MEDICAL BOARD OF CALIFORNIA - 2019 TRACKER LIST
May 2, 2019

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 149	Cooper	Controlled Substances: Prescriptions	Chaptered, #4	Support	
AB 156	Voepel	Eye Care: Remote Assessment	Asm. B&P	2-Year Bill	
AB 241	Kamlager-Dove	Implicit Bias: Continuing Education: Requirements	Asm. Approps	Reco: Support	4/30/19
AB 370	Voepel	Physicians and Surgeons: Forms: Fee Limitations	Asm. Health	2-Year Bill	4/22/19
AB 387	Gabriel	Physicians: Pharmacists: Prescriptions	Asm. Approps - Suspense	Reco: Support	4/22/19
AB 407	Santiago	Fluoroscopy Permit or Certification and Continuing Education: Exceptions	Asm. Approps	Reco: Neutral	4/11/19
AB 528	Low	Controlled Substances: CURES	Asm. 3rd Reading	Reco: Support	
AB 544	Brough	Professions and Vocations: Inactive License Fees and Accrued and Unpaid Renewal Fees	Asm. Approps - Suspense	Reco: Oppose Unless Amended	3/21/19
AB 613	Low	Professions and Vocations: Regulatory Fees	Senate	Reco: Support	
AB 714	Wood	Opioid Prescription Drugs: Prescribers	Assembly Consent	Reco: Support	4/4/19
AB 845	Maienschein	Continuing Education: Physicians: Maternal Mental Health	Senate	Reco: Neutral	4/1/19
AB 888	Low	Opioid Prescriptions: Information: Non-Pharmacological Treatments for Pain	Asm. 2nd Reading	Reco: Support	4/11/19
AB 890	Wood	Nurse Practitioners: Scope of Practice: Unsupervised Practice	Asm. Approps		4/22/19
AB 1030	Calderon	Gynecological Examinations: Informational Pamphlet	Senate	Reco: Support	3/26/19
AB 1038	Muratsuchi	Health Data: Rates for Health Care Services: Physicians	Asm. Health	2-Year Bill	4/3/19
AB 1264	Petrie-Norris	Healing Arts Licensees: Self-Administered Hormonal Contraceptives	Asm. 2nd Reading	Reco: Neutral	4/22/19

Pink – Sponsored Bill, Green – For Discussion, Blue – No Discussion Needed, Orange - Chaptered

MEDICAL BOARD OF CALIFORNIA - 2019 TRACKER LIST
May 2, 2019

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1444	Flora	Physicians and Registered Nurses: Loan Repayment Grants	Asm. Health	2-Year Bill	3/25/19
AB 1467	Salas and Low	Optometrists: Scope of Practice: Delegation of Services Agreement	Asm. Consent		
AB 1468	McCarty and Gallagher	Opioid Prevention and Rehabilitation Act	Asm. Rev and Tax	Reco: Support if Amended	4/30/19
AB 1490	Carrillo	Medical Assistants	Asm. B&P	2-Year Bill	
AB 1544	Gipson and Gloria	Community Paramedicine or Triage to Alternate Destination Act	Asm. Approps - Suspense	Reco: Neutral	4/22/19
SB 159	Wiener	HIV: Preexposure and Postexposure Prophylaxis	Sen. Approps	Reco: Oppose	4/30/19
SB 201	Wiener	Medical Procedures: Treatment or Intervention: Sex Characteristics of a Minor	Sen. B&P	2-Year Bill	3/25/19
SB 377	McGuire	Juveniles: Psychotropic Medications: Medical Records	Sen. Approps	Reco: Support if Amended	4/11/19
SB 425	Hill	Health Care Practitioners: Licensee's File: Probationary Physician's Certificate: Unprofessional Conduct	Sen. Approps	Reco: Support	4/30/19
SB 480	Archuleta	Radiologist Assistants	Sen. B&P	2-Year Bill	
SB 697	Caballero	Physician Assistants: Practice Agreement: Supervision	Sen. Approps		4/24/19
SB 786	(B&P Comm.)	Healing Arts	Sen. Approps	Support Provisions Relating to the Board	4/11/19

Pink – Sponsored Bill, Green – For Discussion, Blue – No Discussion Needed, Orange - Chaptered

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	AB 149
AUTHOR:	Cooper
BILL DATE:	Chaptered, #4
SUBJECT:	Controlled Substances: Prescriptions
SPONSOR:	California Medical Association
POSITION:	Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows for a transition period, until January 1, 2021, before the new requirement becomes effective that prescription forms for controlled substances include a uniquely serialized number.

BACKGROUND:

AB 1753 (Low, Chapter 479) was signed into law in 2018 and became effective January 1, 2019. This bill required that all prescription forms include a uniquely serialized number in a manner prescribed by the Department of Justice (DOJ). This bill did not include a transition period to allow time for prescribers to order new prescription forms. This resulted in many prescribers not ordering new forms until right before the new law took effect. This meant that their old prescription forms were not valid on January 1st and they did not have the new forms yet, which resulted in difficulties for patients trying to get prescriptions filled for controlled substances.

To help get information out to prescribers, the Medical Board of California (Board) released a letter regarding the new requirements for prescription forms in December, following statements issued by DOJ and the Board of Pharmacy regarding the new law and their respective plans for enforcing the new law. Due to many calls received by all involved agencies, on January 10, 2019, the Board issued a joint release with DOJ and the Board of Pharmacy to provide further guidance on this issue.

ANALYSIS:

This bill specifies that a prescription for controlled substances written on an otherwise valid prescription form prior to January 1, 2019 that does not comply with the uniquely serialized number requirement, is a valid prescription that may be filled, compounded, or dispensed until January 1, 2021.

In the event that DOJ determines that there is an inadequate availability of compliant prescription forms to meet the demand on or before January 1, 2021, this bill would allow DOJ to extend the period during which prescriptions written on noncompliant prescription forms remain valid for a period no longer than an additional six months.

This bill does not require the uniquely serialized number to be a feature in the printing of new prescription forms until a date determined by DOJ, which shall be no later than January 1, 2020. The specification for the serialized number must be prescribed by DOJ and must be compliant with all state and federal requirements; must be utilizable as a barcode that may be scanned by dispensers; and must be compliant with current National Council for Prescription Drug Program Standards.

This bill includes an urgency clause and took effect when the bill was signed on March 11, 2019.

This bill was needed to allow for a transition period for prescribers to order the new prescription forms. The Board received many calls and emails from prescribers and patients regarding the difficulty of obtaining the new prescription forms and getting prescriptions filled using the old forms. This bill helps ensure that patients receive their medications in a timely manner and the Board was supportive of this bill. The Board has already implemented this bill by posting information on this bill on the Board's website and emailing out information on this bill to all physicians licensed by the Board.

FISCAL: None

SUPPORT: California Medical Association (Sponsor); California Association for Nurse Practitioners; California Academy of Child and Adolescent Psychiatry; California Dental Association; California Pharmacists Association; California Retailers Association; California Society of Anesthesiologists; Kaiser Permanente; Medical Board of California; and National Association of Chain Drug Stores

OPPOSITION: None on file

Assembly Bill No. 149

CHAPTER 4

An act to amend Sections 11162.1 and 11164 of, and to add Section 11162.2 to, the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor March 11, 2019. Filed with Secretary of State March 11, 2019.]

LEGISLATIVE COUNSEL'S DIGEST

AB 149, Cooper. Controlled substances: prescriptions.

Existing law classifies certain controlled substances into designated schedules. Existing law requires prescription forms for controlled substance prescriptions to be obtained from security printers approved by the department, as specified. Existing law requires those prescription forms to be printed with specified features, including a uniquely serialized number.

This bill would delay the requirement for those prescription forms to include a uniquely serialized number until a date determined by the Department of Justice that is no later than January 1, 2020. The bill would require, among other things, the serialized number to be utilizable as a barcode that may be scanned by dispensers. The bill would additionally make any prescription written on a prescription form that was otherwise valid prior to January 1, 2019, but that does not include a uniquely serialized number, or any prescription written on a form approved by the Department of Justice as of January 1, 2019, a valid prescription that may be filled, compounded, or dispensed until January 1, 2021. The bill would authorize the Department of Justice to extend this time period for a period no longer than an additional 6 months, if there is an inadequate availability of compliant prescription forms.

This bill would declare that it is to take effect immediately as an urgency statute.

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

SECTION 1. Section 11162.1 of the Health and Safety Code is amended to read:

11162.1. (a) The prescription forms for controlled substances shall be printed with the following features:

(1) A latent, repetitive "void" pattern shall be printed across the entire front of the prescription blank; if a prescription is scanned or photocopied, the word "void" shall appear in a pattern across the entire front of the prescription.

(2) A watermark shall be printed on the backside of the prescription blank; the watermark shall consist of the words "California Security Prescription."

(3) A chemical void protection that prevents alteration by chemical washing.

(4) A feature printed in thermochromic ink.

(5) An area of opaque writing so that the writing disappears if the prescription is lightened.

(6) A description of the security features included on each prescription form.

(7) (A) Six quantity check off boxes shall be printed on the form so that the prescriber may indicate the quantity by checking the applicable box where the following quantities shall appear:

1–24
25–49
50–74
75–100
101–150
151 and over.

(B) In conjunction with the quantity boxes, a space shall be provided to designate the units referenced in the quantity boxes when the drug is not in tablet or capsule form.

(8) Prescription blanks shall contain a statement printed on the bottom of the prescription blank that the "Prescription is void if the number of drugs prescribed is not noted."

(9) The preprinted name, category of licensure, license number, federal controlled substance registration number, and address of the prescribing practitioner.

(10) Check boxes shall be printed on the form so that the prescriber may indicate the number of refills ordered.

(11) The date of origin of the prescription.

(12) A check box indicating the prescriber's order not to substitute.

(13) An identifying number assigned to the approved security printer by the Department of Justice.

(14) (A) A check box by the name of each prescriber when a prescription form lists multiple prescribers.

(B) Each prescriber who signs the prescription form shall identify themselves as the prescriber by checking the box by the prescriber's name.

(15) A uniquely serialized number, in a manner prescribed by the Department of Justice in accordance with Section 11162.2.

(b) Each batch of controlled substance prescription forms shall have the lot number printed on the form and each form within that batch shall be numbered sequentially beginning with the numeral one.

(c) (1) A prescriber designated by a licensed health care facility, a clinic specified in Section 1200, or a clinic specified in subdivision (a) of Section 1206 that has 25 or more physicians or surgeons may order controlled substance prescription forms for use by prescribers when treating patients

in that facility without the information required in paragraph (9) of subdivision (a) or paragraph (3).

(2) Forms ordered pursuant to this subdivision shall have the name, category of licensure, license number, and federal controlled substance registration number of the designated prescriber and the name, address, category of licensure, and license number of the licensed health care facility the clinic specified in Section 1200, or the clinic specified in Section 1206 that has 25 or more physicians or surgeons preprinted on the form. Licensed health care facilities or clinics exempt under Section 1206 are not required to preprint the category of licensure and license number of their facility or clinic.

(3) Forms ordered pursuant to this section shall not be valid prescriptions without the name, category of licensure, license number, and federal controlled substance registration number of the prescriber on the form.

(4) (A) Except as provided in subparagraph (B), the designated prescriber shall maintain a record of the prescribers to whom the controlled substance prescription forms are issued, that shall include the name, category of licensure, license number, federal controlled substance registration number, and quantity of controlled substance prescription forms issued to each prescriber. The record shall be maintained in the health facility for three years.

(B) Forms ordered pursuant to this subdivision that are printed by a computerized prescription generation system shall not be subject to subparagraph (A) or paragraph (7) of subdivision (a). Forms printed pursuant to this subdivision that are printed by a computerized prescription generation system may contain the prescriber's name, category of professional licensure, license number, federal controlled substance registration number, and the date of the prescription.

(d) Within the next working day following delivery, a security printer shall submit via web-based application, as specified by the Department of Justice, all of the following information for all prescription forms delivered:

(1) Serial numbers of all prescription forms delivered.

(2) All prescriber names and Drug Enforcement Administration Controlled Substance Registration Certificate numbers displayed on the prescription forms.

(3) The delivery shipment recipient names.

(4) The date of delivery.

SEC. 2. Section 11162.2 is added to the Health and Safety Code, to read:

11162.2. (a) Notwithstanding any other law, the uniquely serialized number described in paragraph (15) of subdivision (a) of Section 11162.1 shall not be a required feature in the printing of new prescription forms produced by approved security printers until a date determined by the Department of Justice, which shall be no later than January 1, 2020.

(b) Specifications for the serialized number shall be prescribed by the Department of Justice and shall meet the following minimum requirements:

(1) The serialized number shall be compliant with all state and federal requirements.

(2) The serialized number shall be utilizable as a barcode that may be scanned by dispensers.

(3) The serialized number shall be compliant with current National Council for Prescription Drug Program Standards.

SEC. 3. Section 11164 of the Health and Safety Code is amended to read:

11164. Except as provided in Section 11167, no person shall prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 and shall meet the following requirements:

(1) The prescription shall be signed and dated by the prescriber in ink and shall contain the prescriber's address and telephone number; the name of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services; refill information, such as the number of refills ordered and whether the prescription is a first-time request or a refill; and the name, quantity, strength, and directions for use of the controlled substance prescribed.

(2) The prescription shall also contain the address of the person for whom the controlled substance is prescribed. If the prescriber does not specify this address on the prescription, the pharmacist filling the prescription or an employee acting under the direction of the pharmacist shall write or type the address on the prescription or maintain this information in a readily retrievable form in the pharmacy.

(b) (1) Notwithstanding paragraph (1) of subdivision (a) of Section 11162.1, any controlled substance classified in Schedule III, IV, or V may be dispensed upon an oral or electronically transmitted prescription, which shall be produced in hard copy form and signed and dated by the pharmacist filling the prescription or by any other person expressly authorized by provisions of the Business and Professions Code. Any person who transmits, maintains, or receives any electronically transmitted prescription shall ensure the security, integrity, authority, and confidentiality of the prescription.

(2) The date of issue of the prescription and all the information required for a written prescription by subdivision (a) shall be included in the written record of the prescription; the pharmacist need not include the address, telephone number, license classification, or federal registry number of the prescriber or the address of the patient on the hard copy, if that information is readily retrievable in the pharmacy.

(3) Pursuant to an authorization of the prescriber, any agent of the prescriber on behalf of the prescriber may orally or electronically transmit a prescription for a controlled substance classified in Schedule III, IV, or V, if in these cases the written record of the prescription required by this subdivision specifies the name of the agent of the prescriber transmitting the prescription.

(c) The use of commonly used abbreviations shall not invalidate an otherwise valid prescription.

(d) Notwithstanding subdivisions (a) and (b), prescriptions for a controlled substance classified in Schedule V may be for more than one person in the same family with the same medical need.

(e) (1) Notwithstanding any other law, a prescription written on a prescription form that was otherwise valid prior to January 1, 2019, but that does not comply with paragraph (15) of subdivision (a) of Section 11162.1, or a valid controlled substance prescription form approved by the Department of Justice as of January 1, 2019, is a valid prescription that may be filled, compounded, or dispensed until January 1, 2021.

(2) If the Department of Justice determines that there is an inadequate availability of compliant prescription forms to meet demand on or before the date described in paragraph (1), the department may extend the period during which prescriptions written on noncompliant prescription forms remain valid for a period no longer than an additional six months.

SEC. 4. 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 California Constitution and shall go into immediate effect. The facts constituting the necessity are:

To immediately confirm the validity of prescriptions for medication written on prescription forms issued, filled, compounded, or dispensed following the enactment of Chapter 479 of the Statutes of 2018 and clarify a timeline for implementation that preserves the continuity of treatment for patients.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 241
AUTHOR: Kamlager-Dove
BILL DATE: April 30, 2019, Amended
SUBJECT: Implicit Bias: Continuing Education: Requirements
SPONSOR: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require continuing education courses for physicians, nurses, and physician assistants (PAs) to include the understanding of implicit bias and the promotion of bias-reducing strategies.

BACKGROUND:

Existing law requires physicians and surgeons to complete at least 50 hours of approved CME during each two-year license renewal cycle. Currently, physicians and surgeons only have a mandatory one-time CME requirement of 12 hours in the subject of pain management and the treatment of the terminally ill or on the subject of the treatment and management of opiate-dependent patients. There is also a mandate in existing law that requires general internists and family physicians who have a patient population of which over 25 percent are 65 years of age or older to complete at least 20 percent of all mandatory CME in a course in the field of geriatric medicine or the care of older patients.

Existing CME courses approved by the Medical Board of California's (Board) Licensing Program include:

- Programs accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA), the American Medical Association (AMA), and the Accreditation Council for Continuing Medical Education (ACCME) that qualify for AMA PRA Category 1 Credit(s);
- Programs that qualify for prescribed credit from the American Academy of Family Physicians (AAFP); and
- Other programs offered by other organizations and institutions acceptable to the Board.

ANALYSIS:

This bill would make findings and declarations regarding implicit bias and its contribution to health disparities. This bill would include continuing education requirements for physicians, nurses, and PAs; however, this analysis will only include information on the requirements for physicians.

This bill would require, beginning January 1, 2022, all continuing medical education (CME) courses for physicians to contain curriculum that includes the understanding of implicit bias and the promotion of bias-reducing strategies to address how unintended biases in decision-making may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, socioeconomic status, or other characteristics.

According to the author, California's medical community should be at the forefront to improve treatment and outcomes for patients who have been underserved by their health providers. The author believes this bill would reduce disparities in health care by requiring physicians and other health care practitioners to undergo implicit bias training as part of their already mandated CME.

The Board believes that implicit bias training is important and requires it for all of its employees and other individuals that are involved in the Board's enforcement process. Requiring CME for physicians to include information on implicit bias could help to reduce health disparities, which would further the Board's mission of consumer protection. As such, the Board staff recommends that the Board support this bill.

FISCAL: None

SUPPORT: American Federation of State, County, and Municipal Employees; Anti-Recidivism Coalition; APLA Health; California Black Health Network; California Black Women's Health Project; California Health Executives Association; California LGBTQ Health and Human Services Network; California Voices for Progress; Courage Campaign; Disability Rights California; Equal Justice Society; Hathaway-Sycamores; Maternal Mental Health Now; Perinatal Mental Health Care; Planned Parenthood Affiliates of California; Santa Cruz County Community Coalition to Overcome Racism; San Francisco AIDS Foundation; and United Domestic Workers/AFSCME Local 3930

OPPOSITION: Board of Registered Nursing
California Nurses Association

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 30, 2019

AMENDED IN ASSEMBLY APRIL 4, 2019

AMENDED IN ASSEMBLY MARCH 19, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 241

Introduced by Assembly Member Kamlager-Dove
(Coauthors: Assembly Members Bonta, Gonzalez, Jones-Sawyer, Kalra, McCarty, Weber, and Wicks)
(Coauthor: Senator Wiener)

January 18, 2019

An act to amend Sections 2190.1 and 3524.5 of, and to add Section 2736.5 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 241, as amended, Kamlager-Dove. Implicit bias: continuing education: requirements.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under the act, a physician and surgeon is required to demonstrate satisfaction of continuing education requirements, including cultural and linguistic competency in the practice of medicine, as specified.

This bill, by January 1, 2022, would require ~~the curriculum for~~ *all* continuing education *courses* for a physician and surgeon to ~~include~~ *contain curriculum that includes* specified instruction in the understanding of implicit bias in medical treatment.

Existing law, the Nursing Practice Act, regulates the practice of nursing by the Board of Registered Nursing. The act requires persons

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB241

licensed by the board to complete specified courses of instruction, including instruction regarding alcoholism and substance dependency and spousal abuse.

This bill would require the Board of Registered Nursing, by January 1, 2022, to adopt regulations requiring ~~the curriculum for~~ *all* continuing education *courses* for its licensees to ~~include~~ *contain curriculum that includes* specified instruction in the understanding of implicit bias in treatment.

Existing law, the Physician Assistant Practice Act, authorizes the Physician Assistant Board to require a licensee to complete not more than 50 hours of continuing education every two years as a condition of license renewal.

This bill would require the Physician Assistant Board, by January 1, 2022, to adopt regulations requiring ~~the curriculum for~~ *all* continuing education *courses* for its licensees to ~~include~~ *contain curriculum that includes* specified instruction in the understanding of implicit bias in treatment.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) Implicit bias, meaning the attitudes or internalized
4 stereotypes that affect our perceptions, ~~actions~~ *actions,* and
5 decisions in an unconscious manner, exists, and often contributes
6 to unequal treatment of people based on race, ethnicity, gender
7 identity, sexual orientation, ~~ability,~~ *disability,* and other
8 characteristics.
9 (b) Implicit bias contributes to health disparities by affecting
10 the behavior of physicians and surgeons, nurses, physician
11 assistants, and other healing arts licensees.
12 (c) Evidence of racial and ethnic disparities in health care is
13 remarkably consistent across a range of illnesses and health care
14 services. Racial and ethnic disparities remain even after adjusting
15 for socioeconomic differences, insurance status, and other factors
16 influencing access to health care.
17 (d) African American women are three to four times more likely
18 than white women to die from pregnancy-related causes

1 nationwide. African American patients often are prescribed less
2 pain medication than white patients who present the same
3 complaints, and African American patients with signs of heart
4 problems are not referred for advanced cardiovascular procedures
5 as often as white patients with the same symptoms.
6 (e) Implicit gender bias also impacts treatment decisions and
7 outcomes. Women are less likely to survive a heart attack when
8 they are treated by a male physician and surgeon. LGBTQ and
9 gender-nonconforming patients are less likely to seek timely
10 medical care because they experience disrespect and discrimination
11 from health care staff, with one out of five transgender patients
12 nationwide reporting that they were outright denied medical care
13 due to bias.
14 (f) The Legislature intends to provide specified healing arts
15 licensees with strategies for understanding and reducing the impact
16 of their biases in order to reduce disparate outcomes and ensure
17 that all patients receive fair treatment and quality health care.
18 SEC. 2. Section 2190.1 of the Business and Professions Code
19 is amended to read:
20 2190.1. (a) The continuing medical education standards of
21 Section 2190 may be met by educational activities that meet the
22 standards of the board and that serve to maintain, develop, or
23 increase the knowledge, skills, and professional performance that
24 a physician and surgeon uses to provide care, or to improve the
25 quality of care provided to patients. These may include, but are
26 not limited to, educational activities that meet any of the following
27 criteria:
28 (1) Have a scientific or clinical content with a direct bearing on
29 the quality or cost-effective provision of patient care, community
30 or public health, or preventive medicine.
31 (2) Concern quality assurance or improvement, risk
32 management, health facility standards, or the legal aspects of
33 clinical medicine.
34 (3) Concern bioethics or professional ethics.
35 (4) Are designed to improve the physician-patient relationship.
36 (b) (1) On and after July 1, 2006, all continuing medical
37 education courses shall contain curriculum that includes cultural
38 and linguistic competency in the practice of medicine.
39 (2) Notwithstanding the provisions of paragraph (1), a
40 continuing medical education course dedicated solely to research

1 or other issues that does not include a direct patient care component
2 or a course offered by a continuing medical education provider
3 that is not located in this state is not required to contain curriculum
4 that includes cultural and linguistic competency in the practice of
5 medicine.
6 (3) Associations that accredit continuing medical education
7 courses shall develop standards before July 1, 2006, for compliance
8 with the requirements of paragraph (1). The associations may
9 update these standards, as needed, in conjunction with an advisory
10 group that has expertise in cultural and linguistic competency
11 issues.
12 (4) A physician and surgeon who completes a continuing
13 education course meeting the standards developed pursuant to
14 paragraph (3) satisfies the continuing education requirement for
15 cultural and linguistic competency.
16 (c) In order to satisfy the requirements of subdivision (b),
17 continuing medical education courses shall address at least one or
18 a combination of the following:
19 (1) Cultural competency. For the purposes of this section,
20 "cultural competency" means a set of integrated attitudes,
21 knowledge, and skills that enables a health care professional or
22 organization to care effectively for patients from diverse cultures,
23 groups, and communities. At a minimum, cultural competency is
24 recommended to include the following:
25 (A) Applying linguistic skills to communicate effectively with
26 the target population.
27 (B) Utilizing cultural information to establish therapeutic
28 relationships.
29 (C) Eliciting and incorporating pertinent cultural data in
30 diagnosis and treatment.
31 (D) Understanding and applying cultural and ethnic data to the
32 process of clinical care, including, as appropriate, information
33 pertinent to the appropriate treatment of, and provision of care to,
34 the lesbian, gay, bisexual, transgender, and intersex communities.
35 (2) Linguistic competency. For the purposes of this section,
36 "linguistic competency" means the ability of a physician and
37 surgeon to provide patients who do not speak English or who have
38 limited ability to speak English, direct communication in the
39 patient's primary language.

(3) A review and explanation of relevant federal and state laws and regulations regarding linguistic access, including, but not limited to, the federal Civil Rights Act (42 U.S.C. Sec. ~~1981,~~ *1981* et seq.), Executive Order 13166 of August 11, 2000, of the President of the United States, and the Dymally-Alatorre Bilingual Services Act (Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code).

(d) On and after January 1, 2022, all continuing medical education courses shall contain curriculum that includes the understanding of implicit bias and the promotion of bias-reducing strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in medical treatment along lines of race, ethnicity, gender identity, sexual orientation, socioeconomic status, or other characteristics. ~~A physician and surgeon shall meet the requirements of this subdivision by the physician and surgeon's next license renewal date and each subsequent renewal date thereafter.~~

(e) Notwithstanding subdivision (a), educational activities that are not directed toward the practice of medicine, or are directed primarily toward the business aspects of medical practice, including, but not limited to, medical office management, billing and coding, and marketing shall not be deemed to meet the continuing medical education standards for licensed physicians and surgeons.

(f) Educational activities that meet the content standards set forth in this section and are accredited by the California Medical Association or the Accreditation Council for Continuing Medical Education may be deemed by the Division of Licensing to meet its continuing medical education standards.

SEC. 3. Section 2736.5 is added to the Business and Professions Code, to read:

2736.5. The board shall adopt regulations to require that, on and after January 1, 2022, ~~the~~ *all* continuing education ~~curriculum~~ *courses* for ~~all~~ licensees under this chapter *contain curriculum that* includes the understanding of implicit bias and the promotion of bias-reducing strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in treatment along lines of race, ethnicity, gender identity, sexual orientation, socioeconomic

status, or other characteristics.~~ A licensee shall meet the requirements of this section by the licensee's next license renewal date and each subsequent renewal date thereafter.~~

SEC. 4. Section 3524.5 of the Business and Professions Code is amended to read:

3524.5. (a) The board may require a licensee to complete continuing education as a condition of license renewal under Section 3523 or 3524. The board shall not require more than 50 hours of continuing education every two years. The board shall, as it deems appropriate, accept certification by the National Commission on Certification of Physician Assistants (NCCPA), or another qualified certifying body, as determined by the board, as evidence of compliance with continuing education requirements.

(b) The board shall adopt regulations to require that, on and after January 1, 2022,~~ the~~ *all* continuing education~~ curriculum~~ *courses* for~~ all~~ licensees under this chapter *contain curriculum that* includes the understanding of implicit bias and the promotion of bias-reducing strategies to address how unintended biases in decisionmaking may contribute to health care disparities by shaping behavior and producing differences in treatment along lines of race, ethnicity, gender identity, sexual orientation, socioeconomic status, or other characteristics.~~ A licensee shall meet the requirements of this subdivision by the licensee's next license renewal date and each subsequent renewal date thereafter.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 387
AUTHOR: Gabriel
BILL DATE: April 22, 2019, Amended
SUBJECT: Physicians and Surgeons: Pharmacists: Prescriptions
SPONSOR: California Senior Legislature

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a physician to include the purpose for a drug or device on the prescription, unless the patient opts out.

BACKGROUND:

Current law already requires a prescription label to include the condition or purpose for which the drug was prescribed, if indicated. This information is only provided on the prescription if the patient requests it, which is an “opt-in” system. This means that if a patient does not request a physician to include the medication’s purpose on the prescription, a pharmacist is not required to include it on the prescription label.

According to the author, adverse drug events (ADEs) due to medications with similar names are common and estimated to be responsible for thousands of deaths and millions of dollars in costs every year. One study indicated that up to 25% of medication errors can be attributed to name confusion and 33% to packaging and labeling confusion. In addition to increasing hospital admissions, prolonging hospital stays, requiring additional clinical visits, and increasing risks of disability or death, ADEs are estimated to cost the healthcare system approximately $50 billion annually.

ANALYSIS:

This bill requires a physician to indicate the purpose for a drug or device on the prescription when providing a prescription to a patient, unless the patient chooses to opt out of having the purpose for the drug or device included on the prescription. This bill would require a physician to give the patient the option to opt out of having the purpose for a drug or device before it is included on the prescription.

This bill would specify that if the purpose of a drug or device is not indicated on a prescription, a dispensing pharmacist is not responsible for ascertaining the purpose or determining whether the patient opted out. This bill would require the Board of Pharmacy to adopt revised regulations to provide technical guidance regarding the format and manner in which a pharmacist is to incorporate drug or device purpose indication on the standardized, patient-centered, prescription drug label pursuant to existing law.

This bill would specify that it would become operative on the date the regulations adopted by the Board of Pharmacy are operative.

The author believes that taking steps to ensure that prescription drug containers more frequently feature the purpose for which the medication was prescribed would result in fewer errors due to medications. According to data supplied by the author, medications with similar names often lead to confusion about which medication serves which purpose in a patient's medicine cabinet. These types of errors are especially common within the senior population.

Existing law already allows the purpose to be included on the prescription label. This bill simply changes existing law from an opt-in basis to an opt-out basis, which will help ensure that more prescriptions include the purpose for the drug on the label. This bill will further the Board's mission of consumer protection by possibly preventing ADEs and Board staff recommends that the Board take a support position on this bill.

FISCAL: Minimal and absorbable

SUPPORT: California Senior Legislature (Sponsor)
California Association for Health Services at Home
California State Retirees

OPPOSITION: American Congress of Obstetricians and Gynecologists – District IX; California Chapter of the American College of Emergency Physicians; California Chapter of the American College of Cardiology; California Medical Association; California Pharmacists Association; California Retailers Association; California Society of Plastic Surgeons; and National Association of Chain Drug Stores.

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 22, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 387

Introduced by Assembly Member Gabriel

February 5, 2019

An act to add Section 2051.1 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 387, as amended, Gabriel. Physician and surgeons: *pharmacists:* prescriptions.

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and authorizes a licensed physician and surgeon to use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions.

This bill would require a physician and surgeon to indicate the purpose for a drug or device on the prescription for that drug or device when providing a prescription to a patient unless the patient chooses to opt out of having the purpose for the drug or device included on the prescription.

The Pharmacy Law provides for the licensure and regulation of the practice of pharmacy by the California State Board of Pharmacy. Existing law requires the California State Board of Pharmacy to promulgate regulations that require, on or before January 1, 2011, a standardized, patient-centered, prescription drug label on all prescription medication dispensed to patients in California.

Under the bill, if the purpose of a drug or device is not indicated on a prescription for that drug or device as required by the bill, a dispensing pharmacist would not be responsible for ascertaining the purpose or determining whether the patient opted out of its inclusion on the prescription. The bill would require the California State Board of Pharmacy to adopt revised regulations providing additional technical guidance regarding the format and manner in which a pharmacist is to incorporate drug or device purpose indications on the standardized, patient-centered, prescription drug label.

The provisions of the bill would not become operative until the operative date of the regulations. The bill would require the California State Board of Pharmacy to notify the Secretary of State when regulations have been adopted.

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

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

1 SECTION 1. Section 2051.1 is added to the Business and
2 Professions Code, to read:
3 2051.1. (a) A physician and surgeon shall indicate the purpose
4 for a drug or device on the prescription for that drug or device
5 when providing a prescription to a patient, unless the patient
6 chooses to opt out of having the purpose for the drug or device
7 included on the prescription.
8 (b) Prior to indicating the purpose for a drug or device on a
9 prescription pursuant to subdivision (a), a physician and surgeon
10 shall give the patient the option to opt out of having the purpose
11 for a drug or device included on the prescription.
12 *(c) If the purpose of a drug or device is not indicated on a*
13 *prescription for that drug or device pursuant to subdivision (a),*
14 *a dispensing pharmacist shall not be responsible for ascertaining*
15 *the purpose or determining whether the patient opted out of its*
16 *inclusion on the prescription pursuant to subdivision (b).*
17 *(d) The California State Board of Pharmacy shall adopt revised*
18 *regulations providing additional technical guidance regarding*
19 *the format and manner in which a pharmacist is to incorporate*
20 *drug or device purpose indications on the standardized,*
21 *patient-centered, prescription drug label pursuant to Section*
22 *4076.5.*

1 *(e) This section shall become operative on the operative date*
2 *of the regulations adopted pursuant to subdivision (d). The*
3 *California State Board of Pharmacy shall notify the Secretary of*
4 *State when regulations have been adopted.*

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	AB 407
AUTHOR:	Santiago
BILL DATE:	April 11, 2019, Amended
SUBJECT:	Fluoroscopy Permit or Certification and Continuing Education: Exceptions
SPONSOR:	California Orthopaedic Association California Podiatric Medical Association

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a physician or a doctor of podiatric medicine to provide fluoroscopy services without a fluoroscopy permit or certification if the fluoroscopy services are provided in a setting that is in compliance with the Centers for Medicare and Medicaid Services' (CMS) Conditions for Coverage (CfC) relating to radiation safety.

BACKGROUND:

According to the Food and Drug Administration, fluoroscopy is a type of medical imaging that shows a continuous X-ray image on a monitor, much like an X-ray movie. During a fluoroscopy procedure, an X-ray beam is passed through the body. The image is transmitted to a monitor so that the movement of a body part or of an instrument or contrast agent ("X-ray dye") through the body can be seen in detail. Fluoroscopy is used in a wide variety of examinations and procedures to diagnose or treat patients.

To use fluoroscopy equipment in California, an individual must obtain either a radiologic technologist fluoroscopy permit, a fluoroscopy supervisor and operator permit, or a Physician Assistant's fluoroscopy permit. One of the requirements to obtain a permit is to pass an examination administered by the American Registry of Radiology Technologists (AART). A fluoroscopy supervisor and operator permit is also issued to a licensee of the healing arts defined as a licensed physician and surgeon, licensed podiatrist, or licensed chiropractor. To supervise a radiologic technologist in the operation of fluoroscopy equipment or to operate fluoroscopy equipment, a physician, podiatrist or chiropractor must pass the examination administered by AART. According to the California Department of Public Health, as of June 1, 2018, there are 8,771 physicians and podiatrists with current/valid fluoroscopy permits.

In order to participate in and receive federal payments from Medicare or Medicaid programs, a health care organization must meet the government requirements for program participation, including a certification of compliance with the health and safety requirements, which are set forth in federal regulations. The certification is achieved based on either a survey conducted by a state agency on behalf of the federal government, such as CMS, or by a national accrediting organization, such as The Joint

Commission, that has been recognized by CMS (through a process called “deeming”) as having standards and a survey process that meet or exceed Medicare’s requirements. As of January 1, 2019, all fluoroscopy operators working in facilities accredited by the Joint Commission are now required to undergo radiation safety training to maintain their privileges. This on-site training will be provided on an annual basis and surveyed by the accrediting agency, and, unless the law is changed, this will be in addition to the required examination.

ANALYSIS:

According to the author, with the new radiation safety requirement in place, it makes sense that anyone undergoing training and deemed competent in radiation safety should not be withheld a fluoroscopy certification simply because they need to pass an additional test. These physicians should be able to perform fluoroscopy in any CMS accredited facility following compliance with CMS’ radiation safety guidelines. The author believes it is time to update this archaic system and adopt new training requirements so that more providers are deployed to safely perform these procedures and treat patients.

Due to the new radiation safety training required in CMS certified facilities, it seems reasonable to no longer require physicians and doctors of podiatric medicine working in these facilities to obtain a fluoroscopy permit or certification. Board staff is recommending that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: California Orthopaedic Association (Co-Sponsor)
California Podiatric Medical Association (Co-Sponsor)

OPPOSITION: California Radiological Society

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 11, 2019

AMENDED IN ASSEMBLY MARCH 28, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 407

Introduced by Assembly Member Santiago

February 7, 2019

An act to amend Sections 107110 and 114870 of the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL'S DIGEST

AB 407, as amended, Santiago. Fluoroscopy permit or certification and continuing education: exceptions.

The Radiologic Technology Act makes it unlawful for any licentiate of the healing arts to administer or use diagnostic, mammographic, or therapeutic X-ray on human beings in this state, unless that person is certified by the State Department of Public Health and acting within the scope of that certification. The act requires the department to prescribe minimum qualifications for granting a fluoroscopy permit and continuing education requirements for the holders of that permit. A person who violates a provision of the Radiologic Technology Act or regulation of the department adopted pursuant to that act is guilty of a misdemeanor.

This bill ~~would, notwithstanding any other law,~~ *would* authorize a physician and surgeon, or a doctor of podiatric medicine, ~~to provide fluoroscopy services~~ *who works* in a setting that is in compliance with the Centers for Medicare and Medicaid Services' Conditions for Coverage relating to radiation ~~safety~~ *safety, to provide fluoroscopy services* without a fluoroscopy permit or certification. The bill would

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB407

require the department to provide that working in a setting that is in compliance with the Centers for Medicare and Medicaid Services' Conditions for Coverage relating to radiation safety satisfies a requirement for fluoroscopy continuing education set forth in a specific regulation.

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

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

1 SECTION 1. Section 107110 of the Health and Safety Code
2 is amended to read:
3 107110. (a) It shall be unlawful for any licentiate of the healing
4 arts to administer or use diagnostic, mammographic, or therapeutic
5 X-ray on human beings in this state after January 1, 1972, unless
6 that person is certified pursuant to subdivision (e) of Section
7 114870, Section 114872, or Section 114885, and is acting within
8 the scope of that certification.
9 (b) Notwithstanding ~~any other law, including~~ subdivision (a),
10 a physician and surgeon, or a doctor of podiatric medicine, ~~may~~
11 ~~provide fluoroscopy services~~ *who works* in a setting that is in
12 compliance with the Centers for Medicare and Medicaid Services'
13 Conditions for Coverage relating to radiation ~~safety~~ *safety, may*
14 *provide fluoroscopy services* without a fluoroscopy permit or
15 certification.
16 SEC. 2. Section 114870 of the Health and Safety Code is
17 amended to read:
18 114870. The department shall do all of the following:
19 (a) Upon recommendation of the committee, adopt regulations
20 as may be necessary to accomplish the purposes of this chapter.
21 (b) (1) Provide for certification of radiologic technologists,
22 without limitation as to procedures or areas of application, except
23 as provided in Section 106980. Separate certificates shall be
24 provided for diagnostic radiologic technology, for mammographic
25 radiologic technology, and for therapeutic radiologic technology.
26 If a person has received accreditation to perform mammography
27 from a private accreditation organization, the department shall
28 consider this accreditation when deciding to issue a mammographic
29 radiologic technology certificate.

(2) Provide, upon recommendation of the committee, that a radiologic technologist who operates digital radiography equipment devote a portion of their continuing education credit hours to continuing education in digital radiologic technology.

(c) (1) (A) Provide, as may be deemed appropriate, for granting limited permits to persons to conduct radiologic technology limited to the performance of certain procedures or the application of X-rays to specific areas of the human body, except for mammography, prescribe minimum standards of training and experience for these persons, and prescribe procedures for examining applicants for limited permits. The minimum standards shall include a requirement that persons granted limited permits under this subdivision shall meet those fundamental requirements in basic radiological health training and knowledge similar to those required for persons certified under subdivision (b) as the department determines are reasonably necessary for the protection of the health and safety of the public.

(B) Provide that an applicant for approval as a limited permit X-ray technician in the categories of chest radiography, extremities radiography, gastrointestinal radiography, genitourinary radiography, leg-podiatric radiography, skull radiography, and torso-skeletal radiography, as these categories are defined in Section 30443 of Title 17 of the California Code of Regulations, shall have at least 50 hours of education in radiological protection and safety. The department may allocate these hours as it deems appropriate.

(2) Provide that a limited permit X-ray technician in the categories of chest radiography, extremities radiography, gastrointestinal radiography, genitourinary radiography, leg-podiatric radiography, skull radiography, and torso-skeletal radiography, as these categories are defined in Section 30443 of Title 17 of the California Code of Regulations, may perform digital radiography within their respective scopes of practice after completion of 20 hours or more of instruction in digital radiologic technology approved by the department. This requirement ~~shall not be construed to~~ *does not* preclude limited permit X-ray technicians in the categories of dental laboratory radiography and X-ray bone densitometry from performing digital radiography upon meeting the educational requirements determined by the department.

1 (3) Provide, upon recommendation of the committee, that a
2 limited permit X-ray technician who has completed the initial
3 instruction described in paragraph (2) devote a portion of their
4 required continuing education credit hours to additional continuing
5 instruction in digital radiologic technology.
6 (d) Provide for the approval of schools for radiologic
7 technologists. Schools for radiologic technologists shall include
8 20 hours of approved instruction in digital radiography. The
9 department may exempt a school from this requirement as it deems
10 appropriate.
11 (e) Provide, upon recommendation of the committee, for
12 certification of licentiates of the healing arts to supervise the
13 operation of X-ray machines or to operate X-ray machines, or both,
14 prescribe minimum standards of training and experience for these
15 licentiates of the healing arts, and prescribe procedures for
16 examining applicants for certification. This certification may limit
17 the use of X-rays to certain X-ray procedures and the application
18 of X-rays to specific areas of the human body.
19 (f) (1) Provide for certification of any physician and surgeon
20 to operate, and supervise the operation of, a bone densitometer, if
21 that physician and surgeon provides the department a certificate
22 that evidences training in the use of a bone densitometer by a
23 representative of a bone densitometer machine manufacturer, or
24 through any radiologic technology school. The certification shall
25 be valid for the particular bone densitometer the physician and
26 surgeon was trained to use, and for any other bone densitometer
27 that meets all of the criteria specified in subparagraphs (A) to (C),
28 inclusive, if the physician and surgeon has completed training, as
29 specified in subparagraph (A) of paragraph (2), for the use of that
30 bone densitometer. The physician and surgeon shall, upon request
31 of the department, provide evidence of training, pursuant to
32 subparagraph (A) of paragraph (2), for the use of any bone
33 densitometer used by the physician and surgeon. The activity
34 covered by the certificate shall be limited to the use of an X-ray
35 bone densitometer to which all of the following is applicable:
36 (A) The bone densitometer does not require user intervention
37 for calibration.
38 (B) The bone densitometer does not provide an image for
39 diagnosis.

1 (C) The bone densitometer is used only to estimate bone density
2 of the heel, wrist, or finger of the patient.
3 (2) The certificate shall be accompanied by a copy of the
4 curriculum covered by the manufacturer's representative or
5 radiologic technology school. The curriculum shall include, at a
6 minimum, instruction in all of the following areas:
7 (A) Procedures for operation of the bone densitometer by the
8 physician and surgeon, and for the supervision of the operation of
9 the bone densitometer by other persons, including procedures for
10 quality assurance of the bone densitometer.
11 (B) Proper radiation protection of the operator, the patient, and
12 third parties in proximity to the bone densitometer.
13 (C) Provisions of Article 5 (commencing with Section 106955)
14 of Chapter 4 of Part 1 of Division 104.
15 (D) Provisions of Chapter 6 (commencing with Section 114840)
16 of Part 9 of Division 104.
17 (E) Provisions of Group 1 (commencing with Section 30100)
18 of Subchapter 4 of Chapter 5 of Division 1 of Title 17 of the
19 California Code of Regulations.
20 (F) Provisions of Group 1.5 (commencing with Section 30108)
21 of Subchapter 4 of Chapter 5 of Division 1 of Title 17 of the
22 California Code of Regulations.
23 (G) Provisions of Article 1 (commencing with Section 30252)
24 of Group 3 of Subchapter 4 of Chapter 5 of Division 1 of Title 17
25 of the California Code of Regulations.
26 (H) Provisions of Article 2 (commencing with Section 30254)
27 of Group 3 of Subchapter 4 of Chapter 5 of Division 1 of Title 17
28 of the California Code of Regulations.
29 (I) Provisions of Article 3 (commencing with Section 30275)
30 of Group 3 of Subchapter 4 of Chapter 5 of Division 1 of Title 17
31 of the California Code of Regulations.
32 (J) Provisions of Article 4 (commencing with Section 30305)
33 of Group 3 of Subchapter 4 of Chapter 5 of Division 1 of Title 17
34 of the California Code of Regulations.
35 (K) Provisions of Subchapter 4.5 (commencing with Section
36 30400) of Chapter 5 of Division 1 of Title 17 of the California
37 Code of Regulations.
38 (3) (A) Notwithstanding any other ~~provision of~~ law, this
39 subdivision shall constitute all the requirements that must be met
40 by a physician and surgeon in order to operate, and supervise the

1 operation of, a bone densitometer. The department may adopt
2 regulations consistent with this section in order to administer the
3 certification requirements.
4 (B) No person may be supervised by a physician and surgeon
5 in the use of a bone densitometer unless that person possesses the
6 necessary license or permit required by the department.
7 (C) Nothing in this subdivision shall affect the requirements
8 imposed by the committee or the department for the registration
9 of a bone densitometer machine, or for the inspection of facilities
10 in which any bone densitometer machine is operated.
11 (D) This subdivision shall not apply to a licentiate of the healing
12 arts who is certified pursuant to subdivision (e) or pursuant to
13 Section 107111.
14 (E) The department shall charge a fee for a certificate issued
15 pursuant to this subdivision to the extent necessary to administer
16 certification. The fee shall be in an amount sufficient to cover the
17 department's costs of implementing this subdivision and shall not
18 exceed the fee for certification to operate or supervise the operation
19 of an X-ray machine pursuant to subdivision (e). The fees collected
20 pursuant to this subparagraph shall be deposited into the Radiation
21 Control Fund established pursuant to Section 114980.
22 (g) Upon recommendation of the committee, exempt from
23 certification requirements those licentiates of the healing arts who
24 have successfully completed formal courses in schools certified
25 by the department and who have successfully passed a
26 roentgenology technology and radiation protection examination
27 approved by the department and administered by the board that
28 issued their license.
29 (h) (1) No later than July 1, 2019, the department shall require
30 an applicant to provide either the individual taxpayer identification
31 number or social security number for purposes of applying for or
32 the renewal of a certificate, license, or permit issued under this
33 section or regulations promulgated pursuant thereto.
34 (2) The individual taxpayer identification or the social security
35 number shall serve to establish the identification of persons affected
36 by state tax laws and for purposes of establishing compliance with
37 subsection (a) of Section 666 of Title 42 of the United States Code,
38 Section 60.15 of Title 45 of the Code of Federal Regulations,
39 Section 17520 of the Family Code, and Section 11105 of the Penal

Code, and to that end, the information furnished pursuant to this section shall be used exclusively for those purposes.

(3) The department shall not do either of the following:

(A) Require an applicant to disclose citizenship status or immigration status for purposes of the application or renewal of a certificate, license, or permit issued under this section or regulations promulgated pursuant thereto.

(B) Deny certification to an otherwise qualified and eligible applicant based solely on citizenship status or immigration status.

(4) If the department utilizes a national examination to issue a certificate, and if a reciprocity agreement or comity exists between the State of California and the state requesting release of the individual taxpayer identification number or social security number, any deputy, agent, clerk, officer, or employee of the department may release an individual's taxpayer identification number or social security number to an examination or certifying entity, only for the purpose of verification of certification or examination status.

(i) ~~Provide that working~~ *A physician and surgeon, or a doctor of podiatric medicine, who works* in a setting that is in compliance with the Centers for Medicare and Medicaid Services' Conditions for Coverage relating to radiation ~~safety~~ *safety,* satisfies the requirement for fluoroscopy continuing education as set forth in subdivision (b) of Section 30403 of Title 17 of the California Code of Regulations.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 528
AUTHOR: Low
BILL DATE: February 13, 2019, Introduced
SUBJECT: Controlled Substances: CURES Database
SPONSOR: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would change the timeframe for dispensers to report dispensed prescriptions to the Controlled Substance Utilization Review and Evaluation System (CURES) from seven days to the following working day.

BACKGROUND:

The CURES Program is currently housed in the Department of Justice (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) 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, to access patient controlled substance history information through a secure website. SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that license individuals who prescribe and dispense, for purposes of funding and upgrading the CURES system. This bill also required all prescribers to register with CURES by January 1, 2016, but the law was amended to extend the registration deadline to July 1, 2016. The new CURES 2.0 system, which is a modernized system that has been updated to more efficiently serve prescribers, dispensers and other entities, is now operational and available online, as long as the user uses a compliant browser.

According to the Centers for Disease Control and Prevention, drug overdose deaths continue to increase in the United States. Drug overdose deaths continue to increase in the United States. From 1999 to 2017, more than 700,000 people have died from a drug overdose. Around 68% of the more than 70,200 drug overdose deaths in 2017 involved an opioid. In 2017, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 6 times higher than in 1999. On average, 130 Americans die every day from an opioid overdose.

ANALYSIS:

This bill states that it is the intent of the Legislature that state laws regarding the operation and use of PDMPs continue to empower health care oriented technology solutions to the opioid crisis. This bill would require dispensers to report prescription information to CURES within one working day after the date a controlled substance is dispensed. This bill includes an urgency clause and would take effect immediately upon signature.

According to the author, PDMPs are recognized by experts as a powerful tool to combat the abuse and diversion of prescription drugs like opioids. Data reported to CURES provides health professionals, regulators, and law enforcement with critical information to promote safe prescribing and identify abuse; AB 528 improves these reports. Reducing the time a dispenser has to report to CURES prevents doctor shoppers from visiting multiple prescribers over the course of a week to obtain multiple prescriptions. With this bill, CURES will function even better to help combat the opioid crisis.

Reducing the reporting deadline for dispensers will result in up-to-date information in CURES and will make it even more of an effective aid for physicians to use to prevent doctor shopping. This provision was also included in AB 1752 (Low, 2018), which the Board supported. As such, Board staff is recommending that the Board support this bill.

FISCAL: None

SUPPORT: California Chapter of the American College of Emergency Physicians; California Dental Association; California Medical Association; and County Behavioral Health Directors Association

OPPOSITION: None on file

POSITION: Recommendation: Support

ASSEMBLY BILL No. 528

Introduced by Assembly Member Low

February 13, 2019

An act to amend Section 11165 of the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

legislative counsel's digest

AB 528, as introduced, Low. Controlled substances: CURES database.

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 a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a Schedule II, Schedule III, or Schedule IV controlled substance. Existing law requires a dispensing pharmacy, clinic, or other dispenser to report specified information to the Department of Justice as soon as reasonably possible, but not more than 7 days after the date a controlled substance is dispensed.

This bill would require a dispensing pharmacy, clinic, or other dispenser to report the information required by the CURES database no more than one working day after a controlled substance is dispensed.

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:

1 SECTION 1. It is the intent of the Legislature that state laws
2 regarding the operation and use of prescription drug monitoring
3 programs continue to empower health care-oriented technology
4 solutions to the opioid crisis.
5 SEC. 2. Section 11165 of the Health and Safety Code is
6 amended to read:
7 11165. (a) To assist health care practitioners in their efforts
8 to ensure appropriate prescribing, ordering, administering,
9 furnishing, and dispensing of controlled substances, law
10 enforcement and regulatory agencies in their efforts to control the
11 diversion and resultant abuse of Schedule II, Schedule III, and
12 Schedule IV controlled substances, and for statistical analysis,
13 education, and research, the Department of Justice shall, contingent
14 upon the availability of adequate funds in the CURES Fund,
15 maintain the Controlled Substance Utilization Review and
16 Evaluation System (CURES) for the electronic monitoring of, and
17 Internet access to information regarding, the prescribing and
18 dispensing of Schedule II, Schedule III, and Schedule IV controlled
19 substances by all practitioners authorized to prescribe, order,
20 administer, furnish, or dispense these controlled substances.
21 (b) The Department of Justice may seek and use grant funds to
22 pay the costs incurred by the operation and maintenance of
23 CURES. The department shall annually report to the Legislature
24 and make available to the public the amount and source of funds
25 it receives for support of CURES.
26 (c) (1) The operation of CURES shall comply with all
27 applicable federal and state privacy and security laws and
28 regulations.
29 (2) (A) CURES shall operate under existing provisions of law
30 to safeguard the privacy and confidentiality of patients. Data
31 obtained from CURES shall only be provided to appropriate state,
32 local, and federal public agencies for disciplinary, civil, or criminal
33 purposes and to other agencies or entities, as determined by the
34 Department of Justice, for the purpose of educating practitioners
35 and others in lieu of disciplinary, civil, or criminal actions. Data
36 may be provided to public or private entities, as approved by the
37 Department of Justice, for educational, peer review, statistical, or
38 research purposes, if patient information, including any information

1 that may identify the patient, is not compromised. Further, data
2 disclosed to any individual or agency as described in this
3 subdivision shall not be disclosed, sold, or transferred to any third
4 party, unless authorized by, or pursuant to, state and federal privacy
5 and security laws and regulations. The Department of Justice shall
6 establish policies, procedures, and regulations regarding the use,
7 access, evaluation, management, implementation, operation,
8 storage, disclosure, and security of the information within CURES,
9 consistent with this subdivision.
10 (B) Notwithstanding subparagraph (A), a regulatory board whose
11 licensees do not prescribe, order, administer, furnish, or dispense
12 controlled substances shall not be provided data obtained from
13 CURES.
14 (3) The Department of Justice shall, no later than July 1, 2020,
15 adopt regulations regarding the access and use of the information
16 within CURES. The Department of Justice shall consult with all
17 stakeholders identified by the department during the rulemaking
18 process. The regulations shall, at a minimum, address all of the
19 following in a manner consistent with this chapter:
20 (A) The process for approving, denying, and disapproving
21 individuals or entities seeking access to information in CURES.
22 (B) The purposes for which a health care practitioner may access
23 information in CURES.
24 (C) The conditions under which a warrant, subpoena, or court
25 order is required for a law enforcement agency to obtain
26 information from CURES as part of a criminal investigation.
27 (D) The process by which information in CURES may be
28 provided for educational, peer review, statistical, or research
29 purposes.
30 (4) In accordance with federal and state privacy laws and
31 regulations, a health care practitioner may provide a patient with
32 a copy of the patient's CURES patient activity report as long as
33 no additional CURES data are provided and keep a copy of the
34 report in the patient's medical record in compliance with
35 subdivision (d) of Section 11165.1.
36 (d) For each prescription for a Schedule II, Schedule III, or
37 Schedule IV controlled substance, as defined in the controlled
38 substances schedules in federal law and regulations, specifically
39 Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21
40 of the Code of Federal Regulations, the dispensing pharmacy,

1 clinic, or other dispenser shall report the following information to
2 the Department of Justice as soon as reasonably possible, but not
3 more than ~~seven days~~ *one working day* after the date a controlled
4 substance is dispensed, in a format specified by the Department
5 of Justice:
6 (1) Full name, address, and, if available, telephone number of
7 the ultimate user or research subject, or contact information as
8 determined by the Secretary of the United States Department of
9 Health and Human Services, and the gender, and date of birth of
10 the ultimate user.
11 (2) The prescriber's category of licensure, license number,
12 national provider identifier (NPI) number, the federal controlled
13 substance registration number, and the state medical license number
14 of any prescriber using the federal controlled substance registration
15 number of a government-exempt facility, if provided.
16 (3) Pharmacy prescription number, license number, NPI number,
17 and federal controlled substance registration number.
18 (4) National Drug Code (NDC) number of the controlled
19 substance dispensed.
20 (5) Quantity of the controlled substance dispensed.
21 (6) International Statistical Classification of Diseases, 9th
22 revision (ICD-9) or 10th revision (ICD-10) Code, if available.
23 (7) Number of refills ordered.
24 (8) Whether the drug was dispensed as a refill of a prescription
25 or as a first-time request.
26 (9) Date of origin of the prescription.
27 (10) Date of dispensing of the prescription.
28 (11) The serial number for the corresponding prescription form,
29 if applicable.
30 (e) The Department of Justice may invite stakeholders to assist,
31 advise, and make recommendations on the establishment of rules
32 and regulations necessary to ensure the proper administration and
33 enforcement of the CURES database. All prescriber and dispenser
34 invitees shall be licensed by one of the boards or committees
35 identified in subdivision (d) of Section 208 of the Business and
36 Professions Code, in active practice in California, and a regular
37 user of CURES.
38 (f) The Department of Justice shall, prior to upgrading CURES,
39 consult with prescribers licensed by one of the boards or
40 committees identified in subdivision (d) of Section 208 of the

1 Business and Professions Code, one or more of the boards or
2 committees identified in subdivision (d) of Section 208 of the
3 Business and Professions Code, and any other stakeholder
4 identified by the department, for the purpose of identifying
5 desirable capabilities and upgrades to the CURES Prescription
6 Drug Monitoring Program (PDMP).
7 (g) The Department of Justice may establish a process to educate
8 authorized subscribers of the CURES PDMP on how to access and
9 use the CURES PDMP.
10 (h) (1) The Department of Justice may enter into an agreement
11 with any entity operating an interstate data sharing hub, or any
12 agency operating a prescription drug monitoring program in another
13 state, for purposes of interstate data sharing of prescription drug
14 monitoring program information.
15 (2) Data obtained from CURES may be provided to authorized
16 users of another state's prescription drug monitoring program, as
17 determined by the Department of Justice pursuant to subdivision
18 (c), if the entity operating the interstate data sharing hub, and the
19 prescription drug monitoring program of that state, as applicable,
20 have entered into an agreement with the Department of Justice for
21 interstate data sharing of prescription drug monitoring program
22 information.
23 (3) Any agreement entered into by the Department of Justice
24 for purposes of interstate data sharing of prescription drug
25 monitoring program information shall ensure that all access to data
26 obtained from CURES and the handling of data contained within
27 CURES comply with California law, including regulations, and
28 meet the same patient privacy, audit, and data security standards
29 employed and required for direct access to CURES.
30 (4) For purposes of interstate data sharing of CURES
31 information pursuant to this subdivision, an authorized user of
32 another state's prescription drug monitoring program shall not be
33 required to register with CURES, if he or she is registered and in
34 good standing with that state's prescription drug monitoring
35 program.
36 (5) The Department of Justice shall not enter into an agreement
37 pursuant to this subdivision until the department has issued final
38 regulations regarding the access and use of the information within
39 CURES as required by paragraph (3) of subdivision (c).

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1 SEC. 3. This act is an urgency statute necessary for the
2 immediate preservation of the public peace, health, or safety within
3 the meaning of Article IV of the California Constitution and shall
4 go into immediate effect. The facts constituting the necessity are:
5 In order to address the active crisis of opioid overprescribing
6 and abuse through timely data, it is necessary that this bill go into
7 immediate effect.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 544
AUTHOR: Brough
BILL DATE: March 21, 2019, Amended
SUBJECT: Professions and Vocations: Inactive License Fees and Accrued and Unpaid Renewal Fees
SPONSOR: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would limit the maximum fee for the renewal of a license in inactive status to no more than 50% of the renewal fee for an active license. This bill would prohibit a board from requiring payment of accrued and unpaid renewal fees as a condition of reinstating an expired license or registration.

BACKGROUND:

A physician who wishes to retain a license while not actively practicing medicine in California may apply for an inactive license. A physician requesting inactive status is not required to comply with continuing medical education (CME) requirements. A physician who holds an inactive license may not practice medicine in California. Inactivating a license does not change the expiration date, and the renewal fee is the same as the fee for an active license. To restore an inactive license to active status, the physician must complete the required CME for a single renewal period, which is 50 hours of Category 1 CME.

A physician who applies for a retired license is exempt from payment of the renewal fees and the CME requirements. However, existing law requires physicians to pay a mandatory fee of $25.00 at the time of renewal of his or her license to the Physician Loan Repayment Program. The holder of a retired license may not engage in the practice of medicine. To receive a fee exemption, a physician must apply for the status change before the expiration date of the license. If the license is current, no fee is required.

If a physician's license is in a delinquent status, a payment of all accrued renewal fees, delinquent fee, the $25.00 mandatory fee, and penalty fee must be submitted with the application.

ANALYSIS:

According to the author, this bill would help reduce the barrier to workforce re-entry. Licensed professionals who decide to let their license lapse for a period of time to focus on raising children, dealing with personal or family illness, or other life events should not

be penalized to reactivate their license. Under current law, a board can accrue renewal fees as a requirement to reactivate a license. The author does not believe it is fair to require those individuals to pay several years of accrued renewal fees to reinstate the license and start working again.

The Board does not currently have a status for physicians that would allow them to pay a reduced licensing fee to hold their license if they decide to stop practicing for a period of time or if they move to another state, except for retired status. The Board currently charges the full renewal fee for inactive licenses. To provide a lower cost option for physicians who do not practice for a period of time or move to another state, it may be more reasonable to only charge a 50% renewal fee for inactive licenses. However, if a physician is delinquent on their renewal fees for years, they should be required to pay those fees before they can renew their license. To be more reasonable to physicians who are out of practice for a period of time, Board staff recommends that the Board take an oppose unless amended position on this bill. The amendments would be to keep the 50% renewal fee for inactive status licenses, but to delete the provisions that do not allow the Board to charge accrued fees for licenses that are delinquent. This will incentivize physicians to put their license in inactive status if they decide not to practice in California for a period of time

FISCAL:

This bill would result in a revenue loss of $261,000 per year for the Board. This is based on a loss of revenue from inactive license renewal fees (now we charge the full renewal fee) at an amount of $96,000 and loss of accrued delinquent fees at an amount of $165,000.

SUPPORT: None on File

OPPOSITION: Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
Veterinary Medical Board

POSITION: Recommendation: Oppose Unless Amended

AMENDED IN ASSEMBLY MARCH 21, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 544

Introduced by Assembly Member Brough

February 13, 2019

~~An act to amend Section 4073 of the Business and Professions Code, relating to healing arts.~~ *An act to amend Sections 121.5, 462, 703, 1006.5, 1718, 1718.3, 1936, 2427, 2456.3, 2535.2, 2538.54, 2646, 2734, 2892.1, 2984, 3147, 3147.7, 3524, 3774, 3775.5, 4545, 4843.5, 4901, 4966, 4989.36, 4999.104, 5070.6, 5600.2, 5680.1, 6796, 6980.28, 7076.5, 7417, 7672.8, 7725.2, 7729.1, 7881, 7883, 8024.7, 8802, 9832, 9832.5, 9884.5, 19170.5, and 19290 of the Business and Professions Code, relating to professions and vocations.*

LEGISLATIVE COUNSEL'S DIGEST

AB 544, as amended, Brough. ~~Prescriptions.~~ *Professions and vocations: inactive license fees and accrued and unpaid renewal fees.*

Existing law provides for the licensure and regulation of professions and vocations by various boards within the Department of Consumer Affairs. Existing law provides for the payment of a fee for the renewal of certain licenses, certificates, or permits in an inactive status, and, for certain licenses, certificates, and permits that have expired, requires the payment of all accrued fees as a condition of reinstatement of the license, certificate, or permit.

This bill would limit the maximum fee for the renewal of a license in an inactive status to no more than 50% of the renewal fee for an active license. The bill would also prohibit a board from requiring payment of accrued and unpaid renewal fees as a condition of reinstating an expired license or registration.

~~The Pharmacy Law provides for the licensure and regulation of pharmacists and pharmacies by the California State Board of Pharmacy, which is within the Department of Consumer Affairs, and authorizes a pharmacist filling a prescription order for a drug product prescribed by its brand or trade name to select another drug product with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name of those drug products having the same active chemical ingredients, as specified.~~

~~This bill would make a nonsubstantive change to that provision.~~

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

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

1 *SECTION 1. Section 121.5 of the Business and Professions*
2 *Code is amended to read:*
3 121.5. *(a)* Except as otherwise provided in this code, the
4 application of delinquency fees ~~or accrued and unpaid renewal~~
5 ~~fees~~ for the renewal of expired licenses or registrations shall not
6 apply to licenses or registrations that have lawfully been designated
7 as inactive or retired.
8 *(b) Notwithstanding any other law, a board shall not require a*
9 *person to pay accrued and unpaid renewal fees as a condition of*
10 *reinstating an expired license or registration.*
11 *SEC. 2. Section 462 of the Business and Professions Code is*
12 *amended to read:*
13 462. (a) Any of the boards, bureaus, commissions, or programs
14 within the department may establish, by regulation, a system for
15 an inactive category of licensure for persons who are not actively
16 engaged in the practice of their profession or vocation.
17 (b) The regulation shall contain the following provisions:
18 (1) The holder of an inactive license issued pursuant to this
19 section shall not engage in any activity for which a license is
20 required.
21 (2) An inactive license issued pursuant to this section shall be
22 renewed during the same time period in which an active license
23 is renewed. The holder of an inactive license need not comply with
24 any continuing education requirement for renewal of an active
25 license.

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(3) The renewal fee for a license in ~~an active status shall apply also for a renewal of a license in~~ an inactive ~~status, unless a lesser renewal fee is specified by the board.~~ *status shall be no more than 50 percent of the renewal fee for a license in an active status.*

(4) In order for the holder of an inactive license issued pursuant to this section to restore ~~his or her~~ *the* license to an active status, the holder of an inactive license shall comply with all the following:

(A) Pay the renewal fee.

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

(c) This section shall not apply to any healing arts board as specified in Section 701.

SEC. 3. Section 703 of the Business and Professions Code is amended to read:

703. (a) An inactive healing arts license or certificate issued pursuant to this article shall be renewed during the same time period at which an active license or certificate is renewed. In order to renew a license or certificate issued pursuant to this article, the holder thereof need not comply with any continuing education requirement for renewal of an active license or certificate.

(b) ~~The~~ *Notwithstanding any other law, the* renewal fee for a license or certificate in an ~~active~~ *inactive* status shall ~~apply also for renewal of a license or certificate in an inactive status, unless a lower fee has been established by the issuing board.~~ *be no more than 50 percent of the renewal fee for a license in an active status.*

SEC. 4. Section 1006.5 of the Business and Professions Code is amended to read:

1006.5. Notwithstanding any other law, the amount of regulatory fees necessary to carry out the responsibilities required by the Chiropractic Initiative Act and this chapter are fixed in the following schedule:

(a) Fee to apply for a license to practice chiropractic: three hundred seventy-one dollars ($371).

(b) Fee for initial license to practice chiropractic: one hundred eighty-six dollars ($186).

(c) Fee to renew an active ~~or inactive~~ license to practice chiropractic: three hundred thirteen dollars ($313).

1 *(d) Fee to renew an inactive license to practice chiropractic:*
2 *no more than 50 percent of the renewal fee for an active license.*
3 ~~(d)~~
4 *(e)* Fee to apply for approval as a continuing education provider:
5 eighty-four dollars ($84).
6 ~~(e)~~
7 *(f)* Biennial continuing education provider renewal fee: fifty-six
8 dollars ($56).
9 ~~(f)~~
10 *(g)* Fee to apply for approval of a continuing education course:
11 fifty-six dollars ($56) per course.
12 ~~(g)~~
13 *(h)* Fee to apply for a satellite office certificate: sixty-two dollars
14 ($62).
15 ~~(h)~~
16 *(i)* Fee to renew a satellite office certificate: thirty-one dollars
17 ($31).
18 ~~(i)~~
19 *(j)* Fee to apply for a license to practice chiropractic pursuant
20 to Section 9 of the Chiropractic Initiative Act: three hundred
21 seventy-one dollars ($371).
22 ~~(j)~~
23 *(k)* Fee to apply for a certificate of registration of a chiropractic
24 corporation: one hundred eighty-six dollars ($186).
25 ~~(k)~~
26 *(l)* Fee to renew a certificate of registration of a chiropractic
27 corporation: thirty-one dollars ($31).
28 ~~(*l*)~~
29 *(m)* Fee to file a chiropractic corporation special report:
30 thirty-one dollars ($31).
31 ~~(m)~~
32 *(n)* Fee to apply for approval as a referral service: five hundred
33 fifty-seven dollars ($557).
34 ~~(n)~~
35 *(o)* Fee for an endorsed verification of licensure: one hundred
36 twenty-four dollars ($124).
37 ~~(o)~~
38 *(p)* Fee for replacement of a lost or destroyed license: fifty
39 dollars ($50).
40 ~~(p)~~

1 *(q)* Fee for replacement of a satellite office certificate: fifty
2 dollars ($50).
3 ~~(q)~~
4 *(r)* Fee for replacement of a certificate of registration of a
5 chiropractic corporation: fifty dollars ($50).
6 ~~(r)~~
7 *(s)* Fee to restore a forfeited or canceled license to practice
8 chiropractic: double the annual renewal fee specified in subdivision
9 (c).
10 ~~(s)~~
11 *(t)* Fee to apply for approval to serve as a preceptor: thirty-one
12 dollars ($31).
13 ~~(t)~~
14 *(u)* Fee to petition for reinstatement of a revoked license: three
15 hundred seventy-one dollars ($371).
16 ~~(u)~~
17 *(v)* Fee to petition for early termination of probation: three
18 hundred seventy-one dollars ($371).
19 ~~(v)~~
20 *(w)* Fee to petition for reduction of penalty: three hundred
21 seventy-one dollars ($371).
22 *SEC. 5. Section 1718 of the Business and Professions Code is*
23 *amended to read:*
24 1718. Except as otherwise provided in this chapter, an expired
25 license may be renewed at any time within five years after its
26 expiration on filing of application for renewal on a form prescribed
27 by the board, and payment of ~~all accrued~~ *the* renewal and
28 delinquency fees. If the license is renewed more than 30 days after
29 its expiration, the licensee, as a condition precedent to renewal,
30 shall also pay the delinquency fee prescribed by this chapter.
31 Renewal under this section shall be effective on the date on which
32 the application is filed, on the date on which the renewal fee is
33 paid, or on the date on which the delinquency fee, if any, is paid,
34 whichever last occurs. If so renewed, the license shall continue in
35 effect through the expiration date provided in Section 1715 which
36 next occurs after the effective date of the renewal, when it shall
37 expire if it is not again renewed.
38 *SEC. 6. Section 1718.3 of the Business and Professions Code*
39 *is amended to read:*

1718.3. (a) A license which is not renewed within five years after its expiration may not be renewed, restored, reinstated, or reissued thereafter, but the holder of the license may apply for and obtain a new license if the following requirements are satisfied:

(1) No fact, circumstance, or condition exists which would justify denial of licensure under Section 480.

(2) ~~He or she~~ *The person* pays all of the fees which would be required ~~of him or her if he or she~~ *if the person* were ~~then~~ applying for the license for the first time and ~~all~~ *the* renewal and delinquency ~~fees which have accrued since the date on which he or she last renewed his or her license.~~ *fees.*

(3) ~~He or she~~ *The person* takes and passes the examination, if any, which would be required ~~of him or her if he or she~~ *if the person* were ~~then~~ applying for the license for the first time, or otherwise establishes to the satisfaction of the board that with due regard for the public interest, ~~he or she~~ *the person* is qualified to practice the profession or activity in which ~~he or she again~~ *the person* seeks to be licensed.

(b) The board may impose conditions on any license issued pursuant to this section, as it deems necessary.

(c) The board may by regulation provide for the waiver or refund of all or any part of the examination fee in those cases in which a license is issued without an examination under this section.

SEC. 7. Section 1936 of the Business and Professions Code is amended to read:

1936. Except as otherwise provided in this article, an expired license may be renewed at any time within five years after its expiration by filing an application for renewal on a form prescribed by the hygiene board and payment of ~~all accrued~~ *the* renewal and delinquency fees. If the license is renewed after its expiration, the licensee, as a condition precedent of renewal, shall also pay the delinquency fee prescribed by this article. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect until the expiration date provided in Section 1935 that next occurs after the effective date of the renewal.

SEC. 8. Section 2427 of the Business and Professions Code is amended to read:

2427. (a) Except as provided in Section 2429, a license which has expired may be renewed at any time within five years after its expiration on filing an application for renewal on a form prescribed by the licensing authority and payment of ~~all accrued~~ *the* renewal ~~fees~~ *fee* and any other fees required by Section 2424. If the license is not renewed within 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay the prescribed delinquency fee, if any. Except as provided in Section 2424, renewal under this section shall be effective on the date on which the renewal application is filed, on the date on which the renewal fee ~~or accrued renewal fees are~~ *is* paid, or on the date on which the delinquency fee or the delinquency fee and penalty fee, if any, are paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date set forth in Section 2422 or 2423 which next occurs after the effective date of the renewal, when it shall expire and become invalid if it is not again renewed.

(b) Notwithstanding subdivision (a), the license of a doctor of podiatric medicine which has expired may be renewed at any time within three years after its expiration on filing an application for renewal on a form prescribed by the licensing authority and payment of ~~all accrued~~ *the* renewal ~~fees~~ *fee* and any other fees required by Section 2424. If the license is not renewed within 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay the prescribed delinquency fee, if any. Except as provided in Section 2424, renewal under this section shall be effective on the date on which the renewal application is filed, on the date on which the renewal fee ~~or accrued renewal fees are~~ *is* paid, or on the date on which the delinquency fee or the delinquency fee and penalty fee, if any, are paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date set forth in Section 2422 or 2423 which next occurs after the effective date of the renewal, when it shall expire and become invalid if it is not again renewed.

SEC. 9. Section 2456.3 of the Business and Professions Code is amended to read:

2456.3. Except as provided in Section 2429, a license which has expired may be renewed at any time within five years after its expiration by filing an application for renewal on a form prescribed by the board and payment of ~~all accrued~~ *the* renewal ~~fees~~ *fee* and

any other fees required by Section 2455. Except as provided in Section 2456.2, renewal under this section shall be effective on the date on which the renewal application is filed, on the date on which the renewal fee ~~or accrued renewal fees are~~ *is* paid, or on the date on which the delinquency fee or the delinquency fee and penalty fee, if any, are paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date set forth in Section 2456.1 which next occurs after the effective date of the renewal.

SEC. 10. Section 2535.2 of the Business and Professions Code is amended to read:

2535.2. Except as provided in Section 2535.3, a license that has expired may be renewed at any time within five years after its expiration upon filing of an application for renewal on a form prescribed by the board and payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* If the license is not renewed on or before its expiration, the licensee, as a condition precedent to renewal, shall also pay the prescribed delinquency fee. Renewal under this section shall be effective on the date on which the application is filed, on the date on which ~~all~~ *the* renewal ~~fees are~~ *fee is* paid, or on the date on which the delinquency fee is paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date provided in Section 2535, after the effective date of the renewal, when it shall expire and become invalid if it is not again renewed.

SEC. 11. Section 2538.54 of the Business and Professions Code is amended to read:

2538.54. Except as otherwise provided in this article, an expired license may be renewed at any time within three years after its expiration on filing of an application for renewal on a form prescribed by the board, and payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* If the license is renewed after its expiration the licensee, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this article. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the date provided in Section 2538.53 which next

occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 12. Section 2646 of the Business and Professions Code is amended to read:

2646. A license that has expired may be renewed at any time within five years after its expiration by applying for renewal as set forth in Section 2644. Renewal under this section shall be effective on the date on which the renewal application is filed, on the date on which the renewal fee ~~or accrued renewal fees are~~ *is* paid, or on the date on which the delinquency fee and penalty fee, if any, are paid, whichever last occurs. A renewed license shall continue in effect through the expiration date set forth in Section 2644 that next occurs after the effective date of the renewal, at which time it shall expire and become invalid if it is not so renewed.

SEC. 13. Section 2734 of the Business and Professions Code is amended to read:

2734. Upon application in writing to the board and payment of ~~the~~ *a fee not to exceed 50 percent of the* biennial renewal fee, a licensee may have ~~his~~ *their* license placed in an inactive status for an indefinite period of time. A licensee whose license is in an inactive status may not practice nursing. However, such a licensee does not have to comply with the continuing education standards of Section 2811.5.

SEC. 14. Section 2892.1 of the Business and Professions Code is amended to read:

2892.1. Except as provided in Sections 2892.3 and 2892.5, an expired license may be renewed at any time within four years after its expiration upon filing of an application for renewal on a form prescribed by the board, payment of ~~all accrued and unpaid renewal fees,~~ *the renewal fee,* and payment of any fees due pursuant to Section 2895.1.

If the license is renewed more than 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which ~~all~~ *the* renewal ~~fees are~~ *fee is* paid, or on the date on which the delinquency fee is paid, whichever last occurs. If so renewed, the license shall continue in effect through the date provided in Section 2892 which next occurs after the

effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 15. Section 2984 of the Business and Professions Code is amended to read:

2984. Except as provided in Section 2985, a license that has expired may be renewed at any time within three years after its expiration on filing of an application for renewal on a form prescribed by the board and payment of ~~all accrued and unpaid~~ *the* renewal ~~fees.~~ *fee.* If the license is renewed after its expiration, the licensee, as a condition precedent to renewal, shall also pay the prescribed delinquency fee, if any. Renewal under this section shall be effective on the date on which the application is filed, on the date on which ~~all~~ *the* renewal ~~fees are~~ *fee is* paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date provided in Section 2982 which next occurs after the effective date of the renewal, when it shall expire and become invalid if it is not again renewed.

SEC. 16. Section 3147 of the Business and Professions Code is amended to read:

3147. (a) Except as otherwise provided by Section 114, an expired optometrist license may be renewed at any time within three years after its expiration, and a retired license issued for less than three years may be reactivated to active status, by filing an application for renewal or reactivation on a form prescribed by the board, paying ~~all accrued and unpaid~~ *the* renewal ~~fees~~ *fee* or reactivation ~~fees~~ *fee* determined by the board, paying any delinquency fees prescribed by the board, and submitting proof of completion of the required number of hours of continuing education for the last two years, as prescribed by the board pursuant to Section 3059. Renewal or reactivation to active status under this section shall be effective on the date on which all of those requirements are satisfied. If so renewed or reactivated to active status, the license shall continue as provided in Sections 3146 and 3147.5.

(b) Expired statements of licensure, branch office licenses, and fictitious name permits issued pursuant to Sections 3070, 3077, and 3078, respectively, may be renewed at any time by filing an application for renewal, paying ~~all accrued and unpaid renewal~~

~~fees,~~ *the renewal fee,* and paying any delinquency fees prescribed by the board.

SEC. 17. Section 3147.7 of the Business and Professions Code is amended to read:

3147.7. The provisions of Section 3147.6 shall not apply to a person holding a license that has not been renewed within three years of expiration, if the person provides satisfactory proof that ~~he or she~~ *the person* holds an active license from another state and meets all of the following conditions:

(a) Is not subject to denial of a license under Section 480.

(b) Applies in writing for restoration of the license on a form prescribed by the board.

(c) Pays ~~all accrued and unpaid~~ *the* renewal ~~fees~~ *fee* and any delinquency fees prescribed by the board.

(d) Submits proof of completion of the required number of hours of continuing education for the last two years.

(e) Takes and satisfactorily passes the board's jurisprudence examination.

SEC. 18. Section 3524 of the Business and Professions Code is amended to read:

3524. A license or approval that has expired may be renewed at any time within five years after its expiration by filing an application for renewal on a form prescribed by the board or Medical Board of California, as the case may be, and payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* If the license or approval is not renewed within 30 days after its expiration, the licensed physician assistant and approved supervising physician, as a condition precedent to renewal, shall also pay the prescribed delinquency fee, if any. Renewal under this section shall be effective on the date on which the application is filed, on the date on which ~~all~~ *the* renewal ~~fees are~~ *fee is* paid, or on the date on which the delinquency fee, if any, is paid, whichever occurs last. If so renewed, the license shall continue in effect through the expiration date provided in Section 3522 or 3523 which next occurs after the effective date of the renewal, when it shall expire, if it is not again renewed.

SEC. 19. Section 3774 of the Business and Professions Code is amended to read:

3774. On or before the birthday of a licensed practitioner in every other year, following the initial licensure, the board shall

mail to each practitioner licensed under this chapter, at the latest address furnished by the licensed practitioner to the executive officer of the board, a notice stating the amount of the renewal fee and the date on which it is due. The notice shall state that failure to pay the renewal fee on or before the due date and submit evidence of compliance with Sections 3719 and 3773 shall result in expiration of the license.

Each license not renewed in accordance with this section shall expire but may within a period of three years thereafter be reinstated upon payment of ~~all accrued and unpaid~~ *the* renewal ~~fees~~ and penalty fees required by this chapter. The board may also require submission of proof of the applicant's qualifications, except that during the three-year period no examination shall be required as a condition for the reinstatement of any expired license that has lapsed solely by reason of nonpayment of the renewal fee.

SEC. 20. Section 3775.5 of the Business and Professions Code is amended to read:

3775.5. The fee for an inactive license shall be ~~the same as~~ *no more than 50 percent of* the renewal fee *for an active license* for the practice of respiratory care as specified in Section 3775.

SEC. 21. Section 4545 of the Business and Professions Code is amended to read:

4545. Except as provided in Section 4545.2, a license that has expired may be renewed at any time within four years after its expiration on filing an application for renewal on a form prescribed by the board, payment of ~~all accrued and unpaid renewal fees,~~ *the renewal fee,* and payment of all fees required by this chapter. If the license is renewed more than 30 days after its expiration, the holder, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the date provided in Section 4544 which next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

A certificate which was forfeited for failure to renew under the law in effect before October 1, 1961, shall, for the purposes of this article, be considered to have expired on the date that it became forfeited.

SEC. 22. Section 4843.5 of the Business and Professions Code is amended to read:

4843.5. Except as otherwise provided in this article, an expired certificate of registration may be renewed at any time within five years after its expiration on filing of an application for renewal on a form prescribed by the board, and payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* If the certificate of registration is renewed more than 30 days after its expiration, the registrant, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this article. Renewal under this section shall be effective on the date on which the application is filed, on the date ~~all~~ *the* renewal ~~fees are~~ *fee is* paid, or on the date on which the delinquency fee, if any, is paid, whichever occurs last.

SEC. 23. Section 4901 of the Business and Professions Code is amended to read:

4901. Except as otherwise provided in this chapter, an expired license or registration may be renewed at any time within five years after its expiration on filing of an application for renewal on a form prescribed by the board, and payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* If the license or registration is renewed more than 30 days after its expiration, the licensee or registrant, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which ~~all renewal fees are~~ *the renewal fee is* paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license or registration shall continue in effect through the expiration date provided in Section 4900 that next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 24. Section 4966 of the Business and Professions Code is amended to read:

4966. Except as provided in Section 4969, a license that has expired may be renewed at any time within three years after its expiration by filing of an application for renewal on a form provided by the board, paying ~~all accrued and unpaid renewal fees,~~ *the renewal fee,* and providing proof of completing continuing education requirements. If the license is not renewed prior to its expiration, the acupuncturist, as a condition precedent to renewal,

1 shall also pay the prescribed delinquency fee. Renewal under this
2 section shall be effective on the date on which the application is
3 filed, on the date on which the renewal fee is paid, or on the date
4 the delinquency fee is paid, whichever occurs last. If so renewed,
5 the license shall continue in effect through the expiration date
6 provided in Section 4965, after the effective date of the renewal,
7 when it shall expire and become invalid if it is not again renewed.
8 *SEC. 25. Section 4989.36 of the Business and Professions Code*
9 *is amended to read:*
10 4989.36. A licensee may renew a license that has expired at
11 any time within three years after its expiration date by taking all
12 of the actions described in Section 4989.32 and by paying ~~all~~
13 ~~unpaid prior renewal fees and delinquency fees.~~ *the delinquency*
14 *fee.*
15 *SEC. 26. Section 4999.104 of the Business and Professions*
16 *Code is amended to read:*
17 4999.104. Licenses issued under this chapter that have expired
18 may be renewed at any time within three years of expiration. To
19 renew an expired license described in this section, the licensee
20 shall do all of the following:
21 (a) File an application for renewal on a form prescribed by the
22 board.
23 ~~(b) Pay all fees that would have been paid if the license had not~~
24 ~~become delinquent.~~
25 ~~(c)~~
26 *(b)* Pay ~~all~~ *the* delinquency ~~fees.~~ *fee.*
27 ~~(d)~~
28 *(c)* Certify compliance with the continuing education
29 requirements set forth in Section 4999.76.
30 ~~(e)~~
31 *(d)* Notify the board whether ~~he or she~~ *the licensee* has been
32 convicted, as defined in Section 490, of a misdemeanor or felony,
33 or whether any disciplinary action has been taken by any regulatory
34 or licensing board in this or any other state, subsequent to the
35 licensee's last renewal.
36 *SEC. 27. Section 5070.6 of the Business and Professions Code*
37 *is amended to read:*
38 5070.6. Except as otherwise provided in this chapter, an expired
39 permit may be renewed at any time within five years after its
40 expiration upon the filing of an application for renewal on a form

prescribed by the board, payment of ~~all accrued and unpaid renewal fees~~ *the renewal fee,* and providing evidence satisfactory to the board of compliance as required by Section 5070.5. If the permit is renewed after its expiration, its holder, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the ~~accrued~~ renewal ~~fees are~~ *fee is* paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the permit shall continue in effect through the date provided in Section 5070.5 that next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 28. Section 5600.2 of the Business and Professions Code is amended to read:

5600.2. Except as otherwise provided in this chapter, a license which has expired may be renewed at any time within five years after its expiration on filing of application for renewal on a form prescribed by the board, and payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* If a license is renewed more than 30 days after its expiration, the licenseholder, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the expiration date provided in this chapter which next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 29. Section 5680.1 of the Business and Professions Code is amended to read:

5680.1. Except as otherwise provided in this chapter, a license that has expired may be renewed at any time within five years after its expiration on filing of an application for renewal on a form prescribed by the board, and payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* If the license is renewed more than 30 days after its expiration, the licenseholder, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which ~~all~~ *the* renewal ~~fees are~~ *fee is* paid, or on the date on which the

delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the date provided in Section 5680 that next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 30. Section 6796 of the Business and Professions Code is amended to read:

6796. Except as otherwise provided in this article, certificates of registration as a professional engineer and certificates of authority may be renewed at any time within five years after expiration on filing of application for renewal on a form prescribed by the board and payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* If the certificate is renewed more than 60 days after its expiration, the certificate holder, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs.

The expiration date of a certificate renewed pursuant to this section shall be determined pursuant to Section 6795.

SEC. 31. Section 6980.28 of the Business and Professions Code is amended to read:

6980.28. A locksmith license not renewed within three years following its expiration may not be renewed thereafter. Renewal of the license within three years, or issuance of an original license thereafter, shall be subject to payment of any ~~and all fines~~ *fine* assessed by the chief or the director ~~which are~~ *that is* not pending appeal and all other applicable fees.

SEC. 32. Section 7076.5 of the Business and Professions Code is amended to read:

7076.5. (a) A contractor may inactivate ~~his or her~~ *their* license by submitting a form prescribed by the registrar accompanied by the current active license certificate. When the current license certificate has been lost, the licensee shall pay the fee prescribed by law to replace the license certificate. Upon receipt of an acceptable application to inactivate, the registrar shall issue an inactive license certificate to the contractor. The holder of an inactive license shall not be entitled to practice as a contractor until ~~his or her~~ *their* license is reactivated.

(b) Any licensed contractor who is not engaged in work or activities which require a contractor’s license may apply for an inactive license.

(c) Inactive licenses shall be valid for a period of four years from their due date.

(d) During the period that an existing license is inactive, no bonding requirement pursuant to Section 7071.6, 7071.8 or 7071.9 or qualifier requirement pursuant to Section 7068 shall apply. An applicant for license having met the qualifications for issuance may request that the license be issued inactive unless the applicant is subject to the provisions of Section 7071.8.

(e) The board shall not refund any of the renewal fee which a licensee may have paid prior to the inactivation of ~~his or her~~ *the* license.

(f) An inactive license shall be renewed on each established renewal date by submitting the renewal application and paying the inactive renewal fee.

(g) An inactive license may be reactivated by submitting an application acceptable to the registrar, by paying ~~the full~~ *a fee no more than 50 percent of the* renewal fee for an active ~~license~~ *license,* and by fulfilling all other requirements of this chapter. No examination shall be required to reactivate an inactive license.

(h) The inactive status of a license shall not bar any disciplinary action by the board against a licensee for any of the causes stated in this chapter.

SEC. 33. Section 7417 of the Business and Professions Code is amended to read:

7417. Except as otherwise provided in this article, a license that has expired for failure of the licensee to renew within the time fixed by this article may be renewed at any time within five years following its expiration upon application and payment of ~~all accrued and unpaid~~ *the* renewal ~~fees~~ and delinquency fees. If the license is renewed after its expiration, the licensee, as a condition precedent to renewal, shall also pay the delinquency fee and meet current continuing education requirements, if applicable, prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, or on the date on which the ~~accrued~~ renewal ~~fees are~~ *fee is* paid, or on the date on which the delinquency fee, if any, is paid, whichever occurs last. If so renewed, the license shall continue in effect through the expiration

date provided in this article which next occurs following the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 34. Section 7672.8 of the Business and Professions Code is amended to read:

7672.8. All cremated remains disposer registrations shall expire at midnight on September 30 of each year. A person desiring to renew ~~his or her~~ *their* registration shall file an application for renewal on a form prescribed by the bureau accompanied by the required fee. A registration that has expired may be renewed within five years of its expiration upon payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* The bureau shall not renew the registration of any person who has not filed the required annual report until ~~he or she~~ *the person* has filed a complete annual report with the department.

SEC. 35. Section 7725.2 of the Business and Professions Code is amended to read:

7725.2. Except as otherwise provided in this chapter, a license that has expired may be renewed at any time within five years after its expiration on filing of an application for renewal on a form prescribed by the bureau and payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* If the license is not renewed within 30 days after its expiration the licensee, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which ~~all~~ *the* renewal ~~fees are~~ *fee is* paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the date provided in Section 7725 that next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

If a license is not renewed within one year following its expiration, the bureau may require as a condition of renewal that the holder of the license pass an examination on the appropriate subjects provided by this chapter.

SEC. 36. Section 7729.1 of the Business and Professions Code is amended to read:

7729.1. The amount of fees prescribed for a license or certificate of authority under this act is that fixed by the following provisions of this article. Any license or certificate of authority

1 provided under this act that has expired may be renewed within
2 five years of its expiration upon payment of ~~all accrued and unpaid~~
3 ~~renewal and regulatory fees.~~ *the renewal fee.*
4 *SEC. 37. Section 7881 of the Business and Professions Code*
5 *is amended to read:*
6 7881. Except as otherwise provided in this article, certificates
7 of registration as a geologist or as a geophysicist, or certified
8 specialty certificates, may be renewed at any time within five years
9 after expiration on filing an application for renewal on a form
10 prescribed by the board and payment of ~~all accrued and unpaid~~
11 ~~renewal fees.~~ *the renewal fee.* If the certificate is renewed more
12 than 30 days after its expiration, the certificate holder, as a
13 condition precedent to renewal, shall also pay the delinquency fee
14 prescribed by this chapter. Renewal under this section shall be
15 effective on the date on which the application is filed, on the date
16 on which ~~all~~ *the* renewal ~~fees are~~ *fee is* paid, or on the date on
17 which the delinquency fee, if any, is paid, whichever last occurs.
18 If so renewed, the certificate shall continue in effect through the
19 date provided in Section 7880 that next occurs after the effective
20 date of the renewal, when it shall expire if it is not again renewed.
21 *SEC. 38. Section 7883 of the Business and Professions Code*
22 *is amended to read:*
23 7883. A revoked certificate is subject to expiration as provided
24 in this article, but it may not be renewed. If it is reinstated after its
25 expiration, the holder of the certificate, as a condition precedent
26 to its reinstatement, shall pay a reinstatement fee in an amount
27 equal to the renewal fee in effect on the last regular date before
28 the date on which it is ~~reinstated, plus all accrued and unpaid~~
29 ~~renewal fees~~ *reinstated* and the delinquency fee, if any, accrued
30 at the time of its revocation.
31 *SEC. 39. Section 8024.7 of the Business and Professions Code*
32 *is amended to read:*
33 8024.7. The board shall establish an inactive category of
34 licensure for persons who are not actively engaged in the practice
35 of shorthand reporting.
36 (a) The holder of an inactive license issued pursuant to this
37 section shall not engage in any activity for which a license is
38 required.
39 (b) An inactive license issued pursuant to this section shall be
40 renewed during the same time period in which an active license

is renewed. The holder of an inactive license is exempt from any continuing education requirement for renewal of an active license.

(c) The renewal fee for a license in an active status shall ~~apply also for a renewal of a license in an inactive status, unless a lesser renewal fee is specified by the board.~~ *be no more than 50 percent of the renewal fee for a license in an active status.*

(d) In order for the holder of an inactive license issued pursuant to this section to restore ~~his or her~~ *their* license to an active status, the holder of an inactive license shall comply with both of the following:

(1) Pay the renewal fee.

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

SEC. 40. Section 8802 of the Business and Professions Code is amended to read:

8802. Except as otherwise provided in this article, licenses issued under this chapter may be renewed at any time within five years after expiration on filing of application for renewal on a form prescribed by the board and payment of ~~all accrued and unpaid renewal fees.~~ *the renewal fee.* If the license is renewed more than 30 days after its expiration, the licensee, as a condition precedent to renewal, shall also pay the delinquency fee prescribed by this chapter. Renewal under this section shall be effective on the date on which the application is filed, on the date on which the renewal fee is paid, or on the date on which the delinquency fee, if any, is paid, whichever last occurs. If so renewed, the license shall continue in effect through the date provided in Section 8801 which next occurs after the effective date of the renewal, when it shall expire if it is not again renewed.

SEC. 41. Section 9832 of the Business and Professions Code is amended to read:

9832. (a) Registrations issued under this chapter shall expire no more than 12 months after the issue date. The expiration date of registrations shall be set by the director in a manner to best distribute renewal procedures throughout the year.

(b) To renew an unexpired registration, the service dealer shall, on or before the expiration date of the registration, apply for

renewal on a form prescribed by the director, and pay the renewal fee prescribed by this chapter.

(c) To renew an expired registration, the service dealer shall apply for renewal on a form prescribed by the director, pay the renewal fee in effect on the last regular renewal date, and pay ~~all accrued and unpaid~~ *the* delinquency ~~and renewal fees.~~ *fee.*

(d) Renewal is effective on the date that the application is ~~filed,~~ *filed and* the renewal ~~fee is paid,~~ and ~~all~~ delinquency fees are paid.

(e) For purposes of implementing the distribution of the renewal of registrations throughout the year, the director may extend by not more than six months, the date fixed by law for renewal of a registration, except that in that event any renewal fee that may be involved shall be prorated in a manner that no person shall be required to pay a greater or lesser fee than would have been required had the change in renewal dates not occurred.

SEC. 42. Section 9832.5 of the Business and Professions Code is amended to read:

9832.5. (a) Registrations issued under this chapter shall expire no more than 12 months after the issue date. The expiration date of registrations shall be set by the director in a manner to best distribute renewal procedures throughout the year.

(b) To renew an unexpired registration, the service contractor shall, on or before the expiration date of the registration, apply for renewal on a form prescribed by the director, and pay the renewal fee prescribed by this chapter.

(c) To renew an expired registration, the service contractor shall apply for renewal on a form prescribed by the director, pay the renewal fee in effect on the last regular renewal date, and pay ~~all accrued and unpaid~~ *the* delinquency and renewal fees.

(d) Renewal is effective on the date that the application is ~~filed,~~ *filed and* the renewal ~~fee is paid,~~ and ~~all~~ delinquency fees are paid.

(e) For purposes of implementing the distribution of the renewal of registrations throughout the year, the director may extend, by not more than six months, the date fixed by law for renewal of a registration, except that, in that event, any renewal fee that may be involved shall be prorated in such a manner that no person shall be required to pay a greater or lesser fee than would have been required had the change in renewal dates not occurred.

(f) This section shall remain in effect only until January 1, 2023, and as of that date is repealed.

SEC. 43. Section 9884.5 of the Business and Professions Code is amended to read:

9884.5. A registration that is not renewed within three years following its expiration shall not be renewed, restored, or reinstated thereafter, and the delinquent registration shall be canceled immediately upon expiration of the three-year period.

An automotive repair dealer whose registration has been canceled by operation of this section shall obtain a new registration only if ~~he or she~~ *the automotive repair dealer* again meets the requirements set forth in this chapter relating to registration, is not subject to denial under Section 480, and pays the applicable fees.

An expired registration may be renewed at any time within three years after its expiration upon the filing of an application for renewal on a form prescribed by the bureau and the payment of ~~all accrued~~ *the* renewal and delinquency fees. Renewal under this section shall be effective on the date on which the application is filed and ~~all~~ *the* renewal and delinquency fees are paid. If so renewed, the registration shall continue in effect through the expiration date of the current registration year as provided in Section 9884.3, at which time the registration shall be subject to renewal.

SEC. 44. Section 19170.5 of the Business and Professions Code is amended to read:

19170.5. (a) Except as provided in Section 19170.3, licenses issued under this chapter expire two years from the date of issuance. To renew ~~his or her~~ *a* license, a licensee shall, on or before the date on which it would otherwise expire, apply for renewal on a form prescribed by the chief, and pay the fees prescribed by Sections 19170 and 19213.1. If a licensee fails to renew ~~his or her~~ *their* license before its expiration, a delinquency fee of 20 percent, but not more than one hundred dollars ($100), notwithstanding the provisions of Section 163.5, shall be added to the renewal fee. If the renewal fee and delinquency fee are not paid within 90 days after expiration of a license, the licensee shall be assessed an additional penalty fee of 30 percent of the renewal fee.

(b) Except as otherwise provided in this chapter, a licensee may renew an expired license within six years after expiration of the license by filing an application for renewal on a form prescribed

1 by the bureau, and paying ~~all accrued renewal, delinquent,~~ *the*
2 *renewal, delinquency,* and penalty fees.
3 (c) A license that is not renewed within six years of its expiration
4 shall not be renewed, restored, reinstated, or reissued, but the holder
5 of the license may apply for and obtain a new license if both of
6 the following requirements are satisfied:
7 (1) No fact, circumstance, or condition exists which would
8 justify denial of licensure under Section 480.
9 (2) The licensee pays ~~all~~ *the* renewal, delinquency, and penalty
10 ~~fees that have accrued since the date on which the license was last~~
11 ~~renewed.~~ *fees.*
12 (d) The bureau may impose conditions on any license issued
13 pursuant to subdivision (c).
14 *SEC. 45. Section 19290 of the Business and Professions Code*
15 *is amended to read:*
16 19290. (a) Permits issued under this chapter expire two years
17 from the date of issuance. To renew a permit, a permittee shall,
18 on or before the date on which it would otherwise expire, apply
19 for renewal on a form prescribed by the chief, and continue to pay
20 the fees prescribed in Sections 19288 and 19288.1. Notwithstanding
21 Section 163.5, if a permittee fails to renew the permit before its
22 expiration, a delinquency fee of 20 percent of the most recent fee
23 paid to the bureau pursuant to Sections 19288 and 19288.1 shall
24 be added to the amount due to the bureau at the next fee interval.
25 If the renewal fee and delinquency fee are not paid within 90 days
26 after expiration of a permit, the permittee shall be assessed an
27 additional fee of 30 percent of the most recent fee paid to the
28 bureau pursuant to Sections 19288 and 19288.1.
29 (b) Except as otherwise provided in this chapter, a permittee
30 may renew an expired permit within two years after expiration of
31 the permit by filing an application for renewal on a form prescribed
32 by the bureau, and paying all ~~accrued~~ fees.
33 (c) A permit that is not renewed within two years of its
34 expiration shall not be renewed, restored, reinstated, or reissued,
35 but the holder of the expired permit may apply for and obtain a
36 new permit as provided in this chapter, upon payment of all fees
37 that accrued since the date the permit was last renewed.
38 (d) The bureau may impose conditions on any permit issued
39 pursuant to subdivision (c).

~~SECTION 1. Section 4073 of the Business and Professions Code is amended to read:~~

~~4073. (a) A pharmacist filling a prescription order for a drug product prescribed by its trade or brand name may select another drug product with the same active chemical ingredients of the same strength, quantity, and dosage form, and of the same generic drug name as determined by the United States Adopted Names (USAN) and accepted by the federal Food and Drug Administration (FDA), of those drug products having the same active chemical ingredients.~~

~~(b) In no case shall a selection be made pursuant to this section if the prescriber personally indicates, either orally or in the prescriber's own handwriting, "Do not substitute," or words of similar meaning. Nothing in this subdivision shall prohibit a prescriber from checking a box on a prescription marked "Do not substitute"; provided that the prescriber personally initials the box or checkmark. To indicate that a selection shall not be made pursuant to this section for an electronic data transmission prescription as defined in subdivision (c) of Section 4040, a prescriber may indicate "Do not substitute," or words of similar meaning, in the prescription as transmitted by electronic data, or may check a box marked on the prescription "Do not substitute." In either instance, it shall not be required that the prohibition on substitution be manually initialed by the prescriber.~~

~~(c) Selection pursuant to this section is within the discretion of the pharmacist, except as provided in subdivision (b). The person who selects the drug product to be dispensed pursuant to this section shall assume the same responsibility for selecting the dispensed drug product as would be incurred in filling a prescription for a drug product prescribed by generic name. There shall be no liability on the prescriber for an act or omission by a pharmacist in selecting, preparing, or dispensing a drug product pursuant to this section. In no case shall the pharmacist select a drug product pursuant to this section unless the drug product selected costs the patient less than the prescribed drug product. Cost, as used in this subdivision, is defined to include any professional fee that may be charged by the pharmacist.~~

~~(d) This section shall apply to all prescriptions, including those presented by or on behalf of persons receiving assistance from the federal government or pursuant to the California Medical Assistance Program set forth in Chapter 7 (commencing with~~

~~Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.~~

~~(e) When a substitution is made pursuant to this section, the use of the cost-saving drug product dispensed shall be communicated to the patient and the name of the dispensed drug product shall be indicated on the prescription label, except where the prescriber orders otherwise.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 613
AUTHOR: Low
BILL DATE: February 14, 2019, Introduced
SUBJECT: Professions and Vocations: Regulatory Fees
SPONSOR: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize boards under the Department of Consumer Affairs (DCA) to raise their licensing fees once every four years by an amount not to exceed the increase in the California Consumer Price Index (CPI) for the preceding four years, with specified limitations.

BACKGROUND:

Approximately three dozen regulatory boards and bureaus are under the jurisdiction of DCA and each of these boards is funded through the collection of fees from licensees. The dollar amount charged by a board to a licensee or license applicant is either expressly set in statute or contained in regulations, which may be statutorily capped or limited to within a certain range. Because boards receive no General Fund support, insufficient revenue derived from fees typically means that a board's programs and operations can no longer be sustained and the only solution is to pursue a fee increase.

For fees set in statute, a fee increase requires legislation and for fees contained in regulations, adjustments must be made through the regulatory process, which can take a year or more to complete. During the Legislature's sunset review process, boards report on their fund conditions and whether they are maintaining a healthy reserve. If it is revealed that boards have not appropriately sought needed fee increases, the Legislature is prompted to take action to ensure increases occur. When boards do pursue fee increases, it is common that fees will go up substantially.

For the Medical Board of California (Board), the last statutorily mandated fee increase for physician licensees was passed in 2005 and took effect in 2006, it went from $610 to $790. The last significant statutorily mandated fee increase before 2005 was 1993 and it increased the initial and biennial license renewal fee for physician licensees from $500 to $600. In 2002, legislation was passed to increase the fee for physician licensees from $600 to $610. The Board will need to pursue another fee increase in 2020 to keep the fund solvent with the statutorily mandated reserve of two to four months.

CPI is often used to adjust payments and provide cost-of-living wage adjustments to workers. The CPI is also used by other licensing entities not under the DCA to adjust

their fees administratively in a way that simply corresponds with changes in the value of a dollar.

ANALYSIS:

This bill would authorize boards under DCA to increase any fee by an amount not to exceed the increase in the CPI for the preceding four years, in accordance with the following: the board must provide its calculations and proposed fee, rounded to the nearest whole dollar, to the Director of DCA, and the Director must approve the fee increase unless any of the following apply:

- The board has unencumbered funds in an amount that is equal to more than the board's operating budget for the next two fiscal years.
- The fee would exceed the reasonable regulatory costs to the board in administering provisions for which the fee is authorized.
- The DCA Director determines that the fee increase would be injurious to the public health, safety, or welfare.

This bill would specify that the adjustment of fees and the publication of the adjusted fee is not subject to the regulatory process. This bill would define fee to include any fees authorized to be imposed by a board for regulatory costs. This bill would specify that a fee does not include administrative fines, civil penalties, or criminal penalties.

According to the author, a board looking to increase its fees under the current process must either seek legislation or go through the regulatory process. Because both of these processes are cumbersome, the habit of many boards is to delay addressing revenue shortfalls until their special funds are no longer healthy enough to support ongoing operations. By then, the proposed fee adjustment is significant. This bill would allow for a regulatory board to adjust its fees administratively, allowing boards to make modest, regularly scheduled changes to what they charge licensees. The impact of changes in fees would be less significant for licensees, and the effects of inflation will cease to be a factor in future deficiencies in boards' special funds.

This bill would provide a tool for the Board to use in the future to prevent significant fee increases for licensees and allow the Board's fund to stay solvent. However, this bill does not prevent the Board from pursuing a larger fee increase through statute, if needed. As such, Board staff is recommending that the Board support this bill.

FISCAL: This bill will potentially provide increased resources for the Board.

SUPPORT: California Board of Accountancy
California Pharmacists Association

OPPOSITION: California Orthopaedic Association

POSITION: Recommendation: Support

ASSEMBLY BILL No. 613

Introduced by Assembly Member Low

February 14, 2019

An act to add Section 101.1 to the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

legislative counsel's digest

AB 613, as introduced, Low. Professions and vocations: regulatory fees.

Exiting law establishes the Department of Consumer Affairs, which is comprised of boards that are established for the purpose of regulating various professions and vocations, and generally authorizes a board to charge fees for the reasonable regulatory cost of administering the regulatory program for the profession or vocation. Existing law establishes the Professions and Vocations Fund in the State Treasury, which consists of specified special funds and accounts, some of which are continuously appropriated.

This bill would authorize each board within the department to increase every 4 years any fee authorized to be imposed by that board by an amount not to exceed the increase in the California Consumer Price Index for the preceding 4 years, subject to specified conditions. The bill would require the Director of Consumer Affairs to approve any fee increase proposed by a board except under specified circumstances. By authorizing an increase in the amount of fees deposited into a continuously appropriated fund, this bill would make an appropriation.

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

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB613

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

1 SECTION 1. Section 101.1 is added to the Business and
2 Professions Code, to read:
3 101.1. (a) Notwithstanding any other law, no more than once
4 every four years, any board listed in Section 101 may increase any
5 fee authorized to be imposed by that board by an amount not to
6 exceed the increase in the California Consumer Price Index, as
7 determined pursuant to Section 2212 of the Revenue and Taxation
8 Code, for the preceding four years in accordance with the
9 following:
10 (1) The board shall provide its calculations and proposed fee,
11 rounded to the nearest whole dollar, to the director and the director
12 shall approve the fee increase unless any of the following apply:
13 (A) The board has unencumbered funds in an amount that is
14 equal to more than the board's operating budget for the next two
15 fiscal years.
16 (B) The fee would exceed the reasonable regulatory costs to the
17 board in administering the provisions for which the fee is
18 authorized.
19 (C) The director determines that the fee increase would be
20 injurious to the public health, safety, or welfare.
21 (2) The adjustment of fees and publication of the adjusted fee
22 list is not subject to the Administrative Procedure Act (Chapter
23 3.5 (commencing with Section 11340) of Part 1 of Division 3 of
24 Title 2) of the Government Code.
25 (b) For purposes of this section, "fee" includes any fees
26 authorized to be imposed by a board for regulatory costs. "Fee"
27 does not include administrative fines, civil penalties, or criminal
28 penalties.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 714
AUTHOR: Wood
BILL DATE: April 4, 2019, Amended
SUBJECT: Opioid Prescription Drugs: Prescribers
SPONSOR: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill clarifies existing law that requires prescribers to offer a prescription for naloxone and provide education to a patient to specify that the requirements only apply when an opioid or benzodiazepine is prescribed and expressly exempts patients in inpatient facilities and hospice care.

BACKGROUND:

According to the Centers for Disease Control and Prevention, drug overdose deaths continue to increase in the United States. Drug overdose deaths continue to increase in the United States. From 1999 to 2017, more than 700,000 people have died from a drug overdose. Around 68% of the more than 70,200 drug overdose deaths in 2017 involved an opioid. In 2017, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 6 times higher than in 1999. On average, 130 Americans die every day from an opioid overdose.

According to the author, this bill is a "clarifying" bill for AB 2760 (Wood, Chapter 324, Statutes of 2018). AB 2760 requires a prescriber to offer a prescription for naloxone or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of opioid depression, when: the prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day; or an opioid medication is prescribed concurrently with a prescription for a benzodiazepine; or the patient presents with an increased risk for overdose, including a patient history of overdose, a patient with a history of substance use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant. This bill also requires a prescriber, consistent with the existing standard of care, to provide education to a patient, or the patient's parent or guardian, or designee, on overdose prevention and the use of naloxone or other similar drug approved by the FDA.

Since the passage of AB 2760, the Board has received many calls from stakeholders raising questions regarding when a requirement to offer naloxone is required, specifically around the co-prescribing of a benzodiazepine and the increased risk for overdose, as the bill did not specify if it was related to opioid overdose. Concerns were also raised regarding inpatient facilities and hospice care, as no exemption was

included in AB 2760. The Board put together frequently asked questions and worked with the author's office to alert them of areas of concern in implementing AB 2760.

ANALYSIS:

This bill would define the term "administer" for purposes of this section of law to mean the direct application of a drug or device to the body of a patient by injection, inhalation, ingestion, or other means. This bill would define the term "order" for purposes of this section of law to mean an order entered on the chart or medical record of a patient registered in an inpatient health facility by or on the order of a prescriber.

This bill would clarify the existing requirement for a prescriber to offer naloxone or other FDA approved drug for the complete or partial reversal of opioid-induced respiratory depression is only required when the prescriber is prescribing an opioid or benzodiazepine medication and one or more of the specified at-risk conditions are present. This bill would clarify that a concurrent prescription of an opioid medication and benzodiazepine means that the benzodiazepine medication was dispensed to the patient within the last year. This bill would clarify that the condition related to increased risk for overdose is related to an opioid overdose, not any kind of substance use overdose. This bill would clarify that the requirement to provide education on opioid prevention and the use of naloxone is required when a prescriber is prescribing an opioid or benzodiazepine medication. This bill would provide that a prescriber need not provide the education if the patient declines the education or has received the education within the past 24 months.

This bill would exempt prescribers from the requirements in AB 2760 when ordering medications to be administered to a patient while the patient is in an inpatient or outpatient setting and when prescribing medications to a terminally ill patient as defined in subdivision (c) of Section 11159.2 of the Health and Safety Code.

This bill includes an urgency clause and would take effect immediately upon signature.

This bill is needed to clarify the law that was enacted pursuant to AB 2760. The Board received many calls from stakeholders with implementation concerns. This bill addresses those concerns and will provide clarity, which will help the Board enforce these requirements. Board staff recommends that the Board support this bill.

FISCAL: None

SUPPORT: California Association for Health Services at Home; California Dental Association; California Hospital Association; California Pharmacists Association; and Providence St. Joseph

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 4, 2019

AMENDED IN ASSEMBLY MARCH 19, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 714

Introduced by Assembly Member Wood

February 19, 2019

An act to amend Sections 740 and 741 of the Business and Professions Code, relating to healing arts, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 714, as amended, Wood. Opioid prescription drugs: prescribers.

Existing law requires a prescriber, as defined, to offer to a patient a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid depression when certain conditions are present, including if the patient presents with an increased risk for overdose or a history of substance use disorder, and to provide education on overdose prevention to patients receiving a prescription and specified other persons.

This bill would make those provisions applicable only to a patient receiving a prescription for an opioid or benzodiazepine medication, and would make the provisions specific to opioid-induced respiratory depression, opioid overdose, opioid use disorder, and opioid overdose prevention, as specified. The ~~bill~~ *bill, among other exclusions,* would exclude from the above-specified provisions requiring prescribers to offer a prescription and provide education prescribers when ~~prescribing, ordering, or administering~~ *ordering* medications to *be administered to*

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a patient in an inpatient ~~health facility and prescribers prescribing to a patient in outpatient-based hospice care.~~ *or outpatient setting.* The bill would define terms for purposes of those provisions.

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. Section 740 of the Business and Professions Code is amended to read:

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

(a) “Administer” means the direct application of a drug or device to the body of a patient by injection, inhalation, ingestion, or other means.

~~(b) “Hospice care” means a specialized form of multidisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and to provide supportive care for the primary caregiver and the family of the hospice patient and shall include both inpatient and outpatient care.~~

~~(c)~~

(b) “Order” means an order entered on the chart or medical record of a patient registered in an inpatient health facility by or on the order of a prescriber.

~~(d)~~

(c) “Prescriber” means a person licensed, certified, registered, or otherwise subject to regulation pursuant to this division, or an initiative act referred to in this division, who is authorized to prescribe prescription drugs.

SEC. 2. Section 741 of the Business and Professions Code is amended to read:

741. (a) Notwithstanding any other law, when prescribing an opioid or benzodiazepine medication to a patient, a prescriber shall do the following:

(1) Offer the patient a prescription for naloxone hydrochloride or another drug approved by the United States Food and Drug

Administration for the complete or partial reversal of opioid-induced respiratory depression when one or more of the following conditions are present:

(A) The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.

(B) An opioid medication is prescribed ~~concurrently with~~ *within a year from the date* a prescription for ~~benzodiazepine.~~ *benzodiazepine has been dispensed to the patient.*

(C) The patient presents with an increased risk for opioid overdose, including a patient with a history of opioid overdose, a patient with a history of opioid use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

(2) Consistent with the existing standard of care, provide education to the patient on opioid overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression.

(3) Consistent with the existing standard of care, provide education on opioid overdose prevention and the use of naloxone hydrochloride or another drug approved by the United States Food and Drug Administration for the complete or partial reversal of opioid-induced respiratory depression to one or more persons designated by the patient, or, for a patient who is a minor, to the minor's parent or guardian.

(b) A prescriber is not required to provide the education specified in paragraphs (2) or (3) of subdivision (a) if the patient receiving the prescription declines the education or has received the education within the past 24 months.

~~(b)~~

(c) This section does not apply to a prescriber ~~when~~ *under any of the following circumstances:*

(1) When prescribing to an inmate or a youth under the jurisdiction of the Department of Corrections and Rehabilitation or the Division of Juvenile Justice within the Department of Corrections and Rehabilitation.

~~(c) This section does not apply to a prescriber when prescribing, ordering, or administering medications to a patient in an inpatient health facility, as defined in Section 1250 of the Health and Safety Code.~~

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1 ~~(d) This section does not apply to a prescriber when prescribing~~
2 ~~medications to a patient in outpatient-based hospice care.~~
3 *(2) When ordering medications to be administered to a patient*
4 *while the patient is in either an inpatient or outpatient setting.*
5 *(3) When prescribing medications to a patient who is terminally*
6 *ill, as defined in subdivision (c) of Section 11159.2 of the Health*
7 *and Safety Code.*
8 SEC. 3. This act is an urgency statute necessary for the
9 immediate preservation of the public peace, health, or safety within
10 the meaning of Article IV of the California Constitution and shall
11 go into immediate effect. The facts constituting the necessity are:
12 In order to properly address the health crisis caused by opioid
13 addiction and the loss of life caused by opioid-induced respiratory
14 failure in this state as soon as possible, it is necessary that this bill
15 take effect immediately.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	AB 845
AUTHOR:	Maienschein
BILL DATE:	April 1, 2019, Amended
SUBJECT:	Continuing Education: Physicians and Surgeons: Maternal Mental Health
SPONSOR:	Maternal Mental Health NOW

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow for an optional continuing medical education (CME) course in maternal mental health.

BACKGROUND:

Existing law requires physicians and surgeons to complete at least 50 hours of approved CME during each two-year license renewal cycle. Currently, physicians and surgeons only have a mandatory one-time CME requirement of 12 hours in the subject of pain management and the treatment of the terminally ill or on the subject of the treatment and management of opiate-dependent patients. There is also a mandate in existing law that requires general internists and family physicians who have a patient population of which over 25 percent are 65 years of age or older to complete at least 20 percent of all mandatory CME in a course in the field of geriatric medicine or the care of older patients.

Existing CME courses approved by the Medical Board of California's (Board) Licensing Program include:

- Programs accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA), the American Medical Association (AMA), and the Accreditation Council for Continuing Medical Education (ACCME) that qualify for AMA PRA Category 1 Credit(s);
- Programs that qualify for prescribed credit from the American Academy of Family Physicians (AAFP); and
- Other programs offered by other organizations and institutions acceptable to the Board.

ANALYSIS:

This bill would require the Board, when determining CME requirements, to consider including a course in maternal mental health, which must address the following:

- Best practices in screening for maternal mental health disorders, including cultural competency and unintended bias as a means to build trust with mothers.
- The range of maternal mental health disorders.

- The range of evidence-based treatment options, including the importance of allowing a mother to be involved in developing the treatment plan.
- When an obstetrician or a primary care doctor should consult with a psychiatrist versus making a referral.
- Applicable requirements under Sections 123640 and 123616.5 of the Health and Safety Code.

Although the Board has historically opposed mandated CME, this bill would not mandate particular CME for physicians. This bill only requires the Board to consider a course on maternal mental health. If the Board decides that it is important to get out information to physicians on this particular type of CME to encourage attendance in these types of CME courses, it could include an article in its Newsletter or put information out on the Board's website. Board staff recommends that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: Maternal Mental Health NOW (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 1, 2019

AMENDED IN ASSEMBLY MARCH 14, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 845

Introduced by Assembly Member Maienschein

February 20, 2019

An act to add Section 2196.9 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 845, as amended, Maienschein. Continuing education: physicians and surgeons: maternal mental health.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California within the Department of Consumer Affairs. Under that act, the board is required to adopt and administer standards for the continuing education of physicians and surgeons.

By July 1, 2019, existing law requires a licensed healthcare practitioner who provides prenatal or postpartum care for a patient to offer to screen or appropriately screen a mother for maternal mental health conditions. Existing law also requires a general acute care hospital or special hospital that has a perinatal unit to develop to implement, by January 1, 2020, a program relating to maternal mental health conditions including, but not limited to, postpartum depression.

This bill would require the board, in determining the continuing education requirements for physicians and surgeons, to ~~include~~ *consider including* a course in maternal mental health, addressing, among other provisions, the requirements described above. The bill would require

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the board to periodically update ~~the~~ *any* curricula developed pursuant to the bill to account for new research.

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 2196.9 is added to the Business and Professions Code, to read:

2196.9. (a) In determining its continuing education requirements for physicians and surgeons, the board shall ~~include~~ *consider including* a course in maternal mental health, which shall address the following:

(1) Best practices in screening for maternal mental health disorders, including cultural competency and unintended bias as a means to build trust with mothers.

(2) The range of maternal mental health disorders.

(3) The range of evidence-based treatment options, including the importance of allowing a mother to be involved in developing the treatment plan.

(4) When an obstetrician or a primary care doctor should consult with a psychiatrist versus making a referral.

(5) Applicable requirements under Sections 123640 and 123616.5 of the Health and Safety Code.

(b) Subject to Section 2001.1, the board shall periodically update ~~the~~ *any* curriculum developed pursuant to this section to account for new research.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 888
AUTHOR: Low
BILL DATE: April 11, 2019, Amended
SUBJECT: Opioid Prescriptions: Information: Non-pharmacological Treatments for Pain
SPONSOR: California Chiropractic Association

DESCRIPTION OF CURRENT LEGISLATION:

This bill would expand current requirements for a prescriber to discuss the risks associated with opioids with their patient prior to issuing a first prescription for an opioid and also requires information about the availability of certain non-pharmacological treatments for pain to be provided, along with an offer for a referral, if appropriate.

BACKGROUND:

According to the Centers for Disease Control and Prevention, drug overdose deaths continue to increase in the United States. Drug overdose deaths continue to increase in the United States. From 1999 to 2017, more than 700,000 people have died from a drug overdose. Around 68% of the more than 70,200 drug overdose deaths in 2017 involved an opioid. In 2017, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 6 times higher than in 1999. On average, 130 Americans die every day from an opioid overdose.

SB 1109 (Bates, Chapter 693, Statutes of 2018) required existing pain management continuing education courses to include the risks of addiction associated with the use of Schedule II drugs. The bill also required a warning label on all Schedule II controlled substance prescription bottles on the associated addiction and overdose risks. SB 1109 required a prescriber to discuss specified information with the minor or the minor's parent or guardian before prescribing an opioid for the first time. Lastly, the bill required a youth sports organization to annually give the Opioid Factsheet for Patients to each athlete, and for the athlete's parent or guardian to sign a document acknowledging receipt before participation in an organized sports team. The Medical Board of California (Board) took a support position on this bill.

ANALYSIS:

This bill would make findings and declarations regarding the opioid crisis and the effectiveness of non-pharmacological therapies to treat certain causes of pain.

This bill would expand on the requirements in existing law put in place by SB 1109, and now require a prescriber to have a discussion with any patient, not just minor patients

and their parents or guardians, before directly dispensing or issuing the first prescription in a single course of treatment for a controlled substance containing an opioid. This bill would exempt patients receiving addiction treatment or hospice care from this requirement. This bill would expand on the current required discussion and require the discussion to include the following:

- The risks of addiction and overdose associated with the use of opioids.
- The increased risk of addiction to an opioid for an individual who is suffering from both mental and substance abuse disorders.
- The danger of taking an opioid with a benzodiazepine, alcohol, or another central nervous system depressant.
- The availability of non-pharmacological treatments for pain – this is a new requirement.
- Any other information required by law.

After discussing the required information, this bill would require the prescriber to obtain informed written consent from the patient, a minor patient's parent or guardian, or another adult authorized to consent to the minor patient's medical treatment, which must be placed in the patient's medical record and contain all of the following:

- The name and quantity of the controlled substance being prescribed or issued to the patient, and the amount of the initial dose.
- A statement certifying that the prescriber discussed with the patient the information required by this bill.
- A space for the signature of the patient, a minor's parent or guardian, or another adult authorized to consent to the minor patient's medical treatment.

This bill would also require the prescriber to offer, as deemed appropriate by the prescriber, a referral for a provider of non-pharmacological treatments for pain. This bill would define "non-pharmacological treatments for pain" to include, but not be limited to, acupuncture, chiropractic care, physical therapy, occupational therapy, and licensed mental health provider services.

This bill would specify that it does not apply if: the patient's treatment includes emergency services and care; or the patient's treatment is associated with, or incidental to, an emergency surgery, regardless of whether the surgery is performed on an inpatient or outpatient basis; or in the prescriber's professional judgment, fulfilling the requirements would be detrimental to the patient's health or safety, or in violation of the patient's legal rights regarding confidentiality.

This bill would specify that it shall not be construed as requiring health care coverage, or changing existing health care coverage requirements, for non-pharmacological treatments for pain.

According to the California Health Care Foundation, enough opioids are prescribed in a single year in California for every person in the state to medicate themselves around the clock for a month; as many as 50,000 Americans have died of an opioid overdose in a single year. According to the author, patients are rarely made aware of non-opioid

treatments for serious pain management needs and studies have shown that, for many patients, pursuing non-pharmacological therapies can be equally or more effective for treating pain, without the risks of addiction or overdose associated with pharmaceutical painkillers. The author believes this bill would recognize the expansive body of research into the efficacy of less invasive treatments for pain that do not pose the same serious risks as opioid medication, empowering patients with the choice of less invasive options, while preserving the important relationship between health professionals and their patients.

This bill would expand upon a bill from last year, which the Board supported, and require prescribers to discuss important information about the risks associated with opioids with all patients, not just minor patients. This bill would also require written informed consent that must be included in the patient's medical records, which will help the Board to enforce the bill's requirements. The growing opioid abuse epidemic remains a matter of concern for the Board. This bill will increase education for all patients, which will further the Board's mission of consumer protection. Board staff recommends that the Board support this bill.

FISCAL: Minor and absorbable.

SUPPORT: California Chiropractic Association (Sponsor); California Acupuncture and Traditional Medicine Association; California Health Coalition Advocacy; Independent Physical Therapists of California; and Occupational Therapy Association of California

OPPOSITION: California Medical Association

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 11, 2019

AMENDED IN ASSEMBLY MARCH 21, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 888

Introduced by Assembly Member Low

February 20, 2019

An act to amend Section 11158.1 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

AB 888, as amended, Low. Opioid prescriptions: information: nonpharmacological treatments for pain.

Existing law requires a prescriber, with certain exceptions, before directly dispensing or issuing for a minor the first prescription for a controlled substance containing an opioid in a single course of treatment, to discuss specified information with the minor, the minor's parent or guardian, or another adult authorized to consent to the minor's medical treatment.

This bill would extend that requirement for the prescriber by applying it to any patient, not only a minor, under those circumstances. The bill would also require the prescriber to discuss the availability of nonpharmacological treatments for pain, as defined.

Existing law makes an exception to the requirement for the prescriber in the case of a patient who is being treated for a diagnosis of chronic intractable pain, as specified.

This bill would remove that exception and would instead make an exception in the case of a patient who is currently receiving hospice care.

The bill would require the prescriber, after discussing the information, to ~~offer~~ *offer, as deemed appropriate by the prescriber,* a referral for a provider of nonpharmacological treatments for pain, and to obtain informed written consent from the patient, a minor patient's parent or guardian, or another authorized adult, as specified.

Existing federal law, the federal Patient Protection and Affordable Care Act (PPACA), requires a health benefit plan issuer that offers coverage in the small group or individual market to ensure that the coverage includes the essential health benefits package, as defined.

This bill would make legislative findings and declarations relating to addiction associated with overreliance on prescription medication for pain management, and providing that nonpharmacological treatments for pain should be considered during the next update to the state's essential health benefits benchmark plan.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) The opioid crisis has devastated communities within
4 California, which has prompted an urgent discussion about the
5 risks of addiction associated with overreliance on prescription
6 medication for pain management.
7 (b) A growing body of research indicates that certain
8 nonpharmacological therapies are proven to be equally effective
9 to treat certain causes of pain as prescription opioids, without
10 placing patients at risk for addiction or overdose.
11 (c) To this end, awareness of, and access to, nonpharmacological
12 treatments for pain are vitally important to the state's efforts to
13 combat the opioid crisis, and that coverage of these treatments
14 should be considered during the next update to the state's essential
15 health ~~benefit~~ *benefits* benchmark plan pursuant to Section 156.111
16 of Title 45 of the Code of Federal Regulations.
17 SEC. 2. Section 11158.1 of the Health and Safety Code is
18 amended to read:
19 11158.1. (a) Except when a patient is being treated as set forth
20 in Sections 11159, 11159.2, and 11167.5, and Article 2
21 (commencing with Section 11215) of Chapter 5, pertaining to the

1 treatment of addicts, or except when a patient is currently receiving
2 hospice care, a prescriber shall discuss all of the following
3 information with the patient, or, if the patient is a minor, the minor,
4 the minor's parent or guardian, or another adult authorized to
5 consent to the minor's medical treatment, before directly dispensing
6 or issuing to a patient the first prescription in a single course of
7 treatment for a controlled substance containing an opioid:
8 (1) The risks of addiction and overdose associated with the use
9 of opioids.
10 (2) The increased risk of addiction to an opioid for an individual
11 who is suffering from both mental and substance abuse disorders.
12 (3) The danger of taking an opioid with a benzodiazepine,
13 alcohol, or another central nervous system depressant.
14 (4) The availability of nonpharmacological treatments for pain.
15 (5) Any other information required by law.
16 (b) After discussing the information required by subdivision
17 (a), the prescriber shall do both of the following:
18 (1) Obtain informed written consent from the patient, a minor
19 patient's parent or guardian, or another adult authorized to consent
20 to the minor patient's medical treatment, which shall be placed in
21 the patient's medical record and shall contain all of the following:
22 (A) The name and quantity of the controlled substance being
23 prescribed or issued to the patient, and the amount of the initial
24 dose.
25 (B) A statement certifying that the prescriber discussed with
26 the patient, a minor patient's parent or guardian, or another adult
27 authorized to consent to the minor patient's medical treatment, the
28 information required by subdivision (a).
29 (C) A space for the signature of the patient, a minor patient's
30 parent or guardian, or another adult authorized to consent to the
31 minor patient's medical treatment.
32 (2) ~~Offer~~ *Offer, as deemed appropriate by the prescriber,* a
33 referral for a provider of nonpharmacological treatments for pain.
34 (c) This section does not apply in any of the following
35 circumstances:
36 (1) If the patient's treatment includes emergency services and
37 care as defined in Section 1317.1.
38 (2) If the patient's treatment is associated with, or incidental to,
39 an emergency surgery, regardless of whether the surgery is
40 performed on an inpatient or outpatient basis.

1 (3) If, in the prescriber's professional judgment, fulfilling the
2 requirements of subdivision (a) or (b) would be detrimental to the
3 patient's health or safety, or in violation of the patient's legal rights
4 regarding confidentiality.
5 (d) For purposes of this section, "nonpharmacological treatments
6 for pain" include, but are not limited to, acupuncture, chiropractic
7 care, physical therapy, occupational therapy, and licensed mental
8 health provider services.
9 *(e) This section shall not be construed as requiring health care*
10 *coverage, or changing existing health care coverage requirements,*
11 *for nonpharmacological treatments for pain.*
12 ~~(e)~~
13 *(f)* Notwithstanding any other law, including Section 11374,
14 failure to comply with this section shall not constitute a criminal
15 offense.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	AB 890
AUTHOR:	Wood
BILL DATE:	April 22, 2019, Amended
SUBJECT:	Nurse Practitioners: Scope of Practice: Unsupervised Practice
SPONSOR:	Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would create the Advanced Practice Registered Nursing Board (APRNB) within the Department of Consumer Affairs (DCA). This bill would authorize a nurse practitioner (NP) who practices in certain settings or organizations to perform specified functions without physician supervision. This bill would authorize an NP who holds an active certification issued by BRN to practice without physician supervision outside of specified settings or organizations in accordance with specified conditions and requirements if the NP meets specified education and other requirements, including completion of a transition practice, as defined in this bill.

BACKGROUND:

Existing law provides for the regulation and licensure of the practice of nursing by the Board of Registered Nursing (BRN) under the Nursing Practice Act. (Act). Existing law defines the nursing scope of practice as functions, including basic healthcare, that help people cope with or treat difficulties in daily living that are associated with their actual or potential health or illness problems, and that require a substantial amount of scientific knowledge or technical skill. Existing law includes within the scope of nursing practice all of the following:

- Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients; and the performance of disease prevention and restorative measures.
- Direct and indirect patient care services, including the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist.
- The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.
- Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in

treatment regimen in accordance with "standardized procedures," or the initiation of emergency procedures.

Existing law defines "standardized procedures" as either of the following: policies and protocols developed by a licensed health facility through collaboration among administrators and health professionals including physicians and nurses; and policies and protocols developed through collaboration among administrators and health professionals, including physicians and nurses, by an organized health care system that is not a licensed health facility.

Existing law provides for the additional certification of registered nurses as NPs and specifies requirements and conditions of the certification.

Existing law requires applicants for qualification or certification as an NP under California law to meet the following requirements:

- Hold a valid and active registered nursing license.
- Possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing.
- Complete an NP program approved by the BRN.

Existing law authorizes an NP, pursuant to standardized procedures, to do any of the following:

- Order durable medical equipment.
- After performance of a physical examination by the NP and collaboration with a physician and surgeon, certify disability for purposes of unemployment.
- For individuals receiving home health services or personal care services, after consultation with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

Existing law allows an NP to furnish or order drugs or devices pursuant to standardized procedures, as specified.

ANALYSIS:

This bill would state the intent of the Legislature that the requirements under this bill shall not be an undue or unnecessary burden to licensure or practice. The requirements are intended to ensure the new category of licensed NPs have the least restrictive amount of education, training, and testing necessary to ensure competent practice.

This bill would create the APRNB within DCA, consisting of nine members. This bill would specify that this section shall remain in effect only until January 1, 2026, and as of that date is repealed. This bill would specify that until January 1, 2026, four members of the APRNB shall be licensed registered nurses (RN) who shall be active as an NP and shall be active in the practice of their profession engaged primarily in direct patient care with at least five continuous years of experience. This bill would specify that beginning January 1, 2026, four members of the APRNB shall be NPs licensed under

the provisions of this bill. This bill would specify that three members of the APRNB shall be physicians licensed by the Medical Board of California (Board) or the Osteopathic Medical Board of California, at least one of the physician members shall work closely with an NP. This bill would specify that the remaining physician members shall focus on primary care in their practice. This bill would specify that two members of the APRNB shall represent the public at large and shall not be licensed under any board under DCA.

This bill would specify that an NP who holds a certification as an NP from a national certifying body recognized by the APRNB may perform the functions authorized in this bill without supervision by a physician if the NP meets all of the requirements of this bill and practices in one of the following settings or organizations in which one or more physicians practice with the NP:

- A licensed clinic,
- A health facility,
- A county medical facility, or
- A medical group practice, including a professional medical corporation, another form of corporation controlled by physicians, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians and surgeons that provides health care services.

This bill would specify that in health care agencies that have governing bodies, the following apply:

- An NP shall adhere to all bylaws.
- An NP shall be eligible to serve on medical staff and hospital committees. An NP who is not the holder of an active certificate shall not serve as chair of medical staff committees.
- An NP shall be eligible to attend meetings of the department to which the NP is assigned. An NP who is not the holder of an active certificate shall not vote at department, division, or other meetings.

This bill would specify that a facility shall not interfere with, control, or otherwise direct the professional judgment of an NP functioning pursuant to this bill in a manner prohibited by Section 2400 or any other law, subjecting these NPs to the ban on the corporate practice of medicine. This bill would also subject NPs who meet the requirements of this bill to peer review laws in Business and Professions Code Section 805.

In addition to any other practices authorized by law, this bill would specify that an NP who meets the requirements of this bill may perform the following functions without the supervision of a physician, in accordance with their education and training:

- Conduct an advanced assessment.
- Order and interpret diagnostic procedures.
- Establish primary and differential diagnoses.
- Prescribe, order, administer, dispense, and furnish therapeutic measures, including, but not limited to, the following:

  - Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources.
  - Prescribe, administer, dispense, and furnish pharmacological agents, including over-the-counter, legend, and controlled substances.
  - Plan and initiate a therapeutic regimen that includes ordering and prescribing non-pharmacological interventions, including, but not limited to, durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services, including, but not limited to, home health care, hospice, and physical and occupational therapy.
- After performing a physical examination, certify disability.
- Delegate tasks to a medical assistant.

This bill would require an NP to refer a patient to a physician or other licensed health care provider if a situation or condition of a patient is beyond the scope of the education and training of the NP.

This bill would require an NP practicing under this section to maintain professional liability insurance appropriate for the practice setting.

This bill would specify that the following would apply to an NP who is actively licensed under this article and who holds an active certification issued by the APRNB under this bill:

- The NP may practice without supervision by a physician and surgeon in any setting, outside of the settings or organizations specified in this bill.
- Subject to any applicable conflict of interest policies of the bylaws, the NP shall be eligible for membership of an organized medical staff.
- Subject any applicable conflict of interest policies of the bylaws, an NP member may vote at meetings of the department to which NPs are assigned.

This bill would specify that the APRNB shall issue a certificate to practice outside of the settings and organizations specified in this bill, if, in addition to satisfying the requirements of this article, the NP satisfies all of the following requirements:

- The NP meets one of the following:
  - Holds a Doctorate of Nursing Practice degree (DNP) and holds active national certification in a nurse practitioner role and population foci by a national certifying body recognized by the APRNB.
  - Holds a Master of Science degree in Nursing (MSN) and holds active national certification in an NP role and population foci by a national certifying body recognized by the APRNB and has two years of licensed practice as an NP.
- The NP has successfully completed a transition to practice.

This bill would specify that upon application of an applicant who meets the requirements for a certificate under this bill, the APRNB shall issue an inactive certificate. This bill would specify that upon application of a holder of a certificate issued pursuant to this section, the APRNB shall change the status of an active certificate to inactive. This bill

would specify that the holder of an inactive certificate shall not engage in any activity for which an active certificate is required. This bill would specify that upon application of the holder of a certificate issued pursuant to this bill, the APRNB shall change the status of an inactive certificate to active if the holder's license is in good standing and the holder pays the renewal fee.

This bill would specify that an NP authorized to practice pursuant to this bill must comply with all of the following:

- The NP, consistent with applicable standards of care, shall practice within the scope of their clinical and professional education and training and within the limits of their knowledge and experience.
- The NP shall consult and collaborate with other healing arts providers based on the clinical condition of the patient to whom health care is provided.
- The NP shall establish a plan for referral of complex medical cases and emergencies to a physician and surgeon or other appropriate healing arts providers.

This bill would define "transition to practice" to mean additional clinical experience and mentorship provided to prepare an NP to practice without the routine presence of a physician. This bill would require a transition to practice to meet all of the following requirements:

- The transition to practice shall consist of a minimum of three years or 4,600 hours.
- The transition to practice shall require proficiency in competencies identified by the APRNB by regulation.
- The transition to practice is conducted in one of the settings or organizations specified in this bill, in which one or more physicians practice with the NP.
- After the required three years or 4,600 hours of additional training, the NP shall pass an objective examination developed and administered by the APRNB. This bill would require the examination to test the proficiency competencies identified in the regulation.

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This bill would specify that an NP practicing under this bill outside of the settings or organization, must maintain professional liability insurance appropriate for the practice setting.

This bill would specify that corporations and other artificial legal entities shall have no professional rights, privileges, or powers unless the certificate issued is inactive, surrendered, revoked, or otherwise restricted by the APRNB or the NP is employed pursuant to the exemptions under the ban on the corporate practice of medicine.

According to the author, "as the Legislature and Administration work together to increase coverage, access and affordability to healthcare for all Californian, it is apparent that our current workforce is not equipped to adequately address these goals. Less than half of the 139,000 licensed physicians in California are actively engaged in providing patient care. Of this number, only 32% are primary care physicians. The

distribution of physicians also varies greatly by region with the San Joaquin Valley, Inland Empire and rural areas suffering the greatest shortages. While a number of initiatives, including loan forgiveness and expanded residency programs, have focused on improving this situation, we simply cannot train enough interested primary care physicians and need to engage in additional strategies to meet our workforce needs. One of the top recommendations from the California Health Workforce Commission, representing thought leaders from business, health, employment, labor and government, spent a year looking at how to improve California's ability to meet workforce demands. One of their top recommendations was to allow full practice authority for NPs. This bill aims to accomplish that goal in a measured and reasonable approach."

The purpose of this bill is to authorize an NP to practice without physician supervision in specified health settings that have controls and processes in place. This bill would also allow NPs to practice without physician supervision outside of those settings if they complete a "transition to practice program." In both settings, NPs would be subject to the same consumer protection measures as physicians, such as the ban on the corporate practice of medicine and peer review. In the past, the Board has opposed bills that remove physician supervision for NPs and allowed independent practice. However, this bill does include more oversight mechanisms, including a separate board under DCA, and this bill does require three years of training for NPs who practice outside the specified settings, which is intended to be similar to the postgraduate training required for physicians.

<u>FISCAL:</u> None

<u>SUPPORT:</u> AARP; Alliance of Catholic Health Care, Inc.; American Nurses Association/California; Anthem Blue Cross; Association of California Healthcare Districts; Association of Community Human Service Agencies; Association of Physician Groups; California Alliance of Child and Family Services; California Association of Clinical Nurse Specialists; California Association for Health Services at Home; California Association for Nurse Practitioners; California Hospital Association; California Naturopathic Doctors Association; California State Council of Service Employees; Casa Pacifica; Congress of California Seniors; Engineers and Scientists of California Local 20, IFPTE AFL-CIO & CLC; Essential Access Health; Hathaway Sycamores; Mental Health Association in California; Providence St. Joseph; Steinberg Institute; Western University of Health Sciences; and Numerous Individuals, including licensed NPs.

<u>OPPOSITION:</u> California Chapter American College of Cardiology; California Chapter of the American College of Emergency Physicians; California Medical Association (unless amended); California Prolife Council and Right to Life Federation (unless amended); California

Orthopedic Association; California Society of Plastic Surgeons; Physicians for Patient Protection; and Numerous Individuals, including licensed physicians.

AMENDED IN ASSEMBLY APRIL 22, 2019

AMENDED IN ASSEMBLY APRIL 3, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 890

Introduced by Assembly Member Wood
(Coauthors: Assembly Members Aguiar-Curry, Eggman, Friedman, Gallagher, and Gipson)
(Coauthors: Senators Caballero, Hill, Leyva, and Stone)

February 20, 2019

An act to amend Sections 650.01 and 805 of, and to add ~~Sections 2837.1 and 2837.2 to,~~ *Article 8.5 (commencing with Section 2837.100) to Chapter 6 of Division 2 of,* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 890, as amended, Wood. Nurse practitioners: scope of practice: unsupervised practice.

Existing law, the Nursing Practice Act, provides for the certification and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts that are in addition to other authorized practices, including certifying disability after performing a physical examination and collaboration with a physician and surgeon. A violation of the act is a misdemeanor.

This bill would *establish the Advanced Practice Registered Nursing Board within the Department of Consumer Affairs, which would consist of 9 members. The bill would* authorize a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body

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recognized by the board who practices in certain settings *or organizations* to perform specified functions without supervision by a physician and surgeon, including ordering and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and administering controlled substances.

The bill would also authorize a nurse practitioner who holds ~~a~~ *an active* certification ~~as a nurse practitioner from a national certifying body recognized~~ *issued* by the board to practice without supervision by a physician and surgeon *outside of specified settings or organizations* in accordance with specified conditions and requirements if the nurse practitioner ~~has successfully completed~~ *meets specified education and other requirements, including completion of* a transition to ~~practice program,~~ *practice,* as defined by the ~~bill, and a supervising physician and surgeon at the facility at which the nurse practitioner completed the transition to practice program attests to the board that the nurse practitioner is proficient in competencies established by the board by regulation.~~ *bill. The bill would authorize the board, upon application, to issue an inactive certificate.*

Existing law makes it unlawful for specified healing arts practitioners, including physicians and surgeons, psychologists, and acupuncturists, to refer a person for certain services, including laboratory, diagnostic nuclear medicine, and physical therapy, if the physician and surgeon or their immediate family has a financial interest with the person or in the entity that receives the referral. A violation of those provisions is a misdemeanor and subject to specified civil penalties and disciplinary action.

This bill would make those provisions applicable to a nurse practitioner practicing pursuant to the bill's provisions.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process and defines "licentiate" for those purposes.

This bill would include as a licentiate a nurse practitioner practicing pursuant to the bill's provisions.

Because the bill would expand the scope of crimes, the bill would impose a state-mandated local program.

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:

1 SECTION 1. Section 650.01 of the Business and Professions
2 Code is amended to read:
3 650.01. (a) Notwithstanding Section 650, or any other
4 provision of law, it is unlawful for a licensee to refer a person for
5 laboratory, diagnostic nuclear medicine, radiation oncology,
6 physical therapy, physical rehabilitation, psychometric testing,
7 home infusion therapy, or diagnostic imaging goods or services if
8 the licensee or their immediate family has a financial interest with
9 the person or in the entity that receives the referral.
10 (b) For purposes of this section and Section 650.02, the
11 following shall apply:
12 (1) "Diagnostic imaging" includes, but is not limited to, all
13 X-ray, computed axial tomography, magnetic resonance imaging
14 nuclear medicine, positron emission tomography, mammography,
15 and ultrasound goods and services.
16 (2) A "financial interest" includes, but is not limited to, any
17 type of ownership interest, debt, loan, lease, compensation,
18 remuneration, discount, rebate, refund, dividend, distribution,
19 subsidy, or other form of direct or indirect payment, whether in
20 money or otherwise, between a licensee and a person or entity to
21 whom the licensee refers a person for a good or service specified
22 in subdivision (a). A financial interest also exists if there is an
23 indirect financial relationship between a licensee and the referral
24 recipient including, but not limited to, an arrangement whereby a
25 licensee has an ownership interest in an entity that leases property
26 to the referral recipient. Any financial interest transferred by a
27 licensee to any person or entity or otherwise established in any
28 person or entity for the purpose of avoiding the prohibition of this
29 section shall be deemed a financial interest of the licensee. For
30 purposes of this paragraph, "direct or indirect payment" shall not
31 include a royalty or consulting fee received by a physician and
32 surgeon who has completed a recognized residency training
33 program in orthopedics from a manufacturer or distributor as a
34 result of their research and development of medical devices and
35 techniques for that manufacturer or distributor. For purposes of

1 this paragraph, “consulting fees” means those fees paid by the
2 manufacturer or distributor to a physician and surgeon who has
3 completed a recognized residency training program in orthopedics
4 only for their ongoing services in making refinements to their
5 medical devices or techniques marketed or distributed by the
6 manufacturer or distributor, if the manufacturer or distributor does
7 not own or control the facility to which the physician is referring
8 the patient. A “financial interest” shall not include the receipt of
9 capitation payments or other fixed amounts that are prepaid in
10 exchange for a promise of a licensee to provide specified health
11 care services to specified beneficiaries. A “financial interest” shall
12 not include the receipt of remuneration by a medical director of a
13 hospice, as defined in Section 1746 of the Health and Safety Code,
14 for specified services if the arrangement is set out in writing, and
15 specifies all services to be provided by the medical director, the
16 term of the arrangement is for at least one year, and the
17 compensation to be paid over the term of the arrangement is set
18 in advance, does not exceed fair market value, and is not
19 determined in a manner that takes into account the volume or value
20 of any referrals or other business generated between parties.
21 (3) For the purposes of this section, “immediate family” includes
22 the spouse and children of the licensee, the parents of the licensee,
23 and the spouses of the children of the licensee.
24 (4) “Licensee” means a physician, as defined in Section 3209.3
25 of the Labor Code, or a nurse practitioner practicing pursuant to
26 Section ~~2837.1 or 2837.2.~~ *2837.104 or 2837.105.*
27 (5) “Licensee’s office” means either of the following:
28 (A) An office of a licensee in solo practice.
29 (B) An office in which services or goods are personally provided
30 by the licensee or by employees in that office, or personally by
31 independent contractors in that office, in accordance with other
32 provisions of law. Employees and independent contractors shall
33 be licensed or certified when licensure or certification is required
34 by law.
35 (6) “Office of a group practice” means an office or offices in
36 which two or more licensees are legally organized as a partnership,
37 professional corporation, or not-for-profit corporation, licensed
38 pursuant to subdivision (a) of Section 1204 of the Health and Safety
39 Code, for which all of the following apply:

1 (A) Each licensee who is a member of the group provides
2 substantially the full range of services that the licensee routinely
3 provides, including medical care, consultation, diagnosis, or
4 treatment through the joint use of shared office space, facilities,
5 equipment, and personnel.
6 (B) Substantially all of the services of the licensees who are
7 members of the group are provided through the group and are
8 billed in the name of the group and amounts so received are treated
9 as receipts of the group, except in the case of a multispecialty
10 clinic, as defined in subdivision (*l*) of Section 1206 of the Health
11 and Safety Code, physician services are billed in the name of the
12 multispecialty clinic and amounts so received are treated as receipts
13 of the multispecialty clinic.
14 (C) The overhead expenses of, and the income from, the practice
15 are distributed in accordance with methods previously determined
16 by members of the group.
17 (c) It is unlawful for a licensee to enter into an arrangement or
18 scheme, such as a cross-referral arrangement, that the licensee
19 knows, or should know, has a principal purpose of ensuring
20 referrals by the licensee to a particular entity that, if the licensee
21 directly made referrals to that entity, would be in violation of this
22 section.
23 (d) No claim for payment shall be presented by an entity to any
24 individual, third party payer, or other entity for a good or service
25 furnished pursuant to a referral prohibited under this section.
26 (e) No insurer, self-insurer, or other payer shall pay a charge or
27 lien for any good or service resulting from a referral in violation
28 of this section.
29 (f) A licensee who refers a person to, or seeks consultation from,
30 an organization in which the licensee has a financial interest, other
31 than as prohibited by subdivision (a), shall disclose the financial
32 interest to the patient, or the parent or legal guardian of the patient,
33 in writing, at the time of the referral or request for consultation.
34 (1) If a referral, billing, or other solicitation is between one or
35 more licensees who contract with a multispecialty clinic pursuant
36 to subdivision (*l*) of Section 1206 of the Health and Safety Code
37 or who conduct their practice as members of the same professional
38 corporation or partnership, and the services are rendered on the
39 same physical premises, or under the same professional corporation
40 or partnership name, the requirements of this subdivision may be

1 met by posting a conspicuous disclosure statement at the
2 registration area or by providing a patient with a written disclosure
3 statement.
4 (2) If a licensee is under contract with the Department of
5 Corrections or the California Youth Authority, and the patient is
6 an inmate or parolee of either respective department, the
7 requirements of this subdivision shall be satisfied by disclosing
8 financial interests to either the Department of Corrections or the
9 California Youth Authority.
10 (g) A violation of subdivision (a) shall be a misdemeanor. The
11 Medical Board of California shall review the facts and
12 circumstances of any conviction pursuant to subdivision (a) and
13 take appropriate disciplinary action if the licensee has committed
14 unprofessional conduct. Violations of this section may also be
15 subject to civil penalties of up to five thousand dollars ($5,000)
16 for each offense, which may be enforced by the Insurance
17 Commissioner, Attorney General, or a district attorney. A violation
18 of subdivision (c), (d), or (e) is a public offense and is punishable
19 upon conviction by a fine not exceeding fifteen thousand dollars
20 ($15,000) for each violation and appropriate disciplinary action,
21 including revocation of professional licensure, by the Medical
22 Board of California or other appropriate governmental agency.
23 (h) This section shall not apply to referrals for services that are
24 described in and covered by Sections 139.3 and 139.31 of the
25 Labor Code.
26 (i) This section shall become operative on January 1, 1995.
27 SEC. 2. Section 805 of the Business and Professions Code is
28 amended to read:
29 805. (a) As used in this section, the following terms have the
30 following definitions:
31 (1) (A) "Peer review" means both of the following:
32 (i) A process in which a peer review body reviews the basic
33 qualifications, staff privileges, employment, medical outcomes,
34 or professional conduct of licentiates to make recommendations
35 for quality improvement and education, if necessary, in order to
36 do either or both of the following:
37 (I) Determine whether a licentiate may practice or continue to
38 practice in a health care facility, clinic, or other setting providing
39 medical services, and, if so, to determine the parameters of that
40 practice.

(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.

(ii) Any other activities of a peer review body as specified in subparagraph (B).

(B) "Peer review body" includes:

(i) A medical or professional staff of any health care facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare program as an ambulatory surgical center.

(ii) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code.

(iii) Any medical, psychological, marriage and family therapy, social work, professional clinical counselor, dental, midwifery, or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.

(iv) A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

(2) "Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, licensed midwife, physician assistant, or nurse practitioner practicing pursuant to Section ~~2837.1 or 2837.2.~~ *2837.104 or 2837.105.* "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113 or 2168.

(3) "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

(4) "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens

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1 arrangements, and contractual arrangements to provide professional
2 services, including, but not limited to, arrangements to provide
3 outpatient services.
4 (5) "Denial or termination of staff privileges, membership, or
5 employment" includes failure or refusal to renew a contract or to
6 renew, extend, or reestablish any staff privileges, if the action is
7 based on medical disciplinary cause or reason.
8 (6) "Medical disciplinary cause or reason" means that aspect
9 of a licentiate's competence or professional conduct that is
10 reasonably likely to be detrimental to patient safety or to the
11 delivery of patient care.
12 (7) "805 report" means the written report required under
13 subdivision (b).
14 (b) The chief of staff of a medical or professional staff or other
15 chief executive officer, medical director, or administrator of any
16 peer review body and the chief executive officer or administrator
17 of any licensed health care facility or clinic shall file an 805 report
18 with the relevant agency within 15 days after the effective date on
19 which any of the following occur as a result of an action of a peer
20 review body:
21 (1) A licentiate's application for staff privileges or membership
22 is denied or rejected for a medical disciplinary cause or reason.
23 (2) A licentiate's membership, staff privileges, or employment
24 is terminated or revoked for a medical disciplinary cause or reason.
25 (3) Restrictions are imposed, or voluntarily accepted, on staff
26 privileges, membership, or employment for a cumulative total of
27 30 days or more for any 12-month period, for a medical disciplinary
28 cause or reason.
29 (c) If a licentiate takes any action listed in paragraph (1), (2),
30 or (3) after receiving notice of a pending investigation initiated
31 for a medical disciplinary cause or reason or after receiving notice
32 that their application for membership or staff privileges is denied
33 or will be denied for a medical disciplinary cause or reason, the
34 chief of staff of a medical or professional staff or other chief
35 executive officer, medical director, or administrator of any peer
36 review body and the chief executive officer or administrator of
37 any licensed health care facility or clinic where the licentiate is
38 employed or has staff privileges or membership or where the
39 licentiate applied for staff privileges or membership, or sought the

1 renewal thereof, shall file an 805 report with the relevant agency
2 within 15 days after the licentiate takes the action.
3 (1) Resigns or takes a leave of absence from membership, staff
4 privileges, or employment.
5 (2) Withdraws or abandons their application for staff privileges
6 or membership.
7 (3) Withdraws or abandons their request for renewal of staff
8 privileges or membership.
9 (d) For purposes of filing an 805 report, the signature of at least
10 one of the individuals indicated in subdivision (b) or (c) on the
11 completed form shall constitute compliance with the requirement
12 to file the report.
13 (e) An 805 report shall also be filed within 15 days following
14 the imposition of summary suspension of staff privileges,
15 membership, or employment, if the summary suspension remains
16 in effect for a period in excess of 14 days.
17 (f) A copy of the 805 report, and a notice advising the licentiate
18 of their right to submit additional statements or other information,
19 electronically or otherwise, pursuant to Section 800, shall be sent
20 by the peer review body to the licentiate named in the report. The
21 notice shall also advise the licentiate that information submitted
22 electronically will be publicly disclosed to those who request the
23 information.
24 The information to be reported in an 805 report shall include the
25 name and license number of the licentiate involved, a description
26 of the facts and circumstances of the medical disciplinary cause
27 or reason, and any other relevant information deemed appropriate
28 by the reporter.
29 A supplemental report shall also be made within 30 days
30 following the date the licentiate is deemed to have satisfied any
31 terms, conditions, or sanctions imposed as disciplinary action by
32 the reporting peer review body. In performing its dissemination
33 functions required by Section 805.5, the agency shall include a
34 copy of a supplemental report, if any, whenever it furnishes a copy
35 of the original 805 report.
36 If another peer review body is required to file an 805 report, a
37 health care service plan is not required to file a separate report
38 with respect to action attributable to the same medical disciplinary
39 cause or reason. If the Medical Board of California or a licensing
40 agency of another state revokes or suspends, without a stay, the

1 license of a physician and surgeon, a peer review body is not
2 required to file an 805 report when it takes an action as a result of
3 the revocation or suspension. If the California Board of Podiatric
4 Medicine or a licensing agency of another state revokes or
5 suspends, without a stay, the license of a doctor of podiatric
6 medicine, a peer review body is not required to file an 805 report
7 when it takes an action as a result of the revocation or suspension.
8 (g) The reporting required by this section shall not act as a
9 waiver of confidentiality of medical records and committee reports.
10 The information reported or disclosed shall be kept confidential
11 except as provided in subdivision (c) of Section 800 and Sections
12 803.1 and 2027, provided that a copy of the report containing the
13 information required by this section may be disclosed as required
14 by Section 805.5 with respect to reports received on or after
15 January 1, 1976.
16 (h) The Medical Board of California, the California Board of
17 Podiatric Medicine, the Osteopathic Medical Board of California,
18 and the Dental Board of California shall disclose reports as required
19 by Section 805.5.
20 (i) An 805 report shall be maintained electronically by an agency
21 for dissemination purposes for a period of three years after receipt.
22 (j) No person shall incur any civil or criminal liability as the
23 result of making any report required by this section.
24 (k) A willful failure to file an 805 report by any person who is
25 designated or otherwise required by law to file an 805 report is
26 punishable by a fine not to exceed one hundred thousand dollars
27 ($100,000) per violation. The fine may be imposed in any civil or
28 administrative action or proceeding brought by or on behalf of any
29 agency having regulatory jurisdiction over the person regarding
30 whom the report was or should have been filed. If the person who
31 is designated or otherwise required to file an 805 report is a
32 licensed physician and surgeon, the action or proceeding shall be
33 brought by the Medical Board of California. If the person who is
34 designated or otherwise required to file an 805 report is a licensed
35 doctor of podiatric medicine, the action or proceeding shall be
36 brought by the California Board of Podiatric Medicine. The fine
37 shall be paid to that agency but not expended until appropriated
38 by the Legislature. A violation of this subdivision may constitute
39 unprofessional conduct by the licentiate. A person who is alleged
40 to have violated this subdivision may assert any defense available

1 at law. As used in this subdivision, "willful" means a voluntary
2 and intentional violation of a known legal duty.
3 (*l*) Except as otherwise provided in subdivision (k), any failure
4 by the administrator of any peer review body, the chief executive
5 officer or administrator of any health care facility, or any person
6 who is designated or otherwise required by law to file an 805
7 report, shall be punishable by a fine that under no circumstances
8 shall exceed fifty thousand dollars ($50,000) per violation. The
9 fine may be imposed in any civil or administrative action or
10 proceeding brought by or on behalf of any agency having
11 regulatory jurisdiction over the person regarding whom the report
12 was or should have been filed. If the person who is designated or
13 otherwise required to file an 805 report is a licensed physician and
14 surgeon, the action or proceeding shall be brought by the Medical
15 Board of California. If the person who is designated or otherwise
16 required to file an 805 report is a licensed doctor of podiatric
17 medicine, the action or proceeding shall be brought by the
18 California Board of Podiatric Medicine. The fine shall be paid to
19 that agency but not expended until appropriated by the Legislature.
20 The amount of the fine imposed, not exceeding fifty thousand
21 dollars ($50,000) per violation, shall be proportional to the severity
22 of the failure to report and shall differ based upon written findings,
23 including whether the failure to file caused harm to a patient or
24 created a risk to patient safety; whether the administrator of any
25 peer review body, the chief executive officer or administrator of
26 any health care facility, or any person who is designated or
27 otherwise required by law to file an 805 report exercised due
28 diligence despite the failure to file or whether they knew or should
29 have known that an 805 report would not be filed; and whether
30 there has been a prior failure to file an 805 report. The amount of
31 the fine imposed may also differ based on whether a health care
32 facility is a small or rural hospital as defined in Section 124840
33 of the Health and Safety Code.
34 (m) A health care service plan licensed under Chapter 2.2
35 (commencing with Section 1340) of Division 2 of the Health and
36 Safety Code or a disability insurer that negotiates and enters into
37 a contract with licentiates to provide services at alternative rates
38 of payment pursuant to Section 10133 of the Insurance Code, when
39 determining participation with the plan or insurer, shall evaluate,

1 on a case-by-case basis, licentiates who are the subject of an 805
2 report, and not automatically exclude or deselect these licentiates.
3 ~~SEC. 3. Section 2837.1 is added to the Business and Professions~~
4 ~~Code, to read:~~
5 ~~2837.1. (a) Notwithstanding any other law, a nurse practitioner~~
6 ~~who holds a certification as a nurse practitioner from a national~~
7 ~~certifying body recognized by the board may perform the functions~~
8 ~~specified in subdivision (c) without supervision by a physician~~
9 ~~and surgeon if the nurse practitioner meets all of the requirements~~
10 ~~of this article and practices in one of the following settings in which~~
11 ~~one or more physicians and surgeons are concurrently practicing~~
12 ~~with the nurse practitioner:~~
13 ~~(1) A clinic, as defined in Section 1200 of the Health and Safety~~
14 ~~Code.~~
15 ~~(2) A health facility, as defined in Section 1250 of the Health~~
16 ~~and Safety Code.~~
17 ~~(3) A facility described in Chapter 2.5 (commencing with~~
18 ~~Section 1440) of Division 2 of the Health and Safety Code.~~
19 ~~(4) A medical group practice, including a professional medical~~
20 ~~corporation, as defined in Section 2406, another form of~~
21 ~~corporation controlled by physicians and surgeons, a medical~~
22 ~~partnership, a medical foundation exempt from licensure, or another~~
23 ~~lawfully organized group of physicians and surgeons that provides~~
24 ~~health care services.~~
25 ~~(b) An entity described in subdivisions (1) to (4), inclusive, of~~
26 ~~subdivision (a) shall not interfere with, control, or otherwise direct~~
27 ~~the professional judgment of a nurse practitioner functioning~~
28 ~~pursuant to this section in a manner prohibited by Section 2400 or~~
29 ~~any other law.~~
30 ~~(c) In addition to any other practices authorized by law, a nurse~~
31 ~~practitioner who meets the requirements of this section may~~
32 ~~perform the following functions without the supervision of a~~
33 ~~physician and surgeon in accordance with their education and~~
34 ~~training:~~
35 ~~(1) Conduct an advanced assessment.~~
36 ~~(2) Order and interpret diagnostic procedures.~~
37 ~~(3) Establish primary and differential diagnoses.~~
38 ~~(4) Prescribe, order, administer, dispense, and furnish therapeutic~~
39 ~~measures, including, but not limited to, the following:~~

~~(A) Diagnose, prescribe, and institute therapy or referrals of patients to health care agencies, health care providers, and community resources.~~

~~(B) Prescribe, administer, dispense, and furnish pharmacological agents, including over-the-counter, legend, and controlled substances.~~

~~(C) Plan and initiate a therapeutic regimen that includes ordering and prescribing nonpharmacological interventions, including, but not limited to, durable medical equipment, medical devices, nutrition, blood and blood products, and diagnostic and supportive services, including, but not limited to, home health care, hospice, and physical and occupational therapy.~~

~~(5) After performing a physical examination, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.~~

~~(6) Delegate tasks to a medical assistant pursuant to Sections 1206.5, 2069, 2070, and 2071, and Article 2 (commencing with Section 1366) of Chapter 3 of Division 13 of Title 16 of the California Code of Regulations.~~

~~(d) A nurse practitioner shall refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of a patient is beyond the scope of the education and training of the nurse practitioner.~~

~~(e) A nurse practitioner practicing under this section shall maintain professional liability insurance appropriate for the practice setting.~~

~~SEC. 4. Section 2837.2 is added to the Business and Professions Code, to read:~~

~~2837.2. (a) Notwithstanding any other law, a nurse practitioner who holds an active certification by a national certifying body recognized by the board may practice without supervision by a physician and surgeon if, in addition to satisfying the requirements of this article, the nurse practitioner satisfies both of the following requirements:~~

~~(1) The nurse practitioner has successfully completed a transition to practice program.~~

~~(2) A supervising physician and surgeon at the clinic, facility, or medical group attests under penalty of perjury to the board that the nurse practitioner has successfully completed the transition to practice program and is proficient in the competencies identified by the board to practice pursuant to this section.~~

~~(b) A nurse practitioner authorized to practice pursuant to this section shall comply with all of the following:~~

~~(1) The nurse practitioner, consistent with applicable standards of care, shall practice within the scope of their clinical and professional training and within the limits of their knowledge and experience.~~

~~(2) The nurse practitioner shall consult and collaborate with other healing arts providers based on the clinical condition of the patient to whom health care is provided.~~

~~(3) The nurse practitioner shall establish a plan for referral of complex medical cases and emergencies to a physician and surgeon or other appropriate healing arts providers.~~

~~(c) For purposes of this section, "transition to practice program" means a program in which additional clinical experience and mentorship are provided to prepare a nurse practitioner to practice without the routine presence of a physician and surgeon. A transition to practice program shall meet all of the following requirements:~~

~~(1) The transition to practice program shall consist of a minimum of three years or 4,600 hours.~~

~~(2) The transition to practice program shall require proficiency in competencies identified by the board by regulation.~~

~~(3) The transition to practice program is conducted in one of the settings specified in paragraphs (1) to (4), inclusive, of subdivision (a) of Section 2837.1 in which one or more physicians and surgeons practices concurrently with the nurse practitioner.~~

~~(d) A nurse practitioner practicing under this section shall maintain professional liability insurance appropriate for the practice setting.~~

SEC. 3. Article 8.5 (commencing with Section 2837.100) is added to Chapter 6 of Division 2 of the Business and Professions Code, to read:

Article 8.5. Advanced Practice Registered Nurses

2837.100. It is the intent of the Legislature that the requirements under this article shall not be undue or unnecessary burden to licensure or practice. The requirements are intended to ensure the new category of licensed nurse practitioners have the

1 *least restrictive amount of education, training, and testing*
2 *necessary to ensure competent practice.*
3 *2837.101. (a) There is in the Department of Consumer Affairs*
4 *the Advanced Practice Registered Nursing Board consisting of*
5 *nine members.*
6 *(b) For purposes of this article, "board" means the Advanced*
7 *Practice Registered Nursing Board.*
8 *(c) This section shall remain in effect only until January 1, 2026,*
9 *and as of that date is repealed.*
10 *2837.102. Notwithstanding any other law, the repeal of Section*
11 *2837.101 renders the board or its successor subject to review by*
12 *the appropriate policy committees of the Legislature.*
13 *2837.103. (a) (1) Until January 1, 2026, four members of the*
14 *board shall be licensed registered nurses who shall be active as*
15 *a nurse practitioner and shall be active in the practice of their*
16 *profession engaged primarily in direct patient care with at least*
17 *five continuous years of experience.*
18 *(2) Commencing January 1, 2026, four members of the board*
19 *shall be nurse practitioners licensed under this chapter.*
20 *(b) Three members of the board shall be physicians and*
21 *surgeons licensed by the Medical Board of California or the*
22 *Osteopathic Medical Board of California. At least one of the*
23 *physician and surgeon members shall work closely with a nurse*
24 *practitioner. The remaining physician and surgeon members shall*
25 *focus on primary care in their practice.*
26 *(c) Two members of the board shall represent the public at large*
27 *and shall not be licensed under any board under this division or*
28 *any board referred to in Section 1000 or 3600.*
29 *2837.104. (a) (1) Notwithstanding any other law, a nurse*
30 *practitioner who holds a certification as a nurse practitioner from*
31 *a national certifying body recognized by the board may perform*
32 *the functions specified in subdivision (c) without supervision by a*
33 *physician and surgeon if the nurse practitioner meets all of the*
34 *requirements of this article and practices in one of the following*
35 *settings or organizations in which one or more physicians and*
36 *surgeons practice with the nurse practitioner:*
37 *(A) A clinic, as defined in Section 1200 of the Health and Safety*
38 *Code.*
39 *(B) A health facility, as defined in Section 1250 of the Health*
40 *and Safety Code.*

1 *(C) A facility described in Chapter 2.5 (commencing with*
2 *Section 1440) of Division 2 of the Health and Safety Code.*
3 *(D) A medical group practice, including a professional medical*
4 *corporation, as defined in Section 2406, another form of*
5 *corporation controlled by physicians and surgeons, a medical*
6 *partnership, a medical foundation exempt from licensure, or*
7 *another lawfully organized group of physicians and surgeons that*
8 *provides health care services.*
9 *(2) In health care agencies that have governing bodies, as*
10 *defined in Division 5 of Title 22 of the California Code of*
11 *Regulations, including, but not limited to, Sections 70701 and*
12 *70703 of Title 22 of the California Code of Regulations, the*
13 *following apply:*
14 *(A) A nurse practitioner shall adhere to all bylaws.*
15 *(B) A nurse practitioner shall be eligible to serve on medical*
16 *staff and hospital committees. A nurse practitioner who is not the*
17 *holder of an active certificate pursuant to Section 2837.105 shall*
18 *not serve as chair of medical staff committees.*
19 *(C) A nurse practitioner shall be eligible to attend meetings of*
20 *the department to which the nurse practitioner is assigned. A nurse*
21 *practitioner who is not the holder of an active certificate pursuant*
22 *to Section 2837.105 shall not vote at department, division, or other*
23 *meetings.*
24 *(b) An entity described in subparagraphs (A) to (D), inclusive,*
25 *of paragraph (1) of subdivision (a) shall not interfere with, control,*
26 *or otherwise direct the professional judgment of a nurse*
27 *practitioner functioning pursuant to this section in a manner*
28 *prohibited by Section 2400 or any other law.*
29 *(c) In addition to any other practices authorized by law, a nurse*
30 *practitioner who meets the requirements of this section may*
31 *perform the following functions without the supervision of a*
32 *physician and surgeon in accordance with their education and*
33 *training:*
34 *(1) Conduct an advanced assessment.*
35 *(2) Order and interpret diagnostic procedures.*
36 *(3) Establish primary and differential diagnoses.*
37 *(4) Prescribe, order, administer, dispense, and furnish*
38 *therapeutic measures, including, but not limited to, the following:*

1 *(A) Diagnose, prescribe, and institute therapy or referrals of*
2 *patients to health care agencies, health care providers, and*
3 *community resources.*
4 *(B) Prescribe, administer, dispense, and furnish*
5 *pharmacological agents, including over-the-counter, legend, and*
6 *controlled substances.*
7 *(C) Plan and initiate a therapeutic regimen that includes*
8 *ordering and prescribing nonpharmacological interventions,*
9 *including, but not limited to, durable medical equipment, medical*
10 *devices, nutrition, blood and blood products, and diagnostic and*
11 *supportive services, including, but not limited to, home health*
12 *care, hospice, and physical and occupational therapy.*
13 *(5) After performing a physical examination, certify disability*
14 *pursuant to Section 2708 of the Unemployment Insurance Code.*
15 *(6) Delegate tasks to a medical assistant pursuant to Sections*
16 *1206.5, 2069, 2070, and 2071, and Article 2 (commencing with*
17 *Section 1366) of Chapter 3 of Division 13 of Title 16 of the*
18 *California Code of Regulations.*
19 *(d) A nurse practitioner shall refer a patient to a physician and*
20 *surgeon or other licensed health care provider if a situation or*
21 *condition of a patient is beyond the scope of the education and*
22 *training of the nurse practitioner.*
23 *(e) A nurse practitioner practicing under this section shall*
24 *maintain professional liability insurance appropriate for the*
25 *practice setting.*
26 *2837.105. (a) Notwithstanding any other law, the following*
27 *apply to a nurse practitioner who is actively licensed under this*
28 *article and who holds an active certification issued by the board*
29 *under this section:*
30 *(1) The nurse practitioner may practice without supervision by*
31 *a physician and surgeon outside of the settings or organizations*
32 *specified under subparagraphs (A) to (D), inclusive, of paragraph*
33 *(1) of subdivision (a) of Section 2387.104.*
34 *(2) Subject to subdivision (g) and any applicable conflict of*
35 *interest policies of the bylaws, the nurse practitioner shall be*
36 *eligible for membership of an organized medical staff.*
37 *(3) Subject to subdivision (g) and any applicable conflict of*
38 *interest policies of the bylaws, a nurse practitioner member may*
39 *vote at meetings of the department to which nurse practitioners*
40 *are assigned.*

1 *(b) The board shall issue a certificate to practice outside of the*
2 *settings and organizations specified under subparagraphs (A) to*
3 *(D), inclusive, of paragraph (1) of subdivision (a) if, in addition*
4 *to satisfying the requirements of this article, the nurse practitioner*
5 *satisfies all of the following requirements:*
6 *(1) The nurse practitioner meets one of the following:*
7 *(A) Holds a Doctorate of Nursing Practice degree (DNP) and*
8 *holds active national certification in a nurse practitioner role and*
9 *population foci by a national certifying body recognized by the*
10 *board.*
11 *(B) Holds a Master of Science degree in Nursing (MSN) and*
12 *holds active national certification in a nurse practitioner role and*
13 *population foci by a national certifying body recognized by the*
14 *board and has two years of licensed practice as a nurse*
15 *practitioner.*
16 *(2) The nurse practitioner has successfully completed a*
17 *transition to practice.*
18 *(c) (1) Upon application of an applicant who meets the*
19 *requirements for a certificate under this section, the board shall*
20 *issue an inactive certificate.*
21 *(2) Upon application of a holder of a certificate issued pursuant*
22 *to this section, the board shall change the status of an active*
23 *certificate to inactive.*
24 *(3) The holder of an inactive certificate shall not engage in any*
25 *activity for which an active certificate under this section is required*
26 *and is not otherwise subject to the provisions of this section.*
27 *(4) Upon application of the holder of a certificate issued*
28 *pursuant to this section, the board shall change the status of an*
29 *inactive certificate to active if the holder's license is in good*
30 *standing and the holder pays the renewal fee.*
31 *(d) A nurse practitioner authorized to practice pursuant to this*
32 *section shall comply with all of the following:*
33 *(1) The nurse practitioner, consistent with applicable standards*
34 *of care, shall practice within the scope of their clinical and*
35 *professional education and training and within the limits of their*
36 *knowledge and experience.*
37 *(2) The nurse practitioner shall consult and collaborate with*
38 *other healing arts providers based on the clinical condition of the*
39 *patient to whom health care is provided.*

1 *(3) The nurse practitioner shall establish a plan for referral of*
2 *complex medical cases and emergencies to a physician and surgeon*
3 *or other appropriate healing arts providers.*
4 *(e) For purposes of this section, "transition to practice" means*
5 *additional clinical experience and mentorship are provided to*
6 *prepare a nurse practitioner to practice without the routine*
7 *presence of a physician and surgeon. A transition to practice shall*
8 *meet all of the following requirements:*
9 *(1) The transition to practice shall consist of a minimum of three*
10 *years or 4,600 hours.*
11 *(2) The transition to practice shall require proficiency in*
12 *competencies identified by the board by regulation.*
13 *(3) The transition to practice is conducted in one of the settings*
14 *or organizations specified in subparagraphs (A) to (D), inclusive,*
15 *of paragraph (1) of subdivision (a) of Section 2837.104 in which*
16 *one or more physicians and surgeons practice with the nurse*
17 *practitioner.*
18 *(4) After the nurse practitioner satisfies paragraph (1) of this*
19 *subdivision, the nurse practitioner shall pass an objective*
20 *examination developed and administered by the board. The*
21 *examination shall test the competencies identified under paragraph*
22 *(2) of this subdivision.*
23 *(f) A nurse practitioner practicing under this section shall*
24 *maintain professional liability insurance appropriate for the*
25 *practice setting.*
26 *(g) For purposes of this section, corporations and other artificial*
27 *legal entities shall have no professional rights, privileges, or*
28 *powers.*
29 *(h) Subdivision (g) shall not apply to a nurse practitioner if any*
30 *of the following apply:*
31 *(1) The certificate issued pursuant to this section is inactive,*
32 *surrendered, revoked, or otherwise restricted by the board.*
33 *(2) The nurse practitioner is employed pursuant to the*
34 *exemptions under Section 2401.*
35 ~~SEC. 5.~~
36 *SEC. 4.* No reimbursement is required by this act pursuant to
37 Section 6 of Article XIII B of the California Constitution because
38 the only costs that may be incurred by a local agency or school
39 district will be incurred because this act creates a new crime or
40 infraction, eliminates a crime or infraction, or changes the penalty

1 for a crime or infraction, within the meaning of Section 17556 of
2 the Government Code, or changes the definition of a crime within
3 the meaning of Section 6 of Article XIII B of the California
4 Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 1030
AUTHOR: Calderon
BILL DATE: March 26, 2019, Amended
SUBJECT: Gynecological Examinations: Informational Pamphlet
SPONSOR: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board of California (Board), on or before July 1, 2020, in coordination with the American College of Obstetricians and Gynecologists (ACOG), to develop an informational pamphlet for patients undergoing gynecological examinations.

BACKGROUND:

Existing law requires a physician primarily responsible for providing a patient an annual gynecological examination to provide, during the annual examination, a standardized summary containing a description of the symptoms and appropriate methods of diagnoses for gynecological cancers. This information is required to be provided in a layperson's language and in a language understood by the patient. Existing law allows these requirement to be met using existing publications or pamphlets developed by nationally recognized cancer organizations or by the State Department of Health Care Services. Existing law authorizes an administrative fine upon the second and subsequent complaints against a physician who fails to provide the pamphlet.

According to the Assembly Health Committee analysis, many organizations have developed informational brochures or provide information on their website regarding what to expect during a first gynecologic visit including the Centers for Disease Control, Planned Parenthood, and ACOG. ACOG's teen-specific information answers the following questions:

- When should I have my first gynecologic visit?
- Is it normal to be nervous before the first visit?
- What should I expect at the first gynecologic visit?
- What exams are performed?
- What happens during a general physical exam?
- What happens during an external genital exam?
- What are the pelvic exam and Pap test?
- What are vaccinations?
- What special concerns can be discussed with my ob-gyn? and,
- What can I do to stay healthy?

The ACOG document also provides a glossary of terms, and includes the information that the physician should be wearing gloves. The only information required by this bill, that is not already included on the ACOG document, is the information regarding privacy expectations and the telephone number for the Board.

ANALYSIS:

This bill would require the informational pamphlet for patients undergoing gynecological examinations to include, but not be limited to, all of the following:

- What a pelvic exam is and how it is properly performed.
- What a Pap smear is and how it is properly performed.
- The recommended age for a patient receiving a pelvic exam or Pap smear and how often a pelvic exam or Pap smear should be performed.
- Privacy expectations, including that privacy should be provided for the patient both when undressing and dressing and that a gown should be worn during the entire examination.
- An explanation of what a speculum is and how it should be properly used during an examination.
- That gloves should be worn by the practitioner during the examination.
- The duration of a pelvic exam and Pap smear.
- A telephone number for the Board at which a patient may report any misconduct that the patient feels may have occurred.

This bill would require the informational pamphlet to be made available for the use of licensees that provide gynecological services. The information pamphlet must either be posted as a printable file on the Board's website or made available for order as a printed deliverable on the Board's website, or both.

This bill would require a physician primarily responsible for providing a patient an annual gynecological examination to provide the patient with the informational pamphlet required by this bill before a patient's first gynecological examination with the physician. This bill would require the physician to have the patient sign and date a form attesting that the patient has received the informational pamphlet and understood the contents before the first gynecological examination with that physician. This bill would require forms showing receipt of the information to be kept as part of the patient's medical record. This bill would subject physicians who violate the requirements of this bill to existing law. Existing law authorizes an administrative fine upon the second and subsequent complaints against a physician who fails to provide the pamphlet.

According to the author, this bill will empower patients by giving them much needed information. The author states this bill will ensure that female patients receive the information they need to in order to identify, and hopefully prevent, instances of severe misconduct. The author notes that this bill requires the Board and ACOG to develop an informational pamphlet for patients undergoing a gynecological pelvic examination, with basic information regarding how the procedure should be properly performed, privacy

and sanitary expectations, and contact information in order to report any instances of misconduct.

ACOG already has information for teens that addresses most of the requirements in this bill. This bill would require physicians to give information on gynecological examinations to patients, which will help to protect consumers by providing them information on a proper examination. This may help to prevent sexual misconduct and ensure that instances of misconduct are reported to the Board. Board staff recommends that the Board take a support position on this bill.

<u>FISCAL:</u> Minor and absorbable.

<u>SUPPORT:</u> California Health Coalition Advocacy
Consumer Attorneys of California

<u>OPPOSITION:</u> ACOG (Unless Amended)
California Right to Life Committee, Inc.

<u>POSITION:</u> Recommendation: Support

AMENDED IN ASSEMBLY MARCH 26, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 1030

Introduced by Assembly Members Calderon and Petrie-Norris

February 21, 2019

An act to amend Section 2249 of, and to add Section 2248.9 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1030, as amended, Calderon. Gynecological examinations: informational pamphlet.

Existing law establishes the Medical Board of California within the Department of Consumer Affairs to enforce the licensing and regulatory provisions relating to medical practitioners, including physicians and surgeons. Existing law requires a physician and surgeon primarily responsible for providing a patient an annual gynecological examination to provide that patient, during the annual examination in layperson's language and in a language understood by the patient, a standardized summary containing a description of the symptoms and appropriate methods of diagnoses for gynecological cancers. Existing law makes a failure to provide that information punishable by citation and an administrative fine.

This bill, on or before July 1, 2020, would require the board, in coordination with the American College of Obstetricians and Gynecologists, to develop an informational pamphlet for patients undergoing gynecological examinations that includes specified information, including what ~~a Pap smear is~~ *pelvic exams and Pap smears are* and how ~~it is~~ *they are* performed and privacy expectations for patients. The bill would require the board to make the information sheet

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1030

available for the use of licensees that perform gynecological examinations, as specified.

The bill, commencing one month after the board makes the informational pamphlet available, would require a physician and surgeon primarily responsible for providing a patient an annual gynecological examination, to provide a patient with the informational pamphlet ~~prior to~~ *before* a patient's first gynecological examination with that practitioner. The bill would require the practitioner to have the patient sign and date a form attesting that the patient has received the informational pamphlet and understood the contents ~~prior to~~ *before* the first gynecological examination with that practitioner. The bill would make a violation of these provisions punishable by citation and an administrative fine.

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

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

1 SECTION 1. Section 2248.9 is added to the Business and
2 Professions Code, to read:
3 2248.9. (a) On or before July 1, 2020, the Medical Board of
4 California, in coordination with the American College of
5 Obstetricians and Gynecologists, shall develop an informational
6 pamphlet for patients undergoing gynecological examinations that
7 includes, but is not limited to, all of the following:
8 *(1) What a pelvic exam is and how it is properly performed.*
9 ~~(1)~~
10 *(2)* What a Pap smear is and how it is properly performed.
11 ~~(2)~~
12 *(3)* The recommended age for a patient receiving a *pelvic exam*
13 *or* Pap smear and how often a *pelvic exam or* Pap smear should
14 be performed.
15 ~~(3)~~
16 *(4)* Privacy expectations, including that privacy should be
17 provided for the patient both when undressing and dressing and
18 that a gown should be worn during the entire examination.
19 ~~(4) Appropriate questions that a practitioner may ask during the~~
20 ~~examination.~~
21 (5) An explanation of what a speculum is and how it should be
22 properly used during an examination.

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1030

(6) That ~~latex~~ gloves should be worn by the practitioner during the examination.

(7) The duration of a *pelvic exam and* Pap smear.

(8) A telephone number for the Medical Board of California at which a patient may report any misconduct that the patient feels may have occurred.

(b) The informational pamphlet developed pursuant to subdivision (a) shall be made available for the use of licensees that provide gynecological services. The informational pamphlet shall either be posted as a printable file on the board's internet website or made available for order as a printed deliverable on the board's internet website, or both.

SEC. 2. Section 2249 of the Business and Professions Code is amended to read:

2249. (a) A physician and surgeon primarily responsible for providing a patient an annual gynecological examination shall provide that patient, during the annual examination in layperson's language and in a language understood by the patient, a standardized summary containing a description of the symptoms and appropriate methods of diagnoses for gynecological cancers. This section does not preclude the use of existing publications or pamphlets developed by nationally recognized cancer organizations or by the State Department of Public Health pursuant to Section 138.4 of the Health and Safety Code.

(b) (1) A physician and surgeon primarily responsible for providing a patient an annual gynecological examination shall, ~~prior to~~ *before* a patient's first gynecological examination with the physician and surgeon, provide the patient with the informational pamphlet developed pursuant to Section 2248.9. The physician and surgeon shall have the patient sign and date a form attesting that the patient has received the informational pamphlet and understood the contents ~~prior to~~ *before* the first gynecological examination with that physician and surgeon. Forms showing receipt of the information shall be kept as part of the patient's medical record.

(2) This subdivision shall become operative one month after the board posts availability information on its internet website as provided in Section 2248.9.

(c) A physician and surgeon who violates this section may be cited and assessed an administrative fine. A citation shall not be

1 issued and a fine shall not be assessed upon the first complaint
2 against a physician and surgeon who violates this section. Upon
3 the second and subsequent complaints against a physician and
4 surgeon who violates this section, a citation may be issued and an
5 administrative fine may be assessed.
6 (d) Notwithstanding any other law, all fines collected pursuant
7 to this section for a violation of subdivision (a) shall be credited
8 to the Contingent Fund of the Medical Board of California to be
9 used by the Office of Women's Health within the State Department
10 of Public Health for outreach services that provide information to
11 women about gynecological cancers, but shall not be expended
12 until they are appropriated by the Legislature in the Budget Act
13 or another statute.
14 (e) Section 2314 shall not apply to this section.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	AB 1264
AUTHOR:	Petrie-Norris
BILL DATE:	April 22, 2019, Amended
SUBJECT:	Healing Arts Licensees: Self-Administered Hormonal Contraceptives
SPONSOR:	Planned Parenthood Affiliates of California

DESCRIPTION OF CURRENT LEGISLATION:

This bill would clarify that the requirement to provide an “appropriate prior examination” does not require a real time interaction between a healing arts licensee and a patient.

BACKGROUND:

Existing law authorizes a physician, registered nurse, certified nurse-midwife, nurse practitioner, physician assistant, or pharmacist to, within their respective scope of practice, use a self-screening tool to identify patient risk factors for the use of self-administered hormonal contraceptives by a patient. Existing law allows the self-administered hormonal contraceptives to be prescribed, furnished, or dispensed to the patient after an appropriate prior examination.

Existing law defines “synchronous interaction” as a real-time interaction between a patient and a health care provider located at a distant site.

Telehealth is seen as a tool in medical practice, not a separate form of medicine. There are no legal prohibitions to using technology in the practice of medicine, as long as the practice is done by a California licensed physician. The standard of care is the same whether the patient is seen in-person, through telehealth or other methods of electronically enabled health care. Physicians need not reside in California, as long as they have a valid, current California license.

ANALYSIS:

This bill would expressly clarify that an “appropriate prior examination” does not require a synchronous interaction between a healing arts licensee and a patient for purposes of prescribing, furnishing, or dispensing a self-administered hormonal contraceptive, following the use of a self-screening tool. This bill would include an urgency clause and would become effective immediately upon signature.

According to the author, this bill provides needed clarification around certain types of asynchronous care. Today, in order to access birth control on Planned Parenthood Direct, a patient must answer a health questionnaire, self-report their blood pressure,

and schedule a video chat before submitting their request for contraceptives. This is because of an interpretation that using telehealth to meet the requirement for an "appropriate prior examination" to occur after the use of the self-screening tool, it must involve a synchronous interaction between the patient and the heath care practitioner. According to the author, clarifying the ability for birth control to be prescribed via teleconference without a video chat will expand access and address the unmet needs for birth control in California.

The Board does not interpret an appropriate prior examination to require a real-time interaction between a physician and a patient. It depends on the circumstances of each specific patient and their medical history for a physician to determine what is an appropriate prior examination, pursuant to the standard of care. This bill is clarifying in nature and Board staff recommends that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: Planned Parenthood Affiliates of California (Sponsor)

OPPOSITION: None on File

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 22, 2019

AMENDED IN ASSEMBLY MARCH 26, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL **No. 1264**

Introduced by Assembly Member Petrie-Norris

February 21, 2019

An act to amend Section 2242.2 of the Business and Professions Code, relating to healing ~~arts.~~ *arts, and declaring the urgency thereof, to take effect immediately.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1264, as amended, Petrie-Norris. Healing arts licensees: self-administered hormonal contraceptives.

Existing law authorizes certain healing arts licensees to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after appropriate prior examination, to prescribe, furnish, or dispense self-administered hormonal contraceptives to a patient.

This bill would specify that "appropriate prior examination" ~~for purposes of those provisions~~ does not require a ~~real-time~~ *synchronous* interaction between the patient and the healing arts license.

This bill would declare that it is to take effect immediately as an urgency statute.

Vote: ~~majority~~ *2/3*. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

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

SECTION 1. Section 2242.2 of the Business and Professions Code is amended to read:

2242.2. (a) Notwithstanding any other law, a physician and surgeon, a registered nurse acting in accordance with Section 2725.2, a certified nurse-midwife acting within the scope of Section 2746.51, a nurse practitioner acting within the scope of Section 2836.1, a physician assistant acting within the scope of Section 3502.1, and a pharmacist acting within the scope of Section 4052.3 may use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after an appropriate prior examination, prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. Blood pressure, weight, height, and patient health history may be self-reported using the self-screening tool that identifies patient risk factors.

(b) ~~For purposes of this section, an~~ *An* “appropriate prior examination” does not require a ~~real-time~~ *synchronous* interaction between the patient and the healing arts licensee.

SEC. 2. 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 California Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure patients have access to necessary health care services at the earliest possible time, it is imperative that this bill take effect immediately.

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1264

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 1467
AUTHOR: Salas and Low
BILL DATE: February 22, 2019, Introduced
SUBJECT: Optometrists: Scope of Practice: Delegation of Services Agreement
SPONSOR: California Optometric Association (COA)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize an optometrist to provide services set forth in a delegation of services agreement (DSA) between the optometrist and an ophthalmologist.

BACKGROUND:

The Optometry Practice Act (Act) provides for the licensure and regulation of the practice of optometry by the California Board of Optometry (CBO), which is within the Department of Consumer Affairs. That act provides that the practice of optometry includes 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 activities, including, but not limited to, the examination of the human eye or eyes.

ANALYSIS:

This bill would state that it is the intent of the Legislature to authorize ophthalmologists to enter into DSAs with optometrists, which will increase the two professions' collaboration in the treatment of patients, and that the DSAs between ophthalmologists and optometrists will improve access to quality vision care, as well as provide options for screening and early diagnosis of systemic diseases.

This bill would allow, in addition to the authority provided by the Act, an optometrist to provide services set forth in a DSA between an optometrist and an ophthalmologist. This bill would define a DSA to mean a writing between an ophthalmologist and an optometrist authorizing the optometrist to perform services consistent with the Act.

According to the author, "California's health care workforce shortage is in the headlines – and the impact on Californian's health is growing worse. According to a new report from the California Future Health Workforce Commission, seven million Californians already live in Health Professional Shortage Areas, facing long waits or long drives for care. The majority are Latino, African American and Native American. As California's population grows older and the state confronts chronic diseases like diabetes, the state needs to broaden its strategies for meeting the needs of our diverse population. Optometrists are extensively trained and are well-positioned throughout the state to

meet the increasing demand for specialized eye care services." The author's intention is to ultimately develop legislation that would expand the authority of an optometrist to perform certain procedures, while ensuring that a licensed physician ultimately remains involved.

This bill would allow optometrists to provide additional services that are set forth in the DSA, which is required to be between an optometrist and an ophthalmologist. This bill does not require the ophthalmologist to supervise the optometrist, it would be more of a collaboration. The bill does state that the DSA can only authorize the optometrist to perform services consistent with the Act, which is existing law.

FISCAL:	None
SUPPORT:	CAPA (Sponsor); America's Physician Groups; Association of California Healthcare Districts; California Association for Health Services at Home; California Medical Association; and California Psychiatric Association
OPPOSITION:	California Chapter American College of Emergency Physicians (Unless Amended)

ASSEMBLY BILL No. 1467

Introduced by Assembly Members Salas and Low

February 22, 2019

An act to amend Section 3041 of the Business and Professions Code, relating to healing arts.

legislative counsel's digest

AB 1467, as introduced, Salas. Optometrists: scope of practice: delegation of services agreement.

The Optometry Practice Act provides for the licensure and regulation of the practice of optometry by the State Board of Optometry in the Department of Consumer Affairs. Existing law provides that the practice of optometry includes various functions relating to the visual system, including performing certain functions under the direction of, or after consultation with, an ophthalmologist. A violation of the act is a misdemeanor.

This bill would authorize an optometrist to provide services set forth in a delegation of services agreement, as defined, between an optometrist and an ophthalmologist. Because the bill would expand the scope of practice of optometry, this bill would revise the definition of a crime, thereby imposing a state-mandated local program.

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:

1 SECTION 1. The intent of the Legislature in enacting this act
2 is as follows:
3 (a) To authorize ophthalmologists to enter into agreements for
4 the delegation of services by ophthalmologists to optometrists that
5 will increase the two professions' collaboration in the treatment
6 of patients.
7 (b) That delegation of service agreements between
8 ophthalmologists and optometrists improve access to quality vision
9 care as well as provide options for screening and early diagnosis
10 of systemic diseases.
11 SEC. 2. Section 3041 of the Business and Professions Code is
12 amended to read:
13 3041. (a) The practice of optometry includes the prevention
14 and diagnosis of disorders and dysfunctions of the visual system,
15 and the treatment and management of certain disorders and
16 dysfunctions of the visual system, as well as the provision of
17 habilitative or rehabilitative optometric services, and is the doing
18 of any or all of the following:
19 (1) The examination of the human eye or eyes, or its or their
20 appendages, and the analysis of the human vision system, either
21 subjectively or objectively.
22 (2) The determination of the powers or range of human vision
23 and the accommodative and refractive states of the human eye or
24 eyes, including the scope of its or their functions and general
25 condition.
26 (3) The prescribing or directing the use of, or using, any optical
27 device in connection with ocular exercises, visual training, vision
28 training, or orthoptics.
29 (4) The prescribing of contact and spectacle lenses for, or the
30 fitting or adaptation of contact and spectacle lenses to, the human
31 eye, including lenses that may be classified as drugs or devices by
32 any law of the United States or of this state.
33 (5) The use of topical pharmaceutical agents for the purpose of
34 the examination of the human eye or eyes for any disease or
35 pathological condition.
36 (b) (1) An optometrist who is certified to use therapeutic
37 pharmaceutical agents, pursuant to Section 3041.3, may also

1 diagnose and treat the human eye or eyes, or any of its or their
2 appendages, for all of the following conditions:
3 (A) Through medical treatment, infections of the anterior
4 segment and adnexa, excluding the lacrimal gland, the lacrimal
5 drainage system, and the sclera in patients under 12 years of age.
6 (B) Ocular allergies of the anterior segment and adnexa.
7 (C) Ocular inflammation, nonsurgical in cause except when
8 comanaged with the treating physician and surgeon, limited to
9 inflammation resulting from traumatic iritis, peripheral corneal
10 inflammatory keratitis, episcleritis, and unilateral nonrecurrent
11 nongranulomatous idiopathic iritis in patients over 18 years of age.
12 (D) Traumatic or recurrent conjunctival or corneal abrasions
13 and erosions.
14 (E) Nonmalignant ocular surface disease and dry eye disease.
15 (F) Ocular pain, nonsurgical in cause except when comanaged
16 with the treating physician and surgeon, associated with conditions
17 optometrists are authorized to treat.
18 (G) Hypotrichosis and blepharitis.
19 (H) Pursuant to subdivision (e), glaucoma in patients over 18
20 years of age, as described in subdivision (k).
21 (2) For purposes of this section, "treat" means the use of
22 therapeutic pharmaceutical agents, as described in subdivision (c),
23 and the procedures described in subdivision (d).
24 (c) In diagnosing and treating the conditions listed in subdivision
25 (b), an optometrist certified to use therapeutic pharmaceutical
26 agents pursuant to Section 3041.3 may use or prescribe, including
27 for rational off-label purposes, all of the following therapeutic
28 pharmaceutical agents:
29 (1) Topical pharmaceutical agents for the examination of the
30 human eye or eyes for any disease or pathological condition,
31 including, but not limited to, topical miotics.
32 (2) Topical lubricants.
33 (3) Antiallergy agents. In using topical steroid medication for
34 the treatment of ocular allergies, an optometrist shall consult with
35 an ophthalmologist if the patient's condition worsens 21 days after
36 diagnosis.
37 (4) Topical and oral anti-inflammatories.
38 (5) Topical antibiotic agents.
39 (6) Topical hyperosmotics.

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1 (7) Topical and oral antiglaucoma agents pursuant to the
2 certification process defined in subdivision (e).
3 (8) Nonprescription medications used for the rational treatment
4 of an ocular disorder.
5 (9) Oral antihistamines.
6 (10) Prescription oral nonsteroidal anti-inflammatory agents.
7 (11) Oral antibiotics for medical treatment of ocular disease.
8 (12) Topical and oral antiviral medication for the medical
9 treatment of herpes simplex viral keratitis, herpes simplex viral
10 conjunctivitis, periocular herpes simplex viral dermatitis, varicella
11 zoster viral keratitis, varicella zoster viral conjunctivitis, and
12 periocular varicella zoster viral dermatitis.
13 (13) Oral analgesics that are not controlled substances.
14 (14) Codeine with compounds, hydrocodone with compounds,
15 and tramadol as listed in the California Uniform Controlled
16 Substances Act (Division 10 (commencing with Section 11000)
17 of the Health and Safety Code) and the United States Uniform
18 Controlled Substances Act (21 U.S.C. Sec. 801 et seq.). The use
19 of these agents shall be limited to three days, with a referral to an
20 ophthalmologist if the pain persists.
21 (15) Additional therapeutic pharmaceutical agents pursuant to
22 subdivision (f).
23 (d) An optometrist who is certified to use therapeutic
24 pharmaceutical agents pursuant to Section 3041.3 may also perform
25 all of the following procedures:
26 (1) Corneal scraping with cultures.
27 (2) Debridement of corneal epithelia.
28 (3) Mechanical epilation.
29 (4) Collection of blood by skin puncture or venipuncture for
30 testing patients suspected of having diabetes.
31 (5) Suture removal, with prior consultation with the treating
32 physician and surgeon.
33 (6) Treatment or removal of sebaceous cysts by expression.
34 (7) Administration of oral fluorescein to patients suspected as
35 having diabetic retinopathy.
36 (8) Use of an auto-injector to counter anaphylaxis.
37 (9) Ordering of smears, cultures, sensitivities, complete blood
38 count, mycobacterial culture, acid fast stain, urinalysis, tear fluid
39 analysis, and X-rays necessary for the diagnosis of conditions or
40 diseases of the eye or adnexa. An optometrist may order other

1 types of images subject to prior consultation with an
2 ophthalmologist or appropriate physician and surgeon.
3 (10) A clinical laboratory test or examination classified as
4 waived under the federal Clinical Laboratory Improvement
5 Amendments of 1988 (CLIA) (42 U.S.C. Sec. 263a; Public Law
6 100-578) and designated in paragraph (9) necessary for the
7 diagnosis of conditions and diseases of the eye or adnexa, or if
8 otherwise specifically authorized by this chapter.
9 (11) Punctal occlusion by plugs, excluding laser, diathermy,
10 cryotherapy, or other means constituting surgery as defined in this
11 chapter.
12 (12) The use or prescription of diagnostic or therapeutic contact
13 lenses, including lenses or devices that incorporate a medication
14 or therapy the optometrist is certified to prescribe or provide.
15 (13) Removal of foreign bodies from the cornea, eyelid, and
16 conjunctiva with any appropriate instrument other than a scalpel.
17 Corneal foreign bodies shall be nonperforating, be no deeper than
18 the midstroma, and require no surgical repair upon removal.
19 (14) For patients over 12 years of age, lacrimal irrigation and
20 dilation, excluding probing of the nasal lacrimal tract. The board
21 shall certify any optometrist who graduated from an accredited
22 school of optometry before May 1, 2000, to perform this procedure
23 after submitting proof of satisfactory completion of 10 procedures
24 under the supervision of an ophthalmologist as confirmed by the
25 ophthalmologist. Any optometrist who graduated from an
26 accredited school of optometry on or after May 1, 2000, shall be
27 exempt from the certification requirement contained in this
28 paragraph.
29 (15) Intravenous injection for the purpose of performing ocular
30 angiography at the direction of an ophthalmologist as part of an
31 active treatment plan in a setting where a physician and surgeon
32 is immediately available.
33 (16) Skin testing to diagnose ocular allergies, limited to the
34 superficial layer of the skin.
35 (17) Use of any noninvasive medical device or technology
36 authorized pursuant to subdivision (f).
37 (e) An optometrist certified pursuant to Section 3041.3 shall be
38 certified for the treatment of glaucoma, as described in subdivision
39 (k), in patients over 18 years of age after the optometrist meets the
40 following applicable requirements:

(1) For licensees who graduated from an accredited school of optometry on or after May 1, 2008, submission of proof of graduation from that institution.

(2) For licensees who were certified to treat glaucoma under this section ~~prior to~~ *before* January 1, 2009, submission of proof of completion of that certification program.

(3) For licensees who completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, submission of proof of satisfactory completion of the case management requirements for certification established by the board.

(4) For licensees who graduated from an accredited school of optometry on or before May 1, 2008, and who are not described in paragraph (2) or (3), submission of proof of satisfactory completion of the requirements for certification established by the board under Chapter 352 of the Statutes of 2008.

(f) (1) Any topical or oral therapeutic pharmaceutical agent, which is not a controlled substance, or noninvasive medical device or technology that is not expressly authorized for use or prescription by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 shall be deemed to be authorized if it has received a United States Food and Drug Administration approved indication for the diagnosis or treatment of a condition authorized by this chapter. A licensee shall successfully complete any clinical training imposed by a related manufacturer ~~prior to~~ *before* using any of those therapeutic pharmaceutical agents or noninvasive medical devices or technologies.

(2) Any other topical or oral therapeutic pharmaceutical agent, which is not a controlled substance, or noninvasive medical device or technology that is not expressly authorized for use or prescription by an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 and does not meet the requirements in paragraph (1) shall be deemed authorized if approved by the board through regulation for the rational treatment of a condition authorized by this chapter. Any regulation under this paragraph shall require a licensee to successfully complete an appropriate amount of clinical training to qualify to use each topical or oral therapeutic pharmaceutical agent or

1 noninvasive medical device or technology approved by the board
2 pursuant to this paragraph.
3 (3) This subdivision shall not be construed to authorize any of
4 the following:
5 (A) Any therapeutic pharmaceutical agent, medical device, or
6 technology involving cutting, altering, or otherwise infiltrating
7 human tissue by any means.
8 (B) A clinical laboratory test or imaging study not authorized
9 by paragraphs (1) to (16), inclusive, of subdivision (d).
10 (C) Treatment of any disease or condition that could not be
11 treated by an optometrist before January 1, 2018.
12 (g) (1) An optometrist certified pursuant to Section 3041.3 shall
13 be certified for the administration of immunizations after the
14 optometrist meets all of the following requirements:
15 (A) Completes an immunization training program endorsed by
16 the federal Centers for Disease Control and Prevention (CDC) or
17 the Accreditation Council for Pharmacy Education that, at a
18 minimum, includes hands-on injection technique, clinical
19 evaluation of indications and contraindications of vaccines, and
20 the recognition and treatment of emergency reactions to vaccines,
21 and maintains that training.
22 (B) Is certified in basic life support.
23 (C) Complies with all state and federal recordkeeping and
24 reporting requirements, including providing documentation to the
25 patient's primary care provided and entering information in the
26 appropriate immunization registry designated by the immunization
27 branch of the State Department of Public Health.
28 (D) Applies for an immunization certificate on a board-approved
29 form.
30 (2) For the purposes of this section, "immunization" means the
31 administration of immunizations for influenza, herpes zoster virus,
32 and pneumococcus in compliance with individual Advisory
33 Committee on Immunization Practices (ACIP) vaccine
34 recommendations published by the CDC for persons 18 years of
35 age or older.
36 (h) Other than for prescription ophthalmic devices described in
37 subdivision (b) of Section 2541, any dispensing of a therapeutic
38 pharmaceutical agent by an optometrist shall be without charge.
39 (i) The practice of optometry does not include performing
40 surgery. "Surgery" means any procedure in which human tissue

is cut, altered, or otherwise infiltrated by mechanical or laser means. “Surgery” does not include those procedures specified in paragraphs (1) to (15), inclusive, of subdivision (d). This subdivision does not limit an optometrist’s authority to utilize diagnostic laser and ultrasound technology within ~~his or her~~ *the optometrist’s* scope of practice.

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

(k) For purposes of this chapter, “glaucoma” means either of the following:

(1) All primary open-angle glaucoma.

(2) Exfoliation and pigmentary glaucoma.

(3) (A) Steroid induced glaucoma.

(B) If an optometrist treats a patient for steroid induced ~~glaucoma~~ *glaucoma,* the optometrist shall promptly notify the prescriber of the steroid medication if the prescriber did not refer the patient to the optometrist for treatment.

(*l*) For purposes of this chapter, “adnexa” means ocular adnexa.

(m) 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.

(n) (1) In addition to the authority granted pursuant to this section, an optometrist may provide services set forth in a delegation of services agreement between an optometrist and an ophthalmologist.

(2) For purposes of this subdivision, “delegation of services agreement” means a writing between an ophthalmologist and an optometrist authorizing the optometrist to perform services consistent with this act.

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.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 1468
AUTHOR: McCarty and Gallagher
BILL DATE: April 30, 2019, Amended
SUBJECT: Opioid Prevention and Rehabilitation Act
SPONSOR: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Opioid Prevention and Rehabilitation Act (OPRA), which would be funded by manufacturers and wholesalers of opioid drugs and would become inoperative on July 1, 2027 and be repealed as of January 1, 2028.

BACKGROUND:

According to the Centers for Disease Control and Prevention, drug overdose deaths continue to increase in the United States. Drug overdose deaths continue to increase in the United States. From 1999 to 2017, more than 700,000 people have died from a drug overdose. Around 68% of the more than 70,200 drug overdose deaths in 2017 involved an opioid. In 2017, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 6 times higher than in 1999. On average, 130 Americans die every day from an opioid overdose.

The Medical Board of California (Board) developed a Prescribing Task Force that held multiple meetings to identify best practices, hear from speakers regarding this issue, and update the Board's Guidelines for Prescribing Controlled Substances for Pain. This task force had numerous meetings with interested parties and discussions with experts in the field of pain management to develop this document, which was adopted by the Board in November 2014. These Guidelines are intended to educate physicians on effective pain management in California by avoiding under treatment, overtreatment, or other inappropriate treatment of a patient's pain. The Guidelines' primary objective is improved patient outcomes and reduction of prescription overdose deaths. The Guidelines contain a significant amount of information and are supplemented with as many resources as practical via the appendices and links to websites that further assist a physician when prescribing controlled substances for pain. The Guidelines discuss several areas, including understanding pain, special patient populations, patient evaluation and risk stratification, consultation, treatment plan and objectives, patient consent, pain management agreements, counseling patient on overdose risk and response, initiating an opioid trial, ongoing patient assessment, and several other areas.

ANALYSIS:

This bill would define several terms for the purpose of OPRA. This bill would define "department" as the California Department of Public Health (CDPH). This bill would define "opioid stewardship payment" as the total amount to be paid into the Opioid Prevention and Rehabilitation Program Fund (Fund) for each fiscal year. This bill would define "ratable share" as the individual portion of the opioid stewardship payment to be paid by each manufacturer or wholesaler that is subject to this bill. This bill would define "opioid" as an opiate or any synthetic or semisynthetic narcotic that has opiate-like activities but is not derived from opium and has effects similar to natural opium alkaloids, and any derivatives thereof. This bill would define "opiate" as the dried, condensed juice of a poppy, Papaver somniferum that has a narcotic, soporific, analgesic, and astringent effect. This bill would define "distribute" or "distribution" as the delivery for sale of an opioid drug other than by administering or dispensing to the ultimate user, including intracompany transfers between any division, affiliate, subsidiary, parent, or other entity under complete common ownership and control.

This bill would require, beginning with the 2021-22 fiscal year and for each fiscal year thereafter, a manufacturer or wholesaler that sells or distributes opioid drugs in California to submit to CDPH a report that details all opioid drugs sold or distributed in California during the preceding fiscal year. This bill would require the report to include the following:

- The name, address, telephone number, federal Drug Enforcement Agency (DEA) registration number, and license number of the manufacturer or wholesaler, as applicable.
- The name, address, and DEA registration number of the entity to which the opioid drug was sold or distributed.
- The date of the sale or distribution of the opioid drug.
- The gross receipt total, in dollars, of all opioid drugs sold or distributed.
- The name and National Drug Code (NDC) of the opioid drug sold or distributed.
- The number of containers and the strength and metric quality of controlled substances in each container of the opioid drug sold or distributed.
- The total number of morphine milligram equivalents (MMEs) attributed to the opioid drugs sold or distributed. MMEs shall be determined pursuant to a formulation that is issued by CDPH and updated as CDPH deems necessary to determine the ratable share.
- Any other elements relating to the sale or distribution of the opioid drug, as CDPH deems necessary to determine the ratable share.

Beginning with the 2021–22 fiscal year, and for each fiscal year thereafter, this bill would require CDPH, in consultation with the California State Board of Pharmacy, to calculate the ratable share of a manufacturer or wholesaler, according to all of the following steps:

- The total number of MMEs attributed to opioid drugs sold or distributed in this state by the manufacturer or wholesaler for the preceding fiscal year, divided by the total number of MMEs attributed to opioid drugs sold or distributed in

California by all manufacturers and wholesalers for the preceding fiscal year, in order to determine the payment percentage for the manufacturer or wholesaler.
- The payment percentage shall be multiplied by the opioid stewardship payment.
- The product of the above-described calculation would be the manufacturer's or wholesaler's ratable share.

For purposes of the calculation of the ratable share, the total number of MMEs attributed to opioid drugs sold or distributed by a manufacturer or wholesaler shall not include the number of MMEs attributed to opioid drugs that are manufactured in this state but the final point of delivery or sale is outside this state or the number of MMEs attributed to buprenorphine, methadone, or morphine.

This bill would require CDPH to notify the manufacturer or wholesaler, in writing, of the value of the ratable share for that manufacturer or wholesaler. In any fiscal year that CDPH determines that a manufacturer or wholesaler failed to report information required by this bill, CDPH shall estimate, based on available data, the number of MMEs attributed to opioid drugs sold or distributed by that manufacturer or wholesaler. The other manufacturers and wholesalers complying with the requirements in this bill would receive a decreased assessment of their corresponding ratable share in the following fiscal year, with the decrease equaling the amount that was overpaid by that compliant manufacturer or wholesaler in the current fiscal year.

This bill would allow the manufacturer or wholesaler to have the opportunity to appeal the ratable share determination by submitting information to CDPH explaining why the ratable share determined pursuant to this section is erroneous or otherwise not warranted.

Beginning with the 2021–22 fiscal year, and for each fiscal year thereafter, a manufacturer or a wholesaler subject to the requirements in this bill would be required to make quarterly payments to CDPH, of the manufacturer's or wholesaler's corresponding ratable share of the opioid stewardship payment.

This bill would specify that all ratable share payments, minus refunds and the CDPH's administrative costs, would be deposited quarterly into the Fund. This bill would specify that the opioid stewardship payment shall be equal to fifty million dollars ($50,000,000) for each fiscal year, which shall be the amount used to calculate the ratable share for a manufacturer or wholesaler. This bill would specify that if the total number of morphine milligram equivalents (MMEs) attributed to opioid drugs sold or distributed in California by all manufacturers and wholesalers subject to this bill during the 2021-22 fiscal year, or any fiscal year thereafter, is smaller than the total number of MMEs attributed to opioid drugs sold or distributed in California by all manufacturers and wholesalers subject to this bill during the 2020-21 fiscal year, the opioid stewardship payment shall be reduced from fifty million dollars ($50,000,000) by a percentage equal to the percentage of that reduction in the total number of MMEs. This bill would specify that the combined sum of ratable share payments by manufacturers and wholesalers may

be less than the amount of the opioid stewardship payment in a fiscal year, if CDPH makes adjustments to the ratable share of a manufacturer or wholesaler.

This bill would specify that a manufacturer or wholesaler that fails to comply with the reporting requirements in this bill would be subject to a civil penalty not exceeding five hundred dollars ($500) per calendar day. This bill would specify that a manufacturer or wholesaler that fails to make a ratable share quarterly payment pursuant to this bill would be subject to a civil penalty of not less than 10 percent of, and not greater than 300 percent of, the ratable share quarterly payment that is due. This bill would specify that any penalties collected pursuant to this bill shall be deposited in the Fund.

This bill would create the Fund in the State Treasury. This bill would specify that all moneys in the fund are continuously appropriated to CDPH to carry out the requirements in this bill. This bill would require CDPH to distribute moneys in the Fund to counties or local non-profit community-based organizations, including, but not limited to, community clinics, on an annual basis for purposes of opioid prevention and rehabilitation programs, based on applications submitted by those counties or organizations that elect to participate. This bill would specify that distribution of moneys in the Fund to counties or local non-profit community-based organizations would be based on county needs, using the most recent data of the following information, as provided by CDPH:

- The ratio of opioid overdose deaths per county population.
- The ratio of opioid overdose emergency department visits per county population.
- The ratio of opioid overdose hospitalizations per county population.

According to the author, the opioid epidemic is an ongoing and growing problem that desperately needs assistance for both prevention and treatment. The Fund will generate an important, on-going source of funding for prevention and treatment centers in order to save lives. The money collected will be distributed based on need and population. Dealing with the opioid epidemic requires a holistic approach and participation from all involved parties, including the drug manufacturers and wholesalers.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill will impose fees on manufacturers and wholesalers of opioid drugs, based on the amount of opioid drugs they sold and distributed, which seems to be a reasonable funding source to contribute to the growing opioid abuse epidemic. This bill will help collect funding for opioid prevention and rehabilitation programs, which is much needed in California. The Board took a support if amended position on a similar bill in 2017, and requested an amendment to ensure that the fees are not passed on to consumers. Until recently, this bill would have prohibited a manufacturer or wholesaler from passing the cost of the ratable share quarterly payment to the purchaser of the opioid drug, including the ultimate user of the opioid drug and would specify that if a manufacturer or wholesaler passes the cost of the ratable share quarterly payment to the purchaser of the opioid drug they would be subject to a civil penalty not exceeding one million dollars ($1,000,000) per incident. However, these provisions were deleted

from this bill. As such, Board staff recommends that the Board again take a support if amended position on this bill.

FISCAL: None

SUPPORT: County Behavioral Health Directors Association
County of Humboldt

OPPOSITION: American Cancer Society Cancer Action Network Inc.; Biocom; California Chamber Of Commerce; California Chronic Care Coalition; California Hospice & Palliative Care Association; California Life Sciences Association; California Manufacturers & Technology Association; California Pharmacists Association; Healthcare Distribution Alliance; Howard Jarvis Taxpayers Association; and Pharmaceutical Research and Manufacturers of America

POSITION: Recommendation: Support if Amended

AMENDED IN ASSEMBLY APRIL 30, 2019

AMENDED IN ASSEMBLY APRIL 11, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 1468

Introduced by Assembly Members McCarty and Gallagher

February 22, 2019

An act to add and repeal Division 10.4 (commencing with Section 11730) of the Health and Safety Code, relating to opioids, and making an appropriation therefor, to take effect immediately, tax levy.

LEGISLATIVE COUNSEL'S DIGEST

AB 1468, as amended, McCarty. Opioid Prevention and Rehabilitation Act.

Existing law establishes the State Department of Public Health, which has authority over various programs promoting public health. Existing law requires the department, subject to an appropriation in the Budget Act of 2016, to award naloxone grant funding to local health departments, local government agencies, or other specified entities, in order to reduce the rate of fatal overdose from opioid drugs, including heroin and prescription opioids.

Under existing law, the department licenses and regulates manufacturers of drugs or devices in this state, and the California State Board of Pharmacy licenses and regulates wholesalers of dangerous drugs or devices, as specified.

This bill would, commencing with the 2021–22 fiscal year, require a manufacturer or wholesaler, as defined, that sells or distributes opioid drugs in this state to submit to the department a report, including specified information, that details all opioid drugs sold or distributed

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1468

in this state during the preceding fiscal year. The bill would, commencing with the 2021–22 fiscal year, require the department, in consultation with the board, to calculate the ratable share of a manufacturer or wholesaler, which is the individual portion of the collective sum of ~~$100,000,000~~ *$50,000,000 or a lesser amount, as specified,* to be paid by the manufacturers and wholesalers, based on the information reported. The bill would subject the manufacturer and wholesaler to specified civil penalties for failing to comply with the reporting or payment requirements.

The bill would require the deposit of the payments and penalties, less refunds and the department's administrative costs, into the continuously appropriated Opioid Prevention and Rehabilitation Program Fund, which the bill would create, thereby making an appropriation. The bill would require the department to distribute moneys in the fund to counties *or local nonprofit community-based organizations* for purposes of opioid prevention and rehabilitation programs. The bill would base the distribution of moneys on county needs, using only specified information relating to opioid overdose in the counties.

This bill would make these provisions inoperative on July 1, 2027, and would repeal them as of January 1, 2028.

This bill would state that its provisions are severable.

This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of ⅔ of the membership of each house of the Legislature.

This bill would take effect immediately as a tax levy.

Vote: ⅔. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

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

1 SECTION 1. Division 10.4 (commencing with Section 11730)
2 is added to the Health and Safety Code, to read:

1 DIVISION 10.4. OPIOID PREVENTION AND
2 REHABILITATION ACT
3
4 PART 1. GENERAL PROVISIONS
5
6 11730. (a) This division shall be known, and may be cited, as
7 the Opioid Prevention and Rehabilitation Act.
8 (b) This division shall become inoperative on July 1, 2027, and,
9 as of January 1, 2028, is repealed.
10
11 PART 2. DEFINITIONS
12
13 11731. For purposes of this division, the following definitions
14 apply:
15 (a) "Department" means the State Department of Public Health.
16 (b) "Opioid stewardship payment" means the total amount to
17 be paid into the Opioid Prevention and Rehabilitation Program
18 Fund for each fiscal year, as described in Section 11734.
19 (c) "Ratable share" means the individual portion of the opioid
20 stewardship payment to be paid by each manufacturer or wholesaler
21 that is subject to this division.
22 (d) "Opioid" means an opiate or any synthetic or semisynthetic
23 narcotic that has opiate-like activities but is not derived from opium
24 and has effects similar to natural opium alkaloids, and any
25 derivatives thereof.
26 (e) "Opiate" means the dried, condensed juice of a poppy,
27 Papaver somniferum, that has a narcotic, soporific, analgesic, and
28 astringent effect.
29 (f) "Distribute" or "distribution" means the delivery for sale of
30 an opioid drug other than by administering or dispensing to the
31 ultimate user, including intracompany transactions between any
32 division, affiliate, subsidiary, parent, or other entity under complete
33 common ownership and control.
34 (g) (1) Except as specified in paragraph (2), "wholesaler" has
35 the same meaning as provided in Section 4043 of the Business and
36 Professions Code.
37 (2) "Wholesaler" excludes a chain pharmacy warehouse that
38 engages only in intracompany transfers, not involving a sale,
39 between any division, affiliate, subsidiary, parent, or other entity
40 under complete common ownership and control.

PART 3. OPIOID SALE OR DISTRIBUTION REPORTING

11732. Commencing with the 2021–22 fiscal year, and for each fiscal year thereafter, a manufacturer or wholesaler that sells or distributes opioid drugs in this state shall submit to the department a report that details all opioid drugs sold or distributed by the manufacturer or wholesaler in this state during the preceding fiscal year. To the extent permitted by federal law, the report shall include all of the following information:

(a) The name, address, telephone number, federal Drug Enforcement Agency (DEA) registration number, and license number of the manufacturer or wholesaler, as applicable.

(b) The name, address, and DEA registration number of the entity to which the opioid drug was sold or distributed.

(c) The date of the sale or distribution of the opioid drug.

(d) The gross receipt total, in dollars, of all opioid drugs sold or distributed.

(e) The name and National Drug Code (NDC) of the opioid drug sold or distributed.

(f) The number of containers and the strength and metric quantity of controlled substances in each container of the opioid drug sold or distributed.

(g) The total number of morphine milligram equivalents (MMEs) attributed to the opioid drugs sold or distributed. MMEs shall be determined pursuant to a formulation that is issued by the department and updated as the department deems necessary to determine the ratable share pursuant to Section 11733.

(h) Any other elements relating to the sale or distribution of the opioid drug, as the department deems necessary to determine the ratable share pursuant to Section 11733.

PART 4. RATABLE SHARE DETERMINATION

11733. (a) Commencing with the 2021–22 fiscal year, and for each fiscal year thereafter, the department, in consultation with the California State Board of Pharmacy, shall calculate the ratable share of a manufacturer or wholesaler that is subject to Section 11732, according to all of the following steps:

(1) The total number of morphine milligram equivalents (MMEs) attributed to opioid drugs sold or distributed in this state by the

1 manufacturer or wholesaler for the preceding fiscal year, as
2 reported pursuant to Section 11732, shall be divided by the total
3 number of MMEs attributed to opioid drugs sold or distributed in
4 this state by all manufacturers and wholesalers subject to this
5 division for the preceding fiscal year, in order to determine the
6 payment percentage for the manufacturer or wholesaler.
7 (2) The payment percentage shall be multiplied by the opioid
8 stewardship payment, as described in Section 11734.
9 (3) The product of the calculation described in paragraph (2)
10 shall be the manufacturer's or wholesaler's ratable share.
11 (4) For purposes of the calculation of the ratable share, the total
12 number of MMEs attributed to opioid drugs sold or distributed by
13 a manufacturer or wholesaler shall not include either of the
14 following:
15 (A) The number of MMEs attributed to opioid drugs that are
16 manufactured in this state but the final point of delivery or sale of
17 which is outside this state.
18 (B) The number of MMEs attributed to buprenorphine,
19 methadone, or morphine.
20 (b) The department shall notify the manufacturer or wholesaler,
21 in writing, of the value of the ratable share for that manufacturer
22 or wholesaler.
23 (c) In any fiscal year for which the department determines that
24 a manufacturer or wholesaler that is subject to Section 11732 failed
25 to report information required pursuant to Section 11732, the
26 department shall estimate, based on available data, the number of
27 MMEs attributed to opioid drugs sold or distributed by that
28 manufacturer or wholesaler, and the other manufacturers and
29 wholesalers complying with this division shall receive a decreased
30 assessment of their corresponding ratable share in the following
31 fiscal year, with the decrease equaling the amount that was overpaid
32 by that compliant manufacturer or wholesaler in the current fiscal
33 year.
34 (d) (1) The manufacturer or wholesaler shall have the
35 opportunity to appeal the ratable share determination by submitting
36 information to the department explaining why the ratable share
37 determined pursuant to this section is erroneous or otherwise not
38 warranted.

1 (2) Upon receipt of the information described in paragraph (1),
2 if the department determines that all or a portion of the ratable
3 share is not warranted, the department may do one of the following:
4 (A) Adjust the ratable share if the payment has not yet been
5 made.
6 (B) Adjust the assessment of the ratable share in the following
7 fiscal year by decreasing the ratable share by the amount that was
8 overpaid in the current fiscal year.
9 (C) Refund the amount that was overpaid.
10
11 PART 5. RATABLE SHARE PAYMENT
12
13 11734. (a) Commencing with the 2021–22 fiscal year, and for
14 each fiscal year thereafter, a manufacturer or a wholesaler subject
15 to this division shall make quarterly payments, to the department,
16 of the manufacturer's or wholesaler's corresponding ratable share
17 of the opioid stewardship payment.
18 ~~(b) A manufacturer or wholesaler shall not pass the cost of the~~
19 ~~ratable share quarterly payment to the purchaser of the opioid drug,~~
20 ~~including the ultimate user of the opioid drug.~~
21 ~~(c)~~
22 *(b)* All ratable share payments described in subdivision (a), less
23 refunds and the department's administrative costs, shall be
24 deposited quarterly into the Opioid Prevention and Rehabilitation
25 Program Fund created pursuant to Section 11736.
26 ~~(d) (1) The~~
27 *(c) (1) (A) Except as described in subparagraph (B) and*
28 *paragraph (2), the* opioid stewardship payment shall be equal to
29 ~~one hundred million dollars ($100,000,000)~~ *fifty million dollars*
30 *($50,000,000)* for each fiscal year, which shall be the amount used
31 to calculate the ratable share for a manufacturer or wholesaler
32 pursuant to Section 11733.
33 *(B) Notwithstanding subparagraph (A), if the total number of*
34 *morphine milligram equivalents (MMEs) attributed to opioid drugs*
35 *sold or distributed in this state by all manufacturers and*
36 *wholesalers subject to this division during the 2021–22 fiscal year,*
37 *or any fiscal year thereafter, is smaller than the total number of*
38 *MMEs attributed to opioid drugs sold or distributed in this state*
39 *by all manufacturers and wholesalers subject to this division during*
40 *the 2020–21 fiscal year, the opioid stewardship payment shall be*

reduced from fifty million dollars ($50,000,000) by a percentage equal to the percentage of that reduction in the total number of MMEs.

(2) Notwithstanding paragraph (1), the combined sum of ratable share payments by manufacturers and wholesalers may be less than ~~one hundred million dollars ($100,000,000)~~ *the amount of the opioid stewardship payment* in a fiscal year, if the department makes adjustments to the ratable share of a manufacturer or wholesaler pursuant to Section 11733.

PART 6. PENALTIES

11735. (a) A manufacturer or wholesaler that fails to comply with the reporting requirements described in Section 11732 shall be subject to a civil penalty not exceeding ~~one thousand dollars ($1,000)~~ *five hundred dollars ($500)* per calendar day.

(b) A manufacturer or wholesaler that fails to make a ratable share quarterly payment pursuant to subdivision (a) of Section 11734 shall be subject to a civil penalty of not less than 10 percent of, and not greater than 300 percent of, the ratable share quarterly payment that is due.

~~(c) A manufacturer or wholesaler that fails to comply with subdivision (b) of Section 11734, by passing the cost of the ratable share quarterly payment to the purchaser of the opioid drug, shall be subject to a civil penalty not exceeding one million dollars ($1,000,000) per incident.~~

11735.1. Any penalties collected pursuant to Section 11735 shall be deposited in the Opioid Prevention and Rehabilitation Program Fund created pursuant to Section 11736.

PART 7. OPIOID PREVENTION AND REHABILITATION PROGRAM FUND

11736. (a) There is hereby created in the State Treasury the Opioid Prevention and Rehabilitation Program Fund.

(b) Notwithstanding Section 13340 of the Government Code, all moneys in the fund are continuously appropriated to the department to carry out the purposes described in Section 11736.1.

11736.1. (a) The department shall distribute moneys in the Opioid Prevention and Rehabilitation Program Fund to counties

or local nonprofit community-based organizations, including, but not limited to, community clinics, as defined in Section 1204, on an annual basis pursuant to subdivision (b) for purposes of opioid prevention and rehabilitation ~~programs.~~ *programs, based on applications submitted by those counties or organizations that elect to participate.*

(b) Distribution of moneys in the fund to counties *or local nonprofit community-based organizations* shall be based on county needs, using the most recent data of only the following information, as provided by the department:

(1) The ratio of opioid overdose deaths per county population.

(2) The ratio of opioid overdose emergency department visits per county population.

(3) The ratio of opioid overdose hospitalizations per county population.

SEC. 2. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 3. This act provides for a tax levy within the meaning of Article IV of the California Constitution and shall go into immediate effect.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	AB 1544
AUTHOR:	Gipson and Gloria
BILL DATE:	April 22, 2019, Amended
SUBJECT:	Community Paramedicine or Triage to Alternate Destination Act
SPONSOR:	California Chapter of American College of Emergency Physicians and California Professional Firefighters

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Community Paramedicine or Triage to Alternate Destination Act of 2020 to establish state guidelines to govern the implementation of community paramedicine programs (CPPs) or triage to alternate destination programs (TADPs) by local emergency medical service agencies (LEMSAs) in California. The provisions in this bill would sunset on January 1, 2030.

BACKGROUND:

Under existing law, a paramedic is limited to providing care in emergency situations, during ambulance transports, and while working in a hospital. Beginning in late 2014, thirteen CPP pilot projects began in California, testing six concepts as part of the Health Workforce Pilot Project (HWPP) #173. These HWPP pilot projects were coordinated through the Office of Statewide Health Planning and Development (OSHPD).

ANALYSIS:

This bill would authorize a LEMSA within a county to elect to develop a CPP or TADP. A LEMSA that elects to develop a CPP or TADP is required to do the following:

- Integrate the proposed CPP or TADP into the LEMSA's emergency medical services plan.
- Develop a process to select community paramedicine providers or triage to alternate destination providers, to provide the services authorized by this bill.
- Facilitate any necessary agreements with one or more community paramedicine or triage to alternate destination providers for the delivery of community paramedicine or triage to alternate destination services within the LEMSA's jurisdiction that are consistent with the proposed CPP or TADP. The LEMSA must provide medical control and oversight of the program.
- The LEMSA shall not include the provision of CPP specialties or TADP specialties as part of an existing or proposed contract for the delivery of emergency medical transport services.

- Coordinate, review, and approve any agreements necessary for the provision of community paramedicine specialties or triage to alternate destination services consistent with all of the following:
    - Provide a first right of refusal to the public agency or agencies within the jurisdiction of the proposed program area to provide the proposed program specialties. If the public agency or agencies agree to provide the proposed program specialties, the LEMSA shall review and approve any written agreements necessary to implement the program with those public agencies.
    - Review and approve agreements with community paramedicine triage to alternate destination providers that partner with a private provider to deliver those program specialties.
    - If a public agency declines to provide the proposed program specialties, the LEMSA shall develop a process to select community paramedicine or triage to alternate destination providers to deliver the program specialties.
- Facilitate necessary agreements between the TADP provider and the existing emergency medical transport provider to ensure transport to the appropriate facility.
- At the discretion of the local medical director, develop additional triage and assessment protocols commensurate with the need of the local programs authorized under this act.
- Prohibit triage and assessment protocols or a triage paramedic's decision to authorize transport to an alternate destination facility from being based on, or affected by, a patient's ethnicity, citizenship, age, preexisting medical condition, insurance status, economic status, ability to pay for medical services, or any other characteristic listed in existing law, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental disability is medically significant to the provision of appropriate medical care to the patient.
- Certify and provide documentation and periodic updates to the Emergency Medical Services Authority (EMSA) showing that the alternate destination facility authorized to receive patients maintains adequate licensed medical and professional staff, facilities, and equipment that comply with the requirements of the EMSA's regulations and the provisions of this chapter.
- Secure an agreement with the alternate destination facility that requires the facility to notify the LEMSA within 24 hours if there are changes in the status of the facility with respect to protocols and the facility's ability to care for patients.
- Secure an agreement with the alternate destination that requires the facility to operate in accordance with existing law regarding emergency services and care. The agreement shall provide that failure to operate in accordance with this existing law will result in the immediate termination of use of the facility as part of the triage to alternate destination facility.
- In implementing a TADP, the LEMSA shall continue to use, and coordinate with, any emergency medical transport providers operating within the jurisdiction of the LEMSA. The LEMSA must not in any manner eliminate or reduce the services of the emergency medical transport providers.

- Establish a process to verify training and accreditation of community paramedics in each of the proposed CPP specialties.
- Establish a process for training and accreditation of triage paramedics in each of the proposed TADP specialties.
- Facilitate funding discussions between a CPP, TADP, or incumbent emergency medical transport provider and public or private health system participants to support the implementation of the LEMSA's CPP or TADP.

If a LEMSA elects to develop a CPP or TADP program, the county board of supervisors would be required to establish an emergency medical care committee (EMCC) that would be required to include the following members to advise the LEMSA agency on the development of the CPP or TADP program:

- One emergency medicine physician who is board certified or board eligible and practicing at an emergency department within the LEMSA's jurisdiction
- One registered nurse practicing within the LEMSA's jurisdiction.
- One licensed paramedic practicing in the LEMSA's jurisdiction. Whenever possible, the paramedic should be employed by a public agency.
- One acute care hospital representative with an emergency department operating within the LEMSA's jurisdiction.
- If the LEMSA elects to implement a TADP to a sobering center, one individual with expertise in substance use disorder detoxification and recovery.
- Additional advisory members in the fields of public health, social work, hospice, or mental health practicing within the jurisdiction of the LEMSA with expertise commensurate with the program specialty or specialties that the LEMSA proposes to adopt.

This bill would state the intent of the Legislature to establish state guidelines to govern the implementation of CPPs or TADPs by LEMSAs in California and would state the intent and purpose of CPPs and TADPs.

This bill would require EMSA to review a LEMSA's proposed CPP or TADP and review the LEMSA's program protocols to ensure compliance with the statewide minimum protocols. This bill would allow EMSA to impose conditions as part of the approval of the CPP or TADP. This bill would require EMSA to approve, approve with conditions, or deny the proposed CPP or TADP no later than six months after it is submitted by the LEMSA.

This bill would define a community paramedic as a paramedic who is in good standing and who has completed the curriculum for community paramedic training, has received certification in one or more of the CPP specialties, and is certified and accredited to provide community paramedic services by a LEMSA as part of an approved CPP.

This bill would define a CPP as a program developed by a LEMSA and approved by EMSA to provide community paramedicine services consisting of: providing short-term post-discharge follow-up for persons recently discharged from a hospital due to a serious health condition; providing directly observed therapy to persons with

tuberculosis in collaboration with a public health agency to ensure effective treatment of the tuberculosis and to prevent spread of the disease; and providing case management services to frequent emergency medical services users in collaboration with, and by providing referral to, existing appropriate community resources.

This bill would define a TADP as a program developed by a LEMSA and approved by EMSA to provide triage paramedic assessments operating under triage and assessment protocols developed by the LEMSA that are consistent with the minimum triage and assessment protocols established by EMSA. Triage paramedic assessments may consist of: providing care and comfort services to hospice patient in their homes in response to 911 calls by providing for the patient's and the family's immediate care needs, including grief support in collaboration with the patient's hospice agency until the hospice nurse arrives to treat the patient; and providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility.

This bill would require EMSA to develop regulations that establish minimum standards for the development of a CPP or TADP. This bill would require the Commission on Emergency Medical Services (Commission) to review and approve the regulations. This bill would add the following members to the existing Commission: one physician specializing in the comprehensive care of individuals with co-occurring mental health or psychosocial and substance use disorders appointed by the Governor in consultation with the California Psychiatric Association and the California Society of Addiction Medicine; and one licensed clinical social worker appointed by the Governor in consultation with the California State Council of the Service Employees International Union and the California Chapter of the National Association of Social Workers. The currently required commission member who is a physician who is board prepared or board certified in the specialty of emergency medicine by the American Board of Emergency Medicine and who is knowledgeable in state emergency medical services programs and issues will now be chosen from a list of three names submitted by the California Chapter of the American College of Emergency Physicians.

This bill would require the regulations for CPPs and TADPs to be based upon, and informed by, the Community Paramedicine Pilot Program under HWPP #173 and the protocols and operation of the pilot projects approved. This bill would require the regulations that establish the minimum standards for CPPs and TADPs to consist of all of the following:

- Minimum standards and curriculum for each program specialty for CPPs.
- Minimum standards and curriculum for each program specialty for TADPs.
- A process for verifying on a paramedic's license the successful completion of the required training.
- Staff qualifications to care for a patient's injuries and needs based on degree and severity.
- Standardized medical and nursing procedures for staff.
- The medical equipment and services required to be available at an alternate destination facility to care for patients.

- Limitations that may apply to the ability of an alternate destination facility to treat patients requiring medical services, including, but not limited to, time of day.
- Minimum standards for approval, review, withdrawal, and revocation of a CPP or TADP. Those standards shall include, but not be limited to, both of the following:
  - A requirement that facilities participating in the program accommodate privately or commercially insured, Medi-Cal, Medicare, and uninsured patients.
  - Immediate termination of participation in the program by the alternate destination facility or CPP or TADP if it fails to operate in accordance with existing law regarding emergency services and care.
- Minimum standards for collecting and submitting data to EMSA to ensure patient safety that include consideration of both quality assurance and quality improvement. These standards shall include, but not be limited to, all of the following:
  - Intervals for CPPs or TADPs, participating health facilities, and LEMSAs to submit community paramedicine services data.
  - Relevant program use data and the online posting of program analyses.
  - Exchange of electronic patient health information between CPP or TADP providers and facilities. EMSA may grant a one-time temporary waiver, not to exceed five years, of this requirement for alternate destination facilities that are unable to immediately comply with the electronic patient health information requirement.
  - Emergency medical response system feedback, including feedback from the EMCC.
  - If the CPP or TADP utilizes an alternate destination facility, consideration of ambulance patient offload times for the alternate destination facility, the number of patients that are turned away, diverted, or required to be subsequently transferred to an emergency department, and identification of the reasons for turning away, diverting, or transferring the patient.
  - An assessment of each CPP or TADP’s medical protocols or other processes.
  - An assessment of the impact that implementation of a CPP or TADP has on the delivery of emergency medical services, including the impact on response times in the local EMS agency’s jurisdiction.

This bill would specify that a community paramedicine pilot program approved under OSHPD’s HWPP # 173 before January 1, 2020, is authorized to operate until one year after the above-described regulations become effective.

This bill would specify that regulations adopted by EMSA relating to a triage to alternate destination program must include all of the following:

- LEMSAs participating in providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility shall ensure that any patient who meets the triage criteria for transport to an alternate destination facility, but who requests to be transported to an

emergency department of a general acute care hospital, shall be transported to the emergency department of a general acute care hospital.

- LEMSAs participating in providing patients with advanced life support triage and assessment by a triage paramedic and transportation to an alternate destination facility shall require that a patient who is transported to an alternate destination facility and, upon assessment, is found to no longer meet the criteria for admission to an alternate destination facility, be immediately transported to the emergency department of a general acute care hospital.
- For authorizing transport to an alternate destination facility, training and accreditation for the triage paramedic shall include topics relevant to the needs of the patient population, including, but not limited to, a requirement that a participating triage paramedic complete instruction on all of the following:
    - Mental health crisis intervention, to be provided by a licensed physician and surgeon with experience in the emergency department of a general acute care hospital.
    - Assessment and treatment of intoxicated patients.
    - LEMSA policies for the triage, treatment, transport, and transfer of care, of patients to an alternate destination facility.
    - A requirement that the LEMSA verify that the participating triage paramedic has completed training in all of the following topics meeting the standards of the United States Department of Transportation National Highway Traffic Safety Administration National Emergency Medical Services Education Standards: psychiatric disorders; neuropharmacology; alcohol and substance abuse; patient consent; patient documentation; and medical quality improvement.
- For authorizing transport to a sobering center, a training component that requires a participating triage paramedic to complete instruction on all of the following:
    - The impact of alcohol intoxication on the local public health and emergency medical services system.
    - Alcohol and substance use disorders.
    - Triage and transport parameters.
    - Health risks and interventions in stabilizing acutely intoxicated patients.
    - Common conditions with presentations similar to intoxication.
    - Disease process, behavioral emergencies, and injury patterns common to those with chronic alcohol use disorders.
- A process for LEMSAs to certify and provide periodic updates to EMSA to demonstrate that the alternate destination facility authorized to receive patients maintains adequate licensed medical and professional staff, facilities, and equipment pursuant to the authority's regulations and the provisions of this chapter, which shall include all of the following:
    - Identification of qualified staff to care for the degree of a patient's injuries and needs.
    - Certification of standardized medical and nursing procedures for nursing staff.
    - Certification that the necessary equipment and services are available at the alternate destination facility to care for patients, including, but not

limited to, an automatic external defibrillator and at least one bed or mat per individual patient.

This bill would require EMSA to develop and periodically review and update the minimum medical protocols applicable to each CPP and TADP. This bill would require EMSA to establish and consult with an advisory committee comprised of the following members:

- Individuals in the fields of public health, social work, hospice, substance-use or mental health with expertise commensurate with the program specialty or specialties described in the definition of CPPs.
- Physicians whose primary practice is emergency medicine.
- Two local EMS medical directors selected by the EMS Medical Directors Association of California.
- Two local EMS directors selected by the California Chapter of the American College of Emergency Physicians.

This bill would require EMSA to submit an annual report on the CPPs and TADPs operating in California to the relevant policy committees of the Legislature and post the report on its website. This bill would require EMSA to submit and post its first report six months after EMSA adopts the CPP and TADP regulations, and every January 1 thereafter for the next five years. This bill would allow the annual report to include recommendations for changes to, or elimination of, CP program specialties that do not achieve the goals expressed in this bill. This bill would require the report to include all of the following:

- An assessment of each program specialty, including an assessment of patient outcomes in the aggregate and an assessment of any adverse patient events resulting from services provided under plans approved pursuant to this chapter.
- An assessment of the impact that the program specialties have had on the emergency medical system.
- An update on the implementation of program specialties operating in local EMS agency jurisdictions.
- Policy recommendations for improving the administration of local plans and patient outcomes.

This bill would require EMSA, on or before June 1, 2028, to submit a final report on the results of the CPPs and TADPs operating in California to the relevant policy committees of the Legislature and post the report on its website. This bill would require EMSA to contract with an independent third-party evaluation to develop the final report. This bill would require the final report to include the following:

- A detailed assessment of each CPP and TADP operating in LEMSA jurisdictions.
- An assessment of patient outcomes in the aggregate resulting from services provided under approved plans under the program.
- An assessment of workforce impact due to implementation of the program.
- An assessment of the impact of the program on the emergency medical services system.

- An assessment of how the currently operating program specialties achieve the legislative intent.
- An assessment of community paramedic and triage training.

This bill would allow the final report to include recommendations for changes to, or elimination of, CPP or TADP program specialties that do not achieve the community health and patient goals.

This bill would specify that a person or organization shall not provide community paramedicine or triage to alternate destination services or represent, advertise, or otherwise imply that it is authorized to provide community paramedicine or triage to alternate destination services unless it is expressly authorized by a LEMSA to provide those services as part of a CPP or TADP approved by EMSA.

This bill would specify that a community paramedic shall provide community paramedicine services only if the community paramedic has been certified and accredited to perform those services by a LEMSA and is working as an employee of an authorized community paramedicine provider. This bill would specify that a triage paramedic shall provide triage to alternate destination services only if the triage paramedic has been accredited to perform those services by a LEMSA and is working as an employee of an authorized triage to alternate destination provider.

This bill would specify that entering into an agreement to be a community paramedicine or triage to alternate destination provider pursuant to this bill shall not alter or otherwise invalidate an agency's authority to provide or administer emergency medical services.

According to the author, today's existing model of directing all transports to emergency departments has created gridlock. Patients requiring services such as mental health intervention or a sobering facility, for example, are too often subjected to numerous providers who deny them the expeditious care they need. The author states that community paramedicine can play an important role in improving California's health care delivery system. CPP is an innovative model of care that seeks to improve the effectiveness and efficiency of health care delivery by using specially trained paramedics in partnership with other health care providers to address the needs of local health care systems.

Board staff, working with a Board Member who is a physician, provided input to OSHPD on HWPP #173 and raised patient safety concerns. One of these concerns being that persons recently discharged from the hospital should be seen by their primary care physician for follow up care. The additional training that would be required would not be sufficient enough to teach paramedics the basics of disease management or how to diagnose and treat medical conditions. The other concern raised was that the pilot project did not specifically delineate what services will be allowed to be performed by community paramedics.

However, this bill is very similar to a bill that the Board took a neutral position on, SB 944 (Hertzberg, 2018). The Board took a neutral position because it recognized the important role that emergency responders play in emergency care in California and because SB 944 was amended to increase the oversight of CPPs, to add a sunset date, and add requirements for additional protocols and enhanced reporting. Because this bill includes all of these elements, Board staff recommends that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: California Chapter of the American College of Emergency Physicians (Co-Sponsor)
California Professional Firefighters (Co-Sponsor)

OPPOSITION: California Ambulance Association; California Association for Health Services at Home; and California Nurses Association

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 22, 2019

CALIFORNIA LEGISLATURE—2019–20 REGULAR SESSION

ASSEMBLY BILL No. 1544

Introduced by Assembly Members Gipson and Gloria
(Principal coauthor: Senator Hertzberg)

February 22, 2019

An act to amend Section 1799.2 of, to add Section 1797.259 to, to add and repeal Section 1797.273 of, and to add and repeal Chapter 13 (commencing with Section 1800) of Division 2.5 of, the Health and Safety Code, relating to community paramedicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 1544, as amended, Gipson. Community Paramedicine or Triage to Alternate Destination Act.

(1) Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The existing act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of EMS systems. Among other duties, existing law requires the authority ~~is required~~ to develop planning and implementation guidelines for EMS systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of EMS systems, and receive plans for the implementation of EMS and trauma care systems from local EMS agencies. Existing law makes violation of the act or regulations adopted pursuant to the act punishable as a misdemeanor.

This bill would establish within the act until January 1, 2030, the Community Paramedicine or Triage to Alternate Destination Act of 2019. The bill would authorize a local EMS agency to develop a

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200AB1544

community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services. The bill would require the authority to develop regulations to establish minimum standards for ~~a program,~~ *program* and would further require the Commission on Emergency Medical Services to review and approve those regulations. The bill would require the authority to review a local EMS agency's proposed program and approve, approve with conditions, or deny the proposed program no later than 6 months after it is submitted by the local EMS agency. The bill would require a local EMS agency that opts to develop a program to perform specified duties that include, among others, integrating the proposed program into the local EMS agency's EMS plan. The bill would require the Emergency Medical Services Authority to submit an annual report on the community paramedicine or triage to alternate destination programs operating in California to the Legislature, as specified. The bill would also require the authority to contract with an independent 3rd party to prepare a final report on the results of the community paramedicine or triage to alternate destination programs on or before June 1, 2028, as specified.

The bill would prohibit a person or organization from providing community paramedicine or triage to alternate destination services or representing, advertising, or otherwise implying that it is authorized to provide those services unless it is expressly authorized by a local EMS agency to provide those services as part of a program approved by the authority. The bill would also prohibit a community paramedic or a triage paramedic from providing their respective services unless the community paramedic or triage paramedic has been certified and accredited to perform those services and is working as an employee of an authorized provider. Because a violation of the act described above is punishable as a misdemeanor, and *because* this bill would create new requirements within the act, the bill would expand an existing crime, thereby imposing a state-mandated local program.

(2) Existing law authorizes a county to establish an emergency medical care committee and requires the committee, at least annually, to review the operations of ambulance services operating within the county, emergency medical care offered within the county, and first aid practices in the county. Existing law requires the county board of supervisors to prescribe the membership, and appoint the members, of the committee.

This bill would, ~~notwithstanding these provisions,~~ *if the county elects to develop a community paramedicine or triage to alternate destination*

program, require the committee *to be established, if one is not already established,* to include additional members, as specified, and to advise ~~a~~ *the* local EMS agency ~~within the county~~ on the development of its community paramedicine or triage to alternate destination ~~program if the local EMS agency develops that~~ program. The bill would specifically require the mayor of a city and county to appoint the membership.

The bill would repeal these provisions on January 1, 2030.

(3) Existing law establishes the Commission on Emergency Medical Services with 18 members. The commission, among other things, reviews and approves regulations, standards, and guidelines developed by the authority.

This bill would increase the membership of the commission to 20 members and modify the entities that submit names for appointment to the commission by the Governor, the Senate Committee on Rules, and the Speaker of the Assembly.

(4) 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:

1 SECTION 1. Section 1797.259 is added to the Health and
2 Safety Code, to read:
3 1797.259. A local EMS agency that elects to implement a
4 community paramedicine or triage to alternate destination program
5 pursuant to Section 1840 shall develop and, prior to
6 implementation, submit a plan for that program to the authority
7 according to the requirements of Chapter 13 (commencing with
8 Section 1800).
9 SEC. 2. Section 1797.273 is added to the Health and Safety
10 Code, to read:
11 1797.273. (a) Notwithstanding Sections 1797.270 and
12 1797.272, if a local EMS agency within the county elects to
13 develop a community paramedicine or triage to alternate destination
14 program pursuant to Section 1840, the county board of supervisors,

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or in the case of a city and county, the mayor, shall establish an emergency medical care committee.

(b) The board of supervisors or the mayor shall ensure that the membership of the committee includes all of the following members to advise the local EMS agency on the development of the community paramedicine or triage to alternate destination program:

(1) One emergency medicine physician and surgeon who is board certified or board eligible practicing at an emergency department within the jurisdiction of the local EMS agency.

(2) One registered nurse practicing within the jurisdiction of the local EMS agency.

(3) One licensed paramedic practicing within the jurisdiction of the local EMS agency. Whenever possible, the paramedic shall be employed by a public agency.

(4) One acute care hospital representative with an emergency department ~~operating~~ *that operates* within the jurisdiction of the local EMS agency.

(5) If a local EMS agency elects to implement a triage to alternate destination program to a sobering center, one individual with expertise in substance use disorder detoxification and recovery.

(6) Additional advisory members in the fields of public health, social work, hospice, or mental health practicing within the jurisdiction of the local EMS agency with expertise commensurate with the program specialty or specialties described in Section 1815 that the local EMS agency proposes to adopt.

(c) The requirements of this section shall apply to any emergency medical care ~~committees, or other committees, created for the purposes described in Section 1797.274.~~ *committee established pursuant to this section or Section 1797.270.*

(d) This section shall remain in effect only until January 1, 2030, and as of that date is repealed.

SEC. 3. Section 1799.2 of the Health and Safety Code is amended to read:

1799.2. The commission shall consist of 20 members appointed as follows:

(a) One full-time physician and surgeon, whose primary practice is emergency medicine, appointed by the Senate Committee on

1 Rules from a list of three names submitted by the California
2 Chapter of the American College of Emergency Physicians.
3 (b) One physician and surgeon, who is a trauma surgeon,
4 appointed by the Speaker of the Assembly from a list of three
5 names submitted by the California Chapter of the American
6 College of Surgeons.
7 (c) One physician and surgeon appointed by the Senate
8 Committee on Rules from a list of three names submitted by the
9 California Medical Association.
10 (d) One county health officer appointed by the Governor from
11 a list of three names submitted by the California Conference of
12 Local Health Officers.
13 (e) One registered nurse, who is currently, or has been
14 previously, authorized as a mobile intensive care nurse and who
15 is knowledgeable in state emergency medical services programs
16 and issues, appointed by the Governor from a list of three names
17 submitted by the California Labor Federation.
18 (f) One full-time paramedic or EMT-II, who is not employed
19 as a full-time peace officer, appointed by the Senate Committee
20 on Rules from a list of three names submitted by the California
21 Labor Federation.
22 (g) One prehospital emergency medical service provider from
23 the private sector, appointed by the Speaker of the Assembly from
24 a list of three names submitted by the California Ambulance
25 Association.
26 (h) One management member of an entity providing fire
27 protection and prevention services appointed by the Governor from
28 a list of three names submitted by the California Fire Chiefs
29 Association.
30 (i) One physician and surgeon who is board prepared or board
31 certified in the specialty of emergency medicine by the American
32 Board of Emergency Medicine and who is knowledgeable in state
33 emergency medical services programs and issues appointed by the
34 Speaker of the Assembly from a list of three names submitted by
35 the California Chapter of the American College of Emergency
36 Physicians.
37 (j) One hospital administrator of a base hospital who is appointed
38 by the Governor from a list of three names submitted by the
39 California Hospital Association.

1 (k) One full-time peace officer, who is either an EMT-II or a
2 paramedic, who is appointed by the Governor from a list of three
3 names submitted by the California Peace Officers Association.
4 (*l*) Two public members who have experience in local EMS
5 policy issues, at least one of whom resides in a rural area as defined
6 by the authority, and who are appointed by the Governor.
7 (m) One administrator from a local EMS agency appointed by
8 the Governor from a list of four names submitted by the Emergency
9 Medical Services Administrator's Association of California.
10 (n) One medical director of a local EMS agency who is an active
11 member of the Emergency Medical Directors Association of
12 California and who is appointed by the Governor.
13 (o) One person appointed by the Governor, who is an active
14 member of the California State Firemen's Association.
15 (p) One person who is employed by the Department of Forestry
16 and Fire Protection (CAL-FIRE) appointed by the Governor from
17 a list of three names submitted by the California Professional
18 Firefighters.
19 (q) One person who is employed by a city, county, or special
20 district that provides fire protection appointed by the Governor
21 from a list of three names submitted by the California Professional
22 Firefighters.
23 (r) One physician and surgeon specializing in *the* comprehensive
24 care of individuals with co-occurring mental health or psychosocial
25 and substance use disorders appointed by the Governor in
26 consultation with the California Psychiatric Association and the
27 California Society of Addiction Medicine.
28 (s) One licensed clinical social worker appointed by the
29 Governor in consultation with the California State Council of the
30 Service Employees International Union and the California Chapter
31 of the National Association of Social Workers.
32 SEC. 4. Chapter 13 (commencing with Section 1800) is added
33 to Division 2.5 of the Health and Safety Code, to read:

Chapter 13. Community Paramedicine Or Triage to Alternate Destination

Article 1. General Provisions

1800. This chapter shall be known, and may be cited, as the Community Paramedicine or Triage to Alternate Destination Act of 2019.

1801. (a) It is the intent of the Legislature to establish state standards that govern the implementation of community paramedicine or triage to alternate destination programs by local EMS agencies in California.

(b) It is the intent of the Legislature that community paramedicine or triage to alternate destination programs be community-focused extensions of the traditional emergency response and transportation paramedic model that has developed over the last 50 years and be recognized as an emerging model of care created to meet an unmet need in California's communities.

(c) It is the intent of the Legislature to improve the health of individuals in their communities by authorizing licensed paramedics, working under expert medical oversight, to deliver community paramedicine or triage to alternate destination services in California utilizing existing providers, promoting continuity of care, and maximizing existing efficiencies within the first response and emergency medical services system.

(d) It is the intent of the Legislature that a community paramedicine or triage to alternate destination program achieve all of the following:

(1) Improve coordination among providers of medical services, behavioral health services, and social services.

(2) Preserve and protect the underlying 911 emergency medical services delivery system.

(3) Preserve, protect, and deliver the highest level of patient care to every Californian.

(4) Preserve and protect the current health care workforce and empower local health care systems to provide care more effectively and efficiently.

(e) It is the intent of the Legislature that an alternate destination facility participating as part of an approved program always be

1 staffed by a health care professional with a higher scope of practice,
2 such as, at minimum, a registered nurse.
3 (f) It is the intent of the Legislature that the delivery of
4 community paramedicine or triage to alternate destination services
5 is a public good to be delivered in a manner that promotes the
6 continuity of both care and providers. It is the intent of the
7 Legislature that the delivery of these services be coordinate and
8 consistent with, and complementary to, the existing first response
9 and emergency medical response system in place within the
10 jurisdiction of the local EMS agency.
11 (g) It is the intent of the Legislature that a community
12 paramedicine or triage to alternate destination program be designed
13 to improve community health and be implemented in a fashion
14 that respects the current emergency medical system and its
15 providers, and the health care delivery system. In furtherance of
16 the public interest and good, agencies that provide first response
17 services are well positioned to deliver care under a community
18 paramedicine or triage to alternate destination program.
19 (h) It is the intent of the Legislature that the development of
20 any community paramedicine or triage to alternate destination
21 program reflect input from all practitioners of appropriate medical
22 authorities, including, but not limited to, medical directors,
23 physicians, nurses, mental health professionals, first responder
24 paramedics, hospitals, and other entities within the emergency
25 medical response system.
26 (i) It is the intent of the Legislature that local EMS agencies be
27 authorized to develop a community paramedicine or triage to
28 alternate destination program to improve patient care and
29 community health. A community paramedicine or triage to alternate
30 destination program should not be used to replace or eliminate
31 health care workers, reduce personnel costs, harm the working
32 conditions of emergency medical and health care workers, or
33 otherwise compromise the emergency medical response or health
34 care system. The highest priority of any community paramedicine
35 or triage to alternate destination program shall be improving patient
36 care.

Article 2. Definitions

1810. Unless otherwise indicated in this chapter, the definitions contained in this article govern the provisions of this chapter.

1811. "Alternate destination facility" means a treatment location that is an authorized mental health facility, as defined in Section 1812 or an authorized sobering center as defined in Section 1813.

1812. "Authorized mental health facility" means a designated facility, as defined in subdivision (n) of Section 5008 of the Welfare and Institutions Code, that has at least one registered nurse staffed onsite at the facility at all times.

1813. "Authorized sobering center" means a noncorrectional facility that provides a safe, supportive environment for intoxicated individuals to become sober that meets both of the following requirements:

(a) The facility is staffed at all times with at least one registered nurse.

(b) The facility is a federally qualified health center, including a clinic described in *subdivision (b) of* Section ~~1211.~~ *1206.*

1814. "Community paramedic" means a paramedic in good standing licensed under this division who has completed the curriculum for community paramedic training adopted pursuant to paragraph (1) of subdivision (d) of Section 1830, has received certification in one or more of the community paramedicine program specialties described in Section 1815, and is certified and accredited to provide community paramedic services by a local EMS agency as part of an approved community paramedicine program.

1815. "Community paramedicine program" means a program developed by a local EMS agency and approved by the Emergency Medical Services Authority to provide community paramedicine services consisting of one or more of the program specialties described in this section under the direction of medical protocols developed by the local EMS agency that are consistent with the minimum medical protocols established by the authority. Community paramedicine services may consist of the following program specialties:

(a) Providing short-term postdischarge followup for persons recently discharged from a hospital due to a serious health

1 condition, including collaboration with, and by providing referral
2 to, home health services when eligible.
3 (b) Providing directly observed therapy (DOT) to persons with
4 tuberculosis in collaboration with a public health agency to ensure
5 effective treatment of the tuberculosis and to prevent spread of the
6 disease.
7 (c) Providing case management services to frequent emergency
8 medical services users in collaboration with, and by providing
9 referral to, existing appropriate community resources.
10 1816. "Community paramedicine provider" means an advanced
11 life support provider authorized by a local EMS agency to provide
12 advanced life support who has entered into a contract to deliver
13 community paramedicine services as described in Section 1815
14 as part of an approved community paramedicine program
15 developed by a local EMS agency.
16 1817. "Public agency" means a city, county, city and county,
17 special district, or other political subdivision of the state that
18 provides first response services, including emergency medical
19 care.
20 1818. "Triage paramedic" means a paramedic licensed under
21 this division who has completed the curriculum for triage
22 paramedic services adopted pursuant to paragraph (2) of
23 subdivision (d) of Section 1830 and has been accredited by a local
24 EMS agency in one or more of the triage paramedic specialties
25 described in Section 1819 as part of an approved triage to alternate
26 destination program.
27 1819. (a) "Triage to alternate destination program" means a
28 program developed by a local EMS agency and approved by the
29 Emergency Medical Services Authority to provide triage paramedic
30 assessments consisting of one or more specialties described in this
31 section operating under triage and assessment protocols developed
32 by the local EMS agency that are consistent with the minimum
33 triage and assessment protocols established by the authority. Triage
34 paramedic assessments may consist of the following program
35 specialties:
36 (1) Providing care and comfort services to hospice patients in
37 their homes in response to 911 calls by providing for the patient's
38 and the family's immediate care needs, including grief support in
39 collaboration with the patient's hospice agency until the hospice
40 nurse arrives to treat the patient.

1 (2) Providing patients with advanced life support triage and
2 assessment by a triage paramedic and transportation to an alternate
3 destination facility.
4 (b) This section does not prevent or eliminate any authority to
5 provide continuous transport of a patient to a participating hospital
6 for priority evaluation by a physician, nurse practitioner, or
7 physician assistant before transport to an alternate destination
8 facility.
9 1820. "Triage to alternate destination provider" means an
10 advanced life support provider authorized by a local EMS agency
11 to provide advanced life support triage paramedic assessments as
12 part of an approved triage to alternate destination program
13 specialty, as described in Section 1819.
14
15 Article 3. State Administration
16
17 1830. (a) The Emergency Medical Services Authority shall
18 develop regulations that establish minimum standards for the
19 development of a community paramedicine or triage to alternate
20 destination program.
21 (b) The Commission on Emergency Medical Services shall
22 review and approve the regulations described in this section in
23 accordance with Section 1799.50.
24 (c) The regulations described in this section shall be based upon,
25 and informed by, the Community Paramedicine Pilot Program
26 under the Office of Statewide Health Planning and Development
27 Health Workforce Pilot Project No. 173 and the protocols and
28 operation of the pilot projects approved under the project.
29 (d) The regulations that establish minimum standards for the
30 development of a community paramedicine or triage to alternate
31 destination program shall include all of the following:
32 (1) Minimum standards and curriculum for each program
33 specialty described in Section 1815. The authority, in developing
34 the minimum standards and curriculum, shall provide for
35 community paramedics to be trained in one or more of the program
36 specialties described in Section 1815 and approved by the local
37 EMS agency pursuant to Section 1840.
38 (2) Minimum standards and curriculum for each program
39 specialty described in Section 1819. The authority, in developing
40 the minimum standards and curriculum, shall provide for triage

1 paramedics to be trained in one or more of the program specialties
2 described in Section 1819 and approved by the local EMS agency
3 pursuant to Section 1840.
4 (3) A process for verifying on a paramedic's license the
5 successful completion of the training described in paragraph (1)
6 or (2).
7 (4) Staff qualifications to care for a patient's injuries and needs
8 based on degree and severity.
9 (5) Standardized medical and nursing procedures for nursing
10 staff.
11 (6) The medical equipment and services required to be available
12 at an alternate destination facility to care for patients, including,
13 but not limited to, an automatic external defibrillator and at least
14 one bed or mat per patient.
15 (7) Limitations that may apply to the ability of an alternate
16 destination facility to treat patients requiring medical services,
17 including, but limited to, time of day.
18 (8) Minimum standards for approval, review, withdrawal, and
19 revocation of a community paramedicine or triage to alternate
20 destination program in accordance with Section 1797.105. Those
21 standards shall include, but not be limited to, both of the following:
22 (A) A requirement that facilities participating in the program
23 accommodate privately or commercially insured, Medi-Cal,
24 Medicare, and uninsured patients.
25 (B) Immediate termination of participation in the program by
26 the alternate destination facility or the community paramedicine
27 or triage to alternate destination provider if it fails to operate in
28 accordance with subdivision (b) of Section 1317.
29 (9) Minimum standards for collecting and submitting data to
30 the authority to ensure patient safety that include consideration of
31 both quality assurance and quality improvement. These standards
32 shall include, but not be limited to, all of the following:
33 (A) Intervals for community paramedicine or triage to alternate
34 destination providers, participating health facilities, and local EMS
35 agencies to submit community paramedicine services data.
36 (B) Relevant program use data and the online posting of program
37 analyses.
38 (C) Exchange of electronic patient health information between
39 community paramedicine or triage to alternate destination providers
40 and health providers and facilities. The authority may grant a

1 one-time temporary waiver, not to exceed five years, of this
2 requirement for alternate destination facilities that are unable to
3 immediately comply with the electronic patient health information
4 requirement.
5 (D) Emergency medical response system feedback, including
6 feedback from the emergency medical care committee described
7 in subdivision (b) of Section 1797.273.
8 (E) If the community paramedicine or triage to alternate
9 destination program utilizes an alternate destination facility,
10 consideration of ambulance patient offload times for the alternate
11 destination facility, the number of patients that are turned away,
12 diverted, or required to be subsequently transferred to an
13 emergency department, and identification of the reasons for turning
14 away, diverting, or transferring the patient.
15 (F) An assessment of each community paramedicine or triage
16 to alternate destination program's medical protocols or other
17 processes.
18 (G) An assessment of the impact that implementation of a
19 community paramedicine or triage to alternate destination program
20 has on the delivery of emergency medical services, including the
21 impact on response times in the local EMS agency's jurisdiction.
22 1831. Regulations adopted by the Emergency Medical Services
23 Authority pursuant to Section 1830 relating to a triage to alternate
24 destination program shall include all of the following:
25 (a) Local EMS agencies participating in providing patients with
26 advanced life support triage and assessment by a triage paramedic
27 and transportation to an alternate destination facility shall ensure
28 that any patient who meets the triage criteria for transport to an
29 alternate destination facility, but who requests to be transported
30 to an emergency department of a general acute care hospital, shall
31 be transported to the emergency department of a general acute care
32 hospital.
33 (b) Local EMS agencies participating in providing patients with
34 advanced life support triage and assessment by a triage paramedic
35 and transportation to an alternate destination facility shall require
36 that a patient who is transported to an alternate destination facility
37 and, upon assessment, is found to no longer meet the criteria for
38 admission to an alternate destination facility, be immediately
39 transported to the emergency department of a general acute care
40 hospital.

(c) For authorizing transport to an alternate destination facility, training and accreditation for the triage paramedic ~~and the incumbent transport provider~~ shall include topics relevant to the needs of the patient population, including, but not limited to:

(1) A requirement that a participating triage paramedic complete instruction on all of the following:

(A) Mental health crisis intervention, to be provided by a licensed physician and surgeon with experience in the emergency department of a general acute care hospital.

(B) Assessment and treatment of intoxicated patients.

(C) Local EMS agency policies for the triage, treatment, transport, and transfer of care, of patients to an alternate destination facility.

(2) A requirement that the local EMS agency verify that the participating triage paramedic has completed training in all of the following topics meeting the standards of the United States Department of Transportation National Highway Traffic Safety Administration National Emergency Medical Services Education Standards:

(A) Psychiatric disorders.

(B) Neuropharmacology.

(C) Alcohol and substance abuse.

(D) Patient consent.

(E) Patient documentation.

(F) Medical quality improvement.

(d) For authorizing transport to a sobering center, a training component that requires a participating triage paramedic ~~and the medics staffing the ambulance of the incumbent transport provider~~ to complete instruction on all of the following:

(1) The impact of alcohol intoxication on the local public health and emergency medical services system.

(2) Alcohol and substance use disorders.

(3) Triage and transport parameters.

(4) Health risks and interventions in stabilizing acutely intoxicated patients.

(5) Common conditions with presentations similar to intoxication.

(6) Disease process, behavioral emergencies, and injury patterns common to those with chronic alcohol use disorders.

1 *(e) A process for local EMS agencies to certify and provide*
2 *periodic updates to the authority to demonstrate that the alternate*
3 *destination facility authorized to receive patients maintains*
4 *adequate licensed medical and professional staff, facilities, and*
5 *equipment pursuant to the authority's regulations and the*
6 *provisions of this chapter, which shall include all of the following:*
7 *(1) Identification of qualified staff to care for the degree of a*
8 *patient's injuries and needs.*
9 *(2) Certification of standardized medical and nursing*
10 *procedures for nursing staff.*
11 *(3) Certification that the necessary equipment and services are*
12 *available at the alternate destination facility to care for patients,*
13 *including, but not limited to, an automatic external defibrillator*
14 *and at least one bed or mat per individual patient.*
15 1832. (a) The Emergency Medical Services Authority shall
16 develop and periodically review and update the minimum medical
17 protocols applicable to each community paramedicine program
18 specialty described in Section 1815 and the minimum triage and
19 assessment protocols for triage to alternate destination program
20 specialties described in Section 1819.
21 (b) In complying with the requirements of this section, the
22 authority shall establish and consult with an advisory committee
23 comprised of the following members:
24 (1) Individuals in the fields of public health, social work,
25 hospice, substance-use or mental health with expertise
26 commensurate with the program specialty or specialties described
27 in Section 1815.
28 (2) Physicians and surgeons whose primary practice is
29 emergency medicine.
30 (3) Two local EMS medical directors selected by the EMS
31 Medical Directors Association of California.
32 (4) Two local EMS directors selected by the California Chapter
33 of the American College of Emergency Physicians.
34 (c) The protocols developed and revised pursuant to this section
35 shall be based upon, and informed by, the Community
36 Paramedicine Pilot Program under the Office of Statewide Health
37 Planning and Development's Health Workforce Pilot Project No.
38 173, and further refinements provided by local EMS agencies
39 during the course and operation of the pilot projects.

1833. (a) Notwithstanding Section 10231.5 of the Government Code, the Emergency Medical Services Authority shall submit an annual report on the community paramedicine or triage to alternate destination programs operating in California to the relevant policy committees of the Legislature in accordance with Section 9795 of the Government Code and shall post the annual report on its internet website. The authority shall submit and post its first report six months after the authority adopts the regulations described in Section 1830. Thereafter, the authority shall submit and post its report annually on or before January 1, for a period of five years.

(b) The report required by this section shall include all of the following:

(1) An assessment of each program specialty, including an assessment of patient outcomes in the aggregate and an assessment of any adverse patient events resulting from services provided under plans approved pursuant to this chapter.

(2) An assessment of the impact that the program specialties have had on the emergency medical system.

(3) An update on the implementation of program specialties operating in local EMS agency jurisdictions.

(4) Policy recommendations for improving the administration of local plans and patient outcomes.

(c) All data collected by the authority shall be posted on its internet website in a downloadable format and in a manner that protects the confidentiality of individually identifiable patient information.

~~1834~~

1834. (a) Notwithstanding Section 10231.5 of the Government Code, on or before June 1, 2028, the Emergency Medical Services Authority shall submit a final report on the results of the community paramedicine or triage to alternate destination programs operating in California to the relevant policy committees of the Legislature, in accordance with Section 9795 of the Government Code, and shall post the report on its internet website.

(b) The authority shall identify and contract with an independent third-party evaluator to develop the report required by this section.

(c) The report shall include all of the following:

(1) A detailed assessment of each community paramedicine or triage to alternate destination program operating in local EMS agency jurisdictions.

1 (2) An assessment of patient outcomes in the aggregate resulting
2 from services provided under approved plans under the program.
3 (3) An assessment of workforce impact due to implementation
4 of the program.
5 (4) An assessment of the impact of the program on the
6 emergency medical services system.
7 (5) An assessment of how the currently operating program
8 specialties achieve the legislative intent stated in Section 1801.
9 (6) An assessment of community paramedic and triage training.
10 (d) The report may include recommendations for changes to,
11 or the elimination of, community paramedicine or triage to alternate
12 destination program specialties that do not achieve the community
13 health and patient goals described in Section 1801.
14 1835. (a) The Emergency Medical Services Authority shall
15 review a local EMS agency's proposed community paramedicine
16 or triage to alternate destination program using procedures
17 consistent with Section 1797.105 and review the local EMS
18 agency's program protocols in order to ensure compliance with
19 the statewide minimum protocols developed under Section 1832.
20 (b) The authority may impose conditions as part of the approval
21 of a community paramedicine or triage to alternate destination
22 program that the local EMS agency is required to incorporate into
23 its program to achieve consistency with the authority's regulations
24 and the provisions of this chapter.
25 (c) The authority shall approve, approve with conditions, or
26 deny the proposed community paramedicine or triage to alternate
27 destination program no later than six months after it is submitted
28 by the local EMS agency.
29 1836. A community paramedicine pilot program approved
30 under the Office of Statewide Health Planning and Development's
31 Health Workforce Pilot Project No. 173 before January 1, 2020,
32 is authorized to operate until one year after the regulations
33 described in Section 1830 become effective.
34
35 Article 4. Local Administration
36
37 1840. A local EMS agency may develop a community
38 paramedicine or triage to alternate destination program that is
39 consistent with the Emergency Medical Services Authority's
40 regulations and the provisions of this chapter and submit evidence

1 of compliance with the requirements of Section 1841 to the
2 authority for approval pursuant to Section 1835.
3 1841. A local EMS agency that elects to develop a community
4 paramedicine or triage to alternate destination program shall do
5 all of the following:
6 (a) Integrate the proposed community paramedicine or triage
7 to alternate destination program into the local EMS agency's
8 emergency medical services plan described in Article 2
9 (commencing with Section 1797.250) of Chapter 4.
10 (b) Consistent with this article, develop a process to select
11 community paramedicine providers or triage to alternate destination
12 providers, to provide services as described in Section 1815 or 1819,
13 at a periodic interval established by the local EMS agency.
14 (c) Facilitate any necessary agreements with one or more
15 community paramedicine or triage to alternate destination providers
16 for the delivery of community paramedicine or triage to alternate
17 destination services within the local EMS agency's jurisdiction
18 that are consistent with the proposed community paramedicine or
19 triage to alternate destination program. The local EMS agency
20 shall provide medical control and oversight of the program.
21 (d) The local EMS agency shall not include the provision of
22 community paramedic program specialties or triage to alternate
23 destination program specialties as part of an existing or proposed
24 contract for the delivery of emergency medical transport services
25 awarded pursuant to Section 1797.224.
26 (e) Coordinate, review, and approve any agreements necessary
27 for the provision of community paramedicine specialties or triage
28 to alternate destination services consistent with all of the following:
29 (1) Provide a first right of refusal to the public agency or
30 agencies within the jurisdiction of the proposed program area to
31 provide the proposed program specialties. If the public agency or
32 agencies agree to provide the proposed program specialties, the
33 local EMS agency shall review and approve any written agreements
34 necessary to implement the program with those public agencies.
35 (2) Review and approve agreements with community
36 paramedicine triage to alternate destination providers that partner
37 with a private provider to deliver those program specialties.
38 (3) If a public agency declines to provide the proposed program
39 specialties pursuant to paragraph (1) or (2), the local EMS agency

1 shall develop a process to select community paramedicine or triage
2 to alternate destination providers to deliver the program specialties.
3 (f) Facilitate necessary agreements between the triage to
4 alternate destination program provider and the existing emergency
5 medical transport provider to ensure transport to the appropriate
6 facility.
7 (g) At the discretion of the local medical director, develop
8 additional triage and assessment protocols commensurate with the
9 need of the local programs authorized under this act.
10 (h) Prohibit triage and assessment protocols or a triage
11 paramedic's decision to authorize transport to an alternate
12 destination facility from being based on, or affected by, a patient's
13 ethnicity, citizenship, age, preexisting medical condition, insurance
14 status, economic status, ability to pay for medical services, or any
15 other characteristic listed or defined in subdivision (b) or (e) of
16 Section 51 of the Civil Code, except to the extent that a
17 circumstance such as age, sex, preexisting medical condition, or
18 physical or mental disability is medically significant to the
19 provision of appropriate medical care to the patient.
20 (i) Certify and provide documentation and periodic updates to
21 the Emergency Medical Service Authority showing that the
22 alternate destination facility authorized to receive patients
23 maintains adequate licensed medical and professional staff,
24 facilities, and equipment that comply with the requirements of the
25 Emergency Medical Services Authority's regulations and the
26 provisions of this chapter.
27 (j) Secure an agreement with the alternate destination facility
28 that requires the facility to notify the local EMS agency within 24
29 hours if there are changes in the status of the facility with respect
30 to protocols and the facility's ability to care for patients.
31 (k) Secure an agreement with the alternate destination that
32 requires the facility to operate in accordance with Section 1317.
33 The agreement shall provide that failure to operate in accordance
34 with Section 1317 will result in the immediate termination of use
35 of the facility as part of the triage to alternate destination facility.
36 (*l*) In implementing a triage to alternate destination program
37 specialties described in Section 1819, the local EMS agency shall
38 continue to use, and coordinate with, any emergency medical
39 transport providers operating within the jurisdiction of the local
40 EMS agency pursuant to Section 1797.201 or 1797.224. The local

EMS agency shall not in any manner eliminate or reduce the services of the emergency medical transport providers.

(m) Establish a process to verify training and accreditation of community paramedics in each of the proposed community paramedicine program specialties described in subdivisions (a) to (c), inclusive, of Section 1815.

(n) Establish a process for training and accreditation of triage paramedics in each of the proposed triage to alternate destination program's specialties described in Section 1819.

(o) Facilitate funding discussions between a community paramedicine, triage to alternate destination provider, or incumbent emergency medical transport provider and public or private health system participants to support the implementation of the local EMS agency's community paramedicine or triage to alternate destination program.

Article 5. Miscellaneous

1850. A community paramedicine pilot program approved under the Office of Statewide Health Planning and Development's Health Workforce Pilot Project No. 173 before January 1, 2020, to deliver community paramedicine ~~services~~ *services,* as described in Section 1815, *or triage to alternate destination services, as described in Section 1819,* is authorized to continue the use of existing providers and is exempt from subdivisions (d) and (e) of Section 1841 until the provider elects to reduce or eliminate one or more of those community paramedicine services approved under the pilot program or fails to comply with the program standards as required by this chapter.

1851. A person or organization shall not provide community paramedicine or triage to alternate destination services or represent, advertise, or otherwise imply that it is authorized to provide community paramedicine or triage to alternate destination services unless it is expressly authorized by a local EMS agency to provide those services as part of a community paramedicine or triage to alternate destination program approved by the Emergency Medical Services Authority in accordance with Section 1835.

1852. A community paramedic shall provide community paramedicine services only if the community paramedic has been certified and accredited to perform those services by a local EMS

1 agency and is working as an employee of an authorized community
2 paramedicine provider.
3 1853. A triage paramedic shall provide triage to alternate
4 destination services only if the triage paramedic has been accredited
5 to perform those services by a local EMS agency and is working
6 as an employee of an authorized triage to alternate destination
7 provider.
8 1854. The disciplinary procedures for a community paramedic
9 shall be consistent with subdivision (d) of Section 1797.194.
10 1855. Entering into an agreement to be a community
11 paramedicine or triage to alternate destination provider pursuant
12 to this chapter shall not alter or otherwise invalidate an agency's
13 authority to provide or administer emergency medical services
14 pursuant to Section 1797.201 or 1797.224.
15 1856. The liability provisions described in Chapter 9
16 (commencing with Section 1799.100) apply to this chapter.
17 1857. This chapter shall remain in effect only until January 1,
18 2030, and as of that date is repealed.
19 SEC. 5. No reimbursement is required by this act pursuant to
20 Section 6 of Article XIII B of the California Constitution because
21 the only costs that may be incurred by a local agency or school
22 district will be incurred because this act creates a new crime or
23 infraction, eliminates a crime or infraction, or changes the penalty
24 for a crime or infraction, within the meaning of Section 17556 of
25 the Government Code, or changes the definition of a crime within
26 the meaning of Section 6 of Article XIII B of the California
27 Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	SB 159
AUTHOR:	Wiener
BILL DATE:	April 30, 2019, Amended
SUBJECT:	HIV: Preexposure and postexposure prophylaxis
SPONSOR:	California Pharmacists Association Equality California

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow a pharmacist to furnish preexposure prophylaxis (PrEP) and postexposure prophylaxis (PEP), in accordance with protocols established by this bill. This bill would also prohibit a health plan or insurer from subjecting combination antiretroviral drug treatments that are medically necessary for the prevention of AIDS/HIV, including PrEP and PEP, to prior authorization or step therapy. This bill would prohibit plans and insurers from prohibiting, or allowing a pharmacy benefit manager to prohibit, a pharmacy provider from providing PrEP or PEP. This bill would require Medi-Cal to reimburse pharmacies for initiating and furnishing PrEP and PEP.

BACKGROUND:

According to the committee analysis:

In 2012, the U.S. Food and Drug Administration (FDA) approved Truvada, a name brand daily-use drug for PrEP that can reduce the risk of sexually acquired HIV-infection in adults at high risk. According to the CDC, PrEP is “highly effective for preventing HIV if used as prescribed, but it is much less effective when not taken consistently. Daily PrEP reduces the risk of getting HIV from sex by more than 90%. Among people who inject drugs, it reduces the risk by more than 70%.” For over 20 years, CDC has recommended PEP to protect healthcare workers who have been accidentally exposed to HIV in the workplace.

PEP involves taking certain HIV medicines within 72 hours after a possible exposure to HIV to prevent infection. PEP involves taking HIV medications every day for 28 days, and the CDC indicates that it should be used only in emergency situations, and is not intended to replace regular use of other HIV prevention methods, such as PrEP.

In 2017, the CDC published Preexposure Prophylaxis for HIV Prevention in the United States – 2017 Update: A Clinical Practice Guideline, which provided comprehensive information for the use of daily oral antiretroviral PrEP to reduce the risk of acquiring HIV infection in adults. The CDC Guidelines indicate that “Daily oral PrEP … has been shown to be safe and effective in reducing the risk of sexual HIV acquisition in adults; therefore, PrEP is recommended as one prevention option for sexually-active adult men

who have sex with men, ...adult heterosexually active men and women, …and injection drugs users at substantial risk of HIV acquisition."

In assessing an individual's clinical eligibility prior to prescribing PrEP, CDC recommends the person have a documented negative HIV test, no signs or symptoms of acute HIV infection, normal renal function, no use of contraindicated medications, no documented hepatitis B virus infection, and a hepatitis B vaccination.

The CDC further recommends that HIV infection should be assessed at least every 3 months while patients are taking PrEP, renal function should be assessed at baseline and monitored at least every 6 months, and follow-up visits at least every 3 months should provide the following: HIV testing, medication adherence counseling, behavioral risk reduction support, side effect assessment, and STI symptom assessment.

The most recent CDC guidelines for PEP, Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Non-occupational Exposure to HIV— United States, 2016, encourage health care providers to evaluate individuals for PEP when care is sought within 72 hours after a potential non-occupational exposure that presents a substantial risk for HIV acquisition.

CDC recommends individuals considering PEP take an HIV test, but if one is unavailable and PEP is otherwise indicated, PEP "should be initiated without delay and can be discontinued if the patient is later determined to have HIV infection already or the source is determined not to have HIV infection." A complete course of PEP is 28 days of a 3-drug antiretroviral regimen. The guidelines further indicate, "All persons evaluated for possible PEP should be provided any indicated prevention, treatment, or supportive care for other exposure-associated health risks and conditions (e.g., bacterial sexually transmitted infections, traumatic injuries, hepatitis B virus and hepatitis C virus infection, or pregnancy). All persons who report behaviors or situations that place them at risk for frequently recurring HIV exposures (e.g., injection drug use, or sex without condoms) or who report receipt of [more than one] course of PEP in the past year should be provided risk-reduction counseling and intervention services, including consideration of preexposure prophylaxis."

ANALYSIS:

This bill would allow a pharmacist to initiate and furnish HIV PrEP and PEP in accordance with this bill.

This bill would define PrEP to mean a fixed-dose combination of tenofovir disoproxil fumarate (TDF) (300 mg) with emtricitabine (FTC) (200 mg), or another drug or drug combination that meets the same clinical eligibility recommendations provided in CDC guidelines.

This bill would define PEP as either of the following:

- TDF (300 mg) with FTC (200 mg), taken once daily, in combination with either raltegravir (400 mg), taken twice daily, or dolutegravir (50 mg), taken once daily.
- TDF (300 mg) and FTC (200 mg), taken once daily, in combination with darunavir (800 mg) and ritonavir (100 mg), taken once daily.

This bill would define “CDC guidelines” to mean either of the following publications by the federal Centers for Disease Control and Prevention:

- “Preexposure Prophylaxis for the Prevention of HIV Infection in the United States – 2017 Update: A Clinical Practice Guideline.”
- “Updated Guidelines for Antiretroviral Postexposure Prophylaxis After Sexual, Injection Drug Use, or Other Nonoccupational Exposure to HIV – United States, 2016.”

This bill would require a pharmacist, before furnishing PrEP or PEP to a patient, to complete a training program approved by the Board of Pharmacy (BOP) on the use of PrEP and PEP. This bill would require the BOP to consult with the California Pharmacists Association and the Office of AIDS, within the California Department of Public Health, on training programs that are appropriate to meet the training program requirements.

This bill would allow a pharmacist to furnish a 30-day supply of PrEP if all of the following conditions are met:

- The patient is HIV negative, as documented by a negative HIV test result obtained within the previous seven days from an HIV antigen/antibody test or antibody-only test, or from a rapid, point-of-care finger stick blood test approved by the FDA. If the patient does not provide evidence of a negative HIV test in accordance with this paragraph, the pharmacist shall order an HIV test. If the test results are not transmitted directly to the pharmacist, the pharmacist shall verify the test results to the pharmacist’s satisfaction. If the patient tests positive for HIV infection, the pharmacist or person administering the test shall direct the patient to a primary care provider and provide a list of providers and clinics in the region.
- The patient does not report any signs or symptoms of acute HIV infection on a self-reported checklist of acute HIV infection signs and symptoms.
- The patient does not report taking any contraindicated medications.
- The pharmacist provides counseling to the patient on the ongoing use of PrEP, which may include education about side effects, safety during pregnancy and breastfeeding, adherence to recommended dosing, and the importance of timely testing and treatment, as applicable, for HIV, renal function, hepatitis B, hepatitis C, sexually transmitted diseases, and pregnancy for individuals of child-bearing capacity. The pharmacist shall notify the patient that the patient must be seen by a primary care provider to receive subsequent prescriptions for PrEP and that a pharmacist may not furnish a 30-day supply of PrEP to a single patient more than once every two years.
- The patient reports having normal kidney function, and the pharmacist orders a test to measure kidney function. The patient shall provide contact information for

the patient and sign an agreement to stop taking PrEP if laboratory results indicate that the patient should not take PrEP. The pharmacist shall contact the patient if laboratory results indicate that the patient should not take PrEP.

- The pharmacist documents, to the extent possible, the services provided by the pharmacist in the patient's health record. The pharmacist shall maintain records of PrEP furnished to each patient.
- The pharmacist does not furnish a 30-day supply of PrEP to a single patient more than once every two years, unless directed otherwise by a prescriber.
- The pharmacist notifies the patient's primary care provider that the pharmacist completed the requirements specified in this bill. If the patient does not have a primary care provider, or refuses consent to notify the patient's primary care provider, the pharmacist shall provide the patient a list of physicians and surgeons, clinics, or other health care service providers to contact regarding ongoing care for PrEP.

This bill would allow a pharmacist to furnish a complete course of PEP if all of the following conditions are met:

- The pharmacist screens the patient and determines the exposure occurred within the previous 72 hours and otherwise meets the clinical criteria for PEP consistent with CDC guidelines.
- The pharmacist provides HIV testing or determines the patient is willing to undergo HIV testing consistent with CDC guidelines. If the patient refuses to undergo HIV testing but is otherwise eligible for PEP under this section, the pharmacist may furnish PEP.
- The pharmacist provides counseling to the patient on the use of PEP consistent with CDC guidelines, which may include education about side effects, safety during pregnancy and breastfeeding, adherence to recommended dosing, and the importance of timely testing and treatment, as applicable, for HIV and sexually transmitted diseases.
- The pharmacist notifies the patient's primary care provider of the PEP treatment. If the patient does not have a primary care provider, or refuses consent to notify the patient's primary care provider, the pharmacist shall provide the patient a list of physicians and surgeons, clinics, or other health care service providers to contact regarding follow-up care for PEP.
- The pharmacist does not furnish PEP to a single individual more than two times in a calendar year.

This bill would specify that a pharmacist initiating or furnishing PrEP or PEP shall not permit the person to whom the drug is furnished to waive the consultation required by BOP.

This bill would require BOP, by July 1, 2020, to adopt emergency regulations to implement this bill in accordance with CDC guidelines. The adoption of regulations pursuant to this subdivision shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare.

This bill would specify that a health care service plan shall not subject combination antiretroviral drug treatments that are medically necessary for the prevention of AIDS/HIV, including PrEP or PEP, to prior authorization or step therapy. This bill would specify that a health care service plan shall not prohibit, or permit a delegated pharmacy benefit manager to prohibit, a pharmacy provider from dispensing PrEP or PEP. This bill would specify that it does not require a health care service plan to cover PrEP or PEP by a pharmacist at an out-of-network pharmacy, unless the health care service plan has an out-of-network pharmacy benefit.

This bill would specify that a health insurer shall not subject combination antiretroviral drug treatments that are medically necessary for the prevention of AIDS/HIV, including PrEP or PEP, to prior authorization or step therapy. This bill would specify that a health insurer shall not prohibit, or permit a contracted pharmacy benefit manager to prohibit, a pharmacist from dispensing PrEP or PEP.

This bill would specify that a pharmacist initiating and furnishing PrEP or PEP is a covered service under Medi-Cal.

According to the author's office, "Currently, PrEP and PEP both require a physician's prescription, which delays or prevents some people from accessing it. Some people are not comfortable going to see a doctor. Others struggle to access a doctor or are confronted with long delays to obtain an appointment. And, sadly, although many doctors understand the need for PrEP, too many doctors don't know much about it, judge people for requesting it, try to persuade them not to request it, and, generally, don't know enough about sexual health, particularly LGBTQ sexual health. To be clear, many doctors 'get it' and do a great job in this area. Significant work remains to educate the profession. Another barrier to PrEP and PEP uptake is the requirement by some insurance companies for prior authorization. Notably, Medi-Cal does not require a prior authorization. Prior authorizations can lead to delays of weeks or months in accessing PrEP and can lead to someone becoming HIV positive."

Although the purpose of this bill is well intended, PrEP has risks from long-term use, including impaired kidney function and the depleting of bone mineral. PrEP can also cause drug interactions and requires regular rigorous monitoring and testing during use. This bill would also allow patients to obtain a full regimen of PEP without any requirement to see a physician for follow up care. For these reasons, Board staff is recommending that the Board take an oppose position on this bill.

FISCAL: None

SUPPORT: California Pharmacists Association (co-sponsor); Equality California (co-sponsor); American Academy of HIV Medicine; American Civil Liberties Union of California; APLA Health; California Korean American Pharmacists Association; California LGBTQ Health and Human Services Network; California Life Sciences Association; California Retailers Association; California Sexual Assault Forensic

Examiners Association; CaliforniaHealth+ Advocates; City of West Hollywood; Indian Pharmacists Association of California; Los Angeles LGBT Center; Mission Wellness Pharmacy; National Association of Chain Drug Stores; National Association of Social Workers, California Chapter; Sacramento Valley Pharmacists Association; San Francisco AIDS Foundation; San Francisco Department of Public Health; San Francisco Hepatitis C Task Force; San Francisco Lesbian Gay Bisexual Transgender Community Center; Santa Clara County; Shanti; St. Anthony's; St. James Infirmary; and Nine Individuals

OPPOSITION: AIDS Healthcare Foundation (oppose unless amended); America's Health Insurance Plans; American College of Obstetricians and Gynecology District IX; Association of California Life and Health Insurance Companies; California Association of Health Plans; California Chapter of the American College of Cardiology; California Chapter of the American College of Emergency Physicians; California Medical Association (oppose unless amended); California Urological Association; Infectious Diseases Association of California; and Kaiser Permanente (oppose unless amended)

AMENDED IN SENATE APRIL 30, 2019

AMENDED IN SENATE APRIL 11, 2019

AMENDED IN SENATE APRIL 1, 2019

AMENDED IN SENATE FEBRUARY 27, 2019

SENATE BILL No. 159

Introduced by Senator Wiener
(Principal coauthors: Assembly Members Gipson and Gloria)
(Coauthor: Assembly Member Chiu)

January 23, 2019

An act to amend Section 4052 of, and to add Section 4052.02 to, the Business and Professions Code, to add Section 1342.74 to the Health and Safety Code, to add Section 10123.1933 to the Insurance Code, and to amend Section 14132.968 of the Welfare and Institutions Code, relating to HIV prevention.

LEGISLATIVE COUNSEL'S DIGEST

SB 159, as amended, Wiener. HIV: preexposure and postexposure prophylaxis.

Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy, and makes a violation of these requirements a crime. Existing law generally authorizes a pharmacist to dispense or furnish drugs only pursuant to a valid prescription, except as provided, such as furnishing emergency contraceptives, hormonal contraceptives, and naloxone hydrochloride, pursuant to standardized procedures.

This bill would authorize a pharmacist to furnish preexposure prophylaxis and postexposure prophylaxis, in specified amounts, if the pharmacist completes a training program approved by the board and

complies with specified requirements, such as assessing a patient and providing a patient with counseling and tests. Because a violation of these requirements would be a crime, this bill would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services pursuant to a schedule of benefits, including pharmacist services, which are subject to approval by the federal Centers for Medicare and Medicaid Services. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions.

This bill would expand the Medi-Cal schedule of benefits to include preexposure prophylaxis and postexposure prophylaxis as pharmacist services.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law authorizes health care service plans and health insurers that cover prescription drugs to utilize reasonable medical management practices, including prior authorization and step therapy, consistent with applicable law. For combination antiretroviral drug treatments medically necessary for the prevention of AIDS/HIV, existing law prohibits plans and insurers, until January 1, 2023, from having utilization management policies or procedures that rely on a multitablet drug regimen instead of a single-tablet drug regimen, except as specified.

This bill would additionally prohibit plans and insurers from subjecting those drug treatments, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy. *The bill would also prohibit plans and insurers from prohibiting, or allowing a pharmacy benefit manager to prohibit, a pharmacy provider from providing preexposure prophylaxis or postexposure prophylaxis.* Because a willful violation of these provisions *by a health care service plan* would be a crime, this bill would impose a state-mandated local program.

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:

1 SECTION 1. Section 4052 of the Business and Professions
2 Code is amended to read:
3 4052. (a) Notwithstanding any other law, a pharmacist may:
4 (1) Furnish a reasonable quantity of compounded drug product
5 to a prescriber for office use by the prescriber.
6 (2) Transmit a valid prescription to another pharmacist.
7 (3) Administer drugs and biological products that have been
8 ordered by a prescriber.
9 (4) Perform procedures or functions in a licensed health care
10 facility as authorized by Section 4052.1.
11 (5) Perform procedures or functions as part of the care provided
12 by a health care facility, a licensed home health agency, a licensed
13 clinic in which there is a physician oversight, a provider who
14 contracts with a licensed health care service plan with regard to
15 the care or services provided to the enrollees of that health care
16 service plan, or a physician, as authorized by Section 4052.2.
17 (6) Perform procedures or functions as authorized by Section
18 4052.6.
19 (7) Manufacture, measure, fit to the patient, or sell and repair
20 dangerous devices, or furnish instructions to the patient or the
21 patient's representative concerning the use of those devices.
22 (8) Provide consultation, training, and education to patients
23 about drug therapy, disease management, and disease prevention.
24 (9) Provide professional information, including clinical or
25 pharmacological information, advice, or consultation to other
26 health care professionals, and participate in multidisciplinary
27 review of patient progress, including appropriate access to medical
28 records.
29 (10) Furnish the medications described in subparagraph (A) in
30 accordance with subparagraph (B):
31 (A) (i) Emergency contraception drug therapy and
32 self-administered hormonal contraceptives, as authorized by
33 Section 4052.3.

1 (ii) Nicotine replacement products, as authorized by Section
2 4052.9.
3 (iii) Prescription medications not requiring a diagnosis that are
4 recommended by the federal Centers for Disease Control and
5 Prevention for individuals traveling outside of the United States.
6 (iv) HIV preexposure prophylaxis and postexposure prophylaxis,
7 as authorized by Section 4052.02.
8 (B) The pharmacist shall notify the patient's primary care
9 provider of any drugs or devices furnished to the patient, or enter
10 the appropriate information in a patient record system shared with
11 the primary care provider, as permitted by that primary care
12 provider. If the patient does not have a primary care provider, the
13 pharmacist shall provide the patient with a written record of the
14 drugs or devices furnished and advise the patient to consult a
15 physician of the patient's choice.
16 (11) Administer immunizations pursuant to a protocol with a
17 prescriber.
18 (12) Order and interpret tests for the purpose of monitoring and
19 managing the efficacy and toxicity of drug therapies. A pharmacist
20 who orders and interprets tests pursuant to this paragraph shall
21 ensure that the ordering of those tests is done in coordination with
22 the patient's primary care provider or diagnosing prescriber, as
23 appropriate, including promptly transmitting written notification
24 to the patient's diagnosing prescriber or entering the appropriate
25 information in a patient record system shared with the prescriber,
26 when available and as permitted by that prescriber.
27 (b) A pharmacist who is authorized to issue an order to initiate
28 or adjust a controlled substance therapy pursuant to this section
29 shall personally register with the federal Drug Enforcement
30 Administration.
31 (c) This section does not affect the applicable requirements of
32 law relating to either of the following:
33 (1) Maintaining the confidentiality of medical records.
34 (2) The licensing of a health care facility.
35 SEC. 2. Section 4052.02 is added to the Business and
36 Professions Code, to read:
37 4052.02. (a) Notwithstanding any other law, a pharmacist may
38 initiate and furnish HIV preexposure prophylaxis and postexposure
39 prophylaxis in accordance with this section.
40 (b) For purposes of this section, the following definitions apply:

1 (1) "Preexposure prophylaxis" means a fixed-dose combination
2 of tenofovir disoproxil fumarate (TDF) (300 mg) with emtricitabine
3 (FTC) (200 mg), or another drug or drug combination that meets
4 the same clinical eligibility recommendations provided in CDC
5 guidelines.
6 (2) "Postexposure prophylaxis" means either of the following:
7 (A) Tenofovir disoproxil fumarate (TDF) (300 mg) with
8 emtricitabine (FTC) (200 mg), taken once daily, in combination
9 with either raltegravir (400 mg), taken twice daily, or dolutegravir
10 (50 mg), taken once daily.
11 (B) Tenofovir disoproxil fumarate (TDF) (300 mg) and
12 emtricitabine (FTC) (200 mg), taken once daily, in combination
13 with darunavir (800 mg) and ritonavir (100 mg), taken once daily.
14 (3) "CDC guidelines" means either of the following publications
15 by the federal Centers for Disease Control and Prevention:
16 (A) "2017 Preexposure Prophylaxis for the Prevention of HIV
17 Infection in the United States – 2017 Update: A Clinical Practice
18 Guideline."
19 (B) "Updated Guidelines for Antiretroviral Postexposure
20 Prophylaxis After Sexual, Injection Drug Use, or Other
21 Nonoccupational Exposure to HIV – United States, 2016."
22 (c) Before furnishing preexposure prophylaxis or postexposure
23 prophylaxis to a patient, a pharmacist shall complete a training
24 program approved by the board on the use of preexposure
25 prophylaxis and postexposure prophylaxis. The board shall consult
26 with the California Pharmacists Association and the Office of
27 AIDS, within the State Department of Public Health, on training
28 programs that are appropriate to meet the requirements of this
29 subdivision.
30 (d) A pharmacist may furnish a 30-day supply of preexposure
31 prophylaxis if all of the following conditions are met:
32 (1) The patient is HIV negative, as documented by a negative
33 HIV test result obtained within the previous seven days from an
34 HIV antigen/antibody test or antibody-only test, or from a rapid,
35 point-of-care fingerstick blood test approved by the federal Food
36 and Drug Administration. If the patient does not provide evidence
37 of a negative HIV test in accordance with this paragraph, the
38 pharmacist shall order an HIV test. If the test results are not
39 transmitted directly to the pharmacist, the pharmacist shall verify
40 the test results to the pharmacist's satisfaction. If the patient tests

positive for HIV infection, the pharmacist or person administering the test shall direct the patient to a primary care provider and provide a list of providers and clinics in the region.

(2) The patient does not report any signs or symptoms of acute HIV infection on a self-reported checklist of acute HIV infection signs and symptoms.

(3) The patient does not report taking any contraindicated medications.

(4) The pharmacist provides counseling to the patient on the ongoing use of preexposure prophylaxis, which may include education about side effects, safety during pregnancy and breastfeeding, adherence to recommended dosing, and the importance of timely testing and treatment, as applicable, for HIV, renal function, hepatitis B, hepatitis C, sexually transmitted diseases, and pregnancy for individuals of child-bearing capacity. The pharmacist shall notify the patient that the patient must be seen by a primary care provider to receive subsequent prescriptions for preexposure prophylaxis and that a pharmacist may not furnish a 30-day supply of preexposure prophylaxis to a single patient more than once every two years.

(5) The patient reports having normal kidney function, and the pharmacist orders a test to measure kidney function. The patient shall provide contact information for the patient and sign an agreement to stop taking preexposure prophylaxis if laboratory results indicate that the patient should not take preexposure prophylaxis. The pharmacist shall contact the patient if laboratory results indicate that the patient should not take preexposure prophylaxis.

(6) The pharmacist documents, to the extent possible, the services provided by the pharmacist in the patient's health record. The pharmacist shall maintain records of preexposure prophylaxis furnished to each patient.

(7) The pharmacist does not furnish a 30-day supply of preexposure prophylaxis to a single patient more than once every two years, unless directed otherwise by a prescriber.

(8) The pharmacist notifies the patient's primary care provider that the pharmacist completed the requirements specified in this subdivision. If the patient does not have a primary care provider, or refuses consent to notify the patient's primary care provider, the pharmacist shall provide the patient a list of physicians and

1 surgeons, clinics, or other health care service providers to contact
2 regarding ongoing care for preexposure prophylaxis.
3 (e) A pharmacist may furnish a complete course of postexposure
4 prophylaxis if all of the following conditions are met:
5 (1) The pharmacist screens the patient and determines the
6 exposure occurred within the previous 72 hours and *the patient*
7 otherwise meets the clinical criteria for postexposure prophylaxis
8 consistent with CDC guidelines.
9 (2) The pharmacist provides HIV testing or determines the
10 patient is willing to undergo HIV testing consistent with CDC
11 guidelines. If the patient refuses to undergo HIV testing but is
12 otherwise eligible for postexposure prophylaxis under this section,
13 the pharmacist may furnish postexposure prophylaxis.
14 (3) The pharmacist provides counseling to the patient on the
15 use of postexposure prophylaxis consistent with CDC guidelines,
16 which may include education about side effects, safety during
17 pregnancy and breastfeeding, adherence to recommended dosing,
18 and the importance of timely testing and treatment, as applicable,
19 for HIV and sexually transmitted diseases.
20 (4) The pharmacist notifies the patient's primary care provider
21 of the postexposure prophylaxis treatment. If the patient does not
22 have a primary care provider, or refuses consent to notify the
23 patient's primary care provider, the pharmacist shall provide the
24 patient a list of physicians and surgeons, clinics, or other health
25 care service providers to contact regarding followup care for
26 postexposure prophylaxis.
27 (5) The pharmacist does not furnish postexposure prophylaxis
28 to a single individual more than two times in a calendar year.
29 (f) A pharmacist initiating or furnishing preexposure prophylaxis
30 or postexposure prophylaxis shall not permit the person to whom
31 the drug is furnished to waive the consultation required by the
32 board.
33 (g) The board, by July 1, 2020, shall adopt emergency
34 regulations to implement this section in accordance with CDC
35 guidelines. The adoption of regulations pursuant to this subdivision
36 shall be deemed to be an emergency and necessary for the
37 immediate preservation of the public peace, health, safety, or
38 general welfare.
39 SEC. 3. Section 1342.74 is added to the Health and Safety
40 Code, immediately following Section 1342.73, to read:

1342.74. *(a)* Notwithstanding Section 1342.71, a health care service plan shall not subject combination antiretroviral drug treatments that are medically necessary for the prevention of AIDS/HIV, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy.

(b) Notwithstanding any other law, a health care service plan shall not prohibit, or permit a delegated pharmacy benefit manager to prohibit, a pharmacy provider from dispensing preexposure prophylaxis or postexposure prophylaxis.

(c) This section does not require a health care service plan to cover preexposure prophylaxis or postexposure prophylaxis by a pharmacist at an out-of-network pharmacy, unless the health care service plan has an out-of-network pharmacy benefit.

SEC. 4. Section 10123.1933 is added to the Insurance Code, immediately following Section 10123.1932, to read:

10123.1933. *(a)* Notwithstanding Section 10123.201, a health insurer shall not subject combination antiretroviral drug treatments that are medically necessary for the prevention of AIDS/HIV, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy.

(b) Notwithstanding any other law, a health insurer shall not prohibit, or permit a contracted pharmacy benefit manager to prohibit, a pharmacist from dispensing preexposure prophylaxis or postexposure prophylaxis.

SEC. 5. Section 14132.968 of the Welfare and Institutions Code is amended to read:

14132.968. (a) (1) Pharmacist services are a benefit under the Medi-Cal program, subject to approval by the federal Centers for Medicare and Medicaid Services.

(2) The department shall establish a fee schedule for the list of pharmacist services.

(3) The rate of reimbursement for pharmacist services shall be at 85 percent of the fee schedule for physician services under the Medi-Cal program.

(b) (1) The following services are covered pharmacist services that may be provided to a Medi-Cal beneficiary:

(A) Furnishing travel medications, as authorized in clause (3) of subparagraph (A) of paragraph (10) of subdivision (a) of Section 4052 of the Business and Professions Code.

1 (B) Furnishing naloxone hydrochloride, as authorized in Section
2 4052.01 of the Business and Professions Code.
3 (C) Furnishing self-administered hormonal contraception, as
4 authorized in subdivision (a) of Section 4052.3 of the Business
5 and Professions Code.
6 (D) Initiating and administering immunizations, as authorized
7 in Section 4052.8 of the Business and Professions Code.
8 (E) Providing tobacco cessation counseling and furnishing
9 nicotine replacement therapy, as authorized in Section 4052.9 of
10 the Business and Professions Code.
11 (F) Initiating and furnishing preexposure prophylaxis and
12 postexposure prophylaxis, as authorized in Section 4052.02 of the
13 Business and Professions Code.
14 (2) Covered pharmacist services shall be subject to department
15 protocols and utilization controls.
16 (c) A pharmacist shall be enrolled as an ordering, referring, and
17 prescribing provider under the Medi-Cal program prior to rendering
18 a pharmacist service that is submitted by a Medi-Cal pharmacy
19 provider for reimbursement pursuant to this section.
20 (d) (1) The director shall seek any necessary federal approvals
21 to implement this section. This section shall not be implemented
22 until the necessary federal approvals are obtained and shall be
23 implemented only to the extent that federal financial participation
24 is available.
25 (2) This section neither restricts nor prohibits any services
26 currently provided by pharmacists as authorized by law, including,
27 but not limited to, this chapter, or the Medicaid state plan.
28 (e) Notwithstanding Chapter 3.5 (commencing with Section
29 11340) of Part 1 of Division 3 of Title 2 of the Government Code,
30 the department may implement, interpret, or make specific this
31 section, and any applicable federal waivers and state plan
32 amendments, by means of all-county letters, plan letters, plan or
33 provider bulletins, or similar instructions, without taking regulatory
34 action. By July 1, 2021, the department shall adopt regulations in
35 accordance with the requirements of Chapter 3.5 (commencing
36 with Section 11340) of Part 1 of Division 3 of Title 2 of the
37 Government Code. Commencing July 1, 2017, the department
38 shall provide a status report to the Legislature on a semiannual
39 basis, in compliance with Section 9795 of the Government Code,
40 until regulations have been adopted.

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

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: SB 377
AUTHOR: McGuire
BILL DATE: April 11, 2019, Amended
SUBJECT: Juveniles: Psychotropic Medications: Medical Records
SPONSOR: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a juvenile court officer to authorize the Medical Board of California (Board) to review the minor's medical records, limited to the diagnosis for the prescription, in order to determine whether there is an excessive prescribing of psychotropic medications.

BACKGROUND:

In August 2014, the Board received a letter from Senator Lieu, who was at the time the Chair of the Senate Business, Professions and Economic Development Committee. The letter asked the Board to look into the issue of inappropriate prescribing of psychotropic medication to foster children. The Board receives very few complaints regarding foster children being prescribed psychotropic medications, so the Board researched other avenues to identify physicians who may be inappropriately prescribing. The Board met with the Department of Health Care Services (DHCS) and the Department of Social Services (DSS) regarding what data was available, what could be provided to the Board, and what data would assist in the identification of inappropriately prescribing physicians. After many meetings, a Data Use Agreement (DUA) was finalized in April 2015 requesting a listing of all physicians who had prescribed three or more psychotropic medications for 90 days or more. For each child that fit into this category, the Board requested a list of the medications prescribed, the start and stop date for each medication, the prescriber's name and contact information, the child's birth date, and any other information that DHCS and DSS thought might be relevant to assist in this process.

Upon receipt of the information requested in the DUA in 2015, the Board secured an expert pediatric psychiatrist to review the information and determine any physician who may be potentially prescribing inappropriately. It is important to note that once a physician is identified, the Board's normal complaint process was followed, including obtaining medical records, conducting a physician interview and having an expert physician review the case. The complaint and investigation process is confidential, and nothing is public until an accusation is filed. Upon review by the Board's expert, it was determined that 86 children were identified as potentially being prescribed to inappropriately. The Board then requested assistance from DSS, since the data

provided to the Board did not include the names of the foster children receiving the prescriptions. Per the data use agreement, DSS will facilitate contact with county child welfare agencies, the juvenile courts, county counsel, children's attorneys and other relevant entities, to assist the Board in obtaining child-specific information, including relevant medical records. The Board and DSS worked with the relevant entities to create an authorization letter to send to current and former foster children and their guardians, as appropriate, to receive authorization to obtain the medical records of the foster children. DSS staff sent out 33 letters to last known addresses of foster children who had transitioned out of foster care. Unfortunately, some of those letters came back as undeliverable/returned. DSS staff also reached out to the counties on 14 children to see if there was a medical rights holder who could authorize the release of information. Of those children, two had a legal guardian with medical rights who was sent the letter and authorization form. The remaining 12 children in those counties require court orders to obtain the release and the medical records. DSS has stated that at least one county counsel is willing to assist with obtaining the court orders and the Board will work with DSS on the process to move forward on seeking court orders. DSS staff are also preparing the letters and authorization forms for the children in the remaining counties to be sent out. The Board only received releases from 4 individuals. It is important to note, that without the authorization for the medical records, the Board cannot move forward with investigating these matters. Although the Board continues to work with DSS, the Board is not receiving the authorizations necessary in order for the Board to obtain the patient records to it can investigate these cases.

SB 1174 (McGuire, Chapter 840, Statutes of 2016) added to the Board's priorities, repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to children without a good faith prior exam and a medical reason. SB 1174 codified the Board's DUA with DHCS and DSS and required the Board to confidentially collect and analyze data submitted by DHCS and DSS, related to physicians prescribing psychotropic medications to children.

ANALYSIS:

This bill would require a juvenile court officer, upon approval of a request for authorization for the administration of psychotropic medication, to also authorize the Board to review the patient medical record of the child authorized to receive the psychotropic medication. This bill would limit the review of the patient record to the diagnosis for the prescription authorized in order to ascertain whether there is excessive prescribing of psychotropic medication inconsistent with the standard of care.

According to the author, this bill will give the Board "the information they need in order to carry out their requirements pursuant to investigating potential overprescribing patterns of psychotropic drugs to foster youth… Following the passage of SB 1174 (McGuire, Chapter 840, Statutes of 2016), the Board is required to contract with an expert consultant who reviews prescribing data from DHCS and DSS for foster youth who have been on three or more psychotropic medications for 90 days or more. The Board has been unable to conduct internal confidential investigations into potential over-

prescribing because they do not have access to the related medical records for the foster youth who fit the requirements under SB 1174. Currently, the Board must work with DSS to get letters out to the identified youth to request authorization for the Board to contact the individuals. If the Board receives authorization to contact the individual, they must next then obtain an authorization for release of medical records." The author further states that "SB 377 will cut through this red tape and allow the Board to carry out their oversight authority. When the juvenile court judicial officer authorizes the administration of a psychotropic medication through the JV 220 form, the judicial officer shall also authorize the Board to review limited patient medical record information of the child authorized to receive psychotropic medication."

The Board needs authorization to receive medical records for foster youths that the Board expert has identified as victims of potential inappropriate prescribing in order to look into these cases. However, just the diagnosis may not be enough for an expert to make this determination. The Board supports the intent of this bill, but an amendment will be needed to allow the Board to obtain more information from the medical records, in addition to the diagnosis. Board staff recommends that the Board take a support if amended position on this bill.

<u>FISCAL:</u> None

<u>SUPPORT:</u> None on File

<u>OPPOSITION:</u> None on File

<u>POSITION:</u> Recommendation: Support if Amended

AMENDED IN SENATE APRIL 11, 2019

AMENDED IN SENATE APRIL 1, 2019

SENATE BILL No. 377

Introduced by Senator McGuire

February 20, 2019

An act to amend ~~Section 369.5~~ *Sections 369.5 and 739.5* of the Welfare and Institutions Code, relating to juveniles.

LEGISLATIVE COUNSEL'S DIGEST

SB 377, as amended, McGuire. ~~Dependents:~~ *Juveniles:* psychotropic medications: medical records.

Existing law establishes the jurisdiction of the juvenile court, which may adjudge a child to be a dependent ~~of the court under certain circumstances, including when the child has suffered, or there is a substantial risk that the child will suffer, serious physical harm or illness, or a parent or guardian fails to adequately supervise or protect the child, as specified.~~ *or ward of the court under certain circumstances.* Existing law authorizes only a juvenile court judicial officer to make orders regarding the administration of psychotropic medications for a dependent child *or a ward* who has been removed from the physical custody of their parent. Existing law requires that court authorization for the administration of psychotropic medications to a child be based on a request from a physician, indicating the reasons for the request, a description of the child's diagnosis and behavior, the expected results of the medication, and a description of any side effects of the medication. Existing law requires, upon the approval or denial by the juvenile court judicial officer of a request for authorization for the administration of psychotropic medication, the county child welfare ~~agency~~ *agency, probation department,* or other person or entity who submitted the

request to provide a copy of the court order approving or denying the request to the child's caregiver.

Existing law requires the Medical Board of California to review specified data provided by the State Department of Health Care Services and the State Department of Social Services regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for dependents and wards of the juvenile court in order to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and, if warranted, to conduct an investigation.

This bill would, upon the approval by the juvenile court judicial officer of a request for authorization for the administration of psychotropic medication, require the juvenile court judicial officer to also authorize the Medical Board of California to review the patient medical record of the child authorized to receive psychotropic medication. The bill would require the patient medical record to be limited to the diagnosis for the authorized prescription of psychotropic medication in order to ascertain whether there is excessive prescribing of psychotropic medication inconsistent with a specified standard of care.

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

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

1 SECTION 1. Section 369.5 of the Welfare and Institutions
2 Code is amended to read:
3 369.5. (a) (1) If a child is adjudged a dependent child of the
4 court under Section 300 and the child has been removed from the
5 physical custody of the parent under Section 361, only a juvenile
6 court judicial officer shall have authority to make orders regarding
7 the administration of psychotropic medications for that child. The
8 juvenile court may issue a specific order delegating this authority
9 to a parent upon making findings on the record that the parent
10 poses no danger to the child and has the capacity to authorize
11 psychotropic medications. Court authorization for the
12 administration of psychotropic medication shall be based on a
13 request from a physician, indicating the reasons for the request, a
14 description of the child's diagnosis and behavior, the expected
15 results of the medication, and a description of any side effects of
16 the medication.

(2) (A) ~~On or before July 1, 2016, the~~ *The* Judicial Council shall amend and adopt rules of court and develop appropriate forms for the implementation of this section, in consultation with the State Department of Social Services, the State Department of Health Care Services, and stakeholders, including, but not limited to, the County Welfare Directors Association of California, the County Behavioral Health Directors Association of California, the Chief Probation Officers of California, associations representing current and former foster children, caregivers, and children's attorneys. This effort shall be undertaken in coordination with the updates required under paragraph (2) of subdivision (a) of Section 739.5.

(B) The rules of court and forms developed pursuant to subparagraph (A) shall address all of the following:

(i) The child and their caregiver and court-appointed special advocate, if any, have an opportunity to provide input on the medications being prescribed.

(ii) Information regarding the child's overall mental health assessment and treatment plan is provided to the court.

(iii) Information regarding the rationale for the proposed medication, provided in the context of past and current treatment efforts, is provided to the court. This information shall include, but not be limited to, information on other pharmacological and nonpharmacological treatments that have been utilized and the child's response to those treatments, a discussion of symptoms not alleviated or ameliorated by other current or past treatment efforts, and an explanation of how the psychotropic medication being prescribed is expected to improve the child's symptoms.

(iv) Guidance is provided to the court on how to evaluate the request for authorization, including how to proceed if information, otherwise required to be included in a request for authorization under this section, is not included in a request for authorization submitted to the court.

(C) The rules of court and forms developed pursuant to subparagraph (A) shall include a process for periodic oversight by the court of orders regarding the administration of psychotropic medications that includes the caregiver's and child's observations regarding the effectiveness of the medication and side effects, information on medication management appointments and other followup appointments with medical practitioners, and information

1 on the delivery of other mental health treatments that are a part of
2 the child's overall treatment plan. The periodic oversight shall be
3 facilitated by the county social worker, public health nurse, or
4 other appropriate county staff. This oversight process shall be
5 conducted in conjunction with other regularly scheduled court
6 hearings and reports provided to the court by the county child
7 welfare agency.
8 (b) (1) In counties in which the county child welfare agency
9 completes the request for authorization for the administration of
10 psychotropic medication, the agency is encouraged to complete
11 the request within three business days of receipt from the physician
12 of the information necessary to fully complete the request.
13 (2) This subdivision does not change current local practice or
14 local court rules with respect to the preparation and submission of
15 requests for authorization for the administration of psychotropic
16 medication.
17 (c) (1) Within seven court days from receipt by the court of a
18 completed request, the juvenile court judicial officer shall either
19 approve or deny in writing a request for authorization for the
20 administration of psychotropic medication to the child, or shall,
21 upon a request by the parent, the legal guardian, or the child's
22 attorney, or upon its own motion, set the matter for hearing.
23 (2) Notwithstanding Section 827 or any other law, upon the
24 approval or denial by the juvenile court judicial officer of a request
25 for authorization for the administration of psychotropic medication,
26 the county child welfare agency or other person or entity who
27 submitted the request shall provide a copy of the court order
28 approving or denying the request to the child's caregiver.
29 (3) Upon the approval of a request for authorization for the
30 administration of psychotropic medication, the juvenile court
31 judicial officer shall also authorize the Medical Board of California
32 to review the patient medical record of the child authorized to
33 receive psychotropic medication. The review of the patient medical
34 record shall be limited to the diagnosis for the prescription
35 authorized under paragraph (1) in order to ascertain whether there
36 is excessive prescribing of psychotropic medication inconsistent
37 with the standard of care described in Section 2245 of the Business
38 and Professions Code.
39 (d) Psychotropic medication or psychotropic drugs are those
40 medications administered for the purpose of affecting the central

1 nervous system to treat psychiatric disorders or illnesses. These
2 medications include, but are not limited to, anxiolytic agents,
3 antidepressants, mood stabilizers, antipsychotic medications,
4 anti-Parkinson agents, hypnotics, medications for dementia, and
5 psychostimulants.
6 (e) This section does not supersede local court rules regarding
7 a minor's right to participate in mental health decisions.
8 (f) This section does not apply to nonminor dependents, as
9 defined in subdivision (v) of Section 11400.
10 *SEC. 2. Section 739.5 of the Welfare and Institutions Code is*
11 *amended to read:*
12 739.5. (a) (1) If a minor who has been adjudged a ward of the
13 court under Section 601 or 602 is removed from the physical
14 custody of the parent under Section 726 and placed into foster
15 care, as defined in Section 727.4, only a juvenile court judicial
16 officer shall have authority to make orders regarding the
17 administration of psychotropic medications for that minor. The
18 juvenile court may issue a specific order delegating this authority
19 to a parent upon making findings on the record that the parent
20 poses no danger to the minor and has the capacity to authorize
21 psychotropic medications. Court authorization for the
22 administration of psychotropic medication shall be based on a
23 request from a physician, indicating the reasons for the request, a
24 description of the minor's diagnosis and behavior, the expected
25 results of the medication, and a description of any side effects of
26 the medication.
27 (2) (A) ~~On or before July 1, 2016, the~~ *The* Judicial Council
28 shall amend and adopt rules of court and develop appropriate forms
29 for the implementation of this section, in consultation with the
30 State Department of Social Services, the State Department of
31 Health Care Services, and stakeholders, including, but not limited
32 to, the County Welfare Directors Association of California, the
33 County Behavioral Health Directors Association of California, the
34 Chief Probation Officers of California, associations representing
35 current and former foster children, caregivers, and minor's
36 attorneys. This effort shall be undertaken in coordination with the
37 updates required under paragraph (2) of subdivision (a) of Section
38 369.5.
39 (B) The rules of court and forms developed pursuant to
40 subparagraph (A) shall address all of the following:

1 (i) The minor and ~~his or her~~ *the minor's* caregiver and
2 court-appointed special advocate, if any, have an opportunity to
3 provide input on the medications being prescribed.
4 (ii) Information regarding the minor's overall mental health
5 assessment and treatment plan is provided to the court.
6 (iii) Information regarding the rationale for the proposed
7 medication, provided in the context of past and current treatment
8 efforts, is provided to the court. This information shall include,
9 but not be limited to, information on other pharmacological and
10 nonpharmacological treatments that have been utilized and the
11 minor's response to those treatments, a discussion of symptoms
12 not alleviated or ameliorated by other current or past treatment
13 efforts, and an explanation of how the psychotropic medication
14 being prescribed is expected to improve the minor's symptoms.
15 (iv) Guidance is provided to the court on how to evaluate the
16 request for authorization, including how to proceed if information,
17 otherwise required to be included in a request for authorization
18 under this section, is not included in a request for authorization
19 submitted to the court.
20 (C) The rules of court and forms developed pursuant to
21 subparagraph (A) shall include a process for periodic oversight by
22 the court of orders regarding the administration of psychotropic
23 medications that includes the caregiver's and minor's observations
24 regarding the effectiveness of the medication and side effects,
25 information on medication management appointments and other
26 followup appointments with medical practitioners, and information
27 on the delivery of other mental health treatments that are a part of
28 the minor's overall treatment plan. This oversight process shall be
29 conducted in conjunction with other regularly scheduled court
30 hearings and reports provided to the court by the county probation
31 agency.
32 (b) (1) The agency that completes the request for authorization
33 for the administration of psychotropic medication is encouraged
34 to complete the request within three business days of receipt from
35 the physician of the information necessary to fully complete the
36 request.
37 (2) Nothing in this subdivision is intended to change current
38 local practice or local court rules with respect to the preparation
39 and submission of requests for authorization for the administration
40 of psychotropic medication.

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB377

1 (c) (1) Within seven court days from receipt by the court of a
2 completed request, the juvenile court judicial officer shall either
3 approve or deny in writing a request for authorization for the
4 administration of psychotropic medication to the minor, or shall,
5 upon a request by the parent, the legal guardian, or the minor's
6 attorney, or upon its own motion, set the matter for hearing.
7 (2) Notwithstanding Section 827 or any other law, upon the
8 approval or denial by the juvenile court judicial officer of a request
9 for authorization for the administration of psychotropic medication,
10 the county probation agency or other person or entity who
11 submitted the request shall provide a copy of the court order
12 approving or denying the request to the minor's caregiver.
13 *(3) Upon the approval of a request for authorization for the*
14 *administration of psychotropic medication, the juvenile court*
15 *judicial officer shall also authorize the Medical Board of California*
16 *to review the patient medical record of the child authorized to*
17 *receive psychotropic medication. The review of the patient medical*
18 *record shall be limited to the diagnosis for the prescription*
19 *authorized under paragraph (1) in order to ascertain whether*
20 *there is excessive prescribing of psychotropic medication*
21 *inconsistent with the standard of care described in Section 2245*
22 *of the Business and Professions Code.*
23 (d) Psychotropic medication or psychotropic drugs are those
24 medications administered for the purpose of affecting the central
25 nervous system to treat psychiatric disorders or illnesses. These
26 medications include, but are not limited to, anxiolytic agents,
27 antidepressants, mood stabilizers, antipsychotic medications,
28 anti-Parkinson agents, hypnotics, medications for dementia, and
29 psychostimulants.
30 (e) Nothing in this section is intended to supersede local court
31 rules regarding a minor's right to participate in mental health
32 decisions.
33 (f) This section does not apply to nonminor dependents, as
34 defined in subdivision (v) of Section 11400.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: SB 425
AUTHOR: Hill
BILL DATE: April 30, 2019, Amended
SUBJECT: Health Care Practitioners: Licensee's File: Probationary Physician's and Surgeon's Certificate: Unprofessional Conduct
SPONSOR: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require health facilities and entities that allow a licensed health care professional to provide care for patients, to report allegations of sexual abuse and sexual misconduct by a licensed health care practitioner to that practitioner's licensing board within 15 days, and would impose a fine for failure to report. This bill would make other changes related to the Medical Board of California's (Board) disciplinary action and enforcement process.

BACKGROUND:

In 2018, an investigation by the LA Times reported on multiple unresolved complaints of alleged sexual misconduct by a doctor who worked at the University of Southern California's (USC) student health center. Although many individuals complained to various employees of USC, none of these complaints were reported to the Board.

The other changes in this bill related to the Board were approved as legislative proposals at the Board's October 2018 Board Meeting.

ANALYSIS:

This bill would require a health facility or clinic or other entity that makes any arrangement under which a healing arts licensee is allowed to practice or provide care for patients to file a report of any allegation of sexual abuse or sexual misconduct made against a healing arts licensee to the appropriate licensing board within 15 days of receiving the allegation of sexual abuse or sexual misconduct. This bill would define an arrangement under which a licensee is allowed to practice or provide care for patients to include, but not be limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

This bill would require an employee or a healing arts licensee that works in any health facility or clinic or other entity who has knowledge of any allegation of sexual abuse or sexual misconduct by a healing arts licensee to file a report with the appropriate licensing board that has regulatory jurisdiction over the healing arts licensee and the administration of the health facility or clinic or other entity within 15 days of knowing about the allegation of sexual abuse or sexual misconduct.

This bill would specify that a willful failure to file the required report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the licensee regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file the report under this section is a licensed physician and surgeon, the action or proceeding shall be brought by the Board. If the person who is designated or otherwise required to file the report required under this section is a licensed doctor of podiatric medicine, the action or proceeding shall be brought by the Podiatric Medical Board of California. The fine shall be paid to that agency, but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licensee. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, “willful” means a voluntary and intentional violation of a known legal duty.

This bill would specify that any failure to file the report is punishable by a fine not to exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file the report required under this section is a licensed physician and surgeon, the action or proceeding shall be brought by the Board. If the person who is designated or otherwise required to file the report required under this section is a licensed doctor of podiatric medicine, the action or proceeding shall be brought by the Podiatric Medical Board of California. The fine shall be paid to that agency, but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether any person who is designated or otherwise required by law to file the report required under this section exercised due diligence despite the failure to file or whether the person knew or should have known that a report required under this section would not be filed; and whether there has been a prior failure to file a report required under this section. The amount of the fine imposed may also differ based on whether a health care facility or clinic is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

This bill would specify that a person, including an employee or individual contracted or subcontracted to provide health care services, a health facility or clinic or other entity

shall not incur any civil or criminal liability as a result of making a report required by this section if made in good faith.

This bill would require the licensing board to investigate the circumstances underlying a report received pursuant to this bill.

The Board supports three of the provisions in this bill already, as they were previously approved as legislative proposals. The Board supports the provision that amends Business and Professions Code (BPC) Section 800(c)(1) to strike the word "comprehensive" in front of summary; the Board supports the provision that amends BPC Section 2221 to require probationary license information to stay on the Board's website after probation is completed for a period of 10 years; and the Board supports the provision that amends BPC Section 2234(h) regarding physician interviews to include in the definition of unprofessional conduct the failure of a licensee, in the absence of good cause, to attend and participate in an interview by the Board, current law requires the failure to be repeated. The Board believes these provisions will help to prevent delays in the Board's enforcement process, which negatively impact the Board's enforcement timelines, and increase transparency to consumers by providing access to information that is public, but not available on the Board's website after the probationary period is completed.

According to the author, "SB 425 closes legal loopholes that can allow a subject of repeated sexual abuse and misconduct complaints to work at a health facility for years because the relevant regulatory board is not notified by the facility of the allegations against a licensee. Allegations of sexual abuse or misconduct by doctors and other medical professionals must be reported swiftly to the appropriate licensing board for review so that regulators can determine whether to conduct an independent, confidential investigation. State regulatory boards cannot fulfill their responsibilities to protect patients and other consumers, if they are not notified of these serious allegations involving their licensees. The failure to do so shields bad actors while exposing patients to greater risks."

The Board already supports three of the provisions in this bill. The requirements for health care facilities and entities and employees and health care practitioners working in those facilities and entities to report allegations of sexual abuse and sexual misconduct by a licensed health care practitioner to that practitioner's licensing board would further the Board's mission of consumer protection and ensure that the Board is aware of these allegations so the Board can look into these incidences of potential sexual abuse and misconduct. Board staff recommends that the Board take a support position on this bill.

FISCAL:

SB 425 will result in a significant increase in complaints, which will impact the Board's enforcement workload. The Board is estimating that the increase will be at least three times the current complaints received via BPC Section 805 reports, since these reports are also for incidents that happened in a facility, although BPC Section 805 reports must

go through a formal peer review process and action must be taken by the peer review body before anything is reported to the Board. In fiscal year 2017/18, the Board received 141 BPC Section 805 reports. Three times that amount would be 423 new complaints per year. The Board is estimating that it will need a .5 PY at an MST level and 1 PY at the AGPA level in the Board's Central Complaint Unit to process and review these 423 new complaints. These ongoing costs per year are $37,000 for the MST and $114,000 for the AGPA.

The Board is estimating that 20% of the 423 complaints will be consolidated into one investigation, which would be 339 new cases. The Board is estimating that each case will take 60 hours to investigate, as they will be more complex. 339 cases times 60 hours equals 20,340 hours. An investigator PY is 1,776 hours per year. This equates to the Board needing to pay for 11 new investigators in HQIU. One investigator costs $132,000 per year and on-going, so this would result in $1,452,000 in fiscal impact to the Board.

The Board is estimating that 1/3 of the cases investigated will go the AG's Office for prosecution, so that results in about 100 cases going to the AG's office. For the AG's Office, each case takes about $20,000 in billing to prosecute. This equals $2,000,000 in AG costs.

The Board is estimating that 20% of the 100 cases will go to the Office of Administrative Hearings (OAH) for a hearing. The costs of each case to go to OAH is $12,500 times 20 is $250,000 in costs for OAH.

The total costs for this bill are $151,000 for Board position costs; $1,452,000 for HQIU Investigator PY costs; $2,000,000 for AG costs and $250,000 for OAH costs. This results in $3,853,000 in total costs to the Board.

<u>SUPPORT:</u> Consumer Attorneys of California
Consumer Watchdog
Medical Board of California (support specified provisions)

<u>OPPOSITION:</u> Association of Life and Health Insurance Companies; California Association of Health Plans; California Chapter of the American College of Cardiology; and California Medical Association

<u>POSITION:</u> Recommendation: Support

AMENDED IN SENATE APRIL 30, 2019

AMENDED IN SENATE APRIL 11, 2019

SENATE BILL **No. 425**

Introduced by Senator Hill

February 21, 2019

An act to amend Sections 800, 2221, and 2234 of, and to add Section 805.8 to, the Business and Profession Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 425, as amended, Hill. Health care practitioners: licensee's file: probationary physician's and surgeon's certificate: unprofessional conduct.

Existing law requires the Medical Board of California and specified other boards responsible for the licensure, regulation, and discipline of health care practitioners to separately create and maintain a central file of the names of all persons who hold a license, certificate, or similar authority from that board, including prescribed historical information for each licensee. Existing law makes the contents of any central file that are not public records confidential, except that the licensee or their counsel or a representative are authorized to inspect and have copies made of the licensee's complete file other than the disclosure of the identity of an information source. Existing law authorizes a board to protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source or by providing a comprehensive summary of the substance of the material.

This bill would delete the specification that the summary be comprehensive.

Existing law establishes a peer review process for certain healing arts licentiates, as defined, and requires the chief of staff of a medical or

professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic to report specified information, including the denial or revocation of staff privileges, as defined, for a medical disciplinary cause or reason, within 15 days of the denial or revocation to the relevant state licensing agency. Existing law makes a violation of this reporting requirement punishable by a civil fine.

This bill would require any health facility or ~~clinic, administrator or chief executive officer of a health care service plan,~~ *clinic* or other entity that makes any arrangement under which a healing arts licensee is allowed to practice or provide care for patients to report any allegation of sexual abuse or sexual misconduct made against a healing arts licensee to the relevant state licensing agency within 15 days of receiving the allegation and would require the relevant agency to investigate the circumstances underlying a received report. The bill would also require an employee or healing arts licensee that works in a health facility or ~~clinic, health care service plan,~~ *clinic* or other entity with knowledge of any allegation of sexual abuse or sexual misconduct by a healing arts licensee to report to the relevant state agency having jurisdiction over the healing arts licensee and the administration of the health facility or ~~clinic, health care service plan,~~ *clinic* or other entity within 15 days of knowing about the allegation of sexual abuse or sexual misconduct. The bill would make a willful failure to file the report by a health facility or ~~clinic, health care service plan,~~ *clinic* or other entity punishable by a civil fine not to exceed $100,000 per violation and any other failure to make that report punishable by a civil fine not to exceed $50,000 per violation, as specified. The bill would also prohibit a person, including an employee or individual contracted or subcontracted to provide health care services, a health facility or ~~clinic, a health care service plan,~~ *clinic* or other entity from incurring civil or criminal liability as a result of making a ~~report.~~ *report if made in good faith.*

The Medical Practice Act establishes the Medical Board of California for the licensure, regulation, and discipline of physicians and surgeons.

The act authorizes the board to deny a physician's and surgeon's certificate to an applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of their license. The act authorizes the board in its sole discretion to issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions.

This bill would require the board to disclose a probationary physician's and surgeon's certificate and the operative statement of issues to an inquiring member of the public and to post the certificate and statement on the board's internet website for 10 years from issuance.

The act requires the board to take action against any licensee who is charged with unprofessional conduct and provides that unprofessional conduct includes the repeated failure by a certificate holder who is the subject of an investigation by the board, in the absence of good cause, to attend and participate in an interview by the board.

This bill would delete the condition that the failure to attend and participate in an interview by the board be repeated. The bill would also delete an obsolete provision.

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

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

1 SECTION 1. Section 800 of the Business and Professions Code
2 is amended to read:
3 800. (a) The Medical Board of California, the Podiatric
4 Medical Board of California, the Board of Psychology, the Dental
5 Board of California, the Dental Hygiene Board of California, the
6 Osteopathic Medical Board of California, the State Board of
7 Chiropractic Examiners, the Board of Registered Nursing, the
8 Board of Vocational Nursing and Psychiatric Technicians of the
9 State of California, the State Board of Optometry, the Veterinary
10 Medical Board, the Board of Behavioral Sciences, the Physical
11 Therapy Board of California, the California State Board of
12 Pharmacy, the Speech-Language Pathology and Audiology and
13 Hearing Aid Dispensers Board, the California Board of
14 Occupational Therapy, the Acupuncture Board, and the Physician
15 Assistant Board shall each separately create and maintain a central
16 file of the names of all persons who hold a license, certificate, or
17 similar authority from that board. Each central file shall be created
18 and maintained to provide an individual historical record for each
19 licensee with respect to the following information:
20 (1) Any conviction of a crime in this or any other state that
21 constitutes unprofessional conduct pursuant to the reporting
22 requirements of Section 803.

1 (2) Any judgment or settlement requiring the licensee or the
2 licensee's insurer to pay any amount of damages in excess of three
3 thousand dollars ($3,000) for any claim that injury or death was
4 proximately caused by the licensee's negligence, error or omission
5 in practice, or by rendering unauthorized professional services,
6 pursuant to the reporting requirements of Section 801 or 802.
7 (3) Any public complaints for which provision is made pursuant
8 to subdivision (b).
9 (4) Disciplinary information reported pursuant to Section 805,
10 including any additional exculpatory or explanatory statements
11 submitted by the licentiate pursuant to subdivision (f) of Section
12 805. If a court finds, in a final judgment, that the peer review
13 resulting in the 805 report was conducted in bad faith and the
14 licensee who is the subject of the report notifies the board of that
15 finding, the board shall include that finding in the central file. For
16 purposes of this paragraph, "peer review" has the same meaning
17 as defined in Section 805.
18 (5) Information reported pursuant to Section 805.01, including
19 any explanatory or exculpatory information submitted by the
20 licensee pursuant to subdivision (b) of that section.
21 (b) (1) Each board shall prescribe and promulgate forms on
22 which members of the public and other licensees or certificate
23 holders may file written complaints to the board alleging any act
24 of misconduct in, or connected with, the performance of
25 professional services by the licensee.
26 (2) If a board, or division thereof, a committee, or a panel has
27 failed to act upon a complaint or report within five years, or has
28 found that the complaint or report is without merit, the central file
29 shall be purged of information relating to the complaint or report.
30 (3) Notwithstanding this subdivision, the Board of Psychology,
31 the Board of Behavioral Sciences, and the Respiratory Care Board
32 of California shall maintain complaints or reports as long as each
33 board deems necessary.
34 (c) (1) The contents of any central file that are not public
35 records under any other provision of law shall be confidential
36 except that the licensee involved, or the licensee's counsel or
37 representative, may inspect and have copies made of the licensee's
38 complete file except for the provision that may disclose the identity
39 of an information source. For the purposes of this section, a board
40 may protect an information source by providing a copy of the

material with only those deletions necessary to protect the identity of the source or by providing a summary of the substance of the material. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications. The information required to be disclosed pursuant to Section 803.1 shall not be considered among the contents of a central file for the purposes of this subdivision.

(2) The licensee may, but is not required to, submit any additional exculpatory or explanatory statement or other information that the board shall include in the central file.

(3) Each board may permit any law enforcement or regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes to inspect and have copies made of that licensee's file, unless the disclosure is otherwise prohibited by law.

(4) These disclosures shall effect no change in the confidential status of these records.

SEC. 2. Section 805.8 is added to the Business and Professions Code, to read:

805.8. (a) As used in this section, the following terms shall have the following meanings:

(1) "Agency" means the relevant state licensing agency with regulatory jurisdiction over a healing arts licensee listed in paragraph ~~(3).~~ *(2).*

~~(2) "Health care service plan" means a health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.~~

~~(3)~~

(2) "Healing arts licensee" or "licensee" means a licensee licensed under Division 2 (commencing with Section 500) or any initiative act referred to in that division. "Healing arts licensee" or "licensee" also includes a person authorized to practice medicine pursuant to Sections 2064.5, 2113, and 2168.

~~(4)~~

1 *(3)* “Other entity” includes, but is not limited to, a postsecondary
2 educational institution as defined in Section 66261.5 of the
3 Education Code.
4 (b) A health facility or ~~clinic, the administrator or chief~~
5 ~~executive officer of a health care service plan,~~ *clinic* or other entity
6 that makes any arrangement under which a healing arts licensee
7 is allowed to practice or provide care for patients shall file a report
8 of any allegation of sexual abuse or sexual misconduct made
9 against a healing arts licensee to the agency within 15 days of
10 receiving the allegation of sexual abuse or sexual misconduct. An
11 arrangement under which a licensee is allowed to practice or
12 provide care for patients includes, but is not limited to, full staff
13 privileges, active staff privileges, limited staff privileges, auxiliary
14 staff privileges, provisional staff privileges, temporary staff
15 privileges, courtesy staff privileges, locum tenens arrangements,
16 and contractual arrangements to provide professional services,
17 including, but not limited to, arrangements to provide outpatient
18 services.
19 (c) An employee or a healing arts licensee that works in any
20 health facility or ~~clinic, health care service plan,~~ *clinic* or other
21 entity that subdivision (b) applies to who has knowledge of any
22 allegation of sexual abuse or sexual misconduct by a healing arts
23 licensee shall file a report with the agency that has regulatory
24 jurisdiction over the healing arts licensee and the administration
25 of the health facility or ~~clinic, health care service plan,~~ *clinic* or
26 other entity within 15 days of knowing about the allegation of
27 sexual abuse or sexual misconduct.
28 (d) A willful failure to file the report described in subdivision
29 (b) shall be punishable by a fine not to exceed one hundred
30 thousand dollars ($100,000) per violation. The fine may be imposed
31 in any civil or administrative action or proceeding brought by or
32 on behalf of any agency having regulatory jurisdiction over the
33 licensee regarding whom the report was or should have been filed.
34 If the person who is designated or otherwise required to file the
35 report under this section is a licensed physician and surgeon, the
36 action or proceeding shall be brought by the Medical Board of
37 California. If the person who is designated or otherwise required
38 to file the report required under this section is a licensed doctor of
39 podiatric medicine, the action or proceeding shall be brought by
40 the Podiatric Medical Board of California. The fine shall be paid

1 to that agency, but not expended until appropriated by the
2 Legislature. A violation of this subdivision may constitute
3 unprofessional conduct by the licensee. A person who is alleged
4 to have violated this subdivision may assert any defense available
5 at law. As used in this subdivision, "willful" means a voluntary
6 and intentional violation of a known legal duty.
7 (e) Except as provided in subdivision (d), any failure to file the
8 report described in subdivision (b) shall be punishable by a fine
9 not to exceed fifty thousand dollars ($50,000) per violation. The
10 fine may be imposed in any civil or administrative action or
11 proceeding brought by or on behalf of any agency having
12 regulatory jurisdiction over the person regarding whom the report
13 was or should have been filed. If the person who is designated or
14 otherwise required to file the report required under this section is
15 a licensed physician and surgeon, the action or proceeding shall
16 be brought by the Medical Board of California. If the person who
17 is designated or otherwise required to file the report required under
18 this section is a licensed doctor of podiatric medicine, the action
19 or proceeding shall be brought by the Podiatric Medical Board of
20 California. The fine shall be paid to that agency, but not expended
21 until appropriated by the Legislature. The amount of the fine
22 imposed, not exceeding fifty thousand dollars ($50,000) per
23 violation, shall be proportional to the severity of the failure to
24 report and shall differ based upon written findings, including
25 whether the failure to file caused harm to a patient or created a
26 risk to patient safety; whether any person who is designated or
27 otherwise required by law to file the report required under this
28 section exercised due diligence despite the failure to file or whether
29 the person knew or should have known that a report required under
30 this section would not be filed; and whether there has been a prior
31 failure to file a report required under this section. The amount of
32 the fine imposed may also differ based on whether a health care
33 facility or clinic is a small or rural hospital as defined in Section
34 124840 of the Health and Safety Code.
35 (f) A person, including an employee or individual contracted
36 or subcontracted to provide health care services, a health facility
37 or clinic, ~~a health care service plan,~~ or other entity shall not incur
38 any civil or criminal liability as a result of making a report required
39 by this ~~section.~~ *section if made in good faith.*

1 (g) The agency shall investigate the circumstances underlying
2 a report received pursuant to this section.
3 SEC. 3. Section 2221 of the Business and Professions Code is
4 amended to read:
5 2221. (a) The board may deny a physician's and surgeon's
6 certificate to an applicant guilty of unprofessional conduct or of
7 any cause that would subject a licensee to revocation or suspension
8 of their license. The board, in its sole discretion, may issue a
9 probationary physician's and surgeon's certificate to an applicant
10 subject to terms and conditions, including, but not limited to, any
11 of the following conditions of probation:
12 (1) Practice limited to a supervised, structured environment
13 where the licensee's activities shall be supervised by another
14 physician and surgeon.
15 (2) Total or partial restrictions on drug prescribing privileges
16 for controlled substances.
17 (3) Continuing medical or psychiatric treatment.
18 (4) Ongoing participation in a specified rehabilitation program.
19 (5) Enrollment and successful completion of a clinical training
20 program.
21 (6) Abstention from the use of alcohol or drugs.
22 (7) Restrictions against engaging in certain types of medical
23 practice.
24 (8) Compliance with all provisions of this chapter.
25 (9) Payment of the cost of probation monitoring.
26 (b) The board may modify or terminate the terms and conditions
27 imposed on the probationary certificate upon receipt of a petition
28 from the licensee. The board may assign the petition to an
29 administrative law judge designated in Section 11371 of the
30 Government Code. After a hearing on the petition, the
31 administrative law judge shall provide a proposed decision to the
32 board.
33 (c) The board shall deny a physician's and surgeon's certificate
34 to an applicant who is required to register pursuant to Section 290
35 of the Penal Code. This subdivision does not apply to an applicant
36 who is required to register as a sex offender pursuant to Section
37 290 of the Penal Code solely because of a misdemeanor conviction
38 under Section 314 of the Penal Code.
39 (d) An applicant shall not be eligible to reapply for a physician's
40 and surgeon's certificate for a minimum of three years from the

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB425

1 effective date of the denial of their application, except that the
2 board, in its discretion and for good cause demonstrated, may
3 permit reapplication after not less than one year has elapsed from
4 the effective date of the denial.
5 (e) The board shall disclose a probationary physician's and
6 surgeon's certificate issued pursuant to this section and the
7 operative statement of issues to an inquiring member of the public
8 and shall post the certificate and statement on the board's internet
9 website for 10 years from issuance.
10 SEC. 4. Section 2234 of the Business and Professions Code is
11 amended to read:
12 2234. The board shall take action against any licensee who is
13 charged with unprofessional conduct. In addition to other
14 provisions of this article, unprofessional conduct includes, but is
15 not limited to, the following:
16 (a) Violating or attempting to violate, directly or indirectly,
17 assisting in or abetting the violation of, or conspiring to violate
18 any provision of this chapter.
19 (b) Gross negligence.
20 (c) Repeated negligent acts. To be repeated, there must be two
21 or more negligent acts or omissions. An initial negligent act or
22 omission followed by a separate and distinct departure from the
23 applicable standard of care shall constitute repeated negligent acts.
24 (1) An initial negligent diagnosis followed by an act or omission
25 medically appropriate for that negligent diagnosis of the patient
26 shall constitute a single negligent act.
27 (2) When the standard of care requires a change in the diagnosis,
28 act, or omission that constitutes the negligent act described in
29 paragraph (1), including, but not limited to, a reevaluation of the
30 diagnosis or a change in treatment, and the licensee's conduct
31 departs from the applicable standard of care, each departure
32 constitutes a separate and distinct breach of the standard of care.
33 (d) Incompetence.
34 (e) The commission of any act involving dishonesty or
35 corruption that is substantially related to the qualifications,
36 functions, or duties of a physician and surgeon.
37 (f) Any action or conduct that would have warranted the denial
38 of a certificate.
39 (g) The failure by a certificate holder, in the absence of good
40 cause, to attend and participate in an interview by the board. This

1 subdivision shall only apply to a certificate holder who is the
2 subject of an investigation by the board.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	SB 697
AUTHOR:	Caballero
BILL DATE:	April 24, 2019, Amended
SUBJECT:	Physician Assistants: Practice Agreement: Supervision
SPONSOR:	California Academy of Physician Assistants (CAPA)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would revise the Physician Assistant Practice Act (Act) to allow multiple physicians and surgeons to supervise a physician assistant (PA), would replace the delegation of services agreement (DSA) with a practice agreement, would eliminate the existing medical records review requirement, would authorize a physician to supervise two additional PAs for a total of six, and would make other substantive and technical changes.

BACKGROUND:

The first Physician Assistant training program began in 1965 at Duke University with the admission of four ex-military corpsmen into a two-year program. California began regulating the profession in 1970 “to redress the growing shortage and geographic misdistribution of health care services in California." The PA practice act permitted the supervised delegation of certain medical services to PAs, thus freeing physicians to focus their skills on other procedures.

To become licensed in California, a PA must attend and graduate from an accredited PA program associated with a medical school that includes classroom studies and clinical experience. The professional curriculum for PA education includes basic medical, behavioral, and social sciences; introduction to clinical medicine and patient assessment; supervised clinical practice; and health policy and professional practice issues. A PA performs many of the same diagnostic, preventative, and health maintenance services as a physician. These services include, but are not limited to, the following: taking health histories; performing physical examinations; ordering X-rays and laboratory tests; ordering respiratory, occupational, or physical therapy treatments; performing routine diagnostic tests; establishing diagnoses; treating and managing patient health problems; administering immunizations and injections; instructing and counseling patients; providing continuing care to patients in the home, hospital, or extended care facility; providing referrals within the health care system; performing minor surgery; providing preventative health care services; acting as first or second assistants during surgery; and responding to life-threatening emergencies.

Existing law authorizes a PA to perform medical services under the supervision of a physician and surgeon who must be physically available to the PA. Existing law defines a DSA as the writing that delegates to a PA, from a supervising physician, the medical services the PA is authorized to perform. Existing law states that a PA acts as an agent of the supervising physician when performing any activity authorized by the Act. Existing law requires the PA and the PA's supervising physician and surgeon to establish written guidelines for adequate supervision and adhere to specific medical records review processes. Existing law authorizes a supervising physician and surgeon to delegate the authority to issue a drug order to a PA, and may limit this authority by specifying the manner in which the PA may issue delegated prescriptions by adopting a formulary and protocols that specify all criteria for the use of a particular drug or device. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the PA is acting on behalf of and as an agent for a supervising physician and surgeon.

Both PAs and Nurse Practitioners (NPs) are mid-level healthcare professionals with overlapping scopes of practice. Each have distinct training and philosophies: nurses follow a patient-centered model in which they focus on disease prevention and health education, while PAs follow a disease-centered model in which they focus on the biologic and pathologic components of health. In California, a substantial differentiating factor between the two professions is the comparatively higher level of administrative duties related to supervision required by the PA's Practice Act.

Existing law limits a physician and surgeon to supervising up to four PAs at one time and up to four NPs.

NPs operate under supervision of a physician under standardized procedures and protocols. Existing law specifies that physician supervision shall not be construed to require the physical presence of the physician, but does include collaboration on the development of the standardized procedure, approval of the standardized procedure, and availability by telephonic contact at the time of patient examination by the NP. Existing law authorizes a NP to furnish or order drugs or devices when operating in accordance with standardized protocols developed by the NP and supervising physician and authorizes the physician to determine the extent of supervision necessary for an NP to furnish and order drugs.

<u>ANALYSIS:</u>

This bill would revise the Act's legislative intent to emphasize coordinated care between PAs and other health care professionals.

This bill would update the existing definition of a supervising physician by taking out the reference of improper use and replacing it with, prohibiting employment or supervision of a PA. This bill would prohibit physician supervision from requiring the physical presence of the physician.

This bill would define an organized health care system to include a licensed clinic, an outpatient setting, a health facility, a county medical facility, an accountable care organization, a home health agency, a physician's office, a professional medical corporation, a medical partnership, a medical foundation, and any other organized entity that lawfully provides medical service.

This bill would strike all reference to a DSA in the Act and replaces these references with a "practice agreement". This bill would define a practice agreement as a writing, developed through collaboration among one or more physicians, one or more PAs, and, if applicable, administrators of an organized health care system, that outlines the medical services the PA is authorized to perform and that grants approval for physicians on the staff of an organized health care system to supervise one or more PAs in the organized health care system. This bill would specify that any reference to a DSA relating to PAs in any other law shall have the same meaning as a practice agreement.

This bill would delete the medical records review definition and requirement from existing law.

This bill would delete existing law that states a PA acts as an agent of a supervising physician when performing any activity under the Act.

This bill would authorize a PA to perform the medical services set forth in the Act if the following requirements are met:

- The PA renders the services under the supervision of a physician who is not subject to a disciplinary condition imposed by the Medical Board of California (Board) or the Osteopathic Medical Board prohibiting that supervision or prohibiting the employment of a PA.
- The PA renders the services pursuant to a practice agreement.
- The PA is competent to perform the services.
- The PA's education, training, and experience have prepared the PA to render the services.

This bill would prohibit the Act from requiring a supervising physician to review or countersign a patient's medical record who was treated by a PA, unless required by the practice agreement. This bill would allow the Physician Assistant Board (PAB), as a condition of probation of a licensee, to require the review or countersignature of records of patients treated by a PA for a specified duration.

This bill would redraft the provisions of law relating to PAs ordering drugs and devices in relation to the practice agreement changes. This bill would allow a PA to furnish or order a drug or device in accordance with the practice agreement and consistent with the PA's educational preparation or for which clinical competency has been established and maintained. This bill would require the practice agreement to specify which PAs may furnish or order a drug or device, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician supervision, the method of periodic review of the PA's competence, including peer review, and review of the

practice agreement. This bill would require the PA, when furnishing or orderings drugs or devices to adhere to adequate supervision agreed to in the practice agreement. This bill would require the supervising physician to be available by telephone or other electronic communication method at the time the PA examines the patient.

This bill would allow a physician to supervise an additional two PAs at one time, for a total of six.

This bill would require the practice agreement to include the following:

- The types of medical services a PA is authorized to perform and how the services are performed.
- Policies and procedures to ensure adequate supervision of the PA, including, but not limited to, appropriate communication, availability, consultations, and referrals between a physician and the PA in the provision of medical services.
- The methods for continuing evaluation of the competency and qualifications of the PA.
- The furnishing or ordering of drugs or devices by a PA.
- Any additional provisions agreed to by the PA and physician or organized health care system.

This bill would require the practice agreement to be signed by the PA and one or more physicians or a physician who is authorized to approve the practice agreement on behalf of the staff of the physicians or the staff of an organized health care system. This bill would specify that a DSA in effect prior to January 1, 2020, shall be deemed to meet the requirements of this bill. This bill would specify that it shall not be construed to require approval of a practice agreement by the PAB.

This bill would delete existing provisions of law that conflict with the principle of multiple physician and surgeon supervision of a PA. This bill would delete outdated sections of existing law relating to the requirement that a supervising physician apply to the PAB and pay a fee and Board oversight that is outdated. This bill would also make technical changes.

This bill would specify that its provisions are severable, and if any provision of this bill or its application is held invalid, the invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

According to the author's office, "There are several disparities between PAs and other medical professionals in the same arena when it comes to the relationship between PAs and physicians. In practice, this means PAs are subject to burdensome regulations such as chart review, co-signatures, DSA requirements, and outdated ratios for prescribing purposes. These regulations incur a burden upon the physician as well, who may not be incentivized to hire a PA if a less regulated NP is available.

It is very possible that this disincentive to hire PAs may be contributing to the lack of healthcare services across our state, but especially in rural areas. If regulations were

lessened on PAs to better match a NP's status, there would be little or no disparity and PAs could be better utilized by physicians in areas where health care services are lacking. This bill seeks to reduce the burdens on the physician – PA relationship, so practices can thrive and potentially expand."

The purpose of this bill is to align the PA supervision requirements to those of an NP. This bill originally would have deleted all references to physician supervision and would have made PAs independent practitioners. This current version of the bill is a result of negotiations with the author's office, sponsors and various stakeholders who were previously opposed. There have been some concerns raised in committee regarding increasing the number of PAs that a physician can supervise to six, especially in emergency department settings.

<u>FISCAL:</u> None

<u>SUPPORT:</u> CAPA (Sponsor); America's Physician Groups; Association of California Healthcare Districts; California Association for Health Services at Home; California Medical Association; and California Psychiatric Association

<u>OPPOSITION:</u> California Chapter American College of Emergency Physicians (Unless Amended)

AMENDED IN SENATE APRIL 24, 2019

AMENDED IN SENATE APRIL 10, 2019

SENATE BILL No. 697

Introduced by Senator Caballero
(Coauthor: Assembly Member Friedman)

February 22, 2019

An act to amend Sections 3500, 3501, 3502, 3502.1, 3502.3, *3509,* 3516, 3518, 3527, and 3528, of, and to repeal Sections 3516.5, 3521, and 3522 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 697, as amended, Caballero. Physician assistants: practice agreement: supervision.

The Physician Assistant Practice Act provides for licensure and regulation of physician assistants by the Physician Assistant Board, which is within the jurisdiction of the Medical Board of California. The act authorizes a physician assistant to perform medical services as set forth by regulations and the act and when those services are rendered under the supervision of a licensed physician and surgeon. *The act requires the Physician Assistant Board to, among other things, make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration and approval of applications by licensed physicians to supervise physician assistants.* The act prohibits a physician and surgeon from supervising more than 4 physician assistants at any one time. The act requires the medical record to identify the physician and surgeon who is responsible for the supervision of the physician assistant. The act requires the supervising physician and surgeon to be physically available to the physician

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assistant for consultation when that assistance is rendered. The act requires the physician assistant and the supervising physician and surgeon to establish written guidelines for adequate supervision, and authorizes the supervising physician and surgeon to satisfy this requirement by adopting protocols for some or all of the tasks performed by the physician assistant, as provided. The act additionally authorizes a delegation of services agreement to authorize a physician assistant to order durable medical equipment, to approve, sign, modify, or add to a plan of treatment or plan of care for individuals receiving home health services or personal care services, or to certify disability, as provided.

This bill *would remove the requirement that the Physician Assistant Board make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration and approval of applications by licensed physicians and surgeons to supervise physician assistants. The bill,* except as described below, would remove the limit on the number of physician assistants that a physician and surgeon may supervise. The bill would remove the requirements that the medical record identify the responsible supervising physician and surgeon and that those written guidelines for adequate supervision be established. The bill would instead authorize a physician assistant to perform various medical services if certain requirements are met including that the medical services are rendered pursuant to ~~a signed delegation of services agreement or~~ a practice agreement, as defined, and the physician assistant is competent to perform the medical services. The bill would also require a practice agreement between a physician assistant and a physician and surgeon to meet specified requirements.

The act authorizes a physician assistant, under the supervision of a physician and surgeon, to administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device.

This bill would instead authorize a physician assistant to furnish or order a drug or device subject to specified supervision. Specifically, the bill would prohibit a physician and surgeon from supervising more than 6 physician assistants for purposes of the provisions relating to physician assistants furnishing or ordering drugs or devices.

The act defines various terms for its purposes.

This bill would revise and change the definitions as applicable to carry out the bill's provisions. The bill would provide that any reference

to "delegation of services agreement" in any other law means "practice agreement," as defined by the bill, and that "supervision" does not require the supervising physician and surgeon to be physically present. The bill would also make various conforming changes.

The act makes a violation of specified provisions punishable as a misdemeanor.

By revising and recasting the provisions of the act, the bill would change the definition of that crime and would, therefore, result in a state-mandated local program.

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:

1 SECTION 1. Section 3500 of the Business and Professions
2 Code is amended to read:
3 3500. In its concern with the growing shortage and geographic
4 maldistribution of health care services in California, the Legislature
5 intends to establish in this chapter a framework for another category
6 of health manpower—the physician assistant.
7 The purpose of this chapter is to encourage the effective
8 utilization of the skills of physicians and surgeons, and physicians
9 and surgeons and podiatrists practicing in the same medical group
10 practice, by enabling them to work with qualified physician
11 assistants to provide quality care.
12 This chapter is established to encourage the coordinated care
13 between physician assistants, physicians and surgeons, podiatrists,
14 and other qualified health care providers practicing in the same
15 medical group, and to provide health care services. It is also the
16 purpose of this chapter to allow for innovative development of
17 programs for the education, training, and utilization of physician
18 assistants.
19 SEC. 2. Section 3501 of the Business and Professions Code is
20 amended to read:
21 3501. As used in this chapter:

1 (a) “Board” means the Physician Assistant Board.
2 (b) “Approved program” means a program for the education of
3 physician assistants that has been formally approved by the board.
4 (c) “Trainee” means a person who is currently enrolled in an
5 approved program.
6 (d) “Physician assistant” or “PA” means a person who meets
7 the requirements of this chapter and is licensed by the board.
8 (e) “Supervising physician” or “supervising physician and
9 surgeon” means a physician and surgeon licensed by the Medical
10 Board of California or by the Osteopathic Medical Board of
11 California who supervises one or more physician assistants, who
12 possesses a current valid license to practice medicine, and who is
13 not currently on disciplinary probation prohibiting the employment
14 or supervision of a physician assistant.
15 (f) “Supervision” means that a licensed physician and surgeon
16 oversees the activities of, and accepts responsibility for, the medical
17 services rendered by a physician assistant. Supervision shall not
18 be construed to require the physical presence of the physician and
19 surgeon.
20 (g) “Regulations” means the rules and regulations as set forth
21 in Chapter 13.8 (commencing with Section 1399.500) of Title 16
22 of the California Code of Regulations.
23 (h) “Routine visual screening” means noninvasive
24 nonpharmacological simple testing for visual acuity, visual field
25 defects, color blindness, and depth perception.
26 (i) “Program manager” means the staff manager of the diversion
27 program, as designated by the executive officer of the board. The
28 program manager shall have background experience in dealing
29 with substance abuse issues.
30 (j) “Organized health care system” includes a licensed clinic as
31 described in Chapter 1 (commencing with Section 1200) of
32 Division 2 of the Health and Safety Code, an outpatient setting as
33 described in Chapter 1.3 (commencing with Section 1248) of
34 Division 2 of the Health and Safety Code, a health facility as
35 described in Chapter 2 (commencing with Section 1250) of
36 Division 2 of the Health and Safety Code, a county medical facility
37 as described in Chapter 2.5 (commencing with Section 1440) of
38 Division 2 of the Health and Safety Code, an accountable care
39 organization, a home health agency, a physician’s ~~officer,~~ *office,*
40 a professional medical corporation, a medical partnership, a

medical foundation, and any other organized entity that lawfully provides medical services.

(k) "Practice agreement" means the writing, developed through collaboration among one or more physicians and surgeons, one or more physician assistants, and, if applicable, administrators of an organized health care system, that outlines the medical services the physician assistant is authorized to perform and that grants approval for physicians and surgeons on the staff of an organized health care system to supervise one or more physician assistants in the organized health care system. Any reference to a delegation of services agreement relating to physician assistants in any other law shall have the same meaning as a practice agreement.

(*l*) "Other specified medical services" means tests or examinations performed or ordered by a PA practicing in compliance with this chapter or regulations of the board or the Medical Board of California promulgated under this chapter.

SEC. 3. Section 3502 of the Business and Professions Code is amended to read:

3502. (a) Notwithstanding any other law, a PA may perform those medical services as set forth by ~~the regulations to be adopted under~~ this chapter if the following requirements are met:

(1) The PA renders the services under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California or by the Osteopathic Medical Board prohibiting that supervision or prohibiting the employment of a physician assistant.

(2) The PA renders the services pursuant to ~~a delegation of services agreement or~~ a practice agreement that meets the requirements of Section 3502.3.

(3) The PA is competent to perform the services.

(4) The PA's education, training, and experience have prepared the PA to render the services.

(b) (1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from a supervising physician and surgeon.

1 (2) A supervising physician and surgeon shall be available to
2 the physician assistant for consultation when assistance is rendered
3 pursuant to this subdivision. A physician assistant assisting a doctor
4 of podiatric medicine shall be limited to performing those duties
5 included within the scope of practice of a doctor of podiatric
6 medicine.
7 (c) ~~This section shall not be construed to~~ *Nothing in statute or*
8 *regulations shall* require that a physician *and surgeon* review or
9 countersign a medical record of a patient treated by a physician
10 assistant, unless required by the practice agreement. The board
11 may, as a condition of probation of a licensee, require the review
12 or countersignature of records of patients treated by a physician
13 assistant for a specified duration.
14 (d) This chapter does not authorize the performance of medical
15 services in any of the following areas:
16 (1) The determination of the refractive states of the human eye,
17 or the fitting or adaptation of lenses or frames for the aid thereof.
18 (2) The prescribing or directing the use of, or using, any optical
19 device in connection with ocular exercises, visual training, or
20 orthoptics.
21 (3) The prescribing of contact lenses for, or the fitting or
22 adaptation of contact lenses to, the human eye.
23 (4) The practice of dentistry or dental hygiene or the work of a
24 dental auxiliary as defined in Chapter 4 (commencing with Section
25 1600).
26 (e) This section shall not be construed in a manner that shall
27 preclude the performance of routine visual screening as defined
28 in Section 3501.
29 SEC. 4. Section 3502.1 of the Business and Professions Code
30 is amended to read:
31 3502.1. In addition to the medical services authorized in the
32 regulations adopted pursuant to Section 3502, and except as
33 prohibited by Section 3502, a PA may furnish or order a drug or
34 device subject to *all of* the following:
35 (a) The PA shall furnish or order a drug or device in accordance
36 with the practice agreement and consistent with the PA's
37 educational preparation or for which clinical competency has been
38 established and maintained.
39 (b) (1) A practice agreement authorizing a PA to order or
40 furnish a drug or device shall specify which PAs may furnish or

1 order a drug or device, which drugs or devices may be furnished
2 or ordered, under what circumstances, the extent of physician and
3 surgeon supervision, the method of periodic review of the PA's
4 competence, including peer review, and review of the practice
5 agreement.
6 (2) In addition to the requirements in paragraph (1), if the
7 practice agreement authorizes the PA to furnish a Schedule II
8 controlled substance, the practice agreement shall address the
9 diagnosis of the illness, injury, or condition for which the PA may
10 furnish the Schedule II controlled substance.
11 (c) The PA shall furnish or order drugs or devices under
12 physician and surgeon supervision. This subdivision shall not be
13 construed to require the physical presence of the physician and
14 surgeon, but does require the following:
15 (1) Adherence to adequate supervision agreed to in the practice
16 agreement.
17 (2) The physician and surgeon be available by telephone or
18 other electronic communication method at the time the PA
19 examines the patient.
20 (d) For purposes of this section, a physician and surgeon shall
21 not supervise more than six PAs at one time.
22 (e) (1) Except as provided in paragraph (2), the PA may furnish
23 or order only those Schedule II through Schedule V controlled
24 substances under the California Uniform Controlled Substances
25 Act (Division 10 (commencing with Section 11000) of the Health
26 and Safety Code) that have been agreed upon ~~and specified~~ in the
27 practice agreement.
28 (2) The PA may furnish or order Schedule II or III controlled
29 substances, as defined in Sections 11055 and 11056, respectively,
30 of the Health and Safety Code, in accordance with ~~a patient-specific~~
31 ~~protocol~~ *the practice agreement or a patient-specific order*
32 approved by the treating or supervising physician. A copy of the
33 section of the PA's practice agreement relating to controlled
34 substances shall be provided, upon request, to any licensed
35 pharmacist who dispenses drugs or devices, when there is
36 uncertainty about the PA furnishing the order.
37 (f) (1) The PA has satisfactorily completed a course in
38 pharmacology covering the drugs or devices to be furnished or
39 ordered under this section or has completed a program for

1 instruction of PAs that meet the requirements of Section 1399.530
2 of Title 16 of the California Code of Regulations.
3 (2) ~~Except as provided in subdivision (c), a~~ *A* physician and
4 surgeon through a practice agreement may determine the extent
5 of supervision necessary pursuant to this section in the furnishing
6 or ordering of drugs and devices.
7 (3) PAs who hold an active license, who are authorized through
8 a practice agreement to furnish Schedule II controlled substances,
9 and who are registered with the United States Drug Enforcement
10 Administration, shall complete, as part of their continuing
11 education requirements, a course including Schedule II controlled
12 substances, and the risks of addiction associated with their use,
13 based on the standards developed by the board. The board shall
14 establish the requirements for satisfactory completion of this
15 subdivision. Evidence of completion of a course meeting the
16 standards, including pharmacological content, established in
17 Section 1399.610 and 1399.612 of Title 16 of the California Code
18 of Regulations shall be deemed to meet the requirements of this
19 Section.
20 (g) For purposes of this section:
21 (1) "Furnishing" or "ordering" shall include the following:
22 (A) Ordering a drug or device in accordance with the practice
23 agreement.
24 (B) Transmitting an order of a supervising physician and
25 surgeon.
26 (C) Dispensing a medication pursuant to Section 4170.
27 (2) "Drug order" or "order" means an order for medication that
28 is dispensed to or for an ultimate user, issued by a PA as an
29 individual practitioner, within the meaning of Section 1306.02 of
30 Title 21 of the Code of Federal Regulations.
31 (h) Notwithstanding any other law, (1) a drug order issued
32 pursuant to this section shall be treated in the same manner as a
33 prescription of ~~the~~ *a* supervising physician; (2) all references to
34 "prescription" in this code and the Health and Safety Code shall
35 include drug orders issued by physician assistants; and (3) the
36 signature of a PA on a drug order issued in accordance with this
37 section shall be deemed to be the signature of a ~~prescriber.~~
38 *prescriber for purposes of this code and the Health and Safety*
39 *Code.*

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SEC. 5. Section 3502.3 of the Business and Professions Code is amended to read:

3502.3. (a) (1) A practice agreement shall ~~include, but is not limited to,~~ *include* provisions that address the following:

(A) The types of medical services a physician assistant is authorized to perform and how the services are performed.

(B) Policies and procedures to ensure adequate supervision of the physician assistant, including but not limited to, appropriate communication, availability, consultations, and referrals between a physician and surgeon and the physician assistant in the provision of medical services.

(C) The methods for the continuing evaluation of the competency and qualifications of the physician assistant.

(D) The furnishing or ordering of drugs or devices by a physician assistant pursuant to Section 3502.1.

(E) Any additional provisions agreed to by the physician assistant and physician and surgeon or organized health care system.

(2) A practice agreement shall be signed by both of the following:

(A) The physician assistant.

(B) One or more physicians and surgeons or a physician and surgeon who is authorized to approve the practice agreement on behalf of the staff of the physicians and surgeons on the staff of an organized health care system.

(3) ~~For purposes of the act adding this subdivision, a~~ *A* delegation of services agreement in effect prior to January 1, 2020, shall be deemed to meet the requirements of this subdivision.

(4) Nothing in this section shall be construed to require approval of a practice agreement by the board.

(b) Notwithstanding any other law, in addition to any other practices that meet the general criteria set forth in this chapter or regulations adopted by the board or the Medical Board of ~~California for inclusion in a practice agreement,~~ *California,* a practice agreement may authorize a PA to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in Section 3502 or the practice agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) For individuals receiving home health services or personal care services, after consultation with a supervising physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

(3) After performance of a physical examination by the PA under the supervision of a physician and surgeon consistent with this chapter, certify disability pursuant to Section 2708 of the Unemployment Insurance Code. The Employment Development Department shall implement this paragraph on or before January 1, 2017.

(c) This section shall not be construed to affect the validity of any practice agreement in effect prior to the effective date of this section or those adopted subsequent to the effective date of this section.

SEC. 6. Section 3509 of the Business and Professions Code is amended to read:

3509. It shall be the duty of the board to:

(a) Establish standards and issue licenses of approval for programs for the education and training of physician assistants.

(b) Make recommendations to the Medical Board of California concerning the scope of practice for physician assistants.

~~(c) Make recommendations to the Medical Board of California concerning the formulation of guidelines for the consideration of applications by licensed physicians to supervise physician assistants and approval of such applications.~~

~~(d)~~

(c) Require the examination of applicants for licensure as a physician assistant who meet the requirements of this chapter.

~~SEC. 6.~~

SEC. 7. Section 3516 of the Business and Professions Code is amended to read:

3516. (a) Notwithstanding any other provision of law, a physician assistant licensed by the board shall be eligible for employment or supervision by a physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that employment or supervision.

(b) The Medical Board of California may restrict a physician and surgeon to supervising specific types of physician assistants including, but not limited to, restricting a physician and surgeon

from supervising physician assistants outside of the field of specialty of the physician and surgeon.

~~SEC. 7.~~

SEC. 8. Section 3516.5 of the Business and Professions Code is repealed.

~~SEC. 8.~~

SEC. 9. Section 3518 of the Business and Professions Code is amended to read:

3518. The board shall keep a current register for licensed PAs, by specialty if applicable. The register shall show the name of each licensee, the licensee's last known address of record, and the date of the licensee's licensure. Any interested person is entitled to obtain a copy of the register in accordance with the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code) upon application to the board together with a sum as may be fixed by the board, which amount shall not exceed the cost of this list so furnished.

~~SEC. 9.~~

SEC. 10. Section 3521 of the Business and Professions Code is repealed.

~~SEC. 10.~~

SEC. 11. Section 3522 of the Business and Professions Code is repealed.

~~SEC. 11.~~

SEC. 12. Section 3527 of the Business and Professions Code is amended to read:

3527. (a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a PA license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.

(b) The board may order the denial of an application for, or the suspension or revocation of, or the imposition of probationary conditions upon, an approved program after a hearing as required in Section 3528 for a violation of this chapter or the regulations adopted pursuant thereto.

1 (c) The Medical Board of California may order the imposition
2 of probationary conditions upon a physician and surgeon's
3 authority to supervise a PA, after a hearing as required in Section
4 3528, for unprofessional conduct, which includes, but is not limited
5 to, a violation of this chapter, a violation of the Medical Practice
6 Act, or a violation of the regulations adopted by the board or the
7 Medical Board of California.
8 (d) The board may order the denial of an application for, or the
9 suspension or revocation of, or the imposition of probationary
10 conditions upon, a PA license, after a hearing as required in Section
11 3528 for unprofessional conduct that includes, except for good
12 cause, the knowing failure of a licensee to protect patients by
13 failing to follow infection control guidelines of the board, thereby
14 risking transmission of bloodborne infectious diseases from
15 licensee to patient, from patient to patient, and from patient to
16 licensee. In administering this subdivision, the board shall consider
17 referencing the standards, regulations, and guidelines of the State
18 Department of Public Health developed pursuant to Section
19 1250.11 of the Health and Safety Code and the standards,
20 regulations, and guidelines pursuant to the California Occupational
21 Safety and Health Act of 1973 (Part 1 (commencing with Section
22 6300) of Division 5 of the Labor Code) for preventing the
23 transmission of HIV, hepatitis B, and other bloodborne pathogens
24 in health care settings. As necessary, the board shall consult with
25 the Medical Board of California, the Osteopathic Medical Board,
26 the Podiatric Medical Board of California, the Dental Board of
27 California, the Board of Registered Nursing, and the Board of
28 Vocational Nursing and Psychiatric Technicians of the State of
29 California to encourage appropriate consistency in the
30 implementation of this subdivision.
31 The board shall seek to ensure that licensees are informed of the
32 responsibility of licensees and others to follow infection control
33 guidelines, and of the most recent scientifically recognized
34 safeguards for minimizing the risk of transmission of blood-borne
35 infectious diseases.
36 (e) The board may order the licensee to pay the costs of
37 monitoring the probationary conditions imposed on the license.
38 (f) The expiration, cancellation, forfeiture, or suspension of a
39 PA license by operation of law or by order or decision of the board
40 or a court of law, the placement of a license on a retired status, or

1 the voluntary surrender of a license by a licensee shall not deprive
2 the board of jurisdiction to commence or proceed with any
3 investigation of, or action or disciplinary proceeding against, the
4 licensee or to render a decision suspending or revoking the license.
5 ~~SEC. 12.~~
6 *SEC. 13.* Section 3528 of the Business and Professions Code
7 is amended to read:
8 3528. Any proceedings involving the denial, suspension, or
9 revocation of the application for licensure or the license of a PA
10 or the application for approval or the approval of an approved
11 program under this chapter shall be conducted in accordance with
12 Chapter 5 (commencing with Section 11500) of Part 1 of Division
13 3 of Title 2 of the Government Code.
14 ~~SEC. 13.~~
15 *SEC. 14.* The provisions of this measure are severable. If any
16 provision of this measure or its application is held invalid, that
17 invalidity shall not affect other provisions or applications that can
18 be given effect without the invalid provision or application.
19 ~~SEC. 14.~~
20 *SEC. 15.* No reimbursement is required by this act pursuant to
21 Section 6 of Article XIII B of the California Constitution because
22 the only costs that may be incurred by a local agency or school
23 district will be incurred because this act creates a new crime or
24 infraction, eliminates a crime or infraction, or changes the penalty
25 for a crime or infraction, within the meaning of Section 17556 of
26 the Government Code, or changes the definition of a crime within
27 the meaning of Section 6 of Article XIII B of the California
28 Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER:	SB 786
AUTHOR:	Comm. on Business, Professions and Economic Development
BILL DATE:	April 11, 2019, Amended
SUBJECT:	Healing Arts:
SPONSOR:	Various Healing Arts Boards
POSITION:	Support Provisions Related to the Medical Board of California

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the committee bill that includes technical and clarifying changes for healing arts boards under the Department of Consumer Affairs. This analysis will only include the provisions that impact the Medical Board of California (Board). This bill would make technical and clarifying changes and delete outdated sections of the Business and Professions Code (BPC) that are related to the Board.

BACKGROUND:

The technical and clarifying changes in this bill that impact the Board were approved by the Board at the October 2018 Board Meeting.

ANALYSIS:

This bill would clean up inconsistent language in BPC Section 803.1, including changing “physicians and surgeons” to “licensees”.

This bill would delete BPC Section 2234(g), which becomes operative upon implementation of the proposed registration program described in BPC Section 2052.5, as this subdivision is no longer needed because BPC 2052.5 has been repealed.

This bill would delete BPC Sections 2155-2167 (Loans to Medical Students) and 2200-2213 (Physician and Surgeon Incentive Pilot Program), as these programs are not active.

These changes will clean up the code section and delete language regarding programs that are not active; the Board is supportive of these provisions in SB 786.

FISCAL:	None
SUPPORT:	California Board of Behavioral Sciences; Dental Hygiene Board of California; and Medical Board of California
OPPOSITION:	None on file

AMENDED IN SENATE APRIL 11, 2019

SENATE BILL No. 786

Introduced by Committee on Business, Professions and Economic Development (Senators Glazer (Chair), Archuleta, Chang, Dodd, Galgiani, Hill, Leyva, Pan, and Wilk)

March 11, 2019

An act to amend Sections 803.1, 1902, 1902.1, 1902.2, 1902.3, 1903, 1904, 1905, 1905.1, 1905.2, 1906, 1909, 1910.5, 1916, 1917, 1917.1, 1917.3, 1918, 1922, 1926.1, 1926.2, 1926.3, 1926.4, 1930, 1931, 1932, 1934, 1935, 1936, 1936.1, 1940, 1941, 1941.5, 1942, 1943, 1944, 1947, 1949, 1950, 1950.5, 1951, 1952, 1955, 1957, 1958, 1958.1, 1962, 1963, 1964, 1966, 1966.1, 1966.2, 1966.4, 1966.5, 1966.6, 2234, 4980.36, *4980.37, 4980.50, 4980.81, 4989.22, 4992.1,* 4999.32,~~ and 4999.33~~ *4999.33, and 4999.52* of, to repeal Section 4980.395 of, and to repeal Article 8 (commencing with Section 2155) of Chapter 5 of Division 2 of, and Article 11 (commencing with Section 2200) of Chapter 5 of Division 2 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 786, as amended, Committee on Business, Professions and Economic Development. Healing arts.

(1) Existing law requires the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board to disclose to an inquiring member of the public specified information regarding any enforcement action taken against a licensee.

This bill would make nonsubstantive changes to those provisions.

(2) Existing law, the Dental Practice Act, provides for the licensure and regulation of dental hygienists by the Dental Hygiene Board of California within the Department of Consumer Affairs, and specifies that, for purposes of the dental hygiene provisions, "hygiene board" means the Dental Hygiene Board of California.

This bill, in the provisions regulating dental hygienists, would replace all of the references to "hygiene board" with "dental hygiene board."

(3) Existing law authorizes the Medical Board of California to make loans to medical students at a prescribed interest rate in accordance with specified conditions, which are repayable to the Contingent Fund of the Medical Board of California.

This bill would repeal those provisions.

(4) Existing law authorizes the Medical Board of California to award loans to licensed physicians and surgeons who agree to establish a medical practice in an area deficient in primary care services, and requires those loans to be repayable to the Contingent Fund of the Medical Board of California.

This bill would repeal those provisions.

(5) Existing law, the Licensed Marriage and Family Therapist Act and the Licensed Professional Clinical Counselor Act, provides for the licensure and regulation of marriage and family therapists and licensed professional clinical counselors, respectively, by the Board of Behavioral Sciences. Existing law requires an applicant for licensure or regulation as a marriage and family therapist to meet specified educational requirements, including, for specified applicants, possessing a doctoral or master's degree that provides a practicum that involves direct client contact in, among others, prognosis, and instruction in the prognosis of mental disorders, and a supervised practicum in applied psychotherapeutic prognosis. Existing law requires an applicant for licensure as a professional clinical counselor to meet specified educational requirements, including possessing a degree that includes a supervised practicum or field study experience that involves direct client contact in a clinical setting for a range of professional clinical counseling experiences, including prognosis.

This bill would, under both acts, replace the requirement for prognosis with a requirement for treatment planning, as described above.

(6) Existing law, the Licensed Marriage and Family Therapist Act, the Educational Psychologist Practice Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act, requires an applicant for licensure or regulation under those acts to

pass specified board-administered examinations. Those acts prohibit the board from delaying informing a candidate for licensure of the results of the written examination solely upon the receipt of a complaint alleging acts or conduct that would constitute grounds to deny licensure. The Licensed Marriage and Family Therapist Act and the Clinical Social Worker Practice Act authorize the board to withhold the results of a specified clinical examination if the applicant had passed a law and ethics examination but was under the investigation of the board.

This bill would revise those acts to eliminate the prohibitions on the board from delaying informing a candidate for licensure of the results of the written examination solely upon the receipt of a complaint alleging acts or conduct that would constitute grounds to deny licensure. The bill would also revise the Licensed Marriage and Family Therapist Act and the Clinical Social Worker Practice Act to remove the authorization for the board to withhold the results of a specified clinical examination as described above.

~~(5)~~

(7) Existing law, the Licensed Marriage and Family Therapist Act, ~~provides for the licensure and regulation of marriage and family therapists by the Board of Behavioral Sciences, and,~~ as a condition of licensure or registration, requires a person to possess a doctoral or master's degree that meets specified requirements.

This bill would ~~specify~~ *require* that the doctoral or master's degree program that qualifies for licensure or registration ~~shall~~ be a single, integrated program.

~~(6)~~

(8) Existing law, the Licensed Professional Clinical Counselor Act, ~~provides for the licensure and regulation of licensed professional clinical counselors by the Board of Behavioral Sciences. Existing law,~~ as a condition of licensure, requires a person to possess a master's or doctoral degree that is counseling or psychotherapy in content and prescribes requirements for the degree.

This bill would ~~specify~~ *require* that the degree ~~shall~~ be a single, integrated program.

~~(7)~~

(9) This bill would repeal obsolete provisions and would make other nonsubstantive changes.

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

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

1 SECTION 1. Section 803.1 of the Business and Professions
2 Code is amended to read:
3 803.1. (a) Notwithstanding any other law, the Medical Board
4 of California, the Osteopathic Medical Board of California, the
5 California Board of Podiatric Medicine, and the Physician Assistant
6 Board shall disclose to an inquiring member of the public
7 information regarding any enforcement actions taken against a
8 licensee, including a former licensee, by the board or by another
9 state or jurisdiction, including all of the following:
10 (1) Temporary restraining orders issued.
11 (2) Interim suspension orders issued.
12 (3) Revocations, suspensions, probations, or limitations on
13 practice ordered by the board, including those made part of a
14 probationary order or stipulated agreement.
15 (4) Public letters of reprimand issued.
16 (5) Infractions, citations, or fines imposed.
17 (b) Notwithstanding any other law, in addition to the information
18 provided in subdivision (a), the Medical Board of California, the
19 Osteopathic Medical Board of California, the California Board of
20 Podiatric Medicine, and the Physician Assistant Board shall
21 disclose to an inquiring member of the public all of the following:
22 (1) Civil judgments in any amount, whether or not vacated by
23 a settlement after entry of the judgment, that were not reversed on
24 appeal and arbitration awards in any amount of a claim or action
25 for damages for death or personal injury caused by the licensee's
26 negligence, error, or omission in practice, or by rendering
27 unauthorized professional services.
28 (2) (A) All settlements in the possession, custody, or control
29 of the board shall be disclosed for a licensee in the low-risk
30 category if there are three or more settlements for that licensee
31 within the last 10 years, except for settlements by a licensee
32 regardless of the amount paid where (i) the settlement is made as
33 a part of the settlement of a class claim, (ii) the licensee paid in
34 settlement of the class claim the same amount as the other licensees
35 in the same class or similarly situated licensees in the same class,
36 and (iii) the settlement was paid in the context of a case where the
37 complaint that alleged class liability on behalf of the licensee also
38 alleged a products liability class action cause of action. All

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1 settlements in the possession, custody, or control of the board shall
2 be disclosed for a licensee in the high-risk category if there are
3 four or more settlements for that licensee within the last 10 years
4 except for settlements by a licensee regardless of the amount paid
5 where (i) the settlement is made as a part of the settlement of a
6 class claim, (ii) the licensee paid in settlement of the class claim
7 the same amount as the other licensees in the same class or
8 similarly situated licensees in the same class, and (iii) the
9 settlement was paid in the context of a case where the complaint
10 that alleged class liability on behalf of the licensee also alleged a
11 products liability class action cause of action. Classification of a
12 licensee in either a "high-risk category" or a "low-risk category"
13 depends upon the specialty or subspecialty practiced by the licensee
14 and the designation assigned to that specialty or subspecialty by
15 the Medical Board of California, as described in subdivision (f).
16 For the purposes of this paragraph, "settlement" means a settlement
17 of an action described in paragraph (1) entered into by the licensee
18 on or after January 1, 2003, in an amount of thirty thousand dollars
19 ($30,000) or more.
20 (B) The board shall not disclose the actual dollar amount of a
21 settlement but shall put the number and amount of the settlement
22 in context by doing the following:
23 (i) Comparing the settlement amount to the experience of other
24 licensees within the same specialty or subspecialty, indicating if
25 it is below average, average, or above average for the most recent
26 10-year period.
27 (ii) Reporting the number of years the licensee has been in
28 practice.
29 (iii) Reporting the total number of licensees in that specialty or
30 subspecialty, the number of those who have entered into a
31 settlement agreement, and the percentage that number represents
32 of the total number of licensees in the specialty or subspecialty.
33 (3) Current American Board of Medical Specialties certification
34 or board equivalent as certified by the Medical Board of California,
35 the Osteopathic Medical Board of California, or the California
36 Board of Podiatric Medicine.
37 (4) Approved postgraduate training.
38 (5) Status of the license of a licensee. By January 1, 2004, the
39 Medical Board of California, the Osteopathic Medical Board of
40 California, and the California Board of Podiatric Medicine shall

1 adopt regulations defining the status of a licensee. The board shall
2 employ this definition when disclosing the status of a licensee
3 pursuant to Section 2027.
4 (6) Any summaries of hospital disciplinary actions that result
5 in the termination or revocation of a licensee's staff privileges for
6 medical disciplinary cause or reason, unless a court finds, in a final
7 judgment, that the peer review resulting in the disciplinary action
8 was conducted in bad faith and the licensee notifies the board of
9 that finding. In addition, any exculpatory or explanatory statements
10 submitted by the licentiate electronically pursuant to subdivision
11 (f) of Section 805 shall be disclosed. For purposes of this
12 paragraph, "peer review" has the same meaning as defined in
13 Section 805.
14 (c) Notwithstanding any other law, the Medical Board of
15 California, the Osteopathic Medical Board of California, the
16 California Board of Podiatric Medicine, and the Physician Assistant
17 Board shall disclose to an inquiring member of the public
18 information received regarding felony convictions of a licensee.
19 (d) The Medical Board of California, the Osteopathic Medical
20 Board of California, the California Board of Podiatric Medicine,
21 and the Physician Assistant Board may formulate appropriate
22 disclaimers or explanatory statements to be included with any
23 information released, and may by regulation establish categories
24 of information that need not be disclosed to an inquiring member
25 of the public because that information is unreliable or not
26 sufficiently related to the licensee's professional practice. The
27 Medical Board of California, the Osteopathic Medical Board of
28 California, the California Board of Podiatric Medicine, and the
29 Physician Assistant Board shall include the following statement
30 when disclosing information concerning a settlement:
31
32 "Some studies have shown that there is no significant correlation
33 between malpractice history and a licensee's competence. At the
34 same time, the State of California believes that consumers should
35 have access to malpractice information. In these profiles, the State
36 of California has given you information about both the malpractice
37 settlement history for the licensee's specialty and the licensee's
38 history of settlement payments only if in the last 10 years, the
39 licensee, if in a low-risk specialty, has three or more settlements
40 or the licensee, if in a high-risk specialty, has four or more

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1 settlements. The State of California has excluded some class action
2 lawsuits because those cases are commonly related to systems
3 issues such as product liability, rather than questions of individual
4 professional competence and because they are brought on a class
5 basis where the economic incentive for settlement is great. The
6 State of California has placed payment amounts into three statistical
7 categories: below average, average, and above average compared
8 to others in the licensee's specialty. To make the best health care
9 decisions, you should view this information in perspective. You
10 could miss an opportunity for high-quality care by selecting a
11 licensee based solely on malpractice history.
12 When considering malpractice data, please keep in mind:
13 Malpractice histories tend to vary by specialty. Some specialties
14 are more likely than others to be the subject of litigation. This
15 report compares licensees only to the members of their specialty,
16 not to all licensees, in order to make an individual licensee's history
17 more meaningful.
18 This report reflects data only for settlements made on or after
19 January 1, 2003. Moreover, it includes information concerning
20 those settlements for a 10-year period only. Therefore, you should
21 know that a licensee may have made settlements in the 10 years
22 immediately preceding January 1, 2003, that are not included in
23 this report. After January 1, 2013, for licensees practicing less than
24 10 years, the data covers their total years of practice. You should
25 take into account the effective date of settlement disclosure as well
26 as how long the licensee has been in practice when considering
27 malpractice averages.
28 The incident causing the malpractice claim may have happened
29 years before a payment is finally made. Sometimes, it takes a long
30 time for a malpractice lawsuit to settle. Some licensees work
31 primarily with high-risk patients. These licensees may have
32 malpractice settlement histories that are higher than average
33 because they specialize in cases or patients who are at very high
34 risk for problems.
35 Settlement of a claim may occur for a variety of reasons that do
36 not necessarily reflect negatively on the professional competence
37 or conduct of the licensee. A payment in settlement of a medical
38 malpractice action or claim should not be construed as creating a
39 presumption that medical malpractice has occurred.

You may wish to discuss information in this report and the general issue of malpractice with the licensee."

(e) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall, by regulation, develop standard terminology that accurately describes the different types of disciplinary filings and actions to take against a licensee as described in paragraphs (1) to (5), inclusive, of subdivision (a). In providing the public with information about a licensee via the internet pursuant to Section 2027, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall not use the terms "enforcement," "discipline," or similar language implying a sanction unless the licensee has been the subject of one of the actions described in paragraphs (1) to (5), inclusive, of subdivision (a).

(f) The Medical Board of California shall adopt regulations no later than July 1, 2003, designating each specialty and subspecialty practice area as either high risk or low risk. In promulgating these regulations, the board shall consult with commercial underwriters of medical malpractice insurance companies, health care systems that self-insure physicians and surgeons, and representatives of the California medical specialty societies. The board shall utilize the carriers' statewide data to establish the two risk categories and the averages required by subparagraph (B) of paragraph (2) of subdivision (b). Prior to issuing regulations, the board shall convene public meetings with the medical malpractice carriers, self-insurers, and specialty representatives.

(g) The Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, and the Physician Assistant Board shall provide each licensee, including a former licensee under subdivision (a), with a copy of the text of any proposed public disclosure authorized by this section prior to release of the disclosure to the public. The licensee shall have 10 working days from the date the board provides the copy of the proposed public disclosure to propose corrections of factual inaccuracies. Nothing in this section shall prevent the board from disclosing information to the public prior to the expiration of the 10-day period.

1 (h) Pursuant to subparagraph (A) of paragraph (2) of subdivision
2 (b), the specialty or subspecialty information required by this
3 section shall group licensees by specialty board recognized
4 pursuant to paragraph (5) of subdivision (h) of Section 651 unless
5 a different grouping would be more valid and the board, in its
6 statement of reasons for its regulations, explains why the validity
7 of the grouping would be more valid.
8 SEC. 2. Section 1902 of the Business and Professions Code is
9 amended to read:
10 1902. For purposes of this article, the following definitions
11 apply:
12 (a) "Dental hygiene board" means the Dental Hygiene Board
13 of California.
14 (b) "Dental board" means the Dental Board of California.
15 (c) "Direct supervision" means the supervision of dental
16 procedures based on instructions given by a licensed dentist who
17 is required to be physically present in the treatment facility during
18 the performance of those procedures.
19 (d) "General supervision" means the supervision of dental
20 procedures based on instructions given by a licensed dentist who
21 is not required to be physically present in the treatment facility
22 during the performance of those procedures.
23 (e) "Oral prophylaxis" means preventive and therapeutic dental
24 procedures that include bacterial debridements with complete
25 removal, supra and subgingivally, of calculus, soft deposits, plaque,
26 and stains, and the smoothing of tooth surfaces. The objective of
27 this treatment is to create an environment in which the patient can
28 maintain healthy hard and soft tissues.
29 SEC. 3. Section 1902.1 of the Business and Professions Code
30 is amended to read:
31 1902.1. Protection of the public shall be the highest priority
32 for the dental hygiene board in exercising its licensing, regulatory,
33 and disciplinary functions. Whenever the protection of the public
34 is inconsistent with other interests sought to be promoted, the
35 protection of the public shall be paramount.
36 SEC. 4. Section 1902.2 of the Business and Professions Code
37 is amended to read:
38 1902.2. (a) A licensee shall report, upon initial licensure and
39 any subsequent application for renewal or inactive license, the

1 practice or employment status of the licensee, designated as one
2 of the following:
3 (1) Full-time practice or employment in a dental or dental
4 hygiene practice of 32 hours per week or more in California.
5 (2) Full-time practice or employment in a dental or dental
6 hygiene practice of 32 hours or more outside of California.
7 (3) Part-time practice or employment in a dental or dental
8 hygiene practice for less than 32 hours per week in California.
9 (4) Part-time practice or employment in a dental or dental
10 hygiene practice for less than 32 hours per week outside of
11 California.
12 (5) Dental hygiene administrative employment that does not
13 include direct patient care, as may be further defined by the dental
14 hygiene board.
15 (6) Retired.
16 (7) Other practice or employment status, as may be further
17 defined by the dental hygiene board.
18 (b) Information collected pursuant to subdivision (a) shall be
19 posted on the internet website of the dental hygiene board.
20 (c) (1) A licensee may report on an application for renewal,
21 and the dental hygiene board, as appropriate, shall collect,
22 information regarding the licensee's cultural background and
23 foreign language proficiency.
24 (2) Information collected pursuant to this subdivision shall be
25 aggregated on an annual basis, based on categories utilized by the
26 dental hygiene board in the collection of the data, into both
27 statewide totals and ZIP Code of primary practice or employment
28 location totals.
29 (3) Aggregated information under this subdivision shall be
30 compiled annually, and reported on the internet website of the
31 dental hygiene board as appropriate, on or before July 1 of each
32 year.
33 (d) It is the intent of the Legislature to utilize moneys in the
34 State Dental Hygiene Fund to pay any cost incurred by the dental
35 hygiene board in implementing this section.
36 SEC. 5. Section 1902.3 of the Business and Professions Code
37 is amended to read:
38 1902.3. A registered dental hygienist licensed in another state
39 may teach in a dental hygiene college without being licensed in
40 this state if the person has a special permit. The dental hygiene

1 board may issue a special permit to practice dental hygiene in a
2 discipline at a dental hygiene college in this state to any person
3 who submits an application and satisfies all of the following
4 eligibility requirements:
5 (a) Furnishing satisfactory evidence of having a pending contract
6 with a California dental hygiene college approved by the dental
7 hygiene board as a full-time or part-time professor, associate
8 professor, assistant professor, faculty member, or instructor.
9 (b) Furnishing satisfactory evidence of having graduated from
10 a dental hygiene college approved by the dental hygiene board.
11 (c) Furnishing satisfactory evidence of having been certified as
12 a diplomate of a specialty committee or, in lieu thereof, establishing
13 qualifications to take a specialty committee examination or
14 furnishing satisfactory evidence of having completed an advanced
15 educational program in a discipline from a dental hygiene college
16 approved by the dental hygiene board.
17 (d) Furnishing satisfactory evidence of having successfully
18 completed an examination in California law and ethics developed
19 and administered by the dental hygiene board.
20 (e) Paying an application fee, subject to a biennial renewal fee,
21 as provided by Section 1944.
22 SEC. 6. Section 1903 of the Business and Professions Code is
23 amended to read:
24 1903. (a) (1) The dental hygiene board shall consist of nine
25 members as follows:
26 (A) Seven members appointed by the Governor as follows:
27 (i) Two members shall be public members.
28 (ii) One member shall be a practicing general or public health
29 dentist who holds a current license in California.
30 (iii) Four members shall be registered dental hygienists who
31 hold current licenses in California. Of the registered dental
32 hygienist members, one shall be licensed either in alternative
33 practice or in extended functions, one shall be a dental hygiene
34 educator, and two shall be registered dental hygienists. No public
35 member shall have been licensed under this chapter within five
36 years of the date of their appointment or have any current financial
37 interest in a dental-related business.
38 (B) One public member appointed by the Senate Committee on
39 Rules.

1 (C) One public member appointed by the Speaker of the
2 Assembly.
3 (2) (A) The first appointment by the Senate Committee on
4 Rules or the Speaker of the Assembly pursuant to this subdivision
5 shall be made upon the expiration of the term of a public member
6 that is scheduled to occur, or otherwise occurs, on or after January
7 1, 2019.
8 (B) It is the intent of the Legislature that committee members
9 appointed prior to January 1, 2019, remain as hygiene board
10 members until their term expires or except as otherwise provided
11 in law, whichever occurs first.
12 (3) For purposes of this subdivision, a public health dentist is
13 a dentist whose primary employer or place of employment is in
14 any of the following:
15 (A) A primary care clinic licensed under subdivision (a) of
16 Section 1204 of the Health and Safety Code.
17 (B) A primary care clinic exempt from licensure pursuant to
18 subdivision (c) of Section 1206 of the Health and Safety Code.
19 (C) A clinic owned or operated by a public hospital or health
20 system.
21 (D) A clinic owned and operated by a hospital that maintains
22 the primary contract with a county government to fill the county's
23 role under Section 17000 of the Welfare and Institutions Code.
24 (b) (1) Except as specified in paragraph (2), members of the
25 dental hygiene board shall be appointed for a term of four years.
26 Each member shall hold office until the appointment and
27 qualification of the member's successor or until one year shall
28 have lapsed since the expiration of the term for which the member
29 was appointed, whichever comes first.
30 (2) For the term commencing on January 1, 2012, two of the
31 public members, the general or public health dentist member, and
32 two of the registered dental hygienist members, other than the
33 dental hygiene educator member or the registered dental hygienist
34 member licensed in alternative practice or in extended functions,
35 shall each serve a term of two years, expiring January 1, 2014.
36 (c) Notwithstanding any other provision of law and subject to
37 subdivision (e), the Governor may appoint to the dental hygiene
38 board a person who previously served as a member of the former
39 committee or hygiene board even if the person's previous term
40 expired.

1 (d) The dental hygiene board shall elect a president, a vice
2 president, and a secretary from its membership.
3 (e) No person shall serve as a member of the dental hygiene
4 board for more than two consecutive terms.
5 (f) A vacancy in the dental hygiene board shall be filled by
6 appointment to the unexpired term.
7 (g) Each member of the dental hygiene board shall receive a
8 per diem and expenses as provided in Section 103.
9 (h) The Governor shall have the power to remove any member
10 from the dental hygiene board for neglect of a duty required by
11 law, for incompetence, or for unprofessional or dishonorable
12 conduct.
13 (i) The dental hygiene board, with the approval of the director,
14 may appoint a person exempt from civil service who shall be
15 designated as an executive officer and who shall exercise the
16 powers and perform the duties delegated by the dental hygiene
17 board and vested in the executive officer by this article.
18 (j) This section shall remain in effect only until January 1, 2023,
19 and as of that date is repealed.
20 SEC. 7. Section 1904 of the Business and Professions Code is
21 amended to read:
22 1904. The dental hygiene board shall meet at least two times
23 each calendar year and shall conduct additional meetings in
24 appropriate locations that are necessary to transact its business.
25 SEC. 8. Section 1905 of the Business and Professions Code is
26 amended to read:
27 1905. (a) The dental hygiene board shall perform the following
28 functions:
29 (1) Evaluate all registered dental hygienist, registered dental
30 hygienist in alternative practice, and registered dental hygienist in
31 extended functions educational programs that apply for approval
32 and grant or deny approval of those applications in accordance
33 with regulations adopted by the dental hygiene board. Any such
34 educational programs approved by the dental board on or before
35 June 30, 2009, shall be deemed approved by the dental hygiene
36 board. Any dental hygiene program accredited by the Commission
37 on Dental Accreditation may be approved.
38 (2) Withdraw or revoke its prior approval of a registered dental
39 hygienist, registered dental hygienist in alternative practice, or
40 registered dental hygienist in extended functions educational

1 program in accordance with regulations adopted by the dental
2 hygiene board. The dental hygiene board may withdraw or revoke
3 a dental hygiene program approval if the Commission on Dental
4 Accreditation has indicated an intent to withdraw approval or has
5 withdrawn approval.
6 (3) Review and evaluate all registered dental hygienist,
7 registered dental hygienist in alternative practice, and registered
8 dental hygienist in extended functions applications for licensure
9 to ascertain whether the applicant meets the appropriate licensing
10 requirements specified by statute and regulations, maintain
11 application records, cashier application fees, issue and renew
12 licenses, and perform any other tasks that are incidental to the
13 application and licensure processes.
14 (4) Determine the appropriate type of license examination
15 consistent with the provisions of this article, and develop or cause
16 to be developed and administer examinations in accordance with
17 regulations adopted by the dental hygiene board.
18 (5) Determine the amount of fees assessed under this article,
19 not to exceed the actual cost.
20 (6) Determine and enforce the continuing education
21 requirements specified in Section 1936.1.
22 (7) Deny, suspend, or revoke a license under this article, or
23 otherwise enforce the provisions of this article. Any such
24 proceedings shall be conducted in accordance with Chapter 5
25 (commencing with Section 11500) of Part 1 of Division 3 of Title
26 2 of the Government Code, and the dental hygiene board shall
27 have all of the powers granted therein.
28 (8) Make recommendations to the dental board regarding dental
29 hygiene scope of practice issues.
30 (9) Adopt, amend, and revoke rules and regulations to implement
31 the provisions of this article, including the amount of required
32 supervision by a registered dental hygienist, a registered dental
33 hygienist in alternative practice, or a registered dental hygienist
34 in extended functions of a registered dental assistant.
35 (b) The dental hygiene board may employ employees and
36 examiners that it deems necessary to carry out its functions and
37 responsibilities under this article.
38 SEC. 9. Section 1905.1 of the Business and Professions Code
39 is amended to read:

1 1905.1. The dental hygiene board may contract with the dental
2 board to carry out this article. The dental hygiene board may
3 contract with the dental board to perform investigations of
4 applicants and licensees under this article.
5 SEC. 10. Section 1905.2 of the Business and Professions Code
6 is amended to read:
7 1905.2. Recommendations by the dental hygiene board
8 regarding scope of practice issues, as specified in paragraph (8)
9 of subdivision (a) of Section 1905, shall be approved, modified,
10 or rejected by the board within 90 days of submission of the
11 recommendation to the board. If the board rejects or significantly
12 modifies the intent or scope of the recommendation, the dental
13 hygiene board may request that the board provide its reasons in
14 writing for rejecting or significantly modifying the
15 recommendation, which shall be provided by the board within 30
16 days of the request.
17 SEC. 11. Section 1906 of the Business and Professions Code
18 is amended to read:
19 1906. (a) The dental hygiene board shall adopt, amend, and
20 revoke regulations to implement the requirements of this article.
21 (b) All regulations adopted by the dental hygiene board shall
22 comply with the provisions of Chapter 3.5 (commencing with
23 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
24 Code.
25 (c) No regulation adopted by the dental hygiene board shall
26 impose a requirement or a prohibition directly upon a licensed
27 dentist or on the administration of a dental office, unless
28 specifically authorized by this article.
29 (d) Unless contrary to the provisions of this article, regulations
30 adopted by the dental board shall continue to apply to registered
31 dental hygienists, registered dental hygienists in alternative
32 practice, and registered dental hygienists in extended functions
33 until other regulations are adopted by the dental hygiene board.
34 All references in those regulations to “board” shall mean the dental
35 hygiene board, which shall solely enforce the regulations with
36 respect to registered dental hygienists, registered dental hygienists
37 in alternative practice, and registered dental hygienists in extended
38 functions.
39 SEC. 12. Section 1909 of the Business and Professions Code
40 is amended to read:

1 1909. A registered dental hygienist is authorized to perform
2 the following procedures under direct supervision of a licensed
3 dentist, after submitting to the dental hygiene board evidence of
4 satisfactory completion of a course of instruction, approved by the
5 dental hygiene board, in the procedures:
6 (a) Soft-tissue curettage.
7 (b) Administration of local anesthesia.
8 (c) Administration of nitrous oxide and oxygen, whether
9 administered alone or in combination with each other.
10 SEC. 13. Section 1910.5 of the Business and Professions Code
11 is amended to read:
12 1910.5. (a) In addition to the duties specified in Section 1910,
13 a registered dental hygienist is authorized to perform the following
14 additional duties, as specified:
15 (1) Determine which radiographs to perform on a patient who
16 has not received an initial examination by the supervising dentist
17 for the specific purpose of the dentist making a diagnosis and
18 treatment plan for the patient. In these circumstances, the dental
19 hygienist shall follow protocols established by the supervising
20 dentist. This paragraph only applies in the following settings:
21 (A) In a dental office setting.
22 (B) In a public health setting, using telehealth, as defined by
23 Section 2290.5, for the purpose of communication with the
24 supervising dentist, including, but not limited to, schools, head
25 start and preschool programs, and community clinics.
26 (2) Place protective restorations, which for this purpose are
27 identified as interim therapeutic restorations, and defined as a
28 direct provisional restoration placed to stabilize the tooth until a
29 licensed dentist diagnoses the need for further definitive treatment.
30 An interim therapeutic restoration consists of the removal of soft
31 material from the tooth using only hand instrumentation, without
32 the use of rotary instrumentation, and subsequent placement of an
33 interim adhesive restorative material. Local anesthesia shall not
34 be necessary for interim therapeutic restoration placement. Interim
35 therapeutic restorations shall be placed only in accordance with
36 both of the following:
37 (A) In either of the following settings:
38 (i) In a dental office setting.
39 (ii) In a public health setting, using telehealth, as defined by
40 Section 2290.5, for the purpose of communication with the

1 supervising dentist, including, but not limited to, schools, head
2 start and preschool programs, and community clinics.
3 (B) After the diagnosis, treatment plan, and instruction to
4 perform the procedure provided by a dentist.
5 (b) The functions described in subdivision (a) may be performed
6 by a registered dental hygienist only after completion of a program
7 that includes training in performing those functions, or after
8 providing evidence, satisfactory to the dental hygiene board, of
9 having completed a dental hygiene board-approved course in those
10 functions.
11 (c) No later than January 1, 2018, the dental hygiene board shall
12 adopt regulations to establish requirements for courses of
13 instruction for the procedures authorized to be performed by a
14 registered dental hygienist and registered dental hygienist in
15 alternative practice pursuant to Sections 1910.5 and 1926.05, using
16 the competency-based training protocols established by the Health
17 Workforce Pilot Project (HWPP) No. 172 through the Office of
18 Statewide Health Planning and Development. The dental hygiene
19 board shall use the curriculum submitted by the board pursuant to
20 Section 1753.55 to adopt regulatory language for approval of
21 courses of instruction for the Interim Therapeutic Restoration. Any
22 subsequent amendments to the regulations for the Interim
23 Therapeutic Restoration curriculum that are promulgated by the
24 dental hygiene board shall be agreed upon by the board and the
25 dental hygiene board.
26 (d) This section shall become operative on January 1, 2018.
27 SEC. 14. Section 1916 of the Business and Professions Code
28 is amended to read:
29 1916. (a) (1) An applicant for licensure under this article shall
30 furnish electronic fingerprint images for submission to state and
31 federal criminal justice agencies, including, but not limited to, the
32 Federal Bureau of Investigation, in order to establish the identity
33 of the applicant and for the other purposes described in this section.
34 (2) Notwithstanding paragraph (1), an out-of-state applicant or
35 licensee residing out of state for whom an electronic record of the
36 licensee's fingerprints does not exist shall furnish a hardcopy of
37 the applicant's or licensee's fingerprint card if electronic fingerprint
38 images are not available or shared in the applicant's or licensee's
39 state of residence.

1 (b) The dental hygiene board shall submit the fingerprint images
2 or card to the Department of Justice for the purposes of obtaining
3 criminal offender record information regarding state and federal
4 level convictions and arrests, including arrests for which the
5 Department of Justice establishes that the person is free on bail or
6 on their own recognizance pending trial or appeal.
7 (c) When received, the Department of Justice shall forward to
8 the Federal Bureau of Investigation requests for federal summary
9 criminal history information received pursuant to this section. The
10 Department of Justice shall review the information returned from
11 the Federal Bureau of Investigation and compile and disseminate
12 the response to the dental hygiene board.
13 (d) The Department of Justice shall provide a response to the
14 dental hygiene board pursuant to subdivision (p) of Section 11105
15 of the Penal Code.
16 (e) The dental hygiene board shall request from the Department
17 of Justice subsequent arrest notification service, as provided
18 pursuant to Section 11105.2 of the Penal Code.
19 (f) The information obtained as a result of the fingerprinting
20 shall be used in accordance with Section 11105 of the Penal Code,
21 and to determine whether the applicant is subject to denial of
22 licensure pursuant to Division 1.5 (commencing with Section 475)
23 or Section 1943.
24 (g) The Department of Justice shall charge a fee sufficient to
25 cover the cost of processing the request described in this section.
26 SEC. 15. Section 1917 of the Business and Professions Code
27 is amended to read:
28 1917. The dental hygiene board shall grant initial licensure as
29 a registered dental hygienist to a person who satisfies all of the
30 following requirements:
31 (a) Completion of an educational program for registered dental
32 hygienists, approved by the dental hygiene board, accredited by
33 the Commission on Dental Accreditation, and conducted by a
34 degree-granting, postsecondary institution.
35 (b) Within the preceding two years, satisfactory completion of
36 the dental hygiene examination given by the Western Regional
37 Examining Board or any other clinical or dental hygiene
38 examination approved by the dental hygiene board.
39 (c) Satisfactory completion of the National Dental Hygiene
40 Board Examination.

1 (d) Satisfactory completion of the examination in California
2 law and ethics as prescribed by the dental hygiene board.
3 (e) Submission of a completed application form and all fees
4 required by the dental hygiene board.
5 (f) Satisfactory completion of dental hygiene board-approved
6 instruction in gingival soft tissue curettage, nitrous oxide-oxygen
7 analgesia, and local anesthesia.
8 SEC. 16. Section 1917.1 of the Business and Professions Code
9 is amended to read:
10 1917.1. (a) The dental hygiene board may grant a license as
11 a registered dental hygienist to an applicant who has not taken a
12 clinical examination before the dental hygiene board, if the
13 applicant submits all of the following to the dental hygiene board:
14 (1) A completed application form and all fees required by the
15 dental hygiene board.
16 (2) Proof of a current license as a registered dental hygienist
17 issued by another state that is not revoked, suspended, or otherwise
18 restricted.
19 (3) Proof that the applicant has been in clinical practice as a
20 registered dental hygienist or has been a full-time faculty member
21 in an accredited dental hygiene education program for a minimum
22 of 750 hours per year for at least five years immediately preceding
23 the date of application under this section. The clinical practice
24 requirement shall be deemed met if the applicant provides proof
25 of at least three years of clinical practice and commits to
26 completing the remaining two years of clinical practice by filing
27 with the dental hygiene board a copy of a pending contract to
28 practice dental hygiene in any of the following facilities:
29 (A) A primary care clinic licensed under subdivision (a) of
30 Section 1204 of the Health and Safety Code.
31 (B) A primary care clinic exempt from licensure pursuant to
32 subdivision (c) of Section 1206 of the Health and Safety Code.
33 (C) A clinic owned or operated by a public hospital or health
34 system.
35 (D) A clinic owned and operated by a hospital that maintains
36 the primary contract with a county government to fill the county's
37 role under Section 17000 of the Welfare and Institutions Code.
38 (4) Satisfactory performance on a California law and ethics
39 examination and any examination that may be required by the
40 dental hygiene board.

1 (5) Proof that the applicant has not been subject to disciplinary
2 action by any state in which the applicant is or has been previously
3 issued any professional or vocational license. If the applicant has
4 been subject to disciplinary action, the dental hygiene board shall
5 review that action to determine if it warrants refusal to issue a
6 license to the applicant.
7 (6) Proof of graduation from a school of dental hygiene
8 accredited by the Commission on Dental Accreditation.
9 (7) Proof of satisfactory completion of the National Dental
10 Hygiene Board Examination and of a state clinical examination,
11 regional clinical licensure examination, or any other clinical dental
12 hygiene examination approved by the dental hygiene board.
13 (8) Proof that the applicant has not failed the state clinical
14 examination, the examination given by the Western Regional
15 Examining Board, or any other clinical dental hygiene examination
16 approved by the dental hygiene board for licensure to practice
17 dental hygiene under this chapter more than once or once within
18 five years prior to the date of application for a license under this
19 section.
20 (9) Documentation of completion of a minimum of 25 units of
21 continuing education earned in the two years preceding application,
22 including completion of any continuing education requirements
23 imposed by the dental hygiene board on registered dental hygienists
24 licensed in this state at the time of application.
25 (10) Any other information as specified by the dental hygiene
26 board to the extent that it is required of applicants for licensure by
27 examination under this article.
28 (b) The dental hygiene board may periodically request
29 verification of compliance with the requirements of paragraph (3)
30 of subdivision (a), and may revoke the license upon a finding that
31 the employment requirement or any other requirement of paragraph
32 (3) of subdivision (a) has not been met.
33 (c) The dental hygiene board shall provide in the application
34 packet to each out-of-state dental hygienist pursuant to this section
35 the following information:
36 (1) The location of dental manpower shortage areas in the state.
37 (2) Any not-for-profit clinics, public hospitals, and accredited
38 dental hygiene education programs seeking to contract with
39 licensees for dental hygiene service delivery or training purposes.

1 SEC. 17. Section 1917.3 of the Business and Professions Code
2 is amended to read:
3 1917.3. Notwithstanding Section 135, an examinee for a
4 registered dental hygienist license who either fails to pass the
5 clinical examination required by Section 1917 after three attempts
6 or fails to pass the clinical examination as a result of a single
7 incidence of imposing gross trauma on a patient shall not be
8 eligible for further reexamination until the examinee has
9 successfully completed remedial education at an approved dental
10 hygiene program or a comparable organization approved by the
11 dental hygiene board.
12 SEC. 18. Section 1918 of the Business and Professions Code
13 is amended to read:
14 1918. The dental hygiene board shall license as a registered
15 dental hygienist in extended functions a person who meets all of
16 the following requirements:
17 (a) Holds a current license as a registered dental hygienist in
18 California.
19 (b) Completes clinical training approved by the dental hygiene
20 board in a facility affiliated with a dental school under the direct
21 supervision of the dental school faculty.
22 (c) Performs satisfactorily on an examination required by the
23 dental hygiene board.
24 (d) Completes an application form and pays all application fees
25 required by the dental hygiene board.
26 SEC. 19. Section 1922 of the Business and Professions Code
27 is amended to read:
28 1922. The dental hygiene board shall license as a registered
29 dental hygienist in alternative practice a person who demonstrates
30 satisfactory performance on an examination in California law and
31 ethics required by the dental hygiene board and who completes an
32 application form and pays all application fees required by the dental
33 hygiene board and meets either of the following requirements:
34 (a) Holds a current California license as a registered dental
35 hygienist and meets the following requirements:
36 (1) Has been engaged in the practice of dental hygiene, as
37 defined in Section 1908, as a registered dental hygienist in any
38 setting, including, but not limited to, educational settings and public
39 health settings, for a minimum of 2,000 hours during the
40 immediately preceding 36 months.

1 (2) Has successfully completed a bachelor's degree or its
2 equivalent from a college or institution of higher education that is
3 accredited by a national or regional accrediting agency recognized
4 by the United States Department of Education, and a minimum of
5 150 hours of additional educational requirements, as prescribed
6 by the dental hygiene board by regulation, that are consistent with
7 good dental and dental hygiene practice, including, but not
8 necessarily limited to, dental hygiene technique and theory
9 including gerontology and medical emergencies, and business
10 administration and practice management.
11 (b) Has received a letter of acceptance into the employment
12 utilization phase of the Health Manpower Pilot Project No. 155
13 established by the Office of Statewide Health Planning and
14 Development pursuant to Article 1 (commencing with Section
15 128125) of Chapter 3 of Part 3 of Division 107 of the Health and
16 Safety Code.
17 SEC. 20. Section 1926.1 of the Business and Professions Code
18 is amended to read:
19 1926.1. Notwithstanding any other provision of law, a
20 registered dental hygienist in alternative practice may operate a
21 mobile dental hygiene clinic provided by the licensee's property
22 and casualty insurer as a temporary substitute site for the practice
23 registered by the licensee pursuant to Section 1926.3, if both of
24 the following requirements are met:
25 (a) The licensee's registered place of practice has been rendered
26 and remains unusable due to loss or calamity.
27 (b) The licensee's insurer registers the mobile dental hygiene
28 clinic with the dental hygiene board in compliance with Section
29 1926.3.
30 SEC. 21. Section 1926.2 of the Business and Professions Code
31 is amended to read:
32 1926.2. (a) Notwithstanding any other provision of law, a
33 registered dental hygienist in alternative practice may operate one
34 mobile dental hygiene clinic registered as a dental hygiene office
35 or facility. The owner or operator of the mobile dental hygiene
36 clinic or unit shall be registered and operated in accordance with
37 regulations established by the dental hygiene board, which
38 regulations shall not be designed to prevent or lessen competition
39 in service areas, and shall pay the fees described in Section 1944.

1 (b) A mobile service unit, as defined in subdivision (b) of
2 Section 1765.105 of the Health and Safety Code, and a mobile
3 unit operated by an entity that is exempt from licensure pursuant
4 to subdivision (b), (c), or (h) of Section 1206 of the Health and
5 Safety Code, are exempt from this article. Notwithstanding this
6 exemption, the owner or operator of the mobile unit shall notify
7 the dental hygiene board within 60 days of the date on which dental
8 hygiene services are first delivered in the mobile unit, or the date
9 on which the mobile unit's application pursuant to Section
10 1765.130 of the Health and Safety Code is approved, whichever
11 is earlier.
12 (c) A licensee practicing in a mobile unit described in
13 subdivision (b) is not subject to subdivision (a) as to that mobile
14 unit.
15 SEC. 22. Section 1926.3 of the Business and Professions Code
16 is amended to read:
17 1926.3. Every person who is now or hereafter licensed as a
18 registered dental hygienist in alternative practice in this state shall
19 register with the executive officer, on forms prescribed by the
20 dental hygiene board, the person's place of practice, or, if the
21 person has more than one place of practice pursuant to Section
22 1926.4, all of the places of practice. If the person has no place of
23 practice, the person shall notify the executive officer. A person
24 licensed by the dental hygiene board shall register with the
25 executive officer within 30 days after the date of the issuance of
26 the person's license as a registered dental hygienist in alternative
27 practice.
28 SEC. 23. Section 1926.4 of the Business and Professions Code
29 is amended to read:
30 1926.4. When a registered dental hygienist in alternative
31 practice desires to have more than one place of practice, the person
32 shall, before opening the additional office, apply to the dental
33 hygiene board, pay the fee required by Section 1944, and obtain
34 permission in writing from the dental hygiene board to have the
35 additional place of practice, subject to a biennial renewal fee
36 described in Section 1944.
37 SEC. 24. Section 1930 of the Business and Professions Code
38 is amended to read:
39 1930. A registered dental hygienist in alternative practice shall
40 provide to the dental hygiene board documentation of an existing

1 relationship with at least one dentist for referral, consultation, and
2 emergency services.
3 SEC. 25. Section 1931 of the Business and Professions Code
4 is amended to read:
5 1931. (a) (1) A dental hygienist in alternative practice may
6 provide services to a patient without obtaining written verification
7 that the patient has been examined by a dentist or physician and
8 surgeon licensed to practice in this state.
9 (2) If the dental hygienist in alternative practice provides
10 services to a patient 18 months or more after the first date that the
11 person provides services to a patient, the person shall obtain written
12 verification that the patient has been examined by a dentist or
13 physician and surgeon licensed to practice in this state. The
14 verification shall include a prescription for dental hygiene services
15 as described in subdivision (b).
16 (b) A registered dental hygienist in alternative practice may
17 provide dental hygiene services for a patient who presents to the
18 registered dental hygienist in alternative practice a written
19 prescription for dental hygiene services issued by a dentist or
20 physician and surgeon licensed to practice in this state. The
21 prescription shall be valid for a time period based on the dentist's
22 or physician and surgeon's professional judgment, but not to exceed
23 two years from the date it was issued.
24 (c) (1) The dental hygiene board may seek to obtain an
25 injunction against any registered dental hygienist in alternative
26 practice who provides services pursuant to this section, if the dental
27 hygiene board has reasonable cause to believe that the services are
28 being provided to a patient who has not received a prescription for
29 those services from a dentist or physician and surgeon licensed to
30 practice in this state.
31 (2) Providing services pursuant to this section without obtaining
32 a prescription in accordance with subdivision (b) shall constitute
33 unprofessional conduct on the part of the registered dental hygienist
34 in alternative practice, and reason for the dental hygiene board to
35 revoke or suspend the license of the registered dental hygienist in
36 alternative practice pursuant to Section 1947.
37 SEC. 26. Section 1932 of the Business and Professions Code
38 is amended to read:
39 1932. (a) The dental hygiene board may, in its sole discretion,
40 issue a probationary license to an applicant who has satisfied all

1 requirements for licensure as a registered dental hygienist, a
2 registered dental hygienist in alternative practice, or a registered
3 dental hygienist in extended functions. The dental hygiene board
4 may require, as a term or condition of issuing the probationary
5 license, that the applicant comply with certain additional
6 requirements, including, but not limited to, the following:
7 (1) Successfully completing a professional competency
8 examination.
9 (2) Submitting to a medical or psychological evaluation.
10 (3) Submitting to continuing medical or psychological treatment.
11 (4) Abstaining from the use of alcohol or drugs.
12 (5) Submitting to random fluid testing for alcohol or controlled
13 substance abuse.
14 (6) Submitting to continuing participation in a dental hygiene
15 board-approved rehabilitation program.
16 (7) Restricting the type or circumstances of practice.
17 (8) Submitting to continuing education and coursework.
18 (9) Complying with requirements regarding notifying the dental
19 hygiene board of any change of employer or employment.
20 (10) Complying with probation monitoring.
21 (11) Complying with all laws and regulations governing the
22 practice of dental hygiene.
23 (12) Limiting the applicant's practice to a supervised, structured
24 environment in which the applicant's activities are supervised by
25 a specified person.
26 (b) The term of a probationary license is three years. During
27 the term of the license, the licensee may petition the dental hygiene
28 board for a modification of a term or condition of the license or
29 for the issuance of a license that is not probationary.
30 (c) The proceedings under this section shall be conducted in
31 accordance with Chapter 5 (commencing with Section 11500) of
32 Part 1 of Division 3 of Title 2 of the Government Code, and the
33 dental hygiene board shall have all the powers granted in that
34 chapter.
35 SEC. 27. Section 1934 of the Business and Professions Code
36 is amended to read:
37 1934. A licensee who changes their physical address of record
38 or email address shall notify the dental hygiene board within 30
39 days of the change. A licensee who changes their legal name shall

1 provide the dental hygiene board with documentation of the change
2 within 10 days.
3 SEC. 28. Section 1935 of the Business and Professions Code
4 is amended to read:
5 1935. If not renewed, a license issued under the provisions of
6 this article, unless specifically excepted, expires at 12 midnight
7 on the last day of the month of the legal birth date of the licensee
8 during the second year of a two-year term. To renew an unexpired
9 license, the licensee shall, before the time at which the license
10 would otherwise expire, apply for renewal on a form prescribed
11 by the dental hygiene board and pay the renewal fee prescribed
12 by this article.
13 SEC. 29. Section 1936 of the Business and Professions Code
14 is amended to read:
15 1936. Except as otherwise provided in this article, an expired
16 license may be renewed at any time within five years after its
17 expiration by filing an application for renewal on a form prescribed
18 by the dental hygiene board and payment of all accrued renewal
19 and delinquency fees. If the license is renewed after its expiration,
20 the licensee, as a condition precedent of renewal, shall also pay
21 the delinquency fee prescribed by this article. Renewal under this
22 section shall be effective on the date on which the application is
23 filed, on the date on which the renewal fee is paid, or on the date
24 on which the delinquency fee, if any, is paid, whichever last occurs.
25 If so renewed, the license shall continue in effect until the
26 expiration date provided in Section 1935 that next occurs after the
27 effective date of the renewal.
28 SEC. 30. Section 1936.1 of the Business and Professions Code
29 is amended to read:
30 1936.1. (a) The dental hygiene board shall require, as a
31 condition of license renewal, that licensees submit assurances
32 satisfactory to the dental hygiene board that they will, during the
33 succeeding two-year period, inform themselves of the
34 developments in the practice of dental hygiene occurring since the
35 original issuance of their licenses by pursuing one or more courses
36 of study satisfactory to the dental hygiene board, or by other means
37 deemed equivalent by the dental hygiene board. The dental hygiene
38 board shall adopt, amend, and revoke regulations providing for
39 the suspension of the licenses at the end of the two-year period
40 until compliance with the assurances provided for in this section

1 is accomplished. The dental hygiene board shall conduct random
2 audits of at least 5 percent of the licensee population each year to
3 ensure compliance of the continuing education requirement.
4 (b) The dental hygiene board shall also, as a condition of license
5 renewal, require licensees to successfully complete a portion of
6 the required continuing education hours in specific areas adopted
7 in regulations by the dental hygiene board. The dental hygiene
8 board may prescribe this mandatory coursework within the general
9 areas of patient care, health and safety, and law and ethics. The
10 mandatory coursework prescribed by the dental hygiene board
11 shall not exceed seven and one-half hours per renewal period. Any
12 mandatory coursework required by the dental hygiene board shall
13 be credited toward the continuing education requirements
14 established by the dental hygiene board pursuant to subdivision
15 (a).
16 (c) The providers of courses referred to in this section shall be
17 approved by the dental hygiene board. Providers approved by the
18 dental board shall be deemed approved by the dental hygiene board.
19 SEC. 31. Section 1940 of the Business and Professions Code
20 is amended to read:
21 1940. (a) A licensee who desires an inactive license shall
22 submit an application to the dental hygiene board on a form
23 provided by the dental hygiene board.
24 (b) In order to restore an inactive license to active status, the
25 licensee shall submit an application to the dental hygiene board
26 on a form provided by the dental hygiene board, accompanied by
27 evidence that the licensee has completed the required number of
28 hours of approved continuing education in compliance with this
29 article within the last two years preceding the date of the
30 application.
31 (c) The holder of an inactive license shall continue to pay to the
32 dental hygiene board the required biennial renewal fee.
33 (d) Within 30 days of receiving a request either to restore an
34 inactive license or to inactivate a license, the dental hygiene board
35 shall inform the applicant in writing whether the application is
36 complete and accepted for filing or is deficient and, if so, the
37 specific information required to complete the application.
38 SEC. 32. Section 1941 of the Business and Professions Code
39 is amended to read:

1 1941. (a) The dental hygiene board shall grant or renew
2 approval of only those educational programs for a registered dental
3 hygienist, a registered dental hygienist in alternative practice, or
4 a registered dental hygienist in extended functions that continuously
5 maintain a high quality standard of instruction and, where
6 appropriate, meet the minimum standards set by the Commission
7 on Dental Accreditation of the American Dental Association or
8 an equivalent body, as determined by the dental hygiene board.
9 (b) A new educational program for registered dental hygienists
10 shall submit a feasibility study demonstrating a need for a new
11 educational program and shall apply for approval from the dental
12 hygiene board prior to seeking approval for initial accreditation
13 from the Commission on Dental Accreditation of the American
14 Dental Association or an equivalent body, as determined by the
15 dental hygiene board. The dental hygiene board may approve,
16 provisionally approve, or deny approval of any such new
17 educational program.
18 (c) For purposes of this section, a new educational program for
19 registered dental hygienists means a program provided by a college
20 or institution of higher education that is accredited by a regional
21 accrediting agency recognized by the United States Department
22 of Education and that has as its primary purpose providing college
23 level courses leading to an associate or higher degree, that is either
24 affiliated with or conducted by a dental school approved by the
25 dental board, or that is accredited to offer college level or college
26 parallel programs by the Commission on Dental Accreditation of
27 the American Dental Association or an equivalent body, as
28 determined by the dental hygiene board.
29 SEC. 33. Section 1941.5 of the Business and Professions Code
30 is amended to read:
31 1941.5. (a) The dental hygiene board shall renew approval of
32 educational programs for a registered dental hygienist, a registered
33 dental hygienist in alternative practice, or a registered dental
34 hygienist in extended functions that certify to the dental hygiene
35 board on a form prescribed by the dental hygiene board that the
36 program continues to meet the requirements prescribed by the
37 dental hygiene board.
38 (b) The dental hygiene board may conduct periodic surveys,
39 evaluations, and announced and unannounced site visits to existing
40 and new educational programs for a registered dental hygienist, a

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1 registered dental hygienist in alternative practice, or a registered
2 dental hygienist in extended functions to ensure continued
3 compliance of educational program requirements and Commission
4 on Dental Accreditation standards for continued approval.
5 (c) An existing or new educational program for a registered
6 dental hygienist, a registered dental hygienist in alternative practice,
7 or a registered dental hygienist in extended functions that is found
8 to be noncompliant with the educational program requirements
9 and Commission on Dental Accreditation standards may be placed
10 on probation with terms, issued a citation and fine, or have its
11 approval withdrawn if compliance is not met within reasonable
12 specified timelines.
13 (d) The dental hygiene board, or through an authorized
14 representative, may issue a citation containing fines and orders of
15 abatement for any approved educational program for a registered
16 dental hygienist, a registered dental hygienist in alternative practice,
17 or a registered dental hygienist in extended functions for any
18 violation of this section or the regulations adopted pursuant to this
19 section.
20 SEC. 34. Section 1942 of the Business and Professions Code
21 is amended to read:
22 1942. (a) As used in this article "extramural dental facility"
23 means any clinical facility that has contracted with an approved
24 dental hygiene educational program for instruction in dental
25 hygiene, that exists outside or beyond the walls, boundaries, or
26 precincts of the primary campus of the approved program, and in
27 which dental hygiene services are rendered.
28 (b) An approved dental hygiene educational program shall
29 register an extramural dental facility with the dental hygiene board.
30 That registration shall be accompanied by information supplied
31 by the dental hygiene program pertaining to faculty supervision,
32 scope of treatment to be rendered, name and location of the facility,
33 date on which the operation will commence, discipline of which
34 the instruction is a part, and a brief description of the equipment
35 and facilities available. The foregoing information shall be
36 supplemented by a copy of the agreement between the approved
37 dental hygiene educational program or parent university, and the
38 affiliated institution establishing the contractual relationship. Any
39 change in the information initially provided to the dental hygiene
40 board shall be communicated to the dental hygiene board.

1 SEC. 35. Section 1943 of the Business and Professions Code
2 is amended to read:
3 1943. (a) The dental hygiene board may deny an application
4 to take an examination for licensure as a registered dental hygienist,
5 a registered dental hygienist in alternative practice, or a registered
6 dental hygienist in extended functions at any time prior to licensure
7 for any of the following reasons:
8 (1) The applicant committed an act that is a ground for license
9 suspension or revocation under this code or that is a ground for
10 the denial of licensure under Section 480.
11 (2) The applicant committed or aided and abetted the
12 commission of any act for which a license is required under this
13 chapter.
14 (3) Another state or territory suspended or revoked the license
15 that it had issued to the applicant on a ground that constitutes a
16 basis in this state for the suspension or revocation of licensure
17 under this article.
18 (b) The proceedings under this section shall be conducted in
19 accordance with Chapter 5 (commencing with Section 11500) of
20 Part 1 of Division 3 of Title 2 of the Government Code, and the
21 dental hygiene board shall have all of the powers granted therein.
22 SEC. 36. Section 1944 of the Business and Professions Code
23 is amended to read:
24 1944. (a) The dental hygiene board shall establish by resolution
25 the amount of the fees that relate to the licensing of a registered
26 dental hygienist, a registered dental hygienist in alternative practice,
27 and a registered dental hygienist in extended functions. The fees
28 established by board resolution in effect on June 30, 2009, as they
29 relate to the licensure of registered dental hygienists, registered
30 dental hygienists in alternative practice, and registered dental
31 hygienists in extended functions, shall remain in effect until
32 modified by the dental hygiene board. The fees are subject to the
33 following limitations:
34 (1) The application fee for an original license and the fee for
35 issuance of an original license shall not exceed two hundred fifty
36 dollars ($250).
37 (2) The fee for examination for licensure as a registered dental
38 hygienist shall not exceed the actual cost of the examination.

1 (3) The fee for examination for licensure as a registered dental
2 hygienist in extended functions shall not exceed the actual cost of
3 the examination.
4 (4) The fee for examination for licensure as a registered dental
5 hygienist in alternative practice shall not exceed the actual cost of
6 administering the examination.
7 (5) The biennial renewal fee shall not exceed five hundred
8 dollars ($500).
9 (6) The delinquency fee shall not exceed one-half of the renewal
10 fee. Any delinquent license may be restored only upon payment
11 of all fees, including the delinquency fee, and compliance with all
12 other applicable requirements of this article.
13 (7) The fee for issuance of a duplicate license to replace one
14 that is lost or destroyed, or in the event of a name change, shall
15 not exceed twenty-five dollars ($25) or one-half of the renewal
16 fee, whichever is greater.
17 (8) The fee for certification of licensure shall not exceed one-half
18 of the renewal fee.
19 (9) The fee for each curriculum review and feasibility study
20 review for educational programs for dental hygienists who are not
21 accredited by a dental hygiene board-approved agency shall not
22 exceed two thousand one hundred dollars ($2,100).
23 (10) The fee for each review or approval of course requirements
24 for licensure or procedures that require additional training shall
25 not exceed seven hundred fifty dollars ($750).
26 (11) The initial application and biennial fee for a provider of
27 continuing education shall not exceed five hundred dollars ($500).
28 (12) The amount of fees payable in connection with permits
29 issued under Section 1962 is as follows:
30 (A) The initial permit fee is an amount equal to the renewal fee
31 for the applicant's license to practice dental hygiene in effect on
32 the last regular renewal date before the date on which the permit
33 is issued.
34 (B) If the permit will expire less than one year after its issuance,
35 then the initial permit fee is an amount equal to 50 percent of the
36 renewal fee in effect on the last regular renewal date before the
37 date on which the permit is issued.
38 (13) The fee for the dental hygiene board to conduct a site visit
39 to educational programs for a registered dental hygienist, a
40 registered dental hygienist in alternative practice, or a registered

1 dental hygienist in extended functions to ensure compliance of
2 educational program requirements shall not exceed the actual cost
3 incurred by the dental hygiene board for cost recovery of site visit
4 expenditures.
5 (14) The fee for a retired license shall not exceed one-half of
6 the current license renewal fee.
7 (b) The renewal and delinquency fees shall be fixed by the dental
8 hygiene board by resolution at not more than the current amount
9 of the renewal fee for a license to practice under this article nor
10 less than five dollars ($5).
11 (c) Fees fixed by the dental hygiene board by resolution pursuant
12 to this section shall not be subject to the approval of the Office of
13 Administrative Law.
14 (d) Fees collected pursuant to this section shall be collected by
15 the dental hygiene board and deposited into the State Dental
16 Hygiene Fund, which is hereby created. All money in this fund
17 shall, upon appropriation by the Legislature in the annual Budget
18 Act, be used to implement this article.
19 (e) No fees or charges other than those listed in this section shall
20 be levied by the dental hygiene board in connection with the
21 licensure of registered dental hygienists, registered dental
22 hygienists in alternative practice, or registered dental hygienists
23 in extended functions.
24 (f) The fee for registration of an extramural dental facility shall
25 not exceed two hundred fifty dollars ($250).
26 (g) The fee for registration of a mobile dental hygiene unit shall
27 not exceed one hundred fifty dollars ($150).
28 (h) The biennial renewal fee for a mobile dental hygiene unit
29 shall not exceed two hundred fifty dollars ($250).
30 (i) The fee for an additional office permit shall not exceed two
31 hundred fifty dollars ($250).
32 (j) The biennial renewal fee for an additional office as described
33 in Section 1926.4 shall not exceed two hundred fifty dollars ($250).
34 (k) The initial application and biennial special permit fee is an
35 amount equal to the biennial renewal fee specified in paragraph
36 (6) of subdivision (a).
37 (*l*) The fees in this section shall not exceed an amount sufficient
38 to cover the reasonable regulatory cost of carrying out this article.
39 SEC. 37. Section 1947 of the Business and Professions Code
40 is amended to read:

1 1947. A license issued under this article and a license issued
2 under this chapter to a registered dental hygienist, to a registered
3 dental hygienist in alternative practice, or to a registered dental
4 hygienist in extended functions may be revoked or suspended by
5 the dental hygiene board for any reason specified in this article for
6 the suspension or revocation of a license to practice dental hygiene.
7 SEC. 38. Section 1949 of the Business and Professions Code
8 is amended to read:
9 1949. A licensee may have their license revoked or suspended,
10 or may be reprimanded or placed on probation by the dental
11 hygiene board for unprofessional conduct, incompetence, gross
12 negligence, repeated acts of negligence in the licensee's profession,
13 receiving a license by mistake, or for any other cause applicable
14 to the licentiate provided in this article. The proceedings under
15 this article shall be conducted in accordance with Chapter 5
16 (commencing with Section 11500) of Part 1 of Division 3 of Title
17 2 of the Government Code, and the dental hygiene board shall
18 have all the powers granted therein.
19 SEC. 39. Section 1950 of the Business and Professions Code
20 is amended to read:
21 1950. (a) A licensee may have their license revoked or
22 suspended, or may be reprimanded or placed on probation by the
23 dental hygiene board, for conviction of a crime substantially related
24 to the licensee's qualifications, functions, or duties. The record of
25 conviction or a copy certified by the clerk of the court or by the
26 judge in whose court the conviction occurred shall be conclusive
27 evidence of conviction.
28 (b) The dental hygiene board shall undertake proceedings under
29 this section upon the receipt of a certified copy of the record of
30 conviction. A plea or verdict of guilty or a conviction following a
31 plea of nolo contendere made to a charge of a felony or of any
32 misdemeanor substantially related to the licensee's qualifications,
33 functions, or duties is deemed to be a conviction within the
34 meaning of this section.
35 (c) The dental hygiene board may reprimand a licensee or order
36 a license suspended or revoked, or placed on probation or may
37 decline to issue a license, when any of the following occur:
38 (1) The time for appeal has elapsed.
39 (2) The judgment of conviction has been affirmed on appeal.

1 (3) An order granting probation is made suspending the
2 imposition of sentence, irrespective of a subsequent order under
3 any provision of the Penal Code, including, but not limited to,
4 Section 1203.4 of the Penal Code, allowing a person to withdraw
5 their plea of guilty and to enter a plea of not guilty, or setting aside
6 the verdict of guilty, or dismissing the accusation, information, or
7 indictment.
8 SEC. 40. Section 1950.5 of the Business and Professions Code
9 is amended to read:
10 1950.5. Unprofessional conduct by a person licensed under
11 this article is defined as, but is not limited to, any one of the
12 following:
13 (a) The obtaining of any fee by fraud or misrepresentation.
14 (b) The aiding or abetting of any unlicensed person to practice
15 dentistry or dental hygiene.
16 (c) The aiding or abetting of a licensed person to practice
17 dentistry or dental hygiene unlawfully.
18 (d) The committing of any act or acts of sexual abuse,
19 misconduct, or relations with a patient that are substantially related
20 to the practice of dental hygiene.
21 (e) The use of any false, assumed, or fictitious name, either as
22 an individual, firm, corporation, or otherwise, or any name other
23 than the name under which the person is licensed to practice, in
24 advertising or in any other manner indicating that the person is
25 practicing or will practice dentistry, except that name as is specified
26 in a valid permit issued pursuant to Section 1962.
27 (f) The practice of accepting or receiving any commission or
28 the rebating in any form or manner of fees for professional services,
29 radiographs, prescriptions, or other services or articles supplied to
30 patients.
31 (g) The making use by the licensee or any agent of the licensee
32 of any advertising statements of a character tending to deceive or
33 mislead the public.
34 (h) The advertising of either professional superiority or the
35 advertising of performance of professional services in a superior
36 manner. This subdivision shall not prohibit advertising permitted
37 by subdivision (h) of Section 651.
38 (i) The employing or the making use of solicitors.
39 (j) Advertising in violation of Section 651.

1 (k) Advertising to guarantee any dental hygiene service, or to
2 perform any dental hygiene procedure painlessly. This subdivision
3 shall not prohibit advertising permitted by Section 651.
4 (*l*) The violation of any of the provisions of this division.
5 (m) The permitting of any person to operate dental radiographic
6 equipment who has not met the requirements to do so, as
7 determined by the dental hygiene board.
8 (n) The clearly excessive administering of drugs or treatment,
9 or the clearly excessive use of treatment procedures, or the clearly
10 excessive use of treatment facilities, as determined by the
11 customary practice and standards of the dental hygiene profession.
12 Any person who violates this subdivision is guilty of a
13 misdemeanor and shall be punished by a fine of not less than one
14 hundred dollars ($100) or more than six hundred dollars ($600),
15 or by imprisonment for a term of not less than 60 days or more
16 than 180 days, or by both a fine and imprisonment.
17 (o) The use of threats or harassment against any patient or
18 licensee for providing evidence in any possible or actual
19 disciplinary action, or other legal action; or the discharge of an
20 employee primarily based on the employee's attempt to comply
21 with the provisions of this chapter or to aid in the compliance.
22 (p) Suspension or revocation of a license issued, or discipline
23 imposed, by another state or territory on grounds that would be
24 the basis of discipline in this state.
25 (q) The alteration of a patient's record with intent to deceive.
26 (r) Unsanitary or unsafe office conditions, as determined by the
27 customary practice and standards of the dental hygiene profession.
28 (s) The abandonment of the patient by the licensee, without
29 written notice to the patient that treatment is to be discontinued
30 and before the patient has ample opportunity to secure the services
31 of another registered dental hygienist, registered dental hygienist
32 in alternative practice, or registered dental hygienist in extended
33 functions and provided the health of the patient is not jeopardized.
34 (t) The willful misrepresentation of facts relating to a
35 disciplinary action to the patients of a disciplined licensee.
36 (u) Use of fraud in the procurement of any license issued
37 pursuant to this article.
38 (v) Any action or conduct that would have warranted the denial
39 of the license.

1 (w) The aiding or abetting of a registered dental hygienist,
2 registered dental hygienist in alternative practice, or registered
3 dental hygienist in extended functions to practice dental hygiene
4 in a negligent or incompetent manner.
5 (x) The failure to report to the dental hygiene board in writing
6 within seven days any of the following: (1) the death of the
7 licensee's patient during the performance of any dental hygiene
8 procedure; (2) the discovery of the death of a patient whose death
9 is related to a dental hygiene procedure performed by the licensee;
10 or (3) except for a scheduled hospitalization, the removal to a
11 hospital or emergency center for medical treatment for a period
12 exceeding 24 hours of any patient as a result of dental or dental
13 hygiene treatment. Upon receipt of a report pursuant to this
14 subdivision, the dental hygiene board may conduct an inspection
15 of the dental hygiene practice office if the dental hygiene board
16 finds that it is necessary.
17 (y) A registered dental hygienist, registered dental hygienist in
18 alternative practice, or registered dental hygienist in extended
19 functions shall report to the dental hygiene board all deaths
20 occurring in their practice with a copy sent to the dental board if
21 the death occurred while working as an employee in a dental office.
22 A dentist shall report to the dental board all deaths occurring in
23 their practice with a copy sent to the dental hygiene board if the
24 death was the result of treatment by a registered dental hygienist,
25 registered dental hygienist in alternative practice, or registered
26 dental hygienist in extended functions.
27 SEC. 41. Section 1951 of the Business and Professions Code
28 is amended to read:
29 1951. The dental hygiene board may discipline a licensee by
30 placing the licensee on probation under various terms and
31 conditions that may include, but are not limited to, the following:
32 (a) Requiring the licensee to obtain additional training or pass
33 an examination upon completion of training, or both. The
34 examination may be a written or oral examination, or both, and
35 may be a practical or clinical examination, or both, at the option
36 of the dental hygiene board.
37 (b) Requiring the licensee to submit to a complete diagnostic
38 examination by one or more physicians appointed by the dental
39 hygiene board, if warranted by the physical or mental condition
40 of the licensee. If the dental hygiene board requires the licensee

1 to submit to an examination, the dental hygiene board shall receive
2 and consider any other report of a complete diagnostic examination
3 given by one or more physicians of the licensee's choice.
4 (c) Restricting or limiting the extent, scope, or type of practice
5 of the licensee.
6 (d) Requiring restitution of fees to the licensee's patients or
7 payers of services, unless restitution has already been made.
8 (e) Providing the option of alternative community service in
9 lieu of all or part of a period of suspension in cases other than
10 violations relating to quality of care.
11 SEC. 42. Section 1952 of the Business and Professions Code
12 is amended to read:
13 1952. It is unprofessional conduct for a person licensed under
14 this article to do any of the following:
15 (a) Obtain or possess in violation of law, or except as directed
16 by a licensed physician and surgeon, dentist, or podiatrist, a
17 controlled substance, as defined in Division 10 (commencing with
18 Section 11000) of the Health and Safety Code, or any dangerous
19 drug as defined in Section 4022.
20 (b) Use a controlled substance, as defined in Division 10
21 (commencing with Section 11000) of the Health and Safety Code,
22 or a dangerous drug as defined in Section 4022, or alcoholic
23 beverages or other intoxicating substances, to an extent or in a
24 manner dangerous or injurious to themselves, to any person, or
25 the public to the extent that the use impairs the licensee's ability
26 to conduct with safety to the public the practice authorized by their
27 license.
28 (c) Be convicted of a charge of violating any federal statute or
29 rules, or any statute or rule of this state, regulating controlled
30 substances, as defined in Division 10 (commencing with Section
31 11000) of the Health and Safety Code, or any dangerous drug, as
32 defined in Section 4022, or be convicted of more than one
33 misdemeanor, or any felony, involving the use or consumption of
34 alcohol or drugs, if the conviction is substantially related to the
35 practice authorized by their license.
36 (1) The record of conviction or a copy certified by the clerk of
37 the court or by the judge in whose court the conviction is had, shall
38 be conclusive evidence of a violation of this section. A plea or
39 verdict of guilty or a conviction following a plea of nolo contendere
40 is deemed to be a conviction within the meaning of this section.

1 (2) The dental hygiene board may order the license suspended
2 or revoked, or may decline to issue a license, when the time for
3 appeal has elapsed or the judgment of conviction has been affirmed
4 on appeal, or when an order granting probation is made suspending
5 imposition of sentence, irrespective of a subsequent order under
6 any provision of the Penal Code, including, but not limited to,
7 Section 1203.4 of the Penal Code, allowing a person to withdraw
8 a plea of guilty and to enter a plea of not guilty, or setting aside
9 the verdict of guilty, or dismissing the accusation, information, or
10 indictment.
11 SEC. 43. Section 1955 of the Business and Professions Code
12 is amended to read:
13 1955. (a) (1) A licensee who fails or refuses to comply with
14 a request for a patient's dental or dental hygiene records that is
15 accompanied by that patient's written authorization for release of
16 the records to the dental hygiene board, within 15 days of receiving
17 the request and authorization, shall pay to the dental hygiene board
18 a civil or administrative penalty or fine up to a maximum of two
19 hundred fifty dollars ($250) per day for each day that the
20 documents have not been produced after the 15th day, up to a
21 maximum of five thousand dollars ($5,000) unless the licensee is
22 unable to provide the documents within this time period for good
23 cause.
24 (2) A health care facility shall comply with a request for the
25 dental or dental hygiene records of a patient that is accompanied
26 by that patient's written authorization for release of records to the
27 dental hygiene board together with a notice citing this section and
28 describing the penalties for failure to comply with this section.
29 Failure to provide the authorizing patient's dental hygiene records
30 to the dental hygiene board within 30 days of receiving this request,
31 authorization, and notice shall subject the health care facility to a
32 civil or administrative penalty or fine, payable to the dental hygiene
33 board, of up to a maximum of two hundred fifty dollars ($250) per
34 day for each day that the documents have not been produced after
35 the 30th day, up to a maximum of five thousand dollars ($5,000),
36 unless the health care facility is unable to provide the documents
37 within this time period for good cause. This paragraph shall not
38 require health care facilities to assist the dental hygiene board in
39 obtaining the patient's authorization. The dental hygiene board
40 shall pay the reasonable cost of copying the dental hygiene records.

1 (b) (1) A licensee who fails or refuses to comply with a court
2 order issued in the enforcement of a subpoena mandating the
3 release of records to the dental hygiene board shall pay to the dental
4 hygiene board a civil penalty of one thousand dollars ($1,000) per
5 day for each day that the documents have not been produced after
6 the date by which the court order requires the documents to be
7 produced, unless it is determined that the order is unlawful or
8 invalid. Any statute of limitations applicable to the filing of an
9 accusation by the dental hygiene board shall be tolled during the
10 period the licensee is out of compliance with the court order and
11 during any related appeals.
12 (2) A licensee who fails or refuses to comply with a court order
13 issued in the enforcement of a subpoena mandating the release of
14 records to the dental hygiene board is guilty of a misdemeanor
15 punishable by a fine payable to the dental hygiene board not to
16 exceed five thousand dollars ($5,000). The fine shall be added to
17 the licensee's renewal fee if it is not paid by the next succeeding
18 renewal date. Any statute of limitations applicable to the filing of
19 an accusation by the dental hygiene board shall be tolled during
20 the period the licensee is out of compliance with the court order
21 and during any related appeals.
22 (3) A health care facility that fails or refuses to comply with a
23 court order issued in the enforcement of a subpoena mandating
24 the release of patient records to the dental hygiene board, that is
25 accompanied by a notice citing this section and describing the
26 penalties for failure to comply with this section, shall pay to the
27 dental hygiene board a civil penalty of up to one thousand dollars
28 ($1,000) per day for each day that the documents have not been
29 produced, up to ten thousand dollars ($10,000), after the date by
30 which the court order requires the documents to be produced,
31 unless it is determined that the order is unlawful or invalid. Any
32 statute of limitations applicable to the filing of an accusation by
33 the dental hygiene board against a licensee shall be tolled during
34 the period the health care facility is out of compliance with the
35 court order and during any related appeals.
36 (4) A health care facility that fails or refuses to comply with a
37 court order, issued in the enforcement of a subpoena, mandating
38 the release of records to the dental hygiene board is guilty of a
39 misdemeanor punishable by a fine payable to the dental hygiene
40 board not to exceed five thousand dollars ($5,000). Any statute of

1 limitations applicable to the filing of an accusation by the dental
2 hygiene board against a licensee shall be tolled during the period
3 the health care facility is out of compliance with the court order
4 and during any related appeals.
5 (c) Multiple acts by a licensee in violation of subdivision (b)
6 shall be punishable by a fine not to exceed five thousand dollars
7 ($5,000) or by imprisonment in a county jail not exceeding six
8 months, or by both that fine and imprisonment. Multiple acts by
9 a health care facility in violation of subdivision (b) shall be
10 punishable by a fine not to exceed five thousand dollars ($5,000)
11 and shall be reported to the State Department of Public Health and
12 shall be considered as grounds for disciplinary action with respect
13 to licensure, including suspension or revocation of the license or
14 permit.
15 (d) A failure or refusal to comply with a court order issued in
16 the enforcement of a subpoena mandating the release of records
17 to the dental hygiene board constitutes unprofessional conduct and
18 is grounds for suspension or revocation of the person's license.
19 (e) Imposition of the civil or administrative penalties authorized
20 by this section shall be in accordance with the Administrative
21 Procedure Act (Chapter 5 (commencing with Section 11500) of
22 Division 3 of Title 2 of the Government Code).
23 (f) For the purposes of this section, a "health care facility" means
24 a clinic or health care facility licensed or exempt from licensure
25 pursuant to Division 2 (commencing with Section 1200) of the
26 Health and Safety Code.
27 SEC. 44. Section 1957 of the Business and Professions Code
28 is amended to read:
29 1957. (a) A person whose license has been revoked or
30 suspended, who has been placed on probation, or whose license
31 was surrendered pursuant to a stipulated settlement as a condition
32 to avoid a disciplinary administrative hearing, may petition the
33 dental hygiene board for reinstatement or modification of the
34 penalty, including modification or termination of probation, after
35 a period of not less than the following minimum periods have
36 elapsed from the effective date of the decision ordering disciplinary
37 action:
38 (1) At least three years for reinstatement of a license revoked
39 for unprofessional conduct or surrendered pursuant to a stipulated

1 settlement as a condition to avoid an administrative disciplinary
2 hearing.
3 (2) At least two years for early termination, or modification of
4 a condition, of a probation of three years or more.
5 (3) At least one year for modification of a condition, or
6 reinstatement of a license revoked for mental or physical illness,
7 or termination, or modification of a condition, of a probation of
8 less than three years.
9 (b) The petition shall state any fact required by the dental
10 hygiene board.
11 (c) The petition may be heard by the dental hygiene board, or
12 the dental hygiene board may assign the petition to an
13 administrative law judge designated in Section 11371 of the
14 Government Code.
15 (d) In considering reinstatement or modification or penalty, the
16 dental hygiene board or the administrative law judge hearing the
17 petition may consider the following:
18 (1) All activities of the petitioner since the disciplinary action
19 was taken.
20 (2) The offense for which the petitioner was disciplined.
21 (3) The petitioner's activities during the time the license or
22 permit was in good standing.
23 (4) The petitioner's rehabilitative efforts, general reputation for
24 truth, and professional ability.
25 (e) The hearing may be continued from time to time as the dental
26 hygiene board or the administrative law judge as designated in
27 Section 11371 of the Government Code finds necessary.
28 (f) The dental hygiene board or the administrative law judge
29 may impose necessary terms and conditions on the licentiate in
30 reinstating a license or permit or modifying a penalty.
31 (g) A petition shall not be considered while the petitioner is
32 under sentence for any criminal offense, including any period
33 during which the petitioner is on court-imposed probation or parole.
34 (h) A petition shall not be considered while there is an
35 accusation or petition to revoke probation pending against the
36 person.
37 (i) The dental hygiene board may deny without a hearing or
38 argument any petition filed pursuant to this section within a period
39 of two years from the effective date of the prior decision following

1 a hearing under this section. Nothing in this section shall be deemed
2 to alter Sections 822 and 823.
3 SEC. 45. Section 1958 of the Business and Professions Code
4 is amended to read:
5 1958. A person, company, or association is guilty of a
6 misdemeanor, and upon conviction, shall be punished by
7 imprisonment in a county jail not less than 10 days nor more than
8 one year, or by a fine of not less than one hundred dollars ($100)
9 nor more than one thousand five hundred dollars ($1,500), or by
10 both that fine and imprisonment, who does any of the following:
11 (a) Assumes the title of "registered dental hygienist," "registered
12 dental hygienist in alternative practice," or "registered dental
13 hygienist in extended functions" or appends the letters "R.D.H.,"
14 "R.D.H.A.P.," or "R.D.H.E.F." to the person's name without
15 having had the right to assume the title conferred upon the person
16 through licensure.
17 (b) Assumes any title, or appends any letters to the person's
18 name, with the intent to represent falsely that the person has
19 received a dental hygiene degree or a license under this article.
20 (c) Engages in the practice of dental hygiene without causing
21 to be displayed in a conspicuous place in the person's office the
22 person's license under this article to practice dental hygiene.
23 (d) Within 10 days after demand is made by the executive officer
24 of the dental hygiene board, fails to furnish to the dental hygiene
25 board the name and address of all persons practicing or assisting
26 in the practice of dental hygiene in the office of the person,
27 company, or association, at any time within 60 days prior to the
28 demand, together with a sworn statement showing under and by
29 what license or authority this person, company, or association and
30 any employees are or have been practicing or assisting in the
31 practice of dental hygiene. This sworn statement shall not be used
32 in any prosecution under this section.
33 (e) Is under the influence of alcohol or a controlled substance
34 while engaged in the practice of dental hygiene in actual attendance
35 on patients to an extent that impairs the licensee's ability to conduct
36 the practice of dental hygiene with safety to patients and the public.
37 SEC. 46. Section 1958.1 of the Business and Professions Code
38 is amended to read:
39 1958.1. (a) Notwithstanding any other law, with regard to an
40 individual who is required to register as a sex offender pursuant

1 to Section 290 of the Penal Code, or the equivalent in another state
2 or territory, under military law, or under federal law, all of the
3 following shall apply:
4 (1) The dental hygiene board shall deny an application by the
5 individual for licensure pursuant to this article.
6 (2) If the individual is licensed under this article, the dental
7 hygiene board shall promptly revoke the license of the individual.
8 The dental hygiene board shall not stay the revocation nor place
9 the license on probation.
10 (3) The dental hygiene board shall not reinstate or reissue the
11 individual's licensure under this article. The dental hygiene board
12 shall not issue a stay of license denial and place the license on
13 probation.
14 (b) This section shall not apply to any of the following:
15 (1) An individual who has been relieved under Section 290.5
16 of the Penal Code of the individual's duty to register as a sex
17 offender, or whose duty to register has otherwise been formally
18 terminated under California law or the law of the jurisdiction that
19 requires the individual's registration as a sex offender.
20 (2) An individual who is required to register as a sex offender
21 pursuant to Section 290 of the Penal Code solely because of a
22 misdemeanor conviction under Section 314 of the Penal Code.
23 However, nothing in this paragraph shall prohibit the dental
24 hygiene board from exercising its discretion to discipline a licensee
25 under other provisions of state law based upon the licensee's
26 conviction under Section 314 of the Penal Code.
27 (3) Any administrative adjudication proceeding under Chapter
28 5 (commencing with Section 11500) of Part 1 of Division 3 of
29 Title 2 of the Government Code that is fully adjudicated prior to
30 January 1, 2013. A petition for reinstatement of a revoked or
31 surrendered license shall be considered a new proceeding for
32 purposes of this paragraph, and the prohibition against reinstating
33 a license to an individual who is required to register as a sex
34 offender shall be applicable.
35 SEC. 47. Section 1962 of the Business and Professions Code
36 is amended to read:
37 1962. (a) An association, partnership, corporation, or group
38 of three or more registered dental hygienists in alternative practice
39 engaging in practice under a name that would otherwise be in
40 violation of Section 1960 may practice under that name if the

1 association, partnership, corporation, or group holds an unexpired,
2 unsuspended, and unrevoked permit issued by the dental hygiene
3 board under this section.
4 (b) An individual registered dental hygienist in alternative
5 practice or a pair of registered dental hygienists in alternative
6 practice who practice dental hygiene under a name that would
7 otherwise violate Section 1960 may practice under that name if
8 the licensees hold a valid permit issued by the dental hygiene board
9 under this section. The dental hygiene board shall issue a written
10 permit authorizing the holder to use a name specified in the permit
11 in connection with the holder's practice if the dental hygiene board
12 finds all of the following:
13 (1) The applicant or applicants are duly licensed registered
14 dental hygienists in alternative practice.
15 (2) The place where the applicant or applicants practice is owned
16 or leased by the applicant or applicants, and the practice conducted
17 at the place is wholly owned and entirely controlled by the
18 applicant or applicants and is an approved area or practice setting
19 pursuant to Section 1926.
20 (3) The name under which the applicant or applicants propose
21 to operate contains at least one of the following designations:
22 "dental hygiene group," "dental hygiene practice," or "dental
23 hygiene office," contains the family name of one or more of the
24 past, present, or prospective associates, partners, shareholders, or
25 members of the group, and is in conformity with Section 651 and
26 not in violation of subdivisions (i) and (*l*) of Section 1950.5.
27 (4) All licensed persons practicing at the location designated in
28 the application hold valid licenses and no charges of unprofessional
29 conduct are pending against any person practicing at that location.
30 (c) A permit issued under this section shall expire and become
31 invalid unless renewed in the manner provided for in this article
32 for the renewal of permits issued under this article.
33 (d) A permit issued under this section may be revoked or
34 suspended if the dental hygiene board finds that any requirement
35 for original issuance of a permit is no longer being fulfilled by the
36 permitholder. Proceedings for revocation or suspension shall be
37 governed by the Administrative Procedure Act (Chapter 5
38 (commencing with Section 11500) of Part 1 of Division 3 of Title
39 2 of the Government Code).

1 (e) If charges of unprofessional conduct are filed against the
2 holder of a permit issued under this section, or a member of an
3 association, partnership, group, or corporation to whom a permit
4 has been issued under this section, proceedings shall not be
5 commenced for revocation or suspension of the permit until a final
6 determination of the charges of unprofessional conduct, unless the
7 charges have resulted in revocation or suspension of a license.
8 SEC. 48. Section 1963 of the Business and Professions Code
9 is amended to read:
10 1963. The dental hygiene board may file a complaint for
11 violation of any part of this article with any court of competent
12 jurisdiction and may, by its officers, counsel and agents, assist in
13 presenting the law or facts at the trial. The district attorney of each
14 county in this state shall prosecute all violations of this article in
15 their respective counties in which the violations occur.
16 SEC. 49. Section 1964 of the Business and Professions Code
17 is amended to read:
18 1964. In addition to the other proceedings provided for in this
19 article, on application of the dental hygiene board, the superior
20 court of any county shall issue an injunction to restrain an
21 unlicensed person from conducting the practice of dental hygiene,
22 as defined in this article.
23 SEC. 50. Section 1966 of the Business and Professions Code
24 is amended to read:
25 1966. (a) It is the intent of the Legislature that the dental
26 hygiene board seek ways and means to identify and rehabilitate
27 licensees whose competency may be impaired due to abuse of
28 dangerous drugs or alcohol, so that licensees so afflicted may be
29 treated and returned to the practice of dental hygiene in a manner
30 that will not endanger the public health and safety. It is also the
31 intent of the Legislature that the dental hygiene board establish a
32 diversion program as a voluntary alternative approach to traditional
33 disciplinary actions.
34 (b) One or more diversion evaluation committees shall be
35 established by the dental hygiene board. The dental hygiene board
36 shall establish criteria for the selection of each diversion evaluation
37 committee. Each member of a diversion evaluation committee
38 shall receive per diem and expenses as provided in Section 103.
39 SEC. 51. Section 1966.1 of the Business and Professions Code
40 is amended to read:

1966.1. (a) The dental hygiene board shall establish criteria for the acceptance, denial, or termination of licensees in a diversion program. Unless ordered by the dental hygiene board as a condition of a licensee's disciplinary probation, only those licensees who have voluntarily requested diversion treatment and supervision by a diversion evaluation committee shall participate in a diversion program.

(b) A licensee who is not the subject of a current investigation may self-refer to the diversion program on a confidential basis, except as provided in subdivision (f).

(c) A licensee under current investigation by the dental hygiene board may also request entry into a diversion program by contacting the dental hygiene board. The dental hygiene board may refer the licensee requesting participation in the program to a diversion evaluation committee for evaluation of eligibility. Prior to authorizing a licensee to enter into the diversion program, the dental hygiene board may require the licensee, while under current investigation for any violations of this article or other violations, to execute a statement of understanding that states that the licensee understands that the licensee's violations of this article or other statutes, that would otherwise be the basis for discipline, may still be investigated and be the subject of disciplinary action.

(d) If the reasons for a current investigation of a licensee are based primarily on the self-administration of any controlled substance or dangerous drugs or alcohol under Section 1951, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drugs for self-administration that does not involve actual, direct harm to the public, the dental hygiene board shall close the investigation without further action if the licensee is accepted into the dental hygiene board's diversion program and successfully completes the requirements of the program. If the licensee withdraws or is terminated from the program by a diversion evaluation committee, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the dental hygiene board.

(e) Neither acceptance nor participation in the diversion program shall preclude the dental hygiene board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any licensee for any

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1 unprofessional conduct committed before, during, or after
2 participation in the diversion program.
3 (f) All licensees shall sign an agreement of understanding that
4 the withdrawal or termination from the diversion program at a time
5 when a diversion evaluation committee determines the licensee
6 presents a threat to the public's health and safety shall result in the
7 utilization by the dental hygiene board of diversion treatment
8 records in disciplinary or criminal proceedings.
9 (g) Any licensee terminated from the diversion program for
10 failure to comply with program requirements is subject to
11 disciplinary action by the dental hygiene board for acts committed
12 before, during, and after participation in the diversion program. A
13 licensee who has been under investigation by the dental hygiene
14 board and has been terminated from the diversion program by a
15 diversion evaluation committee shall be reported by the diversion
16 evaluation committee to the dental hygiene board.
17 SEC. 52. Section 1966.2 of the Business and Professions Code
18 is amended to read:
19 1966.2. Each diversion evaluation committee shall have the
20 following duties and responsibilities:
21 (a) To evaluate those licensees who request to participate in the
22 diversion program according to the guidelines prescribed by the
23 dental hygiene board and to consider the recommendations of any
24 licensees designated by the dental hygiene board to serve as
25 consultants on the admission of the licensee to the diversion
26 program.
27 (b) To review and designate those treatment facilities to which
28 licensees in a diversion program may be referred.
29 (c) To receive and review information concerning a licensee
30 participating in the program.
31 (d) To consider in the case of each licensee participating in a
32 program whether the licensee may safely continue or resume the
33 practice of dental hygiene.
34 (e) To perform other related duties as the dental hygiene board
35 may by regulation require.
36 SEC. 53. Section 1966.4 of the Business and Professions Code
37 is amended to read:
38 1966.4. Each licensee who requests participation in a diversion
39 program shall agree to cooperate with the treatment program
40 designed by a diversion evaluation committee and to bear all costs

1 related to the program, unless the cost is waived by the dental
2 hygiene board. Any failure to comply with the provisions of a
3 treatment program may result in termination of the licensee's
4 participation in a program.
5 SEC. 54. Section 1966.5 of the Business and Professions Code
6 is amended to read:
7 1966.5. (a) After a diversion evaluation committee, in its
8 discretion, has determined that a licensee has been rehabilitated
9 and the diversion program is completed, the diversion evaluation
10 committee shall purge and destroy all records pertaining to the
11 licensee's participation in the diversion program.
12 (b) Except as authorized by subdivision (f) of Section 1966.1,
13 all dental hygiene board and diversion evaluation committee
14 records and records of proceedings pertaining to the treatment of
15 a licensee in a program shall be kept confidential and are not
16 subject to discovery or subpoena.
17 SEC. 55. Section 1966.6 of the Business and Professions Code
18 is amended to read:
19 1966.6. The dental hygiene board shall provide for the
20 representation of any person making reports to a diversion
21 evaluation committee or the dental hygiene board under this article
22 in any action for defamation for reports or information given to
23 the diversion evaluation committee or the dental hygiene board
24 regarding a licensee's participation in the diversion program.
25 SEC. 56. Article 8 (commencing with Section 2155) of Chapter
26 5 of Division 2 of the Business and Professions Code is repealed.
27 SEC. 57. Article 11 (commencing with Section 2200) of
28 Chapter 5 of Division 2 of the Business and Professions Code is
29 repealed.
30 SEC. 58. Section 2234 of the Business and Professions Code
31 is amended to read:
32 2234. The board shall take action against any licensee who is
33 charged with unprofessional conduct. In addition to other
34 provisions of this article, unprofessional conduct includes, but is
35 not limited to, the following:
36 (a) Violating or attempting to violate, directly or indirectly,
37 assisting in or abetting the violation of, or conspiring to violate
38 any provision of this chapter.
39 (b) Gross negligence.

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1 (c) Repeated negligent acts. To be repeated, there must be two
2 or more negligent acts or omissions. An initial negligent act or
3 omission followed by a separate and distinct departure from the
4 applicable standard of care shall constitute repeated negligent acts.
5 (1) An initial negligent diagnosis followed by an act or omission
6 medically appropriate for that negligent diagnosis of the patient
7 shall constitute a single negligent act.
8 (2) When the standard of care requires a change in the diagnosis,
9 act, or omission that constitutes the negligent act described in
10 paragraph (1), including, but not limited to, a reevaluation of the
11 diagnosis or a change in treatment, and the licensee's conduct
12 departs from the applicable standard of care, each departure
13 constitutes a separate and distinct breach of the standard of care.
14 (d) Incompetence.
15 (e) The commission of any act involving dishonesty or
16 corruption that is substantially related to the qualifications,
17 functions, or duties of a physician and surgeon.
18 (f) Any action or conduct that would have warranted the denial
19 of a certificate.
20 (g) The repeated failure by a certificate holder, in the absence
21 of good cause, to attend and participate in an interview by the
22 board. This subdivision shall only apply to a certificate holder who
23 is the subject of an investigation by the board.
24 SEC. 59. Section 4980.36 of the Business and Professions
25 Code is amended to read:
26 4980.36. (a) This section shall apply to the following:
27 (1) Applicants for licensure or registration who begin graduate
28 study before August 1, 2012, and do not complete that study on
29 or before December 31, 2018.
30 (2) Applicants for licensure or registration who begin graduate
31 study before August 1, 2012, and who graduate from a degree
32 program that meets the requirements of this section.
33 (3) Applicants for licensure or registration who begin graduate
34 study on or after August 1, 2012.
35 (b) To qualify for a license or registration, applicants shall
36 possess a doctoral or master's degree meeting the requirements of
37 this section in marriage, family, and child counseling, marriage
38 and family therapy, couple and family therapy, psychology, clinical
39 psychology, counseling psychology, or counseling with an
40 emphasis in either marriage, family, and child counseling or

1 marriage and family therapy, obtained from a school, college, or
2 university approved by the Bureau for Private Postsecondary
3 Education, or accredited by either the Commission on Accreditation
4 for Marriage and Family Therapy Education, or a regional or
5 national institutional accrediting agency that is recognized by the
6 United States Department of Education. The board has the authority
7 to make the final determination as to whether a degree meets all
8 requirements, including, but not limited to, course requirements,
9 regardless of accreditation or approval.
10 (c) A doctoral or master's degree program that qualifies for
11 licensure or registration shall be a single, integrated program that
12 does the following:
13 (1) Integrate all of the following throughout its curriculum:
14 (A) Marriage and family therapy principles.
15 (B) The principles of mental health recovery-oriented care and
16 methods of service delivery in recovery-oriented practice
17 environments, among others.
18 (C) An understanding of various cultures and the social and
19 psychological implications of socioeconomic position, and an
20 understanding of how poverty and social stress impact an
21 individual's mental health and recovery.
22 (2) Allow for innovation and individuality in the education of
23 marriage and family therapists.
24 (3) Encourage students to develop the personal qualities that
25 are intimately related to effective practice, including, but not
26 limited to, integrity, sensitivity, flexibility, insight, compassion,
27 and personal presence.
28 (4) Permit an emphasis or specialization that may address any
29 one or more of the unique and complex array of human problems,
30 symptoms, and needs of Californians served by marriage and
31 family therapists.
32 (5) Provide students with the opportunity to meet with various
33 consumers and family members of consumers of mental health
34 services to enhance understanding of their experience of mental
35 illness, treatment, and recovery.
36 (d) The degree described in subdivision (b) shall contain no less
37 than 60 semester or 90 quarter units of instruction that includes,
38 but is not limited to, the following requirements:
39 (1) Both of the following:

(A) No less than 12 semester or 18 quarter units of coursework in theories, principles, and methods of a variety of psychotherapeutic orientations directly related to marriage and family therapy and marital and family systems approaches to treatment and how these theories can be applied therapeutically with individuals, couples, families, adults, including elder adults, children, adolescents, and groups to improve, restore, or maintain healthy relationships.

(B) Practicum that involves direct client contact, as follows:

(i) A minimum of six semester or nine quarter units of practicum in a supervised clinical placement that provides supervised fieldwork experience.

(ii) A minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(iii) A student must be enrolled in a practicum course while counseling clients, except as specified in subdivision (c) of Section 4980.42.

(iv) The practicum shall provide training in all of the following areas:

(I) Applied use of theory and psychotherapeutic techniques.

(II) Assessment, diagnosis, and ~~prognosis.~~ *treatment planning.*

(III) Treatment of individuals and premarital, couple, family, and child relationships, including trauma and abuse, dysfunctions, healthy functioning, health promotion, illness prevention, and working with families.

(IV) Professional writing, including documentation of services, treatment plans, and progress notes.

(V) How to connect people with resources that deliver the quality of services and support needed in the community.

(v) Educational institutions are encouraged to design the practicum required by this subparagraph to include marriage and family therapy experience in low income and multicultural mental health settings.

(vi) In addition to the 150 hours required in clause (ii), 75 hours of either of the following, or a combination thereof:

(I) Client centered advocacy, as defined in Section 4980.03.

(II) Face-to-face experience counseling individuals, couples, families, or groups.

(2) Instruction in all of the following:

(A) Diagnosis, assessment, ~~prognosis,~~ *treatment planning,* and treatment of mental disorders, including severe mental disorders, evidence-based practices, psychological testing, psychopharmacology, and promising mental health practices that are evaluated in peer reviewed literature.

(B) Developmental issues from infancy to old age, including instruction in all of the following areas:

(i) The effects of developmental issues on individuals, couples, and family relationships.

(ii) The psychological, psychotherapeutic, and health implications of developmental issues and their effects.

(iii) Aging and its biological, social, cognitive, and psychological aspects. This coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.

(iv) A variety of cultural understandings of human development.

(v) The understanding of human behavior within the social context of socioeconomic status and other contextual issues affecting social position.

(vi) The understanding of human behavior within the social context of a representative variety of the cultures found within California.

(vii) The understanding of the impact that personal and social insecurity, social stress, low educational levels, inadequate housing, and malnutrition have on human development.

(C) The broad range of matters and life events that may arise within marriage and family relationships and within a variety of California cultures, including instruction in all of the following:

(i) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28, and any regulations promulgated thereunder.

(ii) Spousal or partner abuse assessment, detection, intervention strategies, and same gender abuse dynamics.

(iii) Cultural factors relevant to abuse of partners and family members.

(iv) Childbirth, child rearing, parenting, and stepparenting.

(v) Marriage, divorce, and blended families.

(vi) Long-term care.

(vii) End of life and grief.

(viii) Poverty and deprivation.

1 (ix) Financial and social stress.
2 (x) Effects of trauma.
3 (xi) The psychological, psychotherapeutic, community, and
4 health implications of the matters and life events described in
5 clauses (i) to (x), inclusive.
6 (D) Cultural competency and sensitivity, including a familiarity
7 with the racial, cultural, linguistic, and ethnic backgrounds of
8 persons living in California.
9 (E) Multicultural development and cross-cultural interaction,
10 including experiences of race, ethnicity, class, spirituality, sexual
11 orientation, gender, and disability, and their incorporation into the
12 psychotherapeutic process.
13 (F) The effects of socioeconomic status on treatment and
14 available resources.
15 (G) Resilience, including the personal and community qualities
16 that enable persons to cope with adversity, trauma, tragedy, threats,
17 or other stresses.
18 (H) Human sexuality, including the study of physiological,
19 psychological, and social cultural variables associated with sexual
20 behavior and gender identity, and the assessment and treatment of
21 psychosexual dysfunction.
22 (I) Substance use disorders, co-occurring disorders, and
23 addiction, including, but not limited to, instruction in all of the
24 following:
25 (i) The definition of substance use disorders, co-occurring
26 disorders, and addiction. For purposes of this subparagraph,
27 "co-occurring disorders" means a mental illness and substance
28 abuse diagnosis occurring simultaneously in an individual.
29 (ii) Medical aspects of substance use disorders and co-occurring
30 disorders.
31 (iii) The effects of psychoactive drug use.
32 (iv) Current theories of the etiology of substance abuse and
33 addiction.
34 (v) The role of persons and systems that support or compound
35 substance abuse and addiction.
36 (vi) Major approaches to identification, evaluation, and treatment
37 of substance use disorders, co-occurring disorders, and addiction,
38 including, but not limited to, best practices.
39 (vii) Legal aspects of substance abuse.

1 (viii) Populations at risk with regard to substance use disorders
2 and co-occurring disorders.
3 (ix) Community resources offering screening, assessment,
4 treatment, and followup for the affected person and family.
5 (x) Recognition of substance use disorders, co-occurring
6 disorders, and addiction, and appropriate referral.
7 (xi) The prevention of substance use disorders and addiction.
8 (J) California law and professional ethics for marriage and
9 family therapists, including instruction in all of the following areas
10 of study:
11 (i) Contemporary professional ethics and statutory, regulatory,
12 and decisional laws that delineate the scope of practice of marriage
13 and family therapy.
14 (ii) The therapeutic, clinical, and practical considerations
15 involved in the legal and ethical practice of marriage and family
16 therapy, including, but not limited to, family law.
17 (iii) The current legal patterns and trends in the mental health
18 professions.
19 (iv) The psychotherapist-patient privilege, confidentiality, the
20 patient dangerous to self or others, and the treatment of minors
21 with and without parental consent.
22 (v) A recognition and exploration of the relationship between
23 a practitioner's sense of self and human values and the
24 practitioner's professional behavior and ethics.
25 (vi) The application of legal and ethical standards in different
26 types of work settings.
27 (vii) Licensing law and licensing process.
28 (e) The degree described in subdivision (b) shall, in addition to
29 meeting the requirements of subdivision (d), include instruction
30 in case management, systems of care for the severely mentally ill,
31 public and private services and supports available for the severely
32 mentally ill, community resources for persons with mental illness
33 and for victims of abuse, disaster and trauma response, advocacy
34 for the severely mentally ill, and collaborative treatment. This
35 instruction may be provided either in credit level coursework or
36 through extension programs offered by the degree-granting
37 institution.
38 (f) The changes made to law by this section are intended to
39 improve the educational qualifications for licensure in order to
40 better prepare future licentiates for practice, and are not intended

1 to expand or restrict the scope of practice for marriage and family
2 therapists.
3 *SEC. 60. Section 4980.37 of the Business and Professions Code*
4 *is amended to read:*
5 4980.37. (a) This section shall apply to applicants for licensure
6 or registration who began graduate study before August 1, 2012,
7 and completed that study on or before December 31, 2018. Those
8 applicants may alternatively qualify under paragraph (2) of
9 subdivision (a) of Section 4980.36.
10 (b) To qualify for a license or registration, applicants shall
11 possess a doctor's or master's degree in marriage, family, and child
12 counseling, marriage and family therapy, couple and family
13 therapy, psychology, clinical psychology, counseling psychology,
14 or counseling with an emphasis in either marriage, family, and
15 child counseling or marriage and family therapy, obtained from a
16 school, college, or university accredited by a regional or national
17 institutional accrediting agency that is recognized by the United
18 States Department of Education or approved by the Bureau for
19 Private Postsecondary Education. The board has the authority to
20 make the final determination as to whether a degree meets all
21 requirements, including, but not limited to, course requirements,
22 regardless of accreditation or approval. In order to qualify for
23 licensure pursuant to this section, a doctor's or master's degree
24 program shall be a single, integrated program primarily designed
25 to train marriage and family therapists and shall contain no less
26 than 48 semester units or 72 quarter units of instruction. This
27 instruction shall include no less than 12 semester units or 18 quarter
28 units of coursework in the areas of marriage, family, and child
29 counseling, and marital and family systems approaches to
30 treatment. The coursework shall include all of the following areas:
31 (1) The salient theories of a variety of psychotherapeutic
32 orientations directly related to marriage and family therapy, and
33 marital and family systems approaches to treatment.
34 (2) Theories of marriage and family therapy and how they can
35 be utilized in order to intervene therapeutically with couples,
36 families, adults, children, and groups.
37 (3) Developmental issues and life events from infancy to old
38 age and their effect on individuals, couples, and family
39 relationships. This may include coursework that focuses on specific
40 family life events and the psychological, psychotherapeutic, and

health implications that arise within couples and families, including, but not limited to, childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, stepparenting, abuse and neglect of older and dependent adults, and geropsychology.

(4) A variety of approaches to the treatment of children.

The board shall, by regulation, set forth the subjects of instruction required in this subdivision.

(c) (1) In addition to the 12 semester or 18 quarter units of coursework specified in subdivision (b), the doctor's or master's degree program shall contain not less than six semester units or nine quarter units of supervised practicum in applied psychotherapeutic technique, assessments, diagnosis, ~~prognosis,~~ *treatment planning,* and treatment of premarital, couple, family, and child relationships, including dysfunctions, healthy functioning, health promotion, and illness prevention, in a supervised clinical placement that provides supervised fieldwork experience within the scope of practice of a marriage and family therapist.

(2) For applicants who enrolled in a degree program on or after January 1, 1995, the practicum shall include a minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(3) The practicum hours shall be considered as part of the 48 semester or 72 quarter unit requirement.

(d) As an alternative to meeting the qualifications specified in subdivision (b), the board shall accept as equivalent degrees those master's or doctor's degrees granted by educational institutions whose degree program is approved by the Commission on Accreditation for Marriage and Family Therapy Education.

(e) In order to provide an integrated course of study and appropriate professional training, while allowing for innovation and individuality in the education of marriage and family therapists, a degree program that meets the educational qualifications for licensure or registration under this section shall do all of the following:

(1) Provide an integrated course of study that trains students generally in the diagnosis, assessment, ~~prognosis,~~ *treatment planning,* and treatment of mental disorders.

(2) Prepare students to be familiar with the broad range of matters that may arise within marriage and family relationships.

(3) Train students specifically in the application of marriage and family relationship counseling principles and methods.

(4) Encourage students to develop those personal qualities that are intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.

(5) Teach students a variety of effective psychotherapeutic techniques and modalities that may be utilized to improve, restore, or maintain healthy individual, couple, and family relationships.

(6) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

(7) Prepare students to be familiar with cross-cultural mores and values, including a familiarity with the wide range of racial and ethnic backgrounds common among California's population, including, but not limited to, Blacks, Hispanics, Asians, and Native Americans.

(f) Educational institutions are encouraged to design the practicum required by this section to include marriage and family therapy experience in low income and multicultural mental health settings.

~~SEC. 60.~~

SEC. 61. Section 4980.395 of the Business and Professions Code is repealed.

SEC. 62. Section 4980.50 of the Business and Professions Code is amended to read:

4980.50. (a) Every applicant who meets the educational and experience requirements and applies for a license as a marriage and family therapist shall be examined by the board. The examinations shall be as set forth in subdivision (d) of Section 4980.40. The examinations shall be given at least twice a year at a time and place and under supervision as the board may determine. The board shall examine the candidate with regard to ~~his or her~~ *the candidate's* knowledge and professional skills and judgment in the utilization of appropriate techniques and methods.

(b) The board shall not deny any applicant who has submitted a complete application for examination, admission to the licensure examinations required by this section if the applicant meets the educational and experience requirements of this chapter, and has

not committed any acts or engaged in any conduct that would constitute grounds to deny licensure.

(c) The board shall not deny any applicant, whose application for licensure is complete, admission to the clinical examination, nor shall the board postpone or delay any applicant's clinical ~~examination or delay informing the candidate of the results of the clinical~~ examination, solely upon the receipt by the board of a complaint alleging acts or conduct that would constitute grounds to deny licensure.

(d) If an applicant for examination who has passed the California law and ethics examination is the subject of a complaint or is under board investigation for acts or conduct that, if proven to be true, would constitute grounds for the board to deny licensure, the board shall permit the applicant to take the clinical examination for licensure, but may ~~withhold the results of the examination or~~ notify the applicant that licensure will not be granted pending completion of the investigation.

(e) Notwithstanding Section 135, the board may deny any applicant who has previously failed either the California law and ethics examination or the clinical examination permission to retake either examination pending completion of the investigation of any complaints against the applicant. Nothing in this section shall prohibit the board from denying an applicant admission to any ~~examination, withholding the results,~~ *examination* or refusing to issue a license to any applicant when an accusation or statement of issues has been filed against the applicant pursuant to Sections 11503 and 11504 of the Government Code, respectively, or the applicant has been denied in accordance with subdivision (b) of Section 485.

(f) Notwithstanding any other provision of law, the board may destroy all examination materials two years following the date of an examination.

(g) An applicant for licensure shall not be eligible to participate in the clinical examination if ~~he or she~~ *the applicant* fails to obtain a passing score on the clinical examination within seven years from ~~his or her~~ *their* initial attempt, unless ~~he or she~~ *the applicant* takes and obtains a passing score on the current version of the California law and ethics examination.

(h) A passing score on the clinical examination shall be accepted by the board for a period of seven years from the date the examination was taken.

(i) An applicant for licensure who has qualified pursuant to this chapter shall be issued a license as a marriage and family therapist in the form that the board deems appropriate.

SEC. 63. Section 4980.81 of the Business and Professions Code is amended to read:

4980.81. This section applies to persons subject to Section 4980.78 or 4980.79, who apply for licensure or registration on or after January 2016.

(a) For purposes of Sections 4980.78 and 4980.79, an applicant shall meet all of the following educational requirements:

(1) A minimum of two semester units of instruction in the diagnosis, assessment, ~~prognosis,~~ *treatment planning,* and treatment of mental disorders, including severe mental disorders, evidence-based practices, and promising mental health practices that are evaluated in peer reviewed literature.

(2) At least one semester unit or 15 hours of instruction in psychological testing and at least one semester unit or 15 hours of instruction in psychopharmacology.

(3) (A) Developmental issues from infancy to old age, including demonstration of at least one semester unit, or 15 hours, of instruction that includes all of the following subjects:

(i) The effects of developmental issues on individuals, couples, and family relationships.

(ii) The psychological, psychotherapeutic, and health implications of developmental issues and their effects.

(iii) The understanding of the impact that personal and social insecurity, social stress, low educational levels, inadequate housing, and malnutrition have on human development.

(B) An applicant who is deficient in any of these subjects may remediate the coursework by completing three hours of instruction in each deficient subject.

(4) (A) The broad range of matters and life events that may arise within marriage and family relationships and within a variety of California cultures, including instruction in all of the following:

(i) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28 and any regulations promulgated under that section.

1 (ii) A minimum of 10 contact hours of coursework that includes
2 all of the following:
3 (I) The assessment and reporting of, as well as treatment related
4 to, elder and dependent adult abuse and neglect.
5 (II) Aging and its biological, social, cognitive, and psychological
6 aspects.
7 (III) Long-term care.
8 (IV) End-of-life and grief.
9 (iii) A minimum of 15 contact hours of coursework in spousal
10 or partner abuse assessment, detection, intervention strategies, and
11 same-gender abuse dynamics.
12 (iv) Cultural factors relevant to abuse of partners and family
13 members.
14 (v) Childbirth, child rearing, parenting, and stepparenting.
15 (vi) Marriage, divorce, and blended families.
16 (vii) Poverty and deprivation.
17 (viii) Financial and social stress.
18 (ix) Effects of trauma.
19 (x) The psychological, psychotherapeutic, community, and
20 health implications of the matters and life events described in
21 clauses (i) to (ix), inclusive.
22 (5) At least one semester unit, or 15 hours, of instruction in
23 multicultural development and cross-cultural interaction, including
24 experiences of race, ethnicity, class, spirituality, sexual orientation,
25 gender, and disability, and their incorporation into the
26 psychotherapeutic process.
27 (6) A minimum of 10 contact hours of training or coursework
28 in human sexuality, as specified in Section 25 and any regulations
29 promulgated under that section, including the study of
30 physiological, psychological, and social cultural variables
31 associated with sexual behavior and gender identity, and the
32 assessment and treatment of psychosexual dysfunction.
33 (7) A minimum of 15 contact hours of coursework in substance
34 use disorders, and a minimum of 15 contact hours of coursework
35 in cooccurring disorders and addiction. The following subjects
36 shall be included in this coursework:
37 (A) The definition of substance use disorders, cooccurring
38 disorders, and addiction. For purposes of this subparagraph
39 "cooccurring disorders" means a mental illness and substance
40 abuse diagnosis occurring simultaneously in an individual.

(B) Medical aspects of substance use disorders and cooccurring disorders.

(C) The effects of psychoactive drug use.

(D) Current theories of the etiology of substance abuse and addiction.

(E) The role of persons and systems that support or compound substance abuse and addiction.

(F) Major approaches to identification, evaluation, and treatment of substance use disorders, cooccurring disorders, and addiction, including, but not limited to, best practices.

(G) Legal aspects of substance abuse.

(H) Populations at risk with regard to substance use disorders and cooccurring disorders.

(I) Community resources offering screening, assessment, treatment, and followup for the affected person and family.

(J) Recognition of substance use disorders, cooccurring disorders, and addiction, and appropriate referral.

(K) The prevention of substance use disorders and addiction.

(8) A minimum of a two semester or three quarter unit course in law and professional ethics for marriage and family therapists, including instruction in all of the following subjects:

(A) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the scope of practice of marriage and family therapy.

(B) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including, but not limited to, family law.

(C) The current legal patterns and trends in the mental health professions.

(D) The psychotherapist-patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.

(E) A recognition and exploration of the relationship between a practitioner's sense of self and human values and ~~his or her~~ *their* professional behavior and ethics.

(F) Differences in legal and ethical standards for different types of work settings.

(G) Licensing law and licensing process.

SEC. 64. Section 4989.22 of the Business and Professions Code is amended to read:

4989.22. (a) Only persons who satisfy the requirements of Section 4989.20 are eligible to take the licensure examination.

(b) An applicant who fails the written examination may, within one year from the notification date of failure, retake the examination as regularly scheduled without further application. Thereafter, the applicant shall not be eligible for further examination until ~~he or she~~ *the applicant* files a new application, meets all current requirements, and pays all fees required.

(c) Notwithstanding any other provision of law, the board may destroy all examination materials two years after the date of an examination.

(d) The board shall not deny any applicant, whose application for licensure is complete, admission to the written examination, nor shall the board postpone or delay any applicant's written ~~examination or delay informing the candidate of the results of the written~~ examination, solely upon the receipt by the board of a complaint alleging acts or conduct that would constitute grounds to deny licensure.

(e) Notwithstanding Section 135, the board may deny any applicant who has previously failed the written examination permission to retake the examination pending completion of the investigation of any complaint against the applicant. Nothing in this section shall prohibit the board from denying an applicant admission to any examination, withholding the results, or refusing to issue a license to any applicant when an accusation or statement of issues has been filed against the applicant pursuant to Section 11503 or 11504 of the Government Code, or the applicant has been denied in accordance with subdivision (b) of Section 485.

SEC. 65. Section 4992.1 of the Business and Professions Code is amended to read:

4992.1. (a) Only individuals who have the qualifications prescribed by the board under this chapter are eligible to take an examination under this chapter.

(b) Every applicant who is issued a clinical social worker license shall be examined by the board.

(c) Notwithstanding any other provision of law, the board may destroy all examination materials two years following the date of an examination.

(d) The board shall not deny any applicant, whose application for licensure is complete, admission to the clinical examination,

nor shall the board postpone or delay any applicant's clinical ~~examination or delay informing the candidate of the results of the clinical~~ examination, solely upon the receipt by the board of a complaint alleging acts or conduct that would constitute grounds to deny licensure.

(e) If an applicant for examination who has passed the California law and ethics examination is the subject of a complaint or is under board investigation for acts or conduct that, if proven to be true, would constitute grounds for the board to deny licensure, the board shall permit the applicant to take the clinical examination for licensure, but may ~~withhold the results of the examination or~~ notify the applicant that licensure will not be granted pending completion of the investigation.

(f) Notwithstanding Section 135, the board may deny any applicant who has previously failed either the California law and ethics examination or the clinical examination permission to retake either examination pending completion of the investigation of any complaint against the applicant. Nothing in this section shall prohibit the board from denying an applicant admission to any examination~~, withholding the results,~~ or refusing to issue a license to any applicant when an accusation or statement of issues has been filed against the applicant pursuant to Section 11503 or 11504 of the Government Code, or the applicant has been denied in accordance with subdivision (b) of Section 485.

(g) ~~Effective January 1, 2016, no~~ *An* applicant shall *not* be eligible to participate in the clinical examination if ~~he or she~~ *the applicant* fails to obtain a passing score on the clinical examination within seven years from ~~his or her~~ *their* initial attempt, unless ~~he or she~~ *the applicant* takes and obtains a passing score on the current version of the California law and ethics examination.

(h) A passing score on the clinical examination shall be accepted by the board for a period of seven years from the date the examination was taken.

~~(i) This section shall become operative on January 1, 2016.~~

~~SEC. 61.~~

SEC. 66. Section 4999.32 of the Business and Professions Code is amended to read:

4999.32. (a) This section shall apply to applicants for licensure or registration who began graduate study before August 1, 2012, and completed that study on or before December 31, 2018. Those

1 applicants may alternatively qualify under paragraph (2) of
2 subdivision (a) of Section 4999.33.
3 (b) To qualify for licensure or registration, applicants shall
4 possess a master's or doctoral degree that is counseling or
5 psychotherapy in content and that meets the requirements of this
6 section, obtained from an accredited or approved institution, as
7 defined in Section 4999.12. For purposes of this subdivision, a
8 degree is "counseling or psychotherapy in content" if it contains
9 the supervised practicum or field study experience described in
10 paragraph (3) of subdivision (c) and, except as provided in
11 subdivision (d), the coursework in the core content areas listed in
12 subparagraphs (A) to (I), inclusive, of paragraph (1) of subdivision
13 (c).
14 (c) The degree described in subdivision (b) shall be a single,
15 integrated program that contains not less than 48 graduate semester
16 units or 72 graduate quarter units of instruction, which shall, except
17 as provided in subdivision (d), include all of the following:
18 (1) The equivalent of at least three semester units or four quarter
19 units of graduate study in each of the following core content areas:
20 (A) Counseling and psychotherapeutic theories and techniques,
21 including the counseling process in a multicultural society, an
22 orientation to wellness and prevention, counseling theories to assist
23 in selection of appropriate counseling interventions, models of
24 counseling consistent with current professional research and
25 practice, development of a personal model of counseling, and
26 multidisciplinary responses to crises, emergencies, and disasters.
27 (B) Human growth and development across the lifespan,
28 including normal and abnormal behavior and an understanding of
29 developmental crises, disability, psychopathology, and situational
30 and environmental factors that affect both normal and abnormal
31 behavior.
32 (C) Career development theories and techniques, including
33 career development decisionmaking models and interrelationships
34 among and between work, family, and other life roles and factors,
35 including the role of multicultural issues in career development.
36 (D) Group counseling theories and techniques, including
37 principles of group dynamics, group process components,
38 developmental stage theories, therapeutic factors of group work,
39 group leadership styles and approaches, pertinent research and

1 literature, group counseling methods, and evaluation of
2 effectiveness.
3 (E) Assessment, appraisal, and testing of individuals, including
4 basic concepts of standardized and nonstandardized testing and
5 other assessment techniques, norm-referenced and
6 criterion-referenced assessment, statistical concepts, social and
7 cultural factors related to assessment and evaluation of individuals
8 and groups, and ethical strategies for selecting, administering, and
9 interpreting assessment instruments and techniques in counseling.
10 (F) Multicultural counseling theories and techniques, including
11 counselors' roles in developing cultural self-awareness, identity
12 development, promoting cultural social justice, individual and
13 community strategies for working with and advocating for diverse
14 populations, and counselors' roles in eliminating biases and
15 prejudices, and processes of intentional and unintentional
16 oppression and discrimination.
17 (G) Principles of the diagnostic process, including differential
18 diagnosis, and the use of current diagnostic tools, such as the
19 current edition of the Diagnostic and Statistical Manual of Mental
20 Disorders, the impact of co-occurring substance use disorders or
21 medical psychological disorders, established diagnostic criteria
22 for mental or emotional disorders, and the treatment modalities
23 and placement criteria within the continuum of care.
24 (H) Research and evaluation, including studies that provide an
25 understanding of research methods, statistical analysis, the use of
26 research to inform evidence-based practice, the importance of
27 research in advancing the profession of counseling, and statistical
28 methods used in conducting research, needs assessment, and
29 program evaluation.
30 (I) Professional orientation, ethics, and law in counseling,
31 including professional ethical standards and legal considerations,
32 licensing law and process, regulatory laws that delineate the
33 profession's scope of practice, counselor-client privilege,
34 confidentiality, the client dangerous to self or others, treatment of
35 minors with or without parental consent, relationship between
36 practitioner's sense of self and human values, functions and
37 relationships with other human service providers, strategies for
38 collaboration, and advocacy processes needed to address
39 institutional and social barriers that impede access, equity, and
40 success for clients.

1 (2) In addition to the course requirements described in paragraph
2 (1), a minimum of 12 semester units or 18 quarter units of advanced
3 coursework to develop knowledge of specific treatment issues,
4 special populations, application of counseling constructs,
5 assessment and treatment planning, clinical interventions,
6 therapeutic relationships, psychopathology, or other clinical topics.
7 (3) Not less than six semester units or nine quarter units of
8 supervised practicum or field study experience that involves direct
9 client contact in a clinical setting that provides a range of
10 professional clinical counseling experience, including the
11 following:
12 (A) Applied psychotherapeutic techniques.
13 (B) Assessment.
14 (C) Diagnosis.
15 ~~(D) Prognosis.~~
16 *(D) Treatment planning.*
17 (E) Treatment.
18 (F) Issues of development, adjustment, and maladjustment.
19 (G) Health and wellness promotion.
20 (H) Other recognized counseling interventions.
21 (I) A minimum of 150 hours of face-to-face supervised clinical
22 experience counseling individuals, families, or groups.
23 (d) (1) (A) An applicant whose degree is deficient in no more
24 than two of the required areas of study listed in subparagraphs (A)
25 to (I), inclusive, of paragraph (1) of subdivision (c) may satisfy
26 those deficiencies by successfully completing postmaster's or
27 postdoctoral degree coursework at an accredited or approved
28 institution, as defined in Section 4999.12.
29 (B) Notwithstanding subparagraph (A), an applicant shall not
30 be deficient in the required areas of study specified in subparagraph
31 (E) or (G) of paragraph (1) of subdivision (c) unless the applicant
32 meets one of the following criteria and remediates the deficiency:
33 (i) The application for licensure was received by the board on
34 or before August 31, 2020.
35 (ii) The application for registration was received by the board
36 on or before August 31, 2020, and the registration was subsequently
37 issued by the board.
38 (2) Coursework taken to meet deficiencies in the required areas
39 of study listed in subparagraphs (A) to (I), inclusive, of paragraph

1 (1) of subdivision (c) shall be the equivalent of three semester units
2 or four quarter units of study.
3 (3) The board shall make the final determination as to whether
4 a degree meets all requirements, including, but not limited to,
5 course requirements, regardless of accreditation.
6 (e) In addition to the degree described in this section, or as part
7 of that degree, an applicant shall complete the following
8 coursework or training prior to registration as an associate:
9 (1) A minimum of 15 contact hours of instruction in alcoholism
10 and other chemical substance abuse dependency, as specified by
11 regulation.
12 (2) A minimum of 10 contact hours of training or coursework
13 in human sexuality as specified in Section 25, and any regulations
14 promulgated thereunder.
15 (3) A two semester unit or three quarter unit survey course in
16 psychopharmacology.
17 (4) A minimum of 15 contact hours of instruction in spousal or
18 partner abuse assessment, detection, and intervention strategies,
19 including knowledge of community resources, cultural factors,
20 and same gender abuse dynamics.
21 (5) A minimum of seven contact hours of training or coursework
22 in child abuse assessment and reporting as specified in Section 28
23 and any regulations adopted thereunder.
24 (6) A minimum of 18 contact hours of instruction in California
25 law and professional ethics for professional clinical counselors
26 that includes, but is not limited to, instruction in advertising, scope
27 of practice, scope of competence, treatment of minors,
28 confidentiality, dangerous clients, psychotherapist-client privilege,
29 recordkeeping, client access to records, dual relationships, child
30 abuse, elder and dependent adult abuse, online therapy, insurance
31 reimbursement, civil liability, disciplinary actions and
32 unprofessional conduct, ethics complaints and ethical standards,
33 termination of therapy, standards of care, relevant family law,
34 therapist disclosures to clients, and state and federal laws related
35 to confidentiality of patient health information. When coursework
36 in a master's or doctoral degree program is acquired to satisfy this
37 requirement, it shall be considered as part of the 48 semester unit
38 or 72 quarter unit requirement in subdivision (c).
39 (7) A minimum of 10 contact hours of instruction in aging and
40 long-term care, which may include, but is not limited to, the

1 biological, social, and psychological aspects of aging. On and after
2 January 1, 2012, this coursework shall include instruction on the
3 assessment and reporting of, as well as treatment related to, elder
4 and dependent adult abuse and neglect.
5 (8) A minimum of 15 contact hours of instruction in crisis or
6 trauma counseling, including multidisciplinary responses to crises,
7 emergencies, or disasters, and brief, intermediate, and long-term
8 approaches.
9 ~~SEC. 62.~~
10 *SEC. 67.* Section 4999.33 of the Business and Professions Code
11 is amended to read:
12 4999.33. (a) This section shall apply to the following:
13 (1) Applicants for licensure or registration who begin graduate
14 study before August 1, 2012, and do not complete that study on
15 or before December 31, 2018.
16 (2) Applicants for licensure or registration who begin graduate
17 study before August 1, 2012, and who graduate from a degree
18 program that meets the requirements of this section.
19 (3) Applicants for licensure or registration who begin graduate
20 study on or after August 1, 2012.
21 (b) To qualify for licensure or registration, applicants shall
22 possess a master's or doctoral degree that is counseling or
23 psychotherapy in content and that meets the requirements of this
24 section, obtained from an accredited or approved institution, as
25 defined in Section 4999.12. For purposes of this subdivision, a
26 degree is "counseling or psychotherapy in content" if it contains
27 the supervised practicum or field study experience described in
28 paragraph (3) of subdivision (c) and, except as provided in
29 subdivision (f), the coursework in the core content areas listed in
30 subparagraphs (A) to (M), inclusive, of paragraph (1) of
31 subdivision (c).
32 (c) The degree described in subdivision (b) shall be a single,
33 integrated program that contains not less than 60 graduate semester
34 units or 90 graduate quarter units of instruction, which shall, except
35 as provided in subdivision (f), include all of the following:
36 (1) The equivalent of at least three semester units or four quarter
37 units of graduate study in all of the following core content areas:
38 (A) Counseling and psychotherapeutic theories and techniques,
39 including the counseling process in a multicultural society, an
40 orientation to wellness and prevention, counseling theories to assist

http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB786

in selection of appropriate counseling interventions, models of counseling consistent with current professional research and practice, development of a personal model of counseling, and multidisciplinary responses to crises, emergencies, and disasters.

(B) Human growth and development across the lifespan, including normal and abnormal behavior and an understanding of developmental crises, disability, psychopathology, and situational and environmental factors that affect both normal and abnormal behavior.

(C) Career development theories and techniques, including career development decisionmaking models and interrelationships among and between work, family, and other life roles and factors, including the role of multicultural issues in career development.

(D) Group counseling theories and techniques, including principles of group dynamics, group process components, group developmental stage theories, therapeutic factors of group work, group leadership styles and approaches, pertinent research and literature, group counseling methods, and evaluation of effectiveness.

(E) Assessment, appraisal, and testing of individuals, including basic concepts of standardized and nonstandardized testing and other assessment techniques, norm-referenced and criterion-referenced assessment, statistical concepts, social and cultural factors related to assessment and evaluation of individuals and groups, and ethical strategies for selecting, administering, and interpreting assessment instruments and techniques in counseling.

(F) Multicultural counseling theories and techniques, including counselors' roles in developing cultural self-awareness, identity development, promoting cultural social justice, individual and community strategies for working with and advocating for diverse populations, and counselors' roles in eliminating biases and prejudices, and processes of intentional and unintentional oppression and discrimination.

(G) Principles of the diagnostic process, including differential diagnosis, and the use of current diagnostic tools, such as the current edition of the Diagnostic and Statistical manual of Mental Disorders, the impact of co-occurring substance use disorders or medical psychological disorders, established diagnostic criteria for mental or emotional disorders, and the treatment modalities and placement criteria within the continuum of care.

1 (H) Research and evaluation, including studies that provide an
2 understanding of research methods, statistical analysis, the use of
3 research to inform evidence-based practice, the importance of
4 research in advancing the profession of counseling, and statistical
5 methods used in conducting research, needs assessment, and
6 program evaluation.
7 (I) Professional orientation, ethics, and law in counseling,
8 including California law and professional ethics for professional
9 clinical counselors, professional ethical standards and legal
10 considerations, licensing law and process, regulatory laws that
11 delineate the profession's scope of practice, counselor-client
12 privilege, confidentiality, the client dangerous to self or others,
13 treatment of minors with or without parental consent, relationship
14 between practitioner's sense of self and human values, functions
15 and relationships with other human service providers, strategies
16 for collaboration, and advocacy processes needed to address
17 institutional and social barriers that impede access, equity, and
18 success for clients.
19 (J) Psychopharmacology, including the biological bases of
20 behavior, basic classifications, indications, and contraindications
21 of commonly prescribed psychopharmacological medications so
22 that appropriate referrals can be made for medication evaluations
23 and so that the side effects of those medications can be identified.
24 (K) Addictions counseling, including substance abuse,
25 co-occurring disorders, and addiction, major approaches to
26 identification, evaluation, treatment, and prevention of substance
27 abuse and addiction, legal and medical aspects of substance abuse,
28 populations at risk, the role of support persons, support systems,
29 and community resources.
30 (L) Crisis or trauma counseling, including crisis theory;
31 multidisciplinary responses to crises, emergencies, or disasters;
32 cognitive, affective, behavioral, and neurological effects associated
33 with trauma; brief, intermediate, and long-term approaches; and
34 assessment strategies for clients in crisis and principles of
35 intervention for individuals with mental or emotional disorders
36 during times of crisis, emergency, or disaster.
37 (M) Advanced counseling and psychotherapeutic theories and
38 techniques, including the application of counseling constructs,
39 assessment and treatment planning, clinical interventions,
40 therapeutic relationships, psychopathology, or other clinical topics.

1 (2) In addition to the course requirements described in paragraph
2 (1), 15 semester units or 22.5 quarter units of advanced coursework
3 to develop knowledge of specific treatment issues or special
4 populations.
5 (3) Not less than six semester units or nine quarter units of
6 supervised practicum or field study experience that involves direct
7 client contact in a clinical setting that provides a range of
8 professional clinical counseling experience, including the
9 following:
10 (A) Applied psychotherapeutic techniques.
11 (B) Assessment.
12 (C) Diagnosis.
13 ~~(D) Prognosis.~~
14 *(D) Treatment planning.*
15 (E) Treatment.
16 (F) Issues of development, adjustment, and maladjustment.
17 (G) Health and wellness promotion.
18 (H) Professional writing including documentation of services,
19 treatment plans, and progress notes.
20 (I) How to find and use resources.
21 (J) Other recognized counseling interventions.
22 (K) A minimum of 280 hours of face-to-face supervised clinical
23 experience counseling individuals, families, or groups.
24 (d) The 60 graduate semester units or 90 graduate quarter units
25 of instruction required pursuant to subdivision (c) shall, in addition
26 to meeting the requirements of subdivision (c), include instruction
27 in all of the following:
28 (1) The understanding of human behavior within the social
29 context of socioeconomic status and other contextual issues
30 affecting social position.
31 (2) The understanding of human behavior within the social
32 context of a representative variety of the cultures found within
33 California.
34 (3) Cultural competency and sensitivity, including a familiarity
35 with the racial, cultural, linguistic, and ethnic backgrounds of
36 persons living in California.
37 (4) An understanding of the effects of socioeconomic status on
38 treatment and available resources.
39 (5) Multicultural development and cross-cultural interaction,
40 including experiences of race, ethnicity, class, spirituality, sexual

1 orientation, gender, and disability and their incorporation into the
2 psychotherapeutic process.
3 (6) Case management, systems of care for the severely mentally
4 ill, public and private services for the severely mentally ill,
5 community resources for victims of abuse, disaster and trauma
6 response, advocacy for the severely mentally ill, and collaborative
7 treatment. The instruction required in this paragraph may be
8 provided either in credit level coursework or through extension
9 programs offered by the degree-granting institution.
10 (7) Human sexuality, including the study of the physiological,
11 psychological, and social cultural variables associated with sexual
12 behavior, gender identity, and the assessment and treatment of
13 psychosexual dysfunction.
14 (8) Spousal or partner abuse assessment, detection, intervention
15 strategies, and same gender abuse dynamics.
16 (9) A minimum of seven contact hours of training or coursework
17 in child abuse assessment and reporting, as specified in Section
18 28, and any regulations promulgated thereunder.
19 (10) Aging and long-term care, including biological, social,
20 cognitive, and psychological aspects of aging. This coursework
21 shall include instruction on the assessment and reporting of, as
22 well as treatment related to, elder and dependent adult abuse and
23 neglect.
24 (e) A degree program that qualifies for licensure under this
25 section shall do all of the following:
26 (1) Integrate the principles of mental health recovery-oriented
27 care and methods of service delivery in recovery-oriented practice
28 environments.
29 (2) Integrate an understanding of various cultures and the social
30 and psychological implications of socioeconomic position.
31 (3) Provide the opportunity for students to meet with various
32 consumers and family members of consumers of mental health
33 services to enhance understanding of their experience of mental
34 illness, treatment, and recovery.
35 (f) (1) (A) An applicant whose degree is deficient in no more
36 than three of the required areas of study listed in subparagraphs
37 (A) to (M), inclusive, of paragraph (1) of subdivision (c) may
38 satisfy those deficiencies by successfully completing post-master's
39 or postdoctoral degree coursework at an accredited or approved
40 institution, as defined in Section 4999.12.

(B) Notwithstanding subparagraph (A), an applicant shall not be deficient in the required areas of study specified in subparagraphs (E) or (G) of paragraph (1) of subdivision (c) unless the applicant meets one of the following criteria and remediates the deficiency:

(i) The application for licensure was received by the board on or before August 31, 2020.

(ii) The application for registration was received by the board on or before August 31, 2020, and the registration was subsequently issued by the board.

(2) Coursework taken to meet deficiencies in the required areas of study listed in subparagraphs (A) to (M), inclusive, of paragraph (1) of subdivision (c) shall be the equivalent of three semester units or four quarter units of study.

(3) The board shall make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation.

SEC. 68. Section 4999.52 of the Business and Professions Code is amended to read:

4999.52. (a) Every applicant for a license as a professional clinical counselor shall take one or more examinations, as determined by the board, to ascertain ~~his or her~~ *their* knowledge, professional skills, and judgment in the utilization of appropriate techniques and methods of professional clinical counseling.

(b) The examinations shall be given at least twice a year at a time and place and under supervision as the board may determine.

(c) The board shall not deny any applicant admission to an examination who has submitted a complete application for examination admission if the applicant meets the educational and experience requirements of this chapter and has not committed any acts or engaged in any conduct that would constitute grounds to deny licensure.

(d) The board shall not deny any applicant, whose application for licensure is complete, admission to the clinical examination, nor shall the board postpone or delay any applicant's clinical ~~examination or delay informing the candidate of the results of the clinical~~ examination, solely upon the receipt by the board of a complaint alleging acts or conduct that would constitute grounds to deny licensure.

1 (e) If an applicant for the examination specified by paragraph
2 (2) of subdivision (a) of Section 4999.53, who has passed the
3 California law and ethics examination, is the subject of a complaint
4 or is under board investigation for acts or conduct that, if proven
5 to be true, would constitute grounds for the board to deny licensure,
6 the board shall permit the applicant to take this examination, but
7 may notify the applicant that licensure will not be granted pending
8 completion of the investigation.
9 (f) Notwithstanding Section 135, the board may deny any
10 applicant who has previously failed either the California law and
11 ethics examination, or the examination specified by paragraph (2)
12 of subdivision (a) of Section 4999.53, permission to retake either
13 examination pending completion of the investigation of any
14 complaints against the applicant.
15 (g) Nothing in this section shall prohibit the board from denying
16 an applicant admission to any ~~examination, withholding the results,~~
17 *examination* or refusing to issue a license to any applicant when
18 an accusation or statement of issues has been filed against the
19 applicant pursuant to Section 11503 or 11504 of the Government
20 Code, respectively, or the application has been denied in
21 accordance with subdivision (b) of Section 485.
22 (h) Notwithstanding any other provision of law, the board may
23 destroy all examination materials two years following the date of
24 an examination.
25 (i) If the examination specified by paragraph (2) of subdivision
26 (a) of Section 4999.53 is not passed within seven years of an
27 applicant for licensure's initial attempt, the applicant shall obtain
28 a passing score on the current version of the California law and
29 ethics examination in order to be eligible to retake this examination.
30 (j) A passing score on the clinical examination shall be accepted
31 by the board for a period of seven years from the date the
32 examination was taken.

MBC TRACKER II BILLS
5/2/2019

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 4	Arambula	Medi-Cal: Eligibility	Asm. Approps	03/28/19
AB 5	Gonzalez	Worker Status: Employees and Independent Contractors	Asm. Approps	05/01/19
AB 8	Chu	Pupil Health: Mental Health Professionals	Asm. Approps	03/19/19
AB 62	Fong	State Government: FI$Cal: Transparency	2-Year	03/28/19
AB 63	Fong	State Government	Asm. Approps	04/03/19
AB 64	Fong	State Project Audits	2-Year	04/04/19
AB 71	Melendez	Employment Standards: Independent Contractors	2-Year	02/25/19
AB 171	Gonzalez	Employment: Sexual Harassment	Asm. Approps	03/21/19
AB 174	Wood	Health Care Coverage: Financial Assistance	Asm. Approps	03/27/19
AB 193	Patterson	Professions and Vocations	2-Year	03/20/19
AB 196	Gonzalez	Paid Family Leave	Asm. Approps	03/26/19
AB 204	Wood	Hospitals: Community Benefit Plan Reporting	Asm. Approps	
AB 214	Mullin	The Spinal Cord Injury Research Program	Asm. Approps	
AB 262	Gloria	Local Health Officers: Communicable Diseases	Asm. 3rd Reading	03/27/19
AB 289	Fong	California Public Records Act Ombudsperson	Asm. Approps	04/24/19
AB 312	Cooley	State Government: Administrative Review: Regulations	Asm. Approps	
AB 319	Rubio, Blanca	Narcotic Treatment: Medication Assisted Treatment: Medi-Cal	Asm. Approps	03/25/19
AB 362	Eggman	Controlled Substances: Overdose Prevention Program	Asm. 3rd Reading	04/25/19
AB 365	Garcia, C.	State Civil Service: Examination and Hiring Process	Asm. Approps	03/12/19
AB 372	Voepel	State Employees: Infant at Work Programs	Asm. Approps	04/22/19
AB 379	Maienschein	Youth Athletics: Concussion and Sudden Cardiac Arrest Prevention Protocols	Asm. 3rd Reading	04/01/19
AB 388	Limon	Alzheimer's Disease	Asm. Approps	03/26/19
AB 389	Santiago	Substance Use Disorder Treatment: Peer Navigators	2-Year	
AB 414	Bonta	Healthcare Coverage: Minimum Essential Coverage	Asm. Approps	

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 420	Lackey	The California Cannabis Research Program	Sen. B&P	
AB 451	Santiago	Health Care Facilities: Treatment of Psychiatric Emergency Cond.	Asm. 3rd Reading	
AB 476	Rubio, B.	Department of Consumer Affairs: Task Force: Foreign-Trained Prof.	Asm. Approps	
AB 496	Low	Business and Professions	Asm. 3rd Reading	
AB 499	Mayes	Personal Information: SSNs: State Agencies	Assembly	04/11/19
AB 512	Ting	Medi-Cal: Specialty Mental Health Services	Asm. Approps	04/02/19
AB 521	Berman	Physicians: Firearms: Training	Asm. Approps	03/26/19
AB 537	Wood	Medi-Cal Managed Care: Quality Improvement and Value Based Financial Incentive Prog.	Asm. Approps	
AB 538	Berman	Sexual Assault: Forensic Examinations and Reporting	Sen. Public Safety	
AB 555	Gonzalez	Paid Sick Leave	Asm. Approps	04/29/19
AB 565	Maienschein	Public Health Workforce Planning: Loan Forgiveness & Repayment	Senate	03/28/19
AB 577	Eggman	Medi-Cal: Maternal Mental Health	Asm. Approps	03/26/19
AB 598	Bloom	Hearing Aids: Minors	Asm. Approps	
AB 617	Mullin	Stem Cell & Regenerative Therapy Regulation Advisory Group	Asm. Approps	05/01/19
AB 648	Nazarian	Wellness Programs	Asm. Approps	03/28/19
AB 656	Garcia, E.	Office of Healthy and Safe Communities	Asm. Approps	03/21/19
AB 678	Flora	Medi-Cal: Podiatric Services	Asm. Approps	04/09/19
AB 719	Diep	Medi-Cal: Reimbursement Rates	Asm. Approps	04/12/19
AB 739	McCarty	Flavored Tobacco Products	2-Year	
AB 741	Kalra	Early and Periodic Screening Program: Trauma Screening	Asm. Approps	03/28/19
AB 743	Garcia, E.	Pupil Health: Self-Admin. Of Prescribed Asthma Medication	Asm. 3rd Reading	04/22/19
AB 744	Aguiar-Curry	Health Care Coverage: Telehealth		
AB 767	Wicks	Health Care Coverage: Infertility	Asm. Approps	
AB 770	Garcia, E.	Medi-Cal: FQHCs: Rural Health Clinics	Asm. Approps	04/23/19
AB 798	Cervantes	Maternal Mental Health	Asm. Approps	04/09/19

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 802	Stone, M.	Reports to the Legislature	Asm. Consent	04/10/19
AB 805	Obernolte	Reports Submitted to Legislative Committees	Senate	04/02/19
AB 810	Gipson	Organ and Tissue Transplantation: Uninsured or Undocumented Indiv.	Asm. Approps	
AB 822	Irwin	Phlebotomy	Asm. Approps	04/30/19
AB 848	Gray	Medi-Cal: Covered Benefits: Continuous Glucose Monitors	Asm. Approps	
AB 871	Gray	Graduate Medical Education: Funding	2-Year	
AB 873	Irwin	California Consumer Privacy Act of 2018	Asm. Approps	04/30/19
AB 874	Irwin	California Consumer Privacy Act of 2018	Asm. Consent	03/25/19
AB 875	Wicks	Pupil Health: In-School Support Services	Asm. Approps	04/11/19
AB 876	Flora	Health Care Coverage	2-Year	
AB 882	McCarty	Termination of Employment: Drug Testing: Med. Assist. Trtmt.	2-Year	
AB 887	Kalra	Office of Health Equity: Surgeon General	Asm. Approps	03/28/19
AB 898	Wicks	Early and Periodic Screening Program: Behavioral Health	Asm. Approps	03/28/19
AB 916	Muratsuchi	Suicide Prevention	Senate	
AB 922	Burke	Reproductive Health and Research: Oocyte Procurement	Asm. 3rd Reading	04/11/19
AB 939	Frazier	Administrative Procedure Act: Major Regulations	2-Year	04/22/19
AB 952	Voepel	Criminal History Information: Conviction Records: DSS	2-Year	
AB 973	Irwin	Pharmacies: Compounding	Senate	
AB 977	Stone, M.	Medi-Cal: Early and Periodic Screening, Diagnosis and Treatment	2-Year	03/28/19
AB 990	Gallagher	Medi-Cal Managed Care Plans: Financial Incentives	2-Year	03/28/19
AB 993	Nazarian	Health Care Coverage: HIV Specialists	Asm. Consent	04/11/19
AB 1033	Cooper	State Employment: New Employees: Information	Asm. Approps	
AB 1055	Levine	Publicly Funded Technology Projects	Asm. Rules	04/03/19
AB 1058	Salas	Medi-Cal: Specialty Mental Health Svcs. And Substance Use Disorder	Asm. Approps	04/22/19
AB 1076	Ting	Criminal Records: Automatic Relief	Asm. Approps	03/27/19

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1098	O'Donnell	Substance Use Disorders: Youth Programs	Asm. Approps	04/29/19
AB 1105	Gipson	Sickle Cell Disease	Asm. Approps	04/11/19
AB 1107	Chu	Worker's Compensation	Asm. 3rd Reading	04/22/19
AB 1131	Gloria	Medi-Cal: Comprehensive Medication Management	Asm. Approps	04/11/19
AB 1174	Wood	Health Care: Anesthesia Services	Asm. Approps	03/25/19
AB 1184	Gloria	Public Records: Writing Transmitted by Email: Retention	Asm. Approps	04/24/19
AB 1189	Wicks	Abortion	2-Year	03/28/19
AB 1209	Nazarian	Long-Term Care Benefits	Asm. Approps	04/22/19
AB 1223	Aguiar-Curry	Living Organ Donation	Asm. Consent	04/10/19
AB 1224	Gray	Disability Insurance: Paid Family Leave Program	Asm. Approps	04/22/19
AB 1246	Limon	Healthcare Coverage: Basic Health Care Services	Asm. Approps	
AB 1327	Petrie-Norris	Narcotic Treatment Programs: Safe Storage Devices	Asm. Consent	04/04/19
AB 1365	Comm. on Vet. Affairs	Disabled Veteran Business Enterprise Program	Asm. Approps	03/19/19
AB 1372	Grayson	Employers: Prohibited Disclosure of Arrest Information	Asm. Consent	03/27/19
AB 1494	Aguiar-Curry	Medi-Cal: Telehealth: State of Emergency	Asm. Approps	04/11/19
AB 1524	Chiu	Medi-Cal: Provider Enrollment	Asm. Approps	04/02/19
AB 1529	Low	Telephone Medical Advice Services	Sen. B&P	
AB 1531	Salas	State Agencies: Bilingual Services	Asm. Approps	
AB 1550	Bonta	Crisis Stabilization Units: Psychiatric Patients	Asm. Approps	04/30/19
AB 1592	Bonta	Athletic Trainers	2-Year	03/28/19
AB 1600	Kalra	Discovery: Personnel Records: Peace Officers & Custodial Officers	Asm. 3rd Reading	
AB 1606	Gray	UC: School of Medicine: San Joaquin Valley Reg. Campus Med. Ed. Fund	Asm. Rev. & Tax	
AB 1611	Chiu	Emergency Hospital Services : Costs	Asm. Approps	04/29/19
AB 1622	Carrillo	Family Physicians	Asm. Consent	04/04/19
AB 1630	Irwin	Medical Billing Task Force	2-Year	

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1676	Maienschein	Health Care: Mental Health	Asm. Approps	04/22/19
AB 1759	Salas	Health Care Workers: Rural and Underserved Areas	Asm. Approps	03/28/19
AB 1803	Comm. on Health	Pharmacy: HealthCare Coverage: Claims for Prescriptions	Asm. Consent	
AB 1804	Comm. on Lab. And Emp.	Occupational Injuries and Illnesses: Reporting	Asm. Consent	
AB 1805	Comm. on Lab. And Emp.	Occupational Safety and Health	Asm. Approps	04/29/19
AB 1819	Comm. on Jud.	Inspection of Public Records: Use of Requestors Rep. Equip.	Asm. 3rd Reading	04/11/19
ACR 28	Gipson	Sickle Cell Disease: Education and Treatment	Asm. Health	
ACR 50	Chiu	Workforce Development	Asm. Approps	
HR 6	Limon	Relative to Women's Reproductive Health	Adopted	
SB 24	Leyva	Public Health: Public Univ. Stud. Health Ctrs: Abortion by Med.	Sen. Approps	04/08/19
SB 34	Wiener	Cannabis: Donations	Sen. Approps	04/04/19
SB 53	Wilk	Open Meetings	Assembly	03/05/19
SB 56	Roth	UC, Riverside School of Medicine: Expansion	Sen. Approps	03/27/19
SB 156	Nielsen	Health Facilities: Emergency Medical Services	Sen. Approps	04/30/19
SB 163	Portantino	Healthcare Coverage: Pervasive Dev. Disorder or Autism	Sen. Approps	04/09/19
SB 165	Atkins	Medical Interpretation Services	Sen. Approps	
SB 175	Pan	Health Care Coverage: Minimum Essential Coverage	Sen. Approps	04/03/19
SB 179	Nielsen	Excluded Employees: Arbitration	Sen. Approps	
SB 181	Chang	Healing Arts Boards	Sen. Rules	
SB 207	Hurtado	Medi-Cal: Asthma Preventive Services	Sen. Approps	04/08/19
SB 223	Hill	Pupil Health: Administration of Medicinal Cannabis: Schoolsites	Assembly	03/11/19
SB 260	Hurtado	Automatic Health Care Coverage Enrollment	Sen. Approps	03/26/19
SB 275	Pan	Psychologists: Prohibition Against Sexual Behavior	Sen. 3rd Reading	
SB 276	Pan	Immunizations: Medical Exemptions	Sen. Approps	04/30/19
SB 305	Hueso	Compassionate Access to Medical Cannabis Act or Ryan's Law	Sen. 3rd Reading	04/11/19

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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 382	Nielsen	Health Care Coverage: State of Emergency	Sen. Approps	04/29/19
SB 441	Galgiani	Electronic Health Records: Vendors	2-Year	03/25/19
SB 446	Stone	Medi-Cal: Hypertension Medication Management Services	Sen. Approps	04/11/19
SB 452	Jones	Ken Maddy California Cancer Registry	Sen. Approps	04/11/19
SB 464	Mitchell	California Dignity in Pregnancy and Childbirth Act	Sen. Approps	04/11/19
SB 537	Hill	Worker's Compensation: Treatment and Disability	Sen. Approps	04/11/19
SB 546	Hueso	Unlicensed Activity	Sen. Rules	
SB 583	Jackson	Clinical Trials	Sen. Approps	04/29/19
SB 590	Stone	Mental Health Evals: Gravely Disabled Due to Impairment by Chronic Alcoholism	Sen. Approps	03/27/19
SB 600	Portantino	Health Care Coverage: Fertility Preservation	Sen. Approps	04/30/19
SB 601	Morrell	State Agencies: Licenses: Fee Waiver	Sen. Approps	03/28/19
SB 612	Pan	Health Care: Data Reporting	Sen. Approps	
SB 615	Hueso	Public Records: Disclosure	2-Year	
SB 627	Galgiani	Medicinal Cannabis & Products: Veterinary Medicine	Sen. Approps	04/30/19
SB 639	Mitchell	Medical Services: Credit or Loan	Sen. Approps	04/11/19
SB 650	Rubio	Cancer Medication Advisory Task Force	Sen. Approps	04/30/19
SB 700	Roth	Business and Professions: Non-Comp. with Support Orders & Tax Delinq.	Sen. Rules	
SB 706	Galgiani	Public Health: Pulmonary Hypertension Task Force	Sen. Approps	04/29/19
SB 746	Bates	Health Care Coverage: Anti-Cancer Medical Devices	Sen. Approps	
SB 749	Durazo	California Public Records Act: Trade Secrets	Sen. Approps	04/29/19
SJR 4	Leyva	Title X	Asm. Health	
SR 7	Leyva	Relative to Women's Reproductive Health	Adopted	01/07/19