-2028 Strategic Plan was adopted on January 18, 2024. Subsequent amendments were made and adopted on January 23, 2026.

Prepared by:
SOLID Planning Solutions
1747 N. Market Blvd., Ste. 270
Sacramento, CA 95834

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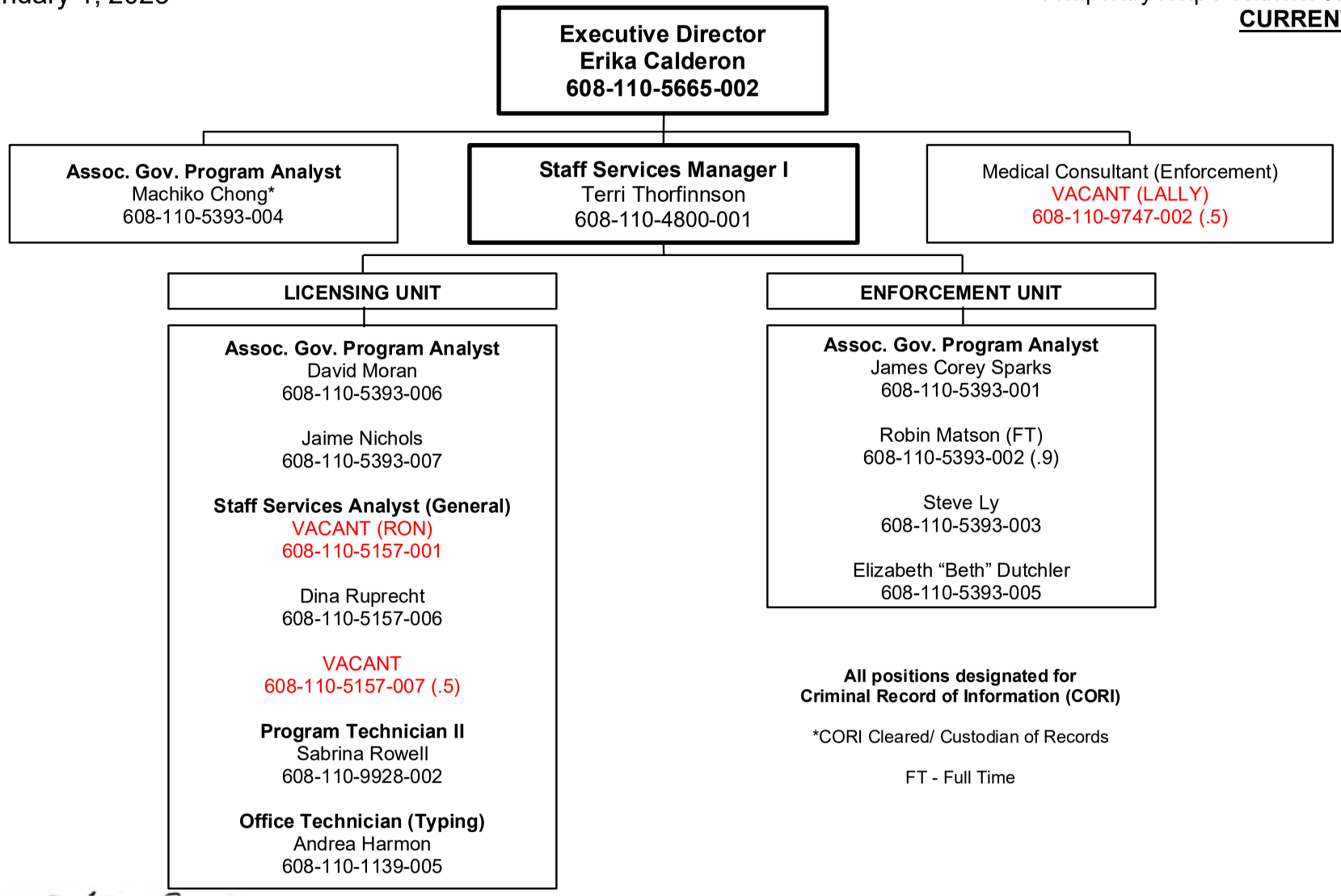
ATTACHMENT D

Year-End Orbitational Charts



Department of Consumer Affairs
Osteopathic Medical Board of California
January 1, 2023

FY 2022-2023
Authorized Positions: 13.9
Temporary Help Positions: 0.1
CURRENT



All positions designated for Criminal Record of Information (CORI)

*CORI Cleared/ Custodian of Records

FT - Full Time

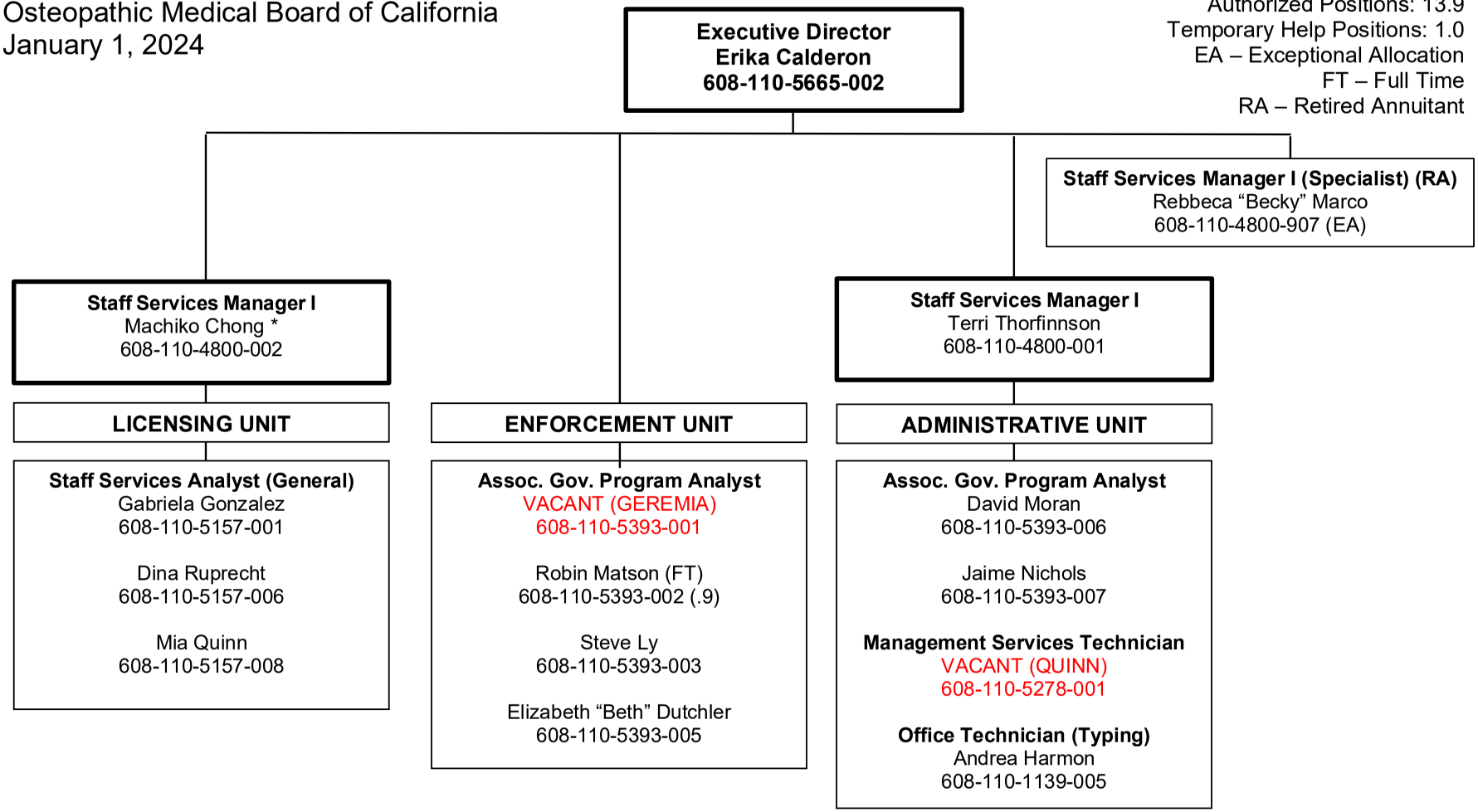
11/28/2022

Erika Calderon, Executive Director — Date

Classification & Recruitment Analyst — Date

Department of Consumer Affairs
Osteopathic Medical Board of California
January 1, 2024

FY 2023-2024
Authorized Positions: 13.9
Temporary Help Positions: 1.0
EA – Exceptional Allocation
FT – Full Time
RA – Retired Annuitant



All positions designated for Criminal Record of Information (CORI)

*CORI Cleared/ Custodian of Records

FT- Full Time

Erika Calderon
Erika Calderon, Executive Director

11/29/23
Date

Classification & Recruitment Analyst

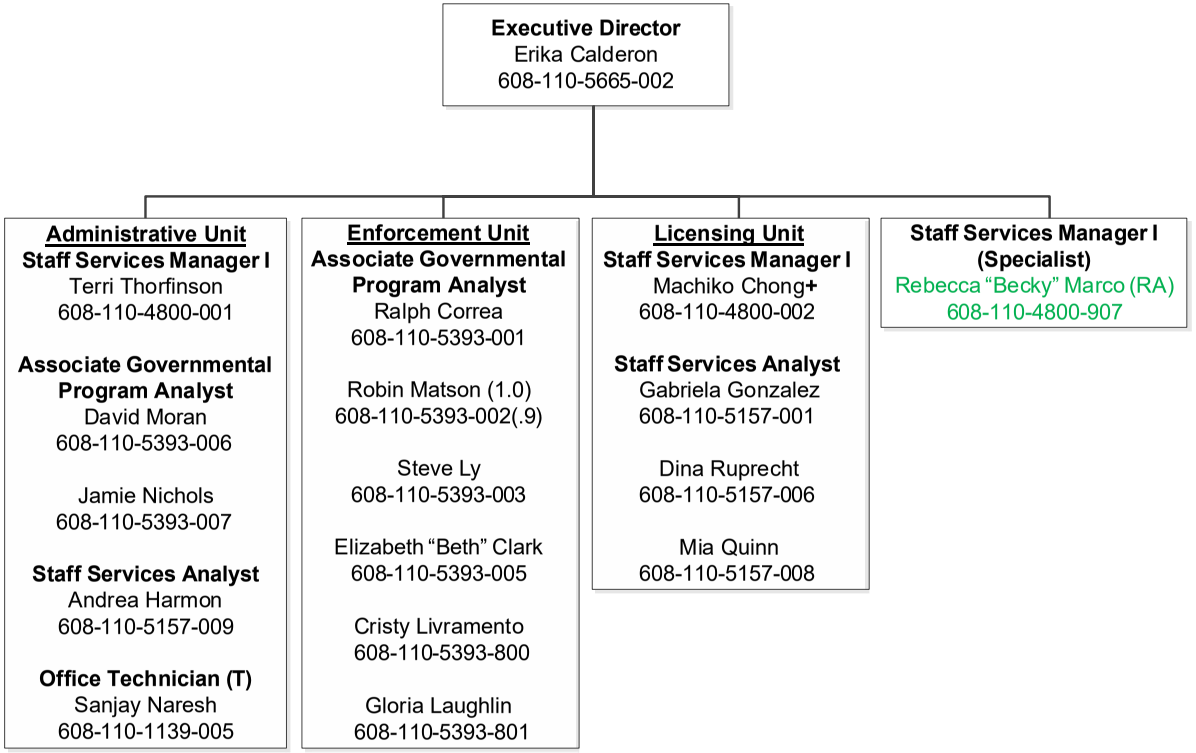
Date

Department of Consumer Affairs (DCA)
Osteopathic Medical Board of California (OMBC)
January 1, 2025

LEGEND
Red: Vacant
Green: Blanket
RA: Retired Annuitant
+: CORI Designated

CURRENT
OMBC STAFFING
FY 2024/2025

Authorized Positions: 15.9
Blanket Positions: 1.0
TOTAL: 16.9



Machiko Chong — 11/25/2024
Executive Director or Designee — Date

Classification & Recruitment Analyst — Date

Department of Consumer Affairs
Osteopathic Medical Board of California
January 1, 2026

LEGEND
Red: Vacant
Green: Blanket
RA: Retired Annuitant
EA: Exceptional Allocation
All positions are CORI Designated

CURRENT
OMBC STAFFING
FY 2025/2026

Authorized Positions: 15.9
Blanket Positions: 1.0
TOTAL: 16.9

Executive Director
Erika Calderon
608-110-5665-002

Licensing Unit
Staff Services Manager I
Machiko Chong
608-110-4800-002

Associate Governmental Program Analyst
David Moran
608-110-5393-006

Jamie Nichols
608-110-5393-007

Staff Services Analyst
Gabriela Gonzalez
608-110-5157-001

Dina Ruprecht
608-110-5157-006

Mia Quinn
608-110-5157-008

Office Technician (T)
Sanjay Naresh
608-110-1139-005

Enforcement Unit
Staff Services Manager I
Cristy Livramento
608-110-4800-003

Associate Governmental Program Analyst
Rachel Molina (1.0)
608-110-5393-002(.9)

Steve Ly
608-110-5393-003

Elizabeth "Beth" Clark
608-110-5393-005

Gloria Laughlin
608-110-5393-801

Staff Services Analyst
Andrea Harmon
608-110-5157-009

Investigations
Special Investigator
Yvonne Natad (LT)
608-110-8612-907

Probation
Associate Governmental Program Analyst
Ralph Correa
608-110-5393-001

Legislation/Regulations
Staff Services Manager I (Specialist)
Terri Thorfinnson (EA)
608-110-4800-001

Erika Calderon — 07/01/2026

Executive Director or Designee — Date

Classification & Recruitment Analyst — Date

OMBC
Osteopathic Medical Board of California
EST. 1922

OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA
SUNSET REVIEW REPORT 2027

PRESENTED TO THE ASSEMBLY COMMITTEE ON BUSINESS AND PROFESSIONS AND
SENATE COMMITTEE ON BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT



GAVIN NEWSOM
GOVERNOR

ROHIT CHOPRA
AGENCY SECRETARY,
BUSINESS AND CONSUMER SERVICES AGENCY

CHRISTINE LALLY
ACTING DIRECTOR,
CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS

ERIKA CALDERON
EXECUTIVE DIRECTOR

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