

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 562	Low	Frontline COVID-19 Provider Mental Health Resiliency Act of 2021: Health Care Providers: Mental Health Services	Senate Appropriations	Support, if Amended	04/08/21
AB 657	Cooper	Healing Arts: Expedited Licensure Process: Applicants Providing Abortions	Senate Floor		08/11/22
AB 852	Wood	Health Care Practitioners: Electronic Prescriptions	Senate Floor	Support	6/23/22
AB 1102	Low	Telephone Medical Advice Services	Senate Floor	Support	N/A
AB 1278	Nazarian	Physicians and Surgeons: Payments: Disclosure: Notice	Senate Floor	Support	08/11/22
AB 1636	Weber	Physician's and Surgeon's Certificate: Registered Sex Offenders	Senate Floor	Support, if Amended	04/20/22
AB 1662	Gipson	Licensing Boards: Disqualification From Licensure: Criminal Conviction	Senate Appropriations	Support, if Amended	04/27/22

AB 1733	Quirk	State Bodies: Open Meetings	Assembly Governmental Organization Cmte.	Support	N/A
AB 2060	Quirk	Medical Board of California	Assembly Floor	Sponsor	04/20/22
AB 2098	Low	Physicians and Surgeons: Unprofessional Conduct	Senate Floor	Support, if Amended	06/21/22
AB 2178	Bloom	Physicians and Surgeons: Special Faculty Permits: Academic Medical Center	Senate Floor	Support	06/14/22
AB 2236	Low	Optometry: Certification: Use of Anterior Segment Lasers and Performing Minor Procedures	Senate Floor		08/11/22
AB 2626	Calderon	Medical Board of California: Licensee Discipline: Abortion	Senate Floor	Support	08/01/22
SB 57	Wiener	Controlled Substances: Overdose Prevention Program	Governor's Desk	Neutral	01/18/22
SB 528	Jones	Juveniles: Health Information Summary: Psychotropic Medication	Assembly Floor	Support	06/16/22

SB 923	Wiener	Gender-Affirming Care	Senate Floor		06/23/22
SB 1259	Laird	Pharmacists: Furnishing Opioid Antagonists	Enrollment		06/13/22
SB 1440	Roth	Licensed Midwifery Practice Act of 1993: Complaints	Senate Floor	Support	N/A
SB 1441	Roth	Healing Arts: Nonconventional Treatment	Assembly Floor		N/A

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 562
AUTHOR: Low
BILL DATE: April 8, 2021, Amended
SUBJECT: Frontline COVID-19 Provider Mental Health Resiliency Act of 2021: Health Care Providers: Mental Health Services.
SPONSOR: United Nurses Associations of California/Union of Health Care Professionals
California Society of Anesthesiologists
California Medical Association
POSITION: Support, if Amended

DESCRIPTION OF CURRENT LEGISLATION

Requires the Department of Consumer Affairs (DCA) to establish a mental health resiliency program, until Jan 1, 2025, in consultation with certain health arts boards, and contract with vendors of mental health services to provide mental health services to eligible licensees who provide, or have provided, consistent in-person health care services to patients with COVID-19, as specified.

During the Medical Board of California's (Board) May 13-14, 2021, meeting, the Board adopted a Support, if Amended position, requesting the following changes:

- All applications be received and approved by the DCA-selected mental health services vendor(s).
- All program expenses be funded by non-Board funds.

This bill has not been amended since the prior Board meeting and is not expected to move forward this year.

BACKGROUND

Existing law establishes the Board and charges it with certain licensing and enforcement responsibilities. Existing law states that the protection of the public is the Board's paramount priority. In addition, current law authorizes the Board to establish a Physician Health and Wellness Program to provide for the prevention of substance abuse issues.

ANALYSIS

According to the author:

“If the true measure of a society is how it treats its most vulnerable people, we should be equally concerned with how well we support heroes who have been working nonstop during a generational crisis. The pandemic has placed our

nurses, physicians, and frontline health care workers under enormous stress, and they have been carrying this unbelievable burden for nearly a year. The trauma they have experienced will not just go away when vaccines become ubiquitous and the pandemic comes to an end. We need urgent action to support these heroes by expanding access to mental and behavioral health services.”

Responsibilities of DCA

The bill requires the DCA Director to, within three months of the effective date of the bill, in consultation with the relevant healing arts boards, establish a mental health resiliency program to provide mental health services to frontline COVID 19 providers. This bill has an urgency clause and would take effect immediately upon approval of the Governor.

DCA shall contract with one or more vendors of mental health services for the duration of the program, supervise all vendors and monitor vendor utilization rates, and authorize termination of any contract. If the vendor’s contract is terminated, the Director must contract with a replacement vendor as soon as practicable.

Responsibilities of the Boards

The bill requires the Medical Board of California, Osteopathic Medical Board of California, Board of Registered Nursing, Physician Assistant Board, and the Respiratory Care Board of California to do the following:

- Notify licensees and solicit applications for access to the mental health resiliency program immediately upon the availability of any services contracted for.
- Receive applications from eligible licensees that include an attestation that the applicant is eligible and includes the following:
 - The location and type of the facility or facilities the applicant worked as a frontline COVID-19 provider.
 - The applicant’s assigned unit or units at the facility or facilities.
 - A voluntary survey of race or ethnicity and gender identity.

A board shall deem the applicant eligible licensee if the attestation is complete, and any facility and unit listed would provide care to COVID-19 patients. It is unclear how a board would determine whether a certain facility provided care to such patients.

Applicants who willfully make a false statement in their attestation are guilty of a misdemeanor.

The bill provides that application to or participation in the mental health resiliency program shall not be used for purposes of disciplinary action and shall be kept confidential, except that deidentified and aggregated statistics on program usage shall be reported to the Legislature.

Implementation Considerations

While the aim of the program is laudable, the program is likely to lead to significant new costs to the various boards to cover expenses to create and review/approve applications. More significantly, there may be substantial increases in pro-rata payments from the boards to DCA to cover expenses related to the services provided to eligible licensees. Those costs are undetermined.

According to the author's staff, they expect that usage of the program will be modest and are open to considering options that would decrease the costs of the program. In addition, the author is pursuing funding through the state budget to cover the program's costs.

The bill states that application or participation in the program shall not be used for purposes of discipline, which may place a board in a difficult position, since the bill requires applicants to apply through the boards for mental health treatment. Further, interested applicants may be hesitant to submit an application to their licensing boards indicating they require mental health treatment.

<u>FISCAL:</u>	Unknown, potentially major costs to the Board.
<u>SUPPORT:</u>	American College of Emergency Physicians, California Chapter California Academy of Family Physicians California Association of Health Facilities California Pharmacists Association California State Association of Psychiatrists Depression and Bipolar Support Alliance National Association of Social Workers, California Chapter
<u>OPPOSITION:</u>	None
<u>ATTACHMENT:</u>	AB 562, Low - Frontline COVID-19 Provider Mental Health Resiliency Act of 2021: health care providers: mental health services. Version: 04/08/21 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 657
AUTHOR: Cooper
BILL DATE: August 11, 2022, Amended
SUBJECT: Healing Arts: Expedited Licensure Process:
Applicants Providing Abortions
SPONSOR: American College of Obstetricians and Gynecologists
(ACOG) District IX

DESCRIPTION OF CURRENT LEGISLATION

This bill requires the Medical Board of California (Board), the Osteopathic Medical Board of California (OMBC), the Board of Registered Nursing (BRN), and the Physician Assistant Board (PAB) to expedite the licensure process for an applicant who demonstrates that they intend to provide abortions.

BACKGROUND

Various statutes¹ within the Business and Professions Code (BPC) require licensing boards to expedite the review of an application for certain applicants, including those who were honorably discharged as an active duty member of the Armed Forces of the United States, are the spouse/domestic partner of an active duty member of the military assigned to duty station in California, or have a certain refugee or immigration status.

[BPC section 2092](#) is within the Medical Practice Act and requires the Board to expedite the review of a physician and surgeon license applicant who intends to practice in a medically underserved area or serve a medically underserved population. To substantiate that the applicant qualifies for this expedited review, the Board requires a letter from the applicant's employer indicating the place and/or population to be served by the applicant and a separate letter from the applicant indicating the same.

These statutes do not change the requirements for receiving a P&S license, rather they simply grant the individual an expedited review of their application.

ANALYSIS

AB 657 includes various legislative findings and declarations indicating, among others, that California is expected to see an increased volume of women seeking an abortion in this state following recent U.S. Supreme Court action.

¹ See BPC sections [115.4](#) and [115.5](#).

This bill is modeled after the Board's practice in BPC section 2092, as discussed above, and requires both a letter from the applicant declaring their intention to provide abortions and a letter from an employer or health care entity indicating the applicant has accepted employment or entered into a contract to provide abortions, as specified.

AB 657 will not impact overall staff workload or application volume and the language makes clear that it shall not be interpreted as changing existing licensure requirements.

If enacted, a qualified application would be reviewed on a priority basis, ahead of other applicants who do not qualify for expedited review. Applicants who qualify under AB 657 could expect to see their completed application approved a few to several weeks earlier than others.

Typically, when an applicant faces a "delay" in the approval of their application, it is because the application was incomplete, or deficient, in some manner. Until all documents required under the law are provided to the Board, a license cannot be issued.

FISCAL: No impact to the Board.

SUPPORT: ACOG District IX (sponsor)
California Medical Association
California Nurse Midwives Association
NARAL Pro-Choice Association
Planned Parenthood Affiliates of California

OPPOSITION: None

POSITION: Recommendation: Support

ATTACHMENT: [AB 657, Cooper – Healing Arts: Expedited Licensure Process: Applicants Providing Abortions](#)
Version: 8/11/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 852
AUTHOR: Wood
BILL DATE: August 22, 2022, Amended
SUBJECT: Health Care Practitioners: Electronic Prescriptions.
SPONSOR: None
POSITION: Support

DESCRIPTION OF CURRENT LEGISLATION

A “clean-up” bill to AB 2789 of 2018 that required health care providers to issue their prescriptions electronically.

RECENT AMENDMENTS

On June 23, AB 852 was amended to remove the language related to nurse practitioners and now only includes the electronic prescribing language supported by the Board during their May 19-20 meeting.

On August 22, the bill was amended to remove the urgency clause, therefore, if signed into law by the Governor, the law change would take effect on January 1, 2023.

BACKGROUND

AB 2789 (Wood) Chapter 438, Statutes of 2018 requires, generally, effective January 1, 2022, health care practitioners authorized to issue prescriptions to submit them to a pharmacy via electronic data transmission prescriptions and requires pharmacies to have the capability to receive those transmissions. That bill created certain exemptions to the requirement to issue a prescription electronically, including temporary technological or electrical failures or that the prescription is to be dispensed outside California.

ANALYSIS

AB 852 makes the following changes to current law:

- Prohibits a pharmacy, pharmacist, or other practitioner authorized to dispense or furnish a prescription from refusing to dispense or furnish an electronic prescription solely because the prescription was not submitted via, or is not compatible with, their proprietary software.
- Permits a pharmacy, pharmacist, or other authorized practitioner to decline to dispense or furnish an electronic prescription submitted via software that fails to meet any one of specified criteria, including compliance with the federal Health Insurance Portability and Accountability Act of 1996.

- Allows a pharmacy to transfer an undispensed prescription to another pharmacy unless it violates state or federal law or the action is not support by the National Council for Prescription Drug Programs SCRIPT standard.
- Adds the following additional exemptions to the requirement to issue a prescription electronically:
 - The prescription is issued by a prescribing health care practitioner serving as a volunteer in a free clinic and receives no remuneration for their services.
 - The prescriber registers annually with the California State Board of Pharmacy stating they meet one or more of the following criteria (and maintain documentation of the relevant circumstances):
 - Their practice is located in the area of an emergency or disaster declared by a federal, state, or local government.
 - They issue 100 or fewer prescriptions per calendar year.
 - They are unable to issue electronic data transmission prescriptions due to circumstances beyond their control.

Board staff have received complaints from licensees about the current electronic prescribing requirements, particularly from those who report they only write a small number of prescriptions and that it is cost prohibitive to adopt an electronic prescribing system for their practice. This bill would mitigate these concerns without substantially eroding the benefits of the broad requirement for prescriptions to be issued electronically. If warranted, the Board would be able to request documentation from its licensees to validate they qualify for the new exemptions created by the bill.

FISCAL: None anticipated for the Board.

SUPPORT: California Medical Association
 California Podiatric Medical Association
 California Dental Association
 University of California

OPPOSITION: The California Retailers Association
 The National Association of Chain Drug Stores

ATTACHMENT: [AB 852, Wood - Health Care Practitioners: Electronic Prescriptions.](#)
 Version: 08/22/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 1102
AUTHOR: Low
BILL DATE: August 16, 2022, Amended
SUBJECT: Telephone Medical Advice Services
SPONSOR: Low
POSITION: Support

DESCRIPTION OF CURRENT LEGISLATION

This bill would clarify existing law that requires health care professionals providing telephone medical advice services from an out-of-state location to do so consistent with the laws governing their respective licenses. The bill also specifies that a telephone medical advice service is required to comply with all directions and requests for information made by the Department of Consumer Affairs and the respective healing arts licensing board.

RECENT AMENDMENTS

On August 16, AB 1102 was amended to require the reporting of certain information from a telephone medical advice service on an as-requested basis. Further, the amendment clarifies that directions and requests for information may come from either the Department of Consumer Affairs (DCA) or the appropriate healing arts licensing board.

BACKGROUND

Prior law required businesses that employed, or contract or subcontract with, the full-time equivalent of five or more persons functioning as health care professionals, and whose primary function was to provide telephone medical advice to a patient at a California address to be registered with the Telephone Medical Advice Services Bureau.

The Telephone Medical Advice Services Bureau (Bureau) was abolished as of January 1, 2017. According to the DCA 2017 Annual Report, when the Bureau was abolished, it oversaw 68 registrants.

ANALYSIS

According to the author:

"This bill would clarify that the telephone medical advice companies must comply with directions and requests for information from not just the DCA, but also any licensing board that has jurisdiction over the type of advice being provided. Further, by virtue of hiring the professionals, the companies themselves may be

providing services under state law. As a result, the oversight over these companies should be clarified to also include the licensing boards."

When the Bureau was abolished, enforcement was transferred to individual board through their existing authority over the practice of the relevant licensed practitioners. However, the language still requires the companies to comply with DCA direction and requests for information.

DCA has limited authority over licensing boards and their licensees. This bill merely clarifies that the enforcement of the regulation of telephone medical advice services is within the jurisdiction of the boards by requiring them to comply with directions and requests from the boards, not just DCA.

It would also clarify that a person who resides out of state and provides telephone medical advice in California must comply with the specific licensing requirements (e.g. not delinquent), not just the scope of practice requirements of their own state's license.

FISCAL: Minor and absorbable

SUPPORT: California Association of Orthodontists

OPPOSITION: None

ATTACHMENT: [AB 1102, Low - Telephone Medical Advice Bureaus.](#)
Version: 8/16/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 1278
AUTHOR: Nazarian
BILL DATE: August 11, 2021, Amended
SUBJECT: Physicians and Surgeons: Payments: Disclosure:
Notice
SPONSOR: The Center for Public Interest Law (CPIL)
POSITION: Support

DESCRIPTION OF CURRENT LEGISLATION

Requires all physicians to provide a written notification informing patients of the federal Centers for Medicare and Medicaid Services (CMS) Open Payments online database and to post a similar notice in an area likely to be seen by patients in each office where they practice.

A violation of the requirements of the bill would constitute unprofessional conduct.

RECENT AMENDMENTS

On August 11, 2022, AB 1278 was amended to change the required notice to be provided every two years, rather than annually. Further, the amendments allow physicians who maintain paper records to use a notice with multiple signature lines so that the same document may be used for multiple years.

BACKGROUND

Current law requires a physician to maintain adequate and accurate records relating to the provision of services to their patients and states that failure to do so constitutes unprofessional conduct.

The Physician Payments Sunshine Act is a federal law that requires medical product manufacturers to disclose to CMS any payments or other transfers of value made to physicians or teaching hospitals. The intention of this law is to increase transparency regarding financial relationships between health care providers and pharmaceutical manufacturers.

According to a [report published by Pro Publica in 2019](#), based upon an analysis of the 50 most prescribed brand-name drugs in Medicare for which manufacturers made payments to physicians in 2016, “[on] average, across all drugs, providers who received payments specifically tied to a drug prescribed it 58% more than providers who did not receive payments.”

ANALYSIS

According to the Author:

"There is currently no state law requiring physicians/surgeons to communicate their financial relationships to patients. This bill empowers patients with relevant information from the Open Payments Database (that already exist) to ask questions about their care or treatment."

The bill contains two requirements. First, all physicians shall provide to patients at the initial office visit, and every two years thereafter, a written notice regarding the Open Payment database. The written disclosure shall include a signature from the patient or patient representative and the date of signature and the following text:

"The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at <https://openpaymentsdata.cms.gov>."

The bill requires physicians to include in the written or electronic records for the patient a record of this disclosure and requires the physician to provide the patient or patient representative a copy of the signed and dated disclosure. Physicians who maintain paper records may use a notice with multiple signature lines so that the same document may be used for multiple years.

Second, the bill requires a physician to post in each location where they practice, in an area likely to be seen, a notice regarding the open payments database. That notice shall include an internet website link to that database and the following text:

"For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here. The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars (\$10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public."

The bill states that for physicians employed by a health care employer, their employer shall be responsible for meeting the requirements of this bill. AB 1278 exempts a physician working in a hospital emergency room from its requirements.

Concerns from Physician and Drug/Device Manufacturers

Opponents of AB 1278 generally argue that federal law is sufficient to support transparency and, therefore, the bill is duplicative. Other groups argue that the bill is burdensome to physicians and interferes with the patient-doctor relationship. The most recent amendments may have mitigated some of these concerns.

FISCAL: Minor and absorbable

SUPPORT: Association for Medical Ethics
Breast Implant Safety Alliance
California Public Interest Research Group
Consumer Attorneys of California
Consumer Federation of California
Consumer Watchdog
Health Access California
Heartland Health Research Institute
Informed Patient Institute
Mending Kids

OPPOSITION: Advanced Medical Technology Association
Association of Northern California Oncologists
Biocom California
Biotechnical Innovation Organization
California Academy of Family Physicians
California Medical Association
California Life Sciences
California Chapter, American College of Cardiology
California Rheumatology Alliance
California Society of Plastic Surgeons
Liver Coalition of San Diego
Medical Oncology Association of Southern California
Osteopathic Physicians and Surgeons of California

ATTACHMENT: [AB 1278, Nazarian - Physicians and Surgeons: Payment: Disclosure: Notice.](#)
Version: 8/11/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 1636
AUTHOR: Weber
BILL DATE: April 20, 2022, Amended
SUBJECT: Physician's and Surgeon's Certificate: Registered Sex Offenders
SPONSOR: California Medical Association
POSITION: Support, if Amended

DESCRIPTION OF CURRENT LEGISLATION

Authorizes the Medical Board of California (Board) to deny a physician and surgeon (P&S) license application due to certain prior acts of professional sexual misconduct. Requires the Board to automatically revoke P&S licensees who were convicted of certain sexual crimes or committed professional sexual misconduct and deny petitions for reinstatement to individuals convicted of, or formally disciplined for, certain sexual offenses involving their current or former patients or clients, as specified.

This bill has not been amended since the prior Board meeting.

BACKGROUND

Business and Professions Code (BPC) section [480](#) specifies the conditions that, generally, a licensing board must follow when considering whether to deny an application for licensure pursuant to the applicant's criminal history. Generally, a board is limited to considering convictions within seven years preceding the date of application. That seven-year limitation does not apply to certain **(but not all)** felony convictions¹ that require registration as a sex offender or specified "serious" felonies².

As of July 1, 2020, this section prohibits a licensing board from requiring an applicant to provide their criminal history and requires a licensing board to rely exclusively upon the conviction history of the applicant as indicated by the California Department of Justice (DOJ) pursuant to an analysis of the applicant's fingerprints (either through a Live Scan, or a physical fingerprint card for out-of-state applicants). These reports are intended to include out-of-state convictions reported by other states.

Further, BPC section 480 does not allow a board to deny a license based on a conviction, including the underlying conduct, that has been dismissed or expunged. This

¹ BPC 480 specifies sexual offenses that require registration pursuant to paragraphs (2) and (3) of [Penal Code \(PC\) section 290 \(d\)](#).

² For the list of felonies, see [PC 1192.7](#).

section also prohibits a board from denying a license to anyone, on the basis of a conviction of a crime, or on the basis of acts underlying a conviction, if that person obtains a certificate of rehabilitation, or has been granted clemency or a pardon, or met the rehabilitation criteria of BPC section [482](#). The law does not exclude individuals convicted of sex offenses from these provisions.

Pursuant to BPC section 482, the Board adopted [regulations](#) that govern how the Board considers whether an individual with a criminal conviction history has been rehabilitated.

BPC section [2221](#) requires the Board to deny a P&S application to anyone currently required to register as a sex offender in California.

Further, BPC section [2232](#) generally requires the Board to automatically revoke a licensee who is required to register as a sex offender in California. In addition, BPC section [2307](#) sets forth requirements related to the Board's consideration of petitions for reinstatement and penalty relief filed by disciplined individuals.

ANALYSIS

According to the author's fact sheet:

“AB 1636 seeks to maintain confidence in the medical profession by ensuring physicians convicted of sexual misconduct with a patient would automatically have their license revoked and cannot acquire or have it reinstated.”

As discussed below, this bill would place new requirements upon the Board regarding the denial of applications for licensure, automatic revocations, and petitions for reinstatement.

Denials of Licensure Applications

The bill expands the options to deny an applicant for a P&S license if they were formally disciplined more than seven years ago by an agency outside California, that if it occurred in this state, would constitute a violation of BPC sections [726](#) or [729 \(a\)](#).

Automatic Revocations

AB 1636 requires the Board to automatically revoke a P&S license if the individual was convicted of a crime in any state, that if committed or attempted in this state would be subject to registration as a sex offender, pursuant to [Penal Code \(PC\) 290 \(c\)](#) in California.

Petitions for Reinstatement

AB 1636 prohibits the Board from reinstating a licensee revoked under any of the following circumstances:

- The license was surrendered or revoked based on a finding by the Board that the person committed an act of sexual misconduct in violation of BPC section 726 or 729 (a).
- The licensee was convicted of a crime in any state, that if committed or attempted in this state would be subject to registration as a sex offender, pursuant to PC 290 (c) in California. This would only be applicable if the applicant engaged in this conduct with certain current or former patients or clients.
- The person has been required to register as a sex offender, except for certain misdemeanor convictions, if the crime involved certain current or former patients or clients.

Also, the bill deletes a pathway in BPC section 2232 that allows a revoked individual who was convicted of a sexual offense to petition the superior court to have their license reinstated.

Implementation Considerations

Restrictions on Reinstatement

The bill language disqualifying a person from being reinstated if they surrendered their license “based upon a finding by the board...” may not have the intended effect. When a P&S surrenders their license, there is not a finding by the Board, as the surrender is accepted by the Executive Director, prior to any decision of a Board disciplinary panel.

Further, for the sake of clarity, it would be helpful to specify in the bill language that the restrictions on reinstatement will impact surrenders and revocations that are effective on or after the effective date of the amendment to statute. This would be consistent with prior court decisions that prevent the Board from applying new requirements retroactively.

Current Board Position

During the May 19-20 meeting, the Board adopted a Support, if Amended position with the following requested amendments to AB 1636:

- Clarify that a license surrender with a pending accusation that includes charges for violating BPC 726 or BPC 729 (a) disqualifies that individual from having their license reinstated.
- Clarify that the restrictions on reinstatement petitions apply to surrenders and revocations that are effective on or after the effective date of the amendment to statute.
- Require the Board to deny an application for licensure or a petition for reinstatement to someone who has committed an offense described in BPC section 2232 (section 2 of the bill, as currently drafted).

FISCAL: Minor and absorbable, one-time information technology costs; possible savings to the Board associated with processing fewer petitions for reinstatement.

SUPPORT: California Medical Association (sponsor)
American Academy of Pediatrics, California
American College of Obstetricians and Gynecologists District IX
California Academy of Family Physicians
California Rheumatology Alliance
California Society of Anesthesiologists
California State Association of Psychiatrists
Consumer Protection Policy Center/University of San Diego School of Law
Los Angeles County District Attorney's Office

OPPOSITION: Alliance for Constitutional Sex Offense Laws

ATTACHMENT: [AB 1636, Weber – Physician’s and Surgeon’s Certificate: Registered Sex Offenders.](#)
Version: 4/20/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 1662
AUTHOR: Gipson
BILL DATE: April 27, 2022, Amended
SUBJECT: Licensing Board: Disqualification from Licensure:
Criminal Conviction
SPONSOR: Council on State Governments – Justice Center
POSITION: Support, if Amended

DESCRIPTION OF CURRENT LEGISLATION

Requires a licensing board within the Department of Consumer Affairs to provide a “preapplication determination” to a prospective applicant that indicates whether their criminal conviction history may disqualify them from licensure.

This bill has not been amended since the prior Board meeting and is not expected to move forward this year.

BACKGROUND

Business and Professions Code (BPC) section [480](#) specifies the conditions that, generally, a licensing board must follow when considering whether to deny an application for licensure pursuant to the applicant’s criminal history. Generally, a board is limited to considering convictions within seven years preceding their date of application. That seven-year limitation does not apply to certain felony crimes¹ that require registration as a sex offender or specified “serious” felonies².

As of July 1, 2020, this section prohibits a licensing board from requiring an applicant to provide their criminal history and requires a licensing board to rely exclusively upon the conviction history of the applicant as indicated by the California Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) pursuant to an analysis of the applicant’s fingerprints (either through a Live Scan, or a physical fingerprint card for out-of-state applicants).

Further, BPC section [2221](#) specifies additional conditions whereby the Medical Board of California (Board) may deny an application, or grant a probationary license, for a physician and surgeon (P&S) or postgraduate training license.

¹ BPC 480 specifies sexual offenses that require registration pursuant to paragraphs (2) and (3) of [Penal Code \(PC\) section 290 \(d\)](#).

² For the list of felonies, see [PC 1192.7](#).

When Medical Board of California (Board) staff receive an application from an individual with a criminal conviction history, staff analyze what bearing that conviction has on the qualifications, functions, and duties related to the license they are seeking. Adopted pursuant to BPC section [482](#), the Board's regulations³ require the Board to consider certain criteria when evaluating whether an applicant with a criminal conviction history has been rehabilitated. To complete this consideration, the Board is generally required to evaluate the applicant's conduct following their conviction, which may include their conduct while completing their required education and training (if completed following the conviction(s) in question).

For example, with P&S licensure applicants, the Board requires the medical school and postgraduate training programs to provide information about the applicant's performance and to disclose any issues that occurred during medical school or training. This information may be relevant to their criminal history and may be considered when evaluating an application.

In Fiscal Year (FY) 2020-21, the Board received approximately the following number of applications from individuals with a criminal conviction history:

- 53 P&S applicants
- 29 postgraduate training license applicants
- 2 polysomnography applicants

The Board did not deny any applicants for licensure due to their criminal conviction history in FY 2020-21 or FY 2019-20. The Board denied two applications related to the applicant's criminal conviction history in FY 2018-19 and five in FY 2017-18.

During their February 10-11 meeting, the Board adopted a Support, if Amended position, requesting the following amendments:

- Clarify that any preapplication determination provided is only based upon the information provided by the requesting individual and is not binding upon the issuing licensing board.
- Establish a fee sufficient to address the Board's costs associated with completing a preapplication determination and to reimburse the Board for any costs related to the rulemaking process necessary to implement the bill.

³ See [16 CCR section 1309](#)

ANALYSIS

According to background information provided by the author's office, 21 states have a process in place for individuals to make a similar request, and further state:

"These mechanisms generally allow petitions to be filed at any time, including prior to meeting applicable education, training, and/or experiential requirements. A petitioner whose conviction is deemed disqualifying may be required to wait a number of years before filing a new petition. Preliminary determinations are not necessarily binding and may be reversed under certain circumstances like a conviction for a new offense."

As currently proposed, AB 1662 allows an applicant to request a preapplication determination whether their criminal conviction history could be cause for denial of a license issued by any licensing board. The bill allows their request to be filed at any time, including before they have obtained any training or education required for licensure.

As noted above, the Board receives a very low volume of applications from those with a criminal conviction history and, at least in the most recent fiscal year, did not deny anyone a license due to those circumstances. Boards may require the requestor to furnish their fingerprints to conduct a criminal history check.

If a board finds that the requestor's criminal history could be cause for denial of a license application, that board shall provide the requestor the following information:

- A summary of the criteria used by the board to consider whether a crime is considered to be substantially related to the qualifications, functions, or duties of the business or profession it regulates.
- The processes for the applicant to request a copy of the applicant's complete conviction history and question the accuracy or completeness of the record.
- That the applicant would have the right to appeal the board's decision.
- Any existing procedure the board has for the prospective applicant would have to challenge the decision or to request reconsideration following the denial of a completed application, including a copy of the criteria relating to rehabilitation.

Boards are required to publish information on this process on their website and may charge a fee of up to a maximum of \$50 to administer the requirements of the bill.

Implementation Considerations

The first of the Board's requested amendments has been addressed in the current version of the bill. The Board will only have to complete the preapplication determination based upon the requestor's fingerprint analysis (if required by the Board) and any other

information voluntarily provided. Further, the Board is not required to make a binding determination.

The second request related to costs, has not been addressed. The bill provides for a maximum fee amount of \$50 per requestor, which is not sufficient to cover the Board's anticipated staff time necessary to process these requests. Further, the language of the bill does not make clear whether the fee is intended to also cover the Board's costs related to fingerprint processing by DOJ and the FBI.

Prior to accepting requests for preapplication determinations, Board staff expect that regulations will be required to establish the fee amount and other requirements related to this process.

Consideration of a Position

Due to the ongoing cost concerns discussed above, the Board may wish to update its Support, if Amended position, and request the following amendments:

- Clarify that all costs associated with the requestor's fingerprint analysis are born by that individual.
- Remove the \$50 maximum fee amount, so that the Board may charge any fee amount necessary to cover the Board's reasonable costs to establish and administer this program.

FISCAL: Estimated costs between \$50,000 to \$100,000 related to application review, information technology, and rulemaking processes, which may be partly offset by fee revenue.

SUPPORT: Council on State Governments – Justice Center (sponsor)
Institute for Justice
Little Hoover Commission

OPPOSITION: Board for Professional Engineers, Land Surveyors, and Geologists
Board of Psychology
Dental Hygiene Board of California
Naturopathic Medicine Committee
Physical Therapy Board of California
Speech-Language Pathology and Audiology and Hearing Aid
Dispensers Board

ATTACHMENT: [AB 1662, Gipson – Licensing Board: Disqualification from Licensure: Criminal Conviction.](#)
Version: 4/27/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 1733
AUTHOR: Quirk
BILL DATE: January 31, 2022, Introduced
SUBJECT: State Bodies: Open Meetings
SPONSOR: None
POSITION: Support

DESCRIPTION OF CURRENT LEGISLATION

Modernizes the Bagley-Keene Open Meeting Act (the Act) to facilitate the use of teleconference-based public meetings, including online meetings. Requires a state body to provide the public the option to participate in teleconference-based meetings at either an in-person location or through an online or telephonic service, as defined.

This bill has not been amended since the prior Board meeting and is not expected to move forward this year.

BACKGROUND

The Act generally requires all state bodies, including the Medical Board of California (Board) to conduct business in meetings that are open to the public, publish their meeting agendas at least 10 calendar days prior to the meeting, and make their meeting materials available to the public.

The Act allows a state body to meet via teleconference, provided the public has access to the location where each board member of that body counting toward the quorum is joining the meeting. Due to the COVID-19 pandemic, under Executive Order No. N-29-20, between March 2020 and March 2022, state bodies were able to meet via teleconference without providing a physical location accessible to the public.

ANALYSIS

According to the author's fact sheet:

“AB 1733 modernizes the teleconferencing statute of Bagley-Keene to encourage more participation and engagement in public service. AB 1733 maintains that public meetings remain transparent, by requiring public meetings that are conducted via teleconference to be observable to the public both audibly and visually. AB 1733 also clarifies that members of a state body participating remotely shall count towards a quorum and would only require public disclosure of one designated primary physical meeting location from which the public may participate. It is also important to note that the reform in this bill is not replacing physical meetings, but authorizing state bodies to have the ability to have a meeting via teleconference in addition to a physical meeting location.”

AB 1733 would allow a state body to hold their public meetings entirely by teleconference or online software, like WebEx, like how the Board met under the now expired Executive Order. The public must be allowed to participate through either a two-way audio-visual platform or a two-way telephonic service, as defined.

The key difference is that each state body must provide a public a physical location at which the public may hear, observe, and address the state body. Each physical location shall be identified in the notice of the meeting.

In addition, AB 1733, generally, provides for the following:

- Members of the state body may remotely participate in the meeting without disclosing their location or may decide to participate from the designated physical meeting location. Members remotely participating shall disclose whether any other individuals 18 years of age or older are present in the room with the member at their remote location and the general nature of the member's relationship to any such individuals.
- If the remote participation technology fails during the meeting and cannot be restored, the state body shall end or adjourn the meeting, and inform interested parties, as specified.
- Does not affect the requirements related to publishing a meeting notice.

FISCAL: Possible minor costs related to new technology needs, offset by savings related to avoided travel costs.

SUPPORT: Disability Rights California
Little Hoover Commission
State Bar of California
Various boards within the Department of Consumer Affairs
[partial list]

OPPOSITION: None identified

ATTACHMENT: [AB 1733, Quirk - State Bodies: Open Meetings.](#)
Version: 01/31/22 – Introduced

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 2060
AUTHOR: Quirk
BILL DATE: April 20, 2022, Introduced
SUBJECT: Medical Board of California
SPONSOR: Medical Board of California

DESCRIPTION OF CURRENT LEGISLATION

Changes the composition of the Medical Board of California (Board) from a physician-member majority to a public-member majority. Allows the Board to determine the composition of disciplinary panels, except that each shall have no fewer than four members.

This bill has not been amended since the prior Board meeting and is not expected to move forward this year.

BACKGROUND

During their February 10-11, 2022, meeting, the Board voted to sponsor legislation that would change the Medical Practice Act (MPA), as follows:

- Change the Board's composition to a public member majority by replacing one physician and surgeon (P&S) member with a public member. The change would not occur until the first physician and surgeon position becomes vacant following the effective date of this bill.
- Due to the reduction of one P&S member, the bill would similarly reduce by one the minimum number of P&S members who must hold faculty appointments in a medical school. It would also make non-substantive updates to antiquated language.
- Update the composition of the Board's disciplinary panels to reflect the public member majority by stating that P&S members may not exceed the number of public members assigned to a panel.

The language approved by the Board was included in the introduced version of AB 2060.

ANALYSIS

During its consideration by the Assembly Committee on Business & Professions, AB 2060 was amended, at the request of the committee, to amend the language to allow the Board to determine the composition of the disciplinary panels. The committee analysis argued that the Board should have flexibility to maintain the current panel requirements. The current version of the bill does not impede the Board from creating

panels that have a majority of public members, or an equal number of public and physician members.

The bill's opponents argue that the current Board composition is appropriate to balance the voices of physician and public members and that physicians are better equipped to understand the standard of care, ethical obligations, professional competency responsibilities, and other matters pertaining to the practice of medicine that relate to the role of a Board member.

They further argue that this change could lead to additional costs to the Board and court system to defend its disciplinary decisions in the court system if non-physician majority panels improperly discipline a licensee.

Staff strongly disagree with these arguments and indicate that the Board relies upon medical expert opinions to advise on departures from the standard of care and that the bill preserves a substantial voice for physician Board members. Staff have asked opponents to provide evidence to support their claim that the bill will increase financial risk to the Board and are awaiting their response.

FISCAL: No costs to the Board.

SUPPORT: A Voice for Choice Advocacy
Consumer Protection Policy Center
Consumer Watchdog

OPPOSITION: California Medical Association
California Orthopaedic Association

ATTACHMENT: [AB 2060, Quirk – Medical Board of California](#)
Version: 4/20/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 2098
AUTHOR: Low
BILL DATE: August 22, 2022, Amended
SUBJECT: Physicians and Surgeons: Unprofessional Conduct
SPONSOR: California Medical Association
POSITION: Support, if Amended

DESCRIPTION OF CURRENT LEGISLATION

Establishes that the dissemination of misinformation or disinformation related to COVID-19 by a physician and surgeon (P&S) constitutes unprofessional conduct, as defined. The bill impacts licensees of the Medical Board of California (Board) and the Osteopathic Medical Board of California.

RECENT AMENDMENTS

Since the prior Board meeting, AB 2098 was amended as follows:

- Strike language that may have required the Board to prove both a violation of the standard of care and harm prior to disciplining a licensee
- The definition of “misinformation” now reads as (new language in underline italics, removed in ~~strikeout~~):
 - “Misinformation” means false information that is contradicted by contemporary scientific consensus contrary to the standard of care ~~to an extent where its dissemination constitutes gross negligence by the licensee.~~

Both amendments were taken at the request of the Board. The Board’s final requested amendment to provide the Board additional record inspection authority has not been taken, therefore, the Board’s position remains as Support, if Amended.

BACKGROUND

Under the Medical Practice Act (MPA), it is unprofessional conduct for any P&S to diagnose or treat their patient in violation of the standard of care, regardless of the malady that their patient is experiencing. A failure to adhere to the standard of care will subject the license of a P&S to discipline.

Prior to filing an accusation and disciplining a licensee, the Board must discover clear and convincing evidence that the licensee in question has violated the MPA.

When conducting an investigation, the most efficient method to obtain a copy of medical records is for the patient in question to authorize their P&S to provide their records to the Board. If the Board knows the identity of the patient, but the patient refuses to consent to release of their records, the Board may seek a subpoena to compel the production of those records if the Board has good cause.

[Business and Professions Code \(BPC\) section 651](#) states that it is unlawful for licensed healthcare professionals to disseminate, or cause to be disseminated, a public communication containing a false, fraudulent, misleading, or deceptive message for the purpose of, or likely to induce, the rendering of professional services or products connected to their licensed practice.

[BPC section 2220.05](#) establishes the Board's priorities for the purpose of maximizing its investigative and prosecutorial resources.

[BPC section 2234.1](#) states that a P&S shall not be subject to discipline solely based on rendering to a patient alternative or complementary medicine, as defined.

ANALYSIS

As provided in the analysis published by the Assembly Business and Professions Committee:

“According to the author: AB 2098 is crucial to addressing the amplification of misinformation and disinformation related to the COVID-19 pandemic. Licensed physicians, doctors, and surgeons possess a high degree of public trust and therefore must be held accountable for the information they spread. Providing patients with accurate, science-based information on the pandemic and COVID-19 vaccinations is imperative to protecting public health. By passing this legislation, California will show its unwavering support for a scientifically informed populous to protect ourselves from COVID-19.”

It is well established that the Board may discipline a licensee for a violation of the standard of care. When a P&S violates the standard of care, they may have communicated some amount of “misinformation” related to the nature of the patient's condition and appropriate treatments. This bill establishes a separate cause for discipline specifically for a P&S who disseminates misinformation or disinformation to a patient under their care related to COVID-19.

Implementation Considerations

Current Investigation Challenges

The Board faces considerable challenges investigating cases involving a violation of the MPA related to COVID-19. Typically, complaints received by the Board pertaining to COVID-19 are made by a member of the public and not the patient of the physician. In some COVID-19 related investigations, the Board is unable to identify any specific patients who have been treated by the physician in question. Without a patient's name

(for any investigation), it is impossible to obtain their consent for records and the Board will be unable to identify what patient records to subpoena and the basis supporting good cause¹ for an investigative subpoena.

To help overcome this challenge that appears in a variety of circumstances, the Board proposed amendments to the MPA in its 2020 Sunset Review Report² and in its 2022 legislative priorities memo³ that would provide enhanced medical record inspection authority. The proposal would authorize a Board investigator to inspect medical records in the possession of a licensee for the limited purpose of determining whether good cause exists to seek an investigative subpoena. A version of this authority was included in SB 920 (Hurtado).

Challenges Specific to AB 2098

The bill focuses on misinformation and disinformation disseminated from a licensee to a patient under their care. Unless the patient in question (or someone who knows the patient's name) files the complaint and consents to release their medical records to the Board, as described above, the Board will likely face significant challenges enforcing AB 2098.

Further, Board staff expect to have great difficulty proving the dissemination of disinformation, as it would be required to establish the intent of the P&S. Under current law, to prove a violation of the standard of care, the intent of the licensee, generally, is not relevant. Fortunately, the author amended this bill to change the definition of misinformation, at the request of the Board.

Additionally, only violations of the law that occurred on or after January 1, 2023, are eligible under this bill. Although staff anticipate a large initial volume of complaints, AB 2098 is not expected to lead to a significant volume of new actionable complaints as any cases related to this bill would likely also involve a violation of the standard of care of treatment for COVID-19, which is already a violation of the MPA.

Consideration of an Updated Board Position

The Legislature is about one week away from adjourning for the year and the Board's requested amendment to receive enhanced record inspection authority will not receive the support necessary to win approval. The author accepted the Board's other amendments and requests that the Board adopt a Support position on the bill.

¹ Generally, to have good cause, a Board investigator must be able to show that the subpoenaed records are necessary to advance the Board's interest and that the scope of the requested records is carefully tailored to the Board's need.

² See p. 212-215: <https://www.mbc.ca.gov/Download/Reports/sunset-report-2020.pdf>

³ See p. 7: <https://www.mbc.ca.gov/Download/Documents/MBCLegislativeRequests-20220105.pdf>

The Board will have the opportunity to continue pursuing enhanced record inspection authority during its sunset review in 2023. Therefore, staff recommend the Board update its position on AB 2098 to Support.

FISCAL: Minor and absorbable costs to process an expected initial influx of complaints after the bill is enacted.

SUPPORT: California Medical Association (Sponsor)
American Academy of Pediatrics, California
American College of Obstetricians and Gynecologists District IX
CA Chapter of the American College of Emergency Physicians
California Podiatric Medical Association
California Rheumatology Alliance
California Society of Anesthesiologists
Children's Specialty Care Coalition
Families for Opening Carlsbad Schools

OPPOSITION: A Voice for Choice Advocacy
California Health Coalition Advocacy
Californians for Good Governance
Catholic Families 4 Freedom CA
Central Coast Health Coalition
Children's Health Defense California Chapter
Concerned Women for America
Depression and Bipolar Support Alliance California
Educate. Advocate.
Frederick Douglass Foundation of California
Homewatch Caregivers of Huntington Beach
Nuremberg 2.0 LTD.
Pacific Justice Institute
Physicians for Informed Consent
Protection of the Educational Rights for Kids
Restore Childhood
Siskiyou Conservative Republicans
Stand Up Sacramento County

ATTACHMENT: [AB 2098, Low - Physicians and Surgeons: Unprofessional Conduct.](#)
Version: 08/22/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 2178
AUTHOR: Bloom
BILL DATE: June 14, 2022, Amended
SUBJECT: Physicians and Surgeons: Special Faculty Permits:
Academic Medical Center
SPONSOR: Cedars-Sinai
POSITION: Support

DESCRIPTION OF CURRENT LEGISLATION:

Clarifies the definition of “academic medical center” for purposes of obtaining a special faculty permit under the Medical Board of California (Board).

RECENT AMENDMENTS

On June 14, 2022, the AMC criteria related to the required number of residents and fellows was amended, as follows (deletions shown in ~~strikeout~~ and new language in underline italics):

- The facility trains a minimum of 250 ~~residents and fellows~~ resident physicians in Accreditation Council for Graduate Medical Education accredited residencies on an annual basis commencing each January 1.

BACKGROUND:

Under prior law, only medical schools approved by the Medical Board of California (Board) were authorized to sponsor applicants for a special faculty permit (SFP). Two legislative bills were enacted in recent years to expand access to the SFP program to academic medical centers (AMC) that met certain requirements.

[Assembly Bill 2273 of 2020](#) changed the law, as follows:

- Defined an AMC as an entity that meets all the following criteria:
 - A facility licensed by the State of California.
 - The facility conducts both internal and external peer review of the faculty for the purpose of conferral of academic appointments on an ongoing basis.
 - The facility conducts clinical and basic research for the purpose of advancing patient care.

- The facility trains a minimum of 250 residents and postdoctoral fellows on an annual basis commencing each January 1.
- The facility has more than 100 research students or postdoctoral researchers annually.
- The facility has foreign medical graduates in clinical research.
- The facility offers clinical observership training.
- The facility has an intern and resident-to-bed ratio meeting the federal Centers for Medicare and Medicaid Services definition as a major teaching hospital and conducts research in an amount of one hundred million dollars (\$100,000,000) or more annually.
- Expanded SFP program eligibility to the following individuals:
 - Someone offered a full-time appointment at the level of full professor in a tenure track position (or its equivalent) at an AMC; or
 - Someone clearly outstanding in a specific field of medicine or surgery who was offered a full-time academic appointment at the level of full professor or associate professor by the dean or chief medical officer of an AMC
- Added one person to the Special Faculty Permit Review Committee (SFPRC) who will represent all AMCs.
 - Specifies that if there is more than one AMC approved by the Board, that the AMCs shall select by consensus one person to represent all AMCs on the SFPRC.
- Allows the Board to approve no more than five SFP applicants sponsored by AMCs in any calendar year.

[Senate Bill 806 of 2021](#) deleted the intern/resident bed ratio and \$100,000,000 annual research AMC requirements. The bill added a requirement that AMCs be accredited by the Western Association of Schools and Colleges and the Accreditation Council for Graduate Medical Education.

The only AMC recognized by the Board is Cedars-Sinai Medical Center.

ANALYSIS:

According to the author and sponsor, certain current definitions of an AMC do not align with academic medical terms or accurately reflect the types of trainees supported and experiences offered at these institutions. This bill is intended to correct those definitions without substantively changing the requirements to qualify as an AMC.

AB 2178 updates certain AMC requirements, as follows (deletions shown in ~~strikeout~~ and additions in *underline italics*):

- The facility trains a minimum of 250 ~~residents and fellows~~ *resident physicians in Accreditation Council for Graduate Medical Education accredited residencies* on an annual basis commencing each January 1.
- The facility has foreign medical graduates in ~~clinical~~ research.
- The facility offers clinical ~~observership training~~. *observer experiences*.

FISCAL: No fiscal impact to the Board.

SUPPORT: Cedars-Sinai (Sponsor)
California Hospital Association
California State Association of Psychiatrists

OPPOSITION: None

ATTACHMENT: [AB 2178, Bloom. Physicians and Surgeons: Special Faculty Permits: Academic Medical Center.](#)
Version: 6/14/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 2236
AUTHOR: Low
BILL DATE: August 11, 2022, Amended
SUBJECT: Optometry: Certification to Perform Advanced
Procedures
SPONSOR: California Optometric Association

DESCRIPTION OF CURRENT LEGISLATION

Allows a qualified optometrist to perform certain advanced surgical procedures, provided they successfully complete specified education and training standards.

Allows a physician board-certified in ophthalmology, as specified, to serve as a qualified educator of an optometrist undergoing training and to certify their competency. Authorizes the Medical Board of California (Board) to establish reasonable standards and expectations for a physician who acts as a qualified educator.

BACKGROUND

Business and Professions Code (BPC) section 3041 provides for the scope of practice for an optometrist. BPC section 3041.3 sets forth additional requirements for an optometrist to use therapeutic pharmaceutical agents, which must also be met to authorize an optometrist to medically treat glaucoma.

Except as otherwise provided in the practice act of another profession regulated under the BPC, an individual must hold a physician and surgeon's license to conduct surgery or any other procedure that punctures the skin or harmfully invades the body.

ANALYSIS

According to author's fact sheet:

"Today's optometrists are trained to do much more than they are permitted in California. Optometrists in other states are performing minor surgical procedures, including the use of lasers to treat glaucoma with no adverse events. This bill would ensure the public has access to the treatments they need.

For more than a decade, the California Optometric Association has been in discussions with the California Medical Association and California Academy of Eye Physicians and Surgeons about legislation to allow a certified optometrist to use the latest technology in treating patients, resulting in more effective and safer eye care than currently allowed by law. In most other states that allow these procedures, optometrists are required to complete a 32-hour course. Most states require the state's board of optometry to establish the training requirements.

These procedures present no increased risk to patients. An optometrist is already trained to perform these procedures as part of their education in school. The bill would provide additional training that will be more rigorous than any other state. The bill also requires national board testing on these procedures to ensure competency. In the ten other states that allow laser procedures and 17 other states that allow lesion removal, there has been no increase in malpractice insurance premiums and few reported problems to the state optometry board.

The position letters of the California Optometric Association (COA) and the California Academy of Eye Physicians and Surgeons (CAEPS) are included in this document below, following this analysis.

Role and Requirements of Qualified Educators

To be a “qualified educator,” a person must be nominated by an accredited California school of optometry, is subject to the regulatory authority of that person’s licensing board in carrying out required responsibilities under this bill, and is either of the following:

- A California-licensed optometrist in good standing certified to perform advanced procedures approved by California Board of Optometry (CBO) who has been continuously certified for three years and has performed at least 10 of the specific advanced procedure for which they will serve as a qualified educator during the preceding two years.
- A California-licensed physician and surgeon who is board-certified in ophthalmology, in good standing with the Board, and in active surgical practice an average of at least 10 hours per week.

A qualified educator shall notify their licensing board of their participation as a qualified educator. The CBO and the Board may each establish reasonable standards and expectations for their respective licensees who act as a qualified educator.

Only qualified educators may supervise the training and course work performed by an optometrist under AB 2236, including the certification of their competency.

Education and Training Standards Established by the Bill

Following successful completion of the requirements of AB 2236, an optometrist who has already met the requirements to treat glaucoma, may perform the following procedures:

- (1) Laser [trabeculoplasty](#).
- (2) Laser [peripheral iridotomy](#) for the prophylactic treatment of a clinically significant narrow drainage angle of the anterior chamber of the eye.

- (3) Laser [posterior capsulotomy](#) after cataract surgery.
- (4) Excision or drainage of nonrecurrent lesions of the adnexa evaluated consistent with the standard of care by the optometrist to be noncancerous, not involving the eyelid margin, lacrimal supply, or drainage systems, no deeper than the orbicularis muscle, excepting [chalazia](#), and smaller than five millimeters in diameter. Tissue excised that is not fully necrotic shall be submitted for surgical pathological analysis.
- (5) Closure of a wound resulting from a procedure described in paragraph (4).
- (6) Injections for the treatment of chalazia and to administer local anesthesia required to perform procedures delineated in paragraph (4).
- (7) [Corneal crosslinking](#) procedure, or the use of medication and ultraviolet light to make the tissues of the cornea stronger.

Subject to certain prescribed timeframes, to be authorized to perform the above procedures, an optometrist shall meet the following education and examination requirements:

- (1) Complete a course approved by the CBO with at least 32 hours that is designed to provide education on the authorized procedures, including, but not limited to, medical decision-making that includes cases that would be poor surgical candidates, an overview and case presentations of known complications, practical experience performing the procedures, including a detailed assessment of the optometrist's technique, and a written examination for which the optometrist achieves a passing score.
- (2) Pass both sections of the [Laser and Surgical Procedures Examination](#) of the National Board of Examiners in Optometry, or, in the event this examination is no longer offered, its equivalent, as determined by CBO.

Further, the optometrist must complete a CBO-approved training program conducted in California, including the performance of all required procedures that shall involve sufficient direct experience with live human patients to permit certification of competency, by an accredited California school of optometry that shall contain the following:

- (A) Hands-on instruction on no less than the following number of simulated eyes before performing the related procedure on live human patients:
 - (i) Five for each laser procedure set forth in clauses (i), (ii), and (iii) of subparagraph (B) below.

(ii) Five to learn the skills to perform excision and drainage procedures and injections authorized by the bill.

(iii) Five to learn the skills related to corneal crosslinking.

(B) The performance of at least 43 complete surgical procedures on live human patients, as follows:

(i) Eight laser trabeculoplasties.

(ii) Eight laser posterior capsulotomies.

(iii) Five laser peripheral iridotomies.

(iv) Five chalazion excisions.

(v) Four chalazion intralesional injections.

(vi) Seven excisions of an authorized lesion of greater than or equal to two millimeters in size.

(vii) Five excisions or drainages of other authorized lesions.

(viii) One surgical corneal crosslinking involving removal of epithelium.

If necessary to certify the competence of the optometrist, the program shall require sufficient additional surgical experience performing complete procedures on live human patients.

Proposed Cohort and Preceptorship Training Models

Subject to the determination of CBO, a certain portion of the required training procedures shall be performed in a cohort model under the direct, in-person supervision of a qualified educator. Under this model, each member of the cohort will independently assess the patient, develop a treatment plan, and complete other specified requirements.

The surgical procedures not completed in a cohort model may be completed under a preceptorship model under the direct, in-person supervision of a qualified educator. Under this model, the optometrist will independently assess the patient, develop a treatment plan, and complete other specified requirements.

Under both models, a qualified educator shall certify that the optometrist is competent to perform the procedures specified in the legislation.

Patient Referrals to an Ophthalmologist

An optometrist performing these advanced procedures shall make a timely referral of a patient and all related records to an ophthalmologist if either of the following occur:

- (1) The optometrist makes an intraoperative determination that a procedure being performed does not meet a specified criterion required by this section.
- (2) The optometrist receives a pathology report for a lesion indicating the possibility of malignancy.

In an urgent or emergent situation when an ophthalmologist is unavailable, a patient shall be referred to a qualified center to provide care, after stabilizing the patient to the degree possible. Within three weeks of the event, any adverse treatment outcomes that required a referral to or consultation with another health care provider shall be reported to CBO.

Continuing Competency Requirements

After being certified to perform the advanced procedures, the optometrist shall attest upon request of CBO or at the time of their license renewal that they have performed at least four surgical procedures, as specified, since their prior license renewal, which may include procedures performed during the certification process.

If the optometrist fails to attest to those performance requirements, the optometrist's advanced procedure certification shall be restricted until they perform at least four procedures, as specified, under the supervision of a qualified educator through either the cohort or preceptorship model.

Requirements Placed on CBO

CBO will oversee the requirements of the program, pursuant to this bill and their existing authority to regulate the practice of optometry. AB 2236 requires CBO to review adverse treatment outcome reports in a timely manner, requesting additional information as necessary to make decisions regarding the need to impose additional training, or to restrict or revoke certifications based on its patient safety authority.

CBO is required to compile a report related to adverse outcomes, that includes, but is not limited to, the percent of adverse outcomes distributions by unidentified licensee and board interventions and shall make the report available on its internet website.

Like the Board, CBO may establish reasonable standards and expectations for their licensees who act as a qualified educator.

Role for the Board Related to Qualified Educators

The authority to set “reasonable standards and expectations” for a physician acting as a qualified education is seemingly broad. Potentially, the Board may be able to add any requirements on a licensee acting as an educator in this regard, provided they are not inconsistent with the purposes and requirements of the bill.

CAEPS believes that the Board should adopt standards for ophthalmologists who choose to serve in this role. They suggest considering standards of adequate performance as a trainer and educator, how to determine an optometrist’s competency, and whether a certain amount of experience in practice should be required.

The Board would need to adopt regulations to establish any such standards and expectations.

Consideration of a Board Position

As discussed in their position letters (see below), COA and CAEPS present conflicting views whether AB 2236 provides adequate training and educational standards for optometrists who wish to perform the advanced procedures authorized in the bill.

Typically, when considering a significant change in policy or guidance that would impact consumer protection, Board staff would suggest a process that includes interested party meetings to discuss and provide written and verbal comments from relevant experts and consumer advocates. In the absence of such a process, staff are unable to provide a recommendation whether the standards in the bill are sufficient to protect consumers.

If the Board has concerns, it could choose to adopt a regulation relative to the role of its licensees who act as a qualified educator. Depending upon what regulations the Board wishes to pursue, and the process involved, the Board may need to consult or contract with appropriate subject matter experts regarding eye surgical procedures and training standards. The Board typically relies upon accrediting bodies, such as the Accreditation Council for Graduate Medical Education, to recommend appropriate standards for medical training and surgical competency.

In addition, the Board could express any concerns it has by adopting a position on the bill.

The Board has some options to consider when adopting a position, including, but not limited to:

- Take no position and reserve the option to engage in the rulemaking process at the appropriate time.
- Adopt an Oppose or Support position consistent with its views on the bill (requesting amendments is likely not practical given the timing of the Board meeting relative to the end of the Legislature’s session on August 31).

FISCAL: Unknown, possible significant costs to the Board, dependent upon whether and how the Board decides to exercise the authority granted in the bill.

SUPPORT: California Optometric Association (sponsor)
California Optometric Student Association
Western University of Health Sciences

OPPOSITION: California Academy of Eye Physicians and Surgeons (unless amended)
California Medical Association (unless amended)
American Medical Association
California Society of Plastic Surgeons
Union of American Physicians and Dentists

POSITION: Staff do not have a recommended position.

ATTACHMENT: [AB 2236, Low – Optometry: Certification to Perform Advanced Procedures](#)
Version: 8/11/22 – Amended



August 21, 2022

The Honorable Evan Low
State Capitol, Room 6110
Sacramento, CA 95814

Re: Sponsor/Support AB 2236

Dear Assembly Member Low,

The California Optometric Association is pleased to sponsor/support your bill, AB 2236, which expands the scope of practice of optometry to include lasers and minor surgical procedures.

For more than a decade, the California Optometric Association has been in discussions with the California Medical Association and California Academy of Eye Physicians and Surgeons about legislation to allow a certified optometrist to use the latest technology in treating patients, resulting in more effective and safer eye care than currently allowed by law. For the most part, we have reached consensus on the definitions of the procedures; however, we have not been able to come to agreement on the training standards. In most other states that allow these procedures, optometrists are required to complete a 32-hour course. Most states require the state's board of optometry to establish the exact details of the training requirements.

Under current law, an optometrist can only use medication to treat glaucoma. Medication has big downsides for some patients. Older patients sometimes have a hard time getting the drops in their eyes so there are compliance issues. Some people can't tolerate the medications. Plus, the medication can be expensive. This bill would allow a certified optometrist to use a laser to focus light on the front part of the eye and allow drainage to occur and reduce eye pressure. The procedure is done in the office on an outpatient basis, is low risk, and takes just a few minutes.

The bill also allows a certified optometrist to remove small, non-cancerous lesions from around the eye. An optometrist is trained just like any other provider to know when something could be cancerous and needs to be referred. There is a tremendous demand for this type of lesion removal, and it can be very expensive to get this done in a physician office. That's why many people remove these lesions at a day spa or at home.

The experience in other states shows these procedures present no increased risk to patients. An optometrist is already trained to perform these procedures as part of their education in school. This training includes evaluating 2500 live human patients with various eye conditions during their clinical rotations. The bill would provide additional training that will be more rigorous than any other state. The bill also requires national board testing on these procedures to ensure competency. In the ten other states that allow these laser procedures and 17 other states that

allow removal of small lesions, there has been no increase in malpractice insurance premiums. Out of the more than 100,000 procedures performed in other states, there has only been one reported problem to a state optometry board.

This bill will ensure that patients will have access to the care they need. In some counties, Medi-Cal patients must wait months to get in with an ophthalmologist. Optometrists already provide 81 percent of the eye care under Medi-Cal. Optometrists are located in almost every county in California. Optometrists are well situated to bridge the provider gap for these eye conditions that are becoming more common as our population ages.

We shouldn't let a turf battle prevent trained health care professionals from using new technology that is safe and effective for patients. Thank you for introducing this important legislation.

Sincerely,

A handwritten signature in cursive script, appearing to read "Kristine Shultz".

Kristine Shultz
Executive Director



California Academy of Eye Physicians & Surgeons

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**Alternate

August 15, 2022

The Honorable Members of the Senate
California State Capitol
Sacramento, CA 95814

Re: AB 2236 (Low) – Oppose

Dear Senators:

On behalf of the California Academy of Eye Physicians and Surgeons, which represents the interests of the approximately 2,000 ophthalmologists practicing in our state and our patients, I am writing to ask you to **Oppose** the above referenced legislation.

The bill would allow optometrists to be certified to perform various surgical procedures on and around the eye.

First and foremost, the procedures **are** surgeries with **real** complications that can be sight-threatening. We therefore take issue with the representation of proponents of the bill that “An optometrist is **already** trained to perform these procedures **as part of their education in school.**”

I will try to make this simple. While the August 11th amendments increase the number of required surgeries (with one notable exception, see below), those same amendments create huge loopholes in how the program operate such that the training might not be meaningful or rigorous.

To that point:

- The bill would allow **unlimited** substitution of one required procedure for another such that a candidate could actually do just **ONE** procedure 43 times and be certified for **ANY and ALL** the procedures.
- The legislation specifies that just **ONE** case could be sufficient training for corneal crosslinking, which is the closest thing to a procedure done in an operating room of the set, and has significant potential risks, including severe infection and corneal melting (the treated tissue can just disintegrate). Furthermore, this **ONE** could be completely **foregone** under the flexibility standard above, a potential that seems totally disrespectful of what is involved.
- The provisions of the “cohort” model [(b) (2) (D)] -- under which a candidate performs his or her **own** surgeries and observes those of the others in the group, thus **“magnifying”** the impact of each procedure -- allow the training program to determine the “percentage” of procedures done under that model, and specify no minimum cohort size. Thus, the number could be very low, which could completely eliminate **any real** potential “magnification” in exchange for “administrative simplicity” for the candidate and the school (since they wouldn’t have to recruit patients).

Thus, the potential to be “exposed” to the educational benefit of *130 surgeries* if, for example, the minimum percentage were 40% and the minimum cohort size was 5 (there are some rounding issues), would drop to a *mere 44* if *all* but *one* were done in the preceptorship model (since it seems that the percentage *doesn't* have to include at least one of each procedure). That magnification was key to being willing to consider the minimum required procedures in the bill, and without it the *required procedure minimums would have been far higher*.

Furthermore, allowing all the procedures to be performed in the preceptor model under the supervision of ophthalmologists or certified optometrists in their private practices or similar risks significantly *inconsistent* training among the candidates, as the schools have far more control of the quality of training done in their own facilities. It also greatly reduces or eliminates any ability of the course administrator to have any meaningful first-hand knowledge of the candidate's skills in *determining and certifying ultimate competency*.

- The bill would allow someone to become fully certified in *all* the procedures, but then choose *just one* to do in actual practice, defeating the idea of a comprehensive certification in the first place. While there are provisions in (f) for “restriction” of a certification, our proposal mandated *loss* of certification (not licensure) if they couldn't attest to having just done just *two* of each of the procedures in a two year attestation period for three successive attestation periods (e.g. within *six* years). Furthermore, the language seems “loose” enough to allow someone to maintain certification for *ALL* laser procedures and/or *ALL* of the remaining procedures by simply having done *one* of just *two* of them in a grouping, which is not reasonable. Surgery is something that must be done continually to maintain proficiency.

Lastly and unbelievably, they could *reinstate* a category of the restricted procedures -- even after *many* years of not performing them -- by just doing *two of each*. This makes no sense and doesn't respect the privileges that could be granted.

All these loopholes drastically limit any hope of *developing the needed “surgical judgment” that we have maintained throughout is the essential goal of the entire process*. This includes:

- Evaluating and determining which patients are actually candidates for a surgical procedure, including assessing risks and benefits of the surgery.
- Learning and practicing every element of a surgery, beginning with development of the surgery treatment plan, establishing a sterile, safe environment to perform the procedure, and anticipating potential complications, and
- Patient post-op care, follow up, and evaluation of outcomes.

Unfortunately, *“real”* training should be what is necessary to treat patients, particularly to perform *eye surgery* on them.

Lastly, from a public policy standpoint and despite proponent's assertion the bill will address access issues to these services:

- adding a \$10,000-20,000 laser device to a rural practice (of any type) is cost-prohibitive and highly unlikely;
- maps (one attached) demonstrate that 97.5% of the state's population lives within at least a 30-60 minute drive of an already qualified provider of these procedures (i.e., an ophthalmologist) and
- despite cited (unpublished?) statistics that optometrists provide 81 percent of the eye care under Medi-Cal, the bulk of that care is almost certainly eye exams. Wait times *for the requested procedures* – if truly medically necessary (and that wouldn't include non-malignant skin tags removed for largely cosmetic reasons) – have *not* been demonstrated to be unreasonable.

We ask you to maintain patient safety for California's residents by voting "**No**" on AB 2236.

Sincerely,

A handwritten signature in blue ink that reads "Craig H. Kliger, MD". The signature is written in a cursive, flowing style.

Craig H. Kliger, MD
Executive Vice President

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: AB 2626
AUTHOR: Calderon
BILL DATE: August 1, 2022, Amended
SUBJECT: Medical Board of California: Licensee Discipline:
Abortion
SPONSOR: None
POSITION: Support (prior version)

DESCRIPTION OF CURRENT LEGISLATION

Prohibits the Medical Board of California (Board) and other licensing boards from disciplining a licensee for performing an abortion in this state provided they performed it in accordance with their practice act and the Reproductive Privacy Act. Prohibits the Board and other licensing boards from denying an applicant for licensure in this state or disciplining a licensee if they were disciplined by another state medical board or convicted in another state solely for performing an abortion in that state. Takes effect immediately upon signature of the Governor.

AB 2626 is not expected to change the Board's licensing and disciplinary outcomes.

RECENT AMENDMENTS

Since the Board's prior meeting, the bill was amended so that it would take effect immediately upon signature of the Governor and to clarify that discipline or criminal convictions in other states solely for performing an abortion will not lead to licensing denials or disciplinary action.

BACKGROUND

Current law sets forth the requirements related to the performance of an abortion by certain authorized licensed health care professionals, including physician and surgeons, osteopathic physicians and surgeons, nurse practitioners, nurse-midwives, and physician assistants. Those requirements are set forth in the respective practice acts of the various licensing boards and the Reproductive Privacy Act, among other provisions.

Recently, various states have enacted legislation that shortens the window of time for a person to obtain an abortion in those states. In Texas, for example, abortions may not be performed, or aided and abetted, by anyone after the detection of a fetal heartbeat.

The Medical Practice Act (MPA) authorizes the Board to discipline a licensee who has been disciplined by another state for unprofessional conduct, if that conduct is also a violation of California law.

ANALYSIS

As provided in the analysis published by the Senate Health Committee:

“According to the author, with the recent overturn of Roe v Wade and 16 states poised to make abortion illegal soon or have already banned abortion through trigger laws, the Guttmacher Institute expects an increase of up to 1.4 million out-of-state individuals of reproductive age finding their nearest clinic in California. Many states across the country are specifically targeting providers by authorizing state officials to revoke, suspend, or restrict a license for performing an abortion. AB 2626 protects California providers by preventing professional boards from revoking or suspending a medical license of a licensee for providing or coordinating abortion care in other states and to Californians or any out-of-state patients seeking care in California.”

Under current law, the Board may discipline a licensee for their out-of-state discipline pursuant to Business and Professions Code (BPC) section 141, 2305, and 2310 but only acts when the out-of-state conduct violates the MPA.

Further, the Board may deny an application for licensure pursuant to BPC section 480 due to discipline from other licensing boards or criminal convictions that occurred, generally, within seven years of the date of their application to the Board if their conduct was substantially related to the qualifications, functions, or duties of the license they are seeking.

The requirements of AB 2626 are consistent with the Board’s existing policy, which is to not deny a license application or discipline a licensee for criminal or unprofessional conduct outside this state that would otherwise be permitted in California.

Therefore, AB 2626 is not anticipated to impact the Board’s licensing or disciplinary programs. Staff recommend the Board maintain its current Support position on the bill.

FISCAL: None for the Board

SUPPORT: California Attorney General Bonta
California Lieutenant Governor Kounalakis
California State Controller Yee
Access Reproductive Justice
American College of Obstetricians and Gynecologists District Ix
ANSIRH (Advancing New Standards in Reproductive Health)
California Latinas for Reproductive Justice
California Nurse Midwives Association
Essential Access Health
NARAL Pro-choice California
National Council of Jewish Women-California
Planned Parenthood Affiliates of California
Women’s Foundation California

[partial list]

OPPOSITION: Right to Life League

POSITION: Recommendation: Support

ATTACHMENT: [AB 2626, Calderon - Medical Board of California: Licensee Discipline: Abortion](#)
Version: 08/01/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: SB 57
AUTHOR: Wiener
BILL DATE: January 18, 2022, Amended
SUBJECT: Controlled Substances: Overdose Prevention Program
SPONSOR: California Association of Alcohol & Drug Program Executives; California Society of Addiction Medicine; Drug Policy Alliance; National Harm Reduction Coalition; Healthright 360, San Francisco AIDS Foundation; Tarzana Treatment Center
POSITION: Neutral

DESCRIPTION OF CURRENT LEGISLATION

This bill authorizes certain local governments to establish overdose prevention programs (OPP) within their respective jurisdiction. Further, the bill would protect a person or entity from certain civil, criminal administrative, and professional disciplinary liability for their good faith involvement in the operation of an OPP, as specified.

The bill specifies that the civil, administrative, and professional disciplinary protection does not pertain to actions performed in a grossly negligent manner or in bad faith. The language, however, allows the Medical Board of California (Board) and Osteopathic Medical Board of California to take disciplinary action against its licensees.

The bill has not been amended since the prior Board meeting and, as of the date of publication, is on the Governor's desk awaiting his signature or veto.

BACKGROUND

Existing law, the Medical Practice Act, establishes the Board for the licensure and regulation of physicians and surgeons. Pursuant to current law and practice, the Board investigates every complaint received pertaining to its licensees, as appropriate, including cases relating to the quality of care provided to consumers. If warranted by the circumstances, and related evidence, licensees who do not adhere to the relevant standard of care may receive discipline against their license, including probation, suspension, or revocation. For technical and/or minor violations of the law, the Board may issue a citation and fine.

Various provisions of law state that possession, use (or being in the same location with knowledge of the use), or owning or maintaining a place for the use, of controlled substances is a crime.

ANALYSIS

According to the author:

California is in the midst of an unprecedented overdose crisis that must be treated as a public health crisis. Since 2011, drug overdose has been the leading cause of accidental death among adults in California. Overdose prevention programs, also called supervised consumption services, are a necessary intervention to prevent overdose deaths. Approximately 165 OPPs exist in 10 countries, and they have been rigorously researched and shown to reduce health and safety problems associated with drug use, including public drug use, discarded syringes, HIV and hepatitis infections, and overdose deaths.

The bill includes various findings and declarations, including the following:

- OPPs are an evidence-based harm reduction strategy that allows individuals to consume drugs in a hygienic environment under the supervision of staff trained to intervene if the individual overdoses. OPPs also provide sterile consumption equipment and offer general medical advice and referrals to substance use disorder treatment, housing, medical care, and other community social services.
- Expresses the intent of the Legislature to prevent fatal and nonfatal drug overdoses, reduce drug use by providing a pathway to drug treatment, as well as medical and social services for high-risk drug users (many of whom are homeless, uninsured, or very low income), prevent the transmission of HIV and hepatitis C, reduce nuisance and public safety problems related to the public use of controlled substances, and reduce emergency room use and hospital utilization related to drug use.

SB 57 establishes a temporary program (until January 1, 2028) that allows the City and County of San Francisco, the City of Los Angeles, the County of Los Angeles, and the City of Oakland to establish an OPP within their respective jurisdictions. The bill establishes various requirements that an entity must comply with to operate an OPP, including, but not limited to:

- Provide a hygienic space to consume controlled substances under supervision of staff trained to prevent and treat drug overdoses.
- Provide sterile consumption supplies, collect used equipment, and provide secure hypodermic needle and syringe disposal services.
- Monitor participants for potential overdose and provide care as necessary to prevent fatal overdose.
- Provide access or referrals to substance use disorder treatment services, primary medical care, mental health services, and social services.
- Educate participants on preventing transmission of HIV and viral hepatitis.
- Provide overdose prevention education and access to or referrals to obtain naloxone hydrochloride or another overdose reversal medication approved by the United States Food and Drug Administration.
- Require all staff present during open hours be certified in cardiopulmonary resuscitation (CPR) and first aid.

- Require all staff present at the program during open hours be authorized to provide emergency administration of an opioid antagonist and be trained for administration of an opioid antagonist.

SB 57 requires the jurisdictions that choose to participate in the program to select an independent entity to conduct a peer-reviewed study of the statewide efficacy of the program, to be submitted to the Legislature and the Governor's Office on or before January 15, 2027.

FISCAL: None to the Board.

SUPPORT: The City of Oakland
The City of San Francisco
County of Los Angeles
County Behavioral Health Directors Association of California
Harm Reduction Coalition (partial list)

OPPOSITION: California Association of Code Enforcement Officers
California State Sheriffs' Association
Peace Officers' Research Association of California
California District Attorney's Association (partial list)

ATTACHMENT: [SB 57, Wiener - Controlled Substances: Overdose Prevention Program](#)
Version: 01/18/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: SB 528
AUTHOR: Jones
BILL DATE: June 16, 2022, Amended
SUBJECT: Juveniles: Health Information Summary: Psychotropic Medication
SPONSOR: California Academy of Child and Adolescent Psychiatry
POSITION: Support (prior version)

DESCRIPTION OF CURRENT LEGISLATION

This bill requires certain forms related to the provision of psychotropic medications be included within a foster youth's case plan.

RECENT AMENDMENTS

The prior version of the bill required the California Department of Social Services (CDSS) to create an electronic health care portal, through which health care providers will be able to access health information included in a foster child or youth's health and education summary.

Currently, the bill requires that a foster youth's case plan include certain documents related to psychotropic medications prescribed to them.

BACKGROUND

Current law sets forth the prioritization of the allegations received by Medical Board of California (Board). Specifically, Business and Professions Code (BPC) section 2220.05 includes the investigation of allegations pertaining to "repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor."

In 2015, the California State Auditor released a report regarding California's foster care system and found that the state and counties failed to adequately oversee the prescription of psychotropic medications to children in foster care. According to this report, the fragmented structure of the state's child welfare system has contributed to its failure to ensure it has the data necessary to monitor the prescription of psychotropic medications to foster children.

Judicial approval is mandated by the California Rules of Court prior to the administration of psychotropic medications to children and youth in foster care. The Psychotropic Medication Protocol, also referred to as the JV-220 process, initiates the court authorization of psychotropic medications for dependents of the court. The JV-220 documentation specifies the dosage and medication plan, ideally including targeted

goals. This is undertaken, to the extent possible, in collaboration with the child, family, caregiver, and other supportive collaterals.

Current law requires, whenever a child is placed in foster care, a case plan for each child to include a summary of the health and education information or records of the child. The summary includes, but is not limited to, mental health information, contact information for health and dental providers, the child's school record, the child's grade level performance, current medications of the child, and any known medical problems, among others.

ANALYSIS

According to proponents of the bill, the current summary level information included in the case file of a foster youth may be incomplete or lacking the detail necessary for a provider to understand their medical history and provide consistent care. SB 528 is expected to help ensure that important health history information relevant to a foster child is made available their current and future caregivers and health care providers by ensuring that key portions of the JV-220 forms, along with prescribing information, are included in their case file.

Impact to the Consumer Protection Mission of the Board

In addition to the benefit the bill provides to support continuity of care for such a vulnerable patient population, this bill may ease the Board's access to medical records necessary to investigate possible violations of the Medical Practice Act regarding treatment provided to children in foster care.

Accordingly, staff recommend the Board adopt a Support position on the current version of SB 528.

FISCAL: None for the Board

SUPPORT: California Academy of Child and Adolescent Psychiatry (sponsor)

OPPOSITION: None reported

ATTACHMENT: [SB 528, Jones - Juveniles: Health Information Summary: Psychotropic Medication.](#)
Version: 06/16/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: SB 923
AUTHOR: Wiener
BILL DATE: August 18, 2022, Amended
SUBJECT: Gender-Affirming Care
SPONSOR: California LGBTQ Health and Human Services
Network, et al.

DESCRIPTION OF CURRENT LEGISLATION

Allows current continuing medical education (CME) requirements related to cultural competency to be satisfied through evidence-based training related to individuals who identify as transgender, gender diverse, or intersex (TGI).

Requires health care service plans, health insurers, and Medi-Cal managed care plans to require their staff in direct contact with enrollees to be trained in evidence-based cultural competency for the purpose of providing trans-inclusive care to TGI communities, as specified.

Requires those entities to publicly report which in-network providers offer gender-affirming services, as defined. Requires establishment of a working group to establish a quality standard for patient experience to measure cultural competency related to TGI communities.

Places monitoring requirements upon, and provides sanctioning authority to, the Department of Managed Healthcare and Department of Insurance, to enforce the provisions of the bill within their respective jurisdictions.

BACKGROUND

CME is intended to maintain, develop, or increase the knowledge, skills, and professional performance that a physician uses to provide care, or to improve the quality of care provided to their patients. The Medical Practice Act (MPA) provides the Board broad authority to establish CME standards and requirements, including mandating CME on certain topics.

[Business and Professions Code section 2190.1](#) requires, among other provisions, all CME courses to contain curriculum that includes cultural and linguistic competency in the practice of medicine to effectively care for patients from diverse cultures, groups, and communities. That section provides suggested topics to meet those requirements.

The MPA also establishes certain topical CME requirements for certain physicians pertaining to pain management, treatment and management of opiate-dependent patients, and geriatric medicine.

Via regulation, the Board requires a physician to complete not less than 50 hours of approved CME during each two-year period prior to renewing their license. Other than the above-described requirements, physicians may exercise discretion to choose CME most appropriate to their patients and medical practice.

ANALYSIS

SB 923 is intended to ensure that physicians and health insurance staff are trained in evidence-based cultural competency related to TGI communities. The bill does so primarily through mandates on organizations that offer various health insurance products, however, this analysis will focus on the CME provisions of SB 923.

According to the author's fact sheet:

“Many transgender patients encounter discrimination and difficulty accessing culturally competent health care. The National Center for Transgender Equality reported that one-third of all transgender individuals who had seen a health care professional in 2014 had at least one negative experience related to being transgender, with higher rates for people of color and people with disabilities. These negative experiences include being refused treatment, verbally harassed, physically or sexually assaulted, or having to teach the provider about transgender people in order to receive appropriate care.”

Proposed Changes to CME Cultural Competency Statute

The bill expands the suggestions in current law related to meeting cultural competency requirements, to include the following:

- Understanding and applying culturally, ethnically, and sociologically inclusive data and evidence-based cultural competency training related to the care and treatment of individuals who identify as queer or questioning, asexual, intersex, or gender diverse.
- Processes related to those seeking gender-affirming care services.
- The effects of historical and contemporary exclusion and oppression of TGI communities.
- Appropriate use of TGI-inclusive terminology, as specified.
- Health inequities within the TGI community, including family and community acceptance.
- Perspectives of diverse, local constituency groups and TGI-serving organizations

- Recognition of the difference between personal values and professional responsibilities related to serving TGI communities
- Recommendations on administrative changes to make health care facilities more inclusive.

Other Provisions of SB 923

By March 1, 2025, health care service plans, health insurers, and Medi-Cal managed care plans shall require their plan staff in direct contact with their insureds, beneficiaries, or enrollees, as appropriate to receive training in evidence-based cultural competency training, as defined. Specialized plans that provide only dental or vision services are excluded from this requirement.

No later than March 1, 2025, those entities shall include information within or accessible from their provider directory, and their call center, that identifies their in-network providers who offer and have provided gender affirming medical services, as specified.

By March 1, 2023, requires the California Health and Human Services Agency to convene a working group charged with establishing quality standards for patient experience to measure cultural competency related to TGI communities and recommend related training curriculum.

Places monitoring requirements upon, and provides sanctioning authority to, the Department of Managed Healthcare and Department of Insurance, to enforce the provisions of the bill within their respective jurisdictions.

Consideration of a Board Position

The language in the bill related to CME requirements is most closely connected to the Board’s consumer protection mission, therefore, the Board may wish to consider limiting the scope of its position to those provisions.

The CME language in the bill builds upon the state’s existing policies to help ensure that physicians are equipped with relevant cultural competency training while maintaining flexibility to meet these requirements. There are no expected costs to the Board to administer the bill.

Accordingly, staff recommend the Board adopt a Support position on the CME provisions of the bill.

FISCAL: No anticipated costs.

SUPPORT: California LGBTQ Health and Human Services Network (Sponsor)
 Equality California (Co-sponsor)
 National Health Law Program (Co-sponsor)
 TransCommunity Project (Co-sponsor)

Trans Family Support Services (Co-sponsor)
Western Center on Law & Poverty (Co-sponsor)
Break the Binary LLC (Co-sponsor)
California TRANScends (Co-sponsor)
Gender Justice LA (Co-sponsor)
Orange County TransLatinas (Co-sponsor)
Queer Works (Co-sponsor)
Rainbow Pride Youth Alliance (Co-sponsor)
San Francisco Office of Transgender Initiatives (Co-sponsor)
The TransPower Project (Co-sponsor)
TransCanWork (Co-sponsor)
Transgender Health and Wellness Center (Co-sponsor)
Tranz of Anarchii INC (Co-sponsor)
Unique Woman's Coalition (Co-sponsor)
Unity Hope (Co-sponsor)
[partial list]

OPPOSITION: California Family Council
Can I Get a Witness
Capitol Resource Institute
Concerned Women for America
International Federation for Therapeutic and Counseling Choice
Our Duty

POSITION: Recommendation: Support

ATTACHMENT: [SB 923, Wiener - Gender-affirming Care.](#)
Version: 8/18/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: SB 1259
AUTHOR: Laird
BILL DATE: June 13, 2022, Amended
SUBJECT: Pharmacists: Furnishing Opioid Antagonists
SPONSOR: None

DESCRIPTION OF CURRENT LEGISLATION

Updates current law to allow a pharmacist, subject to certain protocols adopted by the California State Board of Pharmacy (BOP) and the Medical Board of California (Board), to independently furnish any opioid antagonist approved by the federal Food and Drug Administration (FDA).

BACKGROUND

Under current law, pursuant to Business and Professions Code (BPC) section 4052.01, a pharmacist may independently furnish naloxone hydrochloride to an individual, in accordance with [protocols jointly developed](#) by BOP and the Board.

According to the [Centers for Disease Control](#), provisional data “indicate[s] there were an estimated 107,622 drug overdose deaths in the United States during 2021, an increase of nearly 15% from the 93,655 deaths estimated in 2020. The 2021 increase was half of what it was a year ago, when overdose deaths rose 30% from 2019 to 2020.”

ANALYSIS

According to author’s fact sheet:

“Currently, researchers are developing next generation antagonists that will use molecules other than naloxone, a medicine that rapidly reverses an opioid overdose by quickly restoring normal breathing that has slowed or stopped, that will last longer and only require one dose.

Additional statutory authority is needed to expand access to equip pharmacists with the ability to distribute the most appropriate and effective opioid antagonists to the public.”

Consideration of a Board Position

Subject to the joint oversight of BOP and the Board, this bill is expected to increase the availability of FDA-approved opioid antagonists to the public, reducing overdose fatalities. BOP supports SB 1259 and directly regulates the pharmacists who would furnish these medications.

The bill would require the Board to incur minor costs involved in updating the joint protocols developed with the BOP.

In light of these factors, staff recommend the Board adopt a Support position.

FISCAL: Minor and absorbable costs associated with coordinating with the Board of Pharmacy on updated protocols.

SUPPORT: California Board of Pharmacy
California Retailers Association
City of Santa Monica
National Association of Chain Drug Stores

OPPOSITION: None reported.

POSITION: Recommendation: Support

ATTACHMENT: [SB 1259, Laird – Pharmacists: Furnishing Opioid Antagonists.](#)
Version: 6/13/22 – Amended

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: SB 1440
AUTHOR: Roth
BILL DATE: February 18, 2022, Introduced
SUBJECT: Licensed Midwifery Practice Act of 1993: Complaints
SPONSOR: None
POSITION: Support

DESCRIPTION OF CURRENT LEGISLATION

Makes clarifying changes to one section of the Licensed Midwifery Practice Act of 1993 (LM Act).

This bill has not been amended since the prior Board meeting.

BACKGROUND

The LM Act provides for the licensure and regulation of licensed midwives (LM) by the Medical Board of California (Board).

SB 806 (Roth) of 2021 added [Business and Professions Code \(BPC\) section 2519.5](#) which provides criteria for the Board to follow when reviewing quality-of-care complaints involving a LM. That section is very similar to [BPC section 2220.08](#), which pertains to quality-of-care complaints relating to a physician and surgeon (P&S).

ANALYSIS

This bill provides a technical amendment to BPC section 2519.5 so that it conforms, in relevant part, to BPC section 2220.08.

This amendment clarifies the Board's authority to refer quality-of-care complaints about a LM to the field, even if it does not receive the information requested, pursuant to (a). This conforms to the same process provided for a P&S in BPC section 2220.08.

FISCAL: None for the Board

SUPPORT: None

OPPOSITION: None

ATTACHMENT: [SB 1440, Roth - Licensed Midwifery Practice Act of 1993: Complaints](#)
Version: 02/18/22 – Introduced

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

BILL NUMBER: SB 1441
AUTHOR: Roth
BILL DATE: February 18, 2022, Introduced
SUBJECT: Healing Arts: Nonconventional Treatment
SPONSOR: None

DESCRIPTION OF CURRENT LEGISLATION

Requires the Medical Board of California (Board) and the Osteopathic Medical Board of California (OMBC) to annually update disciplinary policies and procedures related to emerging and innovative medical practices for licensed physicians and surgeons.

This bill has not been amended since the prior Board meeting and is not expected to move forward.

BACKGROUND

[Business and Professions Code \(BPC\) section 2501](#) required the Board and OMBC to develop disciplinary policies and procedures to reflect emerging and innovative medical practices for licensed physicians and surgeons (P&S). The Board adopted those procedures in April 2002.

ANALYSIS

SB 1441 requires the Board to update these procedures on an annual basis, but this bill is expected to either be substantially amended or not move forward.

FISCAL: Minor costs the Board.

SUPPORT: None

OPPOSITION: None

POSITION: Recommendation: Neutral

ATTACHMENT: [SB 1441, Roth - Healing Arts: Nonconventional Treatment](#)
Version: 02/18/22 – Introduced

MBC TRACKER II BILLS
8/19/2022

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 32	Aguiar-Curry	Telehealth	Senate Floor	08/01/22
AB 35	Reyes	Civil Damages: Medical Malpractice	Chaptered	04/27/22
AB 225	Gray	Department of Consumer Affairs: Boards: Veterans: Military Spouses	Sen. BP&ED	06/28/21
AB 305	Maienschein	Veteran services: Notice	Senate Floor	08/26/21
AB 343	Fong	California Public Records Act Ombudsperson	Senate G.O.	06/15/22
AB 581	Irwin	Cybersecurity	Sen. Appropriation	06/20/22
AB 646	Low	Department of Consumer Affairs: Boards: Expunged Convictions	Sen. Appropriation	01/24/22
AB 835	Nazarian	Hospital Emergency Departments: HIV Testing	Sen. Appropriation	07/12/21
AB 975	Rivas	Political Reform Act of 1974: Statement of Economic Interests & Gifts	Senate Floor	06/16/22
AB 1120	Irwin	Clinical Laboratories: Blood Withdrawal	Senate Floor	08/03/22
AB 1242	Bauer-Kahan	Reproductive Rights	Senate Floor	08/11/22
AB 1306	Arambula	Health Professions Careers Opportunity Program	Sen. Appropriations	06/16/21
AB 1308	Ting	Arrest and Conviction Record Relief	Sen. Public Safety	
AB 1328	Irwin	Clinical Laboratory Technology and Pharmacists	Senate Floor	07/14/21
AB 1400	Kalra	Guaranteed Health Care for All	Dead	01/24/22
AB 1429	Holden	State Agency Records: Mgmt. Coord. Duties: Personnel Training	Sen. Appropriations	06/29/21
AB 1436	Chau	Information Privacy: Digital Health Feedback Systems	Sen. Appropriations	07/16/21
AB 1604	Holden	The Upward Mobility Act of 2022	Assm. Approps	03/07/22
AB 1704	Chen	Leg-Podiatric Radiography Permit: Podiatric Medical Board of Ca.	Senate Floor	06/20/22
AB 1706	Bonta	Cannabis Crimes: Resentencing	Senate Floor	08/11/22
AB 1711	Seyarto	Privacy: Breach	Senate Floor	08/08/22
AB 1715	Muratsuchi	Space Force	Senate Floor	06/15/22
AB 1751	Daly	Workers' Compensation: COVID-19: Critical Workers	Senate Floor	08/01/22
AB 1797	Weber	Immunization Registry	Senate Floor	05/02/22
AB 1809	Aguiar-Curry	Nursing Facility Resident Informed Consent Protection Act of 2022	Senate Floor	06/27/22

MBC TRACKER II BILLS
8/19/2022

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1880	Arambula	Prior Authorization and Step Therapy	Senate Floor	06/21/22
AB 1896	Quirk	Gamete Banks	Senate Floor	06/15/22
AB 1914	Davies	Resource Family Approval: Training	Senate Floor	06/06/22
AB 1918	Petrie-Norris	California Reproductive Health Service Corps	Senate Floor	08/11/22
AB 1924	Gipson	Criminal Law: Certificate of Rehabilitation	Senate Floor	05/19/22
AB 1954	Quirk	Physicians and Surgeons: Cannabis Treatment and Medication	Senate Floor	05/19/22
AB 1996	Cooley	State Government: Administrative Regulations: Review	Assm. Approps	
AB 2080	Wood	Health Care Consolidation and Contracting Fairness Act of 2022	Assm. Approps	05/02/22
AB 2085	Holden	Crimes: Mandated Reporters	Senate Floor	08/02/22
AB 2087	Petrie-Norris	Prescription Drugs	Assm. Approps	04/20/22
AB 2089	Bauer-Kahan	Privacy: Mental Health Applications Information	Senate Floor	08/01/22
AB 2091	Bonta	Disclosure of Information: Reproductive Health	Senate Floor	08/01/22
AB 2105	Smith	Contractors: Initial License Fee Reduction: Veterans	Enrollment	05/31/22
AB 2107	Flora	Clinical Laboratory Testing	Senate Floor	05/19/22
AB 2134	Weber	Reproductive Health Care	Senate Floor	06/23/22
AB 2176	Wood	Live Birth Registration	Chaptered	
AB 2199	Wicks	Birthing Justice for California Families Pilot Project	Senate Floor	06/06/22
AB 2274	Rubio	Mandated Reporters: Statute of Limitations	Senate Floor	03/31/22
AB 2288	Choi	Advance Health Care Directives: Mental Health Treatment	Chaptered	03/17/22
AB 2389	Carrillo	Pupil Health: Vision Examinations: Schoolsites	Senate Floor	06/23/22
AB 2338	Gipson	Health Care Decisions: Decisionmakers and Surrogates	Senate Floor	06/20/22
AB 2365	Patterson	Fentanyl Program Grants	Senate Floor	
AB 2370	Levine	Public Records: State Agency Retention	Sen. Appropriations	03/23/22
AB 2409	Davies	Parole: Victims' Rights	Assm. Approps	03/17/22
AB 2436	Bauer-Kahan	Death Certificates: Content	Senate Floor	03/31/22

MBC TRACKER II BILLS
8/19/2022

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2449	Rubio	Open Meetings: Local Agencies: Teleconferences	Senate Floor	08/08/22
AB 2522	Gray	Public Health Workforce Loan Repayment Program	Assm. Approps	06/27/22
AB 2529	Davies	Health Care: Workforce Training Programs	Sen. Appropriations	06/14/22
AB 2574	Salas	Optometry	Senate Floor	06/14/22
AB 2586	Garcia	Reproductive and Sexual Health Inequities	Senate Floor	06/09/22
AB 2647	Levine	Local Government: Open Meetings	Senate Floor	08/04/22
AB 2671	Berman	Occupational Therapy	Senate Floor	08/11/22
AB 2677	Gabriel	Information Practices Act of 1977	Senate Floor	08/11/22
AB 2684	Berman	Nursing	Senate Floor	08/11/22
AB 2685	Cmte. on B&P	Naturopathic Doctors Act: Naturopathic Medicine Cmte.	Senate Floor	08/11/22
AB 2686	Cmte. on B&P	Speech-Language Pathologists, Audiologists, and Hearing Aid Disp.	Senate Floor	06/29/22
AB 2687	Cmte. on B&P	California Massage Therapy Council	Assembly Floor	06/16/22
AB 2754	Bauer-Kahan	Psychology: Supervision	Enrollment	08/09/22
AB 2790	Wicks	Reporting of Crimes: Mandated Reporters	Sen. Appropriations	06/30/22
SB 40	Hurtado	Health Care Workforce Development: Ca Medicine Scholars Program	Assm. Approps	06/28/21
SB 402	Hurtado	Multipayer Payment Reform Collaborative	Assm. Approps	06/14/21
SB 422	Pan	Personal Services Contracts: State Employees: Phys. & Pro Registry	Assembly Floor	
SB 441	Hurtado	Health Care Workforce Training Programs: Geriatric Medicine	Assm. Approps	03/22/21
SB 460	Pan	Long-term Health Facilities: Patient Representatives	Senate Floor	03/16/21
SB 492	Hurtado	Maternal Health	Dead	04/19/21
SB 519	Wiener	Controlled Substances: Hallucinogenic Substances	Senate Floor	08/15/22
SB 523	Leyva	Contraceptive Equity Act of 2022	Assembly Floor	08/15/22
SB 652	Bates	Dentistry: Use of Sedation: Training	Assm. B&P	05/11/21
SB 731	Durazo	Criminal Records: Relief	Senate Floor	06/23/22
SB 866	Wiener	Minors: Vaccine Consent	Assembly Floor	06/16/22
SB 871	Pan	Public Health: Immunizations	Senate Health	

MBC TRACKER II BILLS
8/19/2022

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 872	Dodd	Pharmacies: Mobile Units	Enrollment	06/15/22
SB 962	Jones	Healing Arts: Clinical Lab Technology	Assm. Approps	04/05/22
SB 964	Wiener	Behavioral Health	Assembly Floor	08/15/22
SB 979	Dodd	Health Emergencies	Assembly Floor	06/14/22
SB 988	Hueso	Compassionate Access to Medical Cannabis Act	Enrollment	06/08/22
SB 993	Skinner	Victimes and Persons Erroneously Convicted	Assembly Floor	08/15/22
SB 999	Cortese	Health Coverage: Mental Health and Substance Use Disorders	Assembly Floor	06/30/22
SB 1003	Eggman	Trauma-Informed Care Training Program	Assm. Approps	05/19/22
SB 1029	Hurtado	One Health Program: Zoonotic Diseases	Assembly Floor	08/15/22
SB 1142	Caballero	Abortion Services	Assembly Floor	06/29/22
SB 1165	Bates	Substance Abuse and Mental Health Services	Enrollment	
SB 1171	Caballero	Hearsay Evidence: Exceptions: Medical Diagnosis or Treatment	Assm. Public Safety	04/28/22
SB 1178	Bradford	Criminal Procedure: Sentencing	Assembly Floor	
SB 1184	Cortese	Confidentiality of Medical Information Act	Assembly Floor	05/05/22
SB 1189	Wieckowski	Biometric Information	Sen. Approps	04/07/22
SB 1199	Roth	UC Riverside, School of Medicine	Assm. Higher Educ.	05/19/22
SB 1229	McGuire	Mental Health Workforce Grant Program	Assm. Higher Educ.	04/28/22
SB 1231	Caballero	California Standard Diagnostic for Valley Fever	Sen. Approps	06/21/22
SB 1237	Newman	Licenses: Military Service	Enrollment	03/30/22
SB 1267	Pan	Clinical Laboratories	Assembly Floor	08/15/22
SB 1346	Becker	Surplus Medication Collection and Distribution	Senate Floor	08/01/22
SB 1436	Roth	Respiratory Therapy	Assembly Floor	06/21/22
SB 1438	Roth	Physical Therapy Board of California	Assembly Floor	06/29/22
SB 1443	Roth	The Department of Consumer Affairs	Assembly Floor	06/21/22