BACKGROUND PAPER FOR
The Osteopathic Medical Board of California

(Oversight Hearing, February 27, 2017, Senate Committee on Business, Professions and Economic Development and the 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.

At the end of 2016, OMBC reported that there are over 7,700 licensed D.O.s, almost 6,700 of which are practicing in California.

The current OMBC mission statement, as stated in its 2016-2019 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.

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
Joseph Anthony Zammuto, D.O., President Dr. Zammuto is a Family Practice physician who entered solo practice in 1984 and has been with Center Medical Group in Fremont since 1998. He is a 1983 graduate of Chicago College of Osteopathic Medicine (Midwestern University). Dr. Zammuto is a Diplomate of the National Board of Examiners, was Board certified by the American Osteopathic Board of General Practice in 1991, and is a certified Workers' Compensation Qualified Medical Examiner. In addition to his practice, Dr. Zammuto serves as an Adjunct Clinical Assistant Professor of Family Medicine for Touro University California and New York College of Osteopathic Medicine, as well as an Associate Professor of Family Medicine for WesternU/COMP.	June 4, 2015	June 1, 2019	Governor	Professional
James Michael Lally, D.O., Vice President Dr. Lally has been president and chief medical officer at the Chino Valley Medical Center since 2004, a team physician for the U.S. Olympic Shooting Team since 1993 and owner at Inland Physicians' Services Inc. since 1992. He is a retired U.S. Army officer. Dr. Lally earned a	June 2, 2016	June 1, 2020	Governor	Professional

Doctor of Osteopathic Medicine degree from the College of Osteopathic Medicine of the Pacific.				
Cyrus Fram Buhari, D.O., Secretary-Treasurer Dr. 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. Dr. Buhari earned a Doctor of Osteopathic Medicine degree from the Western University of Health Sciences.	October 20, 2015	June 1, 2019	Governor	Professional
Alan Howard Mr. Howard has served as a project manager for American President Lines, a global leader in container shipping, logistics and technology management since 2004. Mr. Howard previously held several positions including director for the TNT Post Group, where he worked from 1994-2002.	December 19, 2013	January 1, 2017	Governor	Public
Megan Lim Blair Megan Blair joined the San Diego Public Library Foundation as Development Director in September 2008 and helped lead the Development team that raised $77 million in private donations for a new Central Library. Prior to the San Diego Public Library Foundation Megan served as the Capital Campaign and Major Gifts Manager for Girl Scouts, San Diego-Imperial Council, where she successfully completed a $5.5 million capital campaign.	March 2, 2016	June 1, 2018	Speaker of the Assembly	Public
Elizabeth Jensen, D.O. Dr. Jensen has been a Hospitalist at St. Mary's since graduating from St. Mary's Internal Medicine residency in 2008. She also served as Chief Resident for the program in her final year. Dr. Jensen was appointed, in 2015, as Co-Physician Advisor for St. Mary's Medical Center. This role is a multi-disciplinary between Case Managers, Social Workers and the physicians they partner with to optimize patient discharge planning and hospital length of stay. She is also a member of the National Board of Osteopathic Medical Examiners. Dr. Jensen is certified in Fundamental Critical Care Support. She is a member of the Society of Hospitalist Medicine, American Osteopathic Association, and American College of Physicians.	October 28, 2015	June 1, 2019	Governor	Professional
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).	May 12, 2016	June 1, 2019	Senate Committee on Rules	Public

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	January 1, 2017	Governor	Public
Vacant			Governor	Professional

OMBC has one committee, the Diversion Evaluation Committee (DEC) which is established in Business and Professions Code (BPC Section 2360). The purpose of the DEC is to manage 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. The DEC is discussed further in Issue #10 below.

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. At the end of FY 2015/16, OMBC reports that it had a reserve balance of 16 months which is about $3 million and projects to have a fund reserve of 14.8 months at the end of FY 2016/17 and 13.4 months at the end of FY 2017/18. OMBC is required by law to maintain a reserve of no more than 24 months. OMBC provided a $1.5 million loan to the General Fund in FY 2010/11 and has not been repaid.

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

Fund Condition

(Dollars in Thousands)	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17	FY 2017/18*
Beginning Balance**	$2,889	$3,075	$2,982	$3,088	$3,057	$2,880
Revenues and Transfers	$1,569	$1,641	$1,958	$1,807	$2,117	$2,117
Total Revenue	$4,458	$4,716	$4,940	$4,895	$5,174	$4,997
Budget Authority	$1,968	$1,752	$1,899	$1,922	$2,291	$2,337
Expenditures***	$1,382	$1,737	$1,787	$1,838	$2,291	$2,337
Loans to General Fund	-	-	-	-	-	-
Accrued Interest, Loans to General	-	-	-	-	-	-
Loans Repaid From General Fund	-	-	-	-	-	-
Fund Balance	$3,076	$2,979	$3,153	$3,057	$2,880	$2,660
Months in Reserve	21.3	20.0	20.6	16.0	14.8	13.4

* Assumes 2% growth in expenditures and 0.3% growth in income from surplus money
** Includes prior year adjustments
*** Includes direct draw from SCO and Fi$cal

OMBC's primary source of revenue is D.O. license renewal fees. There have not been any fee changes for the past ten years and OMBC does not anticipate raising fees in the foreseeable future.

Fee Schedule and Revenue (dollars in thousands)

Fee	Current Fee Amount	Statutory Limit	FY 2012/13 Revenue	FY 2013/14 Revenue	FY 2014/15 Revenue	FY 2015/16 Revenue	% of Total Revenue
Endorsement Fee	$25	$25	$13	$4	$11	$14	<1%
Duplicate Certificate Fee	$25	$25	$2	$10	$3	$3	<1%
*License Reinstatement Fee	Varies	*	$8	$3	******	******	0%
License Status Change	Varies	**	$2	$9	$2	$2	<1%
Application Filing Fee	$200	$400	$102	$128	$138	$156	8.7%
Initial Licensing Fee	Varies	***	$121	$145	$170	$168	9.4%

Fictitious Name Permit App Fee	$100	$100	$6	$12	$10	$11	<1%
Biennial Active License Renewal	$400	$400	$1,168	$1,185	$1,457	$1,293	72.2%
Biennial Inactive License Renewal	$300	$300	$103	$98	$103	$96	5.4%
Fictitious Name Permit Renewal	$50	$50	$26	$26	$30	$30	1.7%
Biennial Active License Delinquency Fee	$100	$100	$6	$6	$11	$11	<1%
Biennial Inactive License Delinquency Fee	$75	$75	$3	$3	$3	$5	<1%
Cite & Fine	Varies	****	$1	$8	$0	$2	<1%
Sale of Documents	Varies	*****	-	-	$3	-	0%

OMBC is one of 40 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 $309,000 in Pro Rata for FY 2015/16.

Staffing Levels

OMBC is currently authorized in the Governor's 2017/18 budget for a total of 11.4 positions. OMBC reports that it has not had any vacancies in positions in the last four years and has excellent retention, with only two staff turnovers, one due to staff retiring from state service and another accepting a promotion at another state agency.

Licensing

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 over 7,700 licensees, a 15percent increase since the last sunset review. Over the past four years, the OMBC received over 2,620 new applications, issued over 2,497 licenses, and renewed over 14,101 licenses.

OMBC identifies applicants who indicate they are military service veterans. OMBC received 1 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 1 D.O. application 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 one full 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 reports that the implementation of the BreEZe system impacted OMBC's ability to meet its performance target. BreEZe is discussed further in Issue #1 below.

Continuing Medical Education (CME)

D.O.s are required to complete 150 hours of approved CME throughout a three year cycle. OMBC states that it verifies CME compliance by requiring applications for license renewal to be accompanied by certificates of completion of courses attended, thus eliminating any need to audit D.O.s to determine whether CME courses have actually been taken. According to OMBC, licensees who cannot show documentation cannot have their license renewed until CME hours are completed. CME credits can be earned through courses approved by the American Osteopathic Association (AOA) and/or American Medical Association (AMA). OMBC reports that audits of CME providers are performed by the AOA Council of Continuing Medical Education. CME is discussed further in Issue #5 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 reporting to OMBC is discussed further in Issue #8 below). 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. Some OMBC investigations have been referred to the DOI Investigation and Enforcement Unit rather than HQIU due to significant vacancies within HQIU.

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).

Investigators may also present certain confirmed violations to a District Attorney/City Attorney if there is sufficient evidence of criminal violations.

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.

Over the last three years, OMBC:

- Investigated and closed 71 (formal) investigations
- Investigated and closed 1,392 (desk) investigations
- Referred 66 cases to OAG for action
- Filed 61 accusations and/or petitions to revoke probation
- Obtained 4 suspension/restriction orders
- Revoked or accepted the surrender of 25 licenses
- Placed 27 licensees on probation
- Issued 7 public reprimands/public letters of reprimand.

(For more detailed information regarding the responsibilities, operation and functions of the Board please refer to OMBC's "2016 Sunset Review Report." This report is available on its website at http://www.ombc.ca.gov/forms_pubs/sunset_2016.pdf

PRIOR SUNSET REVIEW: CHANGES AND IMPROVEMENTS

OMBC was last reviewed by the Legislature through sunset review in 2012-13. During the previous sunset review, 11 issues were raised. In December 2016, MBC 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 created a Code of Ethics.** During the prior review, the Committees were concerned that OMBC did not have in place an enforceable Code of Ethics for its licensees something highly unusual among consumer protection boards and an issue that was raised dating back to the 2005 review of OMBC. The Committees determined that OMBC certainly had full authority to promulgate regulations concerning the ethics and professional responsibility of its licensees and urged the OMBC to take this important step, what the Committees saw as an "essential characteristic of an administrative agency of any kind." In response, OMBC created a Code of Ethics which is found on its website.

- **OMBC is now regularly webcasting meetings and posting materials to its website.** The Committees noted that OMBC had only webcast one meeting since joining DCA and were

concerned about OMBC's lack of consumer-facing technology use. The Committees also noted that OMBC relied on DCA's Information Technology staff to post OMBC materials thus only posted mandatory and the most basic of information. OMBC has been webcasting all of its meetings since the fall of 2013 and posts agendas and meeting materials on the website.

- **OMBC created a subcommittee to research the issue of Internet prescribing and issued a policy statement.** The Committees recommended that an OMBC subcommittee provide recommendations to OMBC on this issue. In 2013, OMBC issued a statement noting that a doctor-patient relationship must exist, there must be an in-person examination, there must be a valid diagnosis, the prescribed medication must be appropriate and necessary for the treatment of an acute, chronic, or recurrent condition that has been validly diagnosed, there must be retrievable medical records of the encounter, there must be documentation of the prescriptions, there must be a follow-up examination and monitoring of the medications and online questionnaires are not a valid encounter for prescriptions.

- **OMBC is in compliance with BPC Section 115.5 to expedite licensure for military spouses and complies with statutory opportunities for certain individuals to receive fee waivers.**

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 ISSUES

ISSUE #1: (BreEZe.) OMBC transitioned to BreEZe in October 2013 as one of the first entities at DCA utilizing the new system. What is the status of BreEZe? How many of OMBC's service requests are still pending? Does BreEZe track enforcement statistics in a meaningful way for OMBC?

Background: The DCA has been working since 2009 on replacing multiple antiquated standalone IT systems with one fully integrated system. In September 2011, the DCA awarded Accenture LLC with a contract to develop and implement a commercial off-the- shelf customized IT system, which it calls BreEZe. BreEZe is intended to provide applicant tracking, licensing, renewals, enforcement, monitoring, cashiering, and data management capabilities. In addition, BreEZe is web-enabled and designed to allow licensees to complete and submit applications, renewals, and the necessary fees through the internet. The public also will be able to file complaints, access complaint status, and check licensee information if/when the program is fully operational.

The project plan called for BreEZe to be implemented in three releases. The first release was scheduled for July 2012, but delayed until late 2013. OMBC transitioned to BreEZe during Release One in October 2013. Resources OMBC provided for BreEZe are outlined below.

BreEZe Funding Needs								
	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17
Total Costs	$427,051	$1,495,409	$5,349,979	$14,825,159	$14,825,159	$16,657,910	$27,468,154	$23,497,000
Redirected Resources	$427,051	$1,495,409	$3,198,486	$4,818,002	$5,806,881	$7,405,427	$7,430,456	2,080,000
Total BreEZe BCP	-	-	$2,151,493	$1,935,285	$9,018,278	$9,252,483	$20,037,698	$21,417,000
	ACTUAL	**ACTUAL**	**ACTUAL**	**ACTUAL**	**ACTUAL**	**ACTUAL**	**ACTUAL**	**BUDGET**
OMBC	$905	$3,045	$10,544	$16,746	$35,578	$38,795	$82,995	$80,578

OMBC reports that several OMBC staff worked nearly full time during the design and testing phases in the months leading up to the release. According to OMBC, this was extremely challenging for a small board such as OMBC and OMBC faced a staffing shortage, as it had to designate full time staff to participate in user acceptance testing prior to the system going live. OMBC reports that to manage the transition to BreEZe, OMBC management staff established a process that allowed staff to identify possible issues that would impact business procedures due to the data system's design and functionality. OMBC believes that this allowed OMBC staff to evaluate issues, determine a possible solution to these issues and to consider any impact the solution could have to procedures or the data system; and if appropriate, submit a request for modification to DCA's BreEZe team.

According to OMBC, the initial DCA BreEZe implementation period impacted OMBC's ability to meet its licensing performance targets, given how staff intensive the implementation period was and the necessary redirection of staff to BreEZe away from other functions, as OMBC did not have adequate personnel to staff both BreEZe testing functions and its licensing responsibilities. OMBC reports that in the last year, the number of applications significantly increased, which further impacted OMBC's performance target. OMBC notes that it has since reassessed licensing workload and redirected staff to better streamline the licensing process.

OMBC has not conducted any assessment on the impact of licensing delay. However, during the 2013 BreEze implementation and the shortage of staff during that period, OMBC noticed some backlogs in the application process. The staff manager, along with the current staff, has implemented changes to the internal application processes. OMBC believes these changes will reduce the number of days to process applications. Additionally, online license renewals are now available through the BreEze system. With the DCA BreEze system, OMBC has added other online services for licensees, such as, the ability to provide address changes and requesting duplicate or replacement certificates.

It would be helpful for the Committees to understand the continuing cost impacts of BreEZe to OMBC's budget as well as the status of requests for technical fixes and larger change improvements.

Staff Recommendation: ***OMBC should advise the Committees how much it is projected to pay in BreEZe costs for FY 2017/18. OMBC should update the Committees on the number of pending tickets and how swiftly OMBC requests for system upgrades and changes are being processed.***

ISSUE #2: (NOTICE TO CONSUMERS.) Business and Professions Code Section 138 requires DCA entities to adopt regulations requiring licensees to provide notice to consumers that the individual is licensed by the State of California. Notifications to patients may not contain the correct information necessary for consumers to know about OMBC and most importantly, know how to file a complaint with OMBC. Are updates necessary to notification requirements for D.O.s?

Background: Pursuant to legislation passed in 1998 (SB 2238, Senate Committee on Business and Professions, Chapter 879, Statutes of 1998), DCA entities were required to promulgate regulations outlining how licensees should provide notice to consumers that the individual is licensed. BPC Section 138 states:

> 138. Every board in the department, as defined in Section 22, shall initiate the process of adopting regulations on or before June 30, 1999, to require its licentiates, as defined in Section 23.8, to provide notice to their clients or customers that the practitioner is licensed by this state. A board shall be exempt from the requirement to adopt regulations pursuant to this section if the board has in place, in statute or regulation, a requirement that provides for consumer notice of a practitioner's status as a licensee of this state.

MBC developed regulations mandating allopathic physicians and surgeons (M.D.s) post a notice in their office stating, "Medical doctors are licensed and regulated by the Medical Board of California," accompanied by the MBC's phone number and website. However, not all medical doctors are regulated by the MBC.

OMBC licensees represent approximately 7 percent of practicing physicians. Both M.D.s and D.O.s are mandated by law to be accorded equal professional status and privileges, many work in the same offices, and both are called "doctor" by their patients. There is nothing obvious distinguishing between the two types of professionals to consumers. However, licensing and enforcement is handled by separate boards.

OMBC has not developed their own regulations to notify consumers that osteopathic physicians and surgeons are regulated by a different board, nor does MBC indicate that there is another entity regulating physicians. This has the potential to cause consumer confusion. For example, a consumer with a concern about an osteopathic doctor may do an internet search to find out where to send a complaint. The search "California doctor complaint" yields only results for the MBC on the first page. If the consumer saw the D.O. in an office that also employed M.D.s, the required MBC sign would direct the consumer to the MBC. The consumer then goes to the MBC's website, which indicates that "The Medical Board is the licensing agency for physicians and surgeons and other allied health care professionals in California, and is responsible for investigating complaints and taking disciplinary action against the licensee, if a violation of law is confirmed." The consumer then goes to the license lookup area of the website, which lists the following options for BreEZe:

- Physician and Surgeon and Special Faculty Permit
- Licensed Midwife
- Registered Dispensing Optician
- Registered Spectacle Lens Dispenser
- Registered Contact Lens Dispenser

- Registered Nonresident Contact Lens Seller
- Research Psychoanalyst
- Student Research Psychoanalyst
- Registered Polysomnographic Trainee
- Registered Polysomnographic Technician
- Registered Polysomnographic Technologist
- Fictitious Name Permit
- Other Department of Consumer Affairs Licensed Professional

The consumer clicks on "physician and surgeon" and enters their D.O.'s name. The consumer then finds nothing, either assuming their physician is unlicensed or has no record of discipline, or gets the wrong record for someone of the same name. There is no cross-reference to OMBC's database or indication that another board regulates physicians.

In an environment where a person's primary care provider may be a doctor, nurse practitioner, or physician assistant, it is unreasonable to assume that a consumer can or should distinguish between types of doctors for the purpose of registering complaints or investigating a license. While both OMBC and MBC may continue to handle discipline independently, bureaucracy should not impede consumer access to information.

Staff Recommendation: ***OMBC should develop regulations to comply with existing law for consumer notification. In doing so, OMBC should coordinate with MBC on new signage to direct consumers to a single point of entry to look up a physician and surgeon license and register a complaint.***

ISSUE #3: (PRESCRIBER GUIDELINES). Current, appropriate guidelines outlining safe prescribing practices for certain types of medication, or medication prescribed to certain patient populations, are an important tool for D.O.s and OMBC alike. The MBC recently updated its guidelines for prescribing pain medication, but it is unclear what OMBC does to ensure D.O.s read and use these guidelines. Guidance to osteopathic physicians about prescribing psychotropic medication to foster youth and prescribing medical cannabis could also be beneficial. How has OMBC promoted its guidelines for prescribing controlled substances? Is OMBC issuing guidelines related to the appropriate prescribing of psychotropic medication to foster youth or medical cannabis?

Background: D.O.s issue prescriptions to patients for medication through the course of care, according to professional judgment and within the appropriate standard of care. For certain types of medication, and certain types of medication prescribed to certain types of patients, guidelines on appropriate and safe prescribing practices can serve as a helpful tools for the providers, patients and OMBC alike.

Prescription medicine used to treat pain has been the focus of ongoing discussions in the Legislature, particularly in the years since OMBC's last review as California and the nation face an epidemic of prescription drug abuse and related overdose deaths. One of the most high profile cases involving the

role of a prescriber involved a D.O. in Southern California, highlighted in a *Los Angeles Times* series "Dying for Relief" which found that at least eight of the D.O.s patients died of overdoses from the same type of drug she prescribed to them. The D.O. was accused of ignoring red flags about her prescribing habits, including the overdose of a patient in her clinic, as well as calls from authorities informing her that patients had died with drugs in their system. The D.O. was convicted of murder for recklessly prescribing drugs to patients.

OMBC provides a link on its website to the MBC's 2014 Guidelines for Prescribing Controlled Substances for Pain. *It would be helpful for the Committees to understand what steps beyond a static web page OMBC takes to ensure licensees consult the updated guidelines.*

Concern over the use of psychotropic medications among children have also been the subject of recent Legislative consideration and discussion, and have been well-documented in research journals and the mainstream media for more than a decade. The category of psychotropic medication is fairly broad, intending to treat symptoms of conditions ranging from attention deficit hyperactivity disorder (ADHD) to childhood schizophrenia. Some of the drugs used to treat these conditions are U.S. Food and Drug Administration (FDA)-approved, however only about 31 percent of psychotropic medications have been approved by the FDA for use in children or adolescents. It is estimated that more than 75 percent of the prescriptions written for psychiatric illness in this population are "off label" in usage, meaning they have not been approved by the FDA for the prescribed use, though the practice is legal and common across all manner of pharmaceuticals. Studies have found that the off-label use of these anti-psychotics among children is high, particularly among foster children.

In 2012, the DHCS and DSS convened a statewide Quality Improvement Project (QIP) to design, pilot, and evaluate effective practices to improve psychotropic medication use among children and youth in foster care. The QIP's Clinical Workgroup released a set of guidelines to assist prescribers and caregivers in maintaining compliance with State and county regulations and guidelines pertaining to Medi-Cal funded mental health services and psychotropic prescribing practices for foster homes, group homes, and residential treatment centers. In addition, the guidelines include prescriber and caregiver expectations regarding developing and monitoring treatment plans for behavioral health care, principles for informed consent to medications, and governing medication safety. These guidelines are designed as a statement of best practice for the treatment of children and youth in out-of-home care. *It would be helpful for the Committees to understand what steps OMBC takes to ensure licensees consult the QIP's guidelines and what OMBC is doing to raise this important issue with its licensees.*

OMBC licensees are also authorized to recommend the use of cannabis for medical purposes. Since the approval of the Compassionate Use Act (contained in Proposition 215) by voters in 1996, state law has allowed Californians access to marijuana for medical purposes, and prohibited punitive action against physicians for making medical marijuana recommendations. The CUA established the right of patients to obtain and use marijuana to treat specified illnesses and any other illness for which marijuana provides relief. Three laws enacted in 2015 (AB 243, Wood, Chapter 688 Statutes of 2015; AB 266, Bonta, Chapter 689, Statutes of 2015 and; SB 643, McGuire, Chapter 719, Statutes of 2015), known collectively as the Medical Cannabis Regulation and Safety Act (MCRSA), provide a statutory framework to regulate medical cannabis. Under MCRSA, MBC is required to consult with the California Marijuana Research Program, known as the Center for Medicinal Cannabis Research, within DPH in order to develop and adopt medical guidelines for the appropriate administration and use of medical marijuana. *It would be helpful for the Committees to understand what role OMBC is playing in the development of prescriber guidelines for medical cannabis and OMBC's plan for dissemination of guidelines when they are adopted.*

Staff Recommendation: ***OMBC should update the Committees on its efforts related to guidelines for prescriptions of controlled substances for pain, psychotropic medication to foster youth and medical cannabis.***

ISSUE #4: (CURES.) An important tool to monitor controlled substances prescriptions, D.O.s are required to register to use CURES and required to consult the system prior to issuing a prescription for certain scheduled drugs. How does OMBC promote use of the CURES system? Does OMBC use CURES to gain information proactively about D.O. prescribing patterns?

Background: For the past number of years, abuse of prescription drugs (taking a prescription medication that is not prescribed for you, or taking it for reasons or in dosages other than as prescribed) to get high has become increasingly prevalent. Federal data for 2014 showed that abuse of prescription pain killers now ranks second, just behind marijuana, as the nation's most widespread illegal drug problem. Abuse can stem from the fact that prescription drugs are legal and potentially more easily accessible, as they can be found at home in a medicine cabinet. Data shows that individuals who misuse prescription drugs, particularly teens, believe these substances are safer than illicit drugs because they are prescribed by a health care professional and thus are safe to take under any circumstances.

The Centers for Disease Control (CDC) recommends the use of Prescription Drug Monitoring Programs (PDMPs) with a focus on both patients at highest risk in terms of prescription painkiller dosage, numbers of prescriptions and numbers of prescribers, as well as prescribers who deviate from accepted medical practice and those with a high proportion of doctor shoppers among their patients. CDC also recommends that PDMPs link to electronic health records systems so that the information is better integrated into health care providers' day-to-day practices. With rising levels of abuse, PDMPs are a critical tool in assisting law enforcement and regulatory bodies with their efforts to reduce drug diversion.

California has the oldest PDMP in the nation. Controlled Substance Utilization Review and Evaluation System (CURES) is an electronic tracking program that reports all pharmacy (and specified types of prescriber) dispensing of controlled drugs by drug name, quantity, prescriber, patient, and pharmacy. Pharmacies and dispensers are required to report dispensations of Schedules II through IV controlled substances to DOJ at least weekly. CURES provides information that offers the ability to identify if a person is "doctor shopping" (when a prescription-drug addict visits multiple doctors to obtain multiple prescriptions for drugs, or uses multiple pharmacies to obtain prescription drugs). CURES data can be obtained by the Board of Pharmacy, Medical Board of California, Dental Board of California, Board of Registered Nursing, Osteopathic Medical Board of California, Naturopathic Medicine Committee and Veterinary Medical Board.

In 2013, SB 809 (DeSaulnier, Chapter 400, Statutes of 2013) established a funding mechanism to update and maintain CURES while also requiring all prescribing health care practitioners to apply to access CURES information (the date for compliance was moved to July 1, 2016 pursuant to 2015 legislation extending the timeframe for prescribers to enroll in the system).

Pursuant to SB 482 (Lara, Chapter 708, Statutes of 2016), D.O.s and other health care providers authorized to prescribe, order, administer or furnish a controlled substance must consult CURES prior to prescribing a Schedule II, III or IV drug to a patient for the first and at least once every four months thereafter if the substance remains part of the treatment of the patient. The bill exempts health care

providers from these requirements for patients admitted to certain facilities, if a patient receives a non-refillable five-day supply or less prescription in conjunction with a surgery and in the event of a technological failure or inability to access the CURES system.

The upgraded system, CURES 2.0, became operational in late 2015. The new interface has significantly improved timeframes for accessing information, navigating through the system and general usability. Licensees can apply directly within the web based system, a significant shortfall of the prior CURES which required applicants to submit notarized paper applications to DOJ. Prescribers and dispensers are able to easily generate patient activity reports and can securely send communications to one another about a mutual patient through the system. Through CURES 2.0, prescribers can receive daily informational alerts about patients who reach various prescribing thresholds, based on patterns indicative of at-risk patient behavior, which can be used to determine if action by the prescriber is necessary.

It would be helpful for the Committees to understand how OMBC uses CURES and what issues, if any, D.O.s have had registering and effectively using the new CURES 2.0, particularly since OMBC made zero mention of CURES in its 2016 sunset report to the Legislature. It would be helpful for the Committees to understand what steps OMBC will take to ensure all D.O.s have registered as required.

Staff Recommendation: ***OMBC should update the Committees on CURES, including how it transmits information to licensees about requirements to utilize CURES, what challenges licensees have reported about registration and use of the system and how OMBC uses CURES data to gain important information about its licensees' prescribing trends.***

OMBC LICENSING ISSUES

ISSUE #5: (CME.) OMBC requires CME, but verifies D.O.s have completed CME in a different way than other DCA entities. Should OMBC update its CME processes? Are there more effective means by which OMBC can verify that CME was completed other than relying on D.O.s to provide documentation at the time of renewal?

Background: OMBC has discussed whether is can streamline and simplify its renewal process by aligning the Continuing Medical Education (CME) cycle with the renewal cycle for D.O. licenses.

In 1995, OMBC changed its CME reporting and compliance cycle from an annual cycle to a three year cycle, resulting in different cycle times to validate CME and to validate D.O. licenses. This may cause confusion for licensees renewing their license according to one cycle and adhering to a separate cycle for showing compliance with CME requirements which is required for a license to be renewed.

By amending BPC 2454.5, OMBC may be able to be more effective in issuing renewals and confirming CME completion. A two-year cycle for both licensure renewal and CME compliance will not result in changes to the number of CME hours required, as OMBC would still requires 100 hours every two years (the current 150 hour requirement is based on this three-year cycle and 50 CME hours annually).

OMBC also requires D.O.s to provide documentation showing that CME was completed at the time of renewal, but does not require any verification from CME providers (primary source documentation)

that the education was completed. The new Executive Officer of the Board of Registered Nursing recently proposed an innovative solution to receipt of information from third-party sources, specifically uploading materials directly into a cloud that DCA manages. OMBC may consider whether there are more efficient ways to ensure CME completion such as proof of completion provided directly to OMBC through the DCA cloud. OMBC may wish to explore how the receipt of documents in this model could then be noted in BreEZe so that when a D.O. attempts to renew a license, this information data piece is readily available.

Staff Recommendation: ***The Committees should amend the Act to align the CME and license renewal cycles. OMBC should explore innovative methods to confirm CME completion and update the Committees on steps it is taking to streamline processes.***

ISSUE #6: (D.O.s FROM OTHER STATES VOLUNTEERING AT FREE CLINICS.) Current law authorizes boards to provide exemptions for individuals who are licensed in another state but come to California to provide free services at a sponsored event. Has OMBC provided exemptions for anyone? Has anyone even applied to OMBC for an exemption?

Background: AB 2699 (Bass, Chapter 270, Statutes of 2010) allows specified health practitioners licensed or certified in other states that provide health care services on a voluntary basis to uninsured or underinsured persons in California, at a sponsored event, to be exempt from having to become licensed in California. MBC was the first health board to promulgate regulations to implement the provisions of AB 2699 and has approved over 30 physicians. While OMBC has discussed this at meetings, it is unclear what steps OMBC has taken to provide a pathway for out-of-state D.O.s to participate in these sponsored events.

Staff Recommendation: ***OMBC should provide the Committees with an update on its efforts to allow D.O.s licensed in other states to provide services at free clinics that are in compliance with AB 2699.***

OMBC ENFORCEMENT ISSUES

ISSUE #7: (ARREST AND CONVICTION INFORMATION.) OMBC is not currently authorized to receive reports of arrests and convictions of D.O.s after they are licensed. Should BPC Section 144 be amended to ensure OMBC receives this important information?

Background: BPC Section 144 authorizes specified boards to obtain fingerprints of prospective licensees for the purposes of allowing the board 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. When the statute was put into place, OMBC already had regulations requiring all applicants to be fingerprinted prior to issuance of a license.

Subsequent legislation in 2013 (SB 305, Lieu, Chapter 516, Statutes of 2013) amended BPC Section 144.5 to authorize specified boards to receive certified records of all arrests and convictions, certified records regarding probation and any and all other related documentation needed to complete an applicant or licensee investigation from a local or state agency. At the time, boards reported that they were being challenged by courts and local law enforcement agencies about eligibility to obtain this

important information. These records are necessary for boards to determine when disciplinary action is warranted, however, because the new code section was based on the previous code section, OMBC is not one of the boards authorized to receive these records. Yet, OMBC has express authority to take disciplinary action based on certain criminal convictions.

When a D.O. is arrested, OMBC does receive reports from DOJ but needs to be able to determine when administrative action against a license should be taken and having certified copies of police reports and court documents assists OMBC in determining the proper course of disciplinary action. OMBC cites its lack of inclusion in BPC 144.5 as creating challenges for OMBC to take swift action against licensees who pose a risk to the public.

Staff Recommendation: ***OMBC should be authorized to obtain information documents that can assist OMBC in taking swift disciplinary action when necessary. BPC Section 144 should be amended to include OMBC, which in turn will ensure that the provisions of BPC 144.5 apply to them as well.***

ISSUE #8: (MANDATORY REPORTING.) OMBC receives reports related to osteopathic physicians from a variety of sources. These reports are critical tools that ensure OMBC maintains awareness about its licensees and provide important information about licensee activity that may warrant further OMBC investigation. OMBC may not be receiving reports as required and enhancements to the Business and Professions Code may be necessary to ensure OMBC has the information it needs to effectively do its job.

Background: There are a significant number of reporting requirements outlined in BPC designed to inform OMBC about possible matters for investigation. 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.

Staff Recommendation: ***OMBC should provide the Committees an update on the number of reports it receives pursuant to these requirements, whether OMBC believes there is underreporting and what steps OMBC plans to take to address underreporting, as well as enhancements that should be made to ensure OMBC receives this important reports. OMBC should also update the Committees on how these reports are processed and handled by OMBC, given the serious violations of law that may be connected to OMBC receiving one of these reports.***

ISSUE #9: (ENFORCEMENT STAFF.) OMBC did not raise any issues in its 2016 Sunset Review Report to the Legislature about the role a lack of staff may be playing in OMBC's ability to effectively conduct business yet has discussed the need for more enforcement staff at meetings and in its 2016 Strategic Plan. Does OMBC believe it has the personnel and authorized positions necessary to protect consumers and take enforcement action in a timely manner?

Background: OMBC notes that it does not have staffing issues or challenges. Yet OMBC has discussed the need to increase its enforcement staff at meetings and in fact highlighted a number of efforts related to increasing its staff in OMBC's 2016 Strategic Plan. Specifically, in its 2016 Strategic Plan, OMBC outlined goals that include:

- Reviewing and assigning a time limit for expert reviewer contract processing to reduce response times to cases.
- Recruiting additional expert reviewers to increase efficiency of case review and leverage the resources of subject matter experts with specific background in osteopathic medicine.
- Hiring one complaint intake staff member to eliminate backlog, improve customer service, and meet performance measures.
- Hiring one Enforcement Analyst to address excess workload, providing enhanced customer service and meeting performance measures targets.
- Utilizing aging reports in BreEZe to bring the Board into compliance with statutes.
- Initiating a Budget Change Proposal (BCP) to fund travel for enforcement personnel to perform onsite check-ins of probationers.

Each of these goals noted in the enforcement section of OMBC's Strategic Plan have to do with bringing on additional enforcement staff. It would be helpful for the Committees to understand exactly what authority and personnel OMBC believes it needs to effectively fulfill its mission. It would be helpful for the Committees to understand if OMBC is actually facing enforcement shortfalls as a result of its lack of staff.

Staff Recommendation: ***OMBC should report to the Committees on its enforcement staff needs. OMBC should provide the Committees with an update of enforcement statistics, particularly for activities that are handled by OMBC staff (rather than any statistics that have to do with case timeframes related to actions pending at HQIU or OAG).***

ISSUE #10: (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. Has OMBC adopted the Uniform Standards?

Background: OMBC maintains a diversion program to, as OMBC notes, monitor and treat D.O.s who are impaired by the use of alcohol and or drugs. OMBC utilizes a Diversion Evaluation Committee (DEC), comprised of three D.O. members with expertise in substance abuse and psychosocial disorders, which, as OMBC notes, "provides the diversion program with the needed

understanding of impaired D.O.s that could not be obtained by non-physician staff. Face to face meetings with these experts, ensures OMBC staff that the participants are receiving excellent guidance and monitoring in their sobriety, which, in turn, provides consumer safety. When and if there is a need, the DEC may remove a participant from practicing medicine until such time the DEC feels the participant is ready to resume practice."

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. 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.

OMBC reports that the DEC meets with participants in the diversion program on a quarterly basis, along with the MAXIMUS Case Manager and OMBC staff. OMBC states that six to eight participants are interviewed and evaluated at each DEC meeting and the DEC monitors the progress of the program participants and may adjust the treatment plan for these D.O.s.

According to OMBC, the annual cost of the program was $39,439.59 for FY 2015/2016. Participants pay a monthly cost of $348.29. According to OMBC, only a portion of the monthly participation costs are collected based on the participants' ability to pay, which is in turn based on the number of hours a participant is allowed to work as determined by the DEC.

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 #11: (PUBLIC NOTIFICATION OF DISCIPLINARY ACTION.) Access to timely, accurate information about D.O.s 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 yet significant gaps remain in the ability for patients to have full awareness of disciplinary action taken against their physician. For the small number of osteopathic physicians ordered on probation by OMBC, requiring that patients are proactively notified of their probationary can serve as a useful tool in patients' efforts to know their physician and know when their physician has violated the Act. What steps should be taken to ensure patients and the public are properly informed about OMBC disciplinary action and about physician probationary status for the rare cases that result in OMBC having to take such action to protect patients from harm?

Background: Public disclosure of disciplinary action for physicians and surgeons has been a Legislative priority for many years. SB 231 (Figueroa, Chapter 674, Statutes of 2005) required the Little Hoover Commission to conduct a study and make recommendations on the role of public disclosure in the public protection mandate of the MBC. Those responsibilities were then transferred through SB 1438 (Figueroa, Chapter 223, Statutes of 2006) to the CRB of the California State Library. The study, *Physician Misconduct and Public Disclosure Practices at the Medical Board of California*, was completed in November 2008 and offered 11 policy options aimed at improving public disclosure access to information about physician misconduct.

All accusations, petitions to revoke probation, statement of issues and all disciplinary actions are posted on OMBC's website. These disciplinary documents are linked to the licensee's individual online profile, allowing consumers to view all documents outlining formal disciplinary action taken by OMBC.

While it is true that important information is available on OMBC's website, a key issue for the Committees remains how easily available it is for California patients to access easily understandable information about osteopathic physicians who have been the subject of disciplinary action, placed on probation and practicing. When the OMBC places D.O.s on probation, generally they continue to practice and see patients under restricted conditions. Terms of probation may include certain practice limitations and requirements, but most commonly D.O.s on probation are not required to provide any information to their patients regarding discipline taken by OMBC.

A determination of probation is a step in a lengthy disciplinary process, conducted in accordance with the Administrative Procedures Act, and offering due process for accused licensees. Once an individual is placed on probation, they have already had an accusation filed against them which is publicly available on OMBC's website. The filing of an accusation alone requires significant justification that a violation of the Act has occurred. Probationary status is not secret. OMBC only orders probation for a licensee once multiple steps in the life of a case have been taken. Probation is not loosely issued for suspicions or complaints or facts gained during an investigation that lead to the filing of an accusation for which clear and convincing evidence is present.

According to OMBC data, there are currently 41 osteopathic physicians on probation. These individuals represent only a fraction of overall OMBC licensees. (See Appendix in this report attached for a listing of those D.O.s currently on probation.)

Patients may be especially deserving of greater access to information about a physician on probation given the potential for future disciplinary action. The 2008 CRB study reported that physicians who have received serious sanctions in the past are far more likely to receive additional sanctions in the future. According to the CRB report, "These findings strongly imply that disciplinary histories provide patients with important information about the likely qualities of different physicians." The CRB cited research that examined physician discipline data provided by FSMB. The researchers split their sample into two periods, Period A 1994 - 98 and Period B 1999 - 2002. They classified physicians by whether they had no sanctions in the period, or had been assessed with one or more mild, medium or severe sanctions. Severe sanctions encompassed disciplinary actions that resulted in the revocation, suspension, surrender, or mandatory retirement of a license or the loss of privileges afforded by that license. The medium sanctions included actions that resulted in probation, limitation, or conditions on the medical license or a restriction of license privileges. The study found that less than 1 percent of physicians who were unsanctioned during Period A were assessed a disciplinary action during Period B. However, physicians sanctioned during the earlier period were much more likely to be assessed additional sanctions in the second period; for example, 15.7% of those who received a medium sanction in Period A went on to receive either a medium or a severe sanction in Period B; physicians who received a medium sanction in Period A were 28 percent more likely to receive a severe sanction in Period B than someone who received no sanction in period A; and, physicians who received a medium sanction in Period A were 32 percent more likely to receive another medium sanction in Period B than someone who received no sanction in Period A.

Staff Recommendation: ***The Act should be amended to ensure that patients receive timely notification of their physician's probationary status, that patients are easily able to obtain understandable information about violations leading to probation, and that OMBC makes changes to the disciplinary enforcement information displayed on its website to allow for easier public access and understanding of actions OMBC has taken.***

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 strong regulatory boards with oversight of licensed professions. The issue of exactly what regulation of D.O.s should look like in California has been one raised by the Legislature for over ten years, specifically, whether it makes sense for there to be two separate regulatory bodies for virtually identical professions, especially given the clear public policy in this state that D.O.s and M.D.s are to be treated equally. For example, BPC Section 2453(a) states: "It is the policy of this state that holders of MD. degrees and DO degrees shall be accorded equal professional status and privileges as licensed physicians and surgeons."

Moreover, this equality is so firmly established that it extends to a statutorily mandated rule of non-discrimination. BPC Section 2453(b) states:

> Notwithstanding any other provision of law, no health facility subject to licensure under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, no health care service plan, nonprofit hospital service plan, policy of disability insurance, self-insured employer welfare benefit plan, and no agency of the state or of any city, county, city and county, district, or other political subdivision of the state shall discriminate with respect to employment, staff privileges, or the provision of, or contracts for, professional services against a licensed physician and surgeon on the basis of whether the physician and surgeon holds an M.D. or D.O. degree.

In addition to fundamental and statutorily required equality between D.O.s and M.D.s, OMBC manages a relatively small regulatory program, with just over ten staff, to oversee a profession that has an identical license and identical scope of practice as M.D.s regulated by the much larger MBC. It remains very difficult to distinguish differences between the professions and it is unclear what actual regulatory efficiencies are gained, and what consumer benefits are realized, by the continued regulation of physicians by two entities.

As an independent board, OMBC should take steps to ensure consumers are aware of OMBC and ensure that patients know OMBC licenses the D.O. who may provide them services.

Staff Recommendation: ***The licensing and regulation of osteopathic physicians and surgeons should continue to be regulated by the current board members of the Osteopathic Medical Board of California in order to protect the interests of the public, however, consideration should be given to reviewing how MBC and OMBC may be better aligned, while preserving and respecting the Act and profession. OMBC should be reviewed again in four years***.

APPENDIX

Information contained in this Appendix can be found on the Osteopathic Medical Board of California website:

http://www.ombc.ca.gov/consumers/enforce_action.shtml
http://www.ombc.ca.gov/consumers/license_ver.shtml

Information in column one of the tables below is from the accusation filed against the D.O. by the Osteopathic Medical Board of California and the Office of the Attorney General. Accusation information in column one reflects the most recent probation.

The probation summary in column four and the probation date in column five of the tables below are from the most recent probation and in some cases may not reflect terms of probation from prior probations.

Acceptance of a settlement with the Osteopathic Medical Board of California is not an admission of guilt unless the licensee has expressly admitted guilt.

ARMOUR 1. Unprofessional conduct 2. Gross negligence 3. Repeated negligent acts 4. Prescribing w/o medical exam 5. Failure to maintain adequate medical records 6. Sexual misconduct w/patient	RICHARD	20A5860	7 YEARS PROBATION WITH TERMS AND CONDITIONS, 3RD PARTY CHAPERONE FOR ALL FEMALE PATIENTS	4/2/14
BALLAINE 1. Gross negligence 2. Repeated negligent acts 3. Failure to maintain adequate medical records 4. Excess treatment or prescribing	DOUGLAS	20A6840	FIVE YEAR PROBATION WITH TERMS AND CONDITIONS: COST RECOVERY $10,000; CONTROLLED SUBSTANCES PARTIAL RESTRICTION; MAINTAIN CONTROLLED SUBSTANCE RECORD; COURSES IN RECORD KEEPING, PRESCRIBING, AND ETHICS. 25 CME HOURS PER YEAR IN PRESCRIBING/PHARMACOLOGY.	8/9/16

BARCZAK 1. Self-administration of controlled substances 2. Use of dangerous drugs to the extent, or in a manner, as to be dangerous to self, another person, or the public, or to the extent is has impaired his ability to practice medicine safely 3. Conviction of a crime related to the qualifications, functions and duties 4. Violation of drug statutes 5. Dishonesty or corruption 6. Unprofessional conduct.	JEFFREY	20A12066	TEN YEAR PROBATION WITH TERMS AND CONDITIONS. MUST ABSTAIN FROM ALCOHOL AND CONTROLLED SUBSTANCES. NO SOLO PRACTICE. PROHIBITED PRACTICE. DIVERSION PROGRAM REQUIRED. CME REQUIRED. COST RECOVERY REQUIRED. ETHICS REQUIRED. PRESCRIBING PRACTICES REQUIRED. PROBATION-QUARTERLY REPORT REQUIRED. PSYCHIATRIC EVALUATION REQUIRED. PSYCHOTHERAPY REQUIRED	10/13/14
CAREY 1. Repeated negligent acts	TONY	20A6032	STIPULATED SETTLEMENT AND DISCIPLINARY ORDER. FILED 09/21/2016. EFFECTIVE 10/06/2016. ONE (1) YEAR EXTENDED PROBATION WITH TERMS AND CONDITIONS; WHICH INCLUDES COST RECOVERY, PRACTICE MONITOR, AND MEDICAL RECORD KEEPING COURSE.	9/21/16
EDMUNDS 1. Unprofessional conduct 2. Conviction of crime 3. Misuse of alcohol or drugs	JEFFREY	20A13462	FIVE YEARS PROBATION. MUST ABSTAIN FROM ALCOHOL AND CONTROLLED SUBSTANCES. DIVERSION PROGRAM REQUIRED. COST RECOVERY REQUIRED. PROBATION-QUARTERLY REPORT REQUIRED. PSYCHIATRIC EVALUATION REQUIRED	6/24/14

FARHOOMAND, 1. GROSS NEGLIGENCE 2. REPEATED NEGLIGENT ACTS 3. INCOMPETENCE 4. DISHONESTY OR CORRUPTION 5. VIOLATION OF DRUG STATUTES/REG 6. PRESCRBNG TO OR TREATING ADDCT 7. PRESCRIBING W/O MEDICAL EXAM 8. FAIL TO MAINTAIN ADEQ MED RCDS 9. EXCESS TREATMENT OR PRESCRIBNG	KAVEH	20A8295	FIVE YEARS PROBATION. MAINTAIN CONTROLLED SUBSTANCE RECORD. CANNOT SUPERVISE PHYSICIAN ASSISTANT.	9/24/14
FAUCETT 1. UNPROFESSIONAL CONDUCT 2. CONVICTION OF CRIME 3. SELF-USE OF DRGS OR ALCOHOL 4. MENTAL/PHYSICAL ILLNESS	RODNEY	20A5369	FIVE YEAR PROBATION; MUST ABSTAIN FROM ALCOHOL AND CONTROLLED SUBSTANCES	4/12/16
GHURABI 1. DISCIPLINE BY ANOTHER STATE 2. MENTAL/PHYSICAL ILLNESS	RAFFI	20A12210	FIVE YEAR PROBATION; MUST ABSTAIN FROM ALCOHOL AND CONTROLLED SUBSTANCES	3/15/16
IDELSHON 1. Violation of terms of probation	BRADLEY	20A5884	TWO YEARS PROBATION	6/24/16
KASHANI 1. FORGE/ALTERATION PRESCRIPTIONS 2. UNPROFESSIONAL CONDUCT 3. CONVICTION OF CRIME 4. SELF-USE OF DRGS OR ALCOHOL	KAVEH	20A10720	FIVE YEARS PROBATION. MUST ABSTAIN FROM ALCOHOL AND CONTROLLED SUBSTANCES. NO SOLO PRACTICE. SURRENDER DEA PERMIT.	6/8/15
KIEFFER 1. CONVICTION OF CRIME 2. AIDING IN THE UNLICENSED PRACTICE OF MEDICINE	MONICA	20A5594	TWO YEARS PROBATION, PROHIBITED PRACTICE	6/1/16

LILLY 1. GROSS NEGLIGENCE 2. REPEATED NEGLIGENT ACTS 3. INCOMPETENCE 4. VIOLATION OF DRUG STATUTES 5. PRESCRIBING WITHOUT A MEDICAL EXAM 6. AIDING IN THE UNLICENSED PRACTICE OF MEDICINE 7. FAIL TO MAINTAIN ADEQ MED RCDS	WILLA	20A4676	SEVEN YEARS PROBATION. CANNOT SUPERVISE PHYSICIAN ASSISTANTS. MUST SURRENDER DEA PERMIT. TOTAL CONTROLLED SUBSTANCES RESTRICTION	4/13/10
LUU 1. UNPROFESSIONAL CONDUCT 2. CONVICTION OF CRIME 3. AIDING IN THE UNLICENSED PRACTICE OF MEDICINE	JAMES	20A7353	THREE YEAR PROBATION. CME REQUIRED. COST RECOVERY REQUIRED. ETHICS 6 MONTH FOLLOWUP. PROBATION-QUARTERLY REPORT REQUIRED	4/29/14
LY 1. GROSS NEGLIGENCE 2. REPEATED NEGLIGENT ACTS 3. INCOMPETENCE	HONGDU	20A11259	FIVE YEARS PROBATION	11/14/14
MAGANITO 1. DISCIPLINE IN ANOTHER STATE	JAMES PAUL	20A11694	THIRTY FIVE MONTHS PROBATION	10/6/15
MAGNUS 1. DISCIPLINE IN ANOTHER STATE	WARREN	20A 8731	THREE YEARS PROBATION. CME REQUIRED. COST RECOVERY REQUIRED ETHICS REQUIRED. PRACTICE MONITOR REQUIRED. PRESCRIBING PRACTICES REQUIRED. PROBATION-QUARTERLY REPORT REQUIRED	1/5/16
MALABED 1. GROSS NEGLIGENCE 2. REPEATED NEGLIGENT ACTS 3. DISHONESTY OR CORRUPTION 4. FAIL TO MAINTAIN ADEQ MED RCDS 5. EXCESS TREATMENT OR PRESCRIBNG	HELENE	20A6778	10 YERS PROBATION. SURRENDER OF DEA PERMIT. NO PRESCRIBING OF CONTROLLED SUBSTANCES. NO SUPERVISING OF PHYSICIANS ASSISTANTS DURING PROBATION.	7/13/10

MCDOUGALL 1. UNPROFESSIONAL CONDUCT 2. VIOLATION OF DRUG STATUTES/REG 3. MISUSE OF ALCOHOL OR DRUGS 4. DISCIPLINE BY ANOTHER STATE	WILLIAM	20A7843	EIGHT YEARS PROBATION. DIVERSION PROGRAM REQUIRED. COST RECOVERY REQUIRED. NO CONTROLLED SUBSTANCE PRESCRIBING. PROBATION-QUARTERLY REPORT REQUIRED. PSYCHIATRIC EVALUATION REQUIRED. PSYCHOTHERAPY REQUIRED	9/18/12
MILLER 1. UNPROFESSIONAL CONDUCT 2. GROSS NEGLIGENCE 3. REPEATED NEGLIGENT ACTS 4. AIDING UNLICD PRACTICE OF MED. 5. FAIL TO MAINTAIN ADEQ MED RCDS	DENNIS	20A8981	FIVE YEARS PROBATION. MUST ABSTAIN FROM ALCOHOL. CANNOT SUPERVISE PHYSICIAN ASSISTANTS	8/4/16
MOERKE 1. UNPROFESSIONAL CONDUCT 2. CONVICTION OF CRIME 3. MISUSE OF ALCOHOL OR DRUGS	BRETT	20A12098	FIVE YEARS PROBATION. MUST ABSTAIN FROM ALCOHOL. CANNOT SUPERVISE PHYSICIAN ASSISTANTS	6/13/14
NALBANDYAN 1. UNPROFESSIONAL CONDUCT 2. DISHONESTY OR CORRUPTION 3. SEXUAL MISCONDUCT WITH A PATIENT	ARSEN	20A9339	SEVEN YEARS PROBATION. BILLING MONITOR REQUIRED. COST RECOVERY REQUIRED. ETHICS 12 MONTH FOLLOWUP REQUIRED. ETHICS 6 MONTH FOLLOWUP REQUIRED. ETHICS REQUIRED. MEDICAL RECORD KEEPING REQUIRED. PROBATION-QUARTERLY REPORT REQUIRED. PROFESSIONAL BOUNDARIES. REQUIRED PSYCHIATRIC EVALUATION REQUIRED.	8/13/14
NGUYEN 1. GROSS NEGLIGENCE 2. PRESCRIBING W/O MEDICAL EXAM 3. FAIL TO MAINTAIN ADEQ MED RCDS 4. EXCESS TREATMENT OR PRESCRIBNG	TAM	20A9636	FIVE YEARS PROBATION. PARTIAL RESTRICTION ON CONTROLLED SUBSTANCE PRESCRIBING	9/25/13

OLIVEIRA 1. UNPROFESSIONAL CONDUCT 2. GROSS NEGLIGENCE 3. REPEATED NEGLIGENT ACTS 4. PRESCRIBING W/O MEDICAL EXAM 5. FAIL TO MAINTAIN ADEQ MED RCDS 6. EXCESS TREATMENT OR PRESCRIBNG	THOMAS	20A7032	FIVE YEARS PROBATION. MAINTAIN CONTROLLED SUBSTANCE RECORD; PARTIAL RESTRCITION ON CONTROLLED SUBSTANCES PRESCRIBING. PROHIBITED PRACTICE	5/29/15
ORRINGER 1. UNPROFESSIONAL CONDUCT 2. DISCIPLINE IMPOSED BY ANOTHER STATE	DAVID	20A15139	35 MONTHS OF PROBATION WITH TERMS AND CONDITIONS INCLUDING SUPERVISED STRUCTURED ENVIRONMENT.	11/9/16
POST 1. UNPROFESSIONAL CONDUCT 2. SELF-USE OF DRGS OR ALCOHOL	AMANDA	20A11045	FIVE YEARS PROBATION. ABSTAIN FROM ALCOHOL AND CONTROLLED SUBSTANCES. NO SOLO PRACTICE	5/30/12
PRECI 1. UNPROFESSIONAL CONDUCT 2. CONVICTION OF CRIME 3. AIDING UNLICD PRACTICE OF MED.	RICHARD	20A7555	FIVE YEARS PROBATION	5/12/14
SANDS 1. MENTAL/PHYSICAL ILLNESS	SANDRA	20A9069	FIVE YEARS PROBATION. PRACTICE MONITOR REQUIRED. PROBATION-QUARTERLY REPORT REQUIRED. PSYCHIATRIC EVALUATION REQUIRED	5/12/15
SEINFELD 1. Discipline in another state	AMY	20A10343	FIVE YEARS PROBATION	12/4/13

SINGHANIA 1. UNPROFESSIONAL CONDUCT 2. CONVICTION OF CRIME 3. SELF-USE OF DRGS OR ALCOHOL	SUNIL	20A7742	FIVE YEARS PROBATION. COST RECOVERY REQUIRED. MEDICAL EVALUATION REQUIRED. PROBATION-QUARTERLY REPORT REQUIRED. PSYCHIATRIC EVALUATION REQUIRED	4/16/15
SOUTHMAYD 1. CONVICTION OF CRIME 2. SELF-USE OF DRGS OR ALCOHOL	ROBERT	20A5298	5 YEARS PROBATION WITH TERMS AND CONDITIONS INCLUDING DIVERSION; ABSTAIN FROM ALCOHOL AND CONTROLLED SUBSTANCES; CLINICAL DIAGNOSTIC EVALUATION; PSYCHOTHERAPY AND MEDICAL ETHICS.	1/9/17
STEENBLOCK 1. VIOLATION OF PROBATION TERMS	DAVID	20A4160	FIVE YEARS PROBATION WITH 60 DAYS SUSPENSION EFFECTI	2/25/13
STEINBERG 1. PRESCRIBING FOR SELF-USE 2. OBTAINING CONTROLLED SUBSTANCES BY FRAUD 3. FORGE/ALTERATION PRESCRIPTIONS 4. DISHONESTY OR CORRUPTION 5. CONVICTION OF CRIME 6. VIOLATION OF DRUG STATUTES/REG 7. SELF-USE OF DRGS OR ALCOHOL	BRENDA	20A8049	FIVE YEAR PROBATION. MUST ABSTAIN FROM ALCOHOL AND CONTROLLED SUBSTANCES; MUST SURRENDER DEA PERMIT; TOTAL RESTRICTION ON PRESCRIBING CONTROLLED SUBSTANCES	8/14/14

STEVER 1. UNPROFESSIONAL CONDUCT 2. DISHONESTY OR CORRUPTION 3. VIOLATION OF DRUG STATUTES/REG 4. MISUSE OF ALCOHOL OR DRUGS 5. PRESCRIBING W/O MEDICAL EXAM 6. ALTERATION OF MEDICAL RECORDS	JENNIFER	20A10348	FIVE YEARS PROBATION. MUST ABSTAIN FROM ALCOHOL AND CONTROLLED SUBSTANCES; NO SOLO PRACTICE.	2/6/14
STRAUSBERG 1. VIOLATION OF DRUG STATUTES/REG 2. SELF-USE OF DRGS OR ALCOHOL 3. VIOL OF PROBATION TERMS/CONDS	STUART	20A3638	5 years probation; 60 day suspension.	11/4/13
THERMOS 1. DISCIPLINE BY ANOTHER STATE	ALEXANDER	20A11028	FIVE YEARS PROBATION	7/22/13
TORRENTE 1. UNPROFESSIONAL CONDUCT 2. PRESCRIBING W/O MEDICAL EXAM 3. FAIL TO MAINTAIN ADEQ MED RCDS	MICHAEL	20A9080	FIVE YEARS PROBATION WITH TERMS AND CONDITIONS; INCLUDING PROHIBITED PRACTICE, PARTIAL RESTRICTION OF CONTROLLED SUBSTANCES, SUPERVISED STRUCTURED ENVIRONMENT & CLINICAL TRAINING.	10/21/16