2013 LEGISLATION

Agenda Item 23A

LEGISLATIVE PACKET

MEDICAL BOARD OF CALIFORNIA
FULL BOARD MEETING

JULY 18-19, 2013

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
July 10, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 27	Medina	UC Riverside Medical School: Funding	Senate 3rd Reading	Support – Ltr. Sent 6/19/13	7/3/13
AB 154	Atkins	Healing Arts: Reproductive Health Care	Sen. Approps	Neutral	6/24/13
AB 186	Maienschein	Professions & Vocations: Military Spouses: Temporary Licenses	Sen. B&P	Support (amends taken) – Ltr. Sent 6/27/13	6/24/13
AB 496	Gordon	Task Force: LGBT Cultural Competency	Sen. Approps	Support – Ltr. Sent 6/19/13	6/25/13
AB 512	Rendon	Sponsored Health Care Events: Sunset Extension	Assembly - Enrollment	Support – Ltr. Sent 6/19	Intro.
AB 565	Salas	California Physician Corps Program	Sen. Approps	Support – Ltr. Sent 6/6/13	7/2/13
AB 589	Fox	Underrepresented Medical Specialties	Asm. Health	2-year Bill	Intro.
AB 635	Ammiano	Drug Overdose Treatment: Liability	Sen. 3rd Reading	Support – Ltr. Sent 5/8/13	6/24/13
AB 809	Logue	Healing Arts: Telehealth	Sen. Health	Support – Ltr. Sent 6/21/13	6/25/13
AB 831	Bloom	Drug Overdoses	Held in Approps.	Support – Ltr. Sent 5/8/13 – 2-year Bill	4/3/13
AB 860	Perea	Medical School Scholarships	Held in Approps.	Support – Ltr. Sent 5/8/13 – 2-year Bill	4/8/13
AB 916	Eggman	Healing Arts: False or Misleading Advertising	Sen. B&P	Support – Ltr. Sent 5/23/13	Intro.
AB 1000	Wieckowski	Physical Therapists: Direct Access to Services	Sen. Approps	Need Board to review again - amended	6/24/13
AB 1003	Maienschein	Professional Corporations: Healing Arts Practitioners	Asm. B&P	2-year bill – merged into AB 1000	4/1/13
AB 1176	Bocanegra & Bonta	Medical Residency Training Program Grants	Held in Approps.	Support – Ltr. Sent 5/8/13 – 2-year Bill	4/23/13

Orange – For Discussion, Green – Positions Taken, Pink – Chaptered, Blue – Spot or 2-year Bill

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
July 10, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1182	Brown	Medically Underserved Areas	Assembly	SPOT	Intro.
AB 1269	Gray	Medicine: Special Faculty Permit	Asm. B&P	SPOT	Intro.
AB 1278	Hueso	Integrative Cancer Treatment	Now SB 117		SB 117
AB 1288	Perez, V.	Medical Board of California: Licensing Application	Assembly - Concurrence	Neutral	6/6/13
AB 1308	Bonilla	Midwifery	Sen. 2nd Reading	Support if Amended – Ltr. Sent 6/6/13	7/9/13
ACR 40	Perez	Donate Life California Day	Chaptered, #19	Support	4/8/13
SB 20	Hernandez	Health Care: Workforce Training	Asm. Approps	Support – Ltr. Sent 6/19/13	2/14/13
SB 21	Roth	UC Riverside Medical School: Funding	Asm. Higher Ed.	Support – Ltr. Sent 5/8/13	6/26/13
SB 62	Price	Coroners: Reporting Requirements: Prescription Drug Use	Asm. Approps	Support – Ltr. Sent 5/8/13	6/27/13
SB 117	Hueso	Integrative Cancer Treatment	Sen. B&P	Neutral – 2-year Bill	4/30/13
SB 304	Price	Healing Arts: Sunset Bill	Asm. B&P	Support if Amended – Ltr. Sent 5/22/13	4/24/13
SB 305	Price	Healing Arts: Boards	Asm. Approps	Support – Ltr. Sent 6/19/13	6/19/13
SB 352	Pavley	Medical Assistants: Supervision	Asm. 3rd Reading	Support (amends taken) – Ltr. Sent 6/21/13	6/19/13
SB 410	Yee	Anesthesiologist Assistants	Senate	2-year Bill	4/30/13
SB 491	Hernandez	Nurse Practitioners	Asm. B&P	Oppose – Ltr. Sent 5/8/13	5/21/13
SB 492	Hernandez	Optometrist Practice: Licensure	Asm. B&P	Neutral, Reco: OUA	5/8/13

Orange – For Discussion, Green – Positions Taken, Pink – Chaptered, Blue – Spot or 2-year Bill

MEDICAL BOARD OF CALIFORNIA - 2013 TRACKER LIST
July 10, 2013

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
SB 493	Hernandez	Pharmacy Practice	Asm. B&P	Support (amends taken)– Ltr. Sent 5/29/13	5/28/13
SB 670	Steinberg	Physicians and Surgeons: Drug Prescribing Privileges	Asm. B&P	Support if Amended – Ltr. Sent 5/8/13	5/24/13
SB 701	Emmerson	Hospital-Affiliated Outpatient Settings	Sen. B&P	2-year Bill	Intro.
SB 796	Nielsen	Medicine: Physicians and Surgeons	Senate	SPOT	Intro.
SB 809	DeSaulnier	Controlled Substances: Reporting: CURES	Asm. B&P	Support in Concept – Ltr. Sent 6/21/13	6/26/13
SCR 8	DeSaulnier	Prescription Drug Abuse Awareness Month	Chaptered, #26	Support – Ltr. Sent 2/7/13	4/18/13

Orange – For Discussion, Green – Positions Taken, Pink – Chaptered, Blue – Spot or 2-year Bill

AB 27

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 27 and SB 21
Author:	Medina and Roth
Bill Date:	July 3 and June 26, 2013, Amended
Subject:	UC Riverside Medical School: Funding
Sponsor:	Author and the California Medical Association
Position:	Support

STATUS OF BILL:

AB 27 is in the Senate and SB 21 is in Assembly Higher Education Committee.

DESCRIPTION OF CURRENT LEGISLATION:

These bills contain similar language and would both annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California (UC), Riverside. Both bills contain urgency clauses, which mean that the bills would take effect immediately once signed into law. SB 21 would specify that the funds shall be available for planning and startup costs associated with academic programs to be offered at the UC Riverside School of Medicine.

Both AB 27 and SB 21 were amended to add findings and declarations and to require the moneys appropriated to only be used for funding the UC Riverside School of Medicine, not for other purposes or to supplant other funding. The amendments would require the UC Riverside School of Medicine to develop a program to identify eligible medical residents and to assist those residents to apply for physician retention programs, including the Steven M. Thompson Medical School Scholarship Program (STMSSP).

AB 27 and SB 21 were amended to remove the appropriation language as the Higher Education Trailer Bill, AB 94, was amended to include a $15,000,000 appropriation allocated to UC Riverside School of Medicine. Both bills reference AB 94 and the appropriation.

ANALYSIS:

The foundation of the School of Medicine at UC Riverside goes back to 1974, when the UC Riverside / University of California, Los Angeles (UCLA) Thomas Haider Program in Biomedical Sciences was established. This program has allowed approximately 700 students to complete their first two years of medical school at UC Riverside, and their last two years at the David Geffen School of Medicine at UCLA, which confers their medical degrees.

In July 2008, the UC Board of Regents officially approved the proposed establishment of an independent four-year School of Medicine at UC Riverside, intended to serve the medically underserved

in the Inland Empire. However, in the summer of 2011, UC Riverside failed to gain accreditation for an independent four-year medical school from the Liaison Committee on Medical Education (LCME), the national accrediting body for educational programs leading to the Medical Doctor degree in United States. LCME withheld preliminary accreditation due to a lack of stable state funding support for the school. In April 2012, UC Riverside secured substantial new funding from a variety of non-state funding sources, and submitted a second accreditation application to LCME. In June 2012, a second accreditation site visit took place and in October 2012, UC Riverside received notification from LCME that its planned medical school received "preliminary accreditation." Preliminary accreditation from LCME enables prospective students to begin applying to the UC Riverside School of Medicine in order to potentially enroll in August 2013.

The purpose of these bills is to provide funding from the General Fund in order to establish a more viable funding source for the UC Riverside School of Medicine. AB 27 and SB 21 no longer include an appropriation, but refer to AB 94, which includes the appropriation for UC Riverside School of Medicine. Both bills specify that funds provided shall be available for planning and startup costs associated with academic programs to be offered at the UC Riverside School of Medicine, including: Academic planning activities, support of academic program offerings, and faculty recruitment; the acquisition of instructional materials and equipment; and ongoing operating support for faculty, staff, and other annual operating expenses for the UC Riverside School of Medicine. Both bills were also amended to add findings and declarations and to require the moneys appropriated to only be used for funding the UC Riverside School of Medicine, not for other purposes or to supplant other funding. The amendments would also require the UC Riverside School of Medicine to develop a program to identify eligible medical residents and to assist those residents to apply for physician retention programs, including the STMSSP.

According to the author, the highest indicator of where a physician practices is where he or she attends medical school and the Inland Empire trails behind much of the state in several key health indicators, including coronary heart disease and diabetes. The author believes that the establishment of a medical school in the Inland Empire will help to ensure more physicians are trained and remain in the Inland Empire. The author contends that one of the areas that will aid in the UC Riverside School of Medicine receiving final accreditation from LCME and meeting the medical needs of the Inland Empire is for the Medical School to receive a stable funding source, which is why this bill seeks to appropriate General Fund monies.

According to the Public Policy Institute of California, the Inland Empire is the fastest-growing region of the state and it is estimated that more than 300,000 residents of the Inland Empire will have health insurance coverage extended to them as a result of the Affordable Care Act. The U.S. Department of Health and Human Services' Council on Graduate Medical Education recommends that a given region have 60 to 80 primary care physicians per 100,000 residents and 85 to 105 specialists. The Inland Empire has about 40 primary care doctors and 70 specialists per 100,000 residents, which is a severe shortage.

These bills will help to increase access to care and help the Inland Empire area of California to prepare and be ready for implementation of the Affordable Care Act; the Board has taken a support position on these bills.

FISCAL: None to the Board

SUPPORT: SB 21 - California Medical Association (Sponsor); American College of Emergency Physicians; Bourns, Gordon Bourns, CEO; California Association of Physician Groups; California Podiatric Medical Association; California Primary Care Association; City of Murieta; Enterprise Media and the Press-Enterprise; Inland Empire Economic Partnership; Insurance Commissioner Dave Jones; Kaiser Permanente; Mayor Rusty Bailey, City of Riverside; Medical Board of California; Riverside County Superintendent of Schools; Southwest California Legislative Council; Southwest Riverside County Association of Realtors; University of California; University of California Riverside Alumni Association; and Western Riverside Council of Governments

AB 27 – California Primary Care Association; California Podiatric Medical Association; Medical Board of California; and Riverside County Superintendent of Schools

OPPOSITION: None on file

AMENDED IN SENATE JULY 3, 2013

AMENDED IN ASSEMBLY MAY 24, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

AMENDED IN ASSEMBLY MARCH 13, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 27

Introduced by Assembly Member Medina
(Principal coauthor: Senator Roth)
(Coauthor: Assembly Member Linder)

December 3, 2012

An act relating to the University of California, ~~making an appropriation therefor,~~ and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 27, as amended, Medina. University of California: UC Riverside Medical School: funding.

Existing provisions of the California Constitution establish the University of California as a public trust under the administration of the Regents of the University of California. The University of California system includes 10 campuses, which are located in Berkeley, Davis, Irvine, Los Angeles, Merced, Riverside, San Diego, San Francisco, Santa Barbara, and Santa Cruz.

~~This bill would annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside. The bill would require the Regents of the University of California to use these~~

(b) California lags substantially in the number of medical school seats per capita, having just 17.3 seats per 100,000 persons, compared to the United States average of 31.4 seats per 100,000 persons, according to statistics published by the Association of American Medical Colleges.

(c) According to the California HealthCare Foundation, 72 percent of California's 58 counties have an undersupply of primary care physicians, with primary care physicians making up just 34 percent of California's physician workforce.

(d) The University of California, Riverside, (UCR) has had a longstanding two-year medical education program and its independent four-year school of medicine has received preliminary accreditation from the Liaison Committee on Medical Education, the nationally recognized accrediting body for medical education programs leading to M.D. degrees in the United States and Canada. When this new four-year medical school opens in August 2013, it will become the first new public medical school in California in more than 40 years.

(e) This community-based medical school with a public mission to expand and diversify the region's physician workforce and to improve the health of people living in inland southern California has made a commitment to underserved patient populations.

(f) There are two principal determinants of where a physician practices: (1) where he or she grew up, and (2) where he or she completes residency training following medical school graduation.

(g) The UCR medical school has strategies to capitalize on both of these factors. Among these strategies are all of the following: (1) developing student pipeline programs that inspire more young people in the region to pursue careers in medicine and other allied health professions and to recruit them to the UCR medical school; (2) utilizing a holistic review of medical school applicants that takes into account diverse life experiences in addition to their academic performance; (3) teaching a curriculum that emphasizes key competencies for primary care medicine, including wellness and prevention, evidence-based medicine, and chronic disease management; (4) creating new residency training programs in primary care and those short-supply specialties that are most needed in inland southern California; and (5) continuing UCR's commitment to the recruitment, retention, and advancement of talented students, faculty, and staff from historically excluded

~~(3) Ongoing operating support for faculty, staff, and other annual operating expenses for the School of Medicine at the University of California, Riverside.~~

~~(c)~~

SEC. 2. The School of Medicine at the University of California, Riverside, ~~shall~~ *is requested to* develop a program, consistent with its mission, in conjunction with the health facilities of its medical residency programs, to identify eligible medical residents and to assist those medical residents to apply for physician retention programs, including, but not limited to, the Steven M. Thompson ~~Physician Corps Loan Repayment~~ *Medical School Scholarship* Program, established pursuant to Article 6 (commencing with Section 128560) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code.

~~(d) On or before April 1 of each year, the University of California shall provide progress reports to the relevant policy and fiscal committees of the Legislature pertaining to funding, recruitment, hiring, and outcomes for the School of Medicine at the University of California, Riverside. Specifically, the report shall include, but not be limited to, information consistent with the published mission and vision for the School of Medicine at the University of California, Riverside, in all of the following areas:~~

~~(1) The number of students who have applied, been admitted, or been enrolled, broken out by race, ethnicity, and gender.~~

~~(2) The number of full-time faculty, part-time faculty, and administration, broken out by race, ethnicity, and gender.~~

~~(3) Funding and progress of ongoing medical education pipeline programs, including the UCR/UCLA Thomas Haider Program in Biomedical Sciences.~~

~~(4) Operating and capital budgets, including detail by funding source, and an explanation of how such funding affects base funding for other university purposes. The operating budget shall include a breakdown of research activities, instruction costs, administration, and executive management.~~

~~(5) Efforts to meet the health care delivery needs of California and the Inland Empire region of the state, including, but not limited to, the percentage of clinical placements, graduate medical education slots, and medical school graduates in primary care specialties who are providing service within California's medically underserved areas and populations.~~

AB 154

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 154
Author:	Atkins
Bill Date:	June 24, 2013, Amended
Subject:	Abortion
Sponsor:	ACCESS Women's Health Justice American Civil Liberties Union of California Black Women for Wellness California Latinas for Reproductive Justice NARAL Pro-Choice California Planned Parenthood Affiliates of California
Position:	Neutral

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would eliminate the distinction in existing law between "surgical" and "nonsurgical" abortions and would allow physician assistants (PAs), nurse practitioners (NPs), and certified nurse-midwives (CNMs) to perform an abortion by medication or aspiration techniques in the first trimester of pregnancy, if specified training is completed and clinical competency is validated.

This bill was recently amended to require NPs and CNMs to adhere to standardized procedures and for PAs to comply with protocols that include specific information in order to perform an abortion by aspiration techniques. The amendments specify that it is unprofessional conduct for NPs, CNMs or PAs to perform an aspiration abortion without prior completion of training and validation of clinical competency.

ANALYSIS:

This bill will codify the Health Workforce Pilot Project (HWPP) #171, coordinated through the Office of Statewide Health Planning and Development (OSHPD) and sponsored by the Advancing New Standards in Reproductive Health (ANSIRH) program at the University of California, San Francisco (UCSF). The purpose of the pilot project was to evaluate the safety, effectiveness and acceptability of NPs, NMs, and PAs in providing aspiration abortions, and to evaluate the implementation of a standardized, competency based curriculum in provision of aspiration abortion care.

As part of the pilot, 40 NPs, CNMs and PAs were trained to be competent in aspiration abortion care. Clinicians participated in a comprehensive didactic and supervised clinical training program, which included a written exam and competency-based evaluation process. Trainee competency was evaluated daily and at the end of training on confidence, procedural performance, patient care,

communication /interpersonal skills, professionalism, practice-based learning, and clinical knowledge.

This bill would require PAs, NPs, and CNMs to complete specified training and achieve clinical competency, which was also required as a part of the pilot project, before they are allowed to perform abortions by aspiration techniques.

This bill now would require NPs and CNMs to adhere to standardized procedures and for PAs to comply with protocols that include the following information, in order to perform an abortion by aspiration techniques:

- The extent of supervision by a physician and surgeon with relevant training and expertise.
- Procedures for transferring patients to the care of the physician and surgeon or hospital.
- Procedures for obtaining assistance and consultation from a physician and surgeon.
- Procedures for providing emergency care until physician assistance and consultation are available.
- The method of periodic review of the provisions of standardized procedures and protocols.

This bill now specifically states that it is unprofessional conduct for NPs, CNMs or PAs to perform an aspiration abortion without prior completion of training and validation of clinical competency.

STATISTICS of the HWPP Pilot Project (#171) (Taken from the Peer Reviewed Study published in the American Journal of Public Health):

Patient sample selection, enrollment and consent:

- 5,675 first-trimester aspiration abortion procedures were completed by NPs/CNMs/PAs and 5,812 procedures were completed by physicians, for a total of 11,487 abortion procedures.

Abortion-related complications summary:

- A complication is identified at the time of the procedure (immediate) or after the procedure (delayed) and classified as either major (defined by the project's Data and Clinical Safety Monitoring Committee (DCSMC) as "complications requiring abortion-related surgeries, transfusion or hospitalization") or minor.
- Overall abortion-related complication rate: 1.3% of all procedures (152 of 11,487) had abortion-related complication diagnoses.
- Group-specific abortion-related complication rate: 1.8% for NPs, CNMs, and PAs and 0.9% for physicians.
- 96% (146 out of 152) of abortion-related complications were minor; 6 cases have been classified as major complications.
- The most common type of minor abortion-related complication diagnoses reported were incomplete abortion, hematometra, and failed abortion. Major abortion-related complications include hemorrhage, infection, and uterine perforation.
- The peer reviewed study found that abortion complications were clinically equivalent between newly trained NPs, CNMs, and PAs and physicians.

According to the author's office, this bill is needed to ensure that women in California have access to early abortion. According to the author's office early abortion access is a critical public health issue as many women in California do not have sufficient access to aspiration abortion because many counties in California lack an abortion provider, which requires women to travel a significant distance for care. The sponsors believe that increasing the number of providers for aspiration abortions will increase the ability of women to receive safe reproductive health care from providers in their community.

FISCAL: None

SUPPORT: ACCESS Women's Health Justice (sponsor); American Civil Liberties Union of California (Sponsor); Black Women for Wellness California (sponsor); Latinas for Reproductive Justice (sponsor); NARAL Pro-Choice California (sponsor); and Planned Parenthood Affiliates of California (sponsor); ACT for Women and Girls; American Association of University Women; American College of Nurse-Midwives; American Nurses Association; Bay Area Communities for Health Education; Business and Professional Women of Nevada County; California Association for Nurse Practitioners; California Church IMPACT; California Family Health Council; California Medical Association; California Nurse-Midwives Association; California Women's Law Center; Cardea Institute; Center on Reproductive Rights and Justice at UC Berkeley School of Law; Choice USA; Forward Together; Fresno Barrios Unidos; Khmer Girls in Action; Law Students for Reproductive Justice; League of Women Voters of California; National Asian Pacific American Women's Forum; National Center for Lesbian Rights; National Council of Jewish Women – California; National Health Law Program; National Latina Institute for Reproductive Health; National Network of Abortion Funds; Nevada County Citizens for Choice; Nursing Students for Choice – UCSF; Physicians for Reproductive Health; Planned Parenthood Mar Monte; Planned Parenthood of Orange and San Bernardino Counties; Planned Parenthood Pasadena & San Gabriel Valley; Planned Parenthood of Santa Barbara, Ventura, and San Luis Obispo Counties; Planned Parenthood of the Pacific Southwest; Reproductive Justice Coalition of Los Angeles; Six Rivers Planned Parenthood; Students for Reproductive Justice at Stanford University; Women's Community Clinic; Women's Health Specialists of California; and several individuals

OPPOSITION: California Catholic Conference; Coalition for Women and Children; Concerned Women for America; California Right to Life Committee; Capitol Resource Family Impact; Greg Watkins, City Councilman, City of Shasta Lake; John Paul the Great Catholic University Students for Life; Pro-Life Mission: International; San Jose State Students for Life; Traditional Values Coalition; University of Southern California Students for Life and several individuals

AMENDED IN SENATE JUNE 24, 2013

AMENDED IN ASSEMBLY APRIL 30, 2013

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 154

Introduced by Assembly Member Atkins
(Principal coauthor: Senator Jackson)
(Coauthors: Assembly Members Mitchell and Skinner)

January 22, 2013

An act to amend Section 2253 of, and to add Sections 2725.4 and 3502.4 to, the Business and Professions Code, and to amend Section 123468 of the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 154, as amended, Atkins. Abortion.

Existing law makes it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform or assist in performing a surgical abortion if the person does not have a valid license to practice as a physician and surgeon, or to assist in performing a surgical abortion without a valid license or certificate obtained in accordance with some other law that authorizes him or her to perform the functions necessary to assist in performing a surgical abortion. Existing law also makes it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform or assist in performing a nonsurgical abortion if the person does not have a valid license to practice as a physician and surgeon or does not have a valid license or certificate obtained in accordance with some other law authorizing him or her to perform or assist in performing

The people of the State of California do enact as follows:

SECTION 1. Section 2253 of the Business and Professions Code is amended to read:

2253. (a) Failure to comply with the Reproductive Privacy Act (Article 2.5 (commencing with Section 123460) of Chapter 2 of Part 2 of Division 106 of the Health and Safety Code) constitutes unprofessional conduct.

(b) (1) Except as provided in paragraph (2), a person is subject to Section 2052 if he or she performs an abortion, and at the time of so doing, does not have a valid, unrevoked, and unsuspended license to practice as a physician and surgeon.

(2) A person shall not be subject to Section 2052 if he or she performs an abortion by medication or aspiration techniques in the first trimester of pregnancy, and at the time of so doing, has a valid, unrevoked, and unsuspended license or certificate obtained in accordance with the Nursing Practice Act (Chapter 6 (commencing with Section 2700)) or the Physician Assistant Practice Act (Chapter 7.7 (commencing with Section 3500)), that authorizes him or her to perform the functions necessary for an abortion by medication or aspiration techniques.

(c) In order to perform an abortion by aspiration techniques pursuant to paragraph (2) of subdivision (b), a person shall comply with Section 2725.4 or 3502.4.

SEC. 2. Section 2725.4 is added to the Business and Professions Code, to read:

2725.4. ~~(a)~~ *Notwithstanding any other provision of this chapter, the following shall apply:*

(a) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall complete training recognized by the Board of Registered Nursing. Beginning January 1, 2014, and until January 1, 2016, the competency-based training protocols established by Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be used.

(b) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall

comply with protocols developed in compliance with Section 3502 that specify:

(1) The extent of supervision by a physician and surgeon with relevant training and expertise.

(2) Procedures for transferring patients to the care of the physician and surgeon or a hospital.

(3) Procedures for obtaining assistance and consultation from a physician and surgeon.

(4) Procedures for providing emergency care until physician assistance and consultation ~~is~~ *are* available.

(5) The method of periodic review of the provisions of the protocols.

(c) The training protocols established by HWPP No. 171 shall be deemed to meet the standards of the board. A physician assistant who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques pursuant to Section 2253, in adherence to protocols described in subdivision (b).

(d) It is unprofessional conduct for any physician assistant to perform an abortion by aspiration techniques pursuant to Section 2253 without prior completion of training and validation of clinical competency.

SEC. 4. Section 123468 of the Health and Safety Code is amended to read:

123468. The performance of an abortion is unauthorized if either of the following is true:

(a) The person performing the abortion is not a health care provider authorized to perform an abortion pursuant to Section 2253 of the Business and Professions Code.

(b) The abortion is performed on a viable fetus, and both of the following are established:

(1) In the good faith medical judgment of the physician, the fetus was viable.

(2) In the good faith medical judgment of the physician, continuation of the pregnancy posed no risk to life or health of the pregnant woman.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or

AB 496

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 496
Author:	Gordon
Bill Date:	June 25, 2013, Amended
Subject:	Medicine: Sexual Orientation, Gender Identity, and Gender Expression
Sponsor:	Equality California
Position:	Support

STATUS OF BILL:

This bill is in Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would reauthorize the Task Force on Culturally and Linguistically Competent Physicians and Dentists in order to expand the Task Force's membership and charge to include the lesbian, gay, bisexual, transgender, and intersex (LGBTI) community. This bill would require the reconstituted Task Force to report its findings to the Legislature by January 1, 2016. This bill would also expand the definition of cultural competency.

This bill was amended to require local medical societies to develop and distribute a survey for language minority patients and LGBTI patients to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided pursuant to this bill. This bill would require local medical societies to develop an evaluation survey for physicians to assess the quality of education or training programs on cultural and linguistic competency. This bill would require the survey information to be shared with the Board's Cultural and Linguistic Competency (CLC) Workgroup.

ANALYSIS:

This bill would reauthorize the Task Force on Culturally and Linguistically Competent Physicians and Dentists to consist of the following members: The Deputy Director of the Office of Health Equity or his or her designee and the Director of the Department of Consumer Affairs (DCA) or his or her designee to serve as co-chairs; the Executive Director of the Medical Board of California (Board) or his or her designee; the Executive Director of the Dental Board of California or his or her designee; one member appointed by the Senate; and one member appointed by the Assembly. This bill would allow additional members to be appointed by the Director of DCA, in consultation with the Office of Health Equality, as follows: representatives of organizations that advocate on behalf of physicians and dentists; physicians and dentists who provide health services to members of language and ethnic minority groups and LGBTI groups; representatives of entities that offer continuing education for physicians and dentists; representatives of California's medical and dental schools; and individuals with experience in developing, implementing, monitoring, and evaluating cultural and linguistic programs.

This bill would specify that the duties of the Task Force would be the same as before: to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to meet linguistic competence; to identify key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices; and to assess the need for voluntary certification standards and examinations for cultural competency. This bill would require the Task Force to hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups, and this bill would add LGBT groups, to determine their needs and preferences for having culturally competent medical providers. This bill would require the hearings to be held in communities that have large populations of language and ethnic minority groups and LGBTI groups. This bill would require the Task Force to report its findings to the Legislature and appropriate licensing boards by January 1, 2016. This bill would require the Board and the Dental Board to pay the administrative costs of implementing the Task Force, the hearings, and the report.

This bill would also amend the Cultural and Linguistic Competency of Physicians Act of 2003 regarding the cultural and linguistic physician competency program that is operated by local medical societies of the California Medical Association and monitored by the Board. The program is a voluntary program consisting of educational classes. This bill would expand the program to require it to additionally address LGBTI groups of interest to local medical societies. In addition, this bill would require the training programs to be formulated in collaboration with LGBTI medical societies.

This bill was amended to require local medical societies to develop and distribute a survey for language minority patients and LGBTI patients to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided pursuant to this bill. This bill would require local medical societies to develop an evaluation survey for physicians to assess the quality of education or training programs on cultural and linguistic competency. This bill would require the survey information to be shared with the Board's Cultural and Linguistic Competency (CLC) Workgroup.

This bill does not add to or change existing law related to the working group that has already been convened by the Board and that continues to exist, which is the Cultural and Linguistic Physician Competency Program (CLC) Workgroup. Lastly, this bill would define "cultural and linguistic competency" to include understanding and applying the roles that sexual orientation, gender identity, and gender expression play in diagnosis, treatment and clinical care and developing behaviors that increase a patient's satisfaction with, and trust in, his or her physicians and health care institutions.

According to the author's office, LGBTI patients have reported a reluctance to reveal their sexual orientation or gender identity to their providers, despite the importance of such information for their health care. The author believes that cultural competency plays a crucial role in understanding, diagnosing, and delivering appropriate care to LGBTI patients. The ability of physicians to effectively communicate with, and to create a welcoming and safe environment for their LGBTI patients, has an impact on LGBTI patient health outcomes and on provider-patient relationships.

Although DCA, the Board, and the Dental Board already convened and participated in the Task Force on Culturally and Linguistically Competent Physicians and Dentists, LGBTI issues were not

addressed at the Task Force, the hearings, or in the final report to the Legislature. This bill would reauthorize this Task Force and include LGBTI issues for the Task Force to hold hearings on and include in its report to the Legislature. Since this bill does not expand the working group convened by the Board, the Board would only need to include agenda items at future meetings that address understanding and applying the roles that sexual orientation, gender identity, and gender expression play in diagnosis, treatment and clinical care and developing behaviors that increase a patient's satisfaction with, and trust in, his or her physicians and health care institutions. The Board's Executive Director would be required to participate in the reauthorized Task Force and the Board would be partially responsible for the costs associated with the Task Force, hearings, and the report to the Legislature.

FISCAL: $43,000 (this is the Board's portion of the cost associated with the prior Task Force)

SUPPORT: Equality California (sponsor); AIDS Legal Referral Panel; Asian & Pacific Islander Wellness Center; Asian Americans for Civil Rights and Equality; Asian Law Caucus; Asian Pacific Islander Equality – Northern Chapter; Betty T. Yee, Member, First District, State Board of Equalization; California Academy of Family Physicians; California Communities United Institute; California Mental Health Directors Association; California Pan Ethnic Health Network; California Primary Care Association; City of West Hollywood; Gay & Lesbian Medical Association; Gay Asian Pacific Alliance; L.A. Gay & Lesbian Center; Lyon-Martin Health Services; Medical Board of California; Mental Health American of Northern California; National Association of Social Workers – California Chapter; National Center for Lesbian Rights; Our Family Coalition; Planned Parenthood Affiliates of California; San Francisco Eligible Metropolitan Area HIV Health Services Planning Council; The Black AIDS Institute; The Gay & Lesbian Community Services Center of Orange County; The Greenlining Institute; The National Asian Pacific American Women's Forum; The Trevor Project; and 67 individuals

OPPOSITION: California Right to Life Committee, Inc.

AMENDED IN SENATE JUNE 25, 2013

AMENDED IN ASSEMBLY APRIL 10, 2013

AMENDED IN ASSEMBLY APRIL 2, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 496

Introduced by Assembly Member Gordon
(Coauthors: Assembly Members Ammiano and Atkins)
(Coauthors: Senators Lara and Leno)

February 20, 2013

An act to amend Sections 852, 2198, and 2198.1 of the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 496, as amended, Gordon. Medicine: sexual orientation, gender identity, and gender expression.

Existing law creates the Task Force on Culturally and Linguistically Competent Physicians and Dentists. Existing law requires the Director of Health Care Services and the Director of Consumer Affairs to serve as cochairs of the task force. Existing law requires that the task force consist of, among other people, the Executive Director of the Medical Board of California and the Executive Director of the Dental Board of California. Existing law additionally requires the Director of Consumer Affairs, in consultation with the Director of Health Care Services, to appoint as task force members, among other people, California licensed physicians and dentists who provide health services to members of language and ethnic minority groups and representatives of organizations that advocate on behalf of, or provide health services to, members of language and ethnic minority groups. Existing law required the task

Existing law requires local medical societies to develop and distribute a survey for language minority patients to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency described above.

This bill would also require local medical societies to develop and distribute a similar survey to lesbian, gay, bisexual, transgender, and intersex patients.

Existing law also defines "cultural and linguistic competency" for the purposes of those provisions as meaning cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including understanding and applying the roles that culture, ethnicity, and race play in diagnosis, treatment, and clinical care, and awareness of how the attitudes, values, and beliefs of health care providers and patients influence and impact professional and patient relations.

This bill would ~~also~~ redefine the term "cultural and linguistic competency" ~~as~~ *to also include* understanding and applying the roles that ~~culture, ethnicity, race,~~ sexual orientation, gender identity, and gender expression play in diagnosis, treatment, and clinical care, and ~~awareness of how the attitudes, values, and beliefs of health care providers, patients, and society influence and impact professional and patient relations~~ *developing behaviors that increase a patient's satisfaction with, and trust in, his or her physicians and health care institutions*. The bill would also make related technical, nonsubstantive changes.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 852 of the Business and Professions Code is amended to read:

852. (a) The Task Force on Culturally and Linguistically Competent Physicians and Dentists is hereby created and shall consist of the following members:

(1) The Deputy Director of the Office of Health Equity, or his or her designee, and the Director of Consumer Affairs, or his or her designee, who shall serve as cochairs of the task force.

(2) The Executive Director of the Medical Board of California, or his or her designee.

(e) The task force shall report its findings to the Legislature and appropriate licensing boards on or before January 1, 2016.

(f) The Medical Board of California and the Dental Board of California shall pay the state administrative costs of implementing this section.

(g) Nothing in this section shall be construed to require mandatory continuing education of physicians and dentists.

SEC. 2. Section 2198 of the Business and Professions Code is amended to read:

2198. (a) This article shall be known and may be cited as the Cultural and Linguistic Competency of Physicians Act of 2003. The cultural and linguistic physician competency program is hereby established and shall be operated by local medical societies of the California Medical Association and shall be monitored by the Medical Board of California.

(b) This program shall be a voluntary program for all interested physicians. As a primary objective, the program shall consist of educational classes which shall be designed to teach physicians the following:

(1) A foreign language at the level of proficiency that initially improves their ability to communicate with non-English speaking patients.

(2) A foreign language at the level of proficiency that eventually enables direct communication with the non-English speaking patients.

(3) Cultural beliefs and practices that may impact patient health care practices and allow physicians to incorporate this knowledge in the diagnosis and treatment of patients who are not from the predominate culture in California.

(c) The program shall operate through local medical societies and shall be developed to address the ethnic language minority groups, as well as lesbian, gay, bisexual, ~~and transgender~~ *transgender, and intersex* groups, of interest to local medical societies.

(d) In dealing with Spanish language and cultural practices of Mexican immigrant communities, the cultural and linguistic training program shall be developed with direct input from physician groups in Mexico who serve the same immigrant population in Mexico. A similar approach may be used for any of the languages and cultures that are taught by the program or

~~programs on cultural and linguistic competency. This information shall be shared with the workgroup established by the Medical Board of California.~~

(j) (1) Local medical societies shall develop and distribute a survey for both of the following groups of individuals to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided pursuant to this section:

(A) Language minority patients.

(B) Lesbian, gay, bisexual, transgender, and intersex patients.

(2) Local medical societies shall also develop an evaluation survey for physicians to assess the quality of education or training programs on cultural and linguistic competency provided pursuant to this section.

(3) The information provided by these surveys shall be shared with the workgroup established by the Medical Board of California pursuant to subdivision (h).

SEC. 3. Section 2198.1 of the Business and Professions Code is amended to read:

2198.1. For purposes of this article, "cultural and linguistic competency" means cultural and linguistic abilities that can be incorporated into therapeutic and medical evaluation and treatment, including, but not limited to, the following:

(a) Direct communication in the patient-client primary language.

(b) Understanding and applying the roles that culture, ethnicity, race, sexual orientation, gender identity, and gender expression play in diagnosis, treatment, and clinical care.

(c) Awareness of how the attitudes, values, and beliefs of health care providers, patients, and society influence and impact professional and patient relations.

(d) Developing behaviors that increase a patient's satisfaction with, and trust in, his or her physicians and health care institutions.

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AB 512

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 512
Author:	Rendon
Bill Date:	February 20, 2013, Introduced
Subject:	Sponsored Health Care Events: Sunset Extension
Sponsor:	Los Angeles County Board of Supervisors
Position:	Support

STATUS OF BILL:

This bill is in the Assembly and is ready to be sent to enrollment.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would extend the sunset date in existing law, from 2014 to 2018, for provisions that authorize health care practitioners who are licensed or certified in other states to provide health care services on a voluntary basis to uninsured or underinsured individuals in California at sponsored free health care events.

ANALYSIS

AB 2699 (Bass, Chapter 270, Statutes of 2010) allows health care practitioners, including physicians, who are not licensed to practice in California, but that hold a valid license or certificate in good standing in another state, to volunteer to provide health care services at sponsored free health care events, under specified circumstances. The bill required that all appropriate boards under the Department of Consumer Affairs (DCA) promulgate regulations before the bill could be implemented. The Medical Board was the first board under DCA to develop regulations, which became effective on August 20, 2012. Physicians licensed in other states are required to submit a request for authorization to practice without a California license at a sponsored free health care event to the Board and must also submit fingerprints before they can participate. The authorization period may not be for more than 10 days.

Existing law would sunset the ability for out-of-state health care practitioners to participate in sponsored free health care events in 2014. Although the Medical Board has promulgated regulations, many boards under DCA have not. The author and sponsor would like to extend the sunset date in existing law to allow health care practitioners to participate in sponsored free health care events and give the program more time to demonstrate its success. According to Los Angeles County, an extension of the sunset date in existing law will allow California to continue to provide access to needed health care and dental services to uninsured and underinsured consumers in this state.

Although the Board has only issued one physician permit under the program that was created by AB 2699, the Board has already done the work to promulgate regulations; as such, it seems reasonable to extend the sunset date to allow more individuals to provide health care services at sponsored free health care events in California. This bill would enable all boards to collect data and track the number of out-of-state health care practitioners that request authorization to participate in sponsored free health care events. This bill would help to ensure these events have enough providers to serve more uninsured and underinsured consumers in California; the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Los Angeles County Board of Supervisors (Sponsor)
Association of Healthcare Districts
California Board of Behavioral Sciences (if amended)
California State Board of Pharmacy
Medical Board of California

OPPOSITION: California Nurses Association
American Nurses Association of California

ASSEMBLY BILL No. 512

Introduced by Assembly Member Rendon

February 20, 2013

An act to amend Section 901 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 512, as introduced, Rendon. Healing arts: licensure exemption.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which he or she is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

Existing law provides, until January 1, 2014, an exemption from the licensure and regulation requirements for a health care practitioner, as defined, licensed or certified in good standing in another state or states, who offers or provides health care services for which he or she is licensed or certified through a sponsored event, as defined, (1) to uninsured or underinsured persons, (2) on a short-term voluntary basis, (3) in association with a sponsoring entity that registers with the applicable healing arts board, as defined, and provides specified information to the county health department of the county in which the health care services will be provided, and (4) without charge to the recipient or a 3rd party on behalf of the recipient, as specified. Existing law also requires an exempt health care practitioner to obtain prior authorization to provide these services from the applicable licensing

(A) Obtains authorization from the board to participate in the sponsored event after submitting to the board a copy of his or her valid license or certificate from each state in which he or she holds licensure or certification and a photographic identification issued by one of the states in which he or she holds licensure or certification. The board shall notify the sponsoring entity, within 20 calendar days of receiving a request for authorization, whether that request is approved or denied, provided that, if the board receives a request for authorization less than 20 days prior to the date of the sponsored event, the board shall make reasonable efforts to notify the sponsoring entity whether that request is approved or denied prior to the date of that sponsored event.

(B) Satisfies the following requirements:

(i) The health care practitioner has not committed any act or been convicted of a crime constituting grounds for denial of licensure or registration under Section 480 and is in good standing in each state in which he or she holds licensure or certification.

(ii) The health care practitioner has the appropriate education and experience to participate in a sponsored event, as determined by the board.

(iii) The health care practitioner shall agree to comply with all applicable practice requirements set forth in this division and the regulations adopted pursuant to this division.

(C) Submits to the board, on a form prescribed by the board, a request for authorization to practice without a license, and pays a fee, in an amount determined by the board by regulation, which shall be available, upon appropriation, to cover the cost of developing the authorization process and processing the request.

(2) The services are provided under all of the following circumstances:

(A) To uninsured or underinsured persons.

(B) On a short-term voluntary basis, not to exceed a 10-calendar-day period per sponsored event.

(C) In association with a sponsoring entity that complies with subdivision (d).

(D) Without charge to the recipient or to a third party on behalf of the recipient.

(c) The board may deny a health care practitioner authorization to practice without a license if the health care practitioner fails to

his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The sponsoring entity shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.

(h) A contract of liability insurance issued, amended, or renewed in this state on or after January 1, 2011, shall not exclude coverage of a health care practitioner or a sponsoring entity that provides, or arranges for the provision of, health care services under this section, provided that the practitioner or entity complies with this section.

(i) Subdivision (b) shall not be construed to authorize a health care practitioner to render care outside the scope of practice authorized by his or her license or certificate or this division.

(j) (1) The board may terminate authorization for a health care practitioner to provide health care services pursuant to this section for failure to comply with this section, any applicable practice requirement set forth in this division, any regulations adopted pursuant to this division, or for any act that would be grounds for discipline if done by a licensee of that board.

(2) The board shall provide both the sponsoring entity and the health care practitioner with a written notice of termination including the basis for that termination. The health care practitioner may, within 30 days after the date of the receipt of notice of termination, file a written appeal to the board. The appeal shall include any documentation the health care practitioner wishes to present to the board.

(3) A health care practitioner whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless and until a subsequent request for authorization has been approved by the board. A health care practitioner who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of the applicable provisions of this division, and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.

(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall

AB 565

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 565
Author:	Salas
Bill Date:	July 2, 2013, Amended
Subject:	California Physician Corps Program
Sponsor:	California Medical Association
Position:	Support

STATUS OF BILL:

This bill is currently in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would tighten the guidelines for selection of applicants to the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP) and would expand the definition of practice settings for this program.

This bill was recently amended to amend the definition of "practice setting" and to make technical, clarifying amendments related to the STLRP guidelines being developed by the Office of Statewide Health Planning and Development (OSHPD).

ANALYSIS:

The STLRP was created in 2002 via legislation which was co-sponsored by the Medical Board of California (Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to $105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to the Health Professions Education Foundation (HPEF). Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions' students and recent graduates, these programs are funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, and corporations, as well as through a surcharge on the renewal fees of various health professionals, including a $25 fee paid by physicians and surgeons.

AB 565 would amend the STLRP guidelines to require applicants to have three years of experience providing health care services to medically underserved populations or in a medically underserved area, which is defined in existing law as an area that is a health professional shortage area pursuant to the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission. Existing law only requires applicants to have three years of experience working in medically underserved areas or with medically underserved populations. This bill would also delete the existing guideline that would seek to place the most qualified applicants in the areas with the greatest need and replace it with a guideline that would give preference to applicants who

agree to practice in a medically underserved area as defined in existing law, and who agree to serve a medically underserved population. This bill would also require that priority consideration be given to applicants from rural communities who agree to practice in a physician owned and operated medical practice setting, defined in existing law as a medical practice located in a medically underserved area and at least 50 percent of the patients are from a medically underserved population.

For purposes of the STLRP, this bill would also add to the definition of a "practice setting" a private practice that provides primary care located in a medically underserved area and has a minimum of 30 percent uninsured, Medi-Cal, or other publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

Recent amendments delete the above addition and instead add to the definition of a "practice setting" a physician owned and operated medical practice setting that provides primary care located in a medically underserved area and has a minimum of 30 percent of its patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the poverty level.

According to the author, California faces a misdistribution of physicians and there are shortages of primary care physicians in 74 percent of counties in California. In the last five years, only one physician has been selected to practice in Kings and Kern counties under the STLRP. The author and stakeholders have recognized the STLRP's high demand and the need to tighten the criteria to ensure that scarce resources are going to the most medically underserved communities.

Adding medically underserved areas from existing law to the guidelines will help to ensure that STLRP applicants are serving in the areas with the most need, which will further the Board's mission of promoting access to care; the Board has taken a support position on this bill. The recent amendments do not impact the Board's Support position or the reasons for taking that position.

FISCAL: None

SUPPORT: California Medical Association (Sponsor); American Academy of Pediatrics, California; American College of Emergency Physicians, California Chapter; Association of California Healthcare Districts; Board of Trustees of the Delano Joint Union High School District; California Academy of Physician Assistants; California Optometric Association; City of Hanford; Community Action Partnership of Kern; Community Clinic Association of Los Angeles County; Kern Medical Center; Medical Board of California; Osteopathic Physicians and Surgeons of California; Rural County Representatives of California; and Semitropic Elementary School District

OPPOSITION: None on file

AMENDED IN SENATE JULY 2, 2013

AMENDED IN ASSEMBLY APRIL 23, 2013

AMENDED IN ASSEMBLY APRIL 10, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 565

Introduced by Assembly Member Salas
(Coauthors: Assembly Members Chesbro, Logue, and Pan)
(Coauthor: Senator Anderson)

February 20, 2013

An act to amend Sections 128552 and 128553 of the Health and Safety Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 565, as amended, Salas. California Physician Corps Program.

Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program in the California Physician Corps Program within the Health Professions Education Foundation, which provides financial incentives, as specified, to a physician and surgeon for practicing in a medically underserved community. Existing law authorizes the Office of Statewide Health Planning and Development to adopt guidelines by regulation and requires the foundation to use guidelines for selection and placement of program applicants. These guidelines provide priority consideration to applicants who meet specified criteria, including that the applicant has 3 years of experience working in medically underserved areas or with medically underserved populations. The guidelines also must seek to place the most qualified applicants in the areas with the greatest need.

The people of the State of California do enact as follows:

SECTION 1. Section 128552 of the Health and Safety Code is amended to read:

128552. For purposes of this article, the following definitions shall apply:

(a) "Account" means the Medically Underserved Account for Physicians established within the Health Professions Education Fund pursuant to this article.

(b) "Foundation" means the Health Professions Education Foundation.

(c) "Fund" means the Health Professions Education Fund.

(d) "Medi-Cal threshold languages" means primary languages spoken by limited-English-proficient (LEP) population groups meeting a numeric threshold of 3,000, eligible LEP Medi-Cal beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal beneficiaries residing in two contiguous ZIP Codes.

(e) "Medically underserved area" means an area defined as a health professional shortage area in Part 5 of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225.

(f) "Medically underserved population" means the Medi-Cal program, Healthy Families Program, and uninsured populations.

(g) "Office" means the Office of Statewide Health Planning and Development (OSHPD).

(h) "Physician Volunteer Program" means the Physician Volunteer Registry Program established by the Medical Board of California.

(i) "Practice ~~setting~~" *setting," for the purposes of this article only,* means either of the following:

(1) A community clinic as defined in subdivision (a) of Section 1204 and subdivision (c) of Section 1206, a clinic owned or operated by a public hospital and health system, *or* a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to Section 17000 of the Welfare and Institutions Code, which is located in a medically underserved area and at least 50 percent of whose

patients from medically underserved populations and who meet one or more of the following criteria:

(A) Speak a Medi-Cal threshold language.

(B) Come from an economically disadvantaged background.

(C) Have received significant training in cultural and linguistically appropriate service delivery.

(D) Have three years of experience providing health care services to medically underserved populations or in a medically underserved area, as defined in subdivision (e) of Section 128552.

(E) Have recently obtained a license to practice medicine.

(2) Include a process for determining the needs for physician services identified by the practice setting and for ensuring that the practice setting meets the definition specified in subdivision (h) of Section 128552.

(3) Give preference to applicants who have completed a three-year residency in a primary specialty.

(4) Give preference to applicants who agree to practice in a medically underserved area, as defined in subdivision (e) of Section 128552, and who agree to serve a medically underserved population.

(5) Give priority consideration to applicants from rural communities who agree to practice in a physician owned and operated medical practice setting as defined in paragraph (2) of subdivision (i) of Section 128552.

(6) Include a factor ensuring geographic distribution of placements.

(7) Provide priority consideration to applicants who agree to practice in a geriatric care setting and are trained in geriatrics, and who can meet the cultural and linguistic needs and demands of a diverse population of older Californians. On and after January 1, 2009, up to 15 percent of the funds collected pursuant to Section 2436.5 of the Business and Professions Code shall be dedicated to loan assistance for physicians and surgeons who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 years or adults with disabilities.

(d) (1) The foundation may appoint a selection committee that provides policy direction and guidance over the program and that complies with the requirements of subdivision (*l*) of Section 128552.

AB 635

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 635
Author:	Ammiano
Bill Date:	June 24, 2013, Amended
Subject:	Drug Overdose Treatment: Liability
Sponsor:	Harm Reduction Coalition California Society of Addiction Medicine
Position:	Support

STATUS OF BILL:

This bill is on the Senate Third Reading File.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would amend the civil code to allow a licensed health care provider that is authorized by law to prescribe an opioid antagonist, to prescribe and subsequently dispense or distribute an opioid antagonist to a person at risk of on opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose. This bill would allow the licensed health care provider to issue standing orders for the administration of the opioid antagonist. This bill would require a person who is prescribed an opioid antagonist or possesses it pursuant to a standing order to receive specified training. This bill would specify that if a health care provider or person who possesses, distributes, or administers an opioid antagonist pursuant to a prescription or order acts with reasonable care, they shall not be subject to professional review, be found liable in a civil action, or be subject to criminal prosecution for issuing a prescription or order or possessing, distributing, or administering the opioid antagonist.

The recent amendment adds that a person not otherwise licensed to administer an opioid antagonist, but trained as required by this bill, who acts with reasonable care in administering an opioid antagonist in good faith and not for compensation, shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for the administration.

BACKGROUND (taken from the fact sheet)

Naloxone is used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdosing person to breathe normally. Naloxone is a non-scheduled, inexpensive prescription medication with the same level of regulation as ibuprofen. Naloxone only works if a person has opioids in their system, and has no effect if opioids are absent.

In 2008, SB 797 (Ridley-Thomas, Chapter 477, Statutes of 2007) established a three-year overdose prevention pilot project. This bill granted immunity from civil and criminal penalties to licensed health care providers in seven counties (Alameda, Fresno, Humboldt, Los Angeles, Mendocino, San Francisco, and Santa Cruz) who worked with opioid overdose prevention and treatment training programs, if the provider acted with reasonable care when prescribing, dispensing, or distributing naloxone. The pilot was extended in 2010 and extended liability protection to third party administrators of naloxone. This pilot is now scheduled to sunset on January 1, 2016.

California's longest running naloxone prescription program in San Francisco has provided over 3,600 take-home naloxone prescriptions since 2003 through collaboration with the San Francisco Department of Public Health. To date, 916 lives have been saved by laypersons trained by this program who administered the take-home naloxone during an overdose. According to the most recent data released by the Centers for Disease Control and Prevention (CDC), in 2008 there were 36,450 drug overdose deaths in the United States. According to CDC, overdose prevention programs in the United States distributing naloxone have trained over 50,000 lay persons to revive someone during an overdose, resulting in over 10,000 overdose reversals using naloxone.

ANALYSIS

This bill will allow health care providers to prescribe, dispense, and issue standing orders for an opioid antagonist to persons at risk of overdose, or to their family member, friend, or other person in a position to assist persons at risk, without making them professionally, civilly or criminally liable, if acting within reasonable care. It would also extend this same liability protection to individuals assisting in dispensing, distributing, or administering the opioid antagonist during an overdose.

This bill would require a person who is prescribed an opioid antagonist or possesses it pursuant to a standing order to receive training provided by an opioid overdose prevention and treatment training program. An opioid overdose prevention and treatment training program is defined in the bill as a program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in the following: the causes of an opiate overdose; mouth to mouth resuscitation; how to contact appropriate emergency medical services; and how to administer an opioid antagonist.

Language in existing law for the pilot project only provides civil and criminal liability, it does not exclude health care providers from "professional review". According to the author's office, the intent of the professional review language is to make it clear that the action of prescribing an opioid antagonist by standing order cannot be grounds for disciplinary action. Many states that have similar law include this type of language. Kentucky's statute says that a practitioner operating under the law shall not "be subject to disciplinary or other adverse action

under any professional licensing statute". Illinois statute contains the same language, while Washington's statute says that actions under the law "shall not constitute unprofessional conduct". Massachusetts law declares that a naloxone script "shall be regarded as being issued for a legitimate medical purpose in the usual course of professional practice".

Drug overdoses are now the leading cause of injury death in the United States, surpassing motor vehicle crash deaths. According to the author's office, this bill will protect licensed health care providers and encourage them to begin prescribing naloxone to patients on chronic opioid pain medications in order to help address the prescription drug overdose epidemic, as well as to make it easier for providers to participate in comprehensive drug overdose prevention programs that prescribe opioid antagonists. This is one element of many to address the issue of drug related overdose deaths in California.

This bill will help to further the Board's mission of consumer protection, and the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Harm Reduction Coalition (sponsor); California Society of Addiction Medicine (sponsor); Berkeley Needle Exchange Emergency Distribution; California Association of Alcohol & Drug Program Executives, Inc.; California Attorneys for Criminal Justice; California Opioid Maintenance Providers; California Public Defenders Association; City and County of San Francisco; Civil Justice Association of California; Common Ground, the Westside HIV Community Center; County Alcohol & Drug Program Administrators Association of California; Drug Policy Alliance; Harm Reduction Therapy Center; Homeless Health Care Los Angeles; Medical Board of California; National Coalition Against Prescription Drug Abuse; San Francisco Drug Users Union; and Shasta Community Health Center

OPPOSITION: None on file

AMENDED IN SENATE JUNE 24, 2013

AMENDED IN ASSEMBLY APRIL 11, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 635

Introduced by Assembly Member Ammiano

February 20, 2013

An act to amend Section 1714.22 of the Civil Code, relating to drug overdose treatment.

LEGISLATIVE COUNSEL'S DIGEST

AB 635, as amended, Ammiano. Drug overdose treatment: liability.

Existing law authorizes a physician and surgeon to prescribe, dispense, or administer prescription drugs, including prescription-controlled substances, to an addict under his or her treatment, as specified. Existing law prohibits, except in the regular practice of his or her profession, any person from knowingly prescribing, administering, dispensing, or furnishing a controlled substance to or for any person who is not under his or her treatment for a pathology or condition other than an addiction to a controlled substance, except as specified.

Existing law authorizes, until January 1, 2016, and only in specified counties, a licensed health care provider, who is already permitted pursuant to existing law to prescribe an opioid antagonist, as defined, and who is acting with reasonable care, to prescribe and subsequently dispense or distribute an opioid antagonist in conjunction with an opioid overdose prevention and treatment training program, as defined, without being subject to civil liability or criminal prosecution. Existing law requires a local health jurisdiction that operates or registers an opioid overdose prevention and treatment training program to collect prescribed

1714.22. (a) For purposes of this section, the following definitions shall apply:

(1) "Opioid antagonist" means naloxone hydrochloride that is approved by the federal Food and Drug Administration for the treatment of an opioid overdose.

(2) "Opioid overdose prevention and treatment training program" means any program operated by a local health jurisdiction or that is registered by a local health jurisdiction to train individuals to prevent, recognize, and respond to an opiate overdose, and that provides, at a minimum, training in all of the following:

(A) The causes of an opiate overdose.

(B) Mouth to mouth resuscitation.

(C) How to contact appropriate emergency medical services.

(D) How to administer an opioid antagonist.

(b) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may, if acting with reasonable care, prescribe and subsequently dispense or distribute an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose.

(c) (1) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may issue standing orders for the distribution of an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose.

(2) A licensed health care provider who is authorized by law to prescribe an opioid antagonist may issue standing orders for the administration of an opioid antagonist to a person at risk of an opioid-related overdose by a family member, friend, or other person in a position to assist a person experiencing or reasonably suspected of experiencing an opioid overdose.

(d) A person who is prescribed an opioid antagonist or possesses it pursuant to a standing order shall receive the training provided by an opioid overdose prevention and treatment training program.

(e) A licensed health care provider who acts with reasonable care shall not be subject to professional review, be ~~found~~ liable in a civil action, or be subject to criminal prosecution for issuing a prescription or order pursuant to subdivision (b) or (c).

AB 809

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 809
Author:	Logue
Bill Date:	June 25, 2013, Amended
Subject:	Healing Arts: Telehealth
Sponsor:	Author
Position:	Support

STATUS OF BILL:

This bill is currently in the Senate Health Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill, as originally introduced, would revise the existing requirement on health care providers that they must verbally inform and document consent of the patient prior to delivery of health care services via telehealth and would replace it with a requirement that the provider must obtain a waiver for treatment involving telehealth services, as specified.

This bill was recently amended to instead require health care providers to obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of health care and treatment. This consent must be documented in the patient's medical record and the documentation must be transmitted with initiation of any telehealth for the specified course of health care and treatment to any distant-site health care provider from whom telehealth is obtained.

ANALYSIS:

The Telehealth Advancement Act of 2011 was signed into law as a result of AB 415 (Logue, Chapter 547). This bill would delete the requirement included in that Act that is now in existing law that requires physicians, prior to the delivery of health care via telehealth, to verbally inform the patient at the originating site that telehealth may be used and obtain verbal consent from the patient for this use.

This bill was recently amended to instead require health care providers to obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of health care and treatment. This consent must be documented in the patient's medical record and the documentation must be transmitted with initiation of any telehealth for the specified course of health care and treatment to any distant-site health care provider from whom telehealth is obtained. This bill would require the distant-site health care provider to obtain confirmation of the patient's consent from the originating site provider or to separately obtain consent from the patient about the use of telehealth as an acceptable

mode of delivering health care services and public health during a specified course of health care and treatment.

According to the author, under existing law, in order to ensure that both physicians and patients understand that telehealth may be used to treat the patient, a physician is required to obtain verbal consent for each and every visit with the patient. Physicians have reported that this constant requirement is burdensome on their ability to treat patients effectively. This was a requirement added to statute from AB 415 (Logue, Chapter 547, Statutes of 2011). The author of this bill, who also authored AB 415, believes that the requirement included in his bill in 2011 eliminates efficiencies achieved in rendering telehealth services and was an unintended consequence that is inconsistent with the intent and principles of his bill.

The California Association of Physician Groups supports this bill because telehealth is a critical component of expanding access to care and this bill is an important clean up provision.

This bill would allow the Telemedicine Advancement Act of 2011 to be implemented as intended, which will help to improve access to care via telehealth, as such, the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Association of California Healthcare Districts
California Association of Physician Assistants
California Association of Physician Groups
Medical Board of California

OPPOSITION: American Federation of State, County, and Municipal Employees

AMENDED IN SENATE JUNE 25, 2013

AMENDED IN ASSEMBLY APRIL 29, 2013

AMENDED IN ASSEMBLY APRIL 3, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 809

Introduced by Assembly Member Logue
(Coauthor: Senator Galgiani)

February 21, 2013

An act to amend Section 2290.5 of the Business and Professions Code, relating to telehealth, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 809, as amended, Logue. Healing arts: telehealth.

Existing law requires a health care provider, as defined, prior to the delivery of health care services via telehealth, as defined, to verbally inform the patient that telehealth may be used and obtain verbal consent from the patient for this use. Existing law also provides that failure to comply with this requirement constitutes unprofessional conduct.

This bill would ~~allow the verbal consent for the use of telehealth to apply in the present instance and for any subsequent use of telehealth.~~ *require the health care provider initiating the use of telehealth at the originating site to obtain verbal or written consent from the patient for the use of telehealth, as specified. The bill would require that health care provider to document the consent in the patient's medical record and to transmit that documentation with the initiation of any telehealth to any distant-site health care provider from whom telehealth is requested or obtained. The bill would require a distant-site health care*

(b) Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth at the originating site shall ~~verbally~~ inform the patient about the use of telehealth and ~~request the patient's~~ *obtain* verbal *or written* consent~~, which may apply in the present instance and for any subsequent use of telehealth.~~ *from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of health care and treatment.* The ~~verbal~~ consent shall be documented in the patient's medical ~~record.~~ *record, and the documentation shall be transmitted with the initiation of any telehealth for that specified course of health care and treatment to any distant-site health care provider from whom telehealth is requested or obtained. A distant-site health care provider shall either obtain confirmation of the patient's consent from the originating site provider or separately obtain and document consent from the patient about the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of health care and treatment.*

(c) Nothing in this section shall preclude a patient from receiving in-person health care delivery services during a *specified* course of *health care and* treatment after agreeing to receive services via telehealth.

(d) The failure of a health care provider to comply with this section shall constitute unprofessional conduct. Section 2314 shall not apply to this section.

(e) This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

(f) All laws regarding the confidentiality of health care information and a patient's rights to his or her medical information shall apply to telehealth interactions.

(g) This section shall not apply to a patient under the jurisdiction of the Department of Corrections and Rehabilitation or any other correctional facility.

(h) (1) Notwithstanding any other provision of law and for purposes of this section, the governing body of the hospital whose patients are receiving the telehealth services may grant privileges to, and verify and approve credentials for, providers of telehealth services based on its medical staff recommendations that rely on

AB 1000

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1000
Author:	Wieckowski and Maienschein
Bill Date:	June 24, 2013, Amended
Subject:	Physical Therapists: Direct Access to Services: Professional Corporations
Sponsor:	California Physical Therapy Association

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill, as originally introduced, would allow a physical therapist (PT) to make a physical therapy diagnosis. This bill would allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope of a PT as long as specified conditions are met.

This bill was significantly amended to address concerns raised by the opposition. This bill no longer contains the provision that would have allowed a PT to make a physical therapy diagnosis. This bill was also amended to only allow a PT to see a patient for a specified period of time and would require the PT to provide specified notice to the patient regarding the direct PT services.

This bill now also incorporates the language from AB 1003 (Maienschein) which the Board had taken a position of support. The language from AB 1003 would specify that the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation does not limit employment by professional corporations to the licensed professionals listed in that section and would specify that any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act, may be employed to render professional services by a professional corporation listed in existing law. This bill would also add physical therapists, and other licensed professionals, to the listing in the Corporations Code.

ANALYSIS:

This bill no longer allows a PT to make a "physical therapy diagnosis". This bill would allow a patient to directly access PT services, without being referred by a physician, provided that the treatment is within the scope of a PT and the following conditions are met:

- If the PT has reason to believe the patient has signs or symptoms of a condition

that requires treatment beyond the scope of practice of a PT or the patient is not progressing toward documented treatment goals as demonstrated by the objective, measurable, or functional improvement, the PT shall refer the patient to a physician, an osteopathic physician, or to a dentist, podiatrist or chiropractor.

- The PT shall disclose to the patient any financial interest in treating the patient, and, if working in a professional corporation, shall comply with existing law related to advertising.
- The PT shall notify the patient's physician, with the patient's written authorization, that the PT is treating the patient.

This bill was amended to only allow a PT to treat a patient for 45 calendar days or 12 visits, whichever occurs first. Once this limit has been reached, the PT's plan of care must be signed, dated, and approved by a physician, osteopathic physician, or podiatrist, acting within his or her scope of practice. Approval of the PT's plan of care must include an in-person patient examination and evaluation of the patient' condition, and if indicated, testing by the physician, osteopathic physician, or podiatrist.

This bill would specify that it does not expand or modify the scope of practice of a PT, including the prohibition on a PT to diagnose a disease. This bill would also specify that it does not require a health care service plan or insurer to provide coverage for services rendered to a patient who directly accessed the services of a PT.

This bill was amended to require a PT to provide notice to a patient before initiating PT treatment services. The notice must be provided orally and in writing to the patient in at least 14-point type and signed by the patient. The notice states that the patient is receiving direct PT treatment services by a PT licensed by the Physical Therapy Board of California. The notice further states the limits for PT care being provided (45 calendar days or 12 visits, whichever occurs first) and the requirement for approval and sign off by a physician, osteopathic physician or podiatrist, of the PT's plan of care and the requirements for an in-person patient examination and evaluation.

Lastly, this bill adds the language from AB 1003 (Maienschein), which the Board had taken a position of support. The language that was added would specify that the list of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation does not limit employment by professional corporations to the licensed professionals listed in that section and would specify that any person duly licensed under the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act, may be employed to render professional services by a professional corporation listed in existing law. This bill would also add physical therapists, occupational therapists, and other licensed professionals, to the listing in the Corporations Code.

SB 543 (Steinberg, Chapter 448, Statutes of 2011) was signed into law and was effective from January 1, 2012 to January 1, 2013. This bill specified that no physical therapist shall be subject to discipline by the Physical Therapy Board for providing physical therapy services as a professional employee of a professional medical corporation; this provision was sunset on January 1, 2013. The language in SB 543 was added because the Physical Therapy Board was attempting to take action against physical therapists employed by a medical corporation. SB 543 put this issue in a holding pattern, until January 1, 2013; however, this issue was not addressed in legislation last year, so it still remains an issue that must be addressed. This bill will now codify the practice that has been allowed for over 20 years and will allow physicians in medical corporations to employ physical therapists. The Board is supportive of these provisions.

This bill no longer allows a PT to make a "physical therapy diagnosis". Although it would still allow patients to directly access PT services, it would now put limits on how long a patient can see a PT before the PT's plan of care is required to be reviewed by a physician, osteopathic physician, or podiatrist and would require the patient to get an in-patient examination and evaluation before the plan of care can be approved and signed off. This bill would also require the patient to be provided information on the requirements in this bill regarding time limits for receiving direct PT services and would require the patient to sign the notice before the PT can provide services. This bill includes language that has been negotiated by interested parties. Board staff believes that this bill includes adequate safeguards to ensure consumer protection. As such, Board staff is suggesting that the Board no longer oppose this bill and instead take a neutral position.

FISCAL: None

SUPPORT:
California Physical Therapy Association (Sponsor)
California Medical Association
California Orthopaedic Association
Mount St. Mary's College Doctor of Physical Therapy Program
Over 80 Individuals

OPPOSITION:
American College of Physicians
California Board of Chiropractic Examiners
California Chiropractic Association (unless amended)
Independent Physical Therapists of California
Physical Therapy Business Alliance
1061 Individuals

POSITION: Recommendation: Neutral

AMENDED IN SENATE JUNE 24, 2013

AMENDED IN ASSEMBLY MAY 8, 2013

AMENDED IN ASSEMBLY MAY 7, 2013

AMENDED IN ASSEMBLY APRIL 25, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1000

Introduced by Assembly Members Wieckowski and Maienschein

February 22, 2013

An act to amend Sections 2406 and 2660 of, and to add Sections 2406.5 and 2620.1 to, the Business and Professions Code, and to amend Section 13401.5 of the Corporations Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1000, as amended, Wieckowski. Physical therapists: direct access to services: professional corporations.

Existing law, the Physical Therapy Practice Act, creates the Physical Therapy Board of California and makes it responsible for the licensure and regulation of physical therapists. The act makes it a crime to violate any of its provisions. The act authorizes the board to suspend, revoke, or impose probationary conditions on a license, certificate, or approval issued under the act for unprofessional conduct, as specified.

This bill would specify that patients may access physical therapy treatment directly and would, in those circumstances, require a physical therapist to refer his or her patient to another specified healing arts practitioner if the physical therapist has reason to believe the patient

medical corporation. The bill would also provide that specified healing arts licensees may be shareholders, officers, directors, or professional employees of a physical therapy corporation. The bill would also require a practitioner, *except as specified,* who refers a patient to a physical therapist who is employed by a professional corporation to make a specified disclosure to the patient.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares that an individual's access to early intervention to physical therapy treatment may decrease the duration of a disability, reduce pain, and lead to a quicker recovery.

SEC. 2. Section 2406 of the Business and Professions Code is amended to read:

2406. A medical corporation or podiatry corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are physicians and surgeons, psychologists, registered nurses, optometrists, podiatrists, chiropractors, acupuncturists, naturopathic doctors, physical therapists, occupational therapists, or, in the case of a medical corporation only, physician assistants, marriage and family therapists, clinical counselors, or clinical social workers, are in compliance with the Moscone-Knox Professional Corporation Act, the provisions of this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to the corporation and the conduct of its affairs.

With respect to a medical corporation or podiatry corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the board.

person holding a physician and surgeon's certificate issued by the Medical Board of California or by the Osteopathic Medical Board of California or to a person licensed to practice dentistry, podiatric medicine, or chiropractic.

(2) The physical therapist shall comply with Section 2633, and shall disclose to the patient any financial interest he or she has in treating the patient and, if working in a physical therapy corporation, shall comply with Article 6 (commencing with Section 650) of Chapter 1.

(3) With the patient's written authorization, the physical therapist shall notify the patient's physician and surgeon, if any, that the physical therapist is treating the patient.

(4) The physical therapist shall not continue treating the patient beyond 45 calendar days or 12 visits, whichever occurs first, without receiving, from a person holding a physician and surgeon's certificate from the Medical Board of California or the Osteopathic Medical Board of California or from a person holding a certificate to practice podiatric medicine from the California Board of Podiatric Medicine and acting within his or her scope of practice, a dated signature on the physical therapist's plan of care indicating approval of the physical therapist's plan of care. Approval of the physical therapist's plan of care shall include an in-person patient examination and evaluation of the patient's condition and, if indicated, testing by the physician and surgeon or podiatrist.

(b) The conditions in paragraph (4) of subdivision (a) do not apply to a physical therapist when he or she is only providing wellness physical therapy services to a patient as described in subdivision (a) of Section 2620.

(c) This section does not expand or modify the scope of practice for physical therapists set forth in Section 2620, including the prohibition on a physical therapist diagnosing a disease.

(d) This section does not require a health care service plan or insurer to provide coverage for services rendered to a patient who directly accessed the services of a physical therapist.

(e) When a person initiates physical therapy treatment services directly, pursuant to this section, the physical therapist shall not perform physical therapy treatment services without first providing the following notice to the patient, orally and in writing, in at least 14-point type and signed by the patient:

(f) Addiction to the excessive use of any habit-forming drug.

(g) Gross negligence in his or her practice as a physical therapist or physical therapist assistant.

(h) Conviction of a violation of any of the provisions of this chapter or of the Medical Practice Act, or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or of the Medical Practice Act.

(i) The aiding or abetting of any person to violate this chapter or any regulations duly adopted under this chapter.

(j) The aiding or abetting of any person to engage in the unlawful practice of physical therapy.

(k) The commission of any fraudulent, dishonest, or corrupt act that is substantially related to the qualifications, functions, or duties of a physical therapist or physical therapist assistant.

(*l*) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of bloodborne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other bloodborne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the California Board of Podiatric Medicine, the Dental Board of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians of the State of California, to encourage appropriate consistency in the implementation of this subdivision.

The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of bloodborne infectious diseases.

(m) The commission of verbal abuse or sexual harassment.

(n) Failure to comply with the provisions of Section 2620.1.

(8) Licensed physical therapists.
(c) Psychological corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Registered nurses.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed chiropractors.
(8) Licensed acupuncturists.
(9) Naturopathic doctors.
(10) Licensed professional clinical counselors.
(d) Speech-language pathology corporation.
(1) Licensed audiologists.
(e) Audiology corporation.
(1) Licensed speech-language pathologists.
(f) Nursing corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed psychologists.
(4) Licensed optometrists.
(5) Licensed marriage and family therapists.
(6) Licensed clinical social workers.
(7) Licensed physician assistants.
(8) Licensed chiropractors.
(9) Licensed acupuncturists.
(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(g) Marriage and family therapist corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Registered nurses.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Naturopathic doctors.
(8) Licensed professional clinical counselors.
(h) Licensed clinical social worker corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.

(10) Naturopathic doctors.
(11) Licensed professional clinical counselors.
(m) Naturopathic doctor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Registered nurses.
(4) Licensed physician assistants.
(5) Licensed chiropractors.
(6) Licensed acupuncturists.
(7) Licensed physical therapists.
(8) Licensed doctors of podiatric medicine.
(9) Licensed marriage and family therapists.
(10) Licensed clinical social workers.
(11) Licensed optometrists.
(12) Licensed professional clinical counselors.
(n) Dental corporation.
(1) Licensed physicians and surgeons.
(2) Dental assistants.
(3) Registered dental assistants.
(4) Registered dental assistants in extended functions.
(5) Registered dental hygienists.
(6) Registered dental hygienists in extended functions.
(7) Registered dental hygienists in alternative practice.
(o) Professional clinical counselor corporation.
(1) Licensed physicians and surgeons.
(2) Licensed psychologists.
(3) Licensed clinical social workers.
(4) Licensed marriage and family therapists.
(5) Registered nurses.
(6) Licensed chiropractors.
(7) Licensed acupuncturists.
(8) Naturopathic doctors.
(p) Physical therapy corporation.
(1) Licensed physicians and surgeons.
(2) Licensed doctors of podiatric medicine.
(3) Licensed acupuncturists.
(4) Naturopathic doctors.
(5) Licensed occupational therapists.
(6) Licensed speech-language therapists.
(7) Licensed audiologists.

AB 1288

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1288
Author:	Perez, V.
Bill Date:	June 6, 2013, Amended
Subject:	Medical Board & Osteopathic Medical Board: Licensing: Application Processing
Sponsor:	California Medical Association
Position:	Neutral

STATUS OF BILL:

This bill is currently on the Senate Third Reading File.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board of California (Board) to develop a process to give priority review status to the application of an applicant who can demonstrate that he or she intends to practice in a medically underserved area or population. This bill would allow an applicant to demonstrate his or her intent to practice in a medically underserved area by providing proper documentation, including a letter from the employer.

Recent amendments put the same requirements for a priority application review process on the Osteopathic Medical Board of California.

ANALYSIS:

Currently, the Board is completing an initial review of applications within 45 calendar days, well under the statutorily mandated 60 business days. However, many times the application does not have all the required information and primary source documentation at the time of initial review; only about 10% of applications are complete at initial review. The Board does not currently request any information on the application regarding where the applicant is planning on working once licensed.

This bill would require the Board to develop a process to give priority review status to an applicant who can demonstrate that he or she intends to practice in a medically underserved area or serve a medically underserved population as defined in existing law. This bill would allow an applicant to demonstrate his or her intent to practice in a medically underserved area or serve a medically underserved population by providing proper documentation, including but not limited to, a letter from the employer indicating that the applicant has accepted employment and identifying a start date.

The Board does not currently have a process for priority review of applications and the application does not currently request information on where an applicant plans on practicing. However, the Board would be able to review these applications on a priority basis, but would need to revise the application to ask applicants to provide this additional information. The priority review process could be established, but it still would require the applicant to provide all the original source documentation, and this seems to be the factor that extends the time for licensure for the majority of applicants, as it takes only seven working days from receipt of all approved documentation to issue the license.

The purpose of this bill is to ensure that applicants who intend on serving in an underserved area or serve an underserved population are licensed in a timely manner. The Board currently does not have any backlog in processing applications, and many times the initial review of the application is done before all the primary source documents are received. The Board has taken a neutral position on this bill and recent amendments do not impact the Board's position or the reason for taking that position.

FISCAL: Minimal and absorbable costs to develop a process for priority review status and to revise the licensing application.

SUPPORT: California Medical Association (sponsor)
Association of California Healthcare Districts
California Optometric Association

OPPOSITION: None on file

AMENDED IN SENATE JUNE 6, 2013

AMENDED IN ASSEMBLY APRIL 11, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1288

Introduced by Assembly Member V. Manuel Pérez

February 22, 2013

An act to add ~~Section~~ *Sections* 2092 *and 2099.6* to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1288, as amended, V. Manuel Pérez. Medical Board of *California and Osteopathic Medical Board of* California: licensing: application processing.

Existing law, the Medical Practice Act, provides for licensure and regulation of physicians and surgeons by the Medical Board of California. *Existing law establishes the Osteopathic Medical Board of California and authorizes the board to issue an originating or reciprocal osteopathic physician and surgeon's certificate to an applicant who satisfies specified criteria.* Existing law establishes the California Healthcare Workforce Policy Commission and requires the commission to, among other things, identify specific areas of the state where unmet priority needs for primary care exist.

This bill would require the Medical Board of California *and the Osteopathic Medical Board of California* to develop a process to give priority review status to the application of an applicant who can demonstrate, as specified, that he or she intends to practice in a medically underserved area or serve a medical underserved population.

AB 1308

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1308
Author:	Bonilla
Bill Date:	July 9, 2013, Amended
Subject:	Midwifery
Sponsor:	American Congress of Obstetricians and Gynecologists, District IX
Position:	Support if Amended

STATUS OF BILL:

This bill is in the Senate Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill, as originally introduced, would allow a licensed midwife (LM) to directly obtain supplies, order testing, and receive reports that are necessary to the LM's practice of midwifery and consistent with the scope for practice for a LM. This bill would also require the Medical Board of California (Board) to adopt regulations by July 1, 2015 defining the appropriate standard of care and level of supervisions required for the practice of midwifery and identifying complications necessitating referral to a physician. This bill would require a LM to disclose in oral and written form to a prospective client the specific arrangement for the referral of complications to a physician and surgeon.

Recent amendments would also allow a LM to obtain devices and obtain and administer drugs and diagnostic tests. Amendments would specify that a LM is not required to identify a specific physician in the arrangement for the referral of complications to a physician and surgeon for consultation. The amendments would also allow a LM to be an attendant in an alternative birth center (ABC) and change the standards of certification that must be met by an ABC to those established by the American Association of Birth Centers. Lastly, the author took amendments in Senate Business, Professions, and Economic Development Committee (recommended by the Committee) that delete the requirement in this bill and existing law for the Board to develop regulations defining the appropriate standard of care and level of physician supervision required for the practice of midwifery.

ANALYSIS

Current law requires the Board to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery. Due to the inability to reach consensus on the supervision issue, the Board bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery. Three previous attempts to resolve the physician supervision issue via legislation and/or regulation have been unsuccessful due to the widely

divergent opinions of interested parties and their inability to reach consensus.

This bill, as introduced, would allow a LM to directly obtain supplies, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with the scope for practice for a LM. This bill would also require the Board to adopt regulations by July 1, 2015 defining the appropriate standard of care and level of supervision required for the practice of midwifery and identifying complications necessitating referral to a physician and surgeon. This bill would require a LM to disclose in oral and written form to a prospective client the specific arrangement for the referral of complications to a physician.

Recent amendments allow a LM to also obtain devices and administer drugs and diagnostic tests that are consistent with the LM scope of practice and are necessary to his or her practice of midwifery. Amendments would specify that a LM is not required to identify a specific physician in the arrangement for the referral of complications to a physician and surgeon for consultation. Amendments were also taken that delete the requirement in this bill and existing law for the Board to develop regulations defining the appropriate standard of care and level of physician supervision required for the practice of midwifery.

Although required by law, physician supervision is essentially unavailable to LMs performing home births, as California physicians are generally prohibited by their malpractice insurance companies from providing supervision of LMs who perform home births. According to these companies, if a physician supervises or participates in a home birth, the physician will lose insurance coverage resulting in loss of hospital privileges. The physician supervision requirement creates numerous barriers to care, in that if the LM needs to transfer a patient/baby to the hospital, many hospitals will not accept a patient transfer from a LM as the primary provider who does not have a supervising physician. California is currently the only state that requires physician supervision of LMs. Among states that regulate midwives, most require some sort of collaboration between the midwife and a physician.

LMs have difficulty securing diagnostic lab accounts, even though they are legally allowed to have lab accounts. Many labs require proof of physician supervision. In addition, LMs are not able to obtain the medical supplies they have been trained and are expected to use (oxygen and medical supplies that are included in approved licensed midwifery school curriculum (CCR section 1379.30)). The inability for a LM to order lab tests often means the patient will not obtain the necessary tests to help the LM monitor the patient during pregnancy. In addition, not being able to obtain the necessary medical supplies for the practice of midwifery adds additional risk to the LM's patient and the fetus or child.

The Board, through the Midwifery Advisory Council (MAC) has held many meetings regarding physician supervision of LMs and has attempted to create regulations to address this issue. The concepts of collaboration, such as required consultation, referral, transfer of care, and physician liability have been discussed among the interested parties with little success. There is disagreement over the appropriate level of physician supervision, with LMs expressing concern with any limits being placed on their ability to practice independently. The

physician and liability insurance communities have concerns over the safety of midwife-assisted homebirths, specifically delays and/or the perceived reluctance of LMs to refer patients when the situation warrants referral or transfer of care.

The Board, through the MAC, has also held meetings regarding the lab order and medical supplies/medication issues and has attempted to create regulatory language to address this issue. However, based upon discussions with interested parties, it appears the lab order and medical supplies/medication issues will need to be addressed through the legislative process.

This bill would address one of the barriers of care by allowing a LM to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, and to order testing and receive reports necessary to the LM's practice of midwifery and within the scope of practice.

The amendments would also allow a LM to be an attendant in an ABC and change the standards of certification that must be met by an ABC to those established by the American Association of Birth Centers.

This bill no longer requires the Board to adopt regulations to address physician supervision and to identify complications necessitating referral to a physician. However, Board staff still believes that it is essential that this bill address the issue of physician supervision. Board staff will continue to work with the author's office and sponsors on language that will help to solve the issue of physician supervision and remove barriers to care, while at the same time ensuring that consumers are protected. Board staff is suggesting that the Board continue to support this bill, but work with the sponsors, author's office, and interested parties on language that will address the physician supervision issue.

FISCAL: None

SUPPORT: ACOG (sponsor)
California Association of Midwives (if amended)
Medical Board of California (if amended)
Numerous Individuals (if amended)

OPPOSITION: California Families for Access to Midwives

AMENDED IN SENATE JULY 9, 2013

AMENDED IN SENATE JUNE 13, 2013

AMENDED IN ASSEMBLY MARCH 21, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1308

Introduced by Assembly Member Bonilla

February 22, 2013

An act to amend Sections 2507 and 2508 of the Business and Professions Code, and to amend Section 1204.3 of the Health and Safety Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

AB 1308, as amended, Bonilla. Midwifery.

Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensing and regulation of midwives by the Board of Licensing of the Medical Board of California. The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, as specified, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn. Under the act, a licensed midwife is required to make certain oral and written disclosures to prospective clients. A violation of the act is a crime.

This bill would additionally authorize a licensed midwife to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice and would require a licensed midwife to disclose to prospective clients the specific arrangements for referral of complications to a physician

(b) Planned home births are safer when care is provided as part of an integrated delivery model. For a variety of reasons, this integration rarely occurs, and creates a barrier to the best and safest care possible. This is due, in part, to the attempt to fit a midwifery model of care into a medical model of care.

SEC. 2. Section 2507 of the Business and Professions Code is amended to read:

2507. (a) The license to practice midwifery authorizes the holder, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn.

(b) As used in this article, the practice of midwifery constitutes the furthering or undertaking by any licensed midwife, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. All complications shall be referred to a physician and surgeon immediately. The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version.

(c) As used in this article, "supervision" shall not be construed to require the physical presence of the supervising physician and surgeon.

(d) The ratio of licensed midwives to supervising physicians and surgeons shall not be greater than four individual licensed midwives to one individual supervising physician and surgeon.

(e) A midwife is not authorized to practice medicine and surgery by this article.

(f) A midwife is authorized to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice.

~~(g) The board shall, not later than July 1, 2015, revise and adopt in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery and identifying complications necessitating referral to a physician and surgeon.~~

(A) Be located in proximity, in time and distance, to a facility with the capacity for management of obstetrical and neonatal emergencies, including the ability to provide cesarean section delivery, within 30 minutes from time of diagnosis of the emergency.

(B) Require the presence of at least two attendants at all times during birth, one of whom shall be a physician and surgeon, a licensed midwife, or a certified nurse-midwife.

(5) Have a written policy relating to the dissemination of the following information to patients:

(A) A summary of current state laws requiring child passenger restraint systems to be used when transporting children in motor vehicles.

(B) A listing of child passenger restraint system programs located within the county, as required by Section 27362 of the Vehicle Code.

(C) Information describing the risks of death or serious injury associated with the failure to utilize a child passenger restraint system.

(b) The state department shall issue a permit to a primary care clinic licensed pursuant to subdivision (a) of Section 1204 certifying that the primary care clinic has met the requirements of this section and may provide services as an alternative birth center. Nothing in this section shall be construed to require that a licensed primary care clinic obtain an additional license in order to provide services as an alternative birth center.

(c) (1) Notwithstanding subdivision (a) of Section 1206, no place or establishment owned or leased and operated as a clinic or office by one or more licensed health care practitioners and used as an office for the practice of their profession, within the scope of their license, shall be represented or otherwise held out to be an alternative birth center licensed by the state unless it meets the requirements of this section.

(2) Nothing in this subdivision shall be construed to prohibit licensed health care practitioners from providing birth related services, within the scope of their license, in a place or establishment described in paragraph (1).

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school

SB 20

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 20
Author:	Hernandez
Bill Date:	February 14, 2013, Amended
Subject:	Health Care: Workforce Training
Sponsor:	Author
Position:	Support

STATUS OF BILL:

This bill is currently in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require that when the California Major Risk Medical Insurance Program (MRMIP) becomes inoperative, all the funds in the Managed Care Administrative Fines and Penalties Fund (Managed Care Fund) must be transferred each year to the Medically Underserved Account in the Health Professions Education Foundation (HPEF) Fund for use by the Steven M. Thompson Loan Repayment Program (STLRP).

ANALYSIS:

The STLRP was created in 2002 via legislation which was co-sponsored by the Medical Board of California (Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to $105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to HPEF. Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions' students and recent graduates. These programs are funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, and corporations, as well as through a surcharge on the renewal fees of various health professionals, including a $25 fee paid by physicians and surgeons.

Under existing law, revenue from fines and penalties levied on health plans is deposited in the Managed Care Fund. The first $1 million is used for the STLRP, and fines and penalties above $1 million are used to augment funding for MRMIP, which provides subsidized health insurance for individuals unable to obtain coverage due to a pre-existing condition. In 2014, MRMIP will no longer be necessary due to the reforms enacted under the Affordable Care Act (ACA).

This bill would require all funds from the Managed Care Fund to go to HPEF once MRMIP is inoperative, for purposes of funding STLRP. This will provide the STLRP a more robust funding source by shifting monies no longer needed for MRMIP. According to the author's office, implementation of the ACA will result in a further strain on the demand for primary care physicians. This bill will help to ensure that more physicians have incentive to practice in underserved areas of California. As such, this bill promotes the Board's mission of access to care and the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Association of California Healthcare Districts; California Association of Clinical Nurse Specialists; California Association of Physician Groups; California Communities United Institute; California Hospital Association; California Medical Association; California Optometric Association; California Primary Care Association; Hospital Corporation of America; Los Angeles County Board of Supervisors; Medical Board of California; National Association of Pediatric Nurse Practitioners; and Osteopathic Physicians and Surgeons of California

OPPOSITION: None on file

AMENDED IN SENATE FEBRUARY 14, 2013

SENATE BILL No. 20

Introduced by Senator Hernandez

December 3, 2012

An act ~~relating to health care coverage.~~ *to amend Section 1341.45 of the Health and Safety Code, relating to health.*

LEGISLATIVE COUNSEL'S DIGEST

SB 20, as amended, Hernandez. ~~Health care coverage: basic health program.~~ *Health care: workforce training.*

Existing law provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and imposes certain requirements on health care service plans. Existing law imposes, for certain violations of these provisions, various fines and administrative penalties, which are deposited in the Managed Care Administrative Fines and Penalties Fund. Existing law requires the first $1,000,000 in the fund to be transferred each year to the Medically Underserved Account for Physicians in the Health Professions Education Fund for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Existing law requires all remaining funds to be transferred each year to the Major Risk Medical Insurance Fund for purposes of the Major Risk Medical Insurance Program.

This bill, beginning on the date that the Major Risk Medical Insurance Program becomes inoperative, would instead require all the funds in the Managed Care Administrative Fines and Penalties Fund to be transferred each year to the Medically Underserved Account for Physicians in the Health Professions Education Fund for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program.

shall not be used to provide funding for the Physician Volunteer Program.

~~(2)~~

(B) Any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund created pursuant to Section 12739 of the Insurance Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 12739.1 of the Insurance Code.

(C) Transfers under this paragraph shall cease on the date the Managed Risk Medical Insurance Program becomes inoperative. The Director of Finance shall notify the Joint Legislative Budget Committee at the time the program becomes inoperative.

(2) Commencing on the date transfers under paragraph (1) cease, and annually thereafter, the fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

~~SECTION 1. It is the intent of the Legislature to enact legislation that would establish the basic health program described in Section 1331 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18051).~~

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SB 21

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 27 and SB 21
Author:	Medina and Roth
Bill Date:	July 3 and June 26, 2013, Amended
Subject:	UC Riverside Medical School: Funding
Sponsor:	Author and the California Medical Association
Position:	Support

STATUS OF BILL:

AB 27 is in the Senate and SB 21 is in Assembly Higher Education Committee.

DESCRIPTION OF CURRENT LEGISLATION:

These bills contain similar language and would both annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California (UC), Riverside. Both bills contain urgency clauses, which mean that the bills would take effect immediately once signed into law. SB 21 would specify that the funds shall be available for planning and startup costs associated with academic programs to be offered at the UC Riverside School of Medicine.

Both AB 27 and SB 21 were amended to add findings and declarations and to require the moneys appropriated to only be used for funding the UC Riverside School of Medicine, not for other purposes or to supplant other funding. The amendments would require the UC Riverside School of Medicine to develop a program to identify eligible medical residents and to assist those residents to apply for physician retention programs, including the Steven M. Thompson Medical School Scholarship Program (STMSSP).

AB 27 and SB 21 were amended to remove the appropriation language as the Higher Education Trailer Bill, AB 94, was amended to include a $15,000,000 appropriation allocated to UC Riverside School of Medicine. Both bills reference AB 94 and the appropriation.

ANALYSIS:

The foundation of the School of Medicine at UC Riverside goes back to 1974, when the UC Riverside / University of California, Los Angeles (UCLA) Thomas Haider Program in Biomedical Sciences was established. This program has allowed approximately 700 students to complete their first two years of medical school at UC Riverside, and their last two years at the David Geffen School of Medicine at UCLA, which confers their medical degrees.

In July 2008, the UC Board of Regents officially approved the proposed establishment of an independent four-year School of Medicine at UC Riverside, intended to serve the medically underserved

in the Inland Empire. However, in the summer of 2011, UC Riverside failed to gain accreditation for an independent four-year medical school from the Liaison Committee on Medical Education (LCME), the national accrediting body for educational programs leading to the Medical Doctor degree in United States. LCME withheld preliminary accreditation due to a lack of stable state funding support for the school. In April 2012, UC Riverside secured substantial new funding from a variety of non-state funding sources, and submitted a second accreditation application to LCME. In June 2012, a second accreditation site visit took place and in October 2012, UC Riverside received notification from LCME that its planned medical school received "preliminary accreditation." Preliminary accreditation from LCME enables prospective students to begin applying to the UC Riverside School of Medicine in order to potentially enroll in August 2013.

The purpose of these bills is to provide funding from the General Fund in order to establish a more viable funding source for the UC Riverside School of Medicine. AB 27 and SB 21 no longer include an appropriation, but refer to AB 94, which includes the appropriation for UC Riverside School of Medicine. Both bills specify that funds provided shall be available for planning and startup costs associated with academic programs to be offered at the UC Riverside School of Medicine, including: Academic planning activities, support of academic program offerings, and faculty recruitment; the acquisition of instructional materials and equipment; and ongoing operating support for faculty, staff, and other annual operating expenses for the UC Riverside School of Medicine. Both bills were also amended to add findings and declarations and to require the moneys appropriated to only be used for funding the UC Riverside School of Medicine, not for other purposes or to supplant other funding. The amendments would also require the UC Riverside School of Medicine to develop a program to identify eligible medical residents and to assist those residents to apply for physician retention programs, including the STMSSP.

According to the author, the highest indicator of where a physician practices is where he or she attends medical school and the Inland Empire trails behind much of the state in several key health indicators, including coronary heart disease and diabetes. The author believes that the establishment of a medical school in the Inland Empire will help to ensure more physicians are trained and remain in the Inland Empire. The author contends that one of the areas that will aid in the UC Riverside School of Medicine receiving final accreditation from LCME and meeting the medical needs of the Inland Empire is for the Medical School to receive a stable funding source, which is why this bill seeks to appropriate General Fund monies.

According to the Public Policy Institute of California, the Inland Empire is the fastest-growing region of the state and it is estimated that more than 300,000 residents of the Inland Empire will have health insurance coverage extended to them as a result of the Affordable Care Act. The U.S. Department of Health and Human Services' Council on Graduate Medical Education recommends that a given region have 60 to 80 primary care physicians per 100,000 residents and 85 to 105 specialists. The Inland Empire has about 40 primary care doctors and 70 specialists per 100,000 residents, which is a severe shortage.

These bills will help to increase access to care and help the Inland Empire area of California to prepare and be ready for implementation of the Affordable Care Act; the Board has taken a support position on these bills.

FISCAL: None to the Board

SUPPORT: SB 21 - California Medical Association (Sponsor); American College of Emergency Physicians; Bourns, Gordon Bourns, CEO; California Association of Physician Groups; California Podiatric Medical Association; California Primary Care Association; City of Murieta; Enterprise Media and the Press-Enterprise; Inland Empire Economic Partnership; Insurance Commissioner Dave Jones; Kaiser Permanente; Mayor Rusty Bailey, City of Riverside; Medical Board of California; Riverside County Superintendent of Schools; Southwest California Legislative Council; Southwest Riverside County Association of Realtors; University of California; University of California Riverside Alumni Association; and Western Riverside Council of Governments

AB 27 – California Primary Care Association; California Podiatric Medical Association; Medical Board of California; and Riverside County Superintendent of Schools

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 26, 2013

AMENDED IN SENATE MAY 24, 2013

AMENDED IN SENATE APRIL 23, 2013

AMENDED IN SENATE MARCH 18, 2013

SENATE BILL No. 21

Introduced by Senator Roth
(Principal coauthor: Assembly Member Medina)
(Coauthors: Senators Correa and Hueso)

December 3, 2012

An act relating to the University of ~~California, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.~~ *California.*

LEGISLATIVE COUNSEL'S DIGEST

SB 21, as amended, Roth. University of California: UC Riverside Medical ~~School: funding.~~ *School.*

Existing provisions of the California Constitution establish the University of California as a public trust under the administration of the Regents of the University of California. The University of California system includes 10 campuses, which are located in Berkeley, Davis, Irvine, Los Angeles, Merced, Riverside, San Diego, San Francisco, Santa Barbara, and Santa Cruz.

~~This bill would annually appropriate $15,000,000 from the General Fund to the Regents of the University of California for allocation to the School of Medicine at the University of California, Riverside. The bill would require the Regents of the University of California to use these moneys for the sole purpose of funding the School of Medicine at the University of California, Riverside, and would prohibit the regents from~~

independent four-year school of medicine has received preliminary accreditation from the Liaison Committee on Medical Education, the nationally recognized accrediting body for medical education programs leading to M.D. degrees in the United States and Canada. When this new four-year medical school opens in August 2013, it will become the first new public medical school in California in more than 40 years.

(e) This community-based medical school with a public mission to expand and diversify the region's physician workforce and to improve the health of people living in inland southern California has made a commitment to underserved patient populations.

(f) There are two principal determinants of where a physician practices: (1) where he or she grew up, and (2) where he or she completes residency training following medical school graduation.

(g) The UCR medical school has strategies to capitalize on both of these factors. Among these strategies are all of the following: (1) developing student pipeline programs that inspire more young people in the region to pursue careers in medicine and other allied health professions and to recruit them to the UCR medical school; (2) utilizing a holistic review of medical school applicants that takes into account diverse life experiences in addition to academic performance; (3) teaching a curriculum that emphasizes key competencies for primary care medicine, including wellness and prevention, evidence-based medicine, and chronic disease management; (4) creating new residency training programs in primary care and those short-supply specialties that are most needed in inland southern California; and (5) continuing UCR's commitment to the recruitment, retention, and advancement of talented students, faculty, and staff from historically excluded populations who are currently underrepresented in medical education and the practice of medicine.

(h) As a further incentive for medical students to choose primary care specialties, the UCR medical school has developed an innovative "loan-to-scholarship" program, is actively raising nonstate funds to expand that program, and is educating students and graduates about existing public and private physician recruitment and retention programs, including, but not limited to, the Steven M. Thompson ~~Physician Corps Loan Repayment~~ *Medical School Scholarship* Program established pursuant to

with Section 128560) of Chapter 5 of Part 3 of Division 107 of the Health and Safety Code.

~~SEC. 3. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:~~

~~In order to provide crucial funding to launch the vital health care mission of the School of Medicine at the University of California, Riverside, it is necessary that this act take effect immediately.~~

CORRECTIONS:

Text—Page 4.

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SB 62

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 62
Author:	Price
Bill Date:	June 27, 2013, Amended
Subject:	Coroners: Reporting Requirements: Prescription Drug Use
Sponsor:	Author
Position:	Support

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill was previously amended to require a coroner to report deaths to the Medical Board of California (Board) when the contributing factor in the cause of death is related to toxicity from a Schedule II, III, or IV drug. The initial report must include the name of the decedent; date and place of death; attending physicians, podiatrists, or physician assistants; and all other relevant information available. This bill would allow the follow-up coroner's report and autopsy protocol to be filed with the Board within 90 days or as soon as possible once the coroner's final report of investigation is complete.

This bill was amended to specify that deaths are only required to be reported to the Board when the cause of death (instead of a contributing factor in the cause of death) is due to a Schedule II, III, or IV drug. Technical amendments were made to clarify that the pathologist does not have to be board certified, to reflect current practice and clarify language in this bill and in existing law.

ANALYSIS:

Existing law, Business and Professions Code Section 802.5, requires a coroner to report to the Board (and the Osteopathic Medical Board (OMBC), the Board of Podiatric Medicine (BPM), and the Physician Assistant Board (PAB)) when he/she receives information based on findings by a pathologist indicating that a death may be the result of a physician's gross negligence or incompetence. This section requires the coroner to make a determination that the death *may* be the result of the physician's gross negligence or incompetence. Requiring coroners to make the determination, could be the reason the Board has seen a decrease in coroners reports; the number of reports received by the Board is at an all-time low. Only four reports were received in FY 2011/12, and only one of the reports indicated a drug related death.

The Board has reason to believe that numerous death have occurred in California that are related to prescription drug overdoses. However, complaints regarding drug-related offenses are often hard for the Board to obtain. In most instances, patients who are receiving prescription drugs in a manner that is not within the standard of practice, are unlikely to make a complaint to the Board. Some complaints regarding overprescribing come from anonymous tips, which usually do not have enough information to allow forwarding to the Board's district office for investigation, as there is no patient to obtain records for or not enough information to open an investigation. Family members of patients may make a complaint to the Board; however, the Board must have a patient release in order to obtain medical records or seek a subpoena. Sometimes it is difficult to obtain evidence to warrant a subpoena, or the family is not responsive.

The Board included a proposal for required coroner reporting prescription drug related deaths in its Sunset Review Report as a new issue for the Legislature's consideration. Requiring deaths related to prescription drug use to be reported to the Board would allow the Board to review the documentation to determine if the prescribing physician was treating in a correct or inappropriate manner. This would increase consumer protection and ensure the Board is notified of physicians who might pose a danger to the public, so action can be taken prior to another individual suffering the same outcome. If only one physician was found to be overprescribing, this could save numerous lives.

Senator Price introduced this bill in response to several articles run by the LA Times. These articles included cases of physicians prescribing opioid prescription drugs to multiple patients, which may have resulted in these patients' deaths. The Senator introduced this bill to ensure that the Board has knowledge about these types of cases in the future, so the Board can review these cases, investigate, and take appropriate disciplinary action against physicians prescribing inappropriately.

The Board voted to support SB 62 if it is narrowed to only include coroner reporting of deaths related to Schedule II and III controlled substances. The bill was amended to narrow the deaths reported to the Board to those in which a contributing factor in the cause of death is related to toxicity from a Schedule II, III, or IV drug. The Board also requested an amendment to ensure that coroners report these deaths to all boards responsible for licensing prescribers. Of note, the bill was recently amended to only require the coroner reports to go to the Board to make it more efficient for coroners, as they would only have to send their reports to one board, not multiple boards; this was a concern raised by the coroners in meeting with the author's office. The Board could potentially share/disseminate the coroner reports that include a prescriber or dispenser licensed by another board to the appropriate regulatory board under the Department of Consumer Affairs, as is currently done as part of the complaint review process.

Recent amendments narrow the bill to only require reporting of deaths to the Board when the cause of death (instead of a contributing factor in the cause of death) is due to a Schedule II, III, or IV drug. Although this amendment may narrow the number of reports received, this amendment was taken at the request of the coroners to help

ensure that they can implement and meet the mandates of the bill, as all coroners do not list contributing factors in their reports. This bill will still help to ensure that the Board is notified of deaths that are a result of a drug overdose. The Board will handle coroner reports received as it would handle any other complaint and will triage and order medical records, as appropriate. Physicians will be notified when a patient's medical record is being requested by the Board and physicians will still be entitled to a summary of their central file under Business and Professions Code Section 800(c). Board staff believes that this bill will still help to ensure consumer protection and ensure that the Board is aware of these drug overdose deaths, which will allow the Board to review the information and investigate as appropriate. Board staff is suggesting that the Board continue to support this bill.

FISCAL: Using the total data reported in the LA Times articles, the estimated workload created by this bill would result in the need for 1 additional position to handle the upfront review in the Central Complaint Unit, 4 investigators to handle the cases that go to the field for investigation, and 1 additional position in the Discipline Coordination Unit. This additional workload would also result in $441,500 in costs for expert reviewers for the upfront review, investigation, and hearing. Based upon information received by the Attorney General's (AG's) Office, the approximately 50 cases that would be referred to the AG's office would result in approximately $1,803,700 in costs (out of the 50, it is estimated that 35 would settle, or 70%, and the remaining 15 would go to hearing).

SUPPORT: Center for Public Interest Law
Medical Board of California

OPPOSITION: California Medical Association

SB 62 Fiscal Methodology

The LA Times found 3,733 deaths involving prescription medications from 2006 – 2011. In 1,762 of those cases, one or more drugs prescribed for the deceased caused or contributed to the death (indicating physician prescribing).

1,762 divided by 5, equals 350 deaths per year. According to the US Census Bureau information, the 5 counties that the LA Times included in its data (Los Angeles, Orange, San Diego, and Ventura), make up 45% of California's population. This means that 350 deaths per year is only 45% of the what would be seen for California, making the total number of deaths that would be reported to the Board, approximately 700.

Using existing averages, approximately 75% of the cases do not go to the field for investigation, and 25% of the 700 would go to the field for investigation, a total of 175 cases per year.

Regarding the upfront Central Complaint Unit (CCU) review of the 700 cases, the Medical Board estimates that we would need 1 analyst to handle the upfront review of the 700 potential cases.

For the upfront CCU expert review, it equates to 2.0 hours per case for a total of 1400 hours. At the rate of $75 per hour, this equates to $105,000 for CCU expert review.

For the cases that go to the field, the Board is estimating that the workload would generate the need for 4 new investigators in the field, which equates to 40 cases per investigator (because the workload of each case may not be complex due to the known death of a patient), and 1 analyst in the discipline coordination unit (for 50 cases filed per year).

Of the 175 cases that go to the field, 25% will close at the physician interview level. Thus, 130 cases will need to be reviewed by an expert. At $150 per hour and an average of 15 hours per case, this equates to $292,500 for expert review (review medical records, listen/read physician interview, and write report).

For the 175 cases that go to the field, we are estimating that 50 of these cases, or 30% would need to go to the Attorney General's (AG's) Office for prosecution. According to current statistics, approximately 70% or 35 cases would be resolved through stipulation, and the remaining 30% or 15 cases would go to hearing. According to the AG's office for pain management cases that go to hearing, on average these take about 474 hours at $170/hr which equals $1,208,700 for the 15 cases. For the 35 cases that would result in stipulation, according to the AG's office for pain management cases, on average these take about 100 hours at $170/hr, which equals $595,000, for a total AG cost of 1,803,700.

Of the cases that go to the AG's Office, half or 25 will have not expert cost. 10 cases will go to pretrial at 4 hours expert time each, the rate for trial related expert work is $200, this equates to $8,000. 15 cases will go to hearing at 12 hours to prep the expert and for the expert to testify at the hearing at $200 per hour, equates to $36,000.

AMENDED IN ASSEMBLY JUNE 27, 2013

AMENDED IN ASSEMBLY JUNE 14, 2013

AMENDED IN SENATE APRIL 22, 2013

AMENDED IN SENATE APRIL 9, 2013

SENATE BILL No. 62

Introduced by ~~Senator~~ *Senators* Price *and Lieu*

January 8, 2013

An act to amend Section 802.5 of the Business and Professions Code, relating to coroners.

LEGISLATIVE COUNSEL'S DIGEST

SB 62, as amended, Price. Coroners: reporting requirements: prescription drug use.

Existing law requires a coroner to make a report, as specified, when he or she receives information that indicates that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence. Existing law requires the report to be followed, within 90 days, by copies of the coroner's report, autopsy protocol, and all other relevant information.

This bill would require the coroner's report and other information to follow the report within 90 days or as soon as possible once the coroner's final report of investigation is complete. The bill would additionally require a coroner to file a report with the Medical Board of California when he or she receives information that indicates that the cause of death is due to a Schedule II, III, or IV drug. By increasing the duties of county officers, this bill would create a state-mandated local program.

the cause of death is due to a Schedule II, III, or IV drug, a report shall be filed with the Medical Board of California. The initial report shall include, when known, the name of the decedent, date and place of death, attending physicians, podiatrists, or physician assistants, and all other relevant information, including, but not limited to, any information available to identify the prescription drugs, prescribing physicians, and dispensing pharmacy. The initial report shall be followed, within 90 days or as soon as possible once the coroner's final report of investigation is complete, by copies of the coroner's report, autopsy protocol, and all other relevant information.

SEC. 2. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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SB 304

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 304
Author:	Price
Bill Date:	April 24, 2013, Amended
Subject:	Healing Arts: Boards
Sponsor:	Author
Position:	Support if Amended

STATUS OF BILL:

This bill is in the Assembly Business, Professions, and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the bill that includes language on a portion of the new issues from the Board's 2012 Sunset Review Report, and eventually will extend the Board's sunset date. This bill would also remove the sunset date from the provisions in existing law related to vertical enforcement.

This bill was amended and effective January 1, 2014, would transfer all investigators employed by the Medical Board of California (Board) and their staff to the Department of Justice (DOJ).

ANALYSIS:

The Board included new issues in its 2012 Sunset Review Report to the Legislature and in its 2013 Supplemental Report. This report was submitted to the Legislature and the Legislature prepared a background paper that raised 39 issues, some of them related to the new issues included in the Board's Sunset Review Report. Here are the new issues that were included in the Board's Sunset Review Report that would require legislation:

- Revise existing law, Business and Professions (B&P) Code Section 2177, in order to accommodate the upcoming two parts of the United States Medical Licensing Examination (USMLE) Step 3 examination, and any new evolving examination requirement - **This bill includes language to accommodate two parts of the USMLE Step 3 examination**
- Require all licensees who have an email address to provide the Board with an email address, and specify that the email address shall be confidential - **This bill includes language that would require licensees who have an email address to provide the Board with an email address by July 1, 2014 and would specify that the email address is confidential and not subject to public disclosure.**

- The Board recommended that the requirement in existing law for the Board to post a physician's approved postgraduate training be eliminated - The Committee directed the Board to further discuss this proposal with stakeholders, including those stakeholders representing consumer interests and advise the Committee of the results of those discussions, and submit language if appropriate.
- The Board recommended that it be clarified in statute that residents in California accredited resident/fellowship programs are exempt from corporate practice laws related to how they are paid – **This bill includes language that clarifies that the corporate practice laws do not apply to physicians enrolled in an approved residency postgraduate training program or fellowship program.**
- The Board recommended that a section be added to existing law to require coroners to report all deaths related to prescription drug overdoses to the Board – this language is contained in SB 62 (Price), which the Board currently has a position of support.
- The Board recommended that legislation be introduced to provide an adequate funding source for CURES, so it can be funded and upgraded (e.g. funded by all individuals who prescribe or dispense medications, pharmaceutical companies, and the public). The prescribers/dispensers would include physicians, dentists, pharmacists, veterinarians, nurse practitioners, physician assistants, osteopathic physicians, optometrists, and podiatrists. This funding source would support the necessary enhancements to the computer system and provide for adequate staffing to run the system – The CURES funding and upgrading language is included in SB 809 (DeSaulnier and Steinberg).
- The Board recommended that medical malpractice reports received pursuant to Section 801.01 be excluded from the requirements in existing law that require an upfront review by a medical expert with the expertise necessary to evaluate the specific standard of care issue raised in the complaint – **This bill includes language to exclude 801.01 reports from upfront review.**
- The Board recommended that, in the interest of consumer protection, legislation be written to require that regulations be adopted for physician availability in all clinical settings and for the Board to establish by regulation the knowledge, training, and ability a physician must possess in order to supervise other health care providers – This issue was not addressed in the Committee's background paper and language is not included in this bill.
- The Board recommended that the law be amended to allow a facility only 15 days to provide medical records, upon request, if the facility has electronic health records (EHRs) – **This bill includes language to require health care facilities that have EHRs to provide the authorizing patient's certified medical records to the Board within 15 days of receiving the request and would subject the health care facility to penalties if the facility does not adhere to the timeline**.
- The Board recommended an amendment to existing law to require the California Department of Public Health (CDPH) and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the Board and to require these entities to notify the Board if a hospital is not performing peer review - The Board was directed to further discuss this proposal with the Committee,

and consideration should be given to the Board entering into an arrangement or a MOU with CDPH and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the Board; and to further require that these entities notify the Board if a hospital is not performing peer review. This bill does not include language to address this issue.

- The Board recommended elimination of the ten year posting requirement in existing law in order to ensure transparency to the public – In the Committee's background paper, it was recommended that in the interest of transparency and disclosure of information to the public, existing law should be amended to remove the 10 year limit on how long information should be posted on the Board's Internet Web site; however, this bill does not include language that would remove the 10 year limit on posting information.
- The Board recommended amending existing law to require a respondent to provide the full expert reviewer report and to clarify the timeframes in existing law for providing the reports, such as 90 days from the filing of an accusation – **This bill includes language that would require the complete expert reviewer report to be provided and that would require the expert testimony information to be provided within 90 days from the filing of a notice of defense. The Board is working with Committee staff and the California Medical Association (CMA) on amendments to address CMA's concerns.**
- The Board recommended that the provision in existing law that requires the Board to approve non-ABMS specialty boards be deleted. The Board suggested that the law should continue to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the Board – **This bill deletes provisions in existing law that require the Board to approve non-ABMS specialty boards and only allows physicians to advertise that they have been certified by a non-ABMS board approved by the Board if it was approved prior to January 1, 2014. This language will be removed from the bill due to heavy opposition and concerns raised; the Board can bring this back in another bill next legislative session if it wishes to do so.**
- The Board suggested the transfer of the registered dispensing optician (RDO) Program to the Optometry Board or DCA should be examined – The Committee suggested that the Board initiate discussions with all stakeholders and report back to the Committees with findings by July 1, 2014. This bill does not include language to address this issue.
- The Board made suggestions related to the Licensed Midwifery Program, including that the issue of physician supervision and obtaining lab accounts and medical supplies should be addressed through legislation – The Committee agreed and AB 1308, which is sponsored by the American Congress of Obstetricians and Gynecologists, contains these changes. The Board has a support if amended position on this bill.
- The Board recommended that the issue of midwife students/apprenticeships needs to be clarified in legislation, due to confusion in the midwifery community – **This bill includes language that would define a "bona fide student" as an individual who is enrolled and participating in a midwifery education program or who is enrolled in a program of supervised clinical training as part of the instruction of a three year**

postsecondary midwifery education program approved by the Board.

- The Board recommended that the issue of midwife assistants needs to be addressed in legislation, and what duties the assistant may legally perform, as it has been brought to the attention of the Board that licensed midwives use midwife assistants. Currently, there is no definition for a midwife assistant or the specific training requirements or the duties that a midwife assistant may perform – The Committee directed the Board to provide more information regarding the proposal to address the issue of midwife assistants in legislation. This bill does not include language to address this issue.
- The Board suggested that existing law be amended to include certified nurse midwives (CNM) as being able to supervise midwifery students – **This bill includes language that would allow a CNM to supervise a midwifery student.**
- The Board recommended that language be added to existing law to allow the Board the authority to issue a cease practice order in cases where a licensee fails to comply with an order to compel a physical or mental examination - **This bill includes language that would allow the Board to issue a cease practice order when a licensee fails to comply with an order issued under Section 820, which compels a physical or mental examination. The Board is working with Committee staff and CMA on amendments to address CMA's concerns.**
- The Board recommended that existing law be amended to include American Osteopathic Association-Healthcare Facilities Accreditation Program as an approved accreditation agency for hospitals offering accredited postgraduate training programs – **This item, suggested in the Supplemental Report, was not addressed by the background paper as it was included after the paper was drafted and language was not included in this bill.**
- The Board recommended that the Vertical Enforcement Program be continued and stated that the Board and the Health Quality Enforcement Section (HQES) will continue to work together to establish best practices and identify areas where improvements can be made – **This bill deletes the sunset date in the vertical enforcement statutes, making vertical enforcement permanent. This bill would also require the Board, in consultation with DOJ and the Department of Consumer Affairs (DCA) to report and make recommendations to the Governor and the Legislature on the Vertical Enforcement Program by March 1, 2015. This bill was amended, and effective January 1, 2014, would transfer all investigators employed by the Board and their staff to DOJ.**

<u>Transfer of Investigators to DOJ:</u>

Moving the investigators over to DOJ could streamline the enforcement process by placing investigations and prosecutions under the jurisdiction of one agency. Allowing investigations and Deputy Attorneys General to be more easily co-located will also help to enhance communication.

Tenure/Retention Information

Regarding information on retention, this data was broken down into three time periods that equal the last 10 years. In the last 5 years, 53 investigators and supervising investigators left the Board; 29 retired, 21 transferred to another department or agency, and 3 were rejected on probation. In the last 5 to 7.5 years, 25 investigators and supervising investigators left the Board; 15 retired and 20 transferred to another department or agency. In the last 7.5 to 10 years, 22 investigators and supervising investigators left the Board; 20 retired and 2 transferred to another department or agency.

Regarding information on Board tenure, the data reflects a snapshot in time, and the same date was used (June 30) for each year data was collected. In 2013, investigators were employed for an average of 6 years; in 2008, investigators were employed for an average number of 9 years; and in 2003, investigators were employed for an average number of 7 years. In 2013, supervising investigators were employed for an average number of 8 years; in 2008, supervising investigators were employed for an average number of 10 years; and in 2003, supervising investigators were employed for an average number of 6 years.

Transferring investigators to DOJ would allow the investigators to receive a higher salary, which may reduce the number of investigators who retire or transfer from the Board and may increase the length of time investigators remain at the Board.

Issues/Concerns

If the investigators are transferred to DOJ, they will become employees of DOJ, meaning that the Board will no longer have control or authority over investigations and associated timelines, once cases are sent to DOJ for investigation. If investigations are handled by DOJ, the Board will have no input on the decisions made regarding the outcome of a case: whether it is referred for discipline, whether it is closed, whether a public reprimand is offered, etc. In addition, the Board will still be held accountable for its cases and timelines, even though it will have no oversight or control over the investigations and outcomes.

Fiscal Impact

If the investigators are transferred to DOJ, it will result in an increase of $1.294 million per year (for salaries only), due to the fact that the investigators at DOJ are classified as Special Agents and have a higher salary. The funding for these positions would be removed from the Board's salary and wages and moved to the Attorney General line item on the Board's budget as an operating expense. The operating expenses in the Board's budget associated with the current investigator positions would be reduced for all overhead costs, including equipment, vehicle maintenance, rent, travel, training, etc., and would be moved to the Attorney General line item in the Board's budget. The Attorney General would determine the billing methodology and bill the Board an hourly rate for the investigative services – currently the Board charges/is reimbursed

$149/hour for investigative services for physician and surgeon cases. The Board recently voted to approve pay differentials for investigators, which would have a total annual fiscal impact of $110,943 (chart attached), in comparison to the $1.294 million that this proposal would cost the Board.

Implementation

As far as implementation is concerned, investigative staff in the Board's Operation Safe Medicine Unit (OSM) would not be transferred to DOJ, as they do criminal investigations. All other staff in the Enforcement Program (besides staff performing investigations and their staff) would remain at the Board (Central Complain Unit, Discipline Coordination Unit, Probation Unit, Non-Sworn Special Investigative Unit, and the Central File Unit). The Board would need to have an individual assigned to review investigation reports to ensure appropriate action was taken.

Implementation Issues/Concerns

There are some implementation issues and concerns that Board staff has with this proposal. The Office of Standards and Training staff would be needed at both DOJ and at the Board. It is uncertain whether boards who currently utilize the Board's investigators would continue to use the transferred investigators or if they would use the DCA's Division of Investigation (DOI). If the Board hits the financial threshold for the hours that could be paid to DOJ from the line item, the Board would have to HALT investigations until July 1 of the next fiscal year; this is a serious consumer protection issue. Lastly, the implementation date of this bill, January 1, 2014, is not reasonable, as it is only three months after the bill is signed.

Due to discussion that ensued at the last meeting by the Board Members when this proposal was discussed, and the concerns that were raised by the Members, Board staff is suggesting that the Board request amendments to delete this proposal from the bill.

This bill would also extend the timeframe in which an accusation must be filed once an interim suspension order (ISO) is issued. Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an Interim Suspension Order (ISO), which must be granted by an Administrative Law Judge (ALJ). In existing law there is a 15-day time restraint in law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set, which means an investigation must be nearly complete in order to petition for an ISO. This bill would extend the timeframe to file an accusation from 15 days to 30 days, which would help to further the Board's mission of consumer protection.

This bill would address many of the new issues raised in the Board's 2012 Sunset Review Report and the 2013 Supplemental Report and includes language to make the legislative changes suggested by the Board to accommodate the continuing evolution of medical training and testing, to improve the efficiencies of the Board's Licensing and

Enforcement Programs, and most importantly, to enhance consumer protection. There are some issues that the Committee background paper did not address or that recommended the Board's changes be made, but that the changes are not included in this bill, i.e., removing the 10-year posting requirement in existing law. More importantly, this bill no longer extends the Board's sunset date, which must be extended in order for the Board to continue. Board staff is suggesting that the Board continue to take a support if amended position on this bill and request amendments to extend the sunset date and delete the proposal to transfer Board investigators to DOJ.

FISCAL: If the investigators are transferred to DOJ, it will result in an increase of $1.294 million per year (for salaries only), due to the fact that the investigators at DOJ are classified as Special Agents and have a higher salary.

SUPPORT: Center for Public Interest Law
Medical Board of California (if amended)

OPPOSITION: American Board of Cosmetic Surgery
California Academy of Cosmetic Surgery
California Medical Association (unless amended)
Department of Finance

POSITION: Recommendation: Support if Amended – include sunset extension language and delete language that would require Board investigators to be transferred to DOJ.

MBC Tenure and Retention Data

	Average Months Employed with MBC	Average Years Employed with MBC
MBC Investigators as of 6/30/2003	90	7
MBC Investigators as of 6/30/2008	106	9
MBC Investigators as of 6/30/2013	71	6

	Average Months Employed with MBC	Average Years Employed with MBC
MBC Supervisor I as of 6/30/2003	78	6
MBC Supervisor I as of 6/30/2008	125	10
MBC Supervisor I as of 6/30/2013	101	8

MBC Investigator Retention Data 07/01/03 through 06/30/13

	Separated	Retired/ Resigned	Agency Transfer	Rejected
Last 5 years	53	29	21	3
Last 5 - 7.5 years	25	15	20	0
Last 7.5 - 10 years	22	20	2	0

Fiscal Impact of Pay Differentials for MBC Investigators On an Annual Basis

1. Geographic Pay Differential

$200/month for investigators in LA, Alameda, Orange, San Francisco, and Santa Clara Counties

$200 x 39 Investigators x 12 months = $93,600.00/year

2. Range Master Pay Differential

$309.70 (5% of max base pay of $6,194)

$309.70 x 12 Investigators x 1 month = $3,716.40

3. Field Training Officer Pay Differential

$309.70 (5% of max base pay of $6,194)

$309.70 x 11 Investigators x 4 months = $13,626.80

TOTAL ANNUAL FISCAL IMPACT = $110,943.20

Fiscal Impact of Moving MBC Investigators to DOJ On an Annual Basis

MBC	DOJ
Investigators – $74,328	Special Agent – $88,092
Difference – $13,764	
72 investigators = $991,008	
Sup. I Investigator – $81,624	Special Agent Sup – $96,828
Difference – $15,204	
14 Sup. I Investigators = $212,856	
Sup. II Investigator – $92,148	Special Agent In Charge – $107,268
Difference – $15,120	
4 Sup. II Investigators = $60,480	
Chief/Deputy Chief - $30,000	

TOTAL ANNUAL FISCAL IMPACT = $1,294,344

Fiscal Impact of Moving MBC Investigators to DOJ
On an Annual Basis

MBC	DOJ
Investigators - $74,328	Special Agent – $88,092

Difference - $13,764
72 investigators = $991,008

Sup. I Investigator – $81,624	Special Agent Sup - $96,828

Difference – $15,204
14 Sup. I Investigators - $212,856

Sup. II Investigator - $92,148	Special Agent In Charge - $107,268

Difference - $15,120
4 Sup. II Investigators - $60,480

TOTAL - $1,264,334 + $30,000 for Chief/Deputy Chief = $1,294,344

NOTE: This proposal does not include the Operation Safe Medicine Unit and its staff (4 Investigators and 1 Supervising Investigator I)

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 16, 2013

SENATE BILL No. 304

Introduced by Senator Price
(Principal coauthor: Assembly Member Gordon)

February 15, 2013

An act to amend Sections 651, 2021, 2177, 2220.08, 2225.5, 2334, 2514, and 2569 of, and to add Sections 2291.5 and 2403 to, the Business and Professions Code, and to amend Sections ~~11529, 12529.6,~~ *11529* and 12529.7 of, and to amend and repeal Sections 12529 and 12529.5 of, the Government Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 304, as amended, Price. Healing arts: boards.

Existing law makes it unlawful for a healing arts practitioner to disseminate, or cause to be disseminated, any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of, or likely to induce, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. Existing law provides for the licensure of physicians and surgeons by the Medical Board of California. Existing law prohibits a physician and surgeon's advertisements from including a statement that he or she is certified or eligible for certification by a private or public board or parent association, including a multidisciplinary board or association, as defined, unless that board or association meets at least one of several standards, including being a board or association with equivalent requirements approved by that physician and surgeon's licensing board. A violation of these requirements is a crime.

result in the issuance of notification from the board to cease the practice of medicine immediately until the ordered examinations have been completed and would provide that continued failure to comply would be grounds for suspension or revocation of his or her certificate.

Existing law prohibits a party from bringing expert testimony in a matter brought by the board unless certain information is exchanged in written form with counsel for the other party, as specified, within 30 calendar days prior to the commencement of the hearing. Existing law provides that the information exchanged include a brief narrative statement of the testimony the expert is expected to bring.

This bill would instead require that information to be exchanged within 90 days from the filing of a notice of defense and would instead require the information to include a complete expert witness report.

Existing law establishes that corporations and other artificial legal entities have no professional rights, privileges, or powers.

This bill would provide that those provisions do not apply to physicians and surgeons enrolled in approved residency postgraduate training programs or fellowship programs.

Existing law, the Licensed Midwifery Practice Act of 1993, licenses and regulates licensed midwives by the Medical Board of California. Existing law specifies that a midwife student meeting certain conditions is not precluded from engaging in the practice of midwifery as part of his or her course of study, if certain conditions are met, including, that the student is under the supervision of a licensed midwife.

This bill would require that to engage in those practices, the student is to be enrolled and participating in a midwifery education program or enrolled in a program of supervised clinical training, as provided. The bill would add that the student is permitted to engage in those practices if he or she is under the supervision of a licensed nurse-midwife.

Existing law provides for the regulation of registered dispensing opticians by the Medical Board of California and requires that the powers and duties of the board in that regard be subject to review by the Joint Sunset Review Committee as if those provisions were scheduled to be repealed on January 1, 2014.

This bill would instead make the powers and duties of the board subject to review by the appropriate policy committees of the Legislature as if those provisions were scheduled to be repealed on January 1, 2018.

Existing law authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order related to licenses, as provided. Existing law requires that in all of those cases in which an

that individuals performing investigations would retain their status as peace officers.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 651 of the Business and Professions Code is amended to read:

651. (a) It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.

(b) A false, fraudulent, misleading, or deceptive statement, claim, or image includes a statement or claim that does any of the following:

(1) Contains a misrepresentation of fact.

(2) Is likely to mislead or deceive because of a failure to disclose material facts.

(3) (A) Is intended or is likely to create false or unjustified expectations of favorable results, including the use of any photograph or other image that does not accurately depict the results of the procedure being advertised or that has been altered in any manner from the image of the actual subject depicted in the photograph or image.

(B) Use of any photograph or other image of a model without clearly stating in a prominent location in easily readable type the

nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.

(d) Any person so licensed shall not compensate or give anything of value to a representative of the press, radio, television, or other communication medium in anticipation of, or in return for, professional publicity unless the fact of compensation is made known in that publicity.

(e) Any person so licensed may not use any professional card, professional announcement card, office sign, letterhead, telephone directory listing, medical list, medical directory listing, or a similar professional notice or device if it includes a statement or claim that is false, fraudulent, misleading, or deceptive within the meaning of subdivision (b).

(f) Any person so licensed who violates this section is guilty of a misdemeanor. A bona fide mistake of fact shall be a defense to this subdivision, but only to this subdivision.

(g) Any violation of this section by a person so licensed shall constitute good cause for revocation or suspension of his or her license or other disciplinary action.

(h) Advertising by any person so licensed may include the following:

(1) A statement of the name of the practitioner.

(2) A statement of addresses and telephone numbers of the offices maintained by the practitioner.

(3) A statement of office hours regularly maintained by the practitioner.

(4) A statement of languages, other than English, fluently spoken by the practitioner or a person in the practitioner's office.

(5) (A) A statement that the practitioner is certified by a private or public board or agency or a statement that the practitioner limits his or her practice to specific fields.

(B) A statement of certification by a practitioner licensed under Chapter 7 (commencing with Section 3000) shall only include a statement that he or she is certified or eligible for certification by a private or public board or parent association recognized by that practitioner's licensing board.

(D) A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she is certified or eligible or qualified for certification by a private or public board or parent association, including, but not limited to, a multidisciplinary board or association, if that board or association meets one of the following requirements: (i) is approved by the Council on Podiatric Medical Education, (ii) is a board or association with equivalent requirements approved by the California Board of Podiatric Medicine, or (iii) is a board or association with the Council on Podiatric Medical Education approved postgraduate training programs that provide training in podiatric medicine and podiatric surgery. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement. A doctor of podiatric medicine licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification.

For purposes of this subparagraph, a "multidisciplinary board or association" means an educational certifying body that has a psychometrically valid testing process, as determined by the California Board of Podiatric Medicine, for certifying doctors of podiatric medicine that is based on the applicant's education, training, and experience. For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is a Council on Podiatric Medical Education approved board, an organization with equivalent requirements approved by the California Board of Podiatric Medicine, or an organization with a Council on Podiatric Medical Education approved postgraduate training program that provides training in podiatric medicine and podiatric surgery.

The California Board of Podiatric Medicine shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this

service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not, by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.

(j) The Attorney General shall commence legal proceedings in the appropriate forum to enjoin advertisements disseminated or about to be disseminated in violation of this section and seek other appropriate relief to enforce this section. Notwithstanding any other provision of law, the costs of enforcing this section to the respective licensing boards or committees may be awarded against any licensee found to be in violation of any provision of this section. This shall not diminish the power of district attorneys, county counsels, or city attorneys pursuant to existing law to seek appropriate relief.

(k) A physician and surgeon or doctor of podiatric medicine licensed pursuant to Chapter 5 (commencing with Section 2000) by the Medical Board of California who knowingly and intentionally violates this section may be cited and assessed an administrative fine not to exceed ten thousand dollars ($10,000) per event. Section 125.9 shall govern the issuance of this citation and fine except that the fine limitations prescribed in paragraph (3) of subdivision (b) of Section 125.9 shall not apply to a fine under this subdivision.

SEC. 2. Section 2021 of the Business and Professions Code is amended to read:

2021. (a) If the board publishes a directory pursuant to Section 112, it may require persons licensed pursuant to this chapter to

is the subject of a pending accusation or investigation or who is on probation, any complaint determined to involve quality of care, before referral to a field office for further investigation, shall meet the following criteria:

(1) It shall be reviewed by one or more medical experts with the pertinent education, training, and expertise to evaluate the specific standard of care issues raised by the complaint to determine if further field investigation is required.

(2) It shall include the review of the following, which shall be requested by the board:

(A) Relevant patient records.

(B) The statement or explanation of the care and treatment provided by the physician and surgeon.

(C) Any additional expert testimony or literature provided by the physician and surgeon.

(D) Any additional facts or information requested by the medical expert reviewers that may assist them in determining whether the care rendered constitutes a departure from the standard of care.

(b) If the board does not receive the information requested pursuant to paragraph (2) of subdivision (a) within 10 working days of requesting that information, the complaint may be reviewed by the medical experts and referred to a field office for investigation without the information.

(c) Nothing in this section shall impede the board's ability to seek and obtain an interim suspension order or other emergency relief.

SEC. 5. Section 2225.5 of the Business and Professions Code is amended to read:

2225.5. (a) (1) A licensee who fails or refuses to comply with a request for the certified medical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the licensee is unable to provide the documents within this time period for good cause.

(2) A health care facility shall comply with a request for the certified medical records of a patient that is accompanied by that patient's written authorization for release of records to the board

by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

(3) A health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of patient records to the board, that is accompanied by a notice citing this section and describing the penalties for failure to comply with this section, shall pay to the board a civil penalty of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced, up to ten thousand dollars ($10,000), after the date by which the court order requires the documents to be produced, unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(4) Any health care facility that fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). Any statute of limitations applicable to the filing of an accusation by the board against a licensee shall be tolled during the period the health care facility is out of compliance with the court order and during any related appeals.

(c) Multiple acts by a licensee in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) or by imprisonment in a county jail not exceeding six months, or by both that fine and imprisonment. Multiple acts by a health care facility in violation of subdivision (b) shall be punishable by a fine not to exceed five thousand dollars ($5,000) and shall be reported to the State Department of Public Health and shall be considered as grounds for disciplinary action with respect to licensure, including suspension or revocation of the license or certificate.

(d) A failure or refusal of a licensee to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board constitutes unprofessional conduct and is grounds for suspension or revocation of his or her license.

(e) Imposition of the civil penalties authorized by this section shall be in accordance with the Administrative Procedure Act

SEC. 8. Section 2403 is added to the Business and Professions Code, to read:

2403. The provisions of Section 2400 do not apply to physicians and surgeons enrolled in approved residency postgraduate training programs or fellowship programs.

SEC. 9. Section 2514 of the Business and Professions Code is amended to read:

2514. (a) Nothing in this chapter shall be construed to prevent a bona fide student from engaging in the practice of midwifery in this state, as part of his or her course of study, if both of the following conditions are met:

(1) The student is under the supervision of a licensed midwife or certified nurse-midwife, who holds a clear and unrestricted license in this state, who is present on the premises at all times client services are provided, and who is practicing pursuant to Section 2507 or 2746.5, or a physician and surgeon.

(2) The client is informed of the student's status.

(b) For the purposes of this section, a "bona fide student" means an individual who is enrolled and participating in a midwifery education program or who is enrolled in a program of supervised clinical training as part of the instruction of a three year postsecondary midwifery education program approved by the board.

SEC. 10. Section 2569 of the Business and Professions Code is amended to read:

2569. Notwithstanding any other law, the powers and duties of the board, as set forth in this chapter, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.

SEC. 11. Section 11529 of the Government Code is amended to read:

11529. (a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing

(1) There is a reasonable probability that the petitioner will prevail in the underlying action.

(2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order.

(f) In all cases where an interim order is issued, and an accusation is not filed and served pursuant to Sections 11503 and 11505 within 30 days of the date in which the parties to the hearing on the interim order have submitted the matter, the order shall be dissolved.

Upon service of the accusation the licensee shall have, in addition to the rights granted by this section, all of the rights and privileges available as specified in this chapter. If the licensee requests a hearing on the accusation, the board shall provide the licensee with a hearing within 30 days of the request, unless the licensee stipulates to a later hearing, and a decision within 15 days of the date the decision is received from the administrative law judge, or the board shall nullify the interim order previously issued, unless good cause can be shown by the Division of Medical Quality for a delay.

(g) Where an interim order is issued, a written decision shall be prepared within 15 days of the hearing, by the administrative law judge, including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached.

(h) Notwithstanding the fact that interim orders issued pursuant to this section are not issued after a hearing as otherwise required by this chapter, interim orders so issued shall be subject to judicial review pursuant to Section 1094.5 of the Code of Civil Procedure. The relief which may be ordered shall be limited to a stay of the interim order. Interim orders issued pursuant to this section are final interim orders and, if not dissolved pursuant to subdivision (c) or (f), may only be challenged administratively at the hearing on the accusation.

(i) The interim order provided for by this section shall be:

(1) In addition to, and not a limitation on, the authority to seek injunctive relief provided for in the Business and Professions Code.

(2) A limitation on the emergency decision procedure provided in Article 13 (commencing with Section 11460.10) of Chapter 4.5.

~~(d)~~

(e) Funding for the Health Quality Enforcement Section shall be budgeted in consultation with the Attorney General from the special funds financing the operations of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, and the committees under the jurisdiction of the Medical Board of California, with the intent that the expenses be proportionally shared as to services rendered.

SEC. 13. Section 12529 of the Government Code, as amended by Section 113 of Chapter 332 of the Statutes of 2012, is repealed.

SEC. 14. Section 12529.5 of the Government Code, as amended by Section 114 of Chapter 332 of the Statutes of 2012, is amended to read:

12529.5. (a) All complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology shall be made available to the Health Quality Enforcement Section.

(b) The Senior Assistant Attorney General of the Health Quality Enforcement Section shall assign attorneys to work on location at the intake unit of the boards described in subdivision (d) of Section 12529 to assist in evaluating and screening complaints and to assist in developing uniform standards and procedures for processing complaints.

(c) The Senior Assistant Attorney General or his or her deputy attorneys general shall assist the boards or committees in designing and providing initial and in-service training programs for staff of the boards or committees, including, but not limited to, information collection and investigation.

(d) The determination to bring a disciplinary proceeding against a licensee of the boards shall be made by the executive officer of the boards or committees as appropriate in consultation with the senior assistant.

SEC. 15. Section 12529.5 of the Government Code, as amended by Section 115 of Chapter 332 of the Statutes of 2012, is repealed.

~~SEC. 16. Section 12529.6 of the Government Code is amended to read:~~

~~12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state~~

~~(3) Establish and implement a plan to assist in team building between its enforcement staff and the staff of the Health Quality Enforcement Section in order to ensure a common and consistent knowledge base.~~

~~SEC. 17.~~

SEC. 16. Section 12529.7 of the Government Code is amended to read:

12529.7. By March 1, 2015, the Medical Board of California, in consultation with the Department of Justice and the Department of Consumer Affairs, shall report and make recommendations to the Governor and the Legislature on the vertical enforcement and prosecution model created under Section 12529.6.

~~SEC. 18.~~

SEC. 17. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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SB 305

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 305
Author:	Price
Bill Date:	June 19, 2013, Amended
Subject:	Healing Arts: Boards
Sponsor:	Author
Position:	Support provisions related to records of arrests and convictions for applicants and licensees

STATUS OF BILL:

This bill is in the Assembly Appropriations Committee.

DESCRIPTION OF CURRENT LEGISLATION:

Among other provisions, this bill would allow all boards under the Department of Consumer Affairs (DCA) that require licensees to submit fingerprints, including the Medical Board of California (Board), to request from a local or state agency, 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. This bill would specify that a local or state agency may provide these records and that a board may receive these records.

ANALYSIS:

Currently, the Board does receive records of arrests and convictions. However, records regarding probation and records from other state and local agencies would be beneficial for the Board to receive and use in applicant and licensee investigations. This bill would clarify that a local or state agency may provide the records and that a board may receive the records.

Clarifying in statute that state and local agencies can provide boards under DCA with certified arrest, conviction, and probation records, and other documentation needed to complete an applicant or licensee investigation would be beneficial to the Board's Enforcement Program. There is sometime question on what documents can be shared from agency to agency, and this bill would clarify that information can be shared with specified boards, in order to help with a board's investigation. This will further the Board's mission of consumer protection; the Board has taken a support position on this particular provision in the bill. Recent amendments do not impact the Board's support position or the reasons for taking that position.

FISCAL: None

SUPPORT: California Naturopathic Doctors Association; California Optometric Association; California State Board of Optometry; Medical Board of California; National Board of Examiners in Optometry; Naturopathic Medicine Committee; Osteopathic Physicians and Surgeons of California; Physical Therapy Board of California; and SEIU California

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 19, 2013

AMENDED IN ASSEMBLY JUNE 14, 2013

AMENDED IN SENATE APRIL 25, 2013

AMENDED IN SENATE APRIL 15, 2013

SENATE BILL No. 305

Introduced by Senator Price
(Principal coauthor: Assembly Member Gordon)

February 15, 2013

An act to amend Sections 1000, 2450, 2450.3, 2530.2, 2531, 2531.75, 2533, 2570.19, 2602, 2607.5, 3010.5, 3014.6, 3685, 3686, 3710, 3716, ~~3765, 4938, and 4939~~ *and 3765* of, and to add Section 144.5 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 305, as amended, Price. Healing arts: boards.

~~Existing~~

(1) Existing law requires specified regulatory boards within the Department of Consumer Affairs to require an applicant for licensure to furnish to the board a full set of fingerprints in order to conduct a criminal history record check.

This bill would additionally authorize those boards to request and receive from a local or state agency 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 and would authorize a local or state agency to provide those records to the board upon request.

~~The~~

by the California Board of Occupational Therapy. Existing law repeals those provisions on January 1, 2014, and subjects the board to review by the Joint Committee on Boards, Commissions, and Consumer Protection.

This bill would extend the operation of these provisions until January 1, 2018, and provide that the repeal of these provisions subjects the board to review by the appropriate policy committees of the Legislature.

~~Existing~~

(6) Existing law, the Physical Therapy Practice Act, provides for the licensure and regulation of physical therapists by the Physical Therapy Board of California. The act authorizes the board to appoint an executive officer. Existing law repeals these provisions on January 1, 2014.

This bill would extend the operation of these provisions until January 1, 2018.

~~Existing~~

(7) Existing law, the Naturopathic Doctors Act, until January 1, 2014, provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee within the Osteopathic Medical Board of California. Existing law also specifies that the repeal of the committee subjects it to review by the appropriate policy committees of the Legislature.

This bill would extend the operation of these provisions until January 1, 2018, and make conforming changes.

~~Existing~~

(8) Existing law, the Optometry Practice Act, provides for the licensure and regulation of optometrists by the State Board of Optometry. The Respiratory Care Act provides for the licensure and regulation of respiratory care practitioners by the Respiratory Care Board of California. Each of those acts authorizes the board to employ an executive officer. Existing law repeals these provisions on January 1, 2014, and subjects the boards to review by the Joint Committee on Boards, Commissions, and Consumer Protection.

This bill would extend the operation of these provisions until January 1, 2018, and provide that the repeal of these provisions subjects the boards to review by the appropriate policy committees of the Legislature.

~~The~~

(9) The Respiratory Care Act also prohibits a person from engaging in the practice of respiratory care unless he or she is a licensed respiratory care practitioner. However, the act does not prohibit specified

1000. (a) The law governing practitioners of chiropractic is found in an initiative act entitled "An act prescribing the terms upon which licenses may be issued to practitioners of chiropractic, creating the State Board of Chiropractic Examiners and declaring its powers and duties, prescribing penalties for violation hereof, and repealing all acts and parts of acts inconsistent herewith," adopted by the electors November 7, 1922.

(b) The State Board of Chiropractic Examiners is within the Department of Consumer Affairs.

(c) Notwithstanding any other law, the powers and duties of the State Board of Chiropractic Examiners, as set forth in this article and under the act creating the board, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.

SEC. 3. Section 2450 of the Business and Professions Code is amended to read:

2450. There is a Board of Osteopathic Examiners of the State of California, established by the Osteopathic Act, which shall be known as the Osteopathic Medical Board of California which enforces this chapter relating to persons holding or applying for physician's and surgeon's certificates issued by the Osteopathic Medical Board of California under the Osteopathic Act.

Persons who elect to practice using the term of suffix "M.D.," as provided in Section 2275, shall not be subject to this article, and the Medical Board of California shall enforce the provisions of this chapter relating to persons who made the election.

Notwithstanding any other law, the powers and duties of the Osteopathic Medical Board of California, as set forth in this article and under the Osteopathic Act, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2018.

SEC. 4. Section 2450.3 of the Business and Professions Code is amended to read:

2450.3. There is within the jurisdiction of the Osteopathic Medical Board of California a Naturopathic Medicine Committee authorized under the Naturopathic Doctors Act (Chapter 8.2 (commencing with Section 3610)). This section shall become inoperative on January 1, 2018, and, as of that date is repealed,

(2) Nothing in this subdivision shall be construed as a diagnosis. Any observation of an abnormality shall be referred to a physician and surgeon.

(f) A licensed speech-language pathologist shall not perform a flexible fiberoptic nasendoscopic procedure unless he or she has received written verification from an otolaryngologist certified by the American Board of Otolaryngology that the speech-language pathologist has performed a minimum of 25 flexible fiberoptic nasendoscopic procedures and is competent to perform these procedures. The speech-language pathologist shall have this written verification on file and readily available for inspection upon request by the board. A speech-language pathologist shall pass a flexible fiberoptic nasendoscopic instrument only under the direct authorization of an otolaryngologist certified by the American Board of Otolaryngology and the supervision of a physician and surgeon.

(g) A licensed speech-language pathologist shall only perform flexible endoscopic procedures described in subdivision (e) in a setting that requires the facility to have protocols for emergency medical backup procedures, including a physician and surgeon or other appropriate medical professionals being readily available.

(h) "Speech-language pathology aide" means any person meeting the minimum requirements established by the board, who works directly under the supervision of a speech-language pathologist.

(i) (1) "Speech-language pathology assistant" means a person who meets the academic and supervised training requirements set forth by the board and who is approved by the board to assist in the provision of speech-language pathology under the direction and supervision of a speech-language pathologist who shall be responsible for the extent, kind, and quality of the services provided by the speech-language pathology assistant.

(2) The supervising speech-language pathologist employed or contracted for by a public school may hold a valid and current license issued by the board, a valid, current, and professional clear clinical or rehabilitative services credential in language, speech, and hearing issued by the Commission on Teacher Credentialing, or other credential authorizing service in language, speech, and hearing issued by the Commission on Teacher Credentialing that is not issued on the basis of an emergency permit or waiver of

by this section, shall only be performed by a licensed audiologist. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but shall include all of the following:

(1) Collaboration on the development of written standardized protocols. The protocols shall include a requirement that the supervised audiologist immediately refer to an appropriate physician any trauma, including skin tears, bleeding, or other pathology of the ear discovered in the process of cerumen removal as defined in this subdivision.

(2) Approval by the supervising physician of the written standardized protocol.

(3) The supervising physician shall be within the general vicinity, as provided by the physician-audiologist protocol, of the supervised audiologist and available by telephone contact at the time of cerumen removal.

(4) A licensed physician and surgeon may not simultaneously supervise more than two audiologists for purposes of cerumen removal.

SEC. 6. Section 2531 of the Business and Professions Code is amended to read:

2531. (a) There is in the Department of Consumer Affairs the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board in which the enforcement and administration of this chapter are vested. The Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board shall consist of nine members, three of whom shall be public members.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 7. Section 2531.75 of the Business and Professions Code is amended to read:

2531.75. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

(i) The use, or causing the use, of any advertising or promotional literature in a manner that has the capacity or tendency to mislead or deceive purchasers or prospective purchasers.

(j) Any cause that would be grounds for denial of an application for a license.

(k) Violation of Section 1689.6 or 1793.02 of the Civil Code.

(*l*) Violation of a term or condition of a probationary order of a license issued by the board pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 9. Section 2570.19 of the Business and Professions Code is amended to read:

2570.19. (a) There is hereby created a California Board of Occupational Therapy, hereafter referred to as the board. The board shall enforce and administer this chapter.

(b) The members of the board shall consist of the following:

(1) Three occupational therapists who shall have practiced occupational therapy for five years.

(2) One occupational therapy assistant who shall have assisted in the practice of occupational therapy for five years.

(3) Three public members who shall not be licentiates of the board, of any other board under this division, or of any board referred to in Section 1000 or 3600.

(c) The Governor shall appoint the three occupational therapists and one occupational therapy assistant to be members of the board. The Governor, the Senate Committee on Rules, and the Speaker of the Assembly shall each appoint a public member. Not more than one member of the board shall be appointed from the full-time faculty of any university, college, or other educational institution.

(d) All members shall be residents of California at the time of their appointment. The occupational therapist and occupational therapy assistant members shall have been engaged in rendering occupational therapy services to the public, teaching, or research in occupational therapy for at least five years preceding their appointments.

(e) The public members may not be or have ever been occupational therapists or occupational therapy assistants or in training to become occupational therapists or occupational therapy assistants. The public members may not be related to, or have a household member who is, an occupational therapist or an

2602. The Physical Therapy Board of California, hereafter referred to as the board, shall enforce and administer this chapter.

This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

Notwithstanding any other provision of law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 11. Section 2607.5 of the Business and Professions Code is amended to read:

2607.5. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

(b) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 12. Section 3010.5 of the Business and Professions Code is amended to read:

3010.5. (a) There is in the Department of Consumer Affairs a State Board of Optometry in which the enforcement of this chapter is vested. The board consists of 11 members, five of whom shall be public members.

Six members of the board shall constitute a quorum.

(b) The board shall, with respect to conducting investigations, inquiries, and disciplinary actions and proceedings, have the authority previously vested in the board as created pursuant to Section 3010. The board may enforce any disciplinary actions undertaken by that board.

(c) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 13. Section 3014.6 of the Business and Professions Code is amended to read:

3014.6. (a) The board may appoint a person exempt from civil service who shall be designated as an executive officer and who

(a) The performance of respiratory care that is an integral part of the program of study by students enrolled in approved respiratory therapy training programs.

(b) Self-care by the patient or the gratuitous care by a friend or member of the family who does not represent or hold himself or herself out to be a respiratory care practitioner licensed under the provisions of this chapter.

(c) The respiratory care practitioner from performing advances in the art and techniques of respiratory care learned through formal or specialized training.

(d) The performance of respiratory care in an emergency situation by paramedical personnel who have been formally trained in these modalities and are duly licensed under the provisions of an act pertaining to their speciality.

(e) Respiratory care services in case of an emergency. "Emergency," as used in this subdivision, includes an epidemic or public disaster.

(f) Persons from engaging in cardiopulmonary research.

(g) Formally trained licensees and staff of child day care facilities from administering to a child inhaled medication as defined in Section 1596.798 of the Health and Safety Code.

(h) The performance by a person employed by a home medical device retail facility or by a home health agency licensed by the State Department of Public Health of specific, limited, and basic respiratory care or respiratory care related services that have been authorized by the board.

(i) The performance of pulmonary function testing by persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

~~SEC. 19. Section 4938 of the Business and Professions Code is amended to read:~~

~~4938. The board shall issue a license to practice acupuncture to any person who makes an application and meets the following requirements:~~

~~(a) Is at least 18 years of age.~~

~~(b) Furnishes satisfactory evidence of completion of one of the following:~~

~~(1) An educational and training program approved by the board pursuant to Section 4939.~~

~~those schools and colleges and tutorial programs, completion of which will satisfy the requirements of Section 4938.~~

~~(b) Standards for the approval of training programs shall include a minimum of 3,000 hours of study in curriculum pertaining to the practice of an acupuncturist. This subdivision shall apply to all students entering programs on or after January 1, 2005.~~

~~(c) Beginning January 1, 2017, all training programs approved by the board shall be accredited by the Accrediting Commission for Acupuncture and Oriental Medicine.~~

~~(d) Within three years of initial approval by the board, each program so approved by the board shall receive full institutional approval under Article 6 (commencing with Section 94885) of Chapter 8 of Part 59 of Division 10 of Title 3 of the Education Code in the field of traditional Asian medicine, or in the case of institutions located outside of this state, approval by the appropriate governmental educational authority using standards equivalent to those of Article 6 (commencing with Section 94885) of Chapter 8 of Part 59 of Division 10 of Title 3 of the Education Code, or the board's approval of the program shall automatically lapse.~~

~~SEC. 21.~~

SEC. 19. The Legislature finds and declares that a special law, as set forth in Section 18 of this act, is necessary and that a general law cannot be made applicable within the meaning of Section 16 of Article IV of the California Constitution because of the unique circumstances relating to persons who are currently employed by Los Angeles County hospitals and have performed pulmonary function testing for at least 15 years.

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SB 352

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 352
Author:	Pavley
Bill Date:	June 19, 2013, Amended
Subject:	Medical Assistants: Supervision
Sponsor:	California Academy of Physician Assistants (CAPA)
Position:	Support

STATUS OF BILL:

This bill is on the Assembly Third Reading File.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician assistants (PAs), nurse practitioner (NPs) and certified nurse-midwives (CNMs) to supervise medical assistants (MAs)

This bill was amended to specify that if a PA, NP, or CNM authorizes a MA to perform any clinical laboratory test or examination that the MA is not authorized to perform, it would constitute unprofessional conduct.

ANALYSIS:

MAs are unlicensed personnel trained to perform basic administrative, clerical, and technical support services in a medical office or clinical setting. These services include, but are not limited to, taking blood pressure, charting height and weight, administering medication, performing skin tests, and withdrawing blood by venipuncture. The Bureau of Labor and Statistics (2011) reports nearly 82,000 MAs are employed in California.

Currently, a physician must be present in the practice site to supervise an MA in most settings. PAs, NPs, and CNMs can currently supervise MAs in licensed community and free clinics. If a physician is not present, MAs are limited to performing administrative and clerical duties and cannot perform or assist with simple technical supportive services if the physician is not on the premises, except in community and free clinics. This means that in many settings, MAs cannot perform many of the tasks that they are qualified for and are needed to perform. This bill would allow PAs, NPs, and CNMs to supervise MAs in all settings.

According to the sponsors, physicians have been delegating the task of supervising MAs when the physician is not in the office for over a decade in community clinics and the Physician Assistant Board and the Department of Consumer Affairs have not reported any patient safety issues or disciplinary action related to PA supervision of MAs. The sponsors

believe that this bill will eliminate legal restrictions and barriers to efficient coordinated care. The sponsors believe this change is necessary if California hopes to accommodate the dramatic increase in patients expected to result from health care reform.

With the health care reform being implemented in 2014, this bill may help to accommodate the expected increase in patients, as well as help to ensure that MAs are being supervised while a physician is not physically present in the office. Given that PAs, NPs, and NMs are currently allowed to supervise MAs in some settings now, and that this authority would have to be delegated by the physician, it makes sense for this to be allowed in all settings.

The Board had a support if amended position on this bill and requested amendments to specify that if a PA, NP, or NM were to allow the MA to perform tasks that are not in the approved scope of responsibility, that the PA, NP, or NM would be held responsible and subject to discipline by their licensing board. This bill was amended to specify that if a PA, NP, or CNM authorizes a MA to perform any clinical laboratory test or examination that the MA is not authorized to perform, it would constitute unprofessional conduct. This amendment addresses the Board's concern, as such, the Board now has a support position on this bill.

FISCAL: None

SUPPORT: CAPA (sponsor); Bay Area Council; California Academy of Family Physicians; California Association for Nurse Practitioners; California Optometric Association; Kaiser Permanente; Medical Board of California; U.S. HealthWorks Medical Group; United Nurses Associations of California/Union of Health Care Professionals; and 1 individual

OPPOSITION: California Nurses Association

AMENDED IN ASSEMBLY JUNE 19, 2013

AMENDED IN SENATE APRIL 10, 2013

SENATE BILL No. 352

Introduced by Senator Pavley
(Principal coauthor: Senator Hernandez)

February 20, 2013

An act to amend Section 2069 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 352, as amended, Pavley. Medical assistants: supervision.

Existing law authorizes a medical assistant to perform specified services relating to the administration of medication and performance of skin tests and simple routine medical tasks and procedures upon specific authorization from and under the supervision of a licensed physician and surgeon or podiatrist, or in a specified clinic upon specific authorization of a physician assistant, nurse practitioner, or nurse-midwife. Existing law requires the Board of Registered Nursing to issue a certificate to practice nurse-midwifery to a qualifying applicant who is licensed pursuant to the Nursing Practice Act.

This bill would delete the requirement that the services performed by the medical assistant be in a specified clinic when under the specific authorization of a physician assistant, nurse practitioner, or certified nurse-midwife. *The bill would prohibit a nurse practitioner, certified nurse-midwife, or physician assistant from authorizing a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized, as specified, a violation of which would constitute unprofessional conduct.* The bill would also

(b) As used in this section and Sections 2070 and 2071, the following definitions apply:

(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) "Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical practice. A notation of the standing order shall be placed on the patient's medical record.

(3) "Supervision" means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

(C) A physician assistant, nurse practitioner, or certified nurse-midwife as provided in subdivision (a).

(4) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a

SB 491

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 491
Author:	Hernandez
Bill Date:	May 21, 2013, Amended
Subject:	Nurse Practitioners
Sponsor:	Author
Position:	Oppose

STATUS OF BILL:

This bill is in the Assembly Business, Professions and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would make findings and declarations related to the role and importance of nurse practitioners (NPs). This bill would establish independent practice for NPs by removing provisions in existing law that require physician supervision through standardized procedures, collaboration or consultation with a physician. This bill would also expand the scope of practice for a NP and would allow a NP to order, furnish or prescribe drugs.

As amended, this bill would require a NP to only delegate tasks to a medical assistant (MA) pursuant to standardized procedures and protocols that are within the MAs scope of practice. The amendments also make other technical and clarifying changes.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, NPs operate under standardized procedures, that are overseen by a supervising physician. NPs are advanced practice registered nurses (RNs) who have pursued higher education and certification as a NP. There are approximately 17,000 NPs licensed by the Board of Registered Nursing (BRN) in California.

This bill would make findings and declarations regarding the role and importance of NPs. This bill would establish independent practice for NPs by removing provisions in existing law that require physician supervision through standardized procedures, collaboration or consultation with a physician. This bill would require a NP to maintain malpractice insurance. This bill would expand the scope of a NP and would allow a NP to do the following:

- Assess patients, synthesize and analyze data, and apply principles of health care.
- Manage the physical and psychosocial health status of patients.
- Analyze multiple sources of data, identify alternative possibilities as to the nature of a

health care problem, and select, implement, and evaluate appropriate treatment.

- Establish a physical diagnosis by client history, physical examination, and other criteria, consistent with this bill.
- Order, furnish, or prescribe drugs or devices, as specified.
- Refer patients to other health care providers, as specified.
- Delegate tasks to a MA pursuant to standardized procedures and protocols developed by the NP and MA, that are within the MAs scope of practice.
- Perform additional acts that require education and training that are recognized by the nursing profession as proper to be performed by a NP.
- Order hospice care as appropriate.
- Perform procedures that are necessary and consistent with the NPs scope of practice.

As stated in the bullets above, this bill will allow NPs to refer a patient to a physician or other licensed health care provider if the referral will protect the health and welfare of the patient, and must consult with a physician or other licensed health care provider if a situation or condition of a patient is beyond the NPs education, training, or certification. This bill would allow a NP to furnish order or prescribe drugs or devices if they are consistent with the practitioners' education preparation or for which clinical competency has been established and maintained and the BRN has certified that the NP has satisfactorily completed a course in pharmacology covering the drugs or devices. A NP would not be allowed to furnish, order or prescribe a dangerous drug without an appropriate prior examination and a medical indication, unless one of the following applies:

- The NP was a designated practitioner serving in the absence of the patient's physician, podiatrist, or NP and the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but no longer than 72 hours.
- The NP transmitted the order for drugs to a RN or licensed vocational nurse (LVN) in an inpatient facility and the NP consulted with the RN or LVN who reviewed the patients records and the NP was designated as the practitioner to serve in the absence of the patient's physician, podiatrist or NP.
- The NP was a designated practitioner serving in the absence of the patient's physician, podiatrist, or NP and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount for more than one renewal.

Beginning on and after July 1, 2016, this bill would require an applicant for initial qualification or certification as a NP to hold a national certification as a NP from a national certifying body recognized by the BRN. This bill would also require a NP to maintain professional liability insurance that is appropriate for his or her practice setting.

According to the author, this bill will establish independent practice for NPs and enable them to perform all tasks and functions consistent with their education and training and would allow NPs to choose to see Medi-Cal patients. According to the author, the Institutes of Medicine and the National Council of State Boards of Nursing have recommended full practice

for NPs. The author believes this package of bills will allow for better utilization of the existing infrastructure of trained medical providers to bridge the provider gap through expanded practice.

This bill significantly expands the scope of practice of a NP by establishing independent practice and deleting all provisions in existing law that currently require physician supervision, oversight, collaboration or consultation. NPs are well qualified to provide medical care when practicing under standardized procedures and physician supervision; however, the standardized procedures and physician supervision, collaboration, and consultation are in existing law to ensure that the patient care provided by a NP includes physician involvement and oversight, as physicians should be participating in the patient's care in order to ensure consumer protection. It is also unknown how this bill would affect corporate practice, as the bill does not address this issue. The Board's primary mission is consumer protection and by significantly expanding the scope of practice for a NP, patient care and consumer protection could be compromised; as such, the Board is opposed to this bill. The recent amendments do not impact the Board's oppose position, or the reasons for taking that position.

FISCAL: None

SUPPORT: AARP; Association of California Healthcare Districts; Blue Shield of California; C.W. Brower, Inc. (Modesto); California Association for Nurse Practitioners; California Association of Nurse Anesthetists; California Association of Physician Groups; California Hospital Association; California Nurse-Midwives Association; California Optometric Association; California Pharmacists Association/California Society of Health-System Pharmacists; Californians for Patient Care; Ceres Department of Public Safety; Indiana State University College of Nursing, Health and Human Services; Latino Community Roundtable; NAACP; National Asian American Coalition; National Association of Pediatric Nurse Practitioners; United Nurses Associations of California/Union of Health Care Professionals; University of California; and Western University of Health Sciences

OPPOSITION: American Academy of Pediatrics, California; American College of Emergency Physicians - California Chapter; California Academy of Eye Physicians & Surgeons; California Academy of Family Physicians; California Medical Association; California Psychiatric Association; California Right to Life Committee, Inc.; California Society of Anesthesiologists; Canvasback Missions Inc.; Lighthouse for Christ Mission Eye Center; Medical Board of California; Osteopathic Physicians & Surgeons of California; and Union of American Physicians and Dentists

AMENDED IN SENATE MAY 21, 2013

AMENDED IN SENATE MAY 1, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 491

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 2835.5, 2835.7, 2836.1, 2836.2, and 2836.3 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 491, as amended, Hernandez. Nurse practitioners.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. Existing law requires an applicant for initial qualification or certification as a nurse practitioner who has never been qualified or certified as a nurse practitioner in California or in any other state to meet specified requirements, including possessing a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing, and to have satisfactorily completed a nurse practitioner program approved by the board. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including, among others, ordering durable medical equipment, and, in consultation with a physician and surgeon, approving, signing, modifying, or adding to a plan of treatment or plan for an individual receiving home health services or personal care services.

treatment or obtain diagnostic tests that are ordered by a nurse practitioner.

SEC. 2. Section 2835.5 of the Business and Professions Code is amended to read:

2835.5. (a) A registered nurse who is holding himself or herself out as a nurse practitioner or who desires to hold himself or herself out as a nurse practitioner shall, within the time prescribed by the board and prior to his or her next license renewal or the issuance of an initial license, submit educational, experience, and other credentials and information as the board may require for it to determine that the person qualifies to use the title "nurse practitioner," pursuant to the standards and qualifications established by the board.

(b) Upon finding that a person is qualified to hold himself or herself out as a nurse practitioner, the board shall appropriately indicate on the license issued or renewed, that the person is qualified to use the title "nurse practitioner." The board shall also issue to each qualified person a certificate evidencing that the person is qualified to use the title "nurse practitioner."

(c) A person who has been found to be qualified by the board to use the title "nurse practitioner" prior to January 1, 2005, shall not be required to submit any further qualifications or information to the board and shall be deemed to have met the requirements of this section.

(d) On and after January 1, 2008, an applicant for initial qualification or certification as a nurse practitioner under this article who has not been qualified or certified as a nurse practitioner in California or any other state shall meet the following requirements:

(1) Hold a valid and active registered nursing license issued under this chapter.

(2) Possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing.

(3) Satisfactorily complete a nurse practitioner program approved by the board.

(e) On and after July 1, 2016, an applicant for initial qualification or certification as a nurse practitioner shall, in addition, hold a national certification as a nurse practitioner from a national certifying body recognized by the board.

SEC. 3. Section 2835.7 of the Business and Professions Code is amended to read:

~~occurs in a patient that~~ *of a patient* is beyond the nurse practitioner's ~~knowledge and experience~~ *education, training, or certification.*

(c) A nurse practitioner shall maintain ~~medical malpractice~~ *professional liability* insurance *that is appropriate for his or her practice setting.*

SEC. 4. Section 2836.1 of the Business and Professions Code is amended to read:

2836.1. (a) Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing, ordering, or prescribing drugs or devices when both of the following apply:

(1) The drugs or devices that are furnished, ordered, or prescribed are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

(2) (A) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished, ordered, or prescribed under this section.

(B) Nurse practitioners who are certified by the board and hold an active furnishing number and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

(b) A nurse practitioner shall not furnish, order, or prescribe a dangerous drug, as defined in Section 4022, without an appropriate prior examination and a medical indication, unless one of the following applies:

(1) The nurse practitioner was a designated practitioner serving in the absence of the patient's physician and surgeon, podiatrist, or nurse practitioner, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

(2) The nurse practitioner transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

requirements of paragraph (2) of subdivision ~~(b)~~ *(a)* of Section 2836.1. The number shall be included on all transmittals of orders for drugs or devices by the nurse practitioner. The board shall make the list of numbers issued available to the *California State* Board of Pharmacy. The board may charge the applicant a fee to cover all necessary costs to implement this section.

(b) The number shall be renewable at the time of the applicant's registered nurse license renewal.

(c) The board may revoke, suspend, or deny issuance of the numbers for incompetence or gross negligence in the performance of functions specified in Sections 2836.1 and 2836.2.

O

SB 492

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 492
Author:	Hernandez
Bill Date:	May 8, 2013, Amended
Subject:	Optometrist Practice: Licensure
Sponsor:	Author

STATUS OF BILL:

This bill is in the Assembly Business, Professions and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill originally would have deleted the definition of the practice of optometry in existing law and would have expand the scope of an optometrist by allowing an optometrist: to examine, prevent, diagnose, and treat any disease, condition, or disorder of the visual system, the human eye, and adjacent and related structures; to perform surgical and nonsurgical primary care procedures; and to prescribe drugs, including narcotics, among other allowances.

This bill was amended to repeal the language in the April 16 version of the bill and instead revised the current definition of the practice of optometry to allow optometrists to diagnose, treat and manage specific eye disorders and other common diseases such as diabetes, hypertension, and hypercholesterolemia. In addition, this bill would expand the drugs optometrists can prescribe and permits optometrists to perform surgical and non-surgical procedures.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, optometrists measure and correct vision, prescribe and fit lenses, as well as provide some basic primary care services.

This bill would revise the definition of the practice of optometry in existing law and would expand the scope of an optometrist. The bill would do the following:

- Allow an optometrist to provide habilitative optometric services.
- Allow an optometrist who is certified to use therapeutic pharmaceutical agents (TPA) to treat the lacrimal gland, lacrimal drainage system, and the sclera in patients under 12 years of age.
- Allow an optometrist to treat ocular inflammation and pain non-surgically, except when co-managed with the patient's treating physician.

- Allow an optometrist to treat eyelid disorders, including hypotrichosis and blepharitis.
- Remove the requirement in existing law for optometrists to only utilize specific TPAs and would allow optometrists to use all TPAs approved by the Food and Drug Administration (FDA) for use in treating eye conditions, including codeine with compounds and hydrocodone with compounds as listed in the California Uniform Controlled Substances Act and the U.S. Controlled Substances Act. Use of these agents would be limited to three days.
- Allow TPA certified optometrists to remove sutures, upon notification of the treating physician.
- Remove the restriction that optometrists can only administer oral fluorescein to patients suspected as having diabetic retinopathy.
- Delete the list of specific tests optometrists are allowed to order and allow optometrists to order any laboratory and diagnostic imaging tests for conditions authorized to be treated, pursuant to this bill.
- Allow an optometrist to perform a clinical laboratory test or exam classified as waived under CLIA, necessary for the diagnosis of conditions and diseases of the eye or adnexa.
- Allow an optometrist to administer immunizations for influenza, Herpes Zoster Virus, and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency.
- Allow an optometrist to test for and diagnose diabetes mellitus, hypertension, and hypercholesterolemia.
- Require, in any case that an optometrist consults with a physician, for the physician and optometrist to both maintain a written record in the patient's file of the information provided to the physician, the physician's response, and any other relevant information.
- Specify that an optometrist treating eye disease or diagnosing another disease shall be held to the same standard of care as physicians or osteopathic physicians.
- Require an optometrist, if a situation or condition occurs that is beyond the optometrists scope of practice, to consult with and refer the patient to a physician or other appropriate health care provider.

Although this bill was significantly amended, it still expands the scope of practice of an optometrist by allowing optometrists to diagnose diabetes mellitus, hypertension, and hypercholesterolemia, treat ocular inflammation and pain non-surgically and surgically, treat all eyelid disorders, treat the lacrimal gland, lacrimal drainage system, and the sclera in patients under 12 years of age, and use all TPAs approved by the FDA for use in treating eye conditions, including codeine with compounds and hydrocodone with compounds. This is a significant expansion of the scope of practice of an optometrist. Although some provisions in this bill are reasonable, this bill would allow optometrists to diagnose, treat, and manage ocular conditions and common diseases, perform surgical procedures, and be granted full drug prescribing authority, including controlled substances, which is a significant scope expansion. Optometrists do not have the appropriate education to prepare them for this significant scope expansion; as such, this could put patients at serious risk of harm and significantly impact consumer protection. The Board's primary mission is consumer protection and by significantly

expanding the scope of practice for an optometrist, patient care and consumer protection could be compromised. Board staff suggests that the Board oppose this bill unless it is amended to remove the provisions that allow an optometrist to diagnose and treat common diseases, perform surgical procedures, and be granted full drug prescribing authority, including authority to prescribe controlled substances.

FISCAL: None

SUPPORT: Bay Area Council; Blue Shield of California; California Hospital Association; California Optometric Association; California Pharmacists Association/California Society of Health-System Pharmacists; Californians for Patient Care; United Nurses Associations of California/Union of Health Care Professionals; Vision Service Plan; and Western University of Health Sciences

OPPOSITION: American College of Emergency Physicians- California Chapter; Blind Children's Center; California Academy of Eye Physicians & Surgeons; California Academy of Family Physicians; California Association for Medical Laboratory Technology; California Medical Association; California Society of Anesthesiologists; California Society of Plastic Surgeons; Canvasback Missions Inc.; Here4Them; Lighthouse for Christ Mission Eye Center; Osteopathic Physicians & Surgeons of California; and Union of American Physicians and Dentists

POSITION: Oppose Unless Amended

AMENDED IN SENATE MAY 8, 2013

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 492

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 3041 and 3041.1 of the Business and Professions Code, relating to optometry.

LEGISLATIVE COUNSEL'S DIGEST

SB 492, as amended, Hernandez. Optometrist: practice: licensure.

The Optometry Practice Act creates the State Board of Optometry, which licenses optometrists and regulates their practice. Existing law defines the practice of optometry to include, among other things, the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and doing certain things, including, but not limited to, the examination of the human eyes, the determination of the powers or range of human vision, and the prescribing of contact and spectacle lenses. Existing law authorizes an optometrist certified to use therapeutic pharmaceutical agents to diagnose and treat specified conditions, use specified pharmaceutical agents, and order specified diagnostic tests. Any violation of the act is a crime.

This bill would add the provision of habilitative optometric services to the definition of the practice of optometry. The bill would expand the practice parameters of optometrists who are certified to use

(1) The examination of the human eye or eyes, or its or their appendages, and the analysis of the human vision system, either subjectively or objectively.

(2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eye or eyes, including the scope of its or their functions and general condition.

(3) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

(4) The prescribing of contact and spectacle lenses for, or the fitting or adaptation of contact and spectacle lenses to, the human eye, including lenses that may be classified as drugs or devices by any law of the United States or of this state.

(5) The use of topical pharmaceutical agents for the purpose of the examination of the human eye or eyes for any disease or pathological condition.

(b) (1) An optometrist who is certified to use therapeutic pharmaceutical agents, pursuant to Section 3041.3, may also diagnose and treat the human eye or eyes, or any of its or their appendages, for all of the following conditions:

(A) Through medical treatment, infections of the anterior segment and adnexa.

(B) Ocular allergies of the anterior segment and adnexa.

(C) Ocular inflammation, *nonsurgical in cause except when comanaged with the treating physician and surgeon.*

(D) Traumatic or recurrent conjunctival or corneal abrasions and erosions.

(E) Corneal surface disease and dry eyes.

(F) Ocular pain, *nonsurgical in cause except when comanaged with the treating physician and surgeon.*

(G) Pursuant to subdivision ~~(c)~~ *(f)*, glaucoma in patients over 18 years of age, as described in subdivision ~~(i)~~ *(j)*.

(H) Eyelid disorders, *including hypotrichosis and blepharitis.*

(2) For purposes of this section, "treat" means the use of therapeutic pharmaceutical agents, as described in subdivision (c), and the procedures described in subdivision ~~(d)~~ *(e)*.

(c) In diagnosing and treating the conditions listed in subdivision (b), an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may use all therapeutic

(11) Punctal occlusion by plugs, excluding laser, diathermy, cryotherapy, or other means constituting surgery as defined in this chapter.

~~(11)~~

(12) The prescription of therapeutic contact lenses, including lenses or devices that incorporate a medication or therapy the optometrist is certified to prescribe or provide.

~~(12)~~

(13) Removal of foreign bodies from the cornea, eyelid, and conjunctiva with any appropriate instrument other than a scalpel . Corneal foreign bodies shall be nonperforating, be no deeper than the midstroma, and require no surgical repair upon removal.

~~(13)~~

(14) For patients over 12 years of age, lacrimal irrigation and dilation, excluding probing of the nasal lacrimal tract. The board shall certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform this procedure after submitting proof of satisfactory completion of 10 procedures under the supervision of an ophthalmologist as confirmed by the ophthalmologist. Any optometrist who graduated from an accredited school of optometry on or after May 1, 2000, shall be exempt from the certification requirement contained in this paragraph.

~~(14)~~

(15) ~~Immunizations~~ *Administration of immunizations* for influenza ~~and shingles~~, *Herpes Zoster Virus,* and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency.

~~(15)~~

(16) In addition to diagnosing and treating conditions of the visual system pursuant to ~~subdivision (a)~~ *this section, testing for and*, diagnoses of diabetes mellitus, hypertension, and ~~hyperlipidemia~~ *hypercholesterolemia.*

~~(c)~~

(f) The board shall grant a certificate to an optometrist certified pursuant to Section 3041.3 for the treatment of glaucoma, as described in subdivision ~~(i)~~ *(j)*, in patients over 18 years of age after the optometrist meets the following applicable requirements:

(i) An optometrist licensed under this chapter is subject to the provisions of Section 2290.5 for purposes of practicing telehealth.

~~(i)~~

(j) For purposes of this chapter, "glaucoma" means either of the following:

(1) All primary open-angle glaucoma.

(2) Exfoliation and pigmentary glaucoma.

~~(j)~~

(k) For purposes of this chapter, "adnexa" means ocular adnexa.

~~(k)~~

(l) In an emergency, an optometrist shall stabilize, if possible, and immediately refer any patient who has an acute attack of angle closure to an ophthalmologist.

SEC. 2. Section 3041.1 of the Business and Professions Code is amended to read:

3041.1. With respect to the practices set forth in Section 3041, optometrists diagnosing or treating eye *disease* or *diagnosing* other diseases shall be held to the same standard of care to which physicians and surgeons and osteopathic physicians and surgeons are held. An optometrist shall consult with and, if necessary, refer to a physician and surgeon or other appropriate health care provider if a situation or condition occurs that is beyond the optometrist's ~~education and training~~ *scope of practice*.

SEC. 3. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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SB 493

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 493
Author:	Hernandez
Bill Date:	May 28, 2013 Amended
Subject:	Pharmacy Practice
Sponsor:	Author
Position:	Support

STATUS OF BILL:

This bill is in the Assembly Business, Professions and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow pharmacists to furnish medication, order and interpret tests, and furnish self-administered hormonal contraceptives, initiate and administer vaccines, and furnish prescription smoking cessation drugs and devices. This bill would establish an Advanced Practice Pharmacist (APP) recognition. In addition, this bill, as originally introduced, would allow an APP to perform patient assessments and if operating under a protocol, it would allow an APP to initiate, adjust, or discontinue drug therapy and participate in the evaluation and management of disease and health conditions.

This bill was amended to delete the provisions that would have allowed an APP to independently initiate, adjust or discontinue drug therapy and instead would only allow an APP to initiate, adjust or discontinue drug therapy pursuant to a specific written order or authorization made by the individual patient's treating prescriber, pursuant to existing law. This bill was amended to require the pharmacist to consult with the patient's primary care provider before furnishing a smoking cessation drug to the patient that may produce serious neuropsychiatric events, which addresses the concern raised by the Board.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists. Currently, pharmacists provide patient care that optimized medication therapy.

This bill expands the scope of a pharmacist by allowing a pharmacist to do the following:

- Provide training and education to patients about drug therapy, disease management, and disease prevention.

- Participate in multidisciplinary review of patient progress, including access to medical records.
- Furnish emergency contraception drug therapy and self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by the Board of Pharmacy (BOP) and the Medical Board of California (Board).
- Furnish prescription smoking cessation drugs and devices - The pharmacist must maintain records of drugs and devices furnished for three years, notify the patient's primary care provider, be certified in smoking cessation therapy, and complete one hour of continuing education focused on smoking cessation therapy biennially. **This bill was amended to require the pharmacist to consult with the patient's primary care provider before furnishing a smoking cessation drug to the patient that may produce serious neuropsychiatric events.**
- Furnish Prescription medications not requiring a diagnosis that are recommended by the federal Centers for Disease Control and Prevention for individuals traveling outside of the United States.
- Independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices - A pharmacist must complete an immunization training program, be certified in basic life support, and comply with all state and federal recordkeeping reporting requirements, in order to initiate and administer an immunization.

This bill would require the BOP and the Board to develop standardized procedures or protocols for emergency contraception drug therapy and self-administered hormonal contraceptives. This bill would authorize both the BOP and the Board to ensure compliance with procedures or protocols, with respect to the appropriate licensees.

This bill would establish an APP, which means a pharmacist who has been recognized as an APP by BOP. An APP may perform patient assessments; order and interpret drug therapy-related tests; and refer patients to other health care providers. This bill would have allowed an APP to initiate, adjust, or discontinue drug therapy. **This provision is no longer included in the bill.** This bill would also allow an APP to participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers.

This bill would require a pharmacist who seeks recognition as an APP to meet the following requirements:

- Hold an active license to practice pharmacy that is in good standing.
- Either earn certification in a relevant area of practice specified in the bill from an organization recognized by the Accreditation Council for Pharmacy education or another entity recognized by the BOP; or complete a one-year postgraduate residency where at least 50 percent of the experience includes the provision of direct patient care services with interdisciplinary teams; or have actively managed patients for at least one year under a collaborative practice agreement or protocol with a physician, APP,

pharmacist practicing collaborative drug therapy management, or a health system.

- File an application with BOP for recognition as an APP and pay the applicable fee to BOP.
- An APP must complete 10 hours of continuing education each renewal cycle in one or more areas of practice relevant to the pharmacist's clinical practice.

This bill would expand the scope of a pharmacist and create a new APP recognition category. Currently, pharmacists do provide education to patients regarding drug therapy, and allowing this to be expanded would help in the implementation of the Affordable Care Act. Allowing pharmacists to furnish self-administered hormonal contraceptives in accordance with standardized procedures developed by BOP, the Board, and stakeholders and allowing pharmacists to furnish some smoking cessation drugs and devices is in line with their scope (some drugs that are known to have side effects could be exempted from this provision). Allowing pharmacists to initiate and administer routine seems appropriate.

This bill was amended and no longer allows APPs to initiate, adjust, or discontinue drug therapy, except as allowed under existing law. The Board voted to support this bill if it is amended to exempt smoking cessation drugs that are known to have a risk of neuropsychiatric events, like Chantix and Zyban. This bill was amended to require the pharmacist to consult with the patient's primary care provider before furnishing a smoking cessation drug to the patient that may produce serious neuropsychiatric events, which addresses the Board's concern. This bill will help to further the Board's mission of promoting access to care and the Board now has a support position on this bill.

FISCAL: Minimal and absorbable workload to help develop standardized procedures.

SUPPORT: American Society of Health-System Pharmacists; Bay Area Council; Blue Shield of California; California Association for Nurse Practitioners; California Chronic Care Coalition; California Hospital Association; California Korean American Pharmacists Association; California Northstate University, College of Pharmacy; California Optometric Association; California Pharmacists Association; California Retailers Association; California Society of Health-System Pharmacists; California State Board of Pharmacy; Californians for Patient Care; Cedars-Sinai Medical Center; Indian Pharmacists Association of California; Kaiser Permanente; Medical Board of California; National Asian American Coalition; Pharmacy Choice and Access Now; United Nurses Association of California/Union of Health Care Professionals; and Western University of Health Sciences

OPPOSITION: American College of Emergency Physicians, California Chapter; California Academy of Eye Physicians and Surgeons; California Academy of Family Physicians; California Medical Association; California Psychiatric Association; California Right to Life Committee, Inc.; California Society of Anesthesiologists; California Society of Plastic Surgeons; Canvasback Missions, Inc.; Lighthouse for Christ Mission and Eye Center; Osteopathic Physicians and Surgeons of California; Union of American Physicians and Dentists; and Various Individuals

AMENDED IN SENATE MAY 28, 2013

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 493

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 733, 4050, 4051, 4052, 4052.3, and 4060 of, and to add Sections 4016.5, 4052.6, 4052.8, 4052.9, 4210, and 4233 to, the Business and Professions Code, relating to pharmacy.

LEGISLATIVE COUNSEL'S DIGEST

SB 493, as amended, Hernandez. Pharmacy practice.

The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy in the Department of Consumer Affairs. The law specifies the functions pharmacists are authorized to perform, including to administer, orally or topically, drugs and biologicals pursuant to a prescriber's order, and to administer immunizations pursuant to a protocol with a prescriber. Pharmacists may also furnish emergency contraception drug therapy pursuant to standardized procedures if they have completed a training program. A violation of the Pharmacy Law is a crime.

This bill, instead, would authorize a pharmacist to administer drugs and biological products that have been ordered by a prescriber. The bill would expand other functions pharmacists are authorized to perform, including, among other things, to furnish self-administered hormonal contraceptives, prescription smoking cessation drugs, and prescription medications not requiring a diagnosis that are recommended for international travelers, as specified. Additionally, the bill would

drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

(2) The prescription drug or device is not in stock. If an order, other than an order described in Section 4019, or prescription cannot be dispensed because the drug or device is not in stock, the licentiate shall take one of the following actions:

(A) Immediately notify the patient and arrange for the drug or device to be delivered to the site or directly to the patient in a timely manner.

(B) Promptly transfer the prescription to another pharmacy known to stock the prescription drug or device that is near enough to the site from which the prescription or order is transferred, to ensure the patient has timely access to the drug or device.

(C) Return the prescription to the patient and refer the patient. The licentiate shall make a reasonable effort to refer the patient to a pharmacy that stocks the prescription drug or device that is near enough to the referring site to ensure that the patient has timely access to the drug or device.

(3) The licentiate refuses on ethical, moral, or religious grounds to dispense a drug or device pursuant to an order or prescription. A licentiate may decline to dispense a prescription drug or device on this basis only if the licentiate has previously notified his or her employer, in writing, of the drug or class of drugs to which he or she objects, and the licentiate's employer can, without creating undue hardship, provide a reasonable accommodation of the licentiate's objection. The licentiate's employer shall establish protocols that ensure that the patient has timely access to the prescribed drug or device despite the licentiate's refusal to dispense the prescription or order. For purposes of this section, "reasonable accommodation" and "undue hardship" shall have the same meaning as applied to those terms pursuant to subdivision (*l*) of Section 12940 of the Government Code.

(c) For the purposes of this section, "prescription drug or device" has the same meaning as the definition in Section 4022.

(d) This section applies to emergency contraception drug therapy and self-administered hormonal contraceptives described in Section 4052.3.

(e) This section imposes no duty on a licentiate to dispense a drug or device pursuant to a prescription or order without payment for the drug or device, including payment directly by the patient

information, or patient consultation, as set forth in this chapter, if all of the following conditions are met:

(1) The clinical advice, services, information, or patient consultation is provided to a health care professional or to a patient.

(2) The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice.

(3) Access to the information described in paragraph (2) is secure from unauthorized access and use.

SEC. 5. Section 4052 of the Business and Professions Code is amended to read:

4052. (a) Notwithstanding any other law, a pharmacist may:

(1) Furnish a reasonable quantity of compounded drug product to a prescriber for office use by the prescriber.

(2) Transmit a valid prescription to another pharmacist.

(3) Administer drugs and biological products that have been ordered by a prescriber.

(4) Perform procedures or functions in a licensed health care facility as authorized by Section 4052.1.

(5) Perform procedures or functions as part of the care provided by a health care facility, a licensed home health agency, a licensed clinic in which there is a physician oversight, a provider who contracts with a licensed health care service plan with regard to the care or services provided to the enrollees of that health care service plan, or a physician, as authorized by Section 4052.2.

(6) Perform procedures or functions as authorized by Section 4052.6.

(7) Manufacture, measure, fit to the patient, or sell and repair dangerous devices, or furnish instructions to the patient or the patient's representative concerning the use of those devices.

(8) Provide consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

(9) Provide professional information, including clinical or pharmacological information, advice, or consultation to other health care professionals, and participate in multidisciplinary review of patient progress, including appropriate access to medical records.

(10) Furnish the following medications:

(A) Emergency contraception drug therapy and self-administered hormonal contraceptives, as authorized by Section 4052.3.

(b) (1) Notwithstanding any other law, a pharmacist may furnish emergency contraception drug therapy in accordance with either of the following:

(A) Standardized procedures or protocols developed by the pharmacist and an authorized prescriber who is acting within his or her scope of practice.

(B) Standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The board and the Medical Board of California are both authorized to ensure compliance with this clause, and each board is specifically charged with the enforcement of this provision with respect to its respective licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(2) Prior to performing a procedure authorized under this subdivision, a pharmacist shall complete a training program on emergency contraception that consists of at least one hour of approved continuing education on emergency contraception drug therapy.

(3) A pharmacist, pharmacist's employer, or pharmacist's agent shall not directly charge a patient a separate consultation fee for emergency contraception drug therapy services initiated pursuant to this subdivision, but may charge an administrative fee not to exceed ten dollars ($10) above the retail cost of the drug. Upon an oral, telephonic, electronic, or written request from a patient or customer, a pharmacist or pharmacist's employee shall disclose the total retail price that a consumer would pay for emergency contraception drug therapy. As used in this paragraph, total retail price includes providing the consumer with specific information regarding the price of the emergency contraception drugs and the price of the administrative fee charged. This limitation is not intended to interfere with other contractually agreed-upon terms between a pharmacist, a pharmacist's employer, or a pharmacist's agent, and a health care service plan or insurer. Patients who are insured or covered and receive a pharmacy benefit that covers the cost of emergency contraception shall not be required to pay an administrative fee. These patients shall be required to pay copayments pursuant to the terms and conditions of their coverage.

the patient's primary care provider or diagnosing provider, as appropriate.

(c) This section shall not interfere with a physician's order to dispense a prescription drug as written, or other order of similar meaning.

(d) Prior to initiating or adjusting a controlled substance therapy pursuant to this section, a pharmacist shall personally register with the federal Drug Enforcement Administration.

SEC. 8. Section 4052.8 is added to the Business and Professions Code, to read:

4052.8. (a) In addition to the authority provided in paragraph (9) of subdivision (a) of Section 4052, a pharmacist may independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC) for persons three years of age and older.

(b) In order to initiate and administer an immunization described in subdivision (a), a pharmacist shall do all of the following:

(1) Complete an immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and shall maintain that training.

(2) Be certified in basic life support.

(3) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(c) A pharmacist administering immunizations pursuant to this section, or paragraph (9) of subdivision (a) of Section 4052, may also initiate and administer epinephrine or diphenhydramine by injection for the treatment of a severe allergic reaction.

SEC. 9. Section 4052.9 is added to the Business and Professions Code, to read:

SEC. 11. Section 4210 is added to the Business and Professions Code, to read:

4210. (a) A person who seeks recognition as an advanced practice pharmacist shall meet all of the following requirements:

(1) Hold an active license to practice pharmacy issued pursuant to this chapter that is in good standing.

(2) Satisfy any two of the following criteria:

(A) Earn certification in a relevant area of practice, including, but not limited to, ambulatory care, critical care, nuclear pharmacy, nutrition support pharmacy, oncology pharmacy, pediatric pharmacy, pharmacotherapy, or psychiatric pharmacy, from an organization recognized by the Accreditation Council for Pharmacy Education or another entity recognized by the board.

(B) Complete a one-year postgraduate residency through an accredited postgraduate institution where at least 50 percent of the experience includes the provision of direct patient care services with interdisciplinary teams.

(C) Have actively managed patients for at least one year under a collaborative practice agreement or protocol with a physician, advanced practice pharmacist, pharmacist practicing collaborative drug therapy management, or health system.

(3) File an application with the board for recognition as an advanced practice pharmacist.

(4) Pay the applicable fee to the board.

(b) An advanced practice pharmacist recognition issued pursuant to this section shall be valid for two years, coterminous with the certificate holder's license to practice pharmacy.

(c) The board shall adopt regulations establishing the means of documenting completion of the requirements in this section.

(d) The board shall, by regulation, set the fee for the issuance and renewal of advanced practice pharmacist recognition at the reasonable cost of regulating advanced practice pharmacists pursuant to this chapter. The fee shall not exceed three hundred dollars ($300).

SEC. 12. Section 4233 is added to the Business and Professions Code, to read:

4233. A pharmacist who is recognized as an advanced practice pharmacist shall complete 10 hours of continuing education each renewal cycle in addition to the requirements of Section 4231. The

SB 670

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 670
Author:	Steinberg
Bill Date:	May 24, 2013, Amended
Subject:	Physicians: Drug Prescribing Privileges: Investigation
Sponsor:	Author
Position:	Support if Amended

STATUS OF BILL:

This bill is in the Assembly Business, Professions and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize the Medical Board of California (Board) to inspect the medical records of a patient who dies of a prescription drug overdose without the consent of the patient's next of kin or a court order. This bill would make it unprofessional conduct, for a licensee who is under investigation, if the licensee fails to attend and participate in an interview of the Board within 30 days of notification from the Board. Lastly, this bill would allow the Board to impose limitations on the authority of a physician to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is a reasonable suspicion that the physician is overprescribing drugs or whose prescribing has resulted in the death of a patient.

This bill was amended to change the burden of proof for restricting a physician's prescribing privileges to "probable cause" that the physician prescribed, furnished, administered, or dispensed controlled substances in violation of the Medical Practice Act. The amendments would also allow the Board to inspect and copy the medical records of a deceased patient without the consent of the patient's next of kin in any case that involves the death of a patient. The amendments also specify that compliance with this section is consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA)

ANALYSIS:

Currently, if the Board is investigating a physician whose patient has died, the Board must receive written authorization by the patient's next of kin in order to obtain the patient's medical records. The Board needs the medical records in order to determine if a physician is prescribing appropriately. If the Board cannot obtain written authorization to release the medical records, it has to go to court to get the records through a subpoena and it must be

proven that there is a compelling state need in order to obtain those records through a subpoena. In the past, prescription drug monitoring data (from CURES) has not been successful in compelling the state to release those records.

The Board has reason to believe that numerous deaths have occurred in California that are related to prescription drug overdoses. However, complaints regarding drug-related offenses are often hard for the Board to obtain. In most instances, patients who are receiving prescription drugs in a manner that is not within the standard of practice, are unlikely to make a complaint to the Board. Some complaints regarding overprescribing come from anonymous tips, which usually do not have enough information to allow forwarding to the Board's district office for investigation, as there is no patient to obtain records for or not enough information to open an investigation. Family members of patients may make a complaint to the Board; however, the Board must have a patient release in order to obtain medical records or seek a subpoena. Sometimes it is difficult to obtain evidence to warrant a subpoena, or the family is not responsive.

This bill would allow the Board to obtain medical records without a written release by the patient's next of kin or a court order in any case that involves the death of a patient in order to determine the extent to which the death was the result of the physician's conduct in violation of the Medical Practice Act. This bill would also specify that compliance with this section is consistent with the public interest and benefit activities of the federal HIPAA. These provisions will allow the Board to move forward with its investigation in a more expedient manner, and help to ensure consumer protection.

In the Board's 2012 Sunset Review Report, information was included related to existing law regarding unprofessional conduct and physician interviews. Existing law provides that it only constitutes unprofessional conduct if a physician repeatedly fails to appear at the interview that has been scheduled by "mutual agreement" of the physician and the Board. Although the existing statute was well intended, it has been ineffective in reducing the time it takes to complete an interview with a licensee and in fact may have resulted in physicians failing to agree to any interview with the Board. The report recommended that no more than thirty days should elapse between the time the interview is requested and completed.

This bill would require a physician to attend and participate in an interview within 30 days of notification from the Board.

> Requiring the interview to be conducted within 30 days will significantly reduce the timeline for the physician interview and will force the physician to agree to an interview time.

Currently, in order for the Board to stop a physician from practicing while the physician is under investigation, the Board must request an Interim Suspension Order (ISO), which must be granted by an Administrative Law Judge (ALJ). An ISO is considered extraordinary relief and the Board must prove that a physician's continued practice presents an immediate danger

to public health, safety, or welfare. In addition, there is a 15-day time restraint in law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set, which means an investigation must be nearly complete in order to petition for an ISO. The Board can currently only restrict a physician from prescribing if the physician is under probation and limits on prescribing are part of the terms and conditions of that probation that has been adopted or stipulated to by the Board.

This bill would require the Board to impose limitations on the authority of physician to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is probable cause to believe that the physician has prescribed, furnished, administered, or dispensed controlled substances in violation of the Medical Practice Act.

This would give the Board authority to stop physicians from prescribing drugs if the Board is investigating the physician and believes the physician is overprescribing or their prescribing has resulted in the death of the patient. However, the process for when and in what circumstances that Board could put this type of a restriction on the physicians would need to be spelled out in this bill or in regulations. Also, it is not clear in the bill if there would be due process given to the physician if the Board were to impose limitations on a physician's prescribing privileges. If the prescribing restriction were tied to the interim suspension order process, it would allow for due process.

The author introduced this bill due to the Los Angeles Times investigation that uncovered significant issues with physicians, overprescribing and patient deaths. This bill will help to speed up investigations in cases where patients have died as a result of prescription drug overdose. This bill will also make improvements to the Board's enforcement process, which will result in timelier investigations. The Board has a support if amended position on this bill and would like it amended to make it clear when and how the Board can impose limitations on a physician's prescribing privileges and the due process afforded to the physician.

FISCAL: Minimal and absorbable

SUPPORT: Center for Public Interest Law
Medical Board of California (if amended)

OPPOSITION: California Medical Association

AMENDED IN SENATE MAY 24, 2013

AMENDED IN SENATE APRIL 8, 2013

SENATE BILL **No. 670**

Introduced by Senator Steinberg

February 22, 2013

An act to amend Sections 2225 and 2234 of, and to add Section 2221.5 to, the Business and Professions Code, and to amend Section 11529 of the Government Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 670, as amended, Steinberg. Physicians and surgeons: drug prescribing privileges: investigation.

(1) Existing law authorizes investigators and representatives of the Medical Board of California, among others, to inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, and to inspect documents relevant to those investigations, including the inspection and copying of any document relevant to an investigation where patient consent is given.

Existing law requires specified persons, including the administrator of a peer review body, to file a report with the board within 15 days after the effective date of any specified action taken against a licensee for a medical disciplinary cause or reason. Existing law also requires a coroner to make a report to the board, among other specified entities, when he or she receives information that indicates that a death may be the result of a physician and surgeon's, podiatrist's, or physician assistant's gross negligence or incompetence.

This bill would authorize the board, ~~if it receives a report pursuant to either of the provisions described above~~ *in any case* that involves the

2221.5. Notwithstanding Section 11529 of the Government Code, the board shall impose limitations on the authority of a physician and surgeon to prescribe, furnish, administer, or dispense controlled substances during a pending investigation if there is ~~a reasonable suspicion~~ *probable cause to believe* that the physician and surgeon has ~~engaged in either of the following:~~ *prescribed, furnished, administered, or dispensed controlled substances in violation of the Medical Practice Act.*

~~(a) Overprescribing drugs.~~

~~(b) Other behavior related to his or her drug prescribing privileges that has resulted in the death of a patient.~~

SEC. 2. Section 2225 of the Business and Professions Code is amended to read:

2225. (a) Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and shall not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable,

is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

SEC. 3. Section 2234 of the Business and Professions Code is amended to read:

2234. The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption that is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct that would have warranted the denial of a certificate.

(g) The practice of medicine from this state into another state or country without meeting the legal requirements of that state or country for the practice of medicine. Section 2314 shall not apply to this subdivision. This subdivision shall become operative upon

(d) For the purposes of the hearing conducted pursuant to this section, the licentiate shall, at a minimum, have the following rights:

(1) To be represented by counsel.

(2) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the record.

(3) To present written evidence in the form of relevant declarations, affidavits, and documents.

The discretion of the administrative law judge to permit testimony at the hearing conducted pursuant to this section shall be identical to the discretion of a superior court judge to permit testimony at a hearing conducted pursuant to Section 527 of the Code of Civil Procedure.

(4) To present oral argument.

(e) Consistent with the burden and standards of proof applicable to a preliminary injunction entered under Section 527 of the Code of Civil Procedure, the administrative law judge shall grant the interim order if, in the exercise of discretion, the administrative law judge concludes that:

(1) There is a reasonable probability that the petitioner will prevail in the underlying action.

(2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order.

(f) In all cases in which an interim order is issued, and an accusation is not filed and served pursuant to Sections 11503 and 11505 within 15 days of the date on which the parties to the hearing on the interim order have submitted the matter, the order shall be dissolved.

Upon service of the accusation the licensee shall have, in addition to the rights granted by this section, all of the rights and privileges available as specified in this chapter. If the licensee requests a hearing on the accusation, the board shall provide the licensee with a hearing within 30 days of the request, unless the licensee stipulates to a later hearing, and a decision within 15 days of the date the decision is received from the administrative law judge, or the board shall nullify the interim order previously issued, unless good cause can be shown by the Division of Medical Quality for a delay.

SB 809

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 809
Author:	DeSaulnier and Steinberg
Bill Date:	June 26, 2013, Amended
Subject:	Controlled Substances: Reporting
Sponsor:	California Attorney General Kamala Harris

STATUS OF BILL:

This bill is in the Assembly Business, Professions, and Consumer Protection Committee.

DESCRIPTION OF CURRENT LEGISLATION:

This bill, as originally introduced, would establish the Controlled Substance Utilization Review and Evaluation System (CURES) Fund that would be administered by the Department of Justice (DOJ), and would consist of funds collected from boards that license prescribers and dispensers, manufacturers, and health insurers, for purposes of funding the CURES program and upgrading the CURES system. Once the CURES program is funded and the system is upgraded, all prescribers and dispensers would be required to consult CURES before prescribing or dispensing Schedule II, III, or IV controlled substances.

This bill was amended and would no longer mandate that manufacturers and insurers contribute to funding for the CURES system or the DOJ enforcement program. This bill would allow DOJ to seek private funds from qualified manufacturers, insurers, and health care service plans for the purpose of supporting CURES.

The amendments would also allow DOJ to invite stakeholders to assist, advise and make recommendations on the establishment of rules and regulations necessary to ensure proper administration and enforcement of the CURES database. This bill would require DOJ to consult with prescribers, regulatory boards, and other stakeholders to identify desirable capabilities and upgrades to the CURES system. The amendments would also specify how the CURES data can be used.

This bill would require the Medical Board of California (Board) to periodically develop and disseminate information and educational materials related to assessing a patient's risk of abusing or diverting controlled substance and information on CURES to each licensed physician and general acute care hospital (GACH).

Lastly, this bill was amended to no longer require, but strongly encourage, all prescribers and dispensers to consult CURES before prescribing and dispensing Schedule II, III, or IV controlled substances.

ANALYSIS:

The CURES Program is currently housed in DOJ and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) system allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, including the Board, to access patient controlled substance history information through a secure Web site.

According to DOJ, there is currently no permanent funding to support the CURES/PDMP program. The California Budget Act of 2011 eliminated all General Fund support of CURES/PDMP, which included funding for system support, staff support and related operating expenses. To perform the minimum critical functions and to avoid shutting down the program, DOJ opted to assign five staff to perform temporary dual job assignments on a part-time basis. Although some tasks are being performed, the program is faced with a constant backlog (e.g., four-week backlog on processing new user applications, six-week response time on emails, twelve week backlog on voicemails, etc.).

The only funding currently available to DOJ for CURES is through renewable contracts with five separate regulatory boards (including the Board) and one grant. While DOJ has been able to successfully renew contracts with the boards and receive grant funding this year, these sources of funding are not permanent and may not be available in future years and cannot be used to fund staff positions. In addition, these funding sources are insufficient to operate and maintain the PDMP system, make necessary enhancements or fully fund a PDMP modernization effort.

This bill would make findings and declarations related to the importance of CURES. This bill would establish the CURES Fund that would be funded by an annual 1.16% (as of July 1, 2013) licensing, certification and renewal fee increase for licensees of the following boards that are authorized to prescribe or dispense Schedule II, III, or IV controlled substances: Medical Board of California; Dental Board of California; Board of Pharmacy (including wholesalers non-resident wholesalers, and veterinary food-animal drug retailers); Veterinary Medical Board; Board of Registered Nursing; Physician Assistant Board; Osteopathic Medical Board of California; State Board of Optometry; California Board of Podiatric Medicine; and the Naturopathic Medicine Committee. This bill would make the money in the CURES Fund available for allocation to DOJ, upon appropriation by the Legislature, for the purposes of funding the CURES Program. This bill would specify that the fee increase shall be due at time of renewal and shall not exceed the reasonable costs associated with maintaining CURES.

The 1.16% annual fee would result in an increase of $18 for physician renewal fees ($9 each year of the two-year renewal cycle), and a $9 initial licensing fee increase. Staff suggests that the word "annual" be taken out, which would instead result in a $9 renewal fee increase and a $9 initial licensing fee increase.

In addition, it is important to note that this language is consistent with the language included in the Budget Bill (AB 73, Blumenfield), which will require all boards to provide funding to help maintain and upgrade the CURES system. For the Medical Board, this will be $848,000 for the FY 2013/14, and $790,000 for FY 2014/15. The Budget Bill states the legislative intent that the CURES system be jointly developed by DOJ and the Department of Consumer Affairs (DCA) and addresses the needs of the boards funding CURES and DOJ. The Budget Bill requires, before the funds are appropriated for CURES, for the Feasibility Study Report to be approved and mutually agreed upon by DOJ and DCA, and that an interagency agreement be developed between DOJ and DCA on behalf of each board or committee funding the system that includes the roles and responsibilities of each department as to the joint development, implementation, and utilization of CURES.

> This language is very important as it will ensure that the new CURES system will be developed with the regulatory boards' needs in mind and will ensure that input from all boards must be considered and accounted for in development of the new CURES system.

This bill would allow DOJ to seek private funds from qualified manufacturers, insurers, and health care service plans for the purpose of supporting CURES. Information on the private funds received would be made available to the public and reported annually to the Legislature.

This bill would also allow DOJ to invite stakeholders to assist, advise and make recommendations on the establishment of rules and regulations necessary to ensure proper administration and enforcement of the CURES database. This bill would require DOJ to consult with prescribers, regulatory boards, and other stakeholders to identify desirable capabilities and upgrades to the CURES system.

This bill would specify that CURES data shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes, and to other agencies or entities, as determined by DOJ, for the purpose of educating practitioners in lieu of disciplinary, civil, or criminal actions. This bill would allow data to be provided to public or private entities, as approved by DOJ, for educational, peer review, statistical, or research purposes, provided that patient identifying information is not compromised. This bill would specify that data disclosed to any individual or agency shall not be disclosed, sold, or transferred to any third party.

This bill would also require the Board to periodically develop and disseminate information and educational materials related to assessing a patient's risk of abusing or diverting controlled substances and information on CURES to each licensed physician and GACH. The Board must consult with the Department of Health Care Services and DOJ in developing the materials.

Once CURES is funded, upgraded, and able to handle inquiries from all eligible prescribers and dispensers in California, but not before June 1, 2015, this bill would require DOJ to notify all prescribers and dispensers who have submitted

applications to CURES that they are capable of accommodating this workload. DOJ would also be required to notify the Legislature and post the notification on DOJ's Web site. Once DOJ issues this notification, all prescribers and dispensers eligible to prescribe and dispense Schedule II, III, and IV controlled substances would be strongly encouraged, but not required, to access and consult the electronic history of controlled substances dispensed to a patient under his or her care, prior to prescribing or dispensing a Schedule II, III, or IV controlled substance.

Board staff is suggesting the fee increase not be a percentage and annual fee increase, but be a flat fee increase on all initial licenses and renewals. This bill also contains an urgency clause, which means it would take effect immediately once signed into law by the Governor. This bill should include a delayed implementation schedule, as the Board sends out renewal notices 90 days in advance and would need to give licensees appropriate notice of the renewal fee increase. The Board will continue to take part in the working group meetings on this bill and continue to address proposed amendments that the Board may have concerns with. It is important to note that manufacturers and insurers are no longer required to help contribute to the upgrading and funding of CURES; however, if that language would have remained in the bill, it is very likely that the bill would have died in the Senate.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping". Although the Board currently helps to fund CURES at a cost of $150,000 this year, these funds cannot be used for staffing. The Board is aware of the issues DOJ is facing related to insufficient staffing and funding for CURES/PDMP, and due to the importance of this program, is suggesting that the Board support any effort to get CURES more fully funded in order for the PDMP to be at optimum operating capacity. Staff is suggesting that the Board support this bill if it is amended as suggested below to fix the fee and implementation issues.

FISCAL: This bill would result in an annual 1.16% licensing fee increase for physicians, which equates to a $18 increase for renewals and a $9 increase for initial licensing fees. There would be a minimal and absorbable fiscal impact associated with periodically developing and disseminating information and educational materials to all licensed physicians and GACHs.

SUPPORT: California Attorney General Kamala Harris (Sponsor); California American Cancer Society Cancer Action Network; American College of Emergency Physicians, California Chapter; American Medical Association; California Association for Nurse Practitioners; California Association of Oral and Maxillofacial Surgeons; California Department of Insurance; California Medical Association; California Labor Federation; California Narcotic Officers Association; California Pharmacists Association; California Primary Care Association; California Police Chiefs Association; California Society of Health-System Pharmacists; California State Board of Pharmacy; California State Sheriff's

Association; Center for Public Interest Law; City and County of San Francisco; County Alcohol and Drug Program Administrators Association of California; Deputy Sheriffs' Association of San Diego County; Healthcare Distribution Management Association; Health Officers Association of California; Kaiser Permanente; Medical Board of California (in concept); National Coalition Against Prescription Drug Abuse; South Orange County Coalition; Troy and Alana Pack Foundation; Western Occupational and Environmental Medical Association; University of California; and one private individual

OPPOSITION: None

POSITION: Recommended: Support if Amended to make the fee a flat fee for all initial licenses and renewals and to address an implementation schedule for the fee increase, as it is impossible to implement on the day the bill is signed.

Item | Amount

(30) Amount payable from the National Mortgage Special Deposit Fund (Item 0820-001-8071)..... −6,000,000

(31) Amount payable from the Legal Services Revolving Fund (Item 0820-001-9731)..... −208,246,000

(32) Amount payable from the Central Service Cost Recovery Fund (Item 0820-001-9740)..... −1,539,000

Provisions:

1. The Attorney General shall submit to the Legislature, the Director of Finance, and the Governor the quarterly and annual reports that he or she submits to the federal government on the activities of the Medi-Cal Fraud Unit.
2. Notwithstanding any other provision of law, the Department of Justice may purchase or lease vehicles of any type or class that, in the judgment of the Attorney General or his or her designee, are necessary to the performance of the investigatory and enforcement responsibilities of the Department of Justice, from the funds appropriated for that purpose in this item.
3. Of the amount included in Schedule (3), $3,000,000 is available for costs related to the Lloyd's of London (Stringfellow) litigation. Any funds not expended for this specific purpose as of June 30, 2014, shall revert immediately to the General Fund.
4. *It is the intent of the Legislature that the Controlled Substance Utilization Review and Evaluation System be jointly developed by the Department of Justice and the Department of Consumer Affairs and address the respective needs of the boards funding the system and the Department of Justice.*
5. *Notwithstanding any other provision of law, of the funds appropriated in Schedule (6) for reimbursements of this item, up to $3,941,000 shall only be used to fund the cost of maintaining and upgrading the Controlled Substance Utilization Review and Evaluation System and is available for expenditure or encumbrance until June 30, 2015. Reimbursements provided pursuant to this provision are available upon completion of both of the following:*

Item Amount

(a) Department of Technology approval of a Feasibility Study Report that has been mutually agreed upon by both the Department of Justice and the Department of Consumer Affairs.

(b) An interagency agreement between the Department of Justice and the Department of Consumer Affairs on behalf of each board or committee funding the system that includes, but is not limited to, the roles and responsibilities of each department as to the joint development, implementation, and utilization of the system.

0820-001-0012—For support of Department of Justice, for payment to Item 0820-001-0001, payable from the Attorney General Antitrust Account..... 2,410,000

0820-001-0017—For support of Department of Justice, for payment to Item 0820-001-0001, payable from the Fingerprint Fees Account, pursuant to subdivision (e) of Section 11105 of the Penal Code..... 70,261,000

Provisions:

1. The Attorney General may augment the amount appropriated in the Fingerprint Fees Account up to an aggregate of 10 percent above the amount approved in this act for the Division of Criminal Justice Information Services for unanticipated workload associated with this fund. The Attorney General shall notify the chairpersons of the budget committees of both houses of the Legislature, the Joint Legislative Budget Committee, and the Department of Finance within 15 days after the augmentation is made as to the amount and justification of the augmentation.

0820-001-0032—For support of Department of Justice, for payment to Item 0820-001-0001, payable from the Firearm Safety Account..... 343,000

0820-001-0044—For support of Department of Justice, for payment to Item 0820-001-0001, payable from the Motor Vehicle Account, State Transportation Fund..... 25,528,000

0820-001-0142—For support of Department of Justice, for payment to Item 0820-001-0001, payable from the Department of Justice Sexual Habitual Offender Fund..... 2,362,000

Provisions:

1. The amount appropriated in this item includes revenues derived from the assessment of fines

AMENDED IN ASSEMBLY JUNE 26, 2013

AMENDED IN SENATE MAY 28, 2013

AMENDED IN SENATE MAY 24, 2013

AMENDED IN SENATE MAY 14, 2013

AMENDED IN SENATE MAY 1, 2013

SENATE BILL No. 809

Introduced by Senators DeSaulnier and Steinberg
(Coauthors: Senators Hancock, Lieu, Pavley, and Price)
(Coauthor: Assembly Member Blumenfield)

February 22, 2013

An act to add Sections 805.8 and 2196.8 to the Business and Professions Code, and to amend Sections 11164.1, 11165, and 11165.1 of, and to add Section 11165.4 to, the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

SB 809, as amended, DeSaulnier. Controlled substances: reporting.

(1) Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

Existing law requires dispensing pharmacies and clinics to report, on a weekly basis, specified information for each prescription of Schedule

(3) Existing law permits a licensed health care practitioner, as specified, or a pharmacist to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care. Existing law also authorizes the Department of Justice to provide the history of controlled substances dispensed to an individual to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

This bill would require licensed health care practitioners, as specified, and pharmacists to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care, and, upon the happening of specified events, to be strongly encouraged to access and consult that information prior to prescribing or dispensing Schedule II, Schedule III, or Schedule IV controlled substances. The bill would make other related and conforming changes.

(4) This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ⅔. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) The Controlled Substance Utilization Review and Evaluation System (CURES) is a valuable preventive, investigative, and educational tool for health care providers, regulatory boards, educational researchers, and law enforcement. Recent budget cuts to the Attorney General's Division of Law Enforcement have resulted in insufficient funding to support the CURES Prescription Drug Monitoring Program (PDMP). The PDMP is necessary to ensure health care professionals have the necessary data to make informed treatment decisions and to allow law enforcement to investigate diversion of prescription drugs. Without a dedicated funding source, the CURES PDMP is not sustainable.

(b) Each year CURES responds to more than 800,000 requests from practitioners and pharmacists regarding all of the following:

Medical Board of California, the Naturopathic Medicine Committee of the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine shall charge each licensee authorized pursuant to Section 11150 of the Health and Safety Code to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances a fee of up to 1.16 percent of the renewal fee that the licensee was subject to as of July 1, 2013, to be assessed annually. This fee shall be due and payable at the time the licensee renews his or her license and shall be submitted with the licensee's renewal fee. In no case shall this fee exceed the reasonable costs associated with operating and maintaining CURES for the purpose of regulating prescribers and dispensers of controlled substances licensed or certificated by these boards.

(2) In addition to the fees charged for licensure, certification, and renewal, at the time those fees are charged, the California State Board of Pharmacy shall charge wholesalers and nonresident wholesalers of dangerous drugs, licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9, a fee of up to 1.16 percent of the renewal fee that the wholesaler or nonresident wholesaler was subject to as of July 1, 2013, to be assessed annually. This fee shall be due and payable at the time the wholesaler or nonresident wholesaler renews its license and shall be submitted with the wholesaler's or nonresident wholesaler's renewal fee. In no case shall this fee exceed the reasonable costs associated with operating and maintaining CURES for the purpose of regulating wholesalers and nonresident wholesalers of dangerous drugs licensed or certificated by that board.

(3) In addition to the fees charged for licensure, certification, and renewal, at the time those fees are charged, the California State Board of Pharmacy shall charge veterinary food-animal drug retailers, licensed pursuant to Article 15 (commencing with Section 4196) of Chapter 9, a fee of up to 1.16 percent of the renewal fee that the drug retailer was subject to as of July 1, 2013, to be assessed annually. This fee shall be due and payable at the time the drug retailer renews its license and shall be submitted with the drug retailers' renewal fee. In no case shall this fee exceed the reasonable costs associated with operating and maintaining CURES for the purpose of regulating veterinary food-animal drug retailers licensed or certificated by that board.

(b) Pharmacies may dispense prescriptions for Schedule III, Schedule IV, and Schedule V controlled substances from out-of-state prescribers pursuant to Section 4005 of the Business and Professions Code and Section 1717 of Title 16 of the California Code of Regulations.

(c) This section shall become operative on January 1, 2005.

SEC. 5. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES accounts within the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, the Osteopathic Medical Board of California Contingent Fund, the Veterinary Medical Board Contingent Fund, the Optometry Fund, the Board of Podiatric Medicine Fund, and the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The reporting of Schedule III and Schedule IV controlled substance prescriptions to CURES shall be contingent upon the availability of adequate funds for the Department of Justice for the purpose of funding CURES.

(c) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES. Grant funds shall not be appropriated from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State

the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure and license number, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(f) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber invitees shall be licensed by one of the boards or committees identified in subdivision (a) of Section 805.8 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(g) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (a) of Section 805.8 of the Business and Professions Code, one or more of the regulatory boards or committees identified in subdivision (a) of Section 805.8 of the Business and Professions Code, and any other stakeholder identified by the ~~department~~ *department,* for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program.

(h) The Department of Justice may establish a process to educate authorized subscribers of CURES on how to access and use CURES.

(i) The CURES Fund is hereby established within the State Treasury. The CURES Fund shall consist of all funds made

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) (1) Until the Department of Justice has issued the notification described in paragraph (3), in order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(2) Upon the Department of Justice issuing the notification described in paragraph (3), licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and pharmacists shall be strongly encouraged to access and consult the electronic history of controlled substances dispensed to an individual under his or her care prior to prescribing or dispensing a Schedule II, Schedule III, or Schedule IV controlled substance.

(3) The Department of Justice shall notify licensed health care practitioners and pharmacists who have submitted the application required pursuant to subdivision (a) when the department determines that CURES is capable of accommodating all users, but not before June 1, 2015. The department shall provide a copy of the notification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the notification on the department's Internet Web site.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section shall be considered medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

SEC. 8. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the public from the continuing threat of prescription drug abuse at the earliest possible time, it is necessary that this act take effect immediately.

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MBC TRACKER II BILLS
7/9/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 5	Ammiano	Homelessness	2-year	04/08/13
AB 12	Cooley	Standardized Regulatory Impact Analysis	Sen. Approps.	05/24/13
AB 18	Pan	Individual Health Care Coverage	2-year	06/24/13
AB 40	Mansoor	Substance Abuse: Recovery and Treatment Facilities	2-year	05/07/13
AB 58	Wieckowski	Medical Experiments: Human Subjects	Sen. 3rd Reading	04/02/13
AB 213	Logue	Healing Arts: Licensing Requirements: Military	2-year	04/18/13
AB 219	Perea	Health Care Coverage: Cancer Treatment	Sen. Approps.	07/02/13
AB 291	Nestande	California Sunset Review Commission	2-year	
AB 299	Holden	Prescription Drug Benefits	2-year	05/14/13
AB 357	Pan	California Healthy Child Advisory Task Force	2-year	
AB 369	Pan	California Health Benefit Exchange: Report	2-year	
AB 376	Donnelly	Regulations: Notice	2-year	
AB 395	Fox	Alcoholism and Drug Abuse Treatment Facilities	Sen. Approps.	06/24/13
AB 396	Fox	Prescriptions	2-year	
AB 411	Pan	Medi-Cal: Performance Measures	Sen. Approps.	07/02/13
AB 446	Mitchell	HIV Testing	Sen. Approps.	07/08/13
AB 473	Ammiano	Medical Marijuana: State Regulation and Enforcement	2-year	05/24/13
AB 506	Mitchell	HIV Testing: Infants	Assembly Conc.	07/02/13
AB 555	Salas	Social Security Numbers	Enrollment	04/30/13
AB 576	Perez, V.	Revenue Recovery and Collaborative Enforcement Team	Sen. Approps.	05/01/13
AB 591	Fox	Hospital Emergency Room: Geriatric Physician	2-year	
AB 596	Brown	Health Care Services Grants	2-year	
AB 599	Donnelly	Minors: Vaccinations: Parental Consent	2-year	
AB 620	Buchanan	Heath and Care Facilities: Missing Patients & Participants	Sen. Approps.	06/27/13
AB 623	Lowenthal	Inmates: Psychiatric Medication: Informed Consent	2-year	

MBC TRACKER II BILLS
7/9/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 633	Salas	Emergency Medical Services: Civil Liability	Sen. 3rd Reading	07/08/13
AB 657	Nazarian	Women's Health	2-year	
AB 658	Calderon, I.	Personal Information: Disclosure	Sen. 3rd Reading	06/24/13
AB 670	Atkins	Pharmacy Law: Incentive Payments	2-year	04/30/13
AB 676	Fox	Health Care Coverage: Post discharge Care Needs	2-year	04/10/13
AB 678	Gordon	Health Care Districts: Community Health Needs Assessment	Sen. Approps.	04/15/13
AB 689	Bonta	Health Facilities: Influenza	2-year	04/08/13
AB 705	Blumenfield	Combat to Care Act	2-year	04/23/13
AB 710	Pan	California Health Benefit Exchange: Multiemployer Plans	2-year	03/11/13
AB 722	Lowenthal	Drivers License: Medical Examinations	Assembly Conc.	05/28/13
AB 771	Jones	Public Health: Wellness Programs	2-year	03/19/13
AB 808	Fong	Acupuncture: License Requirements	2-year	04/09/13
AB 810	Muratsuchi	Law Enforcement: Data Sharing	2-year	03/21/13
AB 827	Hagman	Department of Consumer Affairs	2-year	
AB 859	Gomez	Professions and Vocations: Military Medical Personnel	2-year	
AB 889	Frazier	Health Care Coverage: Prescription Drugs	Sen. Approps.	05/02/13
AB 894	Mansoor	Consumer Affairs	2-year	
AB 912	Quirk-Silva	Health Care Coverage: Fertility Preservation	Sen. Approps.	07/02/13
AB 926	Bonilla	Reproductive Health and Research	Enrollment	04/23/13
AB 975	Wieckowski & Bonta	Health Facilities: Community Benefits	2-year	05/24/13
AB 980	Pan	Primary Care Clinics: Abortion	Sen. Approps.	06/19/13
AB 1013	Gomez	Consumer Affairs	2-year	
AB 1045	Quirk-Silva	Sterile Compounding and Nonresident Pharmacies	Sen. 3rd Reading	06/19/13
AB 1057	Medina	Professions & Vocations: Licenses: Military Service	Sen. 3rd Reading	06/03/13
AB 1136	Levine	Pharmacists: Drug Disclosures	Sen. 3rd Reading	04/15/13

MBC TRACKER II BILLS
7/9/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1139	Lowenthal	Prescriptions: Biosimilar Products	2-year	
AB 1153	Eggman	Master Esthetician: License	2-year	04/16/13
AB 1180	Pan	Health Care Coverage: Federally Eligible Defined Individuals	Sen. Approps.	06/20/13
AB 1208	Pan	Medical Homes	Sen. 3rd Reading	07/02/13
AB 1231	Perez, V.	Regional Centers: Telehealth	Sen. Approps.	06/27/13
AB 1263	Perez, J.	Medi-Cal: Communical	Sen. Approps.	06/25/13
AB 1297	Perez, J.	Coroners: Organ Donation	Sen. 3rd Reading	06/04/13
AB 1310	Brown	Medi-Cal: Pediatric Subacute Care	Sen. Approps.	05/24/13
AB 1372	Bonilla	Health Insurance: Pervasive Developmental Disorder or Autism	2-year	
ABX1 2	Pan	Health Care Coverage	Sen. 3rd Reading	04/01/13
ACA 1	Donnelly	Administrative Regulations: Legislative Approval	Failed Passage	
ACA 5	Grove	Abortion: Parental Notification	Asm. Health	
ACR 1	Medina	UC Riverside School of Medicine	Sen. Education	
SB 18	Hernandez	California Health Benefits Review Program	Asm. Health	04/17/13
SB 22	Beall	Health Care Coverage: Mental Health Parity	Asm. Approps	07/02/13
SB 28	Hernandez	California Health Benefit Exchange	Asm. Health	05/13/13
SB 44	Yee	State Internet Web sties: online voter registration	Asm. Approps	
SB 126	Steinberg	Health Care Coverage: pervasive developmental disorder/autism	Asm. Approps	06/15/13
SB 138	Hernandez	Confidentiality of Medical Information	Asm. Approps	06/26/13
SB 158	Correa	Autism Services: Demonstration Program	Asm. Approps	05/28/13
SB 176	Galgiani	Administrative Procedures	Asm. A & AR	06/18/13
SB 189	Monning	Health Care Coverage: Wellness Programs	2-year	05/08/13
SB 198	Price	Physical Therapy Board of California	Asm. Approps	06/18/13
SB 204	Corbett	Prescription Drugs: Labeling	Asm. Health	06/27/13
SB 205	Corbett	Prescription Drugs: Labeling	Asm. B&P	07/01/13

MBC TRACKER II BILLS
7/9/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 218	Yee	Healing Arts	Asm. B&P	05/28/13
SB 248	Wyland	Professional Corporations	2-year	
SB 266	Lieu	Health Care Coverage: Out-of-Network Coverage	2-year	04/24/13
SB 270	Padilla	Underground Economy: Enforcement Actions	Asm. L&E	
SB 294	Emmerson	Sterile Drug Products	Asm. Health	07/03/13
SB 306	Torres	Pharmacy: Dangerous Drugs and Devices	Asm. B&P	06/20/13
SB 351	Hernandez	Health Care Coverage: Hospital Billing	2-year	04/23/13
SB 353	Lieu	Health Care Coverage: Language Assistance	Asm. Health	04/16/13
SB 357	Correa	Elective Percutaneous Coronary Intervention Pilot Program	Asm. Consent	06/14/13
SB 381	Yee	Healing Arts: Chiropractic Practice	2-year	
SB 393	Walters	Prescription Drugs: Procurement: False Representation	2-year	
SB 394	Walters	Prescription Drugs	2-year	
SB 439	Steinberg	Medical Marijuana	Asm. Health	06/27/13
SB 445	Price	Pharmacies: Advertising: Controlled Substances	Asm. B&P	
SB 460	Pavley	Prenatal Testing Program: Education	Asm. Health	05/28/13
SB 494	Monning	Health Care Providers	Asm. Health	05/28/13
SB 495	Yee	Postsecondary Education Employees: Physicians	Assembly	05/21/13
SB 528	Yee	Dependents: Care and Treatment	Asm. Approps	06/26/13
SB 532	De Leon	Professions and Vocations: Military Spouses: Temporary Licenses	2-year	
SB 534	Hernandez	Health and Care Facilities	Asm. A & LTC	07/03/13
SB 577	Pavley	Autism & Other Developmental Disabilities: Employment	2-year	04/15/13
SB 588	Emmerson	Medical Records: Reproduction Fees	2-year	04/08/13
SB 598	Hill	Biosimilars	Asm. Approps	06/20/13
SB 631	Beall	Health Care Facilities: Observation	2-year	04/08/13
SB 639	Hernandez	Health Care Coverage	Asm. Health	05/28/13

MBC TRACKER II BILLS
7/9/2013

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 643	Price	Pharmacists: Identity	2-year	
SB 669	Huff	Emergency Medical Care: Epinephrine Auto Injectors	Asm. Judiciary	07/03/13
SB 709	Nielsen	Inmates: Mental Evaluations	2-year	
SB 799	Calderon	Health Care Coverage: Colorectal Cancer: Testing & Screening	2-year	05/08/13
SB 800	Lara	California Health Benefit Exchange: Outreach Services	Asm. Health	05/28/13
SBX1 2	Hernandez	Health Care Coverage	Asm. 3rd Reading	04/01/13
SBX1 3	Hernandez	Health Care Coverage: Bridge Plan	Enrolled	06/19/13