BACKGROUND PAPER FOR
The Osteopathic Medical Board of California

Joint Sunset Review Oversight Hearing, April 9, 2021
Senate Committee on Business, Professions, and Economic Development and Assembly Committee on Business and Professions

IDENTIFIED ISSUES, BACKGROUND AND RECOMMENDATIONS REGARDING THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

BRIEF OVERVIEW OF THE OSTEOPATHIC MEDICAL BOARD OF CALIFORNIA

History and Function of the Osteopathic Medical Board of California

The Osteopathic Initiative Act (Act) was approved by California voters in 1922, establishing a Board of Osteopathic Examiners tasked with licensing osteopathic physicians and surgeons, who had previously been regulated by the Board of Medical Examiners (the predecessor of today's Medical Board of California [MBC]). In 1962, another initiative was passed providing the Legislature the authority to amend the Act. From 1962 to 1974, there were no new Doctors of Osteopathy (D.O.) licenses issued. A series of lawsuits challenged the abolishment of the D.O. license and portions of the Act, however the court restored the authority for D.O. licenses to be issued. Legislation in 1982 changed the name from the Board of Osteopathic Examiners to the Osteopathic Medical Board of California (OMBC) and added board members. The only restriction on the Legislature's power is that it may not fully repeal the Act unless the number of licensed osteopathic physicians falls below 40. In 2002, OMBC volunteered to be included under the umbrella of the California Department of Consumer Affairs (DCA).

OMBC is charged with the licensing and regulation of D.O.s. OMBC's statutes and regulations set forth the requirements for licensure and provide OMBC the authority to discipline a licensee. D.O.s are authorized to prescribe medication and practice in all medical and all surgical specialty areas similar to Medical Doctors (M.D.s). According to OMBC, 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. A D.O. may use the title "Doctor" or "Dr." but must clearly state that he or she is a D.O. or osteopathic physician and surgeon. OMBC states that a key difference between the two professions is that D.O.s have additional dimension in their training and practice, a component that is not taught in allopathic medical schools. Osteopathic medicine gives particular recognition to the musculoskeletal system (the muscles, bones and joints) which comprise 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. D.O.s use structural diagnosis and manipulative

therapy along with all of the other traditional forms of diagnosis and treatment to care for patients. D.O.s utilize all scientifically accepted methods of diagnosis and treatment, including the use of drugs and surgery.

D.O.s are licensed in all 50 states to perform surgery and prescribe medication. D.O.s practice in fully accredited and licensed hospitals and medical centers. Business and Professions Code (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."

OMBC is authorized to monitor licensees for continued competency by requiring approved continuing education; to take appropriate disciplinary action whenever licensees fail to meet the standard of practice; to determine that osteopathic medical schools and hospitals are in compliance with medical education curriculum and post-graduate training requirements and; to provide rehabilitation opportunities for licensees whose competency may be impaired due to abuse of alcohol or other drugs. The OMBC enforces its specific initiative laws within the Business and Professions (BPC) Code § 3600 and the California Code of Regulations (CCR) Title 16 as well as the Medical Practice Act within BPC Chapter 5. The Act requires the OMBC to ensure that consumer protection is the highest priority in exercising its licensing, regulatory, and disciplinary functions.

At the end of 2020, OMBC reported that there are 10,199 D.O.s holding California active status licenses and 553 D.O.s who maintain inactive licenses.

The current OMBC mission statement, as stated in its 2019-2023 Strategic Plan, is as follows:

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

OMBC is comprised of nine members, five D.O.s and four public members. All five D.O.s and two of the public members are appointed by the Governor, one public member is appointed by the Speaker of the Assembly and one is appointed by the Senate Committee on Rules. No member may serve more than two full consecutive terms, which does not include time a new member may spend filling an unexpired term of a previous member. Each of the five D.O. members of OMBC must have, for at least five years preceding appointment, been a California resident in active practice. Each must be a graduate of an osteopathic medical school and hold an unrevoked license to practice osteopathic medicine in this state. No one residing or practicing outside of the state may be appointed to, or sit as a member of, OMBC. The four public members of OMBC may not be licensees of a healing arts board, including the Medical Practice Act, nor of any initiative act.

The composition of OMBC was impacted in 2009 when the Legislature placed the Naturopathic Medicine Committee (NMC) within OMBC. Membership was increased from seven to nine to, adding two naturopathic physicians to OMBC as public members. However, in response to a specific provision in the Act prohibiting public members from being a licensee of a health board, legislation was subsequently passed (SB 1050, Yee, Chapter 143, Statues of 2010) to establish an independent NMC which functions as a board. OMBC meets about four times per year. OMBC members receive a $100-a-day per diem. All meetings are subject to the Bagley-Keene Open Meetings Act.

The following is a listing of the current OMBC members:

Board Member	Appointment Date	Term Expiration Date	Appointing Authority	Professional or Public
Cyrus Fram Buhari, D.O., President Dr. Buhari began serving on the Board in 2015. Buhari has been a physician at the San Joaquin Cardiology Medical Group since 2013. Buhari was an assistant clinical professor of medicine and physician at the Central California Faculty Medical Group from 2012 to 2013 and a physician at the Veterans Affairs Central California Healthcare System from 2012 to 2013 and at the Community Hospitalist Medical Group from 2008 to 2012. Buhari earned a Doctor of Osteopathic Medicine degree from the Western University of Health Sciences. This position does not require Senate confirmation and the compensation is $100 per diem. Buhari is registered without party preference.	October 28, 2015	June 1, 2023	Governor	Professional
Elizabeth Jensen, D.O. Dr. Jensen began serving on the Board in 2015. Osteopathic Medical Board of California, where she has served since 2015. Jensen-Blumberg has been a hospitalist physician at Verity Medical Foundation, Seton Medical Center since 2018, where she also worked as a physician advisor from 2017 to 2018. She was a physician at Apollo Medical/Bay Area Hospitalist Associates Inc. from 2010 to 2018, a hospitalist at St. Mary's Medical Center from 2008 to 2016 and an internal medicine intern and resident at St. Mary's Medical Center from 2005 to 2008. Jensen-Blumberg is a member of the American Osteopathic Association. She earned a Doctor of Osteopathic Medicine degree from the Touro University College of Osteopathic Medicine.	October 28, 2015	June 1, 2023	Governor	Professional
Andrew Moreno, Secretary-Treasurer Moreno has been managing director at the Moreno Law Group since 2015. He was a project manager at the Economic Vitality Corporation of San Luis Obispo County from 2012 to 2014 and a grants manager at RM Associates from 2005 to 2012. He earned a Master of Arts degree in communication and leadership studies from Gonzaga University and a Master of Arts degree in environmental management and sustainability from Harvard University.	July 14, 2017	June 1, 2021	Governor	Public
Gor Adamyan Mr. Adamyan is the CEO of Avia Factoring, Inc., President of Emmanuel	January 11, 2019	June 1, 2021	Speaker of the Assembly	Public

Hospice, Executive Sales Director of Hollywood Health System Inc., as well as CEO of Avia Automation Solutions. In 2019, Mr. Adamyan was appointed to serve the State Government of California by California State Assembly Speaker, Anthony Rendon.				
Claudia L. Mercado Ms. Mercado is President of Ranchito Azul and co-owner of Aztecali. She is a member and Chapter President of the National Society of Hispanic MBAs, and a member of Hispanas Organized for Political Equality (HOPE).	July 2, 2012	June 1, 2022	Senate Committee on Rules	Public
Hemesh M. Patel, D.O. Patel has been a member of the Human Relations Task Force for the City of Huntington Beach since 2020, an emergency roster physician for disaster relief with Project Hope since 2019, a volunteer crisis text counselor at Crisis Text Line since 2018, an expert reviewer for the Osteopathic Medical Board and a volunteer assistant professor of clinical medicine for the patient centered clerkship program at the University of California, Irvine School of Medicine since 2015, and a family physician and obesity medicine specialist at the Southern California Permanente Group since 2011. He was a yoga instructor at Corepower Yoga from 2013 to 2015 and an urgent care physician at Family Care Center Group and at Woodbury Medical Center from 2010 to 2011. Patel was a resident physician at the University of California, Irvine Medical Center from 2008 to 2011, a lecturer in the department of biological sciences at the University of California, Irvine from 2003 to 2004, and a staff reporter and assistant news editor at the Daily Bruin from 1998 to 2002. He is a member of the Osteopathic Physicians and Surgeons of California, Orange County Medical Association, Orange County Chapter of the California Academy of Family Physicians, California Medical Association, American Academy of Family Physicians, Obesity Society, American College of Osteopathic Family Physicians, and the UCLA Alumni Association-Orange County Chapter. He earned a Doctor of Osteopathic Medicine degree from the Western University of Health Sciences, College of Osteopathic Medicine of the Pacific and a Master of Science degree	January 23, 2020	June 1, 2023	Governor	Professional

from Georgetown University.				
Cheryl Williams Ms. Williams has been community relations coordinator at the San Ysidro Health Center since 2010. She was a constituent service manager in the California State Assembly from 2006 to 2010, assistant campaign field manager for Mary Salas for State Assembly from 2005 to 2006 and community development consultant at the Jacobs Foundation, San Diego from 2001 to 2004. Williams was president and chief executive officer at the San Diego Circuit Board Service from 1981 to 2000 and hearing and placement assistant for the San Diego Unified School District from 1977 to 1981.	February 7, 2014	Term expired January 1, 2021 (may continue to serve in 1 year grace period)	Governor	Public
Vacant			Governor	Professional
Vacant			Governor	Professional

OMBC has two committees. The Diversion Evaluation Committee (DEC) is established in BPC Section 2360 with the purpose of managing a treatment program for D.O.s whose competency may be threatened or diminished due to substance abuse. The DEC is comprised of three licensed DOs who are appointed by OMBC and who have experience in the diagnosis and treatment of substance abuse. The DEC not only has the responsibility to accept, deny or terminate a participant but it also prescribes a treatment and rehabilitation plan for each participant in writing which includes requirements for supervision and monitoring. OMBC's committee for developing prescriber guidelines for cannabis was established to research and recommend additional prescriber guidelines for cannabis beyond what are contained in MBC's prescriber guidelines for cannabis. MBC's guidelines serve as the starting point for OMBC's review and guideline development.

OMBC is a voting member of the Federation of State Medical Boards (FSMB), a national nonprofit organization representing the 70 medical and osteopathic boards in the United States territories.

OMBC reports that it uses its website to provide information regarding OMBC activities and legislative and regulatory changes. Public notice for OMBC meetings and committee meetings is provided at least 10 days prior to a meeting and the website includes agendas and meeting materials dating back to 2009. OMBC highlights its "consumer" tab on the website that allows members of the public to access information about OMBC's complaints process, frequently asked questions, information about licensees and enforcement action. OMBC also notes that it offers a subscriber list for consumers to receive alerts regarding disciplinary actions and a subscriber list that allows licensees and consumers to receive alerts with information about upcoming OMBC meetings, legislative changes, opportunities to comment on regulations and enforcement actions.

OMBC provides information about licensees, including the license number, license type, name of the licensee or registrant (as it appears in OMBC's records), the licensee address of record, the status of a license, the original date a license was issued, the date a license expires, and any disciplinary actions taken. OMBC also collects information from licensees that it makes available when the information is provided, including the licensee's activities in medicine, areas of practice, board certification, number

of post graduate training years, and voluntary information such as ethnic background, foreign language(s) and gender.

OMBC notes that it webcasts meetings and has since September 2013. Archived webcasts are available on OMBC's website.

Fiscal, Fund and Fee Analysis

OMBC is a special fund agency whose activities are funded through regulatory fees and license fees.

The OMBC's current reserve level is projected to be 15.8 months in reserve. A statutory reserve level does not currently exist for the OMBC. OMBC provided a $1.5 million loan to the General Fund in FY 2010/11. The loan and related interest were repaid in FY 2019/20.

The following is the past, current and projected fund condition for OMBC:

Fund Condition						
(Dollars in Thousands)	FY 2016/17	FY 2017/18	FY 2018/19	FY 2019/20	FY 2020/21	FY 2021/22
Beginning Balance	$3,058	$3,136	$3,061	$3,344	$5,024	$4,514
Revenues and Transfers	$2,271	$2,112	$2,575	$4,211	$2,604	$2,624
Total Revenue	$5,329	$5,313	$5,590	$6,017	$7,628	$7,138
Budget Authority	$2,341	$2,476	$2,758	$3,351	$3,275	$3,166
Expenditures	$2,193	$2,174	$2,219	$2,493	$3,275	$3,166
Loans to General Fund	N/A	N/A	N/A	N/A	N/A	N/A
Accrued Interest, Loans to General Fund	N/A	N/A	N/A	N/A	N/A	N/A
Loans Repaid From General Fund	N/A	N/A	N/A	$1,500	N/A	N/A
Fund Balance	$3,136	$3,061	$3,344	$5,024	$4,514	$3,700
Months in Reserve	15.2	15.2	16.1	19.4	15.8	12.6

OMBC's primary source of revenue is D.O. license renewal fees. Licenses are renewed on a biennial basis on the licensee's birth month. The fee for an active license is $400 and for an inactive license is $300. Delinquent Tax and Registration fee is $100 for an active license and $75 for an inactive license.

The OMBC collected $48,168 in 2019-20 for the CURES contribution. The CURES contribution is transferred to the Department of Justice to fund their CURES operations.

OMBC does not anticipate raising fees in the foreseeable future.

Fee Schedule and Revenue							(list revenue dollars in thousands)
Fee	Current Fee Amount	Statutory Limit	FY 2016/17 Revenue	FY 2017/18 Revenue	FY 2018/19 Revenue	FY 2019/20 Revenue	% of Total Revenue
Biennial Active License Delinquency Fee	$100	$100	$12	$10	$10	$11	0.5%
Biennial Inactive License Delinquency Fee	$75	$75	$5	$4	$4	$3	0.2%
Biennial Active License Renewal	$400	$400	$1,648	$1,507	$1,888	$1,643	74.1%
Biennial Inactive License Renewal	$300	$300	$11	$86	$109	$78	3.1%
Fictitious Name Permit Renewal	$50	$50	$33	$33	$34	$34	1.5%
Application Filing Fee	$200	$400	$173	$207	$198	$189	8.5%
Initial Licensing Fee	Varies	Varies	$214	$184	$185	$287	9.6%
Fictitious Name Permit App Fee	$100	$100	$10	$7	$13	$11	0.5%
Duplicate Certificate Fee	$25	$25	$3	$2	$3	$4	0.1%
Endorsement Fee	$25	$25	$15	$21	$21	$20	0.9%
License Status Change	Varies	Varies	$2	$2	$2	$2	0.1%
Document Sales	Varies	Varies	$0	$42	$0	$0	0.5%
Misc. Service to the Public	Varies	Varies	$0	$0	$0	$24	0.3%
Cite & Fine	Varies	Varies	$2	$4	$13	$4	0.3%

OMBC is one of 37 entities within the DCA. Through its divisions, the DCA provides centralized administrative services to all boards, committees, commission and bureaus which are funded through a pro rata calculation that appears to be based on the number of authorized staff positions for an entity rather than actual number of employees. OMBC paid DCA over 490,000 in Pro Rata for FY 2019/20.

Staffing Levels

OMBC is currently authorized in the Governor's 2021/22 budget for a total of 13.4 positions. OMBC states that it may need and additional analyst to perform duties like data tracking, assisting with regulations, tracking legislation, helping with IT projects, and working on cloud solutions. OMBC is currently redirecting resources from mission critical areas to process this workload.

Licensing

OMBC has two license types and one permit type: physician and surgeon license, a postgraduate training license (PTL), and a fictitious permit for clinical office locations. All residents must obtain a PTL in order to practice medicine within a California based residency or fellowship. This new license type also gives the OMBC enforcement jurisdiction over residents during their residency. The PTL is further discussed in Issue # 6.

OMBC's licensing program ensures licenses only issued to applicants who meet legal and regulatory requirements and who are not precluded from licensure based on past incidents or activities. OMBC currently has almost 13,000 total licensees. D.O.s are one of the fastest growing segments of health care professionals and California now has the largest population of practicing D.O.s in the country.

OMBC identifies applicants who indicate they are military service veterans. OMBC received 4 D.O. application for a waivers from the license renewal fees and continuing education requirements for military reservists called to active duty pursuant to BPC Section 114.3 and did not receive any D.O. applications that qualified for the expedited license available to military spouses and domestic partners of a military member who is on active duty in California pursuant to BPC Section 115.5.

OMBC relies on approval of osteopathic colleges by the Commission on Osteopathic College Accreditation (COCA). 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.

D.O. applicants for licensure must graduate from an accredited college of osteopathic medicine, complete 36 months year of postgraduate training, which includes a minimum of four months of medicine and successfully complete all levels of a national exam. The exam is, generated and administered by the National Board of Osteopathic Medical Examiners (NBOME), is known as the NBOME Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA) and serves as the recognized national evaluative instrument for osteopathic students and graduates. The examination consists of three levels: COMLEX Level 1 is a problem-based assessment which integrates the foundational and basic biomedical sciences of anatomy, behavioral science, biochemistry microbiology, osteopathic principles, pathology, pharmacology, physiology and other areas of medical knowledge as they relate to solving clinical problems and in providing osteopathic medical care to patients. COMLEX Level 2 Cognitive Evaluation is a problem-based and symptoms-based assessment, which integrates the clinical disciplines of emergency medicine, family medicine, internal medicine, obstetrics/gynecology, osteopathic principles and neuromusculoskeletal medicine, pediatrics, psychiatry, surgery, and other areas relevant to solving clinical problems in proving osteopathic medical care to patients. COMLEX-USA Level 2-Performance Evaluation is a one-day examination of clinical skills where each candidate encounters 12 standardized patients over the course of a seven-hour examination day. Clinical skills tested include: physician-patient communication, interpersonal skills and professionalism, medical history-taking and physical examination skills, osteopathic principles and osteopathic manipulative treatment, and documentation skills. COMLEX Level 3 is also a problem-based and symptoms-based assessment which integrates the clinical disciplines of emergency medicine, family medicine, internal medicine, obstetrics/gynecology, osteopathic principles and neuromusculoskeletal medicine, pediatrics, psychiatry, surgery, and other areas relevant to solving clinical problems in proving osteopathic medical care to patients. The COMLEX-USA is only offered in English.

OMBC requires documents to be sent directly from osteopathic schools, postgraduate training programs, other state medical boards, COMLEX-USA and others to OMBC as means of gauging proof of attendance, completion, licensure in another state and other evidence that is necessary to consider for licensure. OMBC does not accept foreign graduates for licensure.

All applicants must obtain fingerprint criminal record checks from both the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) prior to the issuance of a D.O. license. OMBC queries the National Practitioner Databank, a confidential information clearinghouse created by

Congress to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S., for certain applicants with issues of concern disclosed on the application or during the application process as well as applicants who disclose that he or she holds a license in another state, territory or province. OMBC also queries all applicants in the FSMB database, which contains a record of disciplinary actions taken by other states and jurisdictions, as well as any inappropriate behavior in another state or jurisdiction during an examination.

OMBC has established performance targets for the D.O. license application process at 75 days from the receipt of the application until the issuance of the license. OMBC asserts that all applications are deficient in some way, typically because documents required from primary sources have not been received at the time an application is received. OMBC advises that it continually evaluates the processing of license applications. OMBC added licensing staff to handle added workload associated with the PTL, but OMBC advises that the workload for this new application has far exceeded prior projected workload estimates.

OMBC notes that the total number of applications OMBC receives has steadily increased since the prior sunset review and average processing times have also increased. OMBC is collaborating with the DCA's Organizational Improvement Office to create efficiencies in the licensing process and anticipates that the efficiencies created in this process will enable the Licensing Unit to meet the performance targets/expectations within its existing resources.

Continuing Medical Education (CME)

SB 798 (Hill, Chapter 775, Statutes of 2017) made significant changes to the OMBC's continuing medical education (CME) requirement. Previously OMBC licensees were required to complete 150 hours of CME over a three-year cycle, with 60 hours obtained in Category 1A or 1B as established by the American Osteopathic Association (AOA). SB 798 changed this requirement to 100 hours of CME over a two-year cycle with 40 hours obtained in Category 1A or 1B as established by the AOA.

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

OMBC verifies compliance of CME at the time of renewal. Applications for renewal must be accompanied by certificates of completion of courses attended. Technology is advancing rapidly, and new products are emerging. The OMBC continues to explore technological options that are reliable, secure, and protect confidential information at an affordable price that will ultimately save workload and create efficiencies for the OMBC.

Since the OMBC verifies compliance of CME at the time of renewal, there is no need for CE audits of licensees. Currently, licensees who do not show documentation of the required continuing medical education hours will not have their license renewed until such time all required hours are completed.

CME is further discussed in Issue #4 below.

Enforcement

The enforcement process begins with a complaint. Complaints are received from the public, generated internally by OMBC or based on information OMBC receives from various entities through mandatory reports to OMBC. Mandatory reports to OMBC include:

BPC 801.01 requires OMBC to receive reports of settlements over $30,000 or arbitration awards or civil judgments of any amount. The report must be filed within 30 days by either the insurer providing professional liability insurance to the licensee, the state or governmental agency that self-insures the licensee, the employer of the licensee if the award is against or paid for by the licensee or the licensee if not covered by professional liability insurance.

BPC 802.1 requires physicians to report indictments charging a felony and/or any convictions of any felony or misdemeanor, including a guilty verdict or plea of no contest.

BPC Section 802.5 requires a coroner who receives information, based on findings reached by a pathologist that indicates that a death may be the result of a physician's gross negligence, to submit a report to OMBC. The coroner must provide relevant information, including the name of the decedent and attending physician as well as the final report and autopsy.

BPC Sections 803, 803.5 and 803.6 require the clerk of a court that renders a judgment that a licensee has committed a crime, or is liable for any death or personal injury resulting in a judgment of any amount caused by the licensee's negligence, error or omission in practice, or his or her rendering of unauthorized professional services, to report that judgment to the board within 10 days after the judgment is entered. In addition, the court clerk is responsible for reporting criminal convictions to OMBC and transmitting any felony preliminary hearing transcripts concerning a licensee to OMBC.

BPC Section 805 is one of the most important reporting requirements that allows the OMBC to learn key information about D.O.s. Section 805 requires the chief of staff and chief executive officer, medical director, or administrator of a licensed health care facility to file a report when a physician's application for staff privileges or membership is denied, or the physician's staff privileges or employment is terminated or revoked for a medical disciplinary cause. The reporting entities are also required to file a report when restrictions are imposed or voluntarily accepted on the physician's staff privileges for a cumulative total of 30 days or more for any 12-month period. The report must be filed within 15 days after the effective date of the action taken by a health facility peer review body.

BPC Section 805.01 is a similarly extremely important requirement. The law requires the chief of staff and chief executive officer, medical director, or administrator of a licensed health care facility to file a report within 15 days after the peer review body makes a final decision or recommendation to take disciplinary action which must be reported pursuant to section 805. This reporting requirement became effective January 2011 and is only required if the recommended action is taken for the following reasons:

- Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public.

- The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in BPC Section 4022, or of alcoholic beverages, to the extend or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.

- 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 effort prior examination of the patient and medical reason therefor.

- Sexual misconduct with one or more patients during a course of treatment or an examination.

The purpose of 805.01 reports is to provide OMBC with early information about these serious charges so that OMBC may investigate and take appropriate action to further consumer protection at the earliest possible moment. Accordingly, for any allegations listed above, the Legislature determined that an 805.01 report must be filed once a formal investigation has been completed, and a final decision or recommendation regarding the disciplinary action to be taken against a physician has been determined by the peer review body, even when the licensee has not yet been afforded a hearing to contest the findings.

BPC Section 805.8 became law upon the passage of SB 425 (Hill, Chapter 849, Statutes of 2020). A health care facility or other entity that makes any arrangement under which a healing arts licensee is allowed to practice or provide care for patients must file a report of any allegation of sexual abuse or sexual misconduct made against a healing arts licensee by a patient, if the patient or the patient's representative makes the allegation in writing, to the agency within 15 days of receiving the written allegation of sexual abuse or sexual misconduct. MBC anticipated new enforcement cases stemming from this requirement and it would be helpful for the Committees to understand what outreach MBC has done to ensure it is made aware of serious allegations this reporting requirement covers.

OMBC reports that it has received more mandatory reports than it previously had during the prior review. OMBC received 151 mandatory reports over the past four-year period, the vast majority of which are from insurers.

- In 2016-17, OMBC received 24 reports pursuant to BPC Sections 801 and 801.1 and 5 reports pursuant to BPC Section 805. There were 29 total reports received, 13 of which came from insurers.

- In 2017-18, OMBC received 24 reports pursuant to BPC Sections 801 and 801.1 and 16 reports pursuant to BPC Section 805. There were 40 total reports, 18 of which came from insurers.

- In 2018-19, OMBC received 31 reports pursuant to BPC Sections 801, 801.1 and 801.2 and11 reports pursuant to BPC Section 805. There were 42 total reports, 25 of which came from insurers.

- In 2019-20, OMBC received 33 reports pursuant to BPC Sections 801 and 801.1and 7 reports pursuant to BPC Section 805. There were 40 total reports, 21 of which were from insurers.

On average, OMBC receives about 500 complaints per fiscal year and reports that it has seen an increase in the number of complaints since the prior review. Complaints regarding quality of care are received and reviewed by OMBC's Complaint Unit (CU) in Sacramento by a medical consultant. The CU medical consultant determines whether the quality of care issues presented in the complaint and

supporting documents warrant investigation. If the medical consultant determines the case merits investigation, it is sent to the Health Quality Investigation Unit (HQIU) in the DCA's Division of Investigation (DOI) which handles investigations for a number of health related boards within DCA. Historically, some OMBC investigations have been referred to the DOI Investigation and Enforcement Unit rather than HQIU due to significant vacancies within HQIU.

OMBC reports that the complaint volume intake has increased an average of 8 percent per fiscal year. The average case volume per quarter was 130 in FY 2017/18, 141 in FY 2018/19, and 152 in FY 2019/20. The 152 average case volume per quarter in FY 2019/20 reflects an 18 percent from the 129 average case volume per quarter in FY 2015/16. OMBC indicates that this significant increase is the primary factor contributing to the OMBC not meeting its target performance expectations. The OMBC states it is in the process of hiring an additional enforcement staff to alleviate the backlog.

The performance target for intake in FY 2017/18 and FY 2018/19 was 30 days from the date a complaint was received to the date the complaint was assigned to an investigator. The majority of the performance targets were met during these quarters. The performance target for intake in FY 2019/20 was adjusted to 10 days from the date a complaint is received to the date the complaint is assigned to an investigator. OMBC reports that it did not meet this target in any of the four quarter and is in the process of hiring an additional enforcement staff to process the workload associated with this backlog. With this additional position, the OMBC anticipates alleviating this backlog within existing resources.

During the course of the investigation an expert reviewer is selected and the assigned investigator is the contact for the expert. The investigator tracks the case sent out for review to ensure it is completed within the standard 30-day time limit. After the investigation is completed, the investigator transmits the case to the Health Quality Enforcement Section of the Attorney General's Office (HQE), at which time, a Deputy Attorney General (DAG) is assigned to the case. The expert's report is included in the transmittal to the Office of the Attorney General (OAG).

For complaints that are subsequently investigated and meet the necessary legal prerequisites, a DAG drafts formal charges, known as an "Accusation". A hearing before an Administrative Law Judge (ALJ) is subsequently scheduled, at which point settlement negotiations take place between the DAG, physician and his or her attorney and OMBC staff. Often times these result in a stipulated settlement, similar to a plea bargain in criminal court, where a licensee admits to have violated charges set forth in the accusation and accepts penalties for those violations. If a licensee contests charges, as most do, the case is heard before an ALJ who subsequently drafts a proposed decision. This decision is reviewed by the entire OMBC Board which either adopts the decision as proposed, adopts the decision with a reduced penalty or adopts the decision with an increased penalty. If probation is ordered, a copy of the final decision is referred for assignment to OMBC's probation monitor who monitors the licensees for compliance with the terms of probation.

OMBC uses its Disciplinary Guidelines and the Uniform Standards for Substance-Abusing Licensees as the framework for determining the appropriate penalty for charges filed against a D.O.

- Investigated and closed 96 (formal) investigations
- Investigated and closed 1,633 (desk) investigations
- Referred 70 cases to OAG for action

- Filed 46 accusations and/or petitions to revoke probation
- Obtained 3 suspension/restriction orders
- Revoked or accepted the surrender of 12 licenses
- Placed 19 licensees on probation
- Issued 4 public reprimands/public letters of reprimand.

PRIOR SUNSET REVIEW: CHANGES AND IMPROVEMENTS

OMBC was last reviewed by the Legislature through sunset review in 2016-2017. During the previous sunset review, 12 issues were raised. In January, OMBC submitted its required sunset report to the Senate Committee on Business, Professions and Economic Development and Assembly Committee on Business and Professions (Committees). In this report, OMBC described actions it has taken since its prior review to address the recommendations made. The following are some of the more important programmatic and operational changes, enhancements and other important policy decisions or regulatory changes made. For those which were not addressed and which may still be of concern to the Committees, they are addressed and more fully discussed under “Current Sunset Review Issues.”

- **OMBC has adapted to a growing licensing population and implementation of a new license type.** During the prior review, OMBC indicated that the licensing population nearly doubled since the 2013-14 review. Since then, OMBC’s D.O. licensing population has increased 31 percent from 9,206 to 12,068. OMBC successfully added 2.0 additional staff positions in fiscal year FY 2019/20 to address growing workload.

- **OMBC’s office can now accommodate its staff.** OMBC’s office was renovated in January 2019, during which time staff was able to relocate and maintain daily operations. Now, OMBC’s team, including new staff, can be in the same office.

- **New E.O. was hired.** Following the retirement of OMBC’s former Executive Officer (E.O.), current E.O. Mark Ito was appointed in January 2019. OMBC also voted a new Board leadership team to reflect the departure of long-term OMBC members.

- **Updated strategic plan.** OMBC developed its 2019-2023 Strategic Plan in 2018; the Plan is consistent with OMBC’s mission to protect the public by requiring competency, accountability, and integrity in the safe practice of medicine by osteopathic physicians and surgeons. The updated Plan was adopted at the January 2020 Board Meeting.

- **Guidelines are being developed.** OMBC appointed a special committee to review MBC Prescriber Guidelines and other guidelines in order to provide recommendations for OMBC consideration to include additional language in its own Prescriber Guidelines. OMBC expects a report and recommendations from this new committee to assist in the development of strong guidelines.

- **OMBC is receiving arrest and conviction information.** BPC Section 144 authorizes specified boards to obtain fingerprints of prospective licensees for the purposes of allowing the OMBC to ascertain if an applicant had been convicted of any crimes prior to licensure. The law allows DOJ and FBI to subsequently notify boards of arrests or convictions of an applicant and subsequent licensee. OMBC is now authorized to receive these records.

- **Enforcement staff has been added.** The Committees were concerned that OMBC needed additional enforcement staff. OMBC now has four enforcement analysts to handle its current enforcement caseload and data workload.

CURRENT SUNSET REVIEW ISSUES

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

BOARD ADMINISTRATION AND BUDGET ISSUES

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

According to a 2019 DCA report to the Legislature, *Internal Review of Regulation Procedures*, "the resulting enhanced scrutiny from Agency and DCA's Legal Affairs Division successfully reduced the number of disapproved regulation packages, with the number of disapprovals falling from nine in 2016 to only one in 2018." The report also found that "while disapproval rates plummeted, a consequence was lengthened timelines to adopt regulations. Several boards and bureaus raised objections to the lengthened review time and reported difficulty obtaining timely updates about regulation packages under review." The "pre-review" process required regulations to go through DCA's entire review process prior to the package being submitted for public comment. DCA established a formal Regulations Unit designed to "minimize the length of time it currently takes to review regulatory packages; allow board and bureau attorneys to focus on the increased workload of non-regulatory work; respond to the demand of regulation packages under review and the increase of regulation packages from Chapter 995, Statutes of 2018 (AB 2138); avoid the habitual carry-over of regulation

packages; and, enhance the level of regulation training provided to boards and bureaus to improve the quality of regulations and create efficiencies by having better quality packages submitted for review."

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

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

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

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

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

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

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

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

Staff Recommendation: **O*MBC 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.***

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

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

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

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

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

OMBC BUDGET ISSUES

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

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

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

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

OMBC LICENSING ISSUES

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

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

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

In its sunset report to the Legislature, OMBC now recommends amending the law to adjust CME requirements for D.O.s in California to 50 hours of CME every two years, with 20 of those hours being American Osteopathic Association (AOA) Category 1 credit. In justifying the request, OMBC states that "California's CME requirements for D.O.s are double than the CME requirement for their M.D. colleagues. The OMBC believes that the current difference between CME requirements for M.D.s under the Medical Board of California and D.O.s under the OMBC does not line up with the parity of skill between the two types of medical degrees."

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

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

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

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

<u>Background:</u> In 2018, Assembly Bill 2138 (Chiu/Low, Chapter 995, Statutes of 2018) was signed into law, making substantial reforms to the license application process for individuals with criminal records. Under AB 2138, an application may only be denied on the basis of prior misconduct if the applicant was formally convicted of a substantially related crime or was subject to formal discipline by a licensing board. Further, prior conviction and discipline histories are ineligible for disqualification of applications after seven years, with the exception of serious and registerable felonies, as well as financial crimes for certain boards. Among other provisions, the bill additionally requires each board to report data on license denials, publish its criteria on determining if a prior offense is substantially related to licensure, and provide denied applicants with information about how to appeal the decision and how to request a copy of their conviction history.

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

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

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

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

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

The PTL is intended to be an unrestricted licenses and specifies that a resident possessing this category of recognition from OMBC may engage in the practice of medicine in connection with their duties as an intern or resident physician, including its affiliated sites, or under those conditions as are approved in writing and maintained in the postgraduate training licensee's file by the director of his or her program. These D.O.s are authorized to diagnose and treat patients; prescribe medications without a cosigner, including prescriptions for controlled substances, if the individual has the appropriate Drug Enforcement Agency registration or permit and is registered with CURES; sign birth certificates without a cosigner; and sign death certificates without a cosigner. While law is clear on PTL authority, some agencies have policies or statutes that only authorize an unrestricted medical license holder to

engage in certain activities, thus have directed residents holding a PTL that they are not fully authorized the same as licensees who have completed their three-year residency.

Concerns have been raised that:

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

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

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

Substance Abuse Treatment (CSAT) of their intent. To verify waiver eligibility, physicians provide their DEA number, state medical license number, and training certificate details.

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

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

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

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

OMBC ENFORCEMENT ISSUES

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

Background: Access to timely, accurate information about OMBC licensees is a fundamental means by which patients and the public are informed about medical services provided to them. OMBC posts information on its website and has improved these efforts. When a licensee is placed on probation, generally they continue to practice and interact with patients, often under restricted conditions. As such, increasing the ability of patients and the public to obtain information about health care professionals they interact with has also been the subject of various Legislative and regulatory actions.

Information posted to a licensee's profile and provided to the public is specifically set forth in statute. In 2018, the Legislature passed the Patient's Right to Know Act (SB 1448, Hill, Chapter 570, Statutes of 2018) which required physicians ordered on probation to proactively notify patients of their status and required OMBC to add a probation summary to the profile pages of physicians on probation for acts of serious misconduct.

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

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

- The commission of any act of sexual abuse, misconduct or relations with a patient or client;

- Drug or alcohol abuse directly resulting in harm to patients or the extent that such use impairs the ability of the licensee to practice safely;

- Criminal conviction involving harm to patient safety or health;

- Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

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

<u>ISSUE #9:</u> (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?

<u>Background:</u> OMBC maintains a diversion program to, as OMBC notes, monitor and treat D.O.s who are impaired by the use of alcohol and or drugs. OMBC utilizes a Diversion Evaluation Committee (DEC), comprised of three D.O. members with expertise in substance abuse and psychosocial disorders, which, as OMBC notes, "provides the diversion program with the needed understanding of impaired D.O.s that could not be obtained by non-physician staff. Face to face meetings with these experts, ensures OMBC staff that the participants are receiving excellent guidance and monitoring in their sobriety, which, in turn, provides consumer safety. When and if there is a need, the DEC may remove a participant from practicing medicine until such time the DEC feels the participant is ready to resume practice." OMBC's Diversion program requires all licensees that are disciplined for substance abuse to enter the Diversion Program as a condition of probation. OMBC believes that the combination of requiring successful completion of the Diversion Program for all

substance abusing licensee that is managed by trained case workers ensures the greatest protection of public safety and greatest chance for licensees to successfully recover from their addiction.

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

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

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

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

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

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

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

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

The abuse of prescription drugs was historically viewed as a criminal concern analogous to street narcotics cases regularly investigated by law enforcement. In recent years, however, an expert consensus has evolved around the opinion that the opioid crisis must be addressed through the lens of public health policy. This belief is supported by research demonstrating how health professionals may have inadvertently contributed to the origins of the crisis. It is widely accepted that health professionals will play a critical role in any meaningful solutions.

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

Prescribers are advised to regularly consult the state's prescription drug monitoring program (PDMP), known as CURES. CURES was first established in 1996 as a "technologically sophisticated" database containing prescription records collected through California's Triplicate Prescription Program, which provided the DOJ with copies of all Schedule II drug prescriptions. Subsequent legislation made CURES the state's sole prescription record repository and added Schedule III and IV drugs to the

database. In 2008, CURES was upgraded to function as a PDMP, allowing health professionals, regulators, and law enforcement to conduct web-based searches of the system to inform prescribing practices and support investigations.

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

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

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

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

COVID-19

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

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

19 pandemic – including rules relating to examination, education, experience, and training. Many of the waivers, which affect the OMB, also affected other healing arts licensees under the DCA.

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

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

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

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

- DCA Waiver 20-69 was issued on October 22, 2020. This waiver superseded previous related waivers dated March 31, 2020, July 1, 2020, and August 27, 2020. This waiver, for active licensees expiring between March 31, 2020 and December 31, 2020, waives any statutory or regulatory requirement to complete or demonstrate compliance with any CME requirements in order to renew a license.

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

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

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

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

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

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

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