STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

PHYSICIAN ASSISTANT BOARD
2005 Evergreen Street, Suite 1100, Sacramento, CA 95815
P (916) 561-8780 Fax(916) 263-2671 web www.pac.ca.gov

MEETING NOTICE

August 26, 2013

PHYSICIAN ASSISTANT BOARD
2005 Evergreen Street – Hearing Room #1150
Sacramento, CA 95815
9:00 A.M. – 3:00 P.M.

AGENDA

(Please see below for Webcast information)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

1. Call to Order by President (Sachs)

2. Roll Call (Forsyth)

3. Approval of May 20, 2013 Meeting Minutes (Sachs)

4. Public Comment on Items not on the Agenda (Sachs)

5. Reports
   a. President's Report (Sachs)
   b. Executive Officer's Report (Mitchell)
   c. Licensing Program Activity Report (Caldwell)
   d. Diversion Program Activity Report (Mitchell)
   e. Enforcement Program Activity Report (Tincher)

6. Department of Consumer Affairs
   a. Director's Update (Christine Lally)

7. Presentation and Update from the Department of Consumer Affairs Legislative and Policy Review Division (DCA Representative)

8. The Legislative Committee (Hazelton/Earley)
   a. Proposed Policy regarding Role of Committee
   b. Legislation of Interest to the Physician Assistant Board
   AB 154, AB 186, SB 304, SB 352, SB 491, SB 492, SB 493, SB 494, SB 809, other bills introduced or amended after publication of the agenda

10. Update on Current Budget (Tincher)

11. Presentation from Maximus, Diversion Program (Virginia Mathews, Program Manager, Maximus)

12. **CLOSED SESSION**: Pursuant to Section 11126(c)(3) of the Government Code, the

RETURN TO OPEN SESSION

13. Discussion on Proposed Regulation Change re: Personal Presence (Sachs/Mitchell)

14. Discussion of Revisions to the Model Disciplinary Guidelines (Tincher)

15. Update on BreEZe Implementation (Mitchell)

16. Fluoroscopy Permit Requirements for PAs Update (Mitchell)

17. Mandatory Reporting Requirements for Physician Assistants (Grant)

18. Discussion of Physician Assistant, Consumer Access to Care and Workforce Issues (Rosslyn Byous, OSHPD, Teresa Anderson, CAPA)

19. Discussion regarding current voluntary exam about PA Laws and Regulations available on Board's website (Sachs)

20. Review and Discussion of the Board's Strategic Plan (Sachs)

21. Agenda Items for Next Meeting (Sachs)

22. Adjournment (Sachs)

Note: Agenda discussion and report items are subject to action being taken on them during the meeting by the Board at its discretion. All times when stated are approximate and subject to change without prior notice at the discretion of the Board. Agenda items may be taken out of order and total time allocated for public comment on particular issues may be limited.

While the Board intends to webcast this meeting, it may not be possible to webcast the meeting due to limitations on resources. The webcast can be located at www.dca.ca.gov. If you would like to ensure participation, please plan to attend at the physical location.

Notice: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Lynn Forsyth at (916) 561-8785 or email Lynn.Forsyth@mbc.ca.gov or send a written request to the Physician Assistant Board, 2005 Evergreen Street, Suite 1100, Sacramento, California 95815. Providing your request at least five (5) business days before the meeting will help to ensure availability of the request.

AGENDA ITEM

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STATE OF CALIFORNIA
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BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

PHYSICIAN ASSISTANT BOARD
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MEETING MINUTES

May 20, 2013

PHYSICIAN ASSISTANT BOARD
2005 Evergreen Street – Hearing Room #1150
Sacramento, CA 95815
9:00 A.M. – 3:00 P.M.

1. **Call to Order by President**

President Sachs called the meeting to order at 9:15 a.m.

2. **Roll Call**

Staff called the roll. A quorum was present.

Board Members Present:	Robert Sachs, PA-C Charles Alexander, Ph.D. Cristina Gomez-Vidal Diaz Sonya Earley, PA Jed Grant, PA -C Catherine Hazelton
Board Member Absent:	Rosalee Shorter, PA
Staff Present:	Glenn Mitchell, Executive Officer Laura Freedman, Senior Staff Counsel, Dept. of Consumer Affairs (DCA) Dianne Tincher, Enforcement Analyst Lynn Forsyth, Staff Services Analyst Julie Caldwell, Licensing Technician

3. **Approval of February 11, 2013, Meeting Minutes**

The February 11, 2013 minutes were approved as drafted.
(m/Grant, s/Diaz, motion passes)

4. **Public Comment on Items not on the Agenda**

There was no public comment at this time.

5. **Reports**

a. President Report

President Sachs opened the meeting by introducing the members to the audience.

President Sachs stated that he had the opportunity to participate as a founding member for a new physician assistant training program in Orange County. The program will be a 27 month master's degree program. ARC-PA accreditation review will be in October 2013 and they anticipate their first class will start in September of 2014.

President Sachs also stated that he was asked to be the key note speaker for the graduating class at the USC PA Program.

b. Executive Officer Report

Mr. Mitchell stated that California Academy of Physician Assistant (CAPA) and OSHPD (Office of Statewide Health Planning and Development) have been working together to gather workforce data on the PA practice in California. Mr. Mitchell stated that the board was asked to assist in informing licensees about the survey. The data obtained from the survey will be helpful not only to CAPA and OSHPD but also to the board in learning about and addressing future workforce issues. Mr. Mitchell stated that a link has been placed on our website to the survey.

Mr. Mitchell informed the members that the California Health and Human Services Agency and the State and Consumer Services Agency are collaborating on the California Framework for Regulating Health Care Delivery project. DCA health care boards have been asked to participate in a survey.

Mr. Mitchell stated that the California Framework for Regulating Health Care Delivery project is to document and improve the awareness of state government's framework for regulating health care facilities, clinics, agencies and the health care professionals who provide health care.

Mr. Mitchell informed the members that the board's website has been updated to include the following: the latest edition of the PA Laws and Regulations, information about renewal fee waiver for active duty military personnel, and information about the new 800 series reporting requirements.

Mr. Mitchell provided an update on the regulations for Sponsored Free Health Care Events. The rulemaking file has been reviewed and approved by DCA and the regulatory package was sent to the Department of Finance on 8 May 2013 for their review. Upon their approval the package will be sent to the Office of Administrative Law for review and approval.

c. Licensing Program Activity Report

Between January 1, 2013, and April 1, 2013, 130 physician assistant licenses were issued. As of April 1, 2013, 8,961 physician assistant licenses are renewed and current.

e. Diversion Program Activity Report

As of April 1, 2013, the Diversion Program has 17 participants, which includes 2 self-referred participants and 15 Board referrals, for a total of 107 participants since program implementation in 1990.

f. Enforcement Program Activity Report

Between July 1, 2012 and March 31, 2013, 209 complaints were received; 96 complaints are pending; 41 investigations are pending; 43 probationers, and 25 cases awaiting administrative adjudication at the Office of the Attorney General.

6. **Department of Consumer Affairs**
   a. Director's Update
   b. Executive Officer Performance Evaluation Process and Discussion

   a. Jeannie Wong of the Director's office provided the members with a brief update on department activities. Ms. Wong stated that orientation for new board members would be conducted in Southern California on July 16th 2013. Ms. Wong also stated that this training is mandatory for new board members within the first year of their appointment.
   b. President Sachs informed the members that the Department of Consumer Affairs wanted to ensure that board members are aware of the executive officer evaluation process. President Sachs explained that the executive officer evaluation is generally performed during the last meeting of the year and that a sample copy of the evaluation form was in the meeting packets for their review.

7. **Nomination and Election of Physician Assistant Board Vice-President**

The boards Vice-president position has been vacant since January 2013. Mr. Sachs made a motion to nominate Cristina Gomez-Vidal Diaz as Vice-President. No other nominations were received.

Motion was carried to elect Ms. Diaz as Vice-President for 2013.
(m/Sachs, s/Earley, motion passes)

8. **Update on Current Budget and Presentation on the Budget Process**

Jennifer Espera a budget analyst with the Department of Consumer Affairs provided the board members with information regarding our current budget and a brief overview of the budget process.

9. **Presentation from the Department of Public Health on Flouroscopy Permit Requirements for PAs**

Phillip Scott of the California Department of Public Health provided the members with an overview of fluoroscopy permit requirements and proposed regulations.

Mr. Scott stated that AB 356, which was sponsored by CAPA, became law January 1, 2010. Mr. Scott explained that the law implemented provisions of the Health and Safety Code to permit PAs who meet certain standards of education, training and experience to operate fluoroscopy equipment.

He also stated that the Department of Public Health is currently proposing regulations to implement the various provisions of AB 356. He anticipates that the regulations should be adopted in August 2013.

Mr. Scott also stated that letters have been to schools regarding the new law and proposed regulations and training requirements for PAs. Mr. Scott stated that he is encouraging PA programs to include fluoroscopy training as part of their curriculum.

10. **CLOSED SESSION**: Pursuant to Section 11126(c)(3) of the Government Code, the Board moved into closed session to deliberate on disciplinary matters

RETURN TO OPEN SESSION

11. **Discussion on Proposed Personal Presence Regulations**

President Sachs provided a brief overview of prior discussions on proposed personal presence language.

Following a brief discussion it was determined that PA staff along with board legal counsel meet with the Medical Board of California to address concerns raised by the Medical Board with regard to this regulatory proposal. It was also determined that following this meeting revised language for the regulations would be presented at the next board meeting in August 2013.

12. **Discussion of Title 16, California Code of Regulations Section 1399.546 – Reporting of Physician Assistant Supervision as it Relates to New Electronic Medical Records Technology**

President Sachs provided the members with a brief overview of operational issues relating to new electronic medical records reporting systems that are now being utilized in medical practices.

CAPA stated that they are receiving many calls regarding this issue.

Laura Freedman, Senior Staff Counsel, Dept. of Consumer Affairs (DCA) stated that she would review the current laws and regulations to determine if there are measures that may be implemented to address this issue. Ms. Freedman also stated that since this is a scope of practice issue, any regulatory changes would have to be approved and adopted by the Medical Board of California.

13. **Requests for Interviews of Board Members**

President Sachs informed the members that recently staff has received a number of requests to interview board members. President Sachs stated that generally the requests are from high school students seeking information about the PA profession. President Sachs also stated that staff has been receiving requests to interview board members from students in PA programs as part of an assignment. Following a discussion, the members decided that if staff receives a request for interviews from high school students members agree to be interviewed. However, if the requests are from PA students members won't be able to respond due to the number of students involved.

14. **Update on BreEZe Implementation**

Mr. Mitchell stated that BreEZe is a new computer system designed to replace two legacy computer systems, ATS and CAS. These systems impact the licensing, verification, and enforcement processes.

Mr. Mitchell also stated that user acceptance testing on the new system continues. The vendors and DCA are working with the boards to ensure that a quality product is in place prior to the go live implementation date. At this time DCA is negotiating with the vendors to establish a go-live date.

15. **Consideration of Establishing a Legislation Committee and Appointment of Committee Members**

Following a discussion, the board members expressed an interest in establishing a Legislation Committee. The purpose of the committee would be to review legislation that would impact the board, licensees and consumers, and make recommendations to the board regarding possible positions on proposed legislation.

President Sachs suggested that the committee should consist of two board members. President Sachs recommended that Catherine Hazelton and Sonya Earley be appointed to the Legislation Committee

A motion as made to create a Legislation Committee consisting of Catherine Hazelton and Sonya Earley.
(m/Grant, s/Earley, motion passes)

16. **Consideration of Legislation of Interest to the Physician Assistant Board**
AB 154, AB 186, AB 1057, SB 305, SB 352, SB 491, SB 492, SB 493, SB 494, SB 809, other bills introduced or amended after publication of the agenda

The Board briefly discussed current legislation of interest. President Sachs stated that CAPA has sponsored two bills, SB 352 and SB 494.

Following discussion a motion was made to take a "support" position on Senate Bill 352. Board staff was directed to prepare and send a letter of support to the bill's author.
(m/Grant, s/Diaz, motion passes)

Ms. Freedman also brought to the boards attention, SB 304. SB 304 would impact the board, because it proposes, among other things, to move Medical Board of California investigators to the Office of the Attorney General. The board utilizes the services of Medical Board of California investigators to investigate physician assistant complaints. The board will watch this bill.

17. **Review of and Discussion of Updating the Board's Strategic Plan**

President Sachs stated that the Boards Strategic Plan was last updated in November 2009. President Sachs indicated that DCA is encouraging all Boards to review and update their plans.

Following a brief discussion it was decided that at the August board meeting the members begin reviewing the plan.

Staff informed the board that the Department of Consumer Affairs SOLID Training Office will assist them reviewing, updating, revising, or replacing the current plan.

18. **Agenda Items for Next Meeting**

a. Strategic Plan
b. Report from Legislative Committee
c. BreEZe Update
d. Presentation on Access to Care/Workforce Issues
e. Mandated Reporting Requirements for PAs
f. Presentation from Maximus
g. Fluoroscopy Permit Requirements Update

19. **Adjournment**

The meeting adjourned at 2:45 P.M.

AGENDA ITEM

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AGENDA ITEM 5c
26 August 2013

PHYSICIAN ASSISTANT BOARD

LICENSING PROGRAM ACTIVITY REPORT

INITIAL LICENSES ISSUED

	1 April 2013 – 1 August 2013	1 April 2012 – 1 August 2012
Initial Licenses	217	220

SUMMARY OF RENEWED/CURRENT LICENSES

	As of 1 August 2013	As of 1 August 2012
Physician Assistant	9,105	8,681

PHYSICIAN ASSISTANT BOARD DIVERSION PROGRAM

ACTIVITY REPORT

California licensed physician assistants participating in the Physician Assistant Board drug and alcohol diversion program:

	As of 1 July 2013	As of 1 July 2012	As of 1 July 2011
Voluntary referrals	01	06	06
Board referrals	13	16	20
Total number of participants	14	22	26

HISTORICAL STATISTICS

(Since program inception: 1990)

Total intakes into program as of 1 July 2013.....108

Closed Cases as of 1 July 2013

- Participant expired.....1
- Successful completion.....35
- Dismissed for failure to receive benefit.....4
- Dismissed for non-compliance.....24
- Voluntary withdrawal.....20
- Not eligible.....8

Total closed cases.....92

OTHER DCA BOARD DIVERSION PROGRAM PARTICIPANTS

(As of 1 July 2013)

Dental Board of California.....34
Osteopathic Medical Board of California.....12
Board of Pharmacy.....68

AGENDA ITEM 5E
August 26, 2013

PHYSICIAN ASSISTANT BOARD ENFORCEMENT ACTIVITY REPORT

July 1, 2012 through June 30, 2013

Submitted by: Dianne Tincher

Complaint Statistics

Pending From Previous FY	107
Received	293
Closed	286
Pending	114
At Expert Consultant	4

Violation Category of Complaints Received

Substance Abuse	2
Drug Related	21
Fraud	2
Non Jurisdictional	49
Incompetence/Negligence	116
Other	1
Unprofessional Conduct	39
Sexual Misconduct	3
Discipline by Another State	5
Unlicensed	13
Criminal	42

Investigations

Pending from Previous FY	40
Opened	73
Closed	58
Pending	55

Disposition of Closed Complaint

Closed with merit	128
Closed/Insufficient Evidence	158

Criminal Complaint

Referred to District Attorney	0

Current Probationers

Active	45
Tolled	12
Cost Recovery Ordered	$30,361
Cost Recovery Received	$54,731

Disciplinary Decisions

License Denied	0
Nonadopted	5
Probation	6
Public Reprimand/Reproval	2
Revocation	3
Voluntary Surrender	2
Probationary Licenses	4
Petition for Reinstatement Denied	0
Petition for Reinstatement Granted	0
Petition for Termination of Probation Denied	0
Petition for Termination of Probation Granted	0
Other	0
Out for Vote	2

Accusation/Statement of Issues

Accusation Filed	18
Accusation Withdrawn	0
Statement of Issues Filed	3
Statement of Issues Withdrawn	0
Petition to Revoke Probation Filed	1
Petition to Compel Psychiatric Exam	0
Interim Suspension Orders (ISO)/PC23	4

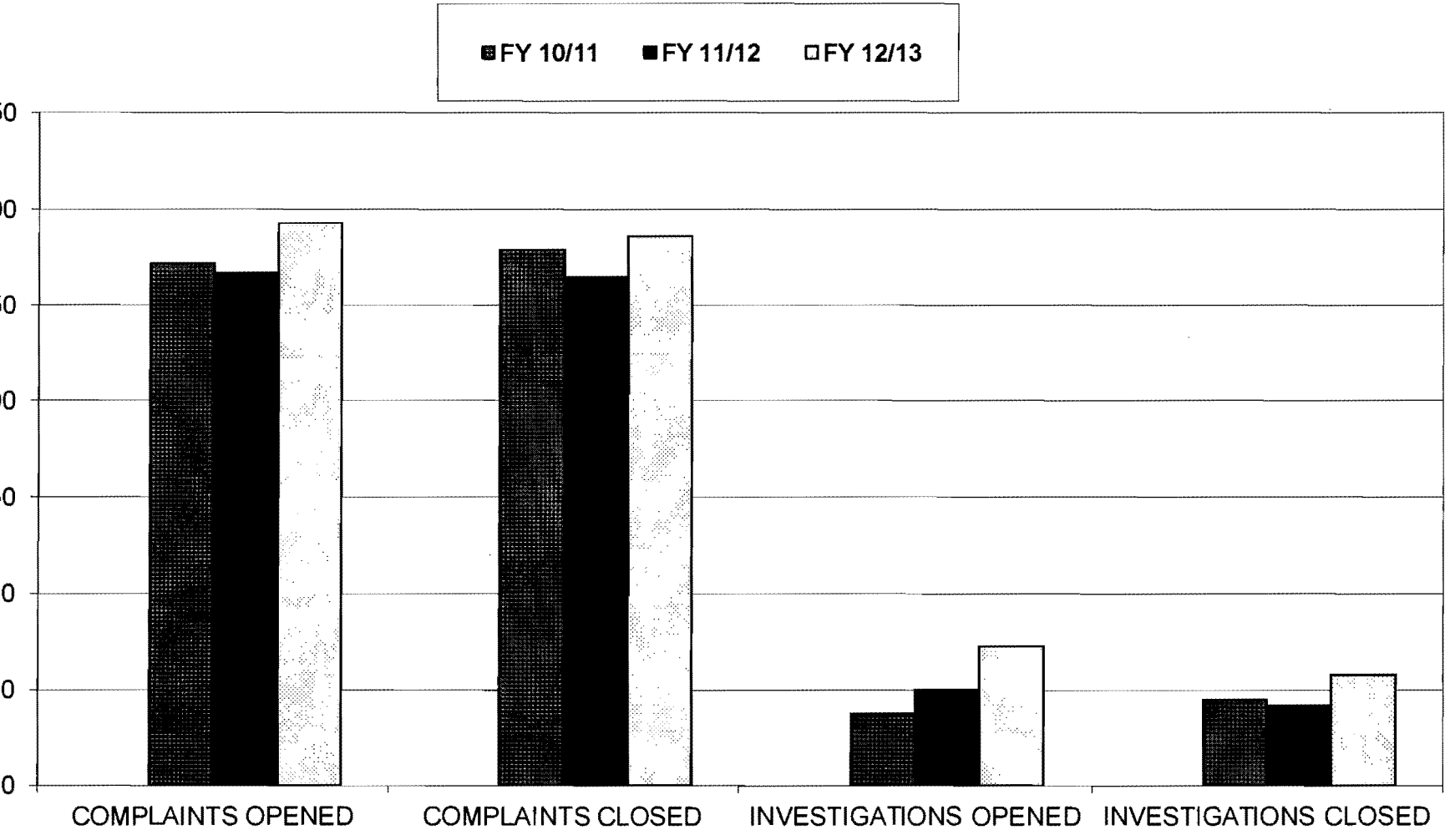
Pending Cases

Attorney General	31

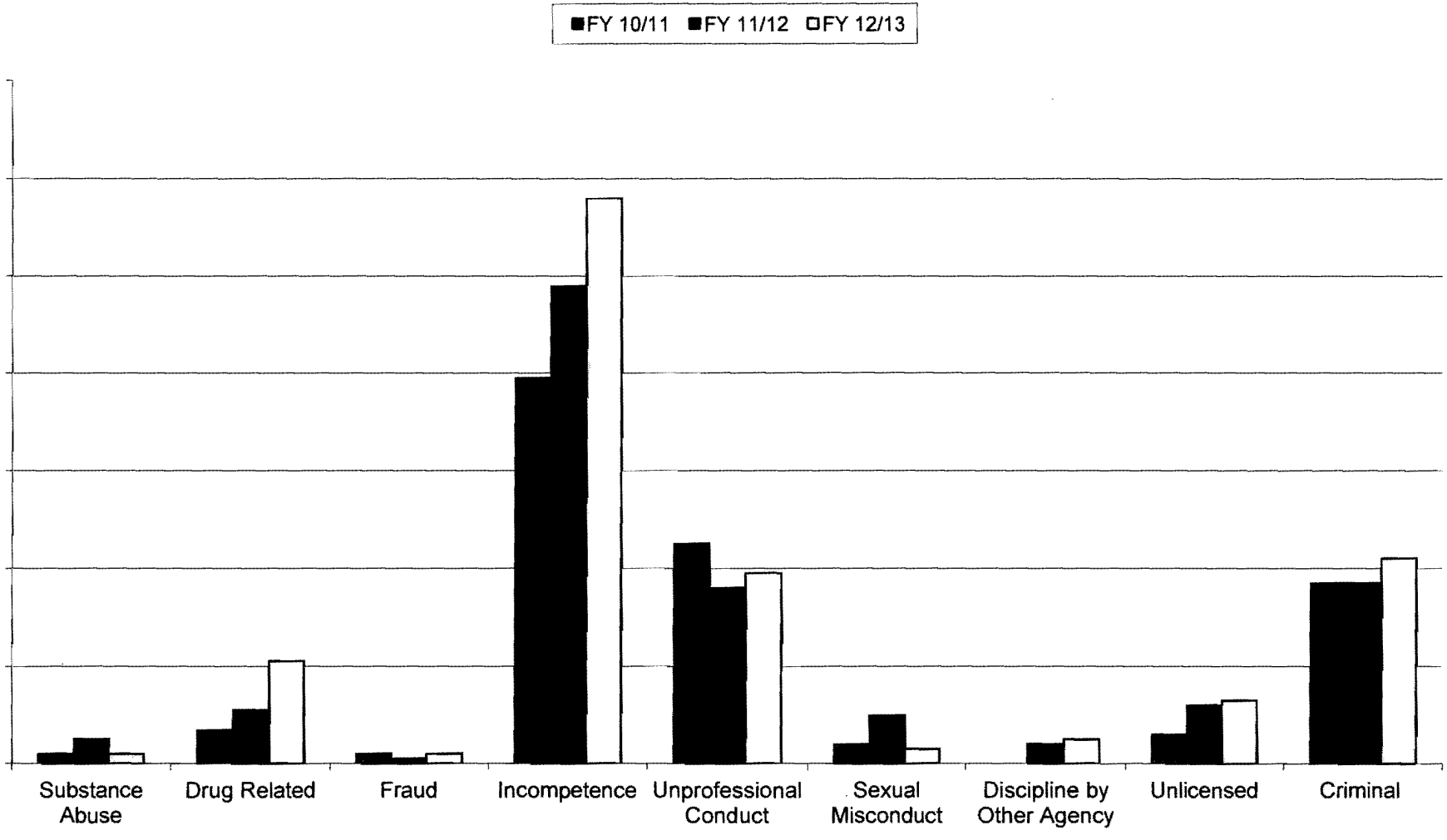
Citation and Fines

Pending from previous FY	0
Issued	9
Closed	6
Withdrawn	0
Sent to AG/noncompliance	0
Pending	3
Initial Fines Issued	$5600
Modified Amount Due	$0
Fines Received	$5250

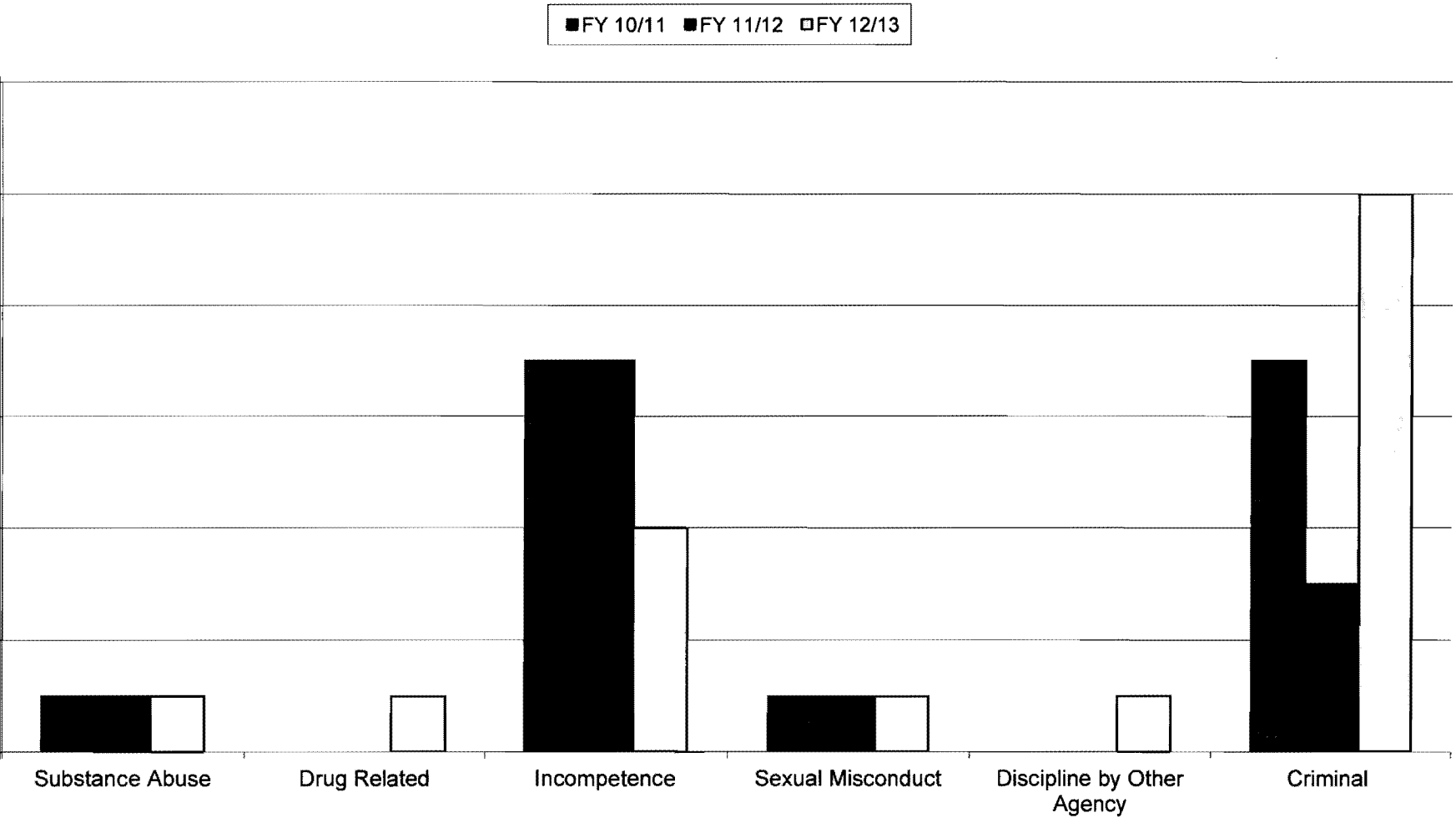
PHYSICIAN ASSISTANT BOARD
COMPLAINTS AND INVESTIGATIONS
JULY 1 THROUGH JUNE 30



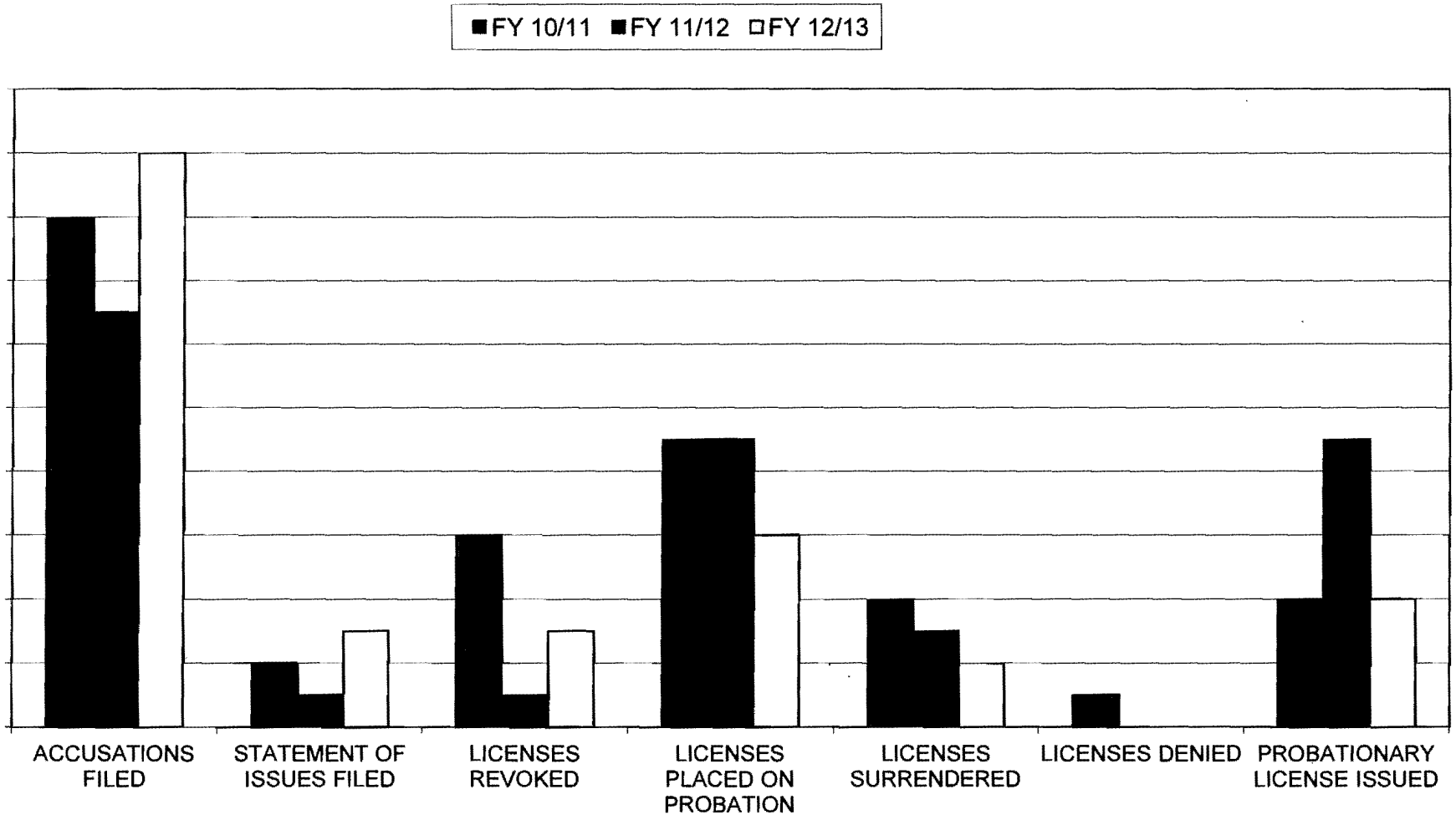
PHYSICIAN ASSISTANT BOARD
CATEGORY OF COMPLAINTS RECEIVED
JULY 1 THROUGH JUNE 30



PHYSICIAN ASSISTANT BOARD
CATEGORY OF ACCUSATIONS FILED
JULY 1 THROUGH JUNE 30



PHYSICIAN ASSISTANT BOARD
DISCIPLINARY ACTIONS
JULY 1 THROUGH JUNE 30



Physician Assistant Board
Cases Over 8 Months Old
As of June 30, 2013

Formal Investigations

Total Number of Formal Investigations pending: 55

Number of Investigations over 8 months old: 19

Status of Cases over 8 months old:

# of cases	Status
10	Scheduling/subpoena for interview/records
3	At expert review
3	Finishing final report
2	Working with other law enforcement agencies
1	Waiting for conclusion of criminal case

Disciplinary Actions

Total Number of Disciplinary Cases pending: 31

Number of Disciplinary Cases over 8 months old: 7

Status of Cases over 8 months old:

# of cases	Status
1	Waiting Decision Effective Date
1	Non-Adopt
4	Waiting for hearing
1	Additional investigation

Physician Assistant Board
Cost Recovery
As of June 30, 2013

Cost Recovery	Amount	# of Licensee
Ordered over last 5 years	**$ 421,616**	**55**
Received over last 5 years	**$ 153,149**	**46**
Outstanding balance (Current Probationers)	**$ 88,537**	**20**
Uncollectable amount*	**$ 190,236**	**12**

*The uncollectable amount is from licensees that surrendered the license, were revoked, and/or sent to FTB over the last 5 years. For surrendered licenses, the cost recovery would be required to be paid in full if they apply for reinstatement of the license.

AGENDA ITEM

8

AGENDA ITEM # 8A

DRAFT

GENERAL AREA: Legislation

SPECIFIC SUBJECT: Legislative Committee – Role and Operating Procedures

STATEMENT:

Role of Committee and Basic Operating Procedures

1. The Physician Assistant Board Legislative Committee ("the committee") is created to identify legislation about which the Physician Assistant Board of the State of California ("the board") may want to be notified and/or take a position.

2. The committee shall be comprised of two members appointed by the President/Chair.

3. The committee reviews state legislation relevant to the board or the education or practice of physician assistants in California. The committee may place on the agenda of the board's public meetings legislation it recommends the board consider. The committee may recommend the board adopt a support, oppose, watch or other position on legislation as defined in the Policy Manual (Legislation, page 26). The committee or the board may suggest additional actions, including but not limited to sending letters to the legislature, recommending amendments to legislation or testifying at legislative hearings.

4. The committee's recommendation may be distributed/included with the board's agenda package, if available. Board members may use the materials to take a position at those meetings if so desired.

5. The board's staff should provide the committee with guidance on selecting and understanding legislation, as further defined below.

6. At board meetings, the committee, or any individual board members, may ask the board to take a position regardless of whether a specific position was recommended in advance of the board meeting.

7. If the board chooses to send the Legislature a letter of support, opposition or another position on specific legislation, the staff drafts the letter based on the board's decision, and the committee chair approves the letter. If the committee chair is unavailable, the other committee member or the President/Chair may sign the letter. On behalf of the board, the staff sends the approved letter to the author, and any other recipients designated by the committee, including the committee reviewing the legislation, the department, or other relevant individuals.

8. In recognition of the limited time and resources committee members have to review legislation, committee members are not expected to spend more than 30 hours per year evaluating legislation, preparing recommendations and preparing follow-up materials.

Sources of information

1. The board, its members, and the board's staff may ask the committee to review specific pieces of legislation.

2. Committee will consider any relevant bills identified by the Medical Board of California, Department of Consumer Affairs' legislative office (DCA), and California Academy of Physician Assistants (CAPA) or other health care related organizations or agencies.

    a. Staff seeks lists and analyses of bills relevant to physician assistants and shares with committee members

    b. Staff provides committee members with contact information for DCA, or other individuals at the aforementioned organizations and others they may contact for additional information

3. Committee members review recent legislative committee and floor analyses to learn about key issues, fiscal and policy impacts, and supporters and opponents. In some cases, it may also be helpful to review legislative language, particularly if a bill has not yet been reviewed by a state legislative committee. Analysis, legislative language, votes and other official information is available here: http://leginfo.legislature.ca.gov/faces/billSearchClient.xhtml.

4. Optionally, committee members may want to conduct additional review, such as contacting the author's office to request a fact sheet or clarification or conducting an internet news search for reactions to the legislation.

Preparing for board meetings

1. At least one month prior to board meetings, staff will provide the committee members with a relevant bill lists as noted above.

2. The committee members review the materials obtained from the above sources and, at least three weeks prior to board meetings, determine and/or develop agenda items and materials.

3. At least two weeks before board meetings, committee members send staff agenda items and materials for any legislation the committee wants the board to consider.

4. Materials sent to the board will include the summary document prepared by the committee, the most recent, relevant bill language, and analysis of bills in question. The summary document may include recommended positions and a brief explanation of the recommendation. At least one copy of the text of the bill will be available at the board meeting

5. At board meetings, the committee, or any individual board members may make a motion that the board take a position on a bill.

NECESSITY:

The Physician Assistant Board needs a method to be informed of proposed legislation so that, where appropriate, it may take a position on bills. This structure allows the board to receive timely notice of relevant bills so that it may take considered, reasoned, and consistent positions and actions regarding proposed legislation.

REVIEWED BY THE LEGISLATION COMMITTEE AND APPROVED FOR PRESENTATION TO THE PHYSICIAN ASSISTANT BOARD: [_____]
APPROVED BY THE PHYSICIAN ASSISTANT BOARD: [_____]

or	Vote summary	Status as of August 15, 2013	Summary	Considerations for PAB	Position/Recommendation
s (D) -- San	Party line	Passed Asm and Sen committees; now on Senate floor	Allows PAs, NPs and CNMs to provide first trimester abortions after receiving required training.	UCSF studied pilot project allowing PAs, NPs and CNMs to provide such abortions and found no health/safety issues. Bill expands scope of practice for PAs and provides additional health care options in rural and other under-served regions where PAs tend to work and abortion providers are limited. Includes appropriate limits such as first trimester only and supervision by physician. CAPA, CMA, Board of Registered Nursing and pro-choice groups support. Opponents primarily religious and/or pro-life groups.	
nschein (R) - Diego	Passed Asm with only 1 "no" vote	Passed Asm. In Senate, awaiting second hearing in Business, Professions and Economic Development	Requires boards under DCA (including PAB) to issue a 18-month temporary license to the spouse or domestic pratner of a military member on active duty licensed in another state.	Other boards "support if amended" to require documentation such as transcripts and/or proof of license be provided and to allow boards to revoke if problems arise. At last PAB meeting, board discussed bill and learned that wait time to receive PAB license is typically very short, like 4 weeks. As a result, the board expressed limited interest in supporting the bill given limited likely effect. Board might want to consider support based on historical ties to military community. Board may want to ask PAB staff about impact: Any anticipated complications to implement? How would the licensing timeline for these applicants change? Should PAB request amendments similar to MBC and BBS?	
na (D) -- side	Passed Asm and Sen BPE with no "no" votes	Passed Asm and Senate committees; now on Senate Floor	Requires DCA licensing boards, including PAB, to ask on license application whether applicant serves in military or has in past.	Would flag for boards applications that may be entitled to special processing due to military status and allow for easier data collection regarding job placement of military personnel and veterans. Board might want to consider support based on historical ties to military community. Board may want to ask PAB staff about potential impact: Does PAB currently offer special processing or rules for military? Cost or other implementation concerns? Also, it would be helpful for staff to explain how military credits affect licensure.	
D) -- nce	Passed Senate and Asm BPC committee with only 2 "no" votes each	Asm Approps	As part of process to extend MBC sunset four years, would have moved licensing board investigators to AGs office. Bill amended to move investigators to DCA so legislature has oversight. Bill includes other MBC sunset-related clean-up provisions including items related to veterinerians.	Addresses concerns over quality of MBC investigation. At last meeting, board members expressed concern that instigations could move more slowly if moved to AGs office. With proposed shift to DCA, it's not clear what the effect on PAs would be, although it appears it could be a positive move if DCA provides appropriate staff oversight. Board may want to ask CAPA/PAB staff: What is potential impact on PAB investigations?	

ley (D) -- ura Hills	Passed Senate and Assembly with only 2 "no" votes	Back to Senate for concurrence with Asm amendments	Allows medical assistants (MAs) to perform technical supportive services, in doctor's offices and all medical clinics, under the supervision of a PA, NP or CNM without a physician on the premises.	Sponsored by CAPA; PAB sent letter of support in May.	PAB supported in May 2013
nning (D) -- mei	Passed Senate Floor and Asm. Health with no "no" votes	Asm Approps	Allows physician to increase patient caseload by 1000 patients if supervising a PA.	Helps address demand issues, expected to increase under ACA. May lead to expansion of PA practice in CA. At the last meeting, one board member raised questions about the potential for dimished quality of care if physician caseloads expand by 1750, as proposed at the time. Other board members and staff were not concerned and bill has since been amended to expand caseload by only 1000 patients. Sponsored by CAPA; supported by CMA and AARP.	
nberg (D) -- ramento, De lnier (D) -- cord	Faced Republican opposition in Senate, until amended on Senate Floor; later unanimous on Senate Floor and in Asm Pub Safety	Asm Business, Professsions and Consumer Protection	Would charge PAs and other medical professionals $6 per year to update and maintain the Controlled Substance Utilization Review and Evaluation System (CURES) and Prescription Drug Monitoring Program (PDMP), requires all prescribing health care practitioners to apply to access CURES information, and establishes processes and procedures for regulating prescribing licensees through CURES and securing private information.	System allows PAs to seek info about patients to whom they are prescribing controlled substances, resulting in better patient care and public safety. AG and others recommend support because funding is in crisis and program will expire without dedicated funds. Former opposition from pharma because of fees to industry was removed when pharma contributions were made voluntary.	
			Committee removed from review list bills regarding scope of practice for related professions such as NPs (SB 491, 492 and 493). However, committee suggests PAB ask CAPA and/or PAB staff to identify any concerns these bills may raise regarding overlapping scope of practice with PAs. Additionally, committee recommends discussion of a similar expanded scope of practice bill for PAs (i.e. Why wasn't such a bill intorduced this year? Is there reason to introduce one in the future?).		

California LEGISLATIVE INFORMATION

AB-154 Abortion. (2013-2014)

AMENDED IN SENATE JUNE 24, 2013

AMENDED IN ASSEMBLY APRIL 30, 2013

AMENDED IN ASSEMBLY MARCH 19, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

ASSEMBLY BILL **No. 154**

Introduced by Assembly Member Atkins
(Principal Coauthor(s): Senator Jackson)
(Coauthor(s): Assembly Member Mitchell, Skinner)

January 22, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

AB 154, as amended, Atkins. Abortion.

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

Existing law, the Nursing Practice Act, provides for the licensure and regulation of registered nurses, including nurse practitioners and certified nurse-midwives, by the Board of Registered Nursing. Existing law, the Physician Assistant Practice Act, provides for the licensure and regulation of physician assistants by the Physician Assistant Board within the jurisdiction of the Medical Board of California.

This bill would instead make it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform an abortion if the person does not have a valid license to practice as a physician

aspiration techniques in the first trimester of pregnancy if he or she holds a license or certificate authorizing him or her to perform the functions necessary for an abortion by medication or aspiration techniques. The bill would also require a nurse practitioner, certified nurse-midwife, or physician assistant to complete training, as specified, and to comply with standardized procedures or protocols, as specified, in order to perform an abortion by aspiration techniques, and would indefinitely authorize a nurse practitioner, certified nurse-midwife, or physician assistant who completed a specified training program and achieved clinical competency to continue to perform abortions by aspiration techniques. The bill would delete the references to a nonsurgical abortion and would delete the restrictions on assisting with abortion procedures. The bill would also make technical, nonsubstantive changes.

Because the bill would change the definition of crimes, the bill would impose a state-mandated local program.

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

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

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

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

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

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

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

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

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

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

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

(b) In order to perform an abortion by aspiration techniques pursuant to Section 2253, a person with a license or certificate to practice as a nurse practitioner or a certified nurse-midwife shall adhere to standardized procedures developed in compliance with subdivision (c) of Section 2725 that specify all of the following:

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

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

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

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

(5) The method of periodic review of the provisions of the standardized procedures.

(c) A nurse practitioner or certified nurse-midwife who has completed training and achieved clinical competency through HWPP No. 171 shall be authorized to perform abortions by aspiration techniques pursuant to Section 2253, in adherence to standardized procedures described in subdivision (b).

(d) It is unprofessional conduct for any nurse practitioner or certified nurse-midwife to perform an abortion by aspiration techniques pursuant to Section 2253 without prior completion of training and validation of clinical competency.

SEC. 3. Section 3502.4 is added to the Business and Professions Code, to read:

3502.4. (a) In order to receive authority from his or her supervising physician and surgeon to perform an abortion by aspiration techniques pursuant to Section 2253, a physician assistant shall complete training either through training programs approved by the board pursuant to Section 3513 or by training to perform medical services which augment his or her current areas of competency pursuant to Section 1399.543 of Title 16 of the California Code of Regulations. Beginning January 1, 2014, and until January 1, 2016, the training and clinical competency protocols established by Health Workforce Pilot Project (HWPP) No. 171 through the Office of Statewide Health Planning and Development shall be used as training and clinical competency guidelines to meet this requirement.

(b) In order to receive authority from his or her supervising physician and surgeon to perform an abortion by aspiration techniques pursuant to Section 2253, a physician assistant shall comply with protocols developed in compliance with Section 3502 that specify:

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.

California LEGISLATIVE INFORMATION

AB-154 Abortion. (2013-2014)

Date	Action
08/14/13	Read second time. Ordered to third reading.
08/13/13	From committee: Do pass. (Ayes 4. Noes 1.) (August 12).
07/08/13	From committee: Do pass and re-refer to Com. on APPR. (Ayes 7. Noes 2.) (July 3). Re-referred to Com. on APPR.
06/24/13	Read second time and amended. Re-referred to Com. on HEALTH.
06/20/13	From committee: Do pass as amended and re-refer to Com. on HEALTH. (Ayes 8. Noes 2.) (June 17).
06/06/13	Referred to Coms. on B., P. & E.D. and HEALTH.
05/28/13	In Senate. Read first time. To Com. on RLS. for assignment.
05/28/13	Read third time. Passed. Ordered to the Senate. (Ayes 50. Noes 25. Page 1664.)
05/24/13	Read second time. Ordered to third reading.
05/24/13	From committee: Do pass. (Ayes 12. Noes 5.) (May 24).
05/15/13	In committee: Set, second hearing. Referred to APPR. suspense file.
05/08/13	In committee: Set, first hearing. Hearing canceled at the request of author.
05/01/13	Re-referred to Com. on APPR.
04/30/13	Read second time and amended.
04/29/13	From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 13. Noes 6.) (April 23).
04/09/13	From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 9. Noes 4.) (April 9). Re-referred to Com. on HEALTH.
03/20/13	Re-referred to Com. on B.,P. & C.P.
03/19/13	From committee chair, with author's amendments: Amend, and re-refer to Com. on B.,P. & C.P. Read second time and amended.
03/19/13	Referred to Coms. on B.,P. & C.P. and HEALTH.
01/23/13	From printer. May be heard in committee February 22.
01/22/13	Read first time. To print.

SENATE RULES COMMITTEE
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THIRD READING

Bill No: AB 154
Author: Atkins (D), et al.
Amended: 6/24/13 in Senate
Vote: 21

SENATE BUSINESS, PROF. & ECON. DEVELOP. COMM.: 8-2, 6/17/13
AYES: Lieu, Block, Corbett, Galgiani, Hernandez, Hill, Padilla, Yee
NOES: Emmerson, Wyland

SENATE HEALTH COMMITTEE: 7-2, 7/3/13
AYES: Hernandez, Beall, De León, DeSaulnier, Monning, Pavley, Wolk
NOES: Anderson, Nielsen

SENATE APPROPRIATIONS COMMITTEE: 4-1, 8/12/13
AYES: De León, Hill, Lara, Steinberg
NOES: Gaines
NO VOTE RECORDED: Walters, Padilla

ASSEMBLY FLOOR: 50-25, 5/28/13 - See last page for vote

SUBJECT: Abortion: authorizations

SOURCE: ACCESS Women's Health Justice
ACLU of California
Black Women for Wellness
California Latinas for Reproductive Justice
NARAL Pro-Choice California
Planned Parenthood Affiliates of California

with specified standardized procedures or protocols, to perform an abortion by aspiration techniques during the first trimester of pregnancy.

ANALYSIS:

Existing law:

1. Establishes the Reproductive Privacy Act (Act) which:

   A. Makes legislative findings that every individual possesses a fundamental right of privacy with respect to personal reproductive decisions.

   B. Defines the terms "abortion" as any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth; "pregnancy" as the human reproductive process, beginning with the implantation of an embryo; "state" as the State of California, and every county, city, town and municipal corporation, and quasi-municipal corporation in the state; and "viability" as the point in a pregnancy when, in the good faith medical judgment of a physician, on the particular facts of the case before that physician, there is a reasonable likelihood of the fetus' sustained survival outside the uterus without the application of extraordinary medical measures.

   C. Provides that the state may not deny or interfere with a woman's right to choose or obtain an abortion prior to viability of the fetus, or when the abortion is necessary to protect the life or health of the woman.

   D. Specifies that the performance of an abortion is unauthorized if either of the following is true: (1) the person performing or assisting in performing the abortion is not a health care provider authorized to perform or assist in performing an abortion pursuant to Section 2253 of the Business and Professions Code; or (2) the abortion is performed on a viable fetus, and it is established that in the good faith medical judgment of the physician, the fetus was viable, and in the good faith medical judgment of the physician, continuation of the pregnancy posed no risk to the life or health of the pregnant woman.

2. Provides that failure to comply with the Reproductive Privacy Act in performing, assisting, procuring or aiding, abetting, attempting, agreeing or offering to procure an illegal abortion constitutes unprofessional conduct

3. Makes it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform or assist in performing a surgical abortion, and at the time of so doing, does not have a valid, unrevoked, and unsuspended license to practice as a physician and surgeon, or to assist in performing a surgical abortion without a valid, unrevoked, and unsuspended license or certificate obtained in accordance with some other provision of law that authorizes him/her to perform the functions necessary to assist in performing a surgical abortion.

4. Makes it a public offense, punishable by a fine not exceeding $10,000 or imprisonment, or both, for a person to perform or assist in performing a nonsurgical abortion if the person does not have a valid, unrevoked, and unsuspended license to practice as a physician and surgeon, or does not have a valid, unrevoked, and unsuspended license or certificate obtained in accordance with some other provision of law that authorizes him/her to perform or assist in performing the functions necessary for a nonsurgical abortion.

5. Provides that "nonsurgical abortion" includes the termination of pregnancy through the use of pharmacological agents.

6. Provides that the practice of nursing may be performed under "standardized procedures," as defined, for specified functions, treatments and procedures.

This bill:

1. Declares that it is unprofessional conduct for any NP, CNM, or PA to perform an abortion by medication or aspiration techniques in the first trimester of pregnancy without completing training and validation of clinical competency.

2. Deletes obsolete references to "performing, assisting, procuring or aiding, abetting, attempting, agreeing or offering to procure an illegal abortion" in regards to what constitutes unprofessional conduct for failure to comply with the Reproductive Privacy Act.

3. Deletes obsolete references to "surgical" and "nonsurgical" abortions and replaces the terms as necessary with abortion by "medication" or "aspiration techniques."

4. Deletes obsolete references to "assisting" in performing an unauthorized

5. States that a person is not guilty of the public offense of practicing medicine without the appropriate legal authorization if he/she performs an abortion by aspiration techniques in the first trimester of pregnancy while having a valid, unrevoked and unsuspended license or certificate authorizing him/her to perform an abortion by aspiration technique, as specified.

6. Notwithstanding any other provision of this bill, requires a NP or CNM to complete training recognized by the Board of Registered Nursing in order to perform an abortion by aspiration techniques.

7. Requires the competency-based training protocols established by Health Workforce Pilot Project No. 171 (HWPP #171) through the Office of Statewide Health Planning and Development (OSHPD) to be utilized from January 1, 2014, until January 1, 2016.

8. Authorizes NPs or CNMs who have completed the HWPP #171 training, achieved clinical competency and adhere to specified standardized procedures to perform abortions by aspiration techniques.

9. Requires an NP and CNM to adhere to standardized procedures in order to perform an abortion by aspiration techniques that must specify all of the following: (a) the extent of supervision by a physician and surgeon with relevant training and expertise; (b) procedures for transferring patients to the care of the physician and surgeon or a hospital; (c) procedures for obtaining assistance and consultation from a physician and surgeon; (d) procedures for providing emergency care until physician assistance and consultation are available; and (e) the method of periodic review of the provisions of the standardized procedures.

10. Requires a PA to complete training either through training programs approved by the Physician Assistant Board or by training to perform medical services which augment his/her current areas of competency, as specified, in order to receive authority from his/her supervising physician and surgeon to perform an abortion by aspiration techniques; further requires the training and clinical competency protocols established by HWPP #171 through OSHPD to be used as training and clinical competency guidelines to meet this requirement from January 1, 2014, through January 1, 2016.

11. Deems the training protocols established by HWPP #171 to meet the Physician

12. Authorizes a PA who has completed the HWPP #171 training, achieved clinical competency, received authority from his/her supervising physician and surgeon, and acts according to specified protocols, to perform abortions by aspiration techniques.

    A. Requires a PA, in order to receive authority from his/her supervising physician and surgeon to perform an abortion by aspiration techniques, to comply with protocols that specify: (a) the extent of supervision by a physician and surgeon with relevant training and expertise; (b) procedures for transferring patients to the care of the physician and surgeon or a hospital; (c) procedures for obtaining assistance and consultation from a physician and surgeon; (d) procedures for providing emergency care until physician assistance and consultation are available; and (e) the method of periodic review of the protocols.

Background

Reproductive Privacy Act. The Reproductive Privacy Act codified the constitutional principles of *Roe v. Wade* and replaced in its entirety the Therapeutic Abortion Act. In 1967, Governor Ronald Reagan signed the Therapeutic Abortion Act, which expanded legal abortion in California under very restrictive criteria. Most of those restrictions were subsequently ruled unconstitutional in the 1972 California Supreme Court case, *People v. Barksdale* (1972). The United States Supreme Court issued its landmark *Roe v. Wade* (1973), and *Doe v. Bolton*, decisions in 1973, which invalidated two of the three remaining provisions of the Therapeutic Abortion Act.

Although *Roe* and *Barksdale* rendered much of the Therapeutic Abortion Act obsolete, the Act itself was not repealed by the Legislature until 2003, pursuant to SB 1301 (Kuehl, Chapter 385, Statutes of 2002), the Reproductive Privacy Act. One rationale for the passage of this Act was the concern that the United States Supreme Court may overturn *Roe v. Wade*, and it would, therefore, be important to have a state law which would protect reproductive rights in the State of California.

Aspiration technique and procedure. Vacuum or suction aspiration uses aspiration to remove uterine contents through the cervix. It may be used as a method of induced abortion, a therapeutic procedure used after miscarriage or a procedure to obtain a sample for endometrial biopsy. The rate of infection is lower than any other surgical abortion procedure at 0.5%. Some sources may use the terms

Vacuum aspiration may be used as a method of induced abortion, as a therapeutic procedure after miscarriage, to aid in menstrual regulation and to obtain a sample for endometrial biopsy. It is also used to terminate molar (abnormal) pregnancy. When used as a miscarriage treatment or an abortion method, vacuum aspiration may be used alone or with cervical dilation anytime in the first trimester (up to 12 weeks gestational age). For more advanced pregnancies, vacuum aspiration may be used as one step in a dilation and evacuation procedure. Vacuum aspiration is the procedure used for almost all first-trimester abortions in many countries.

Vacuum aspiration is an outpatient procedure that generally involves a clinic visit of several hours. The procedure itself typically takes less than 15 minutes. Suction is created with either an electric pump (electric vacuum aspiration or EVA) or a manual pump (manual vacuum aspiration or MVA). Both methods use the same level of suction, and so can be considered equivalent in terms of effectiveness and safety. The clinician may first use a local anesthetic to numb the cervix. Then, the clinician may use instruments called "dilators" to open the cervix, or sometimes medically induce dilation with drugs. Finally, a sterile cannula is inserted into the uterus and attached via tubing to the pump. The pump creates a vacuum which empties uterine contents. After a procedure for abortion or miscarriage treatment, the tissue removed from the uterus is examined for completeness. Expected contents include the embryo or fetus as well as the decidua, chorionic villi, amniotic fluid, amniotic membrane and other tissue. Post-treatment care includes brief observation in a recovery area and a follow-up appointment approximately two weeks later.

HWPP Study #171. In 2007, the Advancing New Standards in Reproductive Health (ANSIRH) program at the University of California, San Francisco, Bixby Center for Global Reproductive Health sponsored HWPP #171. The purpose of the program was to evaluate the safety, effectiveness and acceptability of NPs, CNMs, and PAs in providing first-trimester aspiration abortion. Until September 2012, HWPP #171 operated under the auspices of California's Office of Statewide Health Planning and Development (OSHPD) to improve health care access. For the duration of the project, OSHPD provided a mechanism to temporarily suspend laws and regulations that might otherwise restrict NPs, CNMs and PAs from performing aspiration abortions. The results of the HWPP #171 study were published in the *American Journal of Public Health* (AJPH) on January 17, 2013. The study analyzed 11,487 aspiration procedures performed on patients in their first trimester of pregnancy. Physicians performed 5,812 of the procedures and the

performed aspirations was 1.8%, as compared to physicians' rate of 0.9%. The study further noted that the majority of complications were minor and "complication rates from aspiration abortions performed by recently trained NPs, CNMs, and PAs were statistically no worse than those performed by the more experienced physician group." The study also noted that only 1 additional complication would occur for every 120 procedures as a consequence of having a NP, CNM or PA perform the procedure.

Legislative Counsel's Opinion on aspiration abortion. Legislative Counsel was recently asked whether existing law authorizes an NP, CNM, or PA to perform an aspiration abortion. On April 6, 2012, Counsel opined that existing law does not authorize an NP, CNM or PA to perform an aspiration abortion. Counsel reached the conclusion that an aspiration abortion is a surgical abortion, as that term is used in BPC Section 2253 (b)(1), and, consequently may be performed only by a licensed physician and surgeon.

Waiver for HWPP #171. While the original HWPP #171 application stated that aspiration abortions are within the legal authority of NPs, CNMs and PAs, the application was amended prior to the pilot project approval to reflect the uncertainty of that assertion and the need for suspending BPC Section 2253. The approved version of the application states in relevant part, "There is a discrepancy of opinion among health care professionals, boards and organizations as to whether advanced practice clinicians are prohibited from performing aspiration abortion under BPC Section 2253. Because of this discrepancy in interpretation, ANSIRH seeks a waiver of BPC Section 2253 for trainees participating in the pilot project for the duration of the project." This amendment in the application was in response to the disagreement within the health professional community as to whether aspiration abortion should be classified as surgical or nonsurgical abortion, and, therefore, whether the identified health professionals could legally perform aspiration abortion procedures. The suspension of BPC Section 2253, along with the Title 22 California Code of Regulations (CCR) Section 75043 and Title 16 CCR Section 1399.541, was deemed necessary for these clinicians to legally provide aspiration abortions. A waiver of these provisions was therefore granted by the OSHPD with the approval of the HWPP #171 application on March 31, 2007.

Comments

According to the author, "Early abortion access is a critical public health issue. An

limited number of physicians providing the services in their communities...By authorizing trained and qualified health professionals to provide care, this measure would allow women to receive timely care locally from advanced trained practitioners they already know and trust through a more responsive health care delivery system."

According to the author's office, many NP, CNM and PA programs provide instruction on unintended pregnancy care including medication abortion. Some programs teach uterine aspiration for treating common women's health conditions such as uterine bleeding problems, miscarriage management, or for gynecological cancer diagnosis. These training programs are approved by national accreditation bodies as well as state regulatory agencies.

There are also opportunities for NPs, CNMs and PAs to obtain post-graduate continuing education for early abortion care. This training is currently offered by national professional organizations that are required to meet national accreditation standards established by the Department of Education and health professional accreditation boards (American Nurses Credentialing Center, American Association of Nurse Practitioners, American College of Nurse-Midwives, American Academy of Physician Assistants, and the Accreditation Council for Graduate Medical Education). Further, these nationally accredited continuing education providers are approved by the Board of Registered Nursing and the Physician Assistant Board. For example, numerous published abortion training curricula and guidelines exist through the Association of Reproductive Health Professionals and the National Abortion Federation which provide competency-based training in comprehensive early abortion care including medication/aspiration abortion procedures.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

- One-time costs up to $150,000 for the adoption or revision of regulations by the Board of Registered Nursing (Board of Registered Nursing Fund).

- One-time costs up to $150,000 for the adoption or revision of regulations by the Medical Board of California (Contingent Fund of the Medical Board of California).

impact on state programs is not known, the bill is not likely to increase overall state spending on those programs.

By authorizing more health care providers to provide first trimester aspiration abortions, it is possible that this bill will increase the overall number of abortions performed in the state. However, this impact is uncertain. It is not known whether limitations in the number of providers for first trimester abortions actually limits the number of abortions that are performed in the state. Currently, women who desire a first trimester abortion and face a shortage of providers may travel to an area where services are available or delay their abortion until later in the pregnancy. In such cases, this bill will not increase the overall number of abortions. Given that the cost to provide a first trimester aspiration abortion is less than the cost to provide a second trimester surgical abortion, greater access to first trimester aspiration abortions may reduce state health care costs.

SUPPORT: (Verified 8/14/13)

ACCESS Women's Health Justice (co-source)
ACLU of California (co-source)
Black Women for Wellness (co-source)
California Latinas for Reproductive Justice (co-source)
NARAL Pro-Choice California (co-source)
Planned Parenthood Affiliates of California (co-source)
ACT for Women and Girls
American College of Nurse-Midwives
American Nurses Association\California
Asian Communities for Reproductive Justice
Bay Area Communities for Health Education
Board of Registered Nursing
Business and Professional Women of Nevada County
California Academy of Physician Assistants
California Association for Nurse Practitioners
California Church IMPACT
California Communities United Institute
California Family Health Council
California Medical Association
California National Organization for Women
California Nurse-Midwives Association
California Women's Health Alliance

Cardea Institute
Center on Reproductive Rights and Justice at UC Berkeley Law
Choice USA
Citizens for Choice
Forward Together
Fresno Barrios Unidos
Khmer Girls in Action
Law Students for Reproductive Justice
League of Women Voters of California
National Asian Pacific American Women's Forum
National Association of Social Workers, California Chapter
National Center for Lesbian Rights
National Council of Jewish Women – California
National Health Law Program
National Latina Institute for Reproductive Health
National Network of Abortion Funds
Nevada County Citizens for Choice
Nursing Students for Choice- UCSF
Physicians for Reproductive Health
Planned Parenthood Advocacy Project of Los Angeles County
Planned Parenthood Mar Monte
Planned Parenthood of Santa Barbara, Ventura and San Luis Obispo Counties, Inc.
Planned Parenthood of the Pacific Southwest
Planned Parenthood Shasta Pacific Action Fund
Reproductive Justice Coalition of Los Angeles
SEIU
Students for Reproductive Justice at Stanford University
Women's Community Clinic
Women's Health Specialists of California

OPPOSITION: (Verified 8/14/13)

California Catholic Conference
Capitol Resource Family Impact
City of Shasta Lake, Greg Watkins, City Councilman
Coalition for Women and Children
Concerned Women for America
John Paul the Great Catholic University Students for Life
Life Legal Defense Fund
Pro-Life Missions International

Traditional Values Coalition
University of Southern California Students for Life

ARGUMENTS IN SUPPORT: The California Women's Health Alliance, representing 33 different organizations, including the sponsors of this bill, writes, "AB 154 is necessary. Despite California's history of supporting comprehensive reproductive health care, over half of our counties do not have an accessible abortion provider. This creates barriers to care in both rural and urban areas; in rural areas, some women have to travel five hours by train or bus and also arrange for child care and missed work. In urban areas, many women face long delays in getting medical appointments. These barriers can force women to delay abortions into later stages of pregnancy, which can result in a more complicated procedure."

Planned Parenthood Affiliates of California (sponsor), Planned Parenthood of Santa Barbara, Ventura and San Luis Obispo Counties, Inc., Planned Parenthood Mar Monte, Planned Parenthood Advocacy Project of Los Angeles County, Planned Parenthood of the Pacific Southwest and Planned Parenthood Shasta Pacific Action Fund state, "AB 154 enacts the results and findings from a multi-year study conducted by the University of California at San Francisco's Bixby Center for Global Reproductive Health, under the auspices of the Office of Statewide Health Planning and Development...The study showed exceptionally low rates of complications by both the NPs, CNMs and PAs and the physicians, affirming that aspiration abortion is an extremely safe procedure overall and safe whether performed by the trained NPs, CNMs and Pas, or by the physicians. Access to the full range of first trimester reproductive health services is an important aspect of women's health. An estimated one in three women will decide to terminate a pregnancy by age 45, yet many women often do not have sufficient access to early, safe abortions because of the limited number of physicians providing the services in their communities."

The California Medical Association notes, "When any allied health professional seeks to expand their authority or scope of practice, CMA prioritizes patient safety. Physician supervision and appropriate training and education are paramount factors in this determination. AB 154 addresses both."

The American Nurses Association\California writes, "By expanding the types of trained and qualified health professionals who can provide early abortions to include Nurse Practitioners, Certified Nurse Midwives and Physician Assistants, AB 154 removes a barrier in the law that prevents an Advanced Practice

The California Association for Nurse Practitioners (CANP) writes, "CANP acknowledges the complex personal, political, religious and professional sensitivities that surround the advancement of AB 154. First and foremost, CANP is committed to furthering the practice of nurse practitioners in California. Among CANP's core missions is the promotion of expanding the scope of practice for licensed NPs...In reaching a 'support' position, the association has concluded that AB 154 is amenable to this mission. We believe that the performance of these procedures is consistent with the education and training held by nurse practitioners. Additionally, as fewer physicians are willing or available to provide these services, it becomes important for women to have access to all types of health care services provided by non-physicians."

ARGUMENTS IN OPPOSITION: Concerned Women for America states, "The bill's proponents hold that increasing access to abortion in this manner is a 'critical public health issue.' We contend that allowing non-physicians to supervise medical abortions and perform aspiration abortions presents a critical public health issue as well. Abortion carries the potential for serious complications, including hemorrhage, uterine perforation, cervical injury and incomplete abortion. There is no need to increase the risk to patients for an elective procedure...especially in a state where, according to the Guttmacher Institute, a mere one percent of women live in a county where there is no abortion provider. The need for a very small number of women to potentially have to travel across a county line in order to obtain an elective procedure hardly seems worth the general risk to women's safety."

The Coalition for Women and Children writes, "We must put the health and safety of women first, rather than the profits of the abortion industry. The UCSF pilot project's study was done under the most highly supervised, specially selected, hygienic conditions and even then, women whose abortions were done by non-physicians experienced complication rates twice that of those women whose abortions were performed by physicians. Proponents of this bill argue that these unsafe non-physician providers will increase abortion access to women in rural counties, yet the abortion industry's own Guttmacher Institute lists California already as the #1 state in abortion provider access and publicly funded support for abortion."

Shasta Lake City Councilman Greg Watkins writes, "I strongly oppose AB 154. Women deserve the highest level of medical care, but this bill would lower the standard of care for women in California."

The University of Southern California Students for Life write, "It is surprising that the Legislature would consider approving a lowered standard of care for women. According to the UCSF pilot project's own study, abortions performed by these non-physicians have complication rates twice that of abortions performed by physicians."

San Jose Students for Life and John Paul the Great Catholic University Students for Life both write, "We urge you to put the safety of women first and vote no on AB 154."

The California Catholic Conference, Inc. argues, "The reality of a 'right' to health care, which we support, does not and should not require the government to facilitate access by weakening health standards or reclassifying medical practices...Decisions of this import, made quickly and with no consideration of unintended consequences for women's health, for future health policy, insurance rate, or government subsidized payments, etc. will set a very poor precedent, particularly at a time when the government is playing a more influential role in health care delivery through the implementation of the Federal ACA."

The Traditional Values Coalition state, "Current California Business 4826 requires that an animal abortion be performed only by a veterinary surgeon. Yet AB 154 removes the current requirement that a human abortion be performed only by a trained surgeon. Non-doctors could perform surgical abortions in AB 154 is passed...Why compromise the health of women? Why give animals a higher standard of care than human beings?"

Pro-Life Mission: International argues, "Women deserve the highest level of medical care, but this bill would lower the standard of care for women in California. Abortion is a dangerous surgical medical procedure, often leading to hemorrhage, perforation of the uterus and bowels, and sometimes death. It is one of the least regulated industries in California and a further diminution in the requirements as set out in AB 154 of those who perform the procedure will only put more women at risk."

The Capitol Resource Family Impact contends, "Women, and certainly young girls who are given access in this state to abortion at 12 years of age, are unaware of the complications that even a first term pregnancy can bring. Pregnant women seeking abortions should not be deceived into believing that the experience of a clinician is equal to the training of a physician. This bill simply creates an industry for non-physician abortionists, generating more revenue for the Abortion Industry."

ASSEMBLY FLOOR: 50-25, 05/28/13
AYES: Alejo, Ammiano, Atkins, Bloom, Blumenfield, Bocanegra, Bonilla, Bonta, Bradford, Brown, Buchanan, Ian Calderon, Campos, Chau, Chesbro, Daly, Dickinson, Eggman, Fong, Frazier, Garcia, Gatto, Gomez, Gonzalez, Gordon, Gray, Hall, Roger Hernández, Jones-Sawyer, Levine, Lowenthal, Medina, Mitchell, Mullin, Muratsuchi, Nazarian, Pan, Perea, V. Manuel Pérez, Quirk, Quirk-Silva, Rendon, Skinner, Stone, Ting, Weber, Wieckowski, Williams, Yamada, John A. Pérez
NOES: Achadjian, Bigelow, Chávez, Conway, Dahle, Donnelly, Beth Gaines, Gorell, Grove, Hagman, Harkey, Jones, Linder, Logue, Maienschein, Mansoor, Melendez, Morrell, Nestande, Olsen, Patterson, Salas, Wagner, Waldron, Wilk
NO VOTE RECORDED: Allen, Cooley, Fox, Holden, Vacancy

MW:nl 8/14/13 Senate Floor Analyses

SUPPORT/OPPOSITION: SEE ABOVE

****** END ******

California LEGISLATIVE INFORMATION

AB-186 Professions and vocations: military spouses: temporary licenses. (2013-2014)

AMENDED IN SENATE JUNE 24, 2013

AMENDED IN ASSEMBLY MAY 24, 2013

AMENDED IN ASSEMBLY APRIL 22, 2013

AMENDED IN ASSEMBLY APRIL 01, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

ASSEMBLY BILL **No. 186**

Introduced by Assembly Member Maienschein
(Principal Coauthor(s): Assembly Member Hagman)
(Coauthor(s): Assembly Member Chávez, Dahle, Donnelly, Beth Gaines, *Garcia,* Grove, Harkey, Olsen, Patterson, *V. Manuel Pérez)*
(Coauthor(s): Senator Fuller, Huff)

January 28, 2013

An act to ~~amend~~ *add* Section ~~115.5 of~~ *115.6 to* the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 186, as amended, Maienschein. Professions and vocations: military spouses: temporary licenses.

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law provides for the issuance of reciprocal licenses in certain fields where the applicant, among other requirements, has a license to practice within that field in another jurisdiction, as specified. Existing law requires that the licensing fees imposed by certain boards within the department be deposited in funds that are continuously appropriated. Existing law requires a board within the department to expedite the licensure process for an applicant who holds a current license in another jurisdiction in the same profession or vocation and who supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders.

This bill would, in addition to the expedited licensure provisions described above, establish a temporary licensure process for an applicant who holds a current license in another jurisdiction, as specified, and who supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders. The bill would require the temporary license to expire 12 months after issuance, upon issuance of the expedited license, or upon denial of the application for expedited licensure by

~~This bill would require a board within the department to issue a temporary license to an applicant who qualifies for, and requests, expedited licensure pursuant to the above-described provision if he or she meets specified requirements, except as provided. The bill would require the temporary license to expire 12 months after issuance, upon issuance of the expedited license, or upon denial of the application for expedited licensure by the board, whichever occurs first. The bill would authorize a board to conduct an investigation of an applicant for purposes of denying or revoking a temporary license, and would authorize a criminal background check as part of that investigation. The~~

This bill would require an applicant seeking a temporary license to submit an application to the board that includes a signed affidavit attesting to the fact that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate, as specified. The bill would also require the application to include written verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing. *The bill would authorize a board to conduct an investigation of an applicant for purposes of denying or revoking a temporary license and would authorize a criminal background check as part of that investigation. The bill would require an applicant, upon request by a board, to furnish a full set of fingerprints for purposes of conducting the criminal background check.*

This bill would prohibit a temporary license from being provided to any applicant who has committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license at the time the act was committed. The bill would provide that a violation of the above-described provision may be grounds for the denial or revocation of a temporary license. The bill would further prohibit a temporary license from being provided to any applicant who has been disciplined by a licensing entity in another jurisdiction, or is the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction. ~~The bill would require an applicant, upon request by a board, to furnish a full set of fingerprints for purposes of conducting a criminal background check.~~

This bill would authorize the immediate termination of any temporary license to practice medicine upon a finding that the temporary licenseholder failed to meet any of the requirements described above or provided substantively inaccurate information that would affect his or her eligibility for temporary licensure. The bill would, upon termination of the license, require the board to issue a notice of termination requiring the temporary licenseholder to immediately cease the practice of medicine upon receipt.

This bill would exclude from these provisions a board that has established a temporary licensing process before January 1, 2014.

Because the bill would authorize the expenditure of continuously appropriated funds for a new purpose, the bill would make an appropriation.

Vote: majority Appropriation: yes Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. *Section 115.6 is added to the Business and Professions Code, to read:*

115.6. (a) A board within the department shall, after appropriate investigation, issue a temporary license to an applicant if he or she meets the requirements set forth in subdivision (c). The temporary license shall expire 12 months after issuance, upon issuance of an expedited license pursuant to Section 115.5, or upon denial of the application for expedited licensure by the board, whichever occurs first.

(b) The board may conduct an investigation of an applicant for purposes of denying or revoking a temporary license issued pursuant to this section. This investigation may include a criminal background check.

(c) An applicant seeking a temporary license pursuant to this section shall meet the following requirements:

(1) The applicant shall supply evidence satisfactory to the board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders.

(2) The applicant shall hold a current license in another state, district, or territory of the United States in the profession or vocation for which he or she seeks a temporary license from the board.

(3) The applicant shall submit an application to the board that shall include a signed affidavit attesting to the

verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing in that jurisdiction.

(4) The applicant shall not have committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license under this code at the time the act was committed. A violation of this paragraph may be grounds for the denial or revocation of a temporary license issued by the board.

(5) The applicant shall not have been disciplined by a licensing entity in another jurisdiction and shall not be the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction.

(6) The applicant shall, upon request by a board, furnish a full set of fingerprints for purposes of conducting a criminal background check.

(d) A board may adopt regulations necessary to administer this section.

(e) A temporary license issued pursuant to this section for the practice of medicine may be immediately terminated upon a finding that the temporary licenseholder failed to meet any of the requirements described in subdivision (c) or provided substantively inaccurate information that would affect his or her eligibility for temporary licensure. Upon termination of the temporary license, the board shall issue a notice of termination that shall require the temporary licenseholder to immediately cease the practice of medicine upon receipt.

(f) This section shall not apply to a board that has established a temporary licensing process before January 1, 2014.

~~SECTION 1.Section 115.5 of the Business and Professions Code is amended to read:115.5.~~
~~(a)Except as provided in subdivision (d), a board within the department shall expedite the licensure process for an applicant who meets both of the following requirements:~~

~~(1)Supplies evidence satisfactory to the board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders.~~

~~(2)Holds a current license in another state, district, or territory of the United States in the profession or vocation for which he or she seeks a license from the board.~~

~~(b)(1)A board shall, after appropriate investigation, issue a temporary license to an applicant who is eligible for, and requests, expedited licensure pursuant to subdivision (a) if the applicant meets the requirements described in paragraph (3). The temporary license shall expire 12 months after issuance, upon issuance of the expedited license, or upon denial of the application for expedited licensure by the board, whichever occurs first.~~

~~(2)The board may conduct an investigation of an applicant for purposes of denying or revoking a temporary license issued pursuant to this subdivision. This investigation may include a criminal background check.~~

~~(3)(A)An applicant seeking a temporary license issued pursuant to this subdivision shall submit an application to the board which shall include a signed affidavit attesting to the fact that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate, to the best of his or her knowledge. The application shall also include written verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing in that jurisdiction.~~

~~(B)The applicant shall not have committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license under this code at the time the act was committed. A violation of this subparagraph may be grounds for the denial or revocation of a temporary license issued by the board.~~

~~(C)The applicant shall not have been disciplined by a licensing entity in another jurisdiction and shall not be the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction.~~

~~(D)The applicant shall, upon request by a board, furnish a full set of fingerprints for purposes of conducting a criminal background check.~~

~~(c)~~

~~A board may adopt regulations necessary to administer this section.~~

~~(d)This section shall not apply to a board that has established a temporary licensing process before January 1, 2014.~~

California LEGISLATIVE INFORMATION

AB-186 Professions and vocations: military spouses: temporary licenses. (2013-2014)

Date	Action
07/01/13	In committee: Set, first hearing. Testimony taken. Further hearing to be set.
06/24/13	From committee chair, with author's amendments: Amend, and re-refer to committee. Read second time, amended, and re-referred to Com. on B., P. & E.D.
06/13/13	Referred to Com. on B., P. & E.D.
05/29/13	In Senate. Read first time. To Com. on RLS. for assignment.
05/29/13	Read third time. Passed. Ordered to the Senate. (Ayes 75. Noes 1. Page 1734.)
05/28/13	Read second time. Ordered to third reading.
05/24/13	Read second time and amended. Ordered to second reading.
05/24/13	From committee: Do pass as amended. (Ayes 17. Noes 0.) (May 24).
05/15/13	In committee: Set, first hearing. Referred to APPR. suspense file.
04/30/13	From committee: Do pass and re-refer to Com. on APPR. (Ayes 10. Noes 1.) (April 30). Re-referred to Com. on APPR.
04/23/13	In committee: Set, first hearing. Hearing canceled at the request of author.
04/23/13	Re-referred to Com. on B.,P. & C.P.
04/22/13	From committee chair, with author's amendments: Amend, and re-refer to Com. on B.,P. & C.P. Read second time and amended.
04/02/13	Re-referred to Com. on B.,P. & C.P.
04/01/13	From committee chair, with author's amendments: Amend, and re-refer to Com. on B.,P. & C.P. Read second time and amended.
02/07/13	Referred to Com. on B.,P. & C.P.
01/29/13	From printer. May be heard in committee February 28.
01/28/13	Read first time. To print.

Hearing Date: July 1, 2013 Bill No: AB 186

SENATE COMMITTEE ON BUSINESS, PROFESSIONS AND ECONOMIC DEVELOPMENT
Senator Ted W. Lieu, Chair

Bill No: AB 186 Author: Maienschein
As Amended: June 24, 2013 Fiscal: Yes

SUBJECT: Professions and vocations: military spouses: temporary licenses.

SUMMARY: Requires all licensing entities under the Department of Consumer Affairs (DCA) to provide military spouses and domestic partners, who hold a valid professional license in another state, an 18 month provisional license to practice in California.

Existing law:

1) Provides for the licensure and regulation of various professions and vocations by boards within the DCA.

2) Defines "license" as a license, certificate, registration or other means to engage in a business or profession regulated by the Business and Professions Code (BPC). (BPC § 23.7)

3) Defines "board" as a board, bureau, commission, committee, department, division, examining committee, program or agency within the DCA. (BPC § 22)

4) Defines "military service" as federal service after October 1, 1940, where a military member is on active duty with any branch of service as well as training or education under the supervision of the United States preliminary to induction into the military service. (BPC § 10460 (c))

5) Defines "active service" or "active duty" as the period during which a person in military service is absent from duty on account of sickness, wounds, leave, or other lawful cause. (BPC § 10460 (c))

6) Specifies that a board within DCA shall expedite the licensure process for an applicant who meets both of the following requirements: (BPC § 155.5)

   a) Supplies evidence satisfactory to the board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders.

This bill:

1) Requires the boards within DCA to issue a 12-month temporary license to an applicant who is a military spouse or domestic partner while the license application is being processed, if:

   a) The applicant supplies satisfactory evidence that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders;

   b) The applicant holds a current license in another state, district or territory of the United States in the profession or vocation for which he or she seeks a license from the board;

   c) The applicant submits an affidavit attesting that the information submitted in the application is accurate;

   d) The applicant submits written verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing;

   e) The applicant, upon the board's request, submits fingerprints for a background check;

   f) The applicant has not committed any act in any jurisdiction that constitutes grounds for the denial, suspension, or revocation of the professional license by the board under the Business and Professions Code (BPC) at the time the act was committed; and,

   g) The applicant was not disciplined by a licensing entity in another jurisdiction and is not the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction.

2) Specifies that a board within DCA may adopt necessary regulations to enact this legislation.

3) Indicates that any temporary license for the practice of medicine may be immediately terminated if it is found that the individual violated any requirements or provided inaccurate information that would affect their eligibility for licensure.

4) Permits the boards within DCA to issue a notice to cease the practice of medicine immediately upon receipt of the notification of the termination of the temporary license.

5) Specifies that the provisions of the bill shall not apply to a board within DCA that has established a temporary licensing process before January 1, 2014.

FISCAL EFFECT: According to the Assembly Appropriations Committee analysis dated April 22, 2013, if the BreEZe system is fully implemented prior to the completion of the regulations for the new provisional license type, the cost to DCA would be under $100,000. However if there are delays in the implementation of BreEZe, one-time costs to DCA would be approximately

COMMENTS:

1. **Purpose.** This bill is sponsored by the Author. According to the Author, "The wait time for expedited licenses can be very long, and spouses can't even begin seeking employment until their license has been approved. A December article in *USAA Magazine* described the process as taking many months even after all appropriate documentation has been submitted, fees being paid, and tests taken to receive the license. The unemployment rate amongst military spouses is estimated to be about 26% which is three times the national average."

2. **Background.** According to a 2005 study conducted by the RAND National Defense Research Institute, the majority of military spouses are less likely to be employed, more likely to be seeking work and earn less than comparable civilian spouses. Military spouses versus civilian spouses are more likely to live in metropolitan areas. Moreover, they are more likely to have graduated from high school and to have some college education. These facts would ostensibly increase their employability. However, due to "military lifestyle" which includes frequent moves, deployments and long hours that keep service members from assisting with parenting, employment opportunities for spouses are negatively impacted.

   Current data suggests:

   - 68% of married military members report that their spouse's ability to maintain a career impacts their decision to remain in the military.
   - 67% of military spouses report that they want or need to work.
   - The annual percent of the military spouse population that moves across state lines is14.5%, compared to 11% for civilian spouses.
   - As much as 34% of military spouses in the labor force are required to be fully licensed.
   - 19% of employed spouses experience challenges maintaining their licenses.

3. **United States Department of Defense (DOD) and Department of the Treasury (DOT) Report.** On January 24, 2011, United States President Barack Obama presented *Strengthening Our Military Families: Meeting America's Commitment*, a document urging agencies to support and improve the lives of military families.

   As a result of the President's directive, the United States DOT and the United States DOD issued a joint report to highlight the impact of state occupational licensing requirements on the careers of military spouses, who frequently move across state lines. Released in February 2012, the report, *Supporting our Military Families: Best Practices for Streamlining Occupational Licensing Across State Lines* revealed that approximately 35% of military spouses work in professions that require state licenses or certification and that military spouses are ten times more likely to have moved to another state in the last year compared to their civilian counterparts.

occupation among military spouses, followed by child care services, and nursing. While many of the common occupations among military spouses are not licensed, some of the most popular professions, including teaching and nursing, do require licensure. In a 2008 Defense Manpower Data Center survey of active duty military spouses, participants were asked what would have helped them with their employment search after their last military move. Nearly 40% of those respondents who have moved indicated that 'easier state-to-state transfer of certification' would have helped them."

As a result of the survey, the United States DOT and DOD issued several recommendations, including the authorization of temporary licenses for military spouses if the applicant met state requirements. The report's recommendation specified: "Temporary licenses allow applicants to be employed while they fulfill all of the requirements for a permanent license, including examinations or endorsement, applications and additional fees. In developing expedited approaches that save military spouses time and money, DOD does not want to make licensure easier for military spouses to achieve at the expense of degrading their perceived value in their profession."

4. **Military Spouses Employment Partnership.** On June 29, 2011, the Military Spouse Employment Partnership (MSEP) was launched at the Chamber of Commerce in Washington, D.C. The MSEP program is an expansion of the Army Spouse Employment Partnership program and is focused on helping military spouses from all branches of the military attain financial security and achieve educational and employment goals.

   Through a website, the MSEP creates a gateway for military spouses and corporate and non-profit organizations to interact. The MSEP has been the latest development in an effort backed by President Barack Obama's administration to do more to help military families. In May of 2012, 34 companies joined the MSEP and pledged to recruit, hire, promote and retain military spouses in portable careers.

5. **Expedited Licensure for Military Spouses.** In 2012, AB 1904 (Block, Chapter 399, Statutes of 2012) was passed. This bill required all licensing entities under the DCA to issue an expedited license to the spouse or domestic partner of a military member on active duty, beginning January 1, 2013. To date, there is no available data on how many expedited licenses have been granted by the DCA licensing entities to military spouses or domestic partners.

6. **Arguments in Support.** The American Legion-Department of California, AMVETS-Department of California, California State Commanders Veterans Council, VFW- Department of California and Vietnam Veterans of America- California State Council wrote a joint letter of support for the bill. In it they indicate, "We support this bill because it will help qualified military spouses to be employed in their licensed field of expertise quickly under a provisional license rather than having to wait to get a job until they get through the process of obtaining a California license if they already are licensed in another state."

   Brigadier General Vincent A. Coglianese writes, "The White House Joining Forces initiative has called attention to the barriers currently preventing military spouses from maintaining [illegible] on a normal progression path regardless of relocation. Consequently, the

employable skills than the average population. One often-faced barrier is the lack of broad-based reciprocity among the states for recognizing professional licenses or certificates held by military spouses. This bill, by requiring boards...to issue a temporary license to the spouse of a service member, would help address this barrier."

The Commander, Navy Region Southwest supports the bill and writes, "On behalf of Navy installations in California, I am writing in support of AB 186. The ability of a military spouse to continue their professional life is an important part of maintaining households during periods of long deployments, and is especially needed for military families based in higher cost urban areas such as southern California."

The National Military Family Association, the California Association for Health Services at Home and the San Diego Military Advisory Council also support the bill. They believe that the lack of broad-based reciprocity among the states to recognize professional licenses or certificates creates a significant barrier to employment. With each government ordered move, military spouses incur high costs for recertification and delays before they are able to work. They believe that provisional licenses will permit military spouses to become employed quickly, financially benefiting the family and the state of California.

The Department of Defense states, "We appreciate any concern for protecting the public and would not want a spouse to be licensed when they are not qualified or would pose a danger to those they served. The spouses we are referring to in this bill are all licensed in another state. We understand that the reason for licensing is to safeguard the public, and we believe (as several other states believe) that providing a temporary license to a military spouse who is already licensed in another state and who has had experience in that licensed occupation presents little risk to the public."

7. **Support if Amended.** The Board of Behavioral Sciences (BBS) submitted a letter reflecting their support if amended position. In it they state, "The BBS supports the intent of this bill to assist spouses of military members to quickly obtain employment. However, the Board respectfully requests three additional amendments in order to ensure consumer protection is upheld:

   - An amendment to require that the temporary license applicant provide a transcript to the licensing board;
   - An amendment requiring the temporary license applicant to pass the Board's California Law and Ethics examination prior to the issuance of the temporary license; and,
   - An amendment allowing delayed implementation to accommodate DCA's transition to the new BreEZe database system."

The California Board of Accountancy (CBA) also supports the bill if amended. In their letter they write, "The CBA supports the military and their families; however, it would like to request an amendment to clarify that an individual's license must be current, active and unrestricted with the authority to practice the identified profession in the state that issued the individual's license."

The Medical Board of California indicates, "The Board is supportive of this bill if it is amended to include language that would allow for termination of the temporary license if it is found that the individual issued the temporary license violated any requirements in the bill or provided substantive inaccurate information that would affect their eligibility for licensure. The Board has requested this amendment in order to ensure consumer protection and has been working with the author's office to draft language that will address the Board's concerns, which the author's office has agreed to take. Once this language is amended into the bill, the Board will be supportive of AB 186." *(Note: The Author has taken the amendments suggested by the MBC)*

8. **Oppose Unless Amended.** The American Association for Marriage and Family Therapy-California Division opposes the bill unless the following three amendments are taken:

   - Require either a 12-hour course in California Law and Ethics or successful completion of a state-administered California Law and Ethics exam prior to the issuance of the license;

   - Require that the licensee provide proof that their license is active and in good standing prior to the issuance of the license; and,

   - Require that the licensure requirements of the applicant's home state be substantially equivalent to those of California.

   The Board for Professional Engineers, Land Surveyors and Geologists opposes the bill unless amended. In their letter they write, "The Board voted to oppose AB 186 unless amended because it would not be able to comply with the proposed law in all cases. Most engineers coming to California with a current license in another state can be issued a California license through comity in a matter of weeks. Civil, Geotechnical and Structural engineers, Land Surveyors and Geologists coming to California must take and pass California exams specific to their discipline before they can be issued a license, which would also include a provisional license. The California examinations cover seismic issues specific to California, consequently, the Board would be negligent if it issued a license to someone who may not be familiar with the terrain, soils, and seismic issues of this State. Fortunately these five disciplines can practice, and therefore work, in California under the responsible charge of another licensee who can review their work and sign and stamp plans, but they cannot be issued a license until they have passed the state specific examination."

   The California Architects Board opposes the bill unless amended. They write, "Although the Board unequivocally supports members of our nation's Armed Forces and initiatives that address the challenges facing military families, it cannot waive the California Supplemental Examination requirement (CSE). The CSE is a critical licensure requirement which all licensees in our state must complete, demonstrating competence in California's seismic, accessibility, energy and legal requirements. The Board cannot waive the CSE requirement and simultaneously meet its mandate to protect the health, safety and welfare of the public."

9. **Arguments in Opposition.** The Board of Chiropractic Examiners (BCE) opposes the bill.

Additionally, the mandate to issue temporary licenses in this bill conflicts with the Chiropractic Initiative Act. The Act defines the educational requirements, fees, and conditions under which the BCE may issue a license to practice chiropractic. Lastly, the Act prohibits the BCE from reciprocating licenses with states that do not have similar requirements and do not reciprocate licenses with California. The Act was created through an initiative measure in 1922 and can only be changed through a ballot initiative. Therefore, the BCE is unable to comply with the provisions in this bill."

The Contractors State License Board (CSLB) also opposes the bill. In their letter they write, "The Board respectively requests an amendment to provide an exemption from the bill's provisions. ..CSLB supports the goal of assisting military families. However, as required by recent legislation, CSLB expedites applications for military spouses and does not believe its licensing process is so long as to require the need for a temporary license. Additionally, as there is no exam requirement for the temporary license, these individuals will have the ability to contract but will not be required to be familiar with California law or building code requirements with which they need to comply. We believe this may put California consumers at risk."

10. **Policy Issues for Consideration.** The goal and spirit of this legislation is to promote expedited licensure for military spouses and domestic partners. As illustrated in the background section of this analysis, the need for this action has been well studied and documented. Further, there is a federal effort to encourage state licensing entities to adopt policies that will assist in expediting the licensure process for military spouses. In response, the California Legislature passed AB 1904 in 2012. Despite this, AB 186 attempts to promote *even more timely* expedition of licenses by the DCA licensing entities by granting an immediate provisional license for a military spouse to practice in California.

    Despite this measure's laudable efforts, it is equally important to note that the expediting of licensure should not result in compromised consumer protection or limit the authority of the licensing entities to exercise discretion when issuing licenses. Specifically, as noted in the United States DOT and DOD recommendations, "In developing expedited approaches that save military spouses time and money, DOD does not want to make licensure easier for military spouses to achieve at the expense of degrading their perceived value in their profession." Further, this bill raises concerns about the ability of the DCA licensing entities to carry out the bill's mandates. Notably, as indicated in the opposition letters submitted by several licensing boards, this bill raises questions about consumer protection as necessary background checks and verification of California specific coursework, examinations and training requirements would be waived if a provisional license was immediately granted to a military spouse or domestic partner. Lastly, this bill may be premature as there has not been adequate time to study the results of the new expedited licensure requirements that went into effect on January 1, 2013.

SUPPORT AND OPPOSITION:

Support:

Brigadier General Vincent A. Coglianese
California Architects Board
California Association for Health Services at Home
California State Commanders Veterans Council
Commander, Navy Region Southwest
National Military Family Association
San Diego Military Advisory Council
United States Department of Defense
VFW- Department of California
Vietnam Veterans of America- California State Council

Support if Amended:

Board of Behavioral Sciences
California Board of Accountancy
Medical Board of California

Oppose Unless Amended:

American Association for Marriage and Family Therapy- California Division
Board for Professional Engineers, Land Surveyors and Geologists
California Architects Board

Oppose:

Board of Chiropractic Examiners
Contractors State License Board

Consultant: Le Ondra Clark, Ph.D.

California LEGISLATIVE INFORMATION

SB-304 Healing arts: boards. (2013-2014)

AMENDED IN ASSEMBLY AUGUST 12, 2013

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 16, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL **No. 304**

Introduced by *Senator Lieu*
(Principal Coauthor(s): Assembly Member Gordon)

February 15, 2013

An act to amend Sections ~~651,~~ *160, 160.5, 2001, 2006, 2020,* 2021, *2135.7,* 2177, 2220.08, 2225.5, ~~2334,~~ 2514, ~~and 2569~~ *2569, 4800, 4804.5, 4809.5, 4809.7, and 4809.8* of, *to amend, repeal, and add Section 4836.1 of,* and to add Sections ~~2291.5 and 2403~~ *2216.3, 2216.4, 2403, 4836.2, 4836.3, and 4836.4* to, the Business and Professions Code, ~~and~~ to amend Sections ~~11529~~ *11529, 12529.6,* and 12529.7 of, and to amend and repeal Sections 12529 and 12529.5 of, the Government Code, *to amend Section 1248.15 of the Health and Safety Code, and to amend Section 830.3 of the Penal Code,* relating to healing ~~arts.~~ *arts, and making an appropriation therefor.*

LEGISLATIVE COUNSEL'S DIGEST

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

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

~~This bill would limit the application of that exception to a board or association with equivalent requirements~~

~~the exception continues to apply to a multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2014.~~

~~Because the bill would specify additional provisions regarding the advertising practices of healing art practitioners, the violation of which would be a crime, it would impose a state-mandated local program.~~

(1) Existing law provides for the licensure and regulation of physicians and surgeons by the Medical Board of California within the Department of Consumer Affairs. Existing law authorizes the board to employ an executive director. Existing law provides that those provisions will be repealed on January 1, 2014, and, upon repeal, the board is subject to review by the Joint Sunset Review Committee.

This bill would instead repeal those provisions on January 1, 2018, and subject the board to review by the appropriate policy committees of the Legislature. The bill would authorize the board to employ an executive director by, and with the approval of, the Director of Consumer Affairs.

Existing law authorizes the board to issue a physician and surgeon's license to an applicant who acquired all or part of his or her medical education at a foreign medical school that is not recognized by the board if, among other requirements, the applicant has held an unlimited and unrestricted license as a physician and surgeon in another state or federal territory and has continuously practiced for a minimum of 10 years prior to the date of application or to an applicant who acquired any part of his or her professional instruction at a foreign medical school that has previously been disapproved by the board if, among other requirements, the applicant has held an unlimited and unrestricted license as a physician and surgeon in another state or federal territory and has continuously practiced for a minimum of 20 years prior to the date of application. For the purposes of these provisions, the board may combine the period of time that the applicant has held an unlimited and unrestricted license, but requires each applicant to have a minimum of 5 years continuous licensure and practice in a single state or federal territory.

This bill would instead authorize the board to issue a physician and surgeon's license to an applicant who acquired any part of his or her medical education from an unrecognized or disapproved medical school if, among other requirements, the applicant has held an unlimited and unrestricted license as a physician and surgeon in another state, a federal territory, or a Canadian province and has continuously practiced for a minimum of 10 years prior to the date of application. The bill would reduce the minimum number of years that each applicant must have continuous licensure and practice in a single state or federal territory to 2 years and permit the period of continuous licensure and practice to occur in a Canadian province.

Existing law authorizes the Medical Board of California, if it publishes a directory *of its licensees*, as specified, to require persons licensed, as specified, to furnish specified information to the board for purposes of compiling the directory.

This bill would require that an applicant and licensee who has an electronic mail address report to the board that electronic mail address no later than July 1, 2014. The bill would provide that the electronic mail address is to be considered confidential, as specified.

Existing law requires an applicant for a physician and surgeon's certificate to obtain a passing score on Step 3 of the United States Medical Licensing Examination with not more than 4 attempts, subject to an exception.

This bill would require an applicant to have obtained a passing score on all parts of that examination with not more than 4 attempts, subject to the exception.

Existing law requires that a complaint, with exceptions, received by the board determined to involve quality of care, before referral to a field office for further investigation, meet certain criteria.

This bill would expand the types of reports that are exempted from that requirement.

Existing law provides for a civil penalty of up to $1,000 per day, as specified, to be imposed on a health care facility that fails to comply with a patient's medical record request, as specified, within 30 days.

This bill would shorten the time limit for compliance to 15 days for those health care facilities that have electronic health records.

~~Under existing law, if a healing arts practitioner may be unable to practice his or her profession safely due to mental or physical illness, his or her licensing agency may order the practitioner to be examined by specified professionals.~~

~~This bill would require that a physician and surgeon's failure to comply with an order related to these examination requirements shall result in the issuance of notification from the board to cease the practice of medicine immediately until the ordered examinations have been completed and would provide that continued failure to comply would be grounds for suspension or revocation of his or her certificate.~~

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

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

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

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

~~Existing~~

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

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

~~Existing~~

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

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

(4) Existing law provides for the accreditation of outpatient settings, as defined by the Medical Board of California, and requires outpatient settings to report adverse events, as defined, to the State Department of Public Health within specified time limits. Existing law provides for the imposition of a civil penalty in the event that an adverse event is not reported within the applicable time limit.

This bill would instead require those outpatient settings to report adverse events to the Medical Board of California within specified time limits and authorize the board to impose a civil penalty if an outpatient setting fails to timely report an adverse event.

~~Existing~~

(5) Existing law ~~authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order related to licenses, as provided.~~ *establishes the Medical Quality Hearing Panel, consisting of no fewer than 5 administrative law judges with certain medical training, within the Office of Administrative Hearings. Existing law authorizes those administrative law judges to issue interim orders suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions.* Existing law requires that in all of those cases in which an interim order is issued, and an accusation is not filed and served within 15 days of the date in which the parties to the hearing have submitted the matter, the order be dissolved.

Under existing law, if a healing arts practitioner is unable to practice his or her profession safely due to mental or physical illness, his or her licensing agency may order the practitioner to be examined by specified professionals.

This bill would extend the time in which the accusation must be filed and served to 30 days from the date on

surgeon's failure to comply with an order related to these examination requirements may constitute grounds for an administrative law judge of the Medical Quality Hearing Panel to issue an interim suspension order.

Existing law establishes the Health Quality Enforcement Section within the Department of Justice to carry out certain duties. Existing law provides for the funding for the section, and for the appointment of a Senior Assistant Attorney General to the section to carry out specified duties. Existing law requires that all complaints or relevant information concerning licensees that are within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, or the Board of Psychology be made available to the Health Quality Enforcement Section. Existing law establishes the procedures for processing the complaints, assisting the boards or committees in establishing training programs for their staff, and for determining whether to bring a disciplinary proceeding against a licensee of the boards. Existing law provides for the repeal of those provisions, as provided, on January 1, 2014.

This bill would extend the operation of those provisions indefinitely.

Existing law establishes, until January 1, 2014, a vertical enforcement and prosecution model for cases before the Medical Board of California and requires the board to report to the Governor and Legislature on that model by March 1, 2012.

This bill would extend the date that report is due to March 1, 2015.

~~Existing law authorizes the Medical Board of California and the Dental Board of California to employ individuals who have the authority of peace officers to perform investigative services.~~

~~This bill would transfer all investigators employed by the Medical Board of California and their staff to the Department of Justice on January 1, 2014, and would provide that the transfer would not affect the status, position, or rights of those transferred. The bill would specify that individuals performing investigations would retain their status as peace officers.~~

Existing law creates the Division of Investigation within the Department of Consumer Affairs and requires investigators who have the authority of peace officers to be in the division, except that investigators of the Medical Board of California and the Dental Board of California who have that authority are not required to be in the division.

This bill would require that investigators of the Medical Board of California who have the authority of a peace officer be in the division and would protect the positions, status, and rights of those investigators who are subsequently transferred as a result of these provisions. This bill would also create within the Division of Investigation the Health Quality Investigation Unit.

(6) Existing law, the Veterinary Medicine Practice Act, provides for the licensure and registration of veterinarians and registered veterinary techniclans and the regulation of the practice of veterinary medicine by the Veterinary Medical Board. Existing law repeals the provisions establishing the board, and authorizing the board to appoint an executive officer as of January 1, 2014. Under existing law, the board is subject to evaluation by the Joint Sunset Review Committee prior to its repeal.

This bill would provide that those provisions are instead repealed as of January 1, 2016. The bill, upon repeal of the board, would require that the board be subject to a specifically limited review by the appropriate policy committees of the Legislature.

Existing law authorizes the board, at any time, to inspect the premises in which veterinary medicine, veterinary dentistry, or veterinary surgery is being practiced.

This bill would exclude premises that are not required to be registered with the board from inspection.

Existing law requires the board to establish a regular inspection program that will provide for random, unannounced inspections.

This bill would require the board to make every effort to inspect at least 20% of veterinary premises on an annual basis.

Existing law requires the board to establish an advisory committee, the Veterinary Medicine Multidisciplinary Advisory Committee, to assist, advise, and make recommendations for the implementation of rules and regulations necessary to ensure proper administration and enforcement of specified provisions and to assist the board in its examination, licensure, and registration programs. Existing law requires the committee to consist of

This bill would expand the number of members on the committee to 9 by including one veterinarian member of the board, to be appointed by the board president, and the registered veterinary technician of the board, both of whom would serve concurrently with their terms of office on the board. The bill would additionally require that the committee serve only in an advisory capacity to the board, as specified. The bill would make other technical and conforming changes.

Existing law authorizes a registered veterinary technician or a veterinary assistant to administer a drug under the direct or indirect supervision of a licensed veterinarian when administered pursuant to the order, control, and full professional responsibility of a licensed veterinarian. Existing law limits access to controlled substances by veterinary assistants to persons who have undergone a background check and who, to the best of the licensee manager's knowledge, do not have any drug- or alcohol-related felony convictions. Existing law repeals these provisions on January 1, 2015.

This bill would instead require, until the later of January 1, 2015, or the effective date of a specified legislative determination, a licensee manager to conduct a background check on a veterinary assistant prior to authorizing him or her to obtain or administer a controlled substance by the order of a supervising veterinarian and to prohibit the veterinary assistant from obtaining or administering controlled substances if the veterinary assistant has a drug- or alcohol-related felony conviction.

This bill would require that, upon the later of January 1, 2015, or the effective date of a specified legislative determination, a veterinary assistant be designated by a licensed veterinarian to obtain or administer controlled substances and hold a valid veterinary assistant controlled substances permit from the board. The bill would, as part of the application for a permit, require an applicant to furnish a set of fingerprints to the Department of Justice for the purposes of conducting both a state and federal criminal history record check. The bill would require an applicant for a veterinary assistant controlled substances permit to apply for a renewal of his or her permit on or before the last day of the applicant's birthday month and to update his or her mailing or employer address with the board. The bill would authorize the board to collect a filing fee, not to exceed $100, from applicants for a veterinary assistant controlled substances permit. Because that fee would be deposited in the Veterinary Medical Board Contingent Fund, which is a continuously appropriated fund, the bill would make an appropriation.

~~The~~

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

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

Vote: majority Appropriation: ~~no~~*yes* Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

~~SECTION 1.Section 651 of the Business and Professions Code is amended to read:651.~~
~~(a)It is unlawful for any person licensed under this division or under any initiative act referred to in this division to disseminate or cause to be disseminated any form of public communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. A "public communication" as used in this section includes, but is not limited to, communication by means of mail, television, radio, motion picture, newspaper, book, list or directory of healing arts practitioners, Internet, or other electronic communication.~~

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

~~(1)Contains a misrepresentation of fact.~~

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

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

~~(B)Uses a model without clearly stating in a prominent location in easily~~

~~of this paragraph, a model is anyone other than an actual patient, who has undergone the procedure being advertised, of the licensee who is advertising for his or her services.~~

~~(C)Use of any photograph or other image of an actual patient that depicts or purports to depict the results of any procedure, or presents "before" and "after" views of a patient, without specifying in a prominent location in easily readable type size what procedures were performed on that patient is a violation of subdivision (a). Any "before" and "after" views (i) shall be comparable in presentation so that the results are not distorted by favorable poses, lighting, or other features of presentation, and (ii) shall contain a statement that the same "before" and "after" results may not occur for all patients.~~

~~(4)Relates to fees, other than a standard consultation fee or a range of fees for specific types of services, without fully and specifically disclosing all variables and other material factors.~~

~~(5)Contains other representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived.~~

~~(6)Makes a claim either of professional superiority or of performing services in a superior manner, unless that claim is relevant to the service being performed and can be substantiated with objective scientific evidence.~~

~~(7)Makes a scientific claim that cannot be substantiated by reliable, peer reviewed, published scientific studies.~~

~~(8)Includes any statement, endorsement, or testimonial that is likely to mislead or deceive because of a failure to disclose material facts.~~

~~(c)Any price advertisement shall be exact, without the use of phrases, including, but not limited to, "as low as," "and up," "lowest prices," or words or phrases of similar import. Any advertisement that refers to services, or costs for services, and that uses words of comparison shall be based on verifiable data substantiating the comparison. Any person so advertising shall be prepared to provide information sufficient to establish the accuracy of that comparison. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or any statements of a similar nature. In connection with price advertising, the price for each product or service shall be clearly identifiable. The price advertised for products shall include charges for any related professional services, including dispensing and fitting services, unless the advertisement specifically and clearly indicates otherwise.~~

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

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

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

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

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

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

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

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

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

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

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

~~(C)A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California may include a statement that he or she limits his or her practice to specific fields, but shall not include a statement that he or she is certified or eligible for certification by a private or public board or parent association, unless that board or association is (i) an American Board of Medical Specialties member board, (ii) a board or association with equivalent requirements approved by that physician and surgeon's licensing board prior to January 1, 2014, or (iii) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty. A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by an organization other than a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" in reference to that certification, unless the physician and surgeon is also licensed under Chapter 4 (commencing with Section 1600) and the use of the term "board certified" in reference to that certification is in accordance with subparagraph (A). A physician and surgeon licensed under Chapter 5 (commencing with Section 2000) by the Medical Board of California who is certified by a board or association referred to in clause (i), (ii), or (iii) shall not use the term "board certified" unless the full name of the certifying board is also used and given comparable prominence with the term "board certified" in the statement.~~

~~A multidisciplinary board or association approved by the Medical Board of California prior to January 1, 2014, shall retain that approval.~~

~~For purposes of the term "board certified," as used in this subparagraph, the terms "board" and "association" mean an organization that is an American Board of Medical Specialties member board, an organization with equivalent requirements approved by a physician and surgeon's licensing board prior to January 1, 2014, or an organization with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in a specialty or subspecialty.~~

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

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

~~The California Board of Podiatric Medicine shall adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition pursuant to this subparagraph, to be deposited in the State Treasury in the Podiatry Fund, pursuant to Section 2499. The fee shall not exceed the cost of administering this subparagraph.~~

~~(6)A statement that the practitioner provides services under a specified private or public insurance plan or health care plan.~~

~~(7)A statement of names of schools and postgraduate clinical training programs from which the practitioner has graduated, together with the degrees received.~~

~~(9)A statement of teaching positions currently or formerly held by the practitioner, together with pertinent dates.~~

~~(10)A statement of his or her affiliations with hospitals or clinics.~~

~~(11)A statement of the charges or fees for services or commodities offered by the practitioner.~~

~~(12)A statement that the practitioner regularly accepts installment payments of fees.~~

~~(13)Otherwise lawful images of a practitioner, his or her physical facilities, or of a commodity to be advertised.~~

~~(14)A statement of the manufacturer, designer, style, make, trade name, brand name, color, size, or type of commodities advertised.~~

~~(15)An advertisement of a registered dispensing optician may include statements in addition to those specified in paragraphs (1) to (14), inclusive, provided that any statement shall not violate subdivision (a), (b), (c), or (e) or any other section of this code.~~

~~(16)A statement, or statements, providing public health information encouraging preventative or corrective care.~~

~~(17)Any other item of factual information that is not false, fraudulent, misleading, or likely to deceive.~~

~~(i)Each of the healing arts boards and examining committees within Division 2 shall adopt appropriate regulations to enforce this section in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.~~

~~Each of the healing arts boards and committees and examining committees within Division 2 shall, by regulation, define those efficacious services to be advertised by businesses or professions under their jurisdiction for the purpose of determining whether advertisements are false or misleading. Until a definition for that service has been issued, no advertisement for that service shall be disseminated. However, if a definition of a service has not been issued by a board or committee within 120 days of receipt of a request from a licensee, all those holding the license may advertise the service. Those boards and committees shall adopt or modify regulations defining what services may be advertised, the manner in which defined services may be advertised, and restricting advertising that would promote the inappropriate or excessive use of health services or commodities. A board or committee shall not, by regulation, unreasonably prevent truthful, nondeceptive price or otherwise lawful forms of advertising of services or commodities, by either outright prohibition or imposition of onerous disclosure requirements. However, any member of a board or committee acting in good faith in the adoption or enforcement of any regulation shall be deemed to be acting as an agent of the state.~~

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

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

SECTION 1. *Section 160 of the Business and Professions Code is amended to read:*

160. (a) The Chief and all investigators of the Division of Investigation of the department and all investigators of ~~the Medical Board of California and~~ the Dental Board of California have the authority of peace officers while engaged in exercising the powers granted or performing the duties imposed upon them or the division in investigating the laws administered by the various boards comprising the department or commencing directly or indirectly any criminal prosecution arising from any investigation conducted under these laws. All persons herein referred to shall be deemed to be acting within the scope of employment with respect to all acts and matters set forth in this section.

(b) The Division of Investigation of the department, the Medical Board of California, *department* and the Dental

(c) There is in the Division of Investigation the Health Quality Investigation Unit. The primary responsibility of the unit is to investigate violations of law or regulation by licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California.

SEC. 2. *Section 160.5 of the Business and Professions Code is amended to read:*

160.5. *(a)* All civil service employees currently employed by the Board of Dental Examiners of the Department of Consumer Affairs, whose functions are transferred as a result of the act adding this section shall retain their positions, status, and rights pursuant to Section 19050.9 of the Government Code and the State Civil Service ~~Act, Part~~ *Act (Part* 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government ~~Code.~~ *Code).* The transfer of employees as a result of the act adding this section shall occur no later than July 1, 1999.

(b) (1) All civil service employees currently employed by the Medical Board of California of the Department of Consumer Affairs, whose functions are transferred as a result of the act adding this subdivision shall retain their positions, status, and rights pursuant to Section 19050.9 of the Government Code and the State Civil Service Act (Part 2 (commencing with Section 18500) of Division 5 of Title 2 of the Government Code). The transfer of employees as a result of the act adding this subdivision shall occur no later than January 1, 2014.

(2) The transfer of employees pursuant to this subdivision shall include all peace officer positions and staff support positions that are identified by the department as positions whose functions are primarily enforcement related.

SEC. 3. *Section 2001 of the Business and Professions Code is amended to read:*

2001. (a) There is in the Department of Consumer Affairs a Medical Board of California that consists of 15 members, seven of whom shall be public members.

(b) The Governor shall appoint 13 members to the board, subject to confirmation by the Senate, five of whom shall be public members. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.

~~(c)Notwithstanding any other provision of law, to reduce the membership of the board to 15, the following shall occur:~~

~~(1)Two positions on the board that are public members having a term that expires on June 1, 2010, shall terminate instead on January 1, 2008.~~

~~(2)Two positions on the board that are not public members having a term that expires on June 1, 2008, shall terminate instead on August 1, 2008.~~

~~(3)Two positions on the board that are not public members having a term that expires on June 1, 2011, shall terminate instead on January 1, 2008.~~

~~(d)~~

(c) This section shall remain in effect only until January 1, ~~2014,~~ *2018,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2018,* deletes or extends that date. ~~The~~ *Notwithstanding any other law, the* repeal of this section renders the board subject to ~~the review required by Division 1.2 (commencing with Section 473).~~ *review by the appropriate policy committees of the Legislature.*

SEC. 4. *Section 2006 of the Business and Professions Code is amended to read:*

2006. ~~(a)~~Any reference in this chapter to an investigation by the board shall be deemed to refer to a joint investigation conducted by employees of the Department of Justice and the ~~board~~ *Health Quality Investigation Unit* under the vertical enforcement and prosecution model, as specified in Section 12529.6 of the Government Code.

~~(b)This section shall remain in effect only until January 1, 2014, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2014, deletes or extends that date.~~

SEC. 5. *Section 2020 of the Business and Professions Code is amended to read:*

2020. (a) The ~~board~~ *board, by and with the approval of the director,* may employ an executive director exempt from the provisions of the Civil Service Act and may also employ investigators, legal counsel, medical consultants, and other assistance as it may deem necessary to carry this chapter into effect. The board may fix the compensation to be paid for services subject to the provisions of applicable state laws and regulations and may incur other expenses as it may deem necessary. Investigators employed by the board shall be provided special training in investigating medical practice activities.

(b) The Attorney General shall act as legal counsel for the board for any judicial and administrative proceedings and his or her services shall be a charge against it.

(c) This section shall remain in effect only until January 1, ~~2014,~~ *2018,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2018,* deletes or extends that date.

~~**SEC. 2.**~~***SEC. 6.*** Section 2021 of the Business and Professions Code is amended to read:

2021. (a) If the board publishes a directory pursuant to Section 112, it may require persons licensed pursuant to this chapter to furnish any information as it may deem necessary to enable it to compile the directory.

(b) Each licensee shall report to the board each and every change of address within 30 days after each change, giving both the old and new address. If an address reported to the board at the time of application for licensure or subsequently is a post office box, the applicant shall also provide the board with a street address. If another address is the licensee's address of record, he or she may request that the second address not be disclosed to the public.

(c) Each licensee shall report to the board each and every change of name within 30 days after each change, giving both the old and new names.

(d) Each applicant and licensee who has an electronic mail address shall report to the board that electronic mail address no later than July 1, 2014. The electronic mail address shall be considered confidential and not subject to public disclosure.

(e) The board shall annually send an electronic notice to each applicant and licensee that requests confirmation from the applicant or licensee that his or her electronic mail address is current.

SEC. 7. *Section 2135.7 of the Business and Professions Code is amended to read:*

2135.7. (a) Upon review and recommendation, the board may determine that an applicant for a physician and surgeon's certificate who acquired his or her medical education or a portion thereof at a foreign medical school that is not recognized or has been previously disapproved by the board is eligible for a physician and surgeon's certificate if the applicant meets all of the following criteria:

(1) Has successfully completed a resident course of medical education leading to a degree of medical doctor equivalent to that specified in Sections 2089 to 2091.2, inclusive.

(2) (A) ~~(i)~~For an applicant who acquired any part of his or her medical education from an unrecognized foreign medical school *or from a foreign medical school previously disapproved by the board,* he or she holds an unlimited and unrestricted license as a physician and surgeon in another ~~state or~~ *state, a* federal ~~territory~~ *territory, or a Canadian province* and has held that license and continuously practiced for a minimum of 10 years prior to the date of application.

~~(ii)For an applicant who acquired any part of his or her professional instruction from a foreign medical school previously disapproved by the board, he or she holds an unlimited and unrestricted license as a physician and surgeon in another state or federal territory and has held that license and continuously practiced for a minimum of 20 years prior to the date of application.~~

(B) For the purposes of ~~clauses (i) and (ii) of~~ subparagraph (A), the board may combine the period of time that the applicant has held an unlimited and unrestricted license in other ~~states or~~ *states,* federal ~~territories~~ *territories, or Canadian provinces* and continuously practiced therein, but each applicant under this section shall have a minimum of ~~five~~ *two* years continuous licensure and practice in a single ~~state or~~ *state,* federal ~~territory~~ *territory, or Canadian province.* For purposes of this paragraph, continuous licensure and practice includes any postgraduate training after 24 months in a postgraduate training program that is accredited by the Accreditation Council for Graduate Medical Education (ACGME) or postgraduate training completed in Canada

(3) Is certified by a specialty board that is a member board of the American Board of Medical Specialties.

(4) Has successfully taken and passed the examinations described in Article 9 (commencing with Section 2170).

(5) Has not been the subject of a disciplinary action by a medical licensing authority or of adverse judgments or settlements resulting from the practice of medicine that the board determines constitutes a pattern of negligence or incompetence.

(6) Has successfully completed three years of approved postgraduate training. The postgraduate training required by this paragraph shall have been obtained in a postgraduate training program accredited by the ACGME or postgraduate training completed in Canada that is accredited by the RCPSC.

(7) Is not subject to denial of licensure under Division 1.5 (commencing with Section 475) or Article 12 (commencing with Section 2220).

(8) Has not held a healing arts license and been the subject of disciplinary action by a healing arts board of this state or by another ~~state or~~ *state,* federal ~~territory~~ *territory, or Canadian province.*

(b) The board may adopt regulations to establish procedures for accepting transcripts, diplomas, and other supporting information and records when the originals are not available due to circumstances outside the applicant's control. The board may also adopt regulations authorizing the substitution of additional specialty board certifications for years of practice or licensure when considering the certification for a physician and surgeon pursuant to this section.

(c) This section shall not apply to a person seeking to participate in a program described in Sections 2072, 2073, 2111, 2112, 2113, 2115, or 2168, or seeking to engage in postgraduate training in this state.

~~SEC. 3.~~*SEC. 8.* Section 2177 of the Business and Professions Code is amended to read:

2177. (a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the board.

(b) Applicants may elect to take the written examinations conducted or accepted by the board in separate parts.

(c) (1) An applicant shall have obtained a passing score on all parts of Step 3 of the United States Medical Licensing Examination within not more than four attempts in order to be eligible for a physician's and surgeon's certificate.

(2) Notwithstanding paragraph (1), an applicant who obtains a passing score on all parts of Step 3 of the United States Medical Licensing Examination in more than four attempts and who meets the requirements of Section 2135.5 shall be eligible to be considered for issuance of a physician's and surgeon's certificate.

SEC. 9. *Section 2216.3 is added to the Business and Professions Code, to read:*

2216.3. (a) An outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code shall report an adverse event to the board no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Disclosure of individually identifiable patient information shall be consistent with applicable law.

(b) For the purposes of this section, "adverse event" has the same meaning as in subdivision (b) of Section 1279.1 of the Health and Safety Code.

SEC. 10. *Section 2216.4 is added to the Business and Professions Code, to read:*

2216.4. If an accredited outpatient setting fails to report an adverse event pursuant to Section 2216.3, the board may assess the accredited outpatient setting a civil penalty in an amount not to exceed one hundred dollars ($100) for each day that the adverse event is not reported following the initial five-day period or 24-hour period, as applicable. If the accredited outpatient setting disputes a determination by the board regarding an alleged failure to report an adverse event, the accredited outpatient setting may, within 10 days of notification of the board's determination, request a hearing, which shall be conducted pursuant to the administrative adjudication provisions of Chapter 4.5 (commencing with Section 11400) and Chapter 5 (commencing with

Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. Penalties shall be paid when appeals pursuant to those provisions have been exhausted.

~~**SEC. 4.**~~***SEC. 11.*** Section 2220.08 of the Business and Professions Code is amended to read:

2220.08. (a) Except for reports received by the board pursuant to Section 801.01 or 805 that may be treated as complaints by the board and new complaints relating to a physician and surgeon who is the subject of a pending accusation or investigation or who is on probation, any complaint determined to involve quality of care, before referral to a field office for further investigation, shall meet the following criteria:

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

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

(A) Relevant patient records.

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

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

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

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

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

~~**SEC. 5.**~~***SEC. 12.*** Section 2225.5 of the Business and Professions Code is amended to read:

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

(2) A health care facility shall comply with a request for the certified medical records of a patient that is accompanied by that patient's written authorization for release of records to the board together with a notice citing this section and describing the penalties for failure to comply with this section. Failure to provide the authorizing patient's certified medical records to the board within 30 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 30th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. For health care facilities that have electronic health records, failure to provide the authorizing patient's certified medical records to the board within 15 days of receiving the request, authorization, and notice shall subject the health care facility to a civil penalty, payable to the board, of up to one thousand dollars ($1,000) per day for each day that the documents have not been produced after the 15th day, up to ten thousand dollars ($10,000), unless the health care facility is unable to provide the documents within this time period for good cause. This paragraph shall not require health care facilities to assist the board in obtaining the patient's authorization. The board shall pay the reasonable costs of copying the certified medical records.

(b) (1) A licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board shall pay to the board a civil penalty of one thousand dollars ($1,000) per day for each day that the documents have not been produced after the date by which the court order requires the documents to be produced, up to ten thousand dollars ($10,000), unless it is determined that the order is unlawful or invalid. Any statute of limitations applicable to the filing of an accusation by the

(2) Any licensee who fails or refuses to comply with a court order, issued in the enforcement of a subpoena, mandating the release of records to the board is guilty of a misdemeanor punishable by a fine payable to the board not to exceed five thousand dollars ($5,000). The fine shall be added to the licensee's renewal fee if it is not paid by the next succeeding renewal date. Any statute of limitations applicable to the filing of an accusation by the board shall be tolled during the period the licensee is out of compliance with the court order and during any related appeals.

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

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

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

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

(e) Imposition of the civil penalties authorized by this section shall be in accordance with the Administrative Procedure Act (Chapter 5 (commencing with Section 11500) of Division 3 of Title 2 of the Government Code).

(f) For purposes of this section, "certified medical records" means a copy of the patient's medical records authenticated by the licensee or health care facility, as appropriate, on a form prescribed by the board.

(g) For purposes of this section, a "health care facility" means a clinic or health facility licensed or exempt from licensure pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

~~SEC. 6.Section 2291.5 is added to the Business and Professions Code, to read:2291.5.~~
~~A physician and surgeon's failure to comply with an order issued under Section 820 shall result in the issuance of notification from the board to cease the practice of medicine immediately upon the receipt of that notification. The physician and surgeon shall cease the practice of medicine until the ordered examinations have been completed. A physician and surgeon's continued failure to comply with an order issued under Section 820 shall constitute grounds for suspension or revocation of his or her certificate.~~

~~SEC. 7.Section 2334 of the Business and Professions Code is amended to read:2334.~~
~~(a)Notwithstanding any other provision of law, with respect to the use of expert testimony in matters brought by the Medical Board of California, no expert testimony shall be permitted by any party unless the following information is exchanged in written form with counsel for the other party within 90 days from the filing of a notice of defense:~~

~~(1)A curriculum vitae setting forth the qualifications of the expert.~~

~~(2) A complete expert witness report.~~

~~(3)A representation that the expert has agreed to testify at the hearing.~~

~~(4)A statement of the expert's hourly and daily fee for providing testimony and for consulting with the party~~

~~(b)The Office of Administrative Hearings may adopt regulations governing the required exchange of the information described in this section.~~

~~**SEC. 8.**~~***SEC. 13.*** Section 2403 is added to the Business and Professions Code, to read:

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

~~**SEC. 9.**~~***SEC. 14.*** Section 2514 of the Business and Professions Code is amended to read:

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

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

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

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

~~**SEC. 10.**~~***SEC. 15.*** Section 2569 of the Business and Professions Code is amended to read:

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

SEC. 16. *Section 4800 of the Business and Professions Code is amended to read:*

4800. (a) There is in the Department of Consumer Affairs a Veterinary Medical Board in which the administration of this chapter is vested. The board consists of the following members:

(1) Four licensed veterinarians.

(2) One registered veterinary technician.

(3) Three public members.

(b) This section shall remain in effect only until January 1, ~~2014,~~ *2016,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2016,* deletes or extends that date.

(c) ~~The~~ *Notwithstanding any other law, the* repeal of this section renders the board subject to ~~the~~ review ~~provided for by Division 1.2 (commencing with Section 473).~~ *by the appropriate policy committees of the Legislature. However, the review of the board shall be limited to those issues identified by the appropriate policy committees of the Legislature and shall not involve the preparation or submission of a sunset review document or evaluative questionnaire.*

SEC. 17. *Section 4804.5 of the Business and Professions Code is amended to read:*

4804.5. The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

This section shall remain in effect only until January 1, ~~2014,~~ *2016,* and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, ~~2014,~~ *2016,* deletes or extends that date.

SEC. 18. *Section 4809.5 of the Business and Professions Code is amended to read:*

4809.5. The board may at any time inspect the premises in which veterinary medicine, veterinary dentistry, or veterinary surgery is being practiced. *The board's inspection authority does not extend to premises that are not*

SEC. 19. *Section 4809.7 of the Business and Professions Code is amended to read:*

4809.7. The board shall establish a regular inspection program ~~which~~ *that* will provide for random, unannounced inspections. *The board shall make every effort to inspect at least 20 percent of veterinary premises on an annual basis.*

SEC. 20. *Section 4809.8 of the Business and Professions Code is amended to read:*

4809.8. (a) The board shall establish an advisory committee to assist, advise, and make recommendations for the implementation of rules and regulations necessary to ensure proper administration and enforcement of this chapter and to assist the board in its examination, licensure, and registration programs. ~~This~~ *The committee shall serve only in an advisory capacity to the board and the objectives, duties, and actions of the committee shall not be a substitute for or conflict with any of the powers, duties, and responsibilities of the board. The* committee shall be known as the Veterinary Medicine Multidisciplinary Advisory Committee. ~~Members of the~~ *The multidisciplinary committee shall consist of nine members. The following members of the* multidisciplinary committee shall be appointed by the board from lists of nominees solicited by the ~~board. The committee shall consist of the following seven members:~~ *board:* four licensed veterinarians, two registered veterinary technicians, and one public member. *The committee shall also include one veterinarian member of the board, to be appointed by the board president, and the registered veterinary technician member of the board.* Members of the multidisciplinary committee shall represent a sufficient cross section of the interests in veterinary medicine in order to address the issues before it, as determined by the board, including veterinarians, registered veterinary technicians, and members of the public.

(b) Multidisciplinary committee members ~~shall hold office~~ *appointed by the board shall serve* for a term of three years and appointments shall be staggered accordingly. A member may be reappointed, but no person shall serve as a member of the committee for more than two consecutive terms. Vacancies occurring shall be filled by appointment for the unexpired term, within 90 days after they occur. *Board members of the multidisciplinary committee shall serve concurrently with their terms of office on the board.*

(c) The multidisciplinary committee shall be subject to the requirements of Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Multidisciplinary committee members shall receive a per diem as provided in Section 103 and shall be compensated for their actual travel expenses in accordance with the rules and regulations adopted by the Department of Human Resources.

(e) The board may remove a member of the multidisciplinary committee *appointed by the board* for continued neglect of a duty required by this chapter, for incompetency, or for unprofessional conduct.

(f) It is the intent of the Legislature that the multidisciplinary committee, in implementing this section, give appropriate consideration to issues pertaining to the practice of registered veterinarian technicians.

SEC. 21. *Section 4836.1 of the Business and Professions Code is amended to read:*

4836.1. (a) Notwithstanding any other provision of law, a registered veterinary technician or a veterinary assistant may administer a drug, including, but not limited to, a drug that is a controlled substance, under the direct or indirect supervision of a licensed veterinarian when done pursuant to the order, control, and full professional responsibility of a licensed veterinarian. However, no person, other than a licensed veterinarian, may induce anesthesia unless authorized by regulation of the board.

(b) ~~Access to controlled substances by veterinary assistants under this section is limited to persons who have undergone a background check and who, to the best of the licensee manager's knowledge, do not have any drug or alcohol related felony convictions.~~ *Prior to authorizing a veterinary assistant to obtain or administer a controlled substance by the order of a supervising veterinarian, the licensee manager in a veterinary practice shall conduct a background check on that veterinary assistant. A veterinary assistant who has a drug- or alcohol -related felony conviction, as indicated in the background check, shall be prohibited from obtaining or administering controlled substances.*

(c) Notwithstanding subdivision (b), if the Veterinary Medical Board, in consultation with the Board of Pharmacy, identifies a dangerous drug, as defined in Section 4022, as a drug ~~which~~ *that* has an established

(d) For purposes of this section, the following definitions apply:

(1) "Controlled substance" has the same meaning as that term is defined in Section 11007 of the Health and Safety Code.

(2) "Direct supervision" has the same meaning as that term is defined in subdivision (e) of Section 2034 of Title 16 of the California Code of Regulations.

(3) "Drug" has the same meaning as that term is defined in Section 11014 of the Health and Safety Code.

(4) "Indirect supervision" has the same meaning as that term is defined in subdivision (f) of Section 2034 of Title 16 of the California Code of Regulations.

~~(e)This section shall remain in effect only until January 1, 2015, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2015, deletes or extends that date.~~

(e) This section shall become inoperative on the later of January 1, 2015, or the date Section 4836.2 becomes operative, and, as of January 1 next following that date, is repealed, unless a later enacted statute, that becomes operative on or before that date, deletes or extends the dates on which it becomes inoperative is repealed.

SEC. 22. *Section 4836.1 is added to the Business and Professions Code, to read:*

4836.1. (a) Notwithstanding any other provision of law, a registered veterinary technician or a veterinary assistant may administer a drug, including, but not limited to, a drug that is a controlled substance under the direct or indirect supervision of a licensed veterinarian when done pursuant to the order, control, and full professional responsibility of a licensed veterinarian. However, no person, other than a licensed veterinarian, may induce anesthesia unless authorized by regulation of the board.

(b) A veterinary assistant may obtain or administer a controlled substance pursuant to the order, control, and full professional responsibility of a licensed veterinarian, only if he or she meets both of the following conditions:

(1) Is designated by a licensed veterinarian to obtain or administer controlled substances.

(2) Holds a valid veterinary assistant controlled substance permit issued pursuant to Section 4836.2.

(c) Notwithstanding subdivision (b), if the Veterinary Medical Board, in consultation with the Board of Pharmacy, identifies a dangerous drug, as defined in Section 4022, as a drug that has an established pattern of being diverted, the Veterinary Medical Board may restrict access to that drug by veterinary assistants.

(d) For purposes of this section, the following definitions apply:

(1) "Controlled substance" has the same meaning as that term is defined in Section 11007 of the Health and Safety Code.

(2) "Direct supervision" has the same meaning as that term is defined in subdivision (e) of Section 2034 of Title 16 of the California Code of Regulations.

(3) "Drug" has the same meaning as that term is defined in Section 11014 of the Health and Safety Code.

(4) "Indirect supervision" has the same meaning as that term is defined in subdivision (f) of Section 2034 of Title 16 of the California Code of Regulations.

(e) This section shall become operative on the date Section 4836.2 becomes operative.

SEC. 23. *Section 4836.2 is added to the Business and Professions Code, to read:*

4836.2. (a) Applications for a veterinary assistant controlled substance permit shall be upon a form furnished by the board.

(b) The fee for filing an application for a veterinary assistant controlled substance permit shall be set by the board in an amount the board determines is reasonably necessary to provide sufficient funds to carry out the purposes of this section, not to exceed one hundred dollars ($100).

(c) The board may deny, suspend, or revoke the controlled substance permit of a veterinary assistant after notice and hearing for any cause provided in this subdivision. The proceedings under this section shall be conducted in accordance with the provisions for administrative adjudication in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein. The board may revoke or suspend a veterinary assistant controlled substance permit for any of the following reasons:

(1) The employment of fraud, misrepresentation, or deception in obtaining a veterinary assistant controlled substance permit.

(2) Chronic inebriety or habitual use of controlled substances.

(3) Violating or attempts to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, or of the regulations adopted under this chapter.

(d) The board shall not issue a veterinary assistant controlled substance permit to any applicant with a state or federal felony controlled substance conviction.

(e) The board shall revoke a veterinary assistant controlled substance permit upon notification that the veterinary assistant to whom the license is issued has been convicted of a state or federal felony controlled substance violation.

(f) (1) As part of the application for a veterinary assistant controlled substance permit, the applicant shall submit to the Department of Justice fingerprint images and related information, as required by the Department of Justice for all veterinary assistant applicants, for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her own recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information that it receives pursuant to this section. The Department of Justice shall review any information returned to it from the Federal Bureau of Investigation and compile and disseminate a response to the board summarizing that information.

(3) The Department of Justice shall provide a state or federal level response to the board pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(4) The Department of Justice shall charge a reasonable fee sufficient to cover the cost of processing the request described in this subdivision.

(g) The board shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for persons described in paragraph (1) of subdivision (f).

(h) This section shall become operative upon the later of January 1, 2015, or the effective date of the statute in which the Legislature makes a determination that the board has sufficient staffing to implement this section.

SEC. 24. *Section 4836.3 is added to the Business and Professions Code, to read:*

4836.3. (a) Each person who has been issued a veterinary assistant controlled substance permit by the board pursuant to Section 4836.2 shall biennially apply for renewal of his or her permit on or before the last day of the applicant's birthday month. The application shall be made on a form provided by the board.

(b) The application shall contain a statement to the effect that the applicant has not been convicted of a felony, has not been the subject of professional disciplinary action taken by any public agency in California or any other state or territory, and has not violated any of the provisions of this chapter. If the applicant is unable to make that statement, the application shall contain a statement of the conviction, professional discipline, or violation.

(c) The board may, as part of the renewal process, make necessary inquiries of the applicant and conduct an investigation in order to determine if cause for disciplinary action exists.

(d) The fee for filing an application for a renewal of a veterinary assistant controlled substance permit shall be set by the board in an amount the board determines is reasonably necessary to provide sufficient funds to carry out the purposes of this section, not to exceed fifty dollars ($50).

SEC. 25. *Section 4836.4 is added to the Business and Professions Code, to read:*

4836.4. (a) Every person who has been issued a veterinary assistant controlled substance permit by the board pursuant to Section 4836.2 who changes his or her mailing or employer address shall notify the board of his or her new mailing or employer address within 30 days of the change. The board shall not renew the permit of any person who fails to comply with this section unless the person pays the penalty fee prescribed in Section 4842.5. An applicant for the renewal of a permit shall specify in his or her application whether he or she has changed his or her mailing or employer address and the board may accept that statement as evidence of the fact.

(b) This section shall become operative on the date Section 4836.2 becomes operative.

~~**SEC. 11.**~~***SEC. 26.*** Section 11529 of the Government Code is amended to read:

11529. (a) The administrative law judge of the Medical Quality Hearing Panel established pursuant to Section 11371 may issue an interim order suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare. *The failure to comply with an order issued pursuant to Section 820 of the Business and Professions Code may constitute grounds to issue an interim suspension order under this section.*

(b) All orders authorized by this section shall be issued only after a hearing conducted pursuant to subdivision (d), unless it appears from the facts shown by affidavit that serious injury would result to the public before the matter can be heard on notice. Except as provided in subdivision (c), the licensee shall receive at least 15 days' prior notice of the hearing, which notice shall include affidavits and all other information in support of the order.

(c) If an interim order is issued without notice, the administrative law judge who issued the order without notice shall cause the licensee to be notified of the order, including affidavits and all other information in support of the order by a 24-hour delivery service. That notice shall also include the date of the hearing on the order, which shall be conducted in accordance with the requirement of subdivision (d), not later than 20 days from the date of issuance. The order shall be dissolved unless the requirements of subdivision (a) are satisfied.

(d) For the purposes of the hearing conducted pursuant to this section, the licentiate shall, at a minimum, have the following rights:

(1) To be represented by counsel.

(2) To have a record made of the proceedings, copies of which may be obtained by the licentiate upon payment of any reasonable charges associated with the record.

(3) To present written evidence in the form of relevant declarations, affidavits, and documents.

The discretion of the administrative law judge to permit testimony at the hearing conducted pursuant to this section shall be identical to the discretion of a superior court judge to permit testimony at a hearing conducted pursuant to Section 527 of the Code of Civil Procedure.

(4) To present oral argument.

(e) Consistent with the burden and standards of proof applicable to a preliminary injunction entered under Section 527 of the Code of Civil Procedure, the administrative law judge shall grant the interim order where, in the exercise of discretion, the administrative law judge concludes that:

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

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

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

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

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

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

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

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

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

~~**SEC. 12.**~~***SEC. 27.*** Section 12529 of the Government Code, as amended by Section 112 of Chapter 332 of the Statutes of 2012, is amended to read:

12529. (a) There is in the Department of Justice the Health Quality Enforcement Section. The primary responsibility of the section is to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California.

~~(b)On January 1, 2014, all persons employed by the Medical Board of California who are performing investigations and those person's staff shall be transferred to, and shall become employees of, the Department of Justice. The status, position, and rights of those persons shall, upon transfer, be the same as employees of the Department of Justice holding similar positions, and for those persons transferred who are performing investigations shall include the status of peace officer provided for in Section 830.1 of the Penal Code. Nothing in this section affects or diminishes the duty of the Medical Board of California to preserve the confidentiality of records as otherwise required by law. On and after January 1, 2014, any reference in this code to an investigation conducted by the Medical Board of California shall be deemed to refer to an investigation conducted by employees of the Department of Justice.~~

~~(c)~~

(b) The Attorney General shall appoint a Senior Assistant Attorney General of the Health Quality Enforcement Section. The Senior Assistant Attorney General of the Health Quality Enforcement Section shall be an attorney in good standing licensed to practice in the State of California, experienced in prosecutorial or administrative disciplinary proceedings and competent in the management and supervision of attorneys performing those functions.

~~(d)~~

(c) The Attorney General shall ensure that the Health Quality Enforcement Section is staffed with a sufficient number of experienced and able employees that are capable of handling the most complex and varied types of disciplinary actions against the licensees of the board.

~~(e)~~

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

~~**SEC. 13.**~~***SEC. 28.*** Section 12529 of the Government Code, as amended by Section 113 of Chapter 332 of the Statutes of 2012, is repealed.

~~**SEC. 14.**~~***SEC. 29.*** Section 12529.5 of the Government Code, as amended by Section 114 of Chapter 332 of the Statutes of 2012, is amended to read:

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

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

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

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

~~**SEC. 15.**~~***SEC. 30.*** Section 12529.5 of the Government Code, as amended by Section 115 of Chapter 332 of the Statutes of 2012, is repealed.

SEC. 31. *Section 12529.6 of the Government Code is amended to read:*

12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical enforcement and prosecution model for those investigations is in the best interests of the people of California.

(b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction but not the supervision of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.

(c) The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section.

(d) This section does not affect the requirements of Section 12529.5 as applied to the Medical Board of California where complaints that have not been assigned to a field office for investigation are concerned.

(e) It is the intent of the Legislature to enhance the vertical enforcement and prosecution model as set forth in subdivision (a). The Medical Board of California shall do all of the following:

(1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.

(2) Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model.

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

~~**SEC. 16.**~~***SEC. 32.*** Section 12529.7 of the Government Code is amended to read:

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

SEC. 33. *Section 1248.15 of the Health and Safety Code is amended to read:*

1248.15. (a) The board shall adopt standards for accreditation and, in approving accreditation agencies to perform accreditation of outpatient settings, shall ensure that the certification program shall, at a minimum, include standards for the following aspects of the settings' operations:

(1) Outpatient setting allied health staff shall be licensed or certified to the extent required by state or federal law.

(2) (A) Outpatient settings shall have a system for facility safety and emergency training requirements.

(B) There shall be onsite equipment, medication, and trained personnel to facilitate handling of services sought or provided and to facilitate handling of any medical emergency that may arise in connection with services sought or provided.

(C) In order for procedures to be performed in an outpatient setting as defined in Section 1248, the outpatient setting shall do one of the following:

(i) Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff.

(ii) Permit surgery only by a licensee who has admitting privileges at a local accredited or licensed acute care hospital, with the exception that licensees who may be precluded from having admitting privileges by their professional classification or other administrative limitations, shall have a written transfer agreement with licensees who have admitting privileges at local accredited or licensed acute care hospitals.

(iii) Submit for approval by an accrediting agency a detailed procedural plan for handling medical emergencies that shall be reviewed at the time of accreditation. No reasonable plan shall be disapproved by the accrediting agency.

(D) In addition to the requirements imposed in subparagraph (C), the outpatient setting shall submit for approval by an accreditation agency at the time of accreditation a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery that would place a patient at high risk for injury or harm or to govern emergency and urgent care situations. The plan shall include, at a minimum, that if a patient is being transferred to a local accredited or licensed acute care hospital, the outpatient setting shall do all of the following:

(i) Notify the individual designated by the patient to be notified in case of an emergency.

(ii) Ensure that the mode of transfer is consistent with the patient's medical condition.

(iii) Ensure that all relevant clinical information is documented and accompanies the patient at the time of transfer.

(iv) Continue to provide appropriate care to the patient until the transfer is effectuated.

(E) All physicians and surgeons transferring patients from an outpatient setting shall agree to cooperate with the medical staff peer review process on the transferred case, the results of which shall be referred back to the outpatient setting, if deemed appropriate by the medical staff peer review committee. If the medical staff of the acute care facility determines that inappropriate care was delivered at the outpatient setting, the acute care facility's peer review outcome shall be reported, as appropriate, to the accrediting body or in accordance with existing law.

(3) The outpatient setting shall permit surgery by a dentist acting within his or her scope of practice under Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code or physician and surgeon, osteopathic physician and surgeon, or podiatrist acting within his or her scope of practice under

registered nurse anesthetist acting within his or her scope of practice under Article 7 (commencing with Section 2825) of Chapter 6 of Division 2 of the Business and Professions Code.

(4) Outpatient settings shall have a system for maintaining clinical records.

(5) Outpatient settings shall have a system for patient care and monitoring procedures.

(6) (A) Outpatient settings shall have a system for quality assessment and improvement.

(B) Members of the medical staff and other practitioners who are granted clinical privileges shall be professionally qualified and appropriately credentialed for the performance of privileges granted. The outpatient setting shall grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting.

(C) Clinical privileges shall be periodically reappraised by the outpatient setting. The scope of procedures performed in the outpatient setting shall be periodically reviewed and amended as appropriate.

(7) Outpatient settings regulated by this chapter that have multiple service locations shall have all of the sites inspected.

(8) Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.

(9) Outpatient settings shall post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff.

(10) Outpatient settings shall have a written discharge criteria.

(b) Outpatient settings shall have a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care. Transfer to an unlicensed setting of a patient who does not meet the discharge criteria adopted pursuant to paragraph (10) of subdivision (a) shall constitute unprofessional conduct.

(c) An accreditation agency may include additional standards in its determination to accredit outpatient settings if these are approved by the board to protect the public health and safety.

(d) No accreditation standard adopted or approved by the board, and no standard included in any certification program of any accreditation agency approved by the board, shall serve to limit the ability of any allied health care practitioner to provide services within his or her full scope of practice. Notwithstanding this or any other provision of law, each outpatient setting may limit the privileges, or determine the privileges, within the appropriate scope of practice, that will be afforded to physicians and allied health care practitioners who practice at the facility, in accordance with credentialing standards established by the outpatient setting in compliance with this chapter. Privileges may not be arbitrarily restricted based on category of licensure.

(e) The board shall adopt standards that it deems necessary for outpatient settings that offer in vitro fertilization.

(f) The board may adopt regulations it deems necessary to specify procedures that should be performed in an accredited outpatient setting for facilities or clinics that are outside the definition of outpatient setting as specified in Section 1248.

(g) As part of the accreditation process, the accrediting agency shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest therein, to determine whether there have been any adverse accreditation decisions rendered against them. For the purposes of this section, "conducting a reasonable investigation" means querying the Medical Board of California and the Osteopathic Medical Board of California to ascertain if either the outpatient setting has, or, if its owners are licensed physicians and surgeons, if those physicians and surgeons have, been subject to an adverse accreditation decision.

~~(h)An outpatient setting shall be subject to the reporting requirements in Section 1279.1 and the penalties for failure to report specified in Section 1280.4.~~

SEC. 34. *Section 830.3 of the Penal Code is amended to read:*

with respect to which there is immediate danger to person or property, or of the escape of the perpetrator of that offense, or pursuant to Section 8597 or 8598 of the Government Code. These peace officers may carry firearms only if authorized and under those terms and conditions as specified by their employing agencies:

(a) Persons employed by the Division of Investigation of the Department of Consumer Affairs and investigators of ~~the Medical Board of California and~~ the Board of Dental Examiners, who are designated by the Director of Consumer Affairs, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 160 of the Business and Professions Code.

(b) Voluntary fire wardens designated by the Director of Forestry and Fire Protection pursuant to Section 4156 of the Public Resources Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 4156 of that code.

(c) Employees of the Department of Motor Vehicles designated in Section 1655 of the Vehicle Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 1655 of that code.

(d) Investigators of the California Horse Racing Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of Chapter 4 (commencing with Section 19400) of Division 8 of the Business and Professions Code and Chapter 10 (commencing with Section 330) of Title 9 of Part 1 of this code.

(e) The State Fire Marshal and assistant or deputy state fire marshals appointed pursuant to Section 13103 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 13104 of that code.

(f) Inspectors of the food and drug section designated by the chief pursuant to subdivision (a) of Section 106500 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 106500 of that code.

(g) All investigators of the Division of Labor Standards Enforcement designated by the Labor Commissioner, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Section 95 of the Labor Code.

(h) All investigators of the State Departments of Health Care Services, Public Health, Social Services, Mental Health, and Alcohol and Drug Programs, the Department of Toxic Substances Control, the Office of Statewide Health Planning and Development, and the Public Employees' Retirement System, provided that the primary duty of these peace officers shall be the enforcement of the law relating to the duties of his or her department or office. Notwithstanding any other provision of law, investigators of the Public Employees' Retirement System shall not carry firearms.

(i) The Chief of the Bureau of Fraudulent Claims of the Department of Insurance and those investigators designated by the chief, provided that the primary duty of those investigators shall be the enforcement of Section 550.

(j) Employees of the Department of Housing and Community Development designated under Section 18023 of the Health and Safety Code, provided that the primary duty of these peace officers shall be the enforcement of the law as that duty is set forth in Section 18023 of that code.

(k) Investigators of the office of the Controller, provided that the primary duty of these investigators shall be the enforcement of the law relating to the duties of that office. Notwithstanding any other law, except as authorized by the Controller, the peace officers designated pursuant to this subdivision shall not carry firearms.

(l) Investigators of the Department of Corporations designated by the Commissioner of Corporations, provided that the primary duty of these investigators shall be the enforcement of the provisions of law administered by the Department of Corporations. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(m) Persons employed by the Contractors State License Board designated by the Director of Consumer Affairs pursuant to Section 7011.5 of the Business and Professions Code, provided that the primary duty of these persons shall be the enforcement of the law as that duty is set forth in Section 7011.5, and in Chapter 9 (commencing with Section 7000) of Division 3, of that code. The Director of Consumer Affairs may designate as peace officers not more than 12 persons who shall at the time of their designation be assigned to the special

(n) The Chief and coordinators of the Law Enforcement Branch of the California Emergency Management Agency.

(o) Investigators of the office of the Secretary of State designated by the Secretary of State, provided that the primary duty of these peace officers shall be the enforcement of the law as prescribed in Chapter 3 (commencing with Section 8200) of Division 1 of Title 2 of, and Section 12172.5 of, the Government Code. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(p) The Deputy Director for Security designated by Section 8880.38 of the Government Code, and all lottery security personnel assigned to the California State Lottery and designated by the director, provided that the primary duty of any of those peace officers shall be the enforcement of the laws related to assuring the integrity, honesty, and fairness of the operation and administration of the California State Lottery.

(q) Investigators employed by the Investigation Division of the Employment Development Department designated by the director of the department, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 317 of the Unemployment Insurance Code.

Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(r) The chief and assistant chief of museum security and safety of the California Science Center, as designated by the executive director pursuant to Section 4108 of the Food and Agricultural Code, provided that the primary duty of those peace officers shall be the enforcement of the law as that duty is set forth in Section 4108 of the Food and Agricultural Code.

(s) Employees of the Franchise Tax Board designated by the board, provided that the primary duty of these peace officers shall be the enforcement of the law as set forth in Chapter 9 (commencing with Section 19701) of Part 10.2 of Division 2 of the Revenue and Taxation Code.

(t) Notwithstanding any other provision of this section, a peace officer authorized by this section shall not be authorized to carry firearms by his or her employing agency until that agency has adopted a policy on the use of deadly force by those peace officers, and until those peace officers have been instructed in the employing agency's policy on the use of deadly force.

Every peace officer authorized pursuant to this section to carry firearms by his or her employing agency shall qualify in the use of the firearms at least every six months.

(u) Investigators of the Department of Managed Health Care designated by the Director of the Department of Managed Health Care, provided that the primary duty of these investigators shall be the enforcement of the provisions of laws administered by the Director of the Department of Managed Health Care. Notwithstanding any other provision of law, the peace officers designated pursuant to this subdivision shall not carry firearms.

(v) The Chief, Deputy Chief, supervising investigators, and investigators of the Office of Protective Services of the State Department of Developmental Services, provided that the primary duty of each of those persons shall be the enforcement of the law relating to the duties of his or her department or office.

~~**SEC. 17.**~~***SEC. 35.*** No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.

California LEGISLATIVE INFORMATION

SB-304 Healing arts: boards. (2013-2014)

Date	Action
08/13/13	From committee: Do pass and re-refer to Com. on APPR. (Ayes 11. Noes 2.) (August 13). Re-referred to Com. on APPR.
08/12/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B.,P. & C.P.
08/06/13	Set, first hearing. Hearing canceled at the request of author.
06/14/13	Referred to Com. on B.,P. & C.P.
05/29/13	In Assembly. Read first time. Held at Desk.
05/28/13	Read third time. Passed. (Ayes 35. Noes 2. Page 1099.) Ordered to the Assembly.
05/24/13	Read second time. Ordered to third reading.
05/23/13	From committee: Do pass. (Ayes 5. Noes 0. Page 1011.) (May 23).
05/17/13	Set for hearing May 23.
05/13/13	Placed on APPR. suspense file.
05/03/13	Set for hearing May 13.
04/30/13	From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 0. Page 733.) (April 29). Re-referred to Com. on APPR.
04/24/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B., P. & E.D.
04/16/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B., P. & E.D.
04/05/13	Set for hearing April 29.
02/28/13	Referred to Com. on B., P. & E.D.
02/19/13	From printer. May be acted upon on or after March 21.
02/15/13	Introduced. Read first time. To Com. on RLS. for assignment. To print.

Date of Hearing: August 13, 2013

ASSEMBLY COMMITTEE ON BUSINESS, PROFESSIONS AND CONSUMER PROTECTION
Susan A. Bonilla, Chair
SB 304 (Lieu) – As Amended: August 13, 2013

SENATE VOTE: 35-2

SUBJECT: Healing arts: boards.

SUMMARY: Makes various revisions developed as a result of the joint Sunset Review process, including amending the Medical Practice Act (Act) to transfer inspectors from the Medical Board of California (MBC) to the Division of Investigation (DOI) within the Department of Consumer Affairs (DCA) and extend the sunset date of MBC by four years, and amending the Veterinary Practice Act to extend its sunset date by two years. Specifically, this bill:

1) Transfers the Health Quality Investigation Unit (Unit) from MBC to DOI within DCA, and states that the primary responsibility of the Unit is to investigate violations of law or regulation by licensees and applicants within the jurisdiction of MBC, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of MBC.

2) Clarifies that all civil service employees whose functions are transferred to DOI as a result of this bill and who are currently employed by MBC shall retain their positions, status, and rights, as specified.

3) Requires the transfer of the Unit to DOI to occur by January 1, 2014.

4) Requires that the transfer of employees shall include all peace officer positions and staff support positions that are identified by DCA as positions whose functions are primarily enforcement related.

5) Extends MBC's sunset date until January 1, 2018 and makes MBC subject to review by the appropriate policy committees of the Legislature.

6) Requires that MBC's executive director be approved by the director of DCA.

7) Requires each physician and surgeon applicant and licensee who has an electronic mail address to report it to MBC by July 1, 2014. The electronic mail address shall be considered confidential and not subject to public disclosure.

8) Removes language requiring MBC to send regular mail to those physician and surgeons who do not confirm his or her electronic mail address.

9) Revises provisions relating to qualifications for an applicant from a foreign medical school

a) The applicant may have an unrestricted license from a Canadian province, and that a minimum of 10 years, not 20, is required for eligibility for a California physician and surgeon license; and,

b) The applicant must have a minimum of five, not two, years' continuous licensure in a single state, federal territory, or Canadian province.

10) Clarifies that a physician and surgeon applicant shall have obtained a passing score on all parts of Step 3 of the United States Medical Licensing Examination (USMLE) within not more than four attempts in order to be eligible for a physician's and surgeon's certificate.

11) Clarifies that an applicant who obtains a passing score on all parts of Step 3 of the USMLE in more than four attempts and who meets specified requirements shall be eligible to be considered for issuance of a physician's and surgeon's certificate.

12) Requires an accredited outpatient setting to report an adverse event to MBC no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. States that disclosure of individually identifiable patient information shall be consistent with applicable law.

13) Permits MBC to fine an accredited outpatient setting an amount not to exceed one hundred dollars ($100) for each day that the adverse event is not reported, as specified. If the accredited outpatient setting disputes a determination by MBC regarding alleged failure to report an adverse event, the accredited outpatient setting may, within 10 days of notification of MBC's determination, request a hearing, as specified. Requires that penalties be paid when appeals have been exhausted.

14) Declares that civil settlements are treated as complaints by the board, as specified.

15) States that a health care facility with electronic health records' failure to provide an authorizing patient's certified medical records to MBC within 15 days of receiving the request, authorization, and notice will subject the health care facility to a civil penalty, payable to MBC, of up to $1,000 per day for each day that the documents have not been produced, and after the 15th day, up to ten thousand dollars $10,000, unless the health care facility is unable to provide the documents within this time period for good cause.

16) Strikes provisions of law related to expert testimony before MBC.

17) Permits corporations to employ physicians and surgeons or doctors of podiatric medicine enrolled in approved residency postgraduate training programs or fellowship programs.

18) Permits a bona fide student to engage in the practice of midwifery if the student is under the supervision of a certified nurse-midwife, as specified.

19) Defines a "bona fide student" to mean an individual who is enrolled and participating in a

20) States that the failure of a physician and surgeon to comply with an order to be examined by one or more physicians and surgeons or psychologists designated by DCA for evaluation of competency to practice may constitute grounds to issue an interim suspension order (ISO).

21) Extends the time period from 15 to 30 days between the issuance of an ISO and the filing of an accusation.

22) Deletes the sunset date on the Health Quality Enforcement Section in the Department of Justice (DOJ) and vertical enforcement (VE).

23) Requires MBC, in consultation with DOJ and DCA, to report and make recommendations to the Governor and the Legislature on the vertical enforcement and prosecution model.

24) Extends until January 1, 2016, the provisions establishing the VMB and subjects the VMB to a review by the appropriate policy committees of the Legislature and clarifies that the review of the VMB shall be limited to those issues identified by the appropriate policy committees and does not involve the preparation or submission of a sunset review document or questionnaire.

25) Clarifies that the VMB's inspection authority does not extend to premises that are not required to be registered with the VMB and specifies that this provision does not affect the VMB's ability to investigate alleged unlicensed activity.

26) Requires the VMB to make every effort to inspect at least 20 percent of veterinary premises on an annual basis.

27) Requires the Multidisciplinary Committee (MDC) to only serve in an advisory capacity to the VMB and specifies that the objectives, duties and actions of the MDC shall not be a substitute for or conflict with any of the powers, duties and responsibilities of the VMB.

28) Increases the membership of the MDC from seven to nine by adding a veterinarian member of the VMB, who is to be appointed by the VMB president, and the Registered Veterinary Technician (RVT) member of the VMB and specifies that VMB members on the MDC serve concurrently with their term of office.

29) States the intent of the Legislature that the MDC give appropriate consideration to issues pertaining to the practice of RVTs.

30) Requires prior to authorizing a veterinary assistant (VA) to obtain or administer a controlled substance by the order of a supervising veterinarian, the licensee manager in a veterinary practice to conduct a background check on that VA and specifies that a veterinary assistant who has a drug or alcohol-related felony conviction, as indicated in the background check, shall be prohibited from obtaining or administering controlled substances.

31) Authorizes a RVT or a VA to administer a drug, including but not limited to, a drug that is a controlled substance under the direct or indirect supervision of a licensed veterinarian, who

induce anesthesia unless authorized by regulation of the VMB.

32) Authorizes a VA to obtain or administer a controlled substance pursuant to the order, control, and full professional responsibility of a licensed veterinarian if he or she meets both of the following conditions:

   a) Is designated by a licensed veterinarian to obtain or administer controlled substances; and,

   b) Holds a veterinary assistant controlled substance permit (VACSP) as specified.

33) Permits the VMB to restrict access to a drug that the VMB in consultation with the Board of Pharmacy (BOP) identifies as a dangerous drug that has an established pattern of being diverted, as specified.

34) Provides a definition for "controlled substance," "direct supervision," "drug," and "indirect supervision" as specified.

35) Specifies that the provision pertaining to an RVT or VA administering a drug, as specified, becomes operative on January 1, 2015 or the effective date of the statute in which the Legislature makes a determination that the VMB has sufficient staffing to implement.

36) Requires applications for a VACSP to be on a form furnished by the VMB.

37) Specifies that the application fee for a VACSP is set by the VMB in an amount it determines is reasonably necessary, not to exceed $100.

38) Authorizes the VMB to deny, suspend or revoke the controlled substance permit of a VA after notice and hearing for any cause, as specified, and specifies that proceedings shall be conducted in accordance with the provisions of administrative adjudication as specified.

39) Specifies that the VMB may revoke or suspend a VACSP for any of the following reasons:

   a) The employment of fraud, misrepresentation or deception in obtaining a VACSP;

   b) Chronic inebriety or habitual use of controlled substances; and,

   c) Violating or attempts to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any specified provision or adopted regulations.

40) Specifies that the VMB shall not issue a VACSP to any applicant with state or federal felony controlled substance convictions.

41) Authorizes the VMB to revoke a VACSP upon notification that the VA has been convicted of a state or federal felony controlled substance violation.

42) Requires the applicant for a VACSP, as part of the application

state or federal arrests and also information as to the existence and content of a record of state or federal arrests for which the DOJ establishes that the person is free on bail or on his or her recognizance pending trial or appeal.

43) Requires the DOJ to forward to the Federal Bureau of Investigation (FBI) requests for federal summary criminal history information that it receives, as specified, and requires the DOJ to review any information returned from the FBI and compile and disseminate a response to the VMB summarizing that information.

44) Requires the DOJ to provide a state or federal level response to the VMB as specified.

45) Requires the DOJ to charge a reasonable fee sufficient to cover the cost of processing the requests.

46) Requires the VMB to request from the DOJ subsequent notification service, as specified, for VACSP applicants.

47) Requires each person who has been issued a VACSP by the VMB, to biennially apply for renewal of his or her permit on or before the last day of the applicant's birthday month and requires the application to be made on a form provided by the VMB.

48) Requires the application for a VACSP to contain a statement that the applicant has not been convicted of a felony, has not been the subject of professional disciplinary action taken by any public agency in California or any other state or territory, and has not violated any of the provisions pertaining to the VACSP, and specifies that if the applicant is unable to make that statement, the application shall contain a statement of the conviction, professional discipline, or violation.

49) Permits the VMB, as part of the renewal process, to make the necessary inquiries of the applicant and conduct an investigation in order to determine if cause for disciplinary action exists.

50) Authorizes the VMB to establish the fee for filing a renewal application for a VACSP in an amount the VMB determines is reasonable necessary not to exceed $50.

51) Requires every person who has been issued a VACSP, who changes his or her mailing or employer address to notify the VMB of his or her new mailing or employer address within 30 days of that change and specifies that the VMB may not renew the permit of any person who fails to comply with address change notification requirements unless the person pays a specified penalty fee.

52) Requires an applicant for a renewal permit to specify in his or her application whether he or she has changed his or her mailing or employer address and the VMB may accept that statement as evidence of the fact.

53) Specifies that the provisions pertaining to the VACSP and the renewal application for the VACSP becomes operative on January 1, 2015 or the effective date of the [illegible]

54) Makes clarifying and technical changes.

EXISTING LAW:

1) Licenses and regulates physicians and surgeons under the Medical Practice Act (Act) by MBC within DCA and states that the protection of the public is the highest priority of MBC in exercising its functions. (Business and Professions Code (BPC) 2000 *et seq.*)

2) Requires MBC to annually send an electronic notice to each applicant and licensee who has chosen to receive correspondence by electronic mail that requests confirmation that the electronic mail address is current. (BPC 2021)

3) Requires an applicant for a physician and surgeon's certificate to obtain a passing score on Step 3 of the USMLE with not more than 4 attempts, subject to an exception. (BPC 2177)

4) Requires a health care facility to comply with a request of MBC for certified medical records of a patient, authorized by the patient in writing within 30 days, and provides for a civil penalty of up to $1,000 per day, as specified, imposed on a health care facility that fails to comply with that request. (BPC 2225.5)

5) Provides that whenever it appears that a healing arts practitioner may be unable to practice his or her profession safely because of an impaired ability due to mental illness or physical illness affecting competency, the licensing board may order the licensee to be examined by a physician and surgeon or psychologist; and, provides that if the board determines that the licensee's ability to practice is impaired because of mental or physical illness affecting competency, that board may, revoke the license, suspend the right to practice, place the licensee on probation, or take any other action deemed proper by the board. (BPC 820 and 822)

6) Prohibits a party from bringing expert testimony in a matter brought by MBC unless certain information regarding the expert witness and a brief summary of the testimony is exchanged in written form with counsel for the other party, within 30 calendar days prior to the hearing. (BPC 2334)

7) Prohibits corporations and other artificial legal entities from having any medical professional rights, privileges, or powers. (BPC 2400 *et seq.*)

8) Provides for the licensing and regulation of licensed midwives under the Licensed Midwifery Practice Act of 1993, by MBC, and specifies under that law that a midwife student meeting certain conditions is not precluded from engaging in the practice of midwifery as part of the course of study, if certain conditions are met, including, that the student is under the supervision of a licensed midwife. (BPC 2514)

9) Provides for the regulation of registered dispensing opticians by MBC and requires that the powers and duties of the MBC in that regard be subject to review by the Joint Sunset Review Committee as if those provisions were scheduled to be repealed on January 1, 2014. (BPC

10) Under the Administrative Procedure Act (APA), establishes within the Office of Administrative Hearings (OAH) a Medical Quality Hearing Panel to conduct adjudicative hearings and proceedings relative to licensees of the MBC under the terms and conditions set forth in the APA, except as provided in the Medical Practice Act. (Government Code (GC) Section 11371, 11373)

11) Authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an ISO suspending a license, or imposing drug testing, continuing education, supervision of procedures, or other licensee restrictions. Requires that an accusation must be filed within 15 days of the date the ISO is granted or else the order will be dissolved. (GC 11529)

12) Establishes the Health Quality Enforcement Section within the Department of Justice whose primary responsibility is to investigate and prosecute proceedings against licensees and applicants of MBC and other specified health-care boards. (GC 12529)

    a) Provides for the appointment of a Senior Assistant Attorney General to the section to carry out specified duties, and provides that the section to be staffed by a sufficient number of employees capable of handling the most complex and varied types of disciplinary actions; and,

    b) Provides for the funding for the section, from the special funds financing the MBC and other specified health-care boards.

13) Requires that all complaints or relevant information concerning licensees that are within the jurisdiction of MBC, the California Board of Podiatric Medicine, or the Board of Psychology be made available to the Health Quality Enforcement Section. (GC 12529.5)

    a) Establishes the procedures for processing the complaints, assisting the boards or committees in establishing training programs for their staff, and for determining whether to bring a disciplinary proceeding against a licensee of the boards.

    b) Provides for the repeal of those provisions on January 1, 2014.

14) Establishes a VE prosecution model for cases before MBC. (GC 12529.6)

    a) Requires that a complaint referred to a district office of the MBC for investigation also be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health and Quality Enforcement Section, as provided.

    b) Provides for the repeal of those provisions on January 1, 2014.

15) Requires MBC in consultation with the DOJ to report to the Governor and Legislature on the VE model by March 1, 2012. (BPC 12529.7)

16) Provides for the licensing and regulation of veterinarians registered veterinary technicians (RVTs) by the Veterinary Medical Board (VMB) within DCA. (BPC 4800 *et seq.*)

that VMB shall remain in effect until January 1, 2014, and that the VMB is subject to review by the Legislature. (BPC 4800)

18) Authorizes the VMB to appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the Board; provides that this authority shall remain in effect only until January 1, 2014. (BPC 4804.5)

19) Provides that the VMB may at any time inspect the premises in which veterinary medicine, veterinary dentistry, veterinary surgery is being practiced. (BPC 4809.5)

20) Requires the VMB to establish a regular inspection program which will provide for random, unannounced inspections. (BPC 4809.7)

21) Provides that the VMB shall establish an advisory committee to assist, advise, and make recommendations for the implementation of rules and regulations necessary to ensure proper administration and enforcement of the Veterinary Practice Act and to assist the VMB in its examination, licensure, and registration programs. This committee shall be known as the Veterinary Medicine Multidisciplinary Advisory Committee (MDC). (BPC 4809.8)

22) Provides that members of the MDC shall be appointed by the VMB and shall consist of 7 members; 4 licensed veterinarians, 2 RVTs, and 1 public member. Members shall represent a sufficient cross section of the interests in veterinary medicine in order to address the issues before it, as determined by the VMB, including veterinarians, RVTs and members of the public. (BPC 4809.8.)

23) Provides the terms of the membership of the MDC. (BPC 4809.8 (b))

24) Authorizes a RVT or a veterinary assistant to administer a drug, including, but not limited to, a drug that is a controlled substance, under the direct or indirect supervision of a licensed veterinarian when done pursuant to the order, control, and full professional responsibility of a licensed veterinarian. (BPC 4836.1)

25) Limits access to controlled substances to persons who have undergone a background check and who, to the best of the licensee manager's knowledge, do not have any drug or alcohol related felony convictions. (BPC 4836.1)

FISCAL EFFECT: Unknown

COMMENTS:

1) Purpose of this bill. This bill represents the combined provisions drafted to address many of the issues raised in the 2013 Sunset Review Reports for the MBC and VMB. In addition to extending the sunset dates for the MBC by four years and the VMB by two years, SB 304 includes a number of reforms designed to better protect consumers and make boards more efficient and accountable. This measure is author-sponsored.

for MBC and VMB, they will be repealed on January 1, 2014. In 2013, the Senate and Assembly Business and Professions Committees conducted joint oversight hearings to review 14 regulatory boards within the DCA. The Committees began their review of these licensing agencies in March and conducted three days of hearings. This bill is intended to implement legislative changes as recommended in the Committee's Background/Issue Papers for all of the agencies reviewed by the Committees this year."

3) MBC. MBC was established in 1876 and is a special-funded state entity responsible for regulating physicians and surgeons and a number of other allied health professionals. There are currently 126,483 active physicians and surgeons and 270 licensed midwives in California. This bill makes a number of improvements to streamline enforcement mechanisms and enhance penalties to encourage compliance. Below are several major issues addressed by SB 304:

   a) Vertical enforcement and prosecution (VE). Under current law, VE requires the AG's Office to be involved in MBC's investigation activities as well as its prosecution activities. VE was established in 2006 as a result of an in-depth review of the MBC's Enforcement and Diversion Programs, and included significant recommendations for improvement.

      VE requires that each complaint referred to MBC district office for investigation be simultaneously and jointly assigned to a MBC investigator and HQES deputy. The legislative goal of VE was to bring MBC investigators and HQES Deputies Attorney together, so that each complaint referred to a MBC's district office for investigation is simultaneously and jointly assigned to a MBC investigator and a DAG from the AG's Office. This team approach encourages early coordination and faster decisions, filings, and results. Subsequent legislation extended the sunset date several times. VE has been successful in integrating investigations and prosecutions and has resulted in faster resolutions. This bill deletes the sunset date on VE, extending the program indefinitely.

   b) Transfer of MBC investigators to DOI. As initially drafted in VE's enabling legislation, investigators would have been transferred to HQES in the AG's office. This would have placed the investigator and prosecutor in the same office under the same agency, a practice, as is done in numerous other law enforcement departments throughout the country. Very late in the legislative process the transfer of investigators was removed, but not before receiving support from MBC.

      The impetus to revisit the issue of transferring investigators from MBC comes from the need to improve the enforcement activities and results in MBC enforcement cases. The 2012 *Los Angeles Times* series *"Dying For Relief"* illustrated that MBC has failed to aggressively investigate and pursue actions against dangerous doctors.

      This bill transfers MBC investigators to DCA, rather than DOJ, allowing the Legislature to retain oversight authority over the investigatory process.

   c) Failure to comply with a mental or physical examination. MBC may order a physical or

licentiate's ability to practice his or her profession actually has become impaired because of mental or physical illness.

Failure to comply with an examination order constitutes grounds for suspension or revocation of the individual's certificate or license. However, the process for suspension or revocation for refusal to submit to a duly-ordered examination can be lengthy, as demonstrated by a recent court case in which a licentiate of the Board of Registered Nursing refused a psychiatric examination yet continued to practice for months thereafter.

This bill states that the failure of a licensee to comply with an order to be examined by a physician or psychologist for evaluation of competency to practice may constitute grounds to issue an ISO.

d) Midwives. This bill defines a bona fide midwife student to resolve confusion between the medical and midwifery community. "Bona fide student" means an individual who is enrolled and participating in a midwifery education program or who is enrolled in a program of supervised clinical training as part of the instruction of a three year postsecondary midwifery education program approved by MBC. This bill also clarifies that a bona fide student may engage in the practice of midwifery if the student is under the supervision of a certified nurse-midwife, as specified.

4) Veterinary Medical Board. The VMB licenses and regulates veterinarians, RVTs, schools/programs and veterinary premises/hospitals through the enforcement of the California Veterinary Medicine Practice Act. The VMB develops and enforces the standards for examinations, licensing, and hospital and school inspections. The veterinary medical profession provides health care to a variety of animals including livestock, poultry, and pets from birds, fish, rabbits, hamsters, and snakes to dogs, cats, goats, pigs, horses, and llamas. Currently there are 36 recognized specialties in veterinary medicine such as surgery, internal medicine, pathology, and ophthalmology. The VMB was last reviewed by the former Joint Legislative Sunset Review Committee (JLSRC) in 2004.

The VMB licenses approximately 10,998 Veterinarians and 5,811 RVTs. The VMB also requires registration of all premises where veterinary medicine, veterinary dentistry, veterinary surgery, and the various branches thereof, is being practiced, which totals approximately 3,100 veterinary premises. This bill would extend the provisions establishing the VMB and the term of the executive officer until 2016, where a follow up review of the VMB's outstanding issues from the 2013 sunset review process will be addressed. The VMB will not be required to produce a full report, but will be instructed to address issues as designated by the appropriate policy committees of the Legislature.

a) Veterinary Premise and Facility Inspections. During the 2004 sunset review of the VMB the JLSRC raised the issue that only 13 percent of veterinary premises/facilities were inspected by the VMB, and that once a facility has been inspected, it is generally not inspected again until other facilities have been inspected – perhaps as long as six or more years later. The JLSRC recommended that the VMB should attempt to increase the number of veterinary facilities inspected. In the current 2012 sunset review, limited follow up information was provided pertaining to the VMB's inspection program of veterinary

during the 2013 sunset review process about VMB's premises and facility inspections, this bill requires the VMB to make every effort to inspect at least 20 percent of veterinary premises on an annual basis. The increased inspections will help the VMB enforce and review safety and compliance issues with premises and facilities that care for animals.

In addition to increasing premises and facility inspections, another issue raised during the 2013 sunset review process that the VMB may have been inspecting non-veterinarian premises, including 501(c)(3) animal rescue groups, providing an "inspection report" and possibly issuing citations and fines. The Senate Business, Professions and Economic Development Committee raised the issue that this may not be a reasonable use of resources for the VMB.

In order to better define the inspection authority of the VMB, this bill clarifies existing law so that the VMB is not inspecting non-veterinarian premises so that it can better target their use of scarce enforcement resources.

b) Addressing Registered Veterinarian Technician (RVT) Issues. In 2010, AB 1980 (Hayashi) (Chapter 538, Statutes of 2010) changed the composition of the VMB to include an RVT member on the VMB, made the "multidisciplinary committee" (MDC) permanent, and provided for additional duties to be added to the committee. Among other changes, the bill also eliminated the RVT Committee. According to those representing the RVT profession, there have been RVT issues which either the MDC or the VMB have not addressed or delayed. The MDC was intended to be inclusive of all issues regarding the veterinarian profession. To assure the VMB has direct input and oversight of matters related to the MDC, this bill requires that there be one veterinarian member of the VMB that sits on the MDC, and the RVT member of the VMB also sit on the MDC. This will help ensure that issues pertaining to RVTs are addressed in a more timely and efficient manner.

c) Veterinarian Assistants Access to Controlled Substances. For many years, it had been common practice for RVTs and VAs who assisted veterinarians in practice to administer drugs under indirect supervision of a veterinarian, by the veterinarian's order, control, and full professional responsibility. However, in 2007, the VMB's legal counsel questioned existing law regarding who can administer drugs to animals in a veterinary practice setting. SB 969 (Aanestad), (Chapter 83, Statutes of 2007) made a statutory change to clarify those persons who could provide controlled substances in a veterinary office or clinic and under what level of supervision and also contained a sunset provision. The purpose for the sunset provision was to assure that there were no problems or complaints received by the VMB regarding the access to controlled substances by VAs. The sunset provision was extended to January 1, 2013, pursuant to SB 943 (Committee on Business, Professions and Economic Development) (Chapter 350, Statutes of 2011).

There have been stakeholder discussions pertaining to changes in law to assure that VAs who have access to controlled substances have appropriate oversight and no criminal history. Discussions focused on a fingerprinting requirement for VAs who would have access to controlled substances within the veterinary facility. DOJ indicated that they

substances, so that the VMB could request fingerprints of the VAs that would be provided to DOJ. The VMB could then be provided with the criminal background information from DOJ before they grant a permit. During the 2013 sunset review process, it was recommended that the VMB establish a permitting process for VAs who will have access to controlled substances, both under direct and indirect supervision of a veterinarian, so that the VMB can require a fingerprint check and obtain criminal history information from DOJ for VAs.

This bill establishes the guidelines for the VACSP and the appropriate fingerprinting and background checks necessary for the permitting of VAs in order to ensure the safety of animals receiving medical care, and protect the public from any inappropriate dispensing of controlled substances. Further, this bill specifies that the process should begin by January 1, 2015, unless the legislature determines that sufficient staffing is available prior to the specified implementation date.

REGISTERED SUPPORT / OPPOSITION:

Support

Center for Public Interest Law
California Veterinary Medical Association
Veterinary Medical Board

Opposition

None on file

Analysis Prepared by: Sarah Huchel and Elissa Silva / B.,P. & C.P. / (916) 319-3301

California LEGISLATIVE INFORMATION

SB-352 Medical assistants: supervision. (2013-2014)

AMENDED IN ASSEMBLY JUNE 19, 2013

AMENDED IN SENATE APRIL 10, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL **No. 352**

Introduced by Senator Pavley
(Principal Coauthor(s): Senator Hernandez)

February 20, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

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

Vote: majority Appropriation: no Fiscal Committee: no Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 2069 of the Business and Professions Code is amended to read:

2069. (a) (1) Notwithstanding any other law, a medical assistant may administer medication only by

supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a certified nurse-midwife.

(2) The supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, certified nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, certified nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be performed when the supervising physician and surgeon is not onsite, if either of the following apply:

(A) The nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol, *including instructions for specific authorizations,* shall be developed and approved by the supervising physician and surgeon and the nurse practitioner or certified nurse-midwife.

(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502, *including instructions for specific authorizations,* and is approved to do so by the supervising physician and surgeon.

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

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

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

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

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

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

(4) "Technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a medical assistant who has limited training and who functions under the supervision of a licensed physician and surgeon or a licensed podiatrist, or a physician assistant, a nurse practitioner, or a certified nurse -midwife as provided in subdivision (a).

(c) Nothing in this section shall be construed as authorizing any of the following:

(1) The licensure of medical assistants.

(2) The administration of local anesthetic agents by a medical assistant.

(3) The board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.

(4) A medical assistant to perform any clinical laboratory test or examination for which he or she is not

(5) A nurse practitioner, certified nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.

(d) A nurse practitioner, certified nurse-midwife, or physician assistant shall not authorize a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized by Chapter 3 (commencing with Section 1200). A violation of this subdivision constitutes unprofessional conduct.

~~(d)~~

(e) Notwithstanding any other law, a medical assistant shall not be employed for inpatient care in a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

California LEGISLATIVE INFORMATION

SB-352 Medical assistants: supervision. (2013-2014)

Date	Action
08/12/13	In Senate. Concurrence in Assembly amendments pending.
08/08/13	Read third time. Passed. (Ayes 69. Noes 0. Page 2477.) Ordered to the Senate.
06/26/13	Read second time. Ordered to third reading.
06/25/13	From committee: Do pass. (Ayes 10. Noes 0.) (June 25).
06/19/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B.,P. & C.P.
05/09/13	Referred to Com. on B.,P. & C.P.
04/22/13	In Assembly. Read first time. Held at Desk.
04/22/13	Read third time. Passed. (Ayes 36. Noes 2. Page 606.) Ordered to the Assembly.
04/15/13	Read second time. Ordered to third reading.
04/11/13	Ordered to second reading.
04/11/13	Withdrawn from committee.
04/10/13	Read second time and amended. Re-referred to Com. on APPR.
04/09/13	From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 9. Noes 1. Page 464.) (April 8).
03/21/13	Set for hearing April 8.
02/28/13	Referred to Com. on B., P. & E.D.
02/21/13	From printer. May be acted upon on or after March 23.
02/20/13	Introduced. Read first time. To Com. on RLS. for assignment. To print.

SENATE RULES COMMITTEE
Office of Senate Floor Analyses
1020 N Street, Suite 524
(916) 651-1520 Fax: (916) 327-4478

UNFINISHED BUSINESS

Bill No: SB 352
Author: Pavley (D), et al.
Amended: 6/19/13
Vote: 21

SENATE BUSINESS, PROF. & ECON. DEV. COMM.: 9-1, 4/8/13
AYES: Price, Emmerson, Block, Corbett, Galgiani, Hernandez, Hill, Padilla, Wyland
NOES: Yee

SENATE FLOOR: 36-2, 4/22/13
AYES: Anderson, Beall, Berryhill, Block, Calderon, Cannella, Corbett, Correa, De León, DeSaulnier, Emmerson, Evans, Fuller, Gaines, Galgiani, Hernandez, Hill, Hueso, Huff, Jackson, Knight, Lara, Leno, Lieu, Liu, Monning, Nielsen, Padilla, Pavley, Price, Roth, Steinberg, Walters, Wolk, Wright, Wyland
NOES: Hancock, Yee
NO VOTE RECORDED: Vacancy, Vacancy

ASSEMBLY FLOOR: 69-0, 8/8/13 - See last page for vote

SUBJECT: Medical assistants: supervision

SOURCE: California Academy of Physician Assistants
California Association of Physician Groups

DIGEST: This bill allows medical assistants (MAs) to perform technical supportive services, in doctor's offices and all medical clinics, under the supervision of a physician assistant (PA), nurse practitioner (NP) or certified nurse-midwife (CNM) without a physician on the premises; and makes other

Assembly Amendments prohibit an NP, CNM, or PA from authorizing an MA to perform any clinical laboratory test or exam for which the MA is not authorized, as specified; and make technical changes.

ANALYSIS:

Existing law:

1. Authorizes an MA, as defined, to perform specified services relating to the administration of medication and performance of skin tests and simple routine medical tasks and procedures upon specific authorization from and under the supervision of a licensed physician and surgeon or podiatrist, or in a specified clinic upon specific authorization of a PA, NP, or nurse-midwife.

2. Defines "specific authorization" as a specific written order prepared by the supervising physician, surgeon, podiatrist, NP or nurse-midwife authorizing the procedures to be performed on a patient.

3. Requires the Board of Registered Nursing to issue a certificate to practice nurse-midwifery to a qualifying applicant who is licensed pursuant to the Nursing Practice Act.

4. Authorizes MAs to perform additional technical supportive services, as specified.

This bill:

1. Expands the types of settings where MAs can provide technical supportive services from community and free clinics to any medical setting.

2. Authorizes a physician or surgeon to authorize an NP, CNM, or PA to provide supervision of MAs as they follow written instructions provided by the physician when the physician is not on site, if either:

   A. The NP or CNM is functioning pursuant to standardized procedures, as defined by Business and Professions Code (BPC) Section 2725, or protocol. The standardized procedures or protocol, including instructions for specific authorizations, shall be developed and approved by the supervising physician and surgeon and the NP or CNM.

B. The PA is functioning pursuant to regulated services defined in BPC Section 3502, including instructions for specific authorizations, and is approved to do so by the supervising physician and surgeon.

3. Specifies that the standards established for MAs will be established by the Medical Board of California (MBC), and specifies that the MBC shall not adopt regulations that violate prohibitions on diagnosis or treatment.

4. Specifies that MAs shall not perform any tests or examinations for which he/she is not authorized.

5. Prohibits an NP, CNM, or PA to be a laboratory director of a clinical laboratory.

6. Prohibits an NP, CNM, or PA from authorizing an MA to perform any clinical laboratory test or examination for which the MA is not authorized, as specified, a violation of which constitutes unprofessional conduct.

Background

MAs and their scope of practice. According to the United States Bureau of Labor and Statistics (BLS), the medical assisting professions continue to be some of the fastest growing employment categories. The BLS projects that the number of MAs will grow by 34%, from 483,600 in 2008, to 647,500 by 2018. California employs nearly 82,000 MAs. MAs are unlicensed personnel who work in physician, podiatrist or optometrist offices and clinics. MAs may not work for inpatient care in licensed general acute care hospitals. MAs can perform basic administrative, clerical and technical supportive services when conditions regarding supervision, training, specific authorization and records are met.

Training. An MA must receive training either directly from a physician, surgeon, podiatrist, registered nurse, licensed vocational nurse, PA or a qualified MA. Alternatively, an MA may receive training from a secondary, postsecondary or adult education program in a public school authorized by the California Department of Education, in a community college program, or a postsecondary institution accredited by an accreditation agency recognized by the U.S. Department of Education or approved by the Bureau for Private Postsecondary Education.

Certifying Agencies – the American Association of Medical Assistants who provide Certified Medical Assistant certification, and the American Medical Technologists who provide Registered Medical Assistant certification.

Supervision. MAs can be supervised by physicians, surgeons, podiatrists or optometrists. Additionally, if an MA is working in a community or free clinic, they may work under the direct supervision of a PA, NP or nurse-midwife when the supervising physician or surgeon is not on site, only if the physician or surgeon has created a written protocol for the activities of the MA.

Authorization. MAs must receive specific authorization before providing any technical services. This authorization may be in the form of a specific written order or standing order prepared by the supervising physician, surgeon or podiatrist. The order must include an authorization for the procedure to be performed and it must be noted in the patient's medical record.

Records. MAs are required to document all technical supportive services in the patient's record. In addition, when practicing in a community or free clinic under the supervision of a PA, NP or nurse-midwife, the delegation of supervision from the physician, surgeon or podiatrist to the PA, NP or nurse-midwife, must be documented in a written standard protocol.

Community and free clinics. In response to California's growing population and ensuing need to provide health care services, SB 111 (Alpert, Chapter 358, Statutes of 2000) permitted MAs to perform technical supportive services in community and free clinics under the direct supervision of a PA, NP or nurse-midwife.

There are four types of licensed community clinics in California: (1) Federally Qualified Health Center sites (FQHC); (2) FQHC look-alike sites; (3) free clinic sites; and (4) other independent, non-profit clinic sites.

A key distinction among these different designations is the type of public funding support each clinic receives. FQHC sites and FQHC look-alike sites both meet eligibility requirements for two critical sources of funding support: (1) enhanced Medi-Cal reimbursement rates and (2) a federal operating grant made available by Section 330 of the Public Health Service Act (PHSA). Only FQHC clinics receive PHSA Section 330 operating grants, which are nationally competitive. Conversely, FQHC look-alike clinics have a non-competitive grant process.

Free clinics are statutorily required to not directly [illegible]

reimbursements or a PHSA Section 330 operating grant and are supported largely by private donations.

Since the passage of SB 111, neither the Physician Assistant Committee nor the Board of Registered Nursing of the Department of Consumer Affairs have received any patient safety complaints or enacted any disciplinary action related to PAs, NPs or nurse-midwifes supervising MAs in community and free clinics.

Comments

According to the author's office, existing laws require that a physician must be present at the practice site to supervise an MA. However, MAs can work under the supervision of a PA, NP or nurse-midwife in licensed community and free clinics. With the exception of these clinics, MAs are limited to performing administrative and clerical duties and therefore may not perform or assist with even the simplest technical supportive services if the physician is not on the premises.

FISCAL EFFECT: Appropriation: No Fiscal Com.: No Local: No

SUPPORT: (Verified 8/12/13)

California Academy of Physician Assistants (co-source)
California Association of Physician Groups (co-source)
California Academy of Family Physicians
California Association for Nurse Practitioners
California Optometric Association
United Nurses Associations of California/Union of Health Care Professionals

OPPOSITION: (Verified 8/12/13)

Board of Registered Nursing
California Nurses Association
National Nurses United

ARGUMENTS IN SUPPORT: According to this bill's sponsor, the California Academy of Physician Assistants (CAPA), PAs have been delegated the task of supervising MAs when the physician is not physically present in specified licensed community clinics for over a decade. As such, CAPA proposes to eliminate legal restrictions and barriers to efficient coordinated care by allowing physicians to

in patients expected to result from the Patient Protection and Affordable Care Act (ACA).

The California Association for Nurse Practitioners indicates that this bill will expand the current practice that occurs in community clinics of allowing NPs and PAs to supervise MAs to all settings. This model has been in place for over 10 years with no complications. Allowing NPs to supervise MAs in this way has enabled them to focus their time and services on patient care, delegating some very basic functions to an MA. Expanding this practice to all settings will allow NPs to increase the number of patients they will be able to see, providing much needed increased access to health care. This bill makes no changes to the scope of practice of either an MA or a NP but instead removes the limitations in current law that do not permit this supervision model in a non-clinic setting.

The California Optometric Association believes this bill will expand access and allow more patients to receive care. They state, "...deploying these professionals in a team-based delivery model where they work collaboratively with physician assistants, nurse practitioners or midwives will allow California to meet the demands placed on its health care systems created by a rapidly aging physician population and expansion of health insurance coverage."

The United Nurses Associations of California/Union of Health Care Professionals indicates that with the implementation of the ACA, change is necessary in California in order to accommodate the dramatic increase in patients expected to result from health care reform.

The California Academy of Family Physicians indicates with the large influx of newly insured individuals in California nearing, it is necessary to continue to find more efficient ways of ensuring adequacy in the delivery of primary care. The Academy applauds efforts that streamline delivery of quality care while preserving the team based approach that is best for patients.

ARGUMENTS IN OPPOSITION: According to the California Nurses Association (CNA), "this bill will contribute to the fragmentation of primary care services, and, by consequently expanding the use of MAs, will undermine the delivery of safe health care services at a critical time in the expansion of access to primary care under the Affordable Care Act.... This bill is premature since there is no indication that the impact of the Affordable Care Act will necessitate a deskilling of healthcare services in order to provide primary care provider access to

clinics more rapidly. Quantity care is not quality care and CNA maintains its position that the expansion of access to primary healthcare services does not require existing providers to work more quickly, it simply requires a greater number of those appropriately educated providers."

The Board of Registered Nursing writes that they are concerned that "the increase in venues where medical assistants could function in a technical role could decrease the availability of licensed professionals thus possible having a negative impact on public safety and health."

ASSEMBLY FLOOR: 69-0, 08/08/13
AYES: Achadjian, Alejo, Allen, Ammiano, Atkins, Bigelow, Bloom, Bocanegra, Bonilla, Bonta, Bradford, Buchanan, Ian Calderon, Chau, Chesbro, Conway, Cooley, Dahle, Daly, Donnelly, Eggman, Fong, Fox, Beth Gaines, Gatto, Gomez, Gonzalez, Gordon, Gorell, Gray, Grove, Hagman, Hall, Harkey, Roger Hernández, Holden, Jones, Jones-Sawyer, Levine, Linder, Logue, Lowenthal, Maienschein, Mansoor, Medina, Melendez, Mitchell, Morrell, Mullin, Muratsuchi, Nazarian, Nestande, Olsen, Pan, Patterson, Perea, V. Manuel Pérez, Quirk-Silva, Rendon, Salas, Skinner, Stone, Ting, Wagner, Waldron, Weber, Wilk, Williams, John A. Pérez
NO VOTE RECORDED: Brown, Campos, Chávez, Dickinson, Frazier, Garcia, Quirk, Wieckowski, Yamada, Vacancy, Vacancy

MW:k 8/12/13 Senate Floor Analyses
SUPPORT/OPPOSITION: SEE ABOVE
**** **END** ****

California LEGISLATIVE INFORMATION

SB-491 Nurse practitioners. (2013-2014)

AMENDED IN ASSEMBLY AUGUST 14, 2013

AMENDED IN ASSEMBLY AUGUST 08, 2013

AMENDED IN ASSEMBLY AUGUST 05, 2013

AMENDED IN SENATE MAY 21, 2013

AMENDED IN SENATE MAY 01, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 01, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL No. 491

Introduced by Senator Hernandez

February 21, 2013

An act to add Section 2835.3 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 491, as amended, Hernandez. Nurse practitioners.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including, among others, ordering durable medical equipment, and, in consultation with a physician and surgeon, approving, signing, modifying, or adding to a plan of treatment or plan for an individual receiving home health services or personal care services. A violation of those provisions is a crime.

This bill would authorize a nurse practitioner to perform those acts and certain additional acts without physician supervision if the nurse practitioner meets specified experience and certification requirements *and is practicing in a clinic, health facility, county medical facility, accountable care organization, or group practice*. The bill would require a nurse practitioner to refer a patient to a physician and surgeon or other licensed health care provider under certain circumstances~~, and would require specified nurse practitioners to maintain a current list of licensed health care providers most often used for the purposes of obtaining information or advice~~. The bill would also require a nurse practitioner practicing under these provisions to maintain professional liability insurance, as specified. The bill would also specify that a nurse practitioner practicing under the provisions of

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

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

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 2835.3 is added to the Business and Professions Code, to read:

2835.3. (a) Notwithstanding any other provision of this chapter, a nurse practitioner who holds a certification as a nurse practitioner from a national certifying body may practice under this section without physician supervision if the nurse practitioner ~~meets the requirements of this article and one of the following is met:~~

~~(1)He or she~~ has practiced under the supervision of a physician for at least 4160 hours and is practicing in one of the following:

~~(A)~~

(1) A clinic, health facility, or county medical facility.

~~(B)~~

(2) An accountable care organization, as defined in Section 3022 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

~~(C)~~

(3) A group practice, including a professional medical corporation, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.

~~(2)He or she has practiced under the supervision of a physician for at least 6240 hours.~~

(b) Notwithstanding any other law, in addition to any other practices authorized in statute or regulation, a nurse practitioner practicing under this section may do any of the following:

(1) Order durable medical equipment. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the nurse practitioner, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, approve, sign, modify, or add to a plan of treatment or plan of care.

(4) Assess patients, synthesize and analyze data, and apply principles of health care.

(5) Manage the physical and psychosocial health status of patients.

(6) Analyze multiple sources of data, including patient history, general behavior, and signs and symptoms of illness, identify alternative possibilities as to the nature of a health care problem, and select, implement, and evaluate appropriate treatment.

(7) Establish a diagnosis by client history, physical examination, and other criteria, consistent with this section.

(8) Order, furnish, or prescribe drugs or devices.

(9) Refer patients to physicians or other licensed health care providers as provided in subdivision (c).

(10) Delegate tasks to a medical assistant that are within the medical assistant's scope of practice.

(11) Perform additional acts that require education and training and that are recognized by the board as proper to be performed by a nurse practitioner.

(13) Perform procedures that are necessary and consistent with the nurse practitioner's education and training.

(c) A nurse practitioner shall refer a patient to a physician and surgeon or another licensed health care provider if a situation or condition of the patient is beyond the nurse practitioner's education or training.

~~(d)A nurse practitioner described in paragraph (2) of subdivision (a) shall maintain a current list of licensed health care providers most often used for the purposes of obtaining information or advice.~~

~~(e)~~

(d) A nurse practitioner practicing under this section shall maintain professional liability insurance that is appropriate for his or her practice setting.

~~(f)~~

(e) Nothing in this section shall do either of the following:

(1) Limit a nurse practitioner's authority to practice nursing.

(2) Limit the scope of practice of a registered nurse authorized pursuant to this chapter.

~~(g)~~

(f) The board shall adopt regulations by July 1, 2015, establishing the means of documenting completion of the requirements of this section.

~~(h)~~

(g) A nurse practitioner practicing pursuant to this section shall not supplant a physician and surgeon employed by a health care facility specified in ~~subparagraph (A) of~~ paragraph (1) of subdivision (a).

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.

California LEGISLATIVE INFORMATION

SB-491 Nurse practitioners. (2013-2014)

Date	Action
08/14/13	Read second time and amended. Re-referred to Com. on APPR.
08/13/13	From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 8. Noes 2.) (August 13).
08/08/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B.,P. & C.P.
08/06/13	Set, first hearing. Failed passage in committee. Reconsideration granted.
08/05/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B.,P. & C.P.
06/10/13	Referred to Com. on B.,P. & C.P.
05/29/13	In Assembly. Read first time. Held at Desk.
05/28/13	Read third time. Passed. (Ayes 22. Noes 12. Page 1102.) Ordered to the Assembly.
05/21/13	Read second time and amended. Ordered to third reading.
05/20/13	From committee: Do pass as amended. (Ayes 4. Noes 0. Page 936.) (May 13).
05/03/13	Set for hearing May 13.
05/01/13	Read second time and amended. Re-referred to Com. on APPR.
04/30/13	From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 6. Noes 1. Page 734.) (April 29).
04/25/13	Set for hearing April 29.
04/23/13	Set for hearing April 29.
04/22/13	Hearing postponed by committee.
04/16/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B., P. & E.D.
04/05/13	Set for hearing April 22.
04/03/13	Re-referred to Com. on B., P. & E.D.
04/01/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.
03/11/13	Referred to Com. on RLS.
02/22/13	From printer. May be acted upon on or after March 24.
02/21/13	Introduced. Read first time. To Com. on RLS. for assignment. To print.

Date of Hearing: August 13, 2013

ASSEMBLY COMMITTEE ON BUSINESS, PROFESSIONS AND CONSUMER PROTECTION
Susan A. Bonilla, Chair
SB 491 (Hernandez) – As Amended: August 8, 2013

SENATE VOTE: 22-12

SUBJECT: Nurse practitioners.

SUMMARY: Permits a nurse practitioner (NP) to practice independently after a period of physician supervision if the NP has national certification and liability insurance, and authorizes the NP to perform various other specified tasks related to the practice of nursing without protocols. Specifically, this bill:

1) Permits a NP to practice without physician supervision if the NP is certified by a national certifying body, maintains professional liability insurance that is appropriate for his or her practice setting, and either:

   a) He or she has practiced under the supervision of a physician for at least 4,160 hours and is practicing in one of the following settings:

      i) A clinic, health facility, or county medical facility;

      ii) An accountable care organization, as specified; or,

      iii) A group practice, including a professional medical corporation, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services; or

   b) He or she has practiced under the supervision of a physician for at least 6,240 hours and maintains a list of licensed health care providers most often used for the purposes of obtaining information or advice.

2) Permits an independent NP to do the following without standardized procedures or protocols:

   a) Order durable medical equipment, although nothing in this bill shall prohibit a third-party payer from requiring prior approval;

   b) Certify disability after performing a physical examination;

   c) Approve, sign, modify, or add to a plan of treatment or plan of care for individuals receiving home health services or personal care services;

e) Manage the physical and psychosocial health status of patients;

f) Analyze multiple sources of data, including patient history, general behavior, and signs and symptoms of illness; identify alternative possibilities as to the nature of a health care problem; and select, implement, and evaluate appropriate treatment;

g) Establish a diagnosis by client history, physical examination, and other criteria;

h) Order, furnish, or prescribe drugs or devices;

i) Refer patients to physicians or other licensed health care providers;

j) Delegate tasks to a medical assistant that are within the medical assistant's scope of practice;

k) Perform additional acts that require education and training and that are recognized by the the Board of Registered Nursing (BRN) as proper to be performed by a NP;

l) Order hospice care as appropriate; and,

m) Perform procedures that are necessary and consistent with the NP's education and training.

3) Requires a NP to refer a patient to a physician and surgeon or another licensed health care provider if a situation or condition of the patient is beyond the NP's education or training.

4) Does not limit a NP's authority to practice nursing or limit the scope of practice of a registered nurse.

5) Requires the Board of Registered Nursing (BRN) to adopt regulations by July 1, 2015 establishing the means of documenting completion of this bill's requirements.

6) Specifies that NPs shall not supplant physicians employed by a clinic, health facility, or county medical facility

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

1) Declares that the intent of the Legislature in amending the Nursing Practice Act is to recognize the existence of overlapping functions between physicians and registered nurses and to permit additional sharing of functions within organized health care systems that provide for collaboration between physicians and registered nurses. (Business and Professions Code (BPC) Code Section 2725 (a))

2) Defines the practice of nursing as those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the treatment thereof. (BPC 2725 (a))

3) Defines "standardized procedures" as either policies and protocols developed by a health facility through collaboration among administration and health professionals or policies and protocols developed through collaboration among administrators and health professionals by an organized health care system which is not a health care facility. (BPC 2725 (c))

4) Permits NPs to furnish and order drugs pursuant to standardized procedures developed by the NP and the supervising physician and surgeon when the drugs or devices are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained. (BPC 2836.1)

5) Requires one physician to supervise every four prescribing NPs. (BPC 2836.1)

6) Permits BRN to employ such personnel as it deems necessary to carry out the nursing law, and permits BRN to adopt, amend, or repeal such rules and regulations as may be reasonably necessary to enable it to carry into effect the provisions of the nursing law. (BPC 2715)

FISCAL EFFECT: Unknown

COMMENTS:

1) Purpose of this bill. This bill allows a prescribing NP to practice independently of physician supervision and standardized procedures after a period of supervised practice if the NP has national certification and liability insurance. This bill is author-sponsored.

2) Author's statement. According to the author's office, "Independent practice would allow NPs to choose to see Medi-Cal patients, a decision that is now left up to the physician they work for. Due to the excellent safety and efficacy record NPs have earned historically, the Institutes of Medicine and the National Council of State Boards of Nursing have recommended full practice for NPs. Currently, 17 states allow NPs to practice at the full extent of their training and education with independent practice."

3) NP training and educational requirements. A NP is registered nurse who possesses additional preparation and skills in physical diagnosis, psycho-social assessment, and management of

quarter units of clinical practice (3 hours of clinical practice each week equals one unit). NPs are required to have a Masters degree, and many further pursue a doctorate in nursing. There are currently 17,531 NPs licensed in CA.

NPs may specialize in disciplines such as acute pediatric care, adult gerontological care, family care, women's health, and mental health nursing.

4) This bill in practice. This bill would require NPs who wish to practice independently to be nationally certified. To qualify for national certification, an applicant must have graduated from specified nationally accredited programs, have a minimum of 500 clinical hours of faculty-supervised practice, and demonstrated completed coursework in advanced physical assessment, advanced pharmacology, and advanced pathophysiology.

This bill also requires an NP to have worked under physician supervision for the equivalent of two years of full-time work for certain practice models, and three years for solo practice. These timelines are based on the work of Patricia Benner, who described domains and competencies for advanced nursing practice, and the research of Karen Bryckzynski, who explored the clinical practice of NPs. These competencies are referenced by the U.S. Department of Health and Human Services in guidance reports.

5) Standardized procedures. The NP scope of practice is currently determined by standardized procedures, which are the legal mechanism for NPs to perform functions which would otherwise be considered the practice of medicine. The Medical Practice Act authorizes physicians to diagnose mental and physical conditions, to use drugs in or upon human beings, to sever or penetrate tissue, and to use other methods in the treatment of diseases, injuries, deformities, or other physical or mental conditions. As a general rule, the performance of any of these functions by a NP requires a standardized procedure.

Standardized procedures are defined as policies and protocols developed by a health facility or organized health care system, with input from administrators and health professionals, which establish parameters for medical care. A NP may perform standardized procedure functions only under the conditions specified in a health care system's standardized procedures, and must provide the system with satisfactory evidence that he or she meets its experience, training, and education requirements.

5) Protocols. Protocols are a part of standardized procedures and are designed to describe the steps of medical care for given patient situations. They are used for management of acute or episodic conditions, trauma, chronic conditions, infectious disease contacts, routine gynecological problems, contraception, health promotion exams, and ordering of medications. Protocols are developed in consultation with a supervising physician.

6) Prescribing authority. NPs may furnish drugs by obtaining a DEA number to prescribe Schedule II-V drugs pursuant to a protocol and standardized procedures. The DEA considers a NP to be a "prescriber," but NPs who write prescriptions are considered a "furnishing" NP under California law. Furnishing is the delegated authority to write prescriptions, and is done in accordance with approved standardized procedures and protocols. Physician supervision

NP examines the patient. Furnishing NPs are required to be supervised by a physician, but non-furnishing NPs are not.

7) Supervision requirements. Of the 17,500 NPs in California, 12,500 are furnishing NPs. A physician may supervise up to four furnishing NPs. The law does not specify the quality and extent of supervision necessary, only that the physician be available by phone when a NP examines a patient. There is no requirement that the physician work in the same facility with the NP, meets regularly with the NP, review patient charts, or be within a geographic proximity.

8) The Affordable Care Act (ACA) & NP Autonomy. The federal Affordable Care Act (ACA) was passed in March 2010 to provide quality, affordable healthcare for all Americans and improve the quality and efficiency of that care. The January 2014 implementation date of ACA will result in millions more Californians entering the primary care market. Primary care providers will be responsible for health promotion, disease prevention, early diagnosis, and the coordination of care with other providers for these new entrants to the market.

Accessing these providers will be a challenge given the current state of the nation's health care workforce restrictions. The Association of American Medical Colleges estimates a nationwide shortage of 45,000 primary care physicians by 2020. This shortage is exacerbated by the fact that fewer physicians are choosing to enter the field of primary care than are leaving it.

The Institute of Medicine (IOM), an independent nonprofit organization which is part of the National Academy of Sciences, published a report in 2011 in which it concluded that NPs deliver the same quality of primary care as physicians. IOM noted that although NPs are most immediately sought for their medical skills in primary care, they integrate practices from several disciplines, including social work, nutrition, and physical therapy.

The IOM report notes that some argue that NPs should not be allowed to be independent primary care practitioners because physicians are more qualified due to their extensive academic and clinical training, and unique cognitive and technical skills. However, the IOM report notes that the contention that APRNs are less able than physicians to deliver care that is safe, effective, and efficient is not supported by research. Further, NPs are trained to refer out when conditions rise beyond their competencies and have the ability to coordinate care between providers.

NPs have been slowly granted practice autonomy in other states over the last decade. 16 states allow NPs to evaluate patients, diagnose, order and interpret diagnostic tests, and initiate and manage treatment under the exclusive license authority of the state board of nursing. Today, nurse practitioners (which make up slightly less than a quarter of all primary care professionals), together with physicians and physician assistants, provide most of the primary care in the United States. The demand for a larger primary care workforce will grow as access to coverage, service settings, and services increases under the ACA.

11) Improving access to primary care. It is estimated that the majority of the seven million

likely make that care more accessible, reducing the strain on the already overburdened physician population. NPs have been found to have a greater propensity to care for underserved populations and frequently have less student debt, making them more likely to work in environments with lower profit margins, such as rural areas. There are two major ways in which the independent practice for NPs provided by this bill may provide increased access to primary acre services:

a) Retail clinics. Retail clinics have grown substantially over the last decade. Retail clinics are medical clinics who contract to operate out of pharmacies, grocery stores, and "big box" stores, such as Target. California's ban on the corporate practice of medicine limits operation of these clinics to professional medical corporations, so these clinics must be 51% physician owned. Retail clinics primarily provide care for simple acute conditions—such as bronchitis and vaccinations—typically delivered by a nurse practitioner.

   The Rand Corporation, a nonprofit research organization, reports that the overall cost of care at retail clinics is substantially lower than in physician offices, urgent care centers, and emergency departments - and the care is comparable in quality. The Rand Corporation study further indicates that these clinics do not appear to be disrupting the traditional physician-client relationship, because 60% of retail clinic consumers report having no primary care physician.

   It is anticipated that these clinics may proliferate if NPs are able to operate without physician supervision because it would become more cost-effective for these clinics to employ greater numbers of NPs. Retail clinics are currently constrained by the 1:4 ratio of physician supervision of prescribing NPs.

b) Medi-Cal and Medicare populations. Permitting independent practice by NPs will allow greater access to care for Medi-Cal and Medicare populations. Medi-Cal is the state's Medicaid health insurance program, funded by both the federal and state government for low-income families and children, people with disabilities, pregnant women, and seniors. Medicare is the federal government health insurance program for seniors and persons with disabilities.

   ACA is expanding Medi-Cal eligibility and the California HealthCare Foundation estimates that more than 1.4 million Californians will be newly eligible for coverage. The California HealthCare Foundation reports that presently, adults with Medi-Cal are nearly twice as likely to report difficulty getting a doctor appointment than other insured adults in California. In 2008, there were only 50 primary care providers for every 100,000 Medi-Cal beneficiaries in California, well below the federal guidelines of 60 to 80 per 100,000. NPs are limited in their ability to be reimbursed for care covered by Medi-Cal due to physician supervision constraints.

   According to the Centers for Medicare and Medicaid Services, fewer American doctors are treating patients enrolled in the Medicare health program, reflecting physician frustration with its payment rates and rules. The number of doctors who opted out of Medicare last year nearly tripled from three years earlier. Other

NPs in California may only treat Medicare patients if their supervising physician is a Medicare provider. According to an article in the medical journal Health Affairs, Medicare, Medicaid, and private insurers typically reimburse NPs at rates that are just 75–85% of what they pay physicians for the same services. NPs generally have less overhead than physicians (lower educational debt loads and fewer equipment costs because of the lower complexity of procedures performed), and are therefore more likely to work for a lower reimbursement.

14) Accountability provisions. This bill will require independent NPs to have liability insurance. Presently, supervising physicians are partially accountable for an NP's practice and a physician's license is at stake for unprofessional conduct by a supervised NP. Independence will require that the NP be wholly accountable for his or her actions, and the required liability insurance would arguably help protect consumers in the event of a malpractice action.

15) Arguments in support. AARP writes, "With the implementation of the Affordable Care Act and the expansion of Medi-Cal, millions more Californians will be seeking affordable, quality health care. We need to make better use of the health care resources we have in our state. This bill does this by allowing nurse practitioners to practice up to the full extent of their education and training and provide quality health care without (to an extent) unnecessary, restrictive oversight. By removing most of the unnecessary supervision requirements, SB 491 will increase Californians' access to and choice among quality health professionals, reduce wait times and reduce paperwork burdens.

"Nurse practitioners are educated and trained to provide high quality primary health care. They diagnose and manage patients' care, prescribe medications and refer patients to specialists. Decades of evidence, recently noted by the Institute of Medicine and the National Governors Association, demonstrate that nurse practitioners provide safe, effective care whether or not they are supervised by physicians."

16) Arguments in opposition. The California Medical Association writes, "Allowing nurse practitioner practice without standardized protocols and physician supervision reduces patient safety and quality of care. Patients are best served by a physician-led team that can provide high quality and cost-effective care. Nurse practitioners are an important part of the healthcare team and, when practicing under physician supervision, can significantly increase access to *quality* medical care in a community. Current law requires that nurse practitioner practice include the development and use of standardized protocols and physician review and approval of patient treatment plans. These requirements are in place to ensure that patient care includes the involvement and oversight of a physician who is substantially more qualified and experienced to oversee patient care, both in depth and in years of education and training, than a nurse practitioner practicing alone."

17) Author's amendment. The author would like to amend the bill to remove the independent practice pathway in which an NP may practice without physician supervision after at least 6,240 hours of supervised practice.

treatment plan initiated by a PT. AB 1000 is currently in the Senate Appropriations Committee.

AB 1208 (Pan) defines a "medical home" and "patient centered medical home" as a health care delivery model in which a patient establishes an ongoing relationship with a personal primary care physician or other licensed health care provider acting within the scope of his or her practice. The bill states that the provider shall work in a physician-led practice team to provide comprehensive, accessible, and continuous evidence-based primary and preventative care, and to coordinate the patient's health care needs across the health care system in order to improve quality and health outcomes in a cost-effective manner. AB 1208 is currently on the Senate floor.

SB 352 (Pavley) authorizes medical assistants to perform technical supportive services in any medical setting upon specific authorization of a physician assistant, NP, or certified nurse-midwife without a physician on the premises. SB 352 is currently on the Assembly floor.

19) Previous legislation. SB 726 (Ashburn) of 2010 was an effort to promote healthcare in rural areas allow qualified health care districts and qualified rural hospitals, as specified, to directly employ physicians under an existing pilot project. SB 726 was held in the Senate Business, Professions, and Economic Development Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

AARP
American Nurses Association
American Nurses Association, California
Association of California Healthcare Districts
Bay Area Council
Blue Shield of California
Board of Registered Nursing
C.W. Brower, Inc.
California Association for Nurse Practitioners
California Association of Clinical Nurse Specialists
California Association of Nurse Anesthetists, Inc.
California Association of Physician Groups
California Association of Public Hospitals and Health Systems
California Family Health Center
California Federation of Teachers
California Hospital Association
California Nurse-Midwives Association
California Optometric Association
California Pharmacists Association
California Primary Care Association
California Society of Health-System Pharmacists
California State Association of Occupational Health Nurses

Congress of California Seniors
Dignity Health
Indiana State Nurses Association
Latino Community Roundtable
National Asian American Coalition
National Association for the Advancement of Colored People
National Association of Pediatric Nurse Practitioners
Private Essential Access Community Hospitals
Stanford Hospital and Clinics
United Nurses Associations of California/Union of Health Care Professionals
University of California
University of California, San Francisco
Western University of Health Sciences
134 individuals

Opposition

Aesthetic Institute
AFSCME
Alameda-Contra Costa Medical Association
American Academy of Pediatrics, California
American Federation of State, County and Municipal Employees, AFL-CIO
American Society for Dermatologic Surgery Association
Blind Children's Center
CalDerm
California Academy of Eye Physicians and Surgeons
California Academy of Family Physicians
California Chapter of the American College of Emergency Physicians
California Medical Association
California Podiatric Medical Association
California Psychiatric Association
California Right to Life Committee, Inc.
California Society of Anesthesiologists
California Society of Plastic Surgeons
Canvasback Missions, Inc.
Consumer Attorneys of California
Diabetes Coalition of California
Here For Them, Inc.
Latino Physicians of California
Let's Face it Together
Lighthouse Mission for Christ
Medical Board of California
Minority Health Institute, Inc.
Osteopathic Physicians and Surgeons of California
The Dream Machine Foundation
Time for Change Foundation
Union of American Physicians and Dentists/AFSCME Local 206

Analysis Prepared by: Sarah Huchel / B.,P. & C.P. / (916) 319-3301

California LEGISLATIVE INFORMATION

SB-492 Optometrist: practice: licensure. (2013-2014)

AMENDED IN ASSEMBLY AUGUST 05, 2013

AMENDED IN SENATE MAY 08, 2013

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 01, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL No. 492

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections ~~3041 and 3041.1~~ *3041, 3041.1, and 3110* of the Business and Professions Code, relating to optometry.

LEGISLATIVE COUNSEL'S DIGEST

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

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

~~This bill would add the provision of habilitative optometric services to the definition of the practice of optometry. The bill would expand the practice parameters of optometrists who are certified to use therapeutic pharmaceutical agents by removing certain limitations on their practice and adding certain responsibilities, including, but not limited to, the ability to immunize and treat certain diseases, and deleting the specified drugs the optometrist would be authorized to use, and authorizing the optometrist to use all therapeutic pharmaceutical agents approved by the United States Food and Drug Administration, as provided. The bill would also delete limitations on certain kinds of diagnostic tests an optometrist can order and would authorize an optometrist to order appropriate laboratory and diagnostic imaging tests, as provided.~~

This bill would include the provision of habilitative optometric services within the scope of practice of optometry. The bill would expand the scope of practice of optometrists who are certified to use therapeutic pharmaceutical agents by, among other things, authorizing those optometrists to use all therapeutic pharmaceutical agents approved by the United States Food and Drug Administration for use in treating the eye conditions covered by these provisions. The bill would also expand the ability of an optometrist certified to use therapeutic pharmaceutical agents to diagnose and treat certain diseases, as provided. The bill would require the board to grant a certificate to an optometrist for the use of advanced procedures, which include the administration of certain immunizations, if the optometrist meets certain educational requirements.

Existing law requires optometrists in diagnosing or treating eye disease to be held to the same standard of care as physicians and surgeons and osteopathic physicians and surgeons.

This bill would expand this requirement to include diagnosing other diseases, and would require an optometrist to consult with and, if necessary, refer to a physician and surgeon or other appropriate health care provider if a situation or condition was beyond the optometrist's scope of practice.

This bill would delete obsolete provisions and make conforming changes.

Because this bill would change the definition of a crime, it would create a state-mandated local program.

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

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

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 3041 of the Business and Professions Code is amended to read:

3041. (a) The practice of optometry includes the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of habilitative or rehabilitative optometric services, and is the doing of any or all of the following:

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

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

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

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

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

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

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

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

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

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

(E) Corneal surface disease and dry eyes. *Treatment for purposes of this subparagraph includes, but is not limited to, the use of mechanical lipid extraction of meibomian glands using nonsurgical techniques.*

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

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

(H) Eyelid disorders, including hypotrichosis and blepharitis.

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

(c) In diagnosing and treating the conditions listed in subdivision (b), an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may use all therapeutic pharmaceutical agents approved by the United States Food and Drug Administration for use in treating eye conditions set forth in this chapter, including codeine with compounds and hydrocodone with compounds as listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the ~~United States~~ *federal* Controlled Substances Act (21 U.S.C. Sec. 801 et seq.). The use of ~~these agents~~ *controlled substances* shall be limited to three days.

(d) In any case that an optometrist consults with a physician and surgeon, the optometrist and the physician and surgeon shall both maintain a written record in the patient's file of the information provided to the physician and surgeon, the physician and surgeon's response, and any other relevant information. Upon the request of the optometrist or physician and surgeon and with the patient's consent, a copy of the record shall be furnished to the requesting party.

(e) An optometrist who is certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may also perform all of the following:

(1) Corneal scraping with cultures.

(2) Debridement of corneal epithelia.

(3) Mechanical epilation.

(4) Venipuncture for testing patients suspected of having diabetes.

(5) Suture removal, upon notification of the treating physician and ~~surgeon.~~ *surgeon or optometrist.*

(6) Treatment or removal of sebaceous cysts by expression.

~~(7)Administration of oral fluorescein.~~

~~(8)~~

(7) Use of an auto-injector to counter anaphylaxis.

~~(9)~~

(8) Ordering of appropriate laboratory and diagnostic imaging tests for conditions authorized to be treated pursuant to this section.

~~(10)~~

(9) A clinical laboratory test or examination classified as waived under ~~CLIA and designated as waived in paragraph (9) necessary for the diagnosis of conditions and diseases of the eye or adnexa, or if otherwise specifically authorized by this chapter.~~ *the federal Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. Sec. 263a) (CLIA). These laboratory tests are required to be performed in compliance with both CLIA and all clinical laboratory licensing requirements in Chapter 3 (commencing with Section 1200), and any ancillary personnel utilized shall be in compliance with those same requirements.*

~~(11)~~

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

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

~~(13)~~

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

~~(14)~~

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

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

~~(16)~~

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

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

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

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

~~(3)For licensees who have substantially completed the certification requirements pursuant to this section in effect between January 1, 2001, and December 31, 2008, submission of proof of completion of those requirements on or before December 31, 2009. "Substantially completed" means both of the following:~~

~~(A)Satisfactory completion of a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma.~~

~~(B)Treatment of 50 glaucoma patients with a collaborating ophthalmologist for a period of two years for each patient that will conclude on or before December 31, 2009.~~

~~(4)~~

(3) For licensees who completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, submission of proof of satisfactory completion of the case management requirements for certification established by the board pursuant to Section 3041.10.

~~(5)~~

(4) For licensees who graduated from an accredited school of optometry on or before May 1, 2008, and not described in paragraph ~~(2), (3), or (4),~~ *(2) or (3),* submission of proof of satisfactory completion of the requirements for certification established by the board pursuant to Section 3041.10.

(g) The board shall grant a certificate to an optometrist certified pursuant to subdivision (f) for the use of advanced procedures, as described in subdivision (h), after the optometrist meets the following applicable requirement:

(1) For licensees who graduated from an accredited school of optometry that includes satisfactory curriculum on advanced procedures, as determined by the board, on or after May 1, 2016, submission of proof of graduation

(2) For licensees who graduated from an accredited school before May 1, 2016, submission of proof of completion of a 32-hour course that includes clinical training in advanced procedures and is approved the board.

(h) For the purposes of this chapter, "advanced procedures' means any of the following:

(1) Therapeutic lasers used for posterior capsulotomy secondary to cataract surgery.

(2) Therapeutic lasers appropriate for treatment of glaucoma and peripheral iridotomy for the prophylactic treatment of angle closure glaucoma.

(3) Excision, scraping, and biopsy, or any combination of those, of superficial lesions of the eyelid and adnexa.

(4) Cauterization or suture repairs of the eyelid and conjunctiva.

(5) Injections for the treatment of conditions of the eye and adnexa described in paragraph (1) of subdivision (b), excluding intraorbital injections and injections administered for cosmetic effect.

(6) Administration of immunizations for influenza, Herpes Zoster Virus, and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency in compliance with individual Advisory Committee on Immunization Practices (ACIP) vaccine recommendations published by the federal Centers for Disease Control and Prevention (CDC) for persons three years of age or older.

(7) Any noninvasive technology authorized by the board for the treatment of conditions described in paragraph (1) of subdivision (b).

~~(g)~~

(i) Other than for prescription ophthalmic devices described in subdivision (b) of Section 2541, any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge.

~~(h)The~~

(j) Except as authorized by this section, the practice of optometry does not include performing surgery. "Surgery" means any procedure in which human tissue is cut, altered, or otherwise infiltrated by mechanical or laser means. ~~"Surgery" does not include those procedures specified in subdivision (e).~~ Nothing in this section shall limit an optometrist's authority to utilize diagnostic laser and ultrasound technology within his or her scope of practice.

~~(i)~~

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

~~(j)~~

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

(1) All primary open-angle glaucoma.

(2) Exfoliation and pigmentary glaucoma.

~~(k)~~

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

~~(l)~~

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

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

3041.1. With respect to the practices set forth in Section 3041, optometrists diagnosing or treating eye disease or diagnosing other diseases shall be held to the same standard of care to which physicians and surgeons and osteopathic physicians and surgeons are held. An optometrist shall consult with and, if necessa

SEC. 3. *Section 3110 of the Business and Professions Code is amended to read:*

3110. The board may take action against any licensee who is charged with unprofessional conduct, and may deny an application for a license if the applicant has committed unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly assisting in or abetting the violation of, or conspiring to violate any provision of this chapter or any of the rules and regulations adopted by the board pursuant to this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions.

(d) Incompetence.

(e) The commission of fraud, misrepresentation, or any act involving dishonesty or corruption, that is substantially related to the qualifications, functions, or duties of an optometrist.

(f) Any action or conduct that would have warranted the denial of a license.

(g) The use of advertising relating to optometry that violates Section 651 or 17500.

(h) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license by another state or territory of the United States, by any other governmental agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

(i) Procuring his or her license by fraud, misrepresentation, or mistake.

(j) Making or giving any false statement or information in connection with the application for issuance of a license.

(k) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of an optometrist, in which event the record of the conviction shall be conclusive evidence thereof.

(l) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022, or using alcoholic beverages to the extent, or in a manner, as to be dangerous or injurious to the person applying for a license or holding a license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a license to conduct with safety to the public the practice authorized by the license, or the conviction of a misdemeanor or felony involving the use, consumption, or self administration of any of the substances referred to in this subdivision, or any combination thereof.

(m) Committing or soliciting an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an optometrist.

(n) Repeated acts of excessive prescribing, furnishing or administering of controlled substances or dangerous drugs specified in Section 4022, or repeated acts of excessive treatment.

(o) Repeated acts of excessive use of diagnostic or therapeutic procedures, or repeated acts of excessive use of diagnostic or treatment facilities.

(p) The prescribing, furnishing, or administering of controlled substances or drugs specified in Section 4022, or treatment without a good faith prior examination of the patient and optometric reason.

(q) The failure to maintain adequate and accurate records relating to the provision of services to his or her patients.

(r) Performing, or holding oneself out as being able to perform, or offering to perform, any professional services beyond the scope of the license authorized by this chapter.

(s) The practice of optometry without a valid, unrevoked, unexpired license.

(u) Permitting another person to use the licensee's optometry license for any purpose.

(v) Altering with fraudulent intent a license issued by the board, or using a fraudulently altered license, permit certification or any registration issued by the board.

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

(x) Failure or refusal to comply with a request for the clinical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, unless the licensee is unable to provide the documents within this time period for good cause.

(y) Failure to refer a patient to an appropriate physician~~ in either of the following circumstances:~~ *if an examination of the eyes indicates a substantial likelihood of any pathology that requires the attention of that physician.*

~~(1)Where an examination of the eyes indicates a substantial likelihood of any pathology that requires the attention of that physician.~~

~~(2)As required by subdivision (c) of Section 3041.~~

SEC. 4. *It is the intent of the Legislature that the Office of Statewide Health Planning and Development, under the Health Workforce Pilot Projects Program, designate a pilot project intended to test, demonstrate, and evaluate expanded roles for optometrists in the performance of management and treatment of diabetes mellitus, hypertension, and hypercholesterolemia.*

~~**SEC. 3.**~~***SEC. 5.*** No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.

California LEGISLATIVE INFORMATION

SB-492 Optometrist: practice: licensure. (2013-2014)

Date	Action
08/06/13	Set, first hearing. Hearing canceled at the request of author.
08/05/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B.,P. & C.P.
06/10/13	Referred to Com. on B.,P. & C.P.
05/29/13	In Assembly. Read first time. Held at Desk.
05/28/13	Read third time. Passed. (Ayes 25. Noes 5. Page 1116.) Ordered to the Assembly.
05/24/13	Read second time. Ordered to third reading.
05/23/13	From committee: Do pass. (Ayes 7. Noes 0. Page 1015.) (May 23).
05/21/13	Set for hearing May 23.
05/20/13	Placed on APPR. suspense file.
05/10/13	Set for hearing May 20.
05/08/13	Read second time and amended. Re-referred to Com. on APPR.
05/07/13	From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 8. Noes 0. Page 734.) (April 29).
04/25/13	Set for hearing April 29.
04/24/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B., P. & E.D.
04/23/13	Set for hearing April 29.
04/22/13	Hearing postponed by committee.
04/16/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B., P. & E.D.
04/05/13	Set for hearing April 22.
04/03/13	Re-referred to Com. on B., P. & E.D.
04/01/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.
03/11/13	Referred to Com. on RLS.
02/22/13	From printer. May be acted upon on or after March 24.
02/21/13	Introduced. Read first time. To Com. on RLS. for assignment. To print.

SENATE RULES COMMITTEE
Office of Senate Floor Analyses
1020 N Street, Suite 524
(916) 651-1520 Fax: (916) 327-4478

THIRD READING

Bill No: SB 492
Author: Hernandez (D)
Amended: 5/8/13
Vote: 21

SENATE BUSINESS, PROF. & ECON. DEVELOP. COMM.: 8-0, 4/29/13
AYES: Price, Block, Corbett, Galgiani, Hernandez, Hill, Padilla, Yee
NO VOTE RECORDED: Emmerson, Wyland

SENATE APPROPRIATIONS COMMITTEE: 7-0, 5/23/13
AYES: De León, Walters, Gaines, Hill, Lara, Padilla, Steinberg

SUBJECT: Optometrists: practice: licensure

SOURCE: Author

DIGEST: This bill permits an optometrist to diagnose, treat and manage additional conditions with ocular manifestations; directs the California Board of Optometry to establish educational and examination requirements; and permits optometrists to perform vaccinations and surgical and non-surgical primary care procedures.

ANALYSIS: Existing law defines the practice of optometry; and specifies that an optometrist who is certified to use therapeutic pharmaceutical agents (TPAs) may also diagnose and treat specified conditions, use TPAs, and order specified diagnostic tests.

This bill:

2. Allows an optometrist who is TPA certified to treat the lacrimal gland, lacrimal drainage system and the sclera in patients under 12 years of age.

3. Allows an optometrist to treat ocular inflammation and pain, nonsurgical in cause except when comanaged with the patient's treating physician and surgeon.

4. Permits optometrists to treat eye lid disorders, including hypotrichosis and blepharitis.

5. Allows an optometrist to use all TPAs approved by the Food and Drug Administration (FDA) for use in treating eye conditions including codeine with compounds and hydrocodone with compounds as listed in the California Uniform Controlled Substances Act and the U.S. Controlled Substances Act. Limits the use of these agents to three days.

6. Requires, in any case that an optometrist consults with a physician and surgeon, the optometrist and the physician and surgeon to both maintain a written record in the patient's file of the information provided to the physician and surgeon, the physician and surgeon's response, and any other relevant information. Upon the request of the optometrist or physician and surgeon and with the patient's consent, a copy of the record shall be furnished to the requesting party.

7. Removes the requirement for optometrists to only utilize specific TPAs.

8. Allows TPA-certified optometrists to remove sutures, upon notification of the treating physician and surgeon.

9. Removes the restriction that optometrists can only administer oral fluorescein to patients suspected as having diabetic retinopathy.

10. Deletes the list of specific tests optometrists are permitted to order and permits optometrists to order any laboratory and diagnostic imaging tests for conditions authorized to be treated pursuant to this bill.

11. Authorizes an optometrist to perform a clinical laboratory test or exam classified as waived under CLIA (Clinical Laboratory Improvement

diagnosis of conditions and diseases of the eye or adnexa, or if otherwise specifically authorized.

12. Adds the provision that optometrists can administer immunizations for influenza, Herpes Zoster Virus, and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency.

13. Permits optometrists to test for and diagnose diabetes mellitus, hypertension and hypercholesterolemia.

14. Specifies that an optometrist diagnosing or treating eye disease or diagnosing other diseases shall be held to the same standard of care to which physicians and surgeons and osteopathic physicians and surgeons are held.

15. Requires an optometrist to consult with and refer to a physician and surgeon or other appropriate health care provider if a situation/condition occurs that is beyond the optometrist's scope of practice.

16. Allows an optometrist to consult with and refer to a physician and surgeon or appropriate health care provider if a situation or condition occurs that is beyond the optometrist's education and training.

Background

Shortage of optometrists. According to a report prepared by the Center for the Health Professions at the University of California San Francisco, the number of optometrist licenses in California has declined, but the number of licensees with a secondary practice location has increased. According to the California Board of Optometry, there are approximately 9,000 optometrists in California, the largest population of optometrists in the United States. These optometrists are generally concentrated in coastal counties, the Bay Area and counties in the Sacramento region. Several counties have no licensed optometrists with an address of record in those counties, and a number of other counties have ratios that indicate there is approximately one optometrist for every 10,000 people.

Optometrists' education, training and scope. After completion of an undergraduate degree, optometrists complete four years of an accredited optometry college after which they are awarded the Doctor of Optometry degree. Some optometrists also

experience in a particular area. Students graduate with 2,500-3,000 patient encounters; these include a mix of post-surgical, medical and routine visits.

Optometrists are trained to diagnose mild to severe eye problems such as serious eye infections, inflammations of the eye, trauma, foreign bodies and glaucoma. They also examine the eye for vision prescription and corrective lenses. Optometrists may apply for certification to administer TPA; to perform lacrimal irrigation and dilation; and to diagnose and treat primary open angle glaucoma.

Ophthalmologists' education, training and scope. After obtaining an undergraduate degree, ophthalmologists complete four years at an accredited medical school and earn a Medical Degree. This is followed by a one year internship and a three or four year surgical residency. Many ophthalmologists pursue additional fellowship training in specialized areas such as retina, glaucoma or cornea. Ophthalmologists may become certified by the American Board of Ophthalmology, which requires, serving as primary surgeon or first assistant to the primary surgeon on a minimum of 364 eye surgeries.

The central focus of ophthalmology is surgery and management of complex eye diseases. An ophthalmologist specializes in the refractive, medical and surgical care of the eyes and visual system and in the prevention of disease and injury.

FISCAL EFFECT: Appropriation: No Fiscal Com.: Yes Local: Yes

According to the Senate Appropriations Committee:

- One-time costs of about $950,000 over two years to revise regulations and certify additional optometrists to use therapeutic pharmaceutical agents by the California Board of Optometry (State Optometry Fund).

- Ongoing costs of about $350,000 for certifications and enforcement activities (State Optometry Fund).

- Increased fee revenues of about $80,000 over the first two years and about $10,000 per year thereafter for additional certifications (State Optometry Fund).

- Indeterminate impact on state health care programs, such as the California Public Employees' Retirement System and Medi-Cal.

SUPPORT: (Verified 5/24/13)

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

OPPOSITION: (Verified 5/24/13)

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

ARGUMENTS IN SUPPORT: According to the author's office, this bill is intended to allow optometrists to practice to the full extent of their education and training in order to expand access to the health care delivery system for the millions of Californians who will have new access to coverage through the implementation of the federal Patient Protection and Affordable Care Act (ACA). This bill allows optometrists to diagnose, treat and manage specific eye disorders and common diseases such as diabetes, hypertension and hyperlipidemia; expands the drugs optometrists can prescribe; and permits optometrists to administer immunizations and to perform surgical and non-surgical procedures.

Blue Shield of California states, "Expanding the range of services that these practitioners are able to provide will improve access and quality of care as they are

well trained and highly educated professionals that are already providing integral health services."

Californians for Patient Care note, "It is widely noted that there are not enough trained medical professionals to appropriately care for the influx of new patients. We believe it is important that qualified, educated and trained optometrists be allowed to practice to the extent of their licenses to best serve California's patient population throughout the state."

The California Optometric Association believes that this bill, "addresses the health care provider gap by expanding the scope of practice of optometry. Optometrists are positioned and prepared to be part of the solution to meeting the additional health care needs upon enactment of the ACA in 2014."

The United Nurses Associations of California/ Union of Health Care Professionals indicate, "SB 492 would allow optometrists to practice to the full extent of their education and training in order to expand access to the health care delivery system for the millions of Californians who will have new access to coverage through implementation of the federal ACA."

ARGUMENTS IN OPPOSITION: The California Medical Association (CMA) outline several concerns. Included is the provision of primary care services that optometrists would be permitted to do if the bill passed. CMA believes that this is "...beyond the existing scope of practice related to visual disorders and could result in serious harm to patients." They also note that optometrists "...do not have the training and experience necessary to provide comprehensive primary care. In addition, SB 492 would allow optometrists to practice medicine without being subject to the Medical Practice Act. Currently, optometrists are licensed by the Board of Optometry. Under SB 492, the scope of practice for optometrists would be expanded to the point where they would be practicing as ophthalmologists, who are required to have a medical license, without being subject to the controls and oversight of the Medical Practice Act."

The California Association for Medical Laboratory Technology notes, "While we recognize the ability of optometrists to perform certain waived tests limited to their scope of practice, we have concerns about the broad range of testing contained in this bill. Of greater concern is whether or not optometrists receive the proper education and training to perform as a laboratory director."

The California Academy of Eye Physicians & Surgeons is

they are concerned about the provisions that would allow optometrists to conduct eye surgeries and prescribe medications by all routes with no additional training.

The Union of American Physicians and Dentists states that "SB 492 rolls out an uncertain health care delivery system with patients subject to unintended consequences of the bill. Medical supervision over optometrists is critical to safe patient outcomes. SB 492 raises serious patient safety concerns in allowing optometrists to prescribe medication and perform surgical procedures without and medical supervision."

The Lighthouse for Christ Mission Eye Center and the Canvasback Missions, Inc. states, "The bill would give optometrists greatly increased privileges, including the ability to treat any disease that might have a "manifestation" in the eye without additional specific training requirements. The Board of Optometry, whose members have no experience doing surgery or treating the added diseases would be allowed to decide those training requirements."

The California Society of Anesthesiologists argues, "SB 492 would allow the diagnosis and initiation of treatment of any condition with ocular manifestation. This is a broad and unclear authorization that has not attained scientific consensus. It is not a sufficient basis to authorize comprehensive primary care. Also, by granting full drug prescribing authority to optometrists, the bill would add a new category of authorized controlled substance prescribers at a time when more controls are being sought over excessive prescribing."

MW:d 5/24/13 Senate Floor Analyses

SUPPORT/OPPOSITION: SEE ABOVE

**** **END** ****

California LEGISLATIVE INFORMATION

SB-493 Pharmacy practice. (2013-2014)

AMENDED IN ASSEMBLY AUGUST 05, 2013

AMENDED IN SENATE MAY 28, 2013

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 01, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL **No. 493**

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 733, *4040,* 4050, 4051, 4052, 4052.3, ~~and 4060~~ *4060, 4076, 4111, and 4174* of, and to add Sections 4016.5, 4052.6, 4052.8, 4052.9, 4210, and 4233 to, the Business and Professions Code, relating to pharmacy.

LEGISLATIVE COUNSEL'S DIGEST

SB 493, as amended, Hernandez. Pharmacy practice.

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

This bill, instead, would authorize a pharmacist to administer drugs and biological products that have been ordered by a prescriber. The bill would ~~expand other functions~~ *authorize* pharmacists ~~are authorized~~ to perform *other functions*, including, among other things, to furnish self-administered hormonal contraceptives, ~~prescription smoking cessation drugs~~ *nicotine replacement products*, and prescription medications not requiring a diagnosis that are recommended for international travelers, as specified. Additionally, the bill would authorize pharmacists to order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies, and to independently initiate and administer routine vaccinations, as specified. This bill also would establish board recognition for an advanced practice pharmacist, as defined, would specify the criteria for that recognition, and would specify additional functions that may be performed by an advanced practice pharmacist, including, among other things, performing patient assessments, and certain other functions, as specified. The bill would authorize the board, by regulation, to set the fee for the issuance and renewal of

Because a violation of these provisions would be a crime, the bill would impose a state-mandated local program.

The bill would make other conforming and technical changes.

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

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

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 733 of the Business and Professions Code is amended to read:

733. (a) A licentiate shall not obstruct a patient in obtaining a prescription drug or device that has been legally prescribed or ordered for that patient. A violation of this section constitutes unprofessional conduct by the licentiate and shall subject the licentiate to disciplinary or administrative action by his or her licensing agency.

(b) Notwithstanding any other law, a licentiate shall dispense drugs and devices, as described in subdivision (a) of Section 4024, pursuant to a lawful order or prescription unless one of the following circumstances exists:

(1) Based solely on the licentiate's professional training and judgment, dispensing pursuant to the order or the prescription is contrary to law, or the licentiate determines that the prescribed drug or device would cause a harmful drug interaction or would otherwise adversely affect the patient's medical condition.

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

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

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

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

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

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

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

(e) This section imposes no duty on a licentiate to dispense a drug or device pursuant to a prescription or order without payment for the drug or device, including payment directly by the patient or through a third-party payer accepted by the licentiate or payment of any required copayment by the patient.

(f) The notice to consumers required by Section 4122 shall include a statement that describes patients' rights relative to the requirements of this section.

SEC. 2. Section 4016.5 is added to the Business and Professions Code, to read:

4016.5. "Advanced practice pharmacist" means a licensed pharmacist who has been recognized as an advanced practice pharmacist by the board, pursuant to Section 4210. A board-recognized advanced practice pharmacist is entitled to practice advanced practice pharmacy, as described in Section 4052.6, within or outside of a licensed pharmacy as authorized by this chapter.

SEC. 3. *Section 4040 of the Business and Professions Code is amended to read:*

4040. (a) "Prescription" means an oral, written, or electronic transmission order that is both of the following:

(1) Given individually for the person or persons for whom ordered that includes all of the following:

(A) The name or names and address of the patient or patients.

(B) The name and quantity of the drug or device prescribed and the directions for use.

(C) The date of issue.

(D) Either rubber stamped, typed, or printed by hand or typeset, the name, address, and telephone number of the prescriber, his or her license classification, and his or her federal registry number, if a controlled substance is prescribed.

(E) A legible, clear notice of the condition or purpose for which the drug is being prescribed, if requested by the patient or patients.

(F) If in writing, signed by the prescriber issuing the order, or the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor who issues a drug order pursuant to Section 2746.51, 2836.1, 3502.1, or 3640.5, respectively, or the pharmacist who issues a drug order pursuant to ~~either~~ Section ~~4052.1 or 4052.2~~ *4052.1, 4052.2, or 4052.6.*

(2) Issued by a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7 or, if a drug order is issued pursuant to Section 2746.51, 2836.1, 3502.1, or 3460.5, by a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor licensed in this state, or pursuant to ~~either~~ Section ~~4052.1 or 4052.2~~ *4052.1, 4052.2, or 4052.6* by a pharmacist licensed in this state.

(b) Notwithstanding subdivision (a), a written order of the prescriber for a dangerous drug, except for any Schedule II controlled substance, that contains at least the name and signature of the prescriber, the name and address of the patient in a manner consistent with paragraph (2) of subdivision (a) of Section 11164 of the Health and Safety Code, the name and quantity of the drug prescribed, directions for use, and the date of issue may be treated as a prescription by the dispensing pharmacist as long as any additional information required by subdivision (a) is readily retrievable in the pharmacy. In the event of a conflict between this subdivision and Section 11164 of the Health and Safety Code, Section 11164 of the Health and Safety Code shall prevail.

(c) "Electronic transmission prescription" includes both image and data prescriptions. "Electronic image transmission prescription" means any prescription order for which a facsimile of the order is received by a pharmacy from a licensed prescriber. "Electronic data transmission prescription" means any prescription order, other than an electronic image transmission prescription, that is electronically transmitted from a licensed prescriber to a pharmacy.

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

(e) Nothing in the amendments made to this section (formerly Section 4036) at the 1969 Regular Session of the Legislature shall be construed as expanding or limiting the right that a chiropractor, while acting within the scope of his or her license, may have to prescribe a device.

~~**SEC. 3.**~~***SEC. 4.*** Section 4050 of the Business and Professions Code is amended to read:

4050. (a) In recognition of and consistent with the decisions of the appellate courts of this state, the Legislature hereby declares the practice of pharmacy to be a profession.

(b) Pharmacy practice is a dynamic, patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use, drug-related therapy, and

(c) The Legislature further declares that pharmacists are health care providers who have the authority to provide health care services.

~~**SEC. 4.**~~***SEC. 5.*** Section 4051 of the Business and Professions Code is amended to read:

4051. (a) Except as otherwise provided in this chapter, it is unlawful for any person to manufacture, compound, furnish, sell, or dispense a dangerous drug or dangerous device, or to dispense or compound a prescription pursuant to Section 4040 of a prescriber unless he or she is a pharmacist under this chapter.

(b) Notwithstanding any other law, a pharmacist may authorize the initiation of a prescription, pursuant to Section 4052.1, 4052.2, 4052.3, or 4052.6, and otherwise provide clinical advice, services, information, or patient consultation, as set forth in this chapter, if all of the following conditions are met:

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

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

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

~~**SEC. 5.**~~***SEC. 6.*** Section 4052 of the Business and Professions Code is amended to read:

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

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

(2) Transmit a valid prescription to another pharmacist.

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

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

(5) Perform procedures or functions as part of the care provided by a health care facility, a licensed home health agency, a licensed clinic in which there is a physician oversight, a provider who contracts with a licensed health care service plan with regard to the care or services provided to the enrollees of that health care service plan, or a physician, as authorized by Section 4052.2.

(6) Perform procedures or functions as authorized by Section 4052.6.

(7) Manufacture, measure, fit to the patient, or sell and repair dangerous devices, or furnish instructions to the patient or the patient's representative concerning the use of those devices.

(8) Provide consultation, training, and education to patients about drug therapy, disease management, and disease prevention.

(9) Provide professional information, including clinical or pharmacological information, advice, or consultation to other health care professionals, and participate in multidisciplinary review of patient progress, including appropriate access to medical records.

(10) Furnish the following medications:

(A) Emergency contraception drug therapy and self-administered hormonal contraceptives, as authorized by Section 4052.3.

(B) ~~Prescription smoking cessation drugs and devices,~~ *Nicotine replacement products,* as authorized by Section 4052.9.

(C) Prescription medications not requiring a diagnosis that are recommended by the federal Centers for Disease Control and Prevention for individuals traveling outside of the United States.

(D) The pharmacist shall notify the patient's primary care provider of any drugs or devices furnished to the patient. If the patient does not have a primary care provider, the pharmacist shall provide the patient with a written record of the drugs or devices furnished and advise the patient to consult a physician of the patient's choice.

(12) Order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies.

(b) A pharmacist who is authorized to issue an order to initiate or adjust a controlled substance therapy pursuant to this section shall personally register with the federal Drug Enforcement Administration.

(c) This section does not affect the applicable requirements of law relating to either of the following:

(1) Maintaining the confidentiality of medical records.

(2) The licensing of a health care facility.

~~SEC. 6.~~*SEC. 7.* Section 4052.3 of the Business and Professions Code is amended to read:

4052.3. (a) (1) Notwithstanding any other law, a pharmacist may furnish self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The standardized procedure or protocol shall require that the patient use a self-screening tool *that will identity patient risk factors for use of self-administered hormonal contraceptives*, based on the *current* United States Medical Eligibility Criteria (USMEC) for Contraceptive Use developed by the federal Centers for Disease Control and Prevention, and that the pharmacist refer the patient to the patient's primary care provider or, if the patient does not have a primary care provider, to nearby clinics, *upon furnishing a self-administered hormonal contraceptive pursuant to this subdivision, or if it is determined that use of a self-administered hormonal contraceptive is not recommended.*

(2) The board and the Medical Board of California are both authorized to ensure compliance with this subdivision, and each board is specifically charged with the enforcement of this subdivision with respect to its respective licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(b) (1) Notwithstanding any other law, a pharmacist may furnish emergency contraception drug therapy in accordance with either of the following:

(A) Standardized procedures or protocols developed by the pharmacist and an authorized prescriber who is acting within his or her scope of practice.

(B) Standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The board and the Medical Board of California are both authorized to ensure compliance with this clause, and each board is specifically charged with the enforcement of this provision with respect to its respective licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(2) Prior to performing a procedure authorized under this subdivision, a pharmacist shall complete a training program on emergency contraception that consists of at least one hour of approved continuing education on emergency contraception drug therapy.

(3) A pharmacist, pharmacist's employer, or pharmacist's agent shall not directly charge a patient a separate consultation fee for emergency contraception drug therapy services initiated pursuant to this subdivision, but may charge an administrative fee not to exceed ten dollars ($10) above the retail cost of the drug. Upon an oral, telephonic, electronic, or written request from a patient or customer, a pharmacist or pharmacist's employee shall disclose the total retail price that a consumer would pay for emergency contraception drug therapy. As used in this paragraph, total retail price includes providing the consumer with specific information regarding the price of the emergency contraception drugs and the price of the administrative fee charged. This limitation is not intended to interfere with other contractually agreed-upon terms between a pharmacist, a pharmacist's employer, or a pharmacist's agent, and a health care service plan or insurer. Patients who are insured or covered and receive a pharmacy benefit that covers the cost of emergency contraception shall not be required to pay an administrative fee. These patients shall be required to pay copayments pursuant to the terms and conditions of their coverage. This paragraph shall become inoperative for dedicated emergency contraception drugs if these drugs are reclassified as over-the-counter products by the federal Food and Drug Administration.

(4) A pharmacist shall not require a patient to provide individually identifiable medical information that is not specified in Section 1707.1 of Title 16 of the California Code of Regulations before initiating emergency contraception drug therapy pursuant to this subdivision.

(c) For each emergency contraception drug therapy or self-administered hormonal contraception initiated pursuant to this section, the pharmacist shall provide the recipient of the drug with a standardized factsheet that includes, but is not limited to, the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. The board shall develop this form in consultation with the State Department of Public Health, the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other health care organizations. This section does not preclude the use of existing publications developed by nationally recognized medical organizations.

~~SEC. 7.~~*SEC. 8.* Section 4052.6 is added to the Business and Professions Code, to read:

4052.6. (a) A pharmacist recognized by the board as an advanced practice pharmacist may do all of the following:

(1) Perform patient assessments.

(2) Order and interpret drug therapy-related tests.

(3) Refer patients to other health care providers.

(4) Participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers.

(5) Initiate, adjust, or discontinue drug therapy in the manner specified in paragraph (4) of subdivision (a) of Section 4052.2.

(b) A pharmacist who adjusts or discontinues drug therapy shall promptly transmit written notification to the patient's diagnosing prescriber or enter the appropriate information in a patient record system shared with the prescriber, *as permitted by that prescriber*. A pharmacist who initiates drug therapy shall promptly transmit written notification to, or enter the appropriate information into, a patient record system shared with the patient's primary care provider or diagnosing provider, as ~~appropriate~~ *permitted by that provider*.

(c) This section shall not interfere with a physician's order to dispense a prescription drug as written, or other order of similar meaning.

(d) Prior to initiating or adjusting a controlled substance therapy pursuant to this section, a pharmacist shall personally register with the federal Drug Enforcement Administration.

~~SEC. 8.~~*SEC. 9.* Section 4052.8 is added to the Business and Professions Code, to read:

4052.8. (a) In addition to the authority provided in paragraph ~~(9)~~ *(11)* of subdivision (a) of Section 4052, a pharmacist may independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC) for persons three years of age and older.

(b) In order to initiate and administer an immunization described in subdivision (a), a pharmacist shall do all of the following:

(1) Complete an immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and shall maintain that training.

(2) Be certified in basic life support.

(3) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(c) A pharmacist administering immunizations pursuant to this section, or paragraph ~~(9)~~ *(11)* of subdivision (a) of Section 4052, may also initiate and administer epinephrine or diphenhydramine by injection for the treatment of a severe allergic reaction.

~~**SEC. 9.**~~***SEC. 10.*** Section 4052.9 is added to the Business and Professions Code, to read:

4052.9. *(a)* A pharmacist may furnish ~~prescription smoking cessation drugs and devices,~~ *nicotine replacement products approved by the federal Food and Drug Administration for use by prescription only in accordance with standardized procedures and protocols developed and approved by both the board and the Medical Board of California in consultation with other appropriate entities* and provide smoking cessation services if all of the following conditions are met:

~~(a)~~

(1) The pharmacist maintains records of all prescription drugs and devices furnished for a period of at least three years for purposes of notifying other health care providers and monitoring the patient.

~~(b)~~

(2) The pharmacist notifies the patient's primary care provider of any drugs or devices furnished to the patient. If the patient does not have a primary care provider, the pharmacist provides the patient with a written record of the drugs or devices furnished and advises the patient to consult a physician of the patient's choice.

~~(c)~~

(3) The pharmacist is certified in smoking cessation therapy by an organization recognized by the board.

~~(d)~~

(4) The pharmacist completes one hour of continuing education focused on smoking cessation therapy biennially.

~~(e)The pharmacist shall consult with the patient's primary care provider before furnishing a smoking cessation drug to the patient that may produce serious neuropsychiatric events.~~

(b) The board and the Medical Board of California are both authorized to ensure compliance with this section, and each board is specifically charged with the enforcement of this section with respect to their respective licensees. Nothing in this section shall be construed to expand the authority of a pharmacist to prescribe any other prescription medication.

~~**SEC. 10.**~~***SEC. 11.*** Section 4060 of the Business and Professions Code is amended to read:

4060. A person shall not possess any controlled substance, except that furnished to a person upon the prescription of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7, or furnished pursuant to a drug order issued by a certified nurse-midwife pursuant to Section 2746.51, a nurse practitioner pursuant to Section 2836.1, a physician assistant pursuant to Section 3502.1, a naturopathic doctor pursuant to Section 3640.5, or a pharmacist pursuant to Section 4052.1, 4052.2, or 4052.6. This section does not apply to the possession of any controlled substance by a manufacturer, wholesaler, pharmacy, pharmacist, physician, podiatrist, dentist, optometrist, veterinarian, naturopathic doctor, certified nurse-midwife, nurse practitioner, or physician assistant, if in stock in containers correctly labeled with the name and address of the supplier or producer.

This section does not authorize a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor, to order his or her own stock of dangerous drugs and devices.

SEC. 12. *Section 4076 of the Business and Professions Code is amended to read:*

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except ~~where~~ *when* the prescriber or the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant

described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to ~~either Section 4052.1 or 4052.2~~ *Section 4052.1, 4052.2, or 4052.6* orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to ~~either Section 4052.1 or 4052.2~~ *Section 4052.1, 4052.2, or 4052.6.*

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to a standardized procedure or protocol described in Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to ~~either Section 4052.1 or 4052.2~~ *Section 4052.1, 4052.2, or 4052.6.*

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the

(Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

SEC. 13. *Section 4111 of the Business and Professions Code is amended to read:*

4111. (a) Except as otherwise provided in subdivision (b), (d), or (e), the board shall not issue or renew a license to conduct a pharmacy to any of the following:

(1) A person or persons authorized to prescribe or write a prescription, as specified in Section 4040, in the State of California.

(2) A person or persons with whom a person or persons specified in paragraph (1) shares a community or other financial interest in the permit sought.

(3) Any corporation that is controlled by, or in which 10 percent or more of the stock is owned by a person or persons prohibited from pharmacy ownership by paragraph (1) or (2).

(b) Subdivision (a) shall not preclude the issuance of a permit for an inpatient hospital pharmacy to the owner of the hospital in which it is located.

(c) The board may require any information the board deems is reasonably necessary for the enforcement of this section.

(d) Subdivision (a) shall not preclude the issuance of a new or renewal license for a pharmacy to be owned or owned and operated by a person licensed on or before August 1, 1981, under the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) and qualified on or before August 1, 1981, under subsection (d) of Section 1310 of Title XIII of the federal Public Health Service Act, as amended, whose ownership includes persons defined pursuant to paragraphs (1) and (2) of subdivision (a).

(e) Subdivision (a) shall not preclude the issuance of a new or renewal license for a pharmacy to be owned or owned and operated by a pharmacist authorized to issue a drug order pursuant to ~~either~~ Section ~~4052.1 or 4052.2~~ *4052.1, 4052.2, or 4052.6.*

SEC. 14. *Section 4174 of the Business and Professions Code is amended to read:*

4174. Notwithstanding any other ~~provision of~~ law, a pharmacist may dispense drugs or devices upon the drug order of a nurse practitioner functioning pursuant to Section 2836.1 or a certified nurse-midwife functioning pursuant to Section 2746.51, a drug order of a physician assistant functioning pursuant to Section 3502.1 or a naturopathic doctor functioning pursuant to Section 3640.5, or the order of a pharmacist acting under Section 4052.1, 4052.2, ~~or 4052.3~~ *4052.3, or 4052.6.*

~~**SEC. 11.**~~***SEC. 15.*** Section 4210 is added to the Business and Professions Code, to read:

4210. (a) A person who seeks recognition as an advanced practice pharmacist shall meet all of the following requirements:

(1) Hold an active license to practice pharmacy issued pursuant to this chapter that is in good standing.

(2) Satisfy any two of the following criteria:

(A) Earn certification in a relevant area of practice, including, but not limited to, ambulatory care, critical care, nuclear pharmacy, nutrition support pharmacy, oncology pharmacy, pediatric pharmacy, pharmacotherapy, or psychiatric pharmacy, from an organization recognized by the Accreditation Council for Pharmacy Education or another entity recognized by the board.

(B) Complete ~~a one year~~ postgraduate residency through an accredited postgraduate institution where at least 50 percent of the experience includes the provision of direct patient care services with interdisciplinary teams.

(C) Have ~~actively managed~~ *provided clinical services to* patients for at least one year under a collaborative practice agreement or protocol with a physician, advanced practice pharmacist, pharmacist practicing collaborative drug therapy management, or health system.

(4) Pay the applicable fee to the board.

(b) An advanced practice pharmacist recognition issued pursuant to this section shall be valid for two years, coterminous with the certificate holder's license to practice pharmacy.

(c) The board shall adopt regulations establishing the means of documenting completion of the requirements in this section.

(d) The board shall, by regulation, set the fee for the issuance and renewal of advanced practice pharmacist recognition at the reasonable cost of regulating advanced practice pharmacists pursuant to this chapter. The fee shall not exceed three hundred dollars ($300).

~~SEC. 12.~~*SEC. 16.* Section 4233 is added to the Business and Professions Code, to read:

4233. A pharmacist who is recognized as an advanced practice pharmacist shall complete 10 hours of continuing education each renewal cycle in addition to the requirements of Section 4231. The subject matter shall be in one or more areas of practice relevant to the pharmacist's clinical practice.

~~SEC. 13.~~*SEC. 17.* No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.

California LEGISLATIVE INFORMATION

SB-493 Pharmacy practice. (2013-2014)

Date	Action
08/15/13	From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 18. Noes 0.) (August 13).
08/06/13	From committee: Do pass and re-refer to Com. on HEALTH. (Ayes 14. Noes 0.) (August 6). Re-referred to Com. on HEALTH.
08/05/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B.,P. & C.P.
06/10/13	Referred to Com. on B.,P. & C.P.
05/30/13	In Assembly. Read first time. Held at Desk.
05/29/13	Read third time. Passed. (Ayes 34. Noes 4. Page 1167.) Ordered to the Assembly.
05/28/13	Read second time and amended. Ordered to third reading.
05/24/13	From committee: Do pass as amended. (Ayes 7. Noes 0. Page 1015.) (May 23).
05/17/13	Set for hearing May 23.
05/13/13	Placed on APPR. suspense file.
05/03/13	Set for hearing May 13.
04/30/13	From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 0. Page 734.) (April 29). Re-referred to Com. on APPR.
04/25/13	Set for hearing April 29.
04/24/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B., P. & E.D.
04/23/13	Set for hearing April 29.
04/22/13	Hearing postponed by committee.
04/05/13	Set for hearing April 22.
04/03/13	Re-referred to Com. on B., P. & E.D.
04/01/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.
03/11/13	Referred to Com. on RLS.
02/22/13	From printer. May be acted upon on or after March 24.
02/21/13	Introduced. Read first time. To Com. on RLS. for assignment. To print.

Date of Hearing: August 13, 2013

ASSEMBLY COMMITTEE ON HEALTH
Richard Pan, Chair
SB 493 (Ed Hernandez) – As Amended: August 5, 2013

SENATE VOTE: 34-4

SUBJECT: Pharmacy practice.

SUMMARY: Establishes a new category of pharmacists referred to as advance practice pharmacists (APPs), authorizes the Board of Pharmacy (BOP) to recognize APPs, and establishes functions for APPs; authorizes a pharmacist to independently initiate and administer vaccines, as specified; authorizes a pharmacist to perform additional functions including the furnishing of nicotine replacement products (NRPs), as specified; and, the ordering and interpreting of tests, as specified. Specifically, this bill:

1) Defines APP as a licensed pharmacist who has been recognized as an advanced pharmacist by the BOP, as specified. Provides that a BOP-recognized APP is entitled to practice advance practice pharmacy, as specified, within or outside a licensed pharmacy, as specified.

2) Authorizes APPs to initiate a prescription and provide clinical advice, services, information or patient consultation if certain conditions are met. Applies all of the following existing conditions to APPs when initiating a prescription or providing clinical advice or patient consultation:
   a) The clinical advice, services, information, or patient consultation are provided to a health care professional or to a patient;
   b) The pharmacist has access to prescription, patient profile, or other relevant medical information for purposes of patient and clinical consultation and advice; and,
   c) Access to the information specified in 2)b) above is secure from unauthorized access and use.

3) Authorizes pharmacists to additionally do the following:
   a) Perform procedures or functions authorized for APPs;
   b) Provide consultation, training, and education to patients about drug therapy, disease management, and disease prevention;
   c) Participate in multidisciplinary review of patient progress, including appropriate access to medical records;
   d) Furnish the following medications: i) NRPs, as specified; and, ii) prescription medications not requiring a diagnosis that are recommended by the Federal Centers for Disease Control and Prevention (CDC) for individuals traveling outside the United States. Requires the pharmacist to notify the patient's primary care provider (PCP) of any drugs or devices furnished to the patient. If the patient does not have a PCP, requires the pharmacist to provide the patient with a written record of the drugs or devices furnished and advise the patient to consult a physician of the patient's choice; and,
   e) Order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies.

4) Authorizes pharmacists to furnish self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by both the BOP and the Medical Board of California (MBC) in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, or other appropriate entities. Requires the standardized procedures or protocols to require that the patient use a self-screening tool, based on the United States Medical Eligibility Criteria for Contraceptive Use developed by the CDC, and the pharmacist to refer the patient to the patient's PCP, or, if the patient does not have a PCP, to nearby clinics. Requires pharmacists to provide a recipient of self-administered hormonal contraception a fact sheet about the drug, as specified.

5) Authorizes the BOP and the MBC to ensure compliance with 4) above, and each board is charged with its enforcement with respect to their respective licensees. Indicates that 4) above does not expand the authority of a pharmacist to prescribe any prescription medication.

6) Authorizes pharmacists recognized by the BOP as an APP to do all of the following:
   a) Perform patient assessments;
   b) Order and interpret drug therapy-related tests;
   c) Refer patients to other health care providers;
   d) Participate in the evaluation and management of diseases and health conditions in collaboration with other health care providers; and,
   e) Initiate, adjust, or discontinue drug therapy, pursuant to the manner specified in existing law which includes: the requirement of a specific written order or authorization made by the individual patient's treating prescriber, in accordance with policies, procedures, or protocols, as specified, that adjusting a regimen does not include substituting or selecting a different drug, except as authorized by the protocol, and requiring the pharmacist to provide written notification to the patient's treating prescriber, or enter the appropriate information in an electronic patient record systems shared by the prescriber, of any drug regimen initiated within 24 hours.

7) Requires pharmacists who adjust or discontinue drug therapy to promptly transmit written notification to the patient's diagnosing prescriber or enter the appropriate information in a patient record system shared with the prescriber. Requires pharmacists who initiate drug therapy to promptly transmit written notification to, or enter the appropriate information into, a patient record system shared with the patient's PCP or diagnosing provider, as appropriate. Requires pharmacists, prior to initiating or adjusting a controlled substance therapy to personally register with the federal Drug Enforcement Administration (DEA).

8) Provides that 6) and 7) above is not to interfere with a physician's order to dispense a prescription drug as written, or other order of similar meaning.

9) Authorizes pharmacists, in addition to the current authority of pharmacists to administer immunizations pursuant to a protocol with a prescriber, to independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the CDC for persons three

a) Complete an immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education (ACPE) that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and maintain that training;
b) Be certified in basic life support; and,
c) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the Department of Public Health;

10) Authorizes pharmacists administering immunizations to also initiate and administer epinephrine or diphenhydramine by injection for the treatment of a severe allergic reaction.

11) Authorizes pharmacists to furnish NRPs approved by the Food and Drug Administration for use by prescription only in accordance with standardized procedures and protocols developed and approved by both the BOP and the MBC in consultation with other appropriate entities and provide smoking cessation services if all of the following conditions are met:
a) The pharmacist maintains records of all prescription drugs and devices furnished for a period of at least three years for purposes of notifying other health care providers and monitoring the patient;
b) The pharmacist notifies the patient's PCP of any drugs or devices furnished to the patient. If the patient does not have a PCP, the pharmacist provides the patient with a written record of the drugs or devices furnished and advises the patient to consult a physician of the patient's choice;
c) The pharmacist is certified in smoking cessation therapy by an organization recognized by the BOP; and,
d) The pharmacist completes one hour of continuing education (CE) focused on smoking cessation biennially.

12) Authorizes the BOP and the MBC to ensure pharmacists' compliance with 11) above, and each board is specifically charged with enforcement, as specified, and prohibits construing 11) above to expand the authority of a pharmacist to prescribe any other prescription medication.

13) Requires a person seeking recognition as an APP to meet all of the following requirements:
a) Hold an active license to practice pharmacy, as specified;
b) Satisfy any two of the following criteria:
i) Earn certification in a relevant area of practice, including, but not limited to, ambulatory care, critical care, nuclear pharmacy, nutrition support pharmacy, oncology pharmacy, pediatric pharmacy, pharmacotherapy, or psychiatric pharmacy, from an organization recognized by the ACPE or another entity recognized by the BOP;
ii) Complete a postgraduate residency through an accredited postgraduate institution where at least 50% of the experience includes the provision of direct patient care services with interdisciplinary teams; or,
iii) Have provided clinical services to patients for at least one year under a collaborative

c) File an application with the BOP for recognition as APP and pay the applicable fee.

14) Indicates that APP recognition issued pursuant to 13) above is valid for two years, coterminous with the certificate holder's license to practice pharmacy.

15) Requires the BOP to adopt regulations establishing the means of documenting completion of the requirements for an APP recognition, as specified.

16) Requires the BOP, by regulation, to set the fee for the issuance and renewal of APP recognition at the reasonable cost of regulating the practice of an APP. Prohibits the fee from exceeding $300.

17) Requires a pharmacist recognized as an APP to complete 10 hours of CE each renewal cycle in addition to the other CE requirements. Requires the subject matter to be in one or more areas of practice relevant to the pharmacist's clinical practice.

18) Finds and declares that pharmacists are health care providers who have the authority to provide health care services.

19) Makes other technical, clarifying, and conforming changes.

EXISTING LAW:

1) Establishes the BOP to regulate the practice of pharmacy, including the licensure of pharmacists.

2) Provides that the practice of pharmacy is a dynamic patient-oriented health service that applies a scientific body of knowledge to improve and promote patient health by means of appropriate drug use, drug-related therapy, and communication for clinical and consultative purposes. Indicates that pharmacy practice is continually evolving to include more sophisticated and comprehensive patient care activities.

3) Makes it unlawful for any person to manufacture, compound, furnish, sell, or dispense any dangerous drug or dangerous device, or to dispense or compound any prescription of a prescriber unless that person is a pharmacist.

4) Defines prescription to mean an oral, written, or electronic transmission order that is both: a) given individually for the person or persons for whom it was ordered, as specified; and, b) issued by a physician, dentist, optometrist, podiatrist, veterinarian, or naturopathic doctor, as specified, by a certified nurse-midwife, nurse practitioner (NP), physician assistant (PA), or naturopathic doctor or by a pharmacist, as specified.

5) Authorizes a pharmacist to initiate a prescription in specified settings, including a licensed health care facility, home health agency, or a licensed clinic, as specified.

6) Authorizes a pharmacist to furnish emergency contraception drug therapy in accordance with

7) Authorizes a pharmacist to do the following:
   a) Furnish a reasonable quantity of compounded drug product to a prescriber for office use by the prescriber;
   b) Transmit a valid prescription to another pharmacist;
   c) Administer, orally or topically, drugs and biologicals;
   d) Perform procedures or functions in a licensed health care facility, as specified;
   e) Perform procedures or functions as part of the care provided by a health care facility, licensed home health agency, a licensed clinic, a provider who contracts with a licensed health care service plan, or a physician, as specified;
   f) Manufacture, measure, fit to the patient, or sell and repair dangerous devices or furnish instructions to the patient or the patient's representative concerning the use of those devices;
   g) Provide consultation to patients and professional information, including clinical or pharmacological information, advice, or consultation to other health care professionals; and,
   h) Administer immunizations pursuant to a protocol with a prescriber.

8) Requires a pharmacist who is authorized to issue an order to initiate or adjust a controlled substance therapy to personally register with the DEA.

9) Prohibits the BOP, unless exempted, from issuing or renewing a license to conduct a pharmacy to: a) person/s authorized to prescribe or write a prescription (physician, dentist, optometrist, podiatrist, veterinarian, naturopathic doctors, certified nurse midwife, NP, or PA); b) person/s with whom those specified in 9)a) above share a community or other financial interest in the permit sought; or, c) any corporation that is controlled by, or in which 10% or more of the stock is owned by a person prohibited from pharmacy ownership pursuant to 9)a) or b) above.

10) Prohibits a person from conducting a pharmacy unless he or she has obtained a licensed from the BOP. Requires a license for each pharmacy owned or operated by a specific person.

FISCAL EFFECT: According to the Senate Appropriations Committee:

1) One-time costs of about $200,000 to adopt new regulations and upgrade the existing system for processing license applications (Pharmacy Board Contingent Fund).

2) Ongoing costs of about $300,000 per year for licensing and enforcement (Pharmacy Board Contingent Fund).

3) Indeterminate impact on state health care programs, such as the California Public Employees' Retirement System and Medi-Cal.

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, as a result of the implementation of the Patient Protection and Affordable Care Act, about 4.7 million more Californians will be

existing infrastructure of trained medical providers to bridge the provider gap through expanded practice. Californians deserve access to high quality primary care offered by a range of safe, efficient, and regulated providers. PAs, NPs, pharmacists and optometrists all have significantly advanced degrees and an upgraded program accreditation process. Other states have recognized these advances with practice acts that align with professional competence and advanced education. But California's practice acts have not kept pace. We can no longer afford to get by on a fraction of our professional capacity. California has a robust network of providers who are well-trained, evenly distributed throughout the state, and well positioned to pay particular attention to currently underserved areas. Deploying these professionals in a team-based delivery model where they work collaboratively with physicians will allow California to meet the demands placed on the healthcare systems.

2) BACKGROUND.

a) The Practice of Pharmacy. Current law authorizes pharmacists to furnish compounded drug products, transmit a valid prescription to another pharmacist, administer, orally or topically, drugs and biologicals pursuant to a prescriber's order, perform procedures or functions in a licensed health care facility, licensed home health agency, manufacture, measure, fit to the patient or sell and repair dangerous devices or furnish instructions to the patient regarding the use of such devices, furnish emergency contraception drug therapy, and provide consultation and professional information, including clinical or pharmacological information to patients, advice, or consultation to other health care professionals, and administer immunizations pursuant to a protocol with a prescriber.

In a licensed health care facility, a home health agency, a licensed clinic in which there is physician oversight, a provider who contracts with a licensed health plan for the provision of services to enrollees of the health care service plan or a physician, and pursuant to policies, procedures, or protocols developed by health professionals, a pharmacist could perform additional functions, including: i) ordering or performing routine drug therapy-related patient assessment procedures including temperature, pulse, and respiration; ii) ordering drug therapy-related laboratory tests; iii) administering drugs and biologicals by injection pursuant to a prescriber's order; iv) initiating or adjusting the drug regimen of a patient pursuant to an order or authorization made by the patient's prescriber. It should be noted that many of the functions that this bill authorizes for APPs are functions that are already performed by pharmacists in the above settings.

b) Education and Training of Pharmacists. According to the BOP, there are approximately 40,000 licensed pharmacists in California, and eight pharmacy schools based in the state. The Pharmacy Act requires that pharmacists, to obtain licensure, must have graduated from a college of pharmacy or department of pharmacy of a university recognized by the BOP; have completed at least 150 semester units of collegiate study in the United States, or the equivalent thereof in a foreign country, and no less than 90 of those units must be completed while in resident attendance at a school or college of pharmacy; have earned at least a baccalaureate degree in a course of study devoted to the practice of pharmacy; have completed 1,500 hours of pharmacy practice or experience; and, have passed the North American Pharmacist Licensure Examination and the California Practice Standards

the discretion of the BOP for other experience substantially related to the practice of pharmacy; iii) experience in both community pharmacy and institutional pharmacy settings; and, iv) pharmacy experience that satisfies the requirements for both introductory and advanced pharmacy practice experiences established by the ACPE. The BOP also requires pharmacists to complete 30 hours of CE every two years for purposes of license renewal.

The ACPE is the national agency for the accreditation of professional degree programs in pharmacy and providers of pharmacy CE. All pharmacy schools in the country and California are ACPE-accredited. ACPE initially established standards for the baccalaureate degree in pharmacy, then added the doctor of pharmacy standards as an alternative, and in 2000 announced the conversion to the doctor of pharmacy (PharmD) as the sole entry-level degree for the profession of pharmacy.

c) Vaccines. This bill authorizes a pharmacist to independently administer vaccines listed on the routine immunization schedules recommended by ACIP. According to the CDC, vaccines are responsible for the control of many infectious diseases that were once common in this country and around the world, including polio, measles, diphtheria, pertussis (whooping cough), rubella (German measles), mumps, tetanus, and *Haemophilus influenzae* type b (Hib). Vaccine-preventable diseases have a costly impact, resulting in doctor's visits, hospitalizations, and premature deaths. Sick children can also cause parents to lose time from work. Vaccines contain the same antigens or parts of antigens that cause diseases, but the antigens in vaccines are either killed or greatly weakened. Vaccine antigens are not strong enough to cause disease but they are strong enough to make the immune system produce antibodies against them.

Federal law requires ACIP to provide advice and guidance to the Secretary of the U.S. Department of Health and Human Services (HHS), the Assistant Secretary for Health, and the CDC on the most effective means to prevent vaccine-preventable diseases. Another goal of ACIP is to increase the safe usage of vaccines and related biological products. ACIP consists of 15 experts in fields associated with immunization who have been selected by the HHS Secretary, and is the only entity in the federal government which develops recommendations for the routine administration of vaccines to children and adults, along with schedules regarding the age for vaccine administration, appropriate dosage, dosing intervals, precautions, and contraindications applicable to the vaccines

d) Healthcare Workforce Shortage. On March 23, 2010, President Obama signed the ACA (Public Law (PL) 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (PL 111-152). Among other provisions, the new law requires most U.S. citizens and legal residents to have health insurance; creates state-based American Health Benefit Exchanges through which individuals can purchase coverage, with premium and cost sharing credits, and creates separate exchanges through which small businesses can purchase coverage. A 2011 study by the Center for the Health Professions of the University of California, San Francisco entitled "California's Health Care Workforce: Readiness for the ACA Era" indicates that with California's implementation of the ACA, 4-6 million Californians will obtain coverage. As such, there is a need not only for a

become increasingly important.
In March 2012 and March 2013, the Senate Health Committee conducted informational hearings relating to healthcare workforce and the ACA. The hearings explored the supply, and expected demand, for various healing arts practitioners as part of ACA implementation. Additionally, several options were discussed to address workforce needs.

3) SUPPORT. The University of California states that full and consistent recognition of scope of practice and provider status by health care payers for California pharmacists would enable the pharmacy profession to make significant strides forward. In this era of limited resources, the changes proposed by this bill would help increase workforce capacity, improve access to care, more fully integrate the pharmacy profession into the health care team, and potentially offer much-needed costs savings to California.

   Pharmacy schools such as Touro University state that this bill allows more pharmacists to practice to their level of education. It states that graduates are trained to manage chronic diseases such as hypertension, diabetes, and hyperlipidemia.

   The California Chronic Care Coalition states that pharmacists are highly-trained health care workers, who can provide some preventative health care measures and medications in very safe conditions to people who would otherwise go without health care.

   Blue Shield of California indicates that this bill will help alleviate the healthcare access challenge, help control costs, and reduce the strain in our overburdened healthcare system.

   The California Retailers Association indicates that pharmacists are one of the most underutilized healthcare professionals within the healthcare system and historically their role in providing direct patient care has been fairly limited. However, pharmacists are well-equipped with the clinical and professional experience to do much more and are uniquely and conveniently situated within communities to help patients optimize medication use, prevent medication-related problems, and improve health outcomes through the delivery of direct and frequent patient care services such as Medication Therapy Management, health promotion and education among other functions.

   The California Board of Pharmacy states that the functions and services that an APP may perform under this bill are not new and pharmacists can currently perform these types of functions and services in certain settings under certain conditions. Pharmacists are highly educated, with extensive training in patient care and disease prevention and management, and are one of the most accessible health care providers to patients.

4) OPPOSITION. The California Chapter of the American College of Emergency Physicians opposes a previous version of this bill and states that "pharmacists have no education training to perform physical examinations nor do they have any training to diagnose medical conditions. As physicians educated and trained in the complexities of human physiology and epidemiology, we cannot imagine how someone without adequate education or training could safely perform physical exams or render diagnosis. Additionally, the bill introduces potential

The California Psychiatric Association opposes the APP provisions of this bill because of the potential risks to the health and safety of patients of psychiatrists or other physicians who are taking powerful, sometimes dangerous psychotropic medications which often have serious side effects.

5) OPPOSE UNLESS AMENDED. The California Academy of Family Physicians has an oppose unless amended position on a prior version of this bill and states that the single training course required for pharmacists to administer vaccines puts patients at risk; smoking cessation drugs and devices should only be used under close medical supervision; fragmented primary care received in a pharmacy may not be an appropriate venue in which to monitor patients using these medications; and, the authority of an APP to adjust drug therapy should be contingent upon notice to the prescriber.

   The Osteopathic Physicians and Surgeons of California (OPS) also has an oppose unless amended position on a prior version of this bill and indicates concerns regarding giving authority to pharmacists to furnish self-administered hormonal contraception, prescription smoking-cessation drugs, and medications required for international travelers. OPS states that unlike physicians, pharmacists do not conduct full patient assessments in the course of their practice that would identify potential contraindications from these medications.

6) NEUTRAL. The California Medical Association (CMA) has taken a neutral position on this bill and indicates that this bill, as amended, enables pharmacists, with the appropriate training and education, to attain the APP designation and this would help improve the communication and coordination between the patient, the physician, and their pharmacists. CMA also points out that the amendments have the potential to improve access to vaccines for children and access to nicotine based smoking cessation products for adults seeking to end their addiction to tobacco products.

7) RELATED LEGISLATION.

   a) SB 491(Ed Hernandez), among other provisions, authorizes a NP to practice independently if the NP meets specified experience and certification requirements. SB 491 is pending in the Assembly Business, Professions and Consumer Protection Committee.

   b) SB 492 (Ed Hernandez), among other provisions, expands the scope of practice of optometrists, as specified, and states the Legislature's intent that the Office of Statewide Health Planning and Development, under the Health Workforce Pilot Projects Program, designate a pilot project intended to test, demonstrate, and evaluate expanded roles for optometrists in the performance of management and treatment of diabetes mellitus, hypertension, and hypercholesterolemia. SB 492 is pending in the Assembly Business, Professions and Consumer Protection Committee.

8) PREVIOUS LEGISLATION.

including a health care facility, home health agency, or licensed clinic.

b) AB 1711 (Strickland), Chapter 58, Statutes of 2005, authorizes a registered nurse or licensed pharmacist to administer in skilled nursing facilities influenza and pneumococcal immunizations to patients over 50 years of age, as specified.

c) SB 490 (Alpert), Chapter 651, Statutes of 2003, authorizes a licensed pharmacist to initiate emergency contraceptives in accordance with standardized procedure approved by BOP and MBC.

9) DOUBLE-REFERRAL. This bill is double referred, it was heard in the Assembly Business, Professions and Consumer Protection Committee on August 6, 2013, and passed out on a 14-0 vote.

10) POLICY CONCERNS.

a) Patient Assessments. This bill authorizes an APP to perform patient assessments. However, it is unclear whether patient assessments include conducting full or partial physical examinations. Under existing law, a pharmacist in a health care facility could order and perform routine drug therapy-related patient assessment procedures including temperature, pulse, and respiration. The Chair recommends that the performance of patient assessments should only be for purposes of drug therapy, as in existing law for pharmacists in a health care facility.

b) Vaccines. This bill authorizes a pharmacist to independently initiate and administer vaccines listed on the routine immunization schedules recommended by ACIP for persons three years of age and older and requires a pharmacist to complete an immunization training program, as specified. The Chair recommends that the training required in this bill specifically include demonstrated proficiency annually in the application of ACIP's recommended immunization schedules.

c) Order and Interpret Tests. Provisions relating to the ordering and interpreting of tests are contained in two different sections of this bill. First, Section 4052 (a) (12) authorizes a pharmacist to order and interpret tests for the purpose of monitoring and managing the efficacy and toxicity of drug therapies. According to the author, this authority is limited to monitoring the efficacy and toxicity of drug therapies, and does not allow the pharmacist to take any action/s based on the results of the test. On the other hand, Section 4052.6 authorizes an APP to order and interpret drug therapy-related test which is broader and aligns with an APP's additional authority to adjust, initiate, or discontinue drug therapy pursuant to a protocol, as specified. The Chair is concerned that these provisions provide no parameters on how these functions could be accomplished. For example, this bill provides no practice guidelines for ordering and interpreting these tests, the need to evaluate the test results in the context of a patient's full medical history, which a pharmacist may not have access to, the handling of abnormal test results that require discussion or consultation with a physician, and the need for additional patient assessments. As such, the Chair recommends that a pharmacist orders and interprets these tests under the direction of a physician, who is actively involved in the direct care of

Additionally, there is nothing in this bill that requires a pharmacist to provide a copy of the test results to the patient or the physician who is actively involved in the direct care of the patient, which is required under this bill when drugs and devices are furnished to the patient, and also when a pharmacist initiates, adjusts, or discontinues drug therapy. To be consistent and facilitate communication with the physician, the Chair recommends that a pharmacist who orders and interprets tests must provide a copy of the test results to the patient or the physician who is actively involved in the direct care of the patient.

d) Corporate Influence. This bill expands the role of pharmacists by, among other functions, authorizing them to independently administer vaccines, order and interpret tests, and initiate a prescription (APP). In those instances that a corporation employs these pharmacists, the Chair is concerned that that the financial goals of a corporation may conflict with the professional goals of a pharmacist. The Chair recommends including a provision in this bill to make it unprofessional conduct for a person (defined in the Pharmacy Act to include a firm, association, partnership, corporation, limited liability company, state governmental agency, or political subdivision) who conducts a pharmacy to exert undue influence on a pharmacist to commit any act or omission with the primary purpose of increasing revenue, sales, or other financial influence.

REGISTERED SUPPORT / OPPOSITION:

Support

Adventist Health
American Society of Health-System Pharmacists
Bay Area Council
Blue Shield of California
California Association for Nurse Practitioners
California Association of Physician Groups
California Association of Public Hospitals and Health Systems
California Chronic Care Coalition
California Hospital Association
California Immunization Coalition
California Korean American Pharmacists Association
California Medical Board
California Northstate University, College of Pharmacy
California Optometric Association
California Pharmacists Association
California Primary Care Association
California Retailers Association
California Society of Health-System Pharmacists
California State Board of Pharmacy
Californians for Patient Care
Cedars-Sinai Medical Center
Dignity Health

National Asian American Coalition
National Association of Chain Drug Stores
Pharmacy Choice and Access Now
Private Essential Access Community Hospitals
Safeway
St. Elizabeth Community Hospital
Touro University-California, College of Pharmacy
United Nurses Association of California/Union of Health Care Professionals
University of California
University of California, San Diego, Skaggs School of Pharmacy and Pharmaceutical Sciences
University of California, San Francisco
Western University of Health Sciences
Numerous pharmacy students

Opposition

American College of Emergency Physicians, California Chapter
Blind Children's Center
California Academy of Eye Physicians and Surgeons
California Academy of Family Physicians
California Psychiatric Association
California Right to Life Committee, Inc.
California Society of Anesthesiologists
California Society of Plastic Surgeons
Canvasback Missions, Inc.
Dream Machine Foundation
Here for Them, Inc.
Let's Face It Together Foundation
Lighthouse for Christ Mission and Eye Center
Osteopathic Physicians and Surgeons of California
Sansum Diabetes Research Institute
Time for Change Foundation
Union of American Physicians and Dentists
Ventura County American Chinese Medical Dental Association

Analysis Prepared by: Rosielyn Pulmano / HEALTH / (916) 319-2097

California LEGISLATIVE INFORMATION

SB-494 Health care providers. (2013-2014)

AMENDED IN ASSEMBLY AUGUST 05, 2013

AMENDED IN SENATE MAY 28, 2013

AMENDED IN SENATE APRIL 03, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL **No. 494**

Introduced by Senator Monning
(Principal Coauthor(s): Senator Hernandez)

February 21, 2013

An act to add Section 1375.9 to the Health and Safety Code, to add Section 10133.4 to the Insurance Code, and to amend Sections 14087.48, 14088, and 14254 of, and to add Section 14088.1 to, the Welfare and Institutions Code, relating to health care providers.

LEGISLATIVE COUNSEL'S DIGEST

SB 494, as amended, Monning. Health care providers.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance.

This bill would authorize the assignment of an additional ~~1,750~~ *1,000* enrollees or insureds, as specified, to a primary care physician if that physician supervises one or more nonphysician medical ~~practitioners.~~ *practitioners, as defined.* By imposing new requirements on health care service plans, the willful violation of which would be a crime, this bill would impose a state-mandated local program.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services. Prior to a Medi-Cal managed care plan commencing operations, existing law requires the department to evaluate, among other things, the extent to which the plan has an adequate provider network, including the location, office hours, and language capabilities of the plan's primary care physicians. Existing law defines primary care provider for these purposes as an internist, general practitioner, obstetrician-gynecologist, pediatrician, family practice physician, or, as specified, types of clinics and defines primary care physician as a physician who has the responsibility, among other duties, for providing initial and primary care to patients.

This bill would require that the department evaluate the location, office hours, and language capabilities of a

practitioner as a physician assistant performing services under physician supervision, as specified, or as a nurse practitioner performing services in collaboration with a physician, as specified. The bill would authorize, if the assignment of beneficiaries enrolled in any type of Medi-Cal managed care plan to a primary care physician is authorized by specified provisions of law or contract, the assignment of up to 2,000 beneficiaries to each full-time equivalent primary care physician. The bill would authorize the assignment of an additional ~~1,750~~ *1,000* beneficiaries, as specified, to a primary care physician when that physician supervises one or more nonphysician medical practitioners. The bill would make conforming changes.

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

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

Vote: majority Appropriation: no Fiscal Committee: yes Local Program: yes

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. Section 1375.9 is added to the Health and Safety Code, to read:

1375.9. (a) Notwithstanding any other state law or regulation, if a primary care physician supervises one or more nonphysician medical practitioners, the physician may be assigned an average of an additional ~~1,750~~ *1,000* enrollees for each full-time equivalent nonphysician medical practitioner supervised by that physician, in addition to the number of enrollees assigned to that physician pursuant to current law and approved by the department.

(b) This section shall not require a primary care physician to accept an assignment of enrollees *by a health care service plan without his or her approval, or* that would be contrary to paragraph (2) of subdivision (b) of Section 1375.7.

(c) Nothing in this section shall be interpreted to modify subdivision (b) of Section 3516 of the Business and Professions Code.

(d) For purposes of this section, "nonphysician medical practitioner" means a physician assistant performing services under physician supervision in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code or a nurse practitioner performing services in collaboration with a physician pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

SEC. 2. Section 10133.4 is added to the Insurance Code, to read:

~~10133.4.(a)If the assignment of insureds to a primary care physician is authorized by this part, or any regulation, contract, or policy promulgated thereunder, each full-time equivalent primary care physician may be assigned up to 2,000 insureds. Notwithstanding any other state law or regulation, if a primary care physician supervises one or more nonphysician medical practitioners, the physician may be assigned up to an additional 1,750 insureds for each full-time equivalent nonphysician medical practitioner supervised by that physician.~~

10133.4. *(a) For purposes of insurers who contract with providers for alternate rates pursuant to Section 10133, "nonphysician medical practitioner" means a physician assistant performing services under physician supervision in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions Code or a nurse practitioner performing services in collaboration with a physician pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code. In accordance with Section 14088 of the Welfare and Institutions Code, a nonphysician medical practitioner shall be considered a primary care provider.*

(b) This section shall not require a primary care provider to accept the assignment of a number of insureds that would exceed standards of good health care as provided in Section 10133.5.

(c) Nothing in this section shall be interpreted to modify subdivision (b) of Section 3516 of the Business and Professions Code.

SEC. 3. Section 14087.48 of the Welfare and Institutions Code is amended to read:

14087.48. (a) For purposes of this section, "Medi-Cal managed care plan" means any individual, organization, or entity that enters into a contract with the department pursuant to Article 2.7 (commencing with Section 14087.3), Article 2.8 (commencing with Section 14087.5), Article 2.81 (commencing with Section 14087.96), Article 2.9 (commencing with Section 14088), or Article 2.91 (commencing with Section 14089), or pursuant to Article 1 (commencing with Section 14200), or Article 7 (commencing with Section 14490) of Chapter 8.

(b) Before a Medi-Cal managed care plan commences operations based upon an action of the director that expands the geographic area of Medi-Cal managed care, the department shall perform an evaluation to determine the readiness of any affected Medi-Cal managed care plan to commence operations. The evaluation shall include, at a minimum, all of the following:

(1) The extent to which the Medi-Cal managed care plan demonstrates the ability to provide reliable service utilization and cost data, including, but not limited to, quarterly financial reports, audited annual reports, utilization reports of medical services, and encounter data.

(2) The extent to which the Medi-Cal managed care plan has an adequate provider network, including, but not limited to, the location, office hours, and language capabilities of primary care practitioners, specialists, pharmacies, and hospitals, that the types of specialists in the provider network are based on the population makeup and particular geographic needs, and that whether requirements will be met for availability of services and travel distance standards, as set forth in Sections 53852 and 53885, respectively, of Title 22 of the California Code of Regulations.

(3) The extent to which the Medi-Cal managed care plan has developed procedures for the monitoring and improvement of quality of care, including, but not limited to, procedures for retrospective reviews which include patterns of practice reviews and drug prescribing practice reviews, utilization management mechanisms to detect both under- and over-utilization of health care services, and procedures that specify timeframes for medical authorization.

(4) The extent to which the Medi-Cal managed care plan has demonstrated the ability to meet accessibility standards in accordance with Section 1300.67.2 of Title 28 of the California Code of Regulations, including, but not limited to, procedures for appointments, waiting times, telephone procedures, after hours calls, urgent care, and arrangement for the provision of unusual specialty services.

(5) The extent to which the Medi-Cal managed care plan has met all standards and guidelines established by the department that demonstrate readiness to provide services to enrollees.

(6) The extent to which the Medi-Cal managed care plan has submitted all required contract deliverables to the department, including, but not limited to, quality improvement systems, utilization management, access and availability, member services, member grievance systems, and enrollments and disenrollments.

(7) The extent to which the Medi-Cal managed care plan's Evidence of Coverage, Member Services Guide, or both, conforms to federal and state statutes and regulations, is accurate, and is easily understood.

(8) The extent to which the Medi-Cal managed care plan's primary care and facility sites have been reviewed and evaluated by the department.

SEC. 4. Section 14088 of the Welfare and Institutions Code is amended to read:

14088. (a) It is the purpose of this article to ensure that the Medi-Cal program shall be operated in the most cost-effective and efficient manner possible with the optimum number of Medi-Cal providers and shall ensure quality of care and known access to services.

(b) For the purposes of this article, the following definitions shall apply:

(1) "Primary care provider" means either of the following:

(A) Any internist, general practitioner, obstetrician-gynecologist, pediatrician, family practice physician, nonphysician medical practitioner, or any primary care clinic, rural health clinic, community clinic or hospital outpatient clinic currently enrolled in the Medi-Cal program, which agrees to provide case management to Medi-Cal beneficiaries.

(B) A county or other political subdivision that employs, operates, or contracts with, any of the primary care providers listed in subparagraph (A), and that agrees to use that primary care provider for the purposes of

(2) "Primary care case management" means responsibility for the provision of referral, consultation, ordering of therapy, admission to hospitals, followup care, and prepayment approval of referred services.

(3) "Designation form" or "form" means a form supplied by the department to be executed by a Medi-Cal beneficiary and a primary care provider or other entity eligible pursuant to this article who has entered into a contract with the department pursuant to this article, setting forth the beneficiary's choice of contractor and an agreement to be limited by the case management decisions of that contractor and the contractor's agreement to be responsible for that beneficiary's case management and medical care, as specified in this article.

(4) "Emergency services" means health care services rendered by an eligible Medi-Cal provider to a Medi-Cal beneficiary for those health services required for alleviation of severe pain or immediate diagnosis and treatment of unforeseen medical conditions which if not immediately diagnosed and treated could lead to disability or death.

(5) "Modified primary care case management" means primary care case management wherein capitated services are limited to primary care practitioner office visits only.

(6) "Service area" means an area designated by either a single federal Postal ZIP Code or by two or more Postal ZIP Codes that are contiguous.

(c) For purposes of ~~this part,~~ *Medi-Cal managed care plans, as defined in subdivision (m) of Section 14016.5,* "nonphysician medical practitioner" means a physician assistant performing services under physician supervision in compliance with Chapter 7.7 (commencing with Section 3500) of Division 2 of the Business and Professions ~~Code~~ *Code, a certified nurse-midwife performing services under physician supervision in compliance with Article 2.5 (commencing with Section 2746) of Chapter 6 of Division 2 of the Business and Professions Code,* or a nurse practitioner performing services in collaboration with a physician pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code.

SEC. 5. Section 14088.1 is added to the Welfare and Institutions Code, to read:

14088.1. If the assignment of beneficiaries enrolled in any type of Medi-Cal managed care plan to a primary care physician is authorized or required by a provision of this part, or any regulation, contract, or policy promulgated thereunder, each full-time equivalent primary care physician may be assigned up to 2,000 beneficiaries. Notwithstanding any other state law or regulation, if a primary care physician in that plan supervises one or more nonphysician medical practitioners, the physician may be assigned up to an additional ~~1,750~~ *1,000* beneficiaries for each full-time equivalent nonphysician medical practitioner supervised by that physician.

Nothing in this section shall be interpreted to modify subdivision (b) of Section 3516 of the Business and Professions Code.

SEC. 6. Section 14254 of the Welfare and Institutions Code is amended to read:

14254. "Primary care practitioner" is a physician or nonphysician medical practitioner who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. A primary care physician shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

SEC. 7. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.

California LEGISLATIVE INFORMATION

SB-494 Health care providers. (2013-2014)

Date	Action
08/15/13	From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 18. Noes 0.) (August 13).
08/05/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on HEALTH.
06/17/13	Referred to Com. on HEALTH.
05/30/13	In Assembly. Read first time. Held at Desk.
05/29/13	Read third time. Passed. (Ayes 38. Noes 0. Page 1167.) Ordered to the Assembly.
05/28/13	Read second time and amended. Ordered to third reading.
05/24/13	From committee: Do pass as amended. (Ayes 7. Noes 0. Page 1015.) (May 23).
05/17/13	Set for hearing May 23.
05/06/13	Placed on APPR. suspense file.
04/26/13	Set for hearing May 6.
04/25/13	From committee: Do pass and re-refer to Com. on APPR. (Ayes 9. Noes 0. Page 697.) (April 24). Re-referred to Com. on APPR.
04/12/13	Set for hearing April 24.
04/11/13	Re-referred to Com. on HEALTH.
04/03/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on RLS.
03/11/13	Referred to Com. on RLS.
02/22/13	From printer. May be acted upon on or after March 24.
02/21/13	Introduced. Read first time. To Com. on RLS. for assignment. To print.

Date of Hearing: August 13, 2013

ASSEMBLY COMMITTEE ON HEALTH
Richard Pan, Chair
SB 494 (Monning) – As Amended: August 5, 2013

SENATE VOTE: 38-0

SUBJECT: Health care providers.

SUMMARY: Authorizes health plans licensed by the Department of Managed Health Care (DMHC) and managed care plans participating in the Medi-Cal program to permit the assignment of an average of an additional 1,000 enrollees for each full-time equivalent nonphysician medical practitioner supervised by a primary care physician (PCP). Establishes differing definitions for nonphysician medical practitioners in the Health and Safety, Insurance, and Welfare and Institutions Codes. Specifically, this bill:

1) Authorizes, notwithstanding any other state law or regulation, if a PCP supervises one or more nonphysician medical practitioners, the physician to be assigned an average of an additional 1,000 enrollees for each full-time equivalent nonphysician medical practitioner supervised by that physician, in addition to the number of enrollees assigned to that physician pursuant to current law and approved by the DMHC.

2) States that this bill does not require a PCP to accept an assignment of enrollees by a health plan without his or her approval or that would be contrary to the Health Care Providers' Bill of Rights.

3) States that this bill cannot be interpreted to modify existing law regarding supervision of physician assistants (PAs).

4) Defines a nonphysician medical practitioner as a PA performing services under physician supervision in compliance with existing law or a nurse practitioner (NP) performing services in collaboration with a physician pursuant to existing law.

5) Establishes, for purposes of insurers who contract with providers for alternate rates (Preferred Provider Organizations), a definition of a nonphysician medical practitioner as a PA performing services under physician supervision in compliance with existing law or a NP performing services in collaboration with a physician pursuant to existing law, and adds that in accordance with existing Medi-Cal law, a nonphysician medical practitioner is to be considered a primary care provider.

6) States that this bill does not require a PCP to accept the assignment of a number of insureds that would exceed standards of good health care as provided in existing law related to timely access to health care services.

7) States for purposes of Medi-Cal managed care (MCMC) plans, as defined, nonphysician

physician supervision in compliance with existing law.

8) States that if the assignment of beneficiaries enrolled in any type of MCMC plan to a PCP is authorized or required by a provision in Medi-Cal law, or any regulation, contract, or policy promulgated thereunder, each full-time equivalent PCP may be assigned up to 2,000 beneficiaries. Permits, notwithstanding any other state law or regulation, if a PCP in that plan, supervises one or more nonphysician medical practitioners, the physician may be assigned up to an additional 1,000 beneficiaries for each full-time equivalent nonphysician medical practitioner supervised by that physician.

9) Replaces the term "primary care physician" with "primary care practitioner" in the definition of PCP in Medi-Cal law and includes as a primary care practitioner a nonphysician medical practitioner.

EXISTING LAW:

1) Establishes the California Department of Insurance (CDI) to regulate health and other insurance, the DMHC to license and regulate health care service plans, the Department of Health Care Services (DHCS) to administer California's Medicaid Program (Medi-Cal), the Medical Board of California (MBC) which licenses and regulates physician and surgeons, the Board of Registered Nursing which licenses and regulates nurses, including NPs, and the Physician Assistant Board to license and regulate PAs.

2) Requires pursuant to Medi-Cal managed care regulations that each plan in a designated region retain sufficient professional medical staff to provide access to preventive and managed health care services to its members. Requires access to physicians or physician extenders as follows:
   a) Requires each plan to ensure its provider network satisfies a ratio of at least one full-time equivalent PCP for every 2,000 members;
   b) Requires each plan to ensure its provider network satisfies a ratio of at least one full-time equivalent physician for every 1,200 plan members;
   c) Prohibits plans that utilize nonphysician medical practitioners from allowing a full-time equivalent nonphysician medical practitioner to maintain a caseload of more than 1,000 plan members; and,
   d) Authorizes, if utilized by a plan, members to select a nonphysician medical practitioner as their PCP. Requires nonphysician medical practitioner practitioners, including CNMs, NPs and PAs, to meet the requirements of existing practice and licensure standards for mid-level practitioners, as specified.

3) Defines, "primary care physician" in California law affecting MCMC, as a physician who has the responsibility for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for specialist care. Requires a PCP to be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

to bill Medi-Cal independently for his or her services, requires DHCS to make payment directly to the certified NP.

5) Requires services provided by a PA to be covered under Medi-Cal to the extent authorized by federal law and subject to utilization controls. Requires all services performed by a PA within his or her scope of practice that would be a covered benefit if performed by a physician and surgeon to be a covered benefit under Medi-Cal and prohibits DHCS from imposing chart review, countersignature, or other conditions of coverage or payment on a physician and surgeon supervising PAs that are more stringent than requirements imposed by existing law or regulations of the MBC.

6) Requires pursuant to DMHC regulations, health plans to ensure enrollees have a residence or workplace within 30 minutes or 15 miles of a contracting or plan-operated PCP in such numbers and distribution as to accord to all enrollees a ratio of at least one PCP (on a full-time equivalent basis) to each 2,000 enrollees.

7) Prohibits for DMHC regulated health plans as part of the Health Care Providers' Bill of Rights a contract between a plan and a health care provider from containing a provision that requires a health care provider to accept additional patients beyond the contracted number or in the absence of a number, if in the reasonable professional judgment of the provider, accepting additional patients would endanger patients' access to, or continuity of, care.

8) Includes a NP or PA as a qualified primary care provider in the definition of "Advanced Access" pursuant to DMHC regulations on Timely Access to Non-Emergency Health Care Services.

9) Prohibits a physician and surgeon from supervising more than four PAs at any one time, except as specified. Permits the MBC to restrict a physician and surgeon to supervising specific types of PAs including, but not limited to, restricting a physician and surgeon from supervising PAs outside of the field of specialty of the physician and surgeon.

10) Prohibits a physician and surgeon from supervising more than four NPs at one time.

11) Defines "primary care provider" in federal law pursuant to the federal Patient Protection and Affordable Care Act (ACA) Primary Care Extension Program as a clinician who provides integrated, accessible health care services and who is accountable for addressing a large majority of personal health care needs, including providing preventive and health promotion services for men, women, and children of all ages, developing a sustained partnership with patients and practicing in the context of family and community, as recognized by a state licensing or regulatory authority, unless otherwise specified.

12) Requires under the ACA, if a group health plan or a health insurance issuer offering group or individual health insurance coverage requires or provides for designation by a participant, beneficiary, or enrollee of a participating primary care provider, the plan or issuer to permit each participant, beneficiary, and enrollee to designate any participating primary care provider who is available to accept such individual.

has a primary specialty designation of family medicine, internal medicine, geriatric medicine, or pediatric medicine; or, is a NP, clinical nurse specialist, or PA and for whom primary care services accounted for at least 60% of the allowed charges for such physician or practitioner in a prior period as determined appropriate by the Secretary of the federal Department of Health and Human Services (DHHS).

14) Requires CDI to adopt regulations to ensure that insureds have the opportunity to access needed health care services in a timely manner, and that these regulations are designed to assure accessibility of provider services in a timely manner to individuals comprising the insured or contracted group, including adequacy of number of professional providers, and license classifications of such providers, in relationship to the projected demands for services covered under the group policy or plan.

FISCAL EFFECT: According to the Senate Appropriations Committee analysis, one-time costs of $600,000 to review plan filings by the DMHC (Managed Care Fund). Potential ongoing enforcement cost in the tens of thousands per year by the DMHC (Managed Care Fund). One-time costs of $80,000 to update regulations by the CDI (Insurance Fund).

COMMENTS:

1) PURPOSE OF THIS BILL. According to the author, current Medi-Cal regulation specifies that managed care plans are required to ensure the provider network satisfies a ratio of one full-time equivalent PCP for every 2,000 plan members, further the regulation specifies full-time equivalent nonphysician medical practitioners are permitted to maintain a caseload of 1,000 plan members. The author states, given California's primary care provider workforce shortage, which will become further complicated by additional individuals eligible for coverage under the ACA, this bill proposes that a PCP panel/practice should be allowed to increase up to an additional 1,000 patients based on the use of a PA or NP. The author adds recognizing PAs and NPs as PCPs while still keeping the existing relationship between a supervising physician and the patient would also align federal and state definitions of a "primary care provider." According to the author, the federal definition of a "primary care provider" in the ACA acknowledges PCPs, PAs, and NPs as primary care providers. However, California law, which defines primary care providers for purposes of MCMC, defines them as only PCPs.

   The author states that California is in the midst of a well-documented shortage of primary care providers and a serious misdistribution of specialists throughout the state. Current health care workforce deficits compromise access to care in many areas throughout the state and impede adherence to state-imposed timely access. Further complicating the health workforce capacity challenges is the impending increase of an estimated 4 to 6 million people in California who will become eligible for private or governmental coverage in January 2014 as a result of the ACA. The author believes by essentially increasing the size of a physician's panel, a health plan will immediately add providers to the physician-led team and begin to address the need for more PCPs.

   The California Academy of Physician Assistants (CAPA) indicates that some MCMC

2) BACKGROUND. On March 23, 2010, the federal government enacted the ACA (Public Law 111-148), which was further amended by the Health Care Education Reconciliation Act (H.R. 4872). Much of the ACA is geared toward expanding public and private health insurance coverage and it includes incentive payments for primary care services. The ACA establishes a 10% Medicare bonus for services furnished on and between January 1, 2011 and January 1, 2016 by a "primary care practitioner," which is defined as a physician who has primary specialty designation in family medicine, internal medicine, geriatric medicine, or pediatric medicine, or is a NP, clinical nurse specialist, or PA and for whom primary care services accounted for at least 60% of the allowed charges for such physician or practitioner in a prior period, as determined by the DHHS Secretary. The ACA also provides for a temporary increase in Medicaid payments for certain primary care services furnished in 2013 and 2014 by a physician with a primary specialty designation of family medicine, general internal medicine, or pediatric medicine such that the new rates for those years would be at least 100% of the applicable rate paid for such services under Medicare. The requirement applies to MCMC plans. The additional cost of the increased payment (for the difference between the Medicare rate and the Medicaid payment rate for such services in effect as of July 1, 2009) is fully funded by the federal government. Physician extenders, such as NPs, PAs, and CNMs who work under supervision of an eligible physician are eligible for the increased Medicaid payment. According to a January 8, 2013 presentation by DHCS, physicians self-attest their eligibility and identify specific eligibility criteria. The state will audit a statistically valid sample of providers, and plans may also be required to audit a sample of their providers.

3) NPS AND PAS AND PRIMARY CARE. An August 2011 issue brief published by the University of California San Francisco (UCSF) Center for Health Professions, called "Nurse Practitioners and Physician Assistants Providing Primary Care in California Community Clinics," indicates that most of the primary care provided at one-fifth of the state's Federally Qualified Health Centers (FQHCs) and FQHC look-alike clinics is being provided by NPs and PAs. The study found strong support for staffing models that include significant reliance on NPs and/or PAs to provide primary care; most clinics reported limited availability of clinicians willing to work at these sites; they found that they needed to define their pool of potential clinicians broadly to include NPs and PAs as well as physicians; all the study clinics faced extremely high patient demand and having NPs and/or PAs on staff allowed the clinics to, for the most part, meet patient primary care needs. Additionally, one of the key reasons why PAs and NPs play significant roles in community clinics as PCPs is their cost effectiveness. Finally, while respondents reported that the current range of services NPs and PAs are authorized to provide was appropriate for practice needs, several clinic leaders questioned the usefulness of some requirements such as physician chart reviews for PAs.

4) SUPPORT. One of this bill's sponsors, CAPA, believes this bill will significantly increase the number of lives a practice/physician can be assigned based on the use of a PA or other specified licensed nonphysician medical practitioner. According to CAPA, PAs are licensed health professionals who practice medicine as members of a physician led team, delivering a broad range of medical and surgical services to diverse populations in rural, urban, and suburban settings. CAPA states that PAs have long been recognized as a solution to access to care problems in all settings. The California Association of Physician Groups (CAPG),

team. CAPG asserts that the maximum empanelment ratio is merely that, and most organizations determine internally what their true maximum enrollment ratio should be based on a variety of factors, so it is important to note that this change to Knox-Keene does not mean that all panels across the state will automatically float to the proposed maximums. CAPG adds that the current ratios have been in place for over 30 years, and modern care management and health information technology allow new capabilities to expand access, shrink wait times, and to increase value of encounters that patients have with their health care system. The Bay Area Council asserts that the business community recognizes that strengthening the team-based approach to primary care and allowing these teams of providers to take on additional patients will improve efficiency, help control costs, and create additional capacity in our state's increasingly overburdened healthcare system.

5) SUGGESTED AMENDMENTS. This bill has some inconsistencies in definitions and in several places contains provisions that state "notwithstanding any other state law or regulation" which are not necessary. The author and sponsor have agreed to technical amendments to address these issues. Further, it is not clear what impact this change to the physician to enrollee ratio may have on capacity and access at individual practices. Therefor the committee may wish to include a sunset date of December 31, 2018 to give stakeholders an opportunity to revisit the impacts of this policy change.

6) RELATED LEGISLATION.

   a) SB 491 (Ed Hernandez) permits a NP to practice independently after a period of physician supervision if the NP has national certification and liability insurance, and authorizes the NP to perform various other specified tasks related to the practice of nursing without protocols. SB 491 failed passage in the Assembly Business, Professions and Consumer Protection Committee and was granted reconsideration, therefore could be given an additional hearing and voted on by that committee once more.

   b) SB 352 (Pavley) authorizes medical assistants to perform technical supportive services in any medical setting upon specific authorization of a PA, NP, or CNM without a physician on the premises. SB 352 is currently pending on the Assembly Floor.

7) PREVIOUS LEGISLATION.

   a) SB 2348 (Mitchell), Chapter 460, Statutes of 2012, allows registered nurses (RNs) to dispense and administer hormonal contraceptives under a standardized procedure, as specified, and allows RNs to dispense drugs and devices upon an order by a physician and surgeon, a CNM, a NP, or a PA while functioning within specified clinic settings.

   b) SB 819 (Yee), Chapter 308, Statutes of 2009, among other things, expands the authorized functions that may be performed by a NP practicing under standardized procedures to include: ordering durable medical equipment, as specified; certifying disability, as specified, after performance of a physical examination by the NP and in collaboration with a physician and surgeon; and, approving, signing, modifying, or adding to a plan of treatment or plan of care for individuals receiving home health services or personal care

c) AB 3 (Bass), Chapter 376, Statutes of 2007, increases the maximum number of PAs that may be supervised by a physician and surgeon from two to four, and specifies that services provided by a PA are a covered Medi-Cal benefit if that same service would be a covered benefit if it were performed by a physician and surgeon.

d) AB 1591 (Chan), Chapter 719, Statutes of 2006, permits any certified NP to bill Medi-Cal independently for his or her services.

e) AB 2560 (Montañez), Chapter 205, Statutes of 2004, expands the locations and types of conditions for which NPs can furnish or order prescription drugs or devices under physician protocols.

f) AB 2179 (Cohn), Chapter 797, Statutes of 2002, requires DMHC and CDI to develop and adopt regulations to ensure that enrollees have access to needed health care services, referred to as timely access to services.

REGISTERED SUPPORT / OPPOSITION:

Support

California Academy of Physician Assistants (cosponsor)
California Association of Physician Groups (cosponsor)
AARP
Bay Area Council
California Association of Health Underwriters
California Chiropractic Association
California Medical Association
California Optometric Association
California Physical Therapy Association
California Primary Care Association
Latino Coalition for a Healthy California
United Nurses Associations of California/Union of Health Care Professionals

Opposition

None on file.

Analysis Prepared by: Teri Boughton / HEALTH / (916) 319-2097

California LEGISLATIVE INFORMATION

SB-809 Controlled substances: reporting. (2013-2014)

AMENDED IN ASSEMBLY AUGUST 05, 2013

AMENDED IN ASSEMBLY JUNE 26, 2013

AMENDED IN SENATE MAY 28, 2013

AMENDED IN SENATE MAY 24, 2013

AMENDED IN SENATE MAY 14, 2013

AMENDED IN SENATE MAY 01, 2013

CALIFORNIA LEGISLATURE— 2013–2014 REGULAR SESSION

SENATE BILL **No. 809**

Introduced by Senator DeSaulnier, Steinberg
(Coauthor(s): Senator Hancock, Lieu, Pavley, Price)
(Coauthor(s): Assembly Member Blumenfield)

February 22, 2013

An act to add Sections ~~805.8~~ *208, 209,* and 2196.8 to the Business and Professions Code, and to amend Sections 11164.1, 11165, and 11165.1 of, and to add Section 11165.4 to, the Health and Safety Code, relating to controlled ~~substances, and declaring the urgency thereof, to take effect immediately.~~ *substances.*

LEGISLATIVE COUNSEL'S DIGEST

SB 809, as amended, DeSaulnier. Controlled substances: reporting.

(1) Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances.

Existing law requires dispensing pharmacies and clinics to report, on a weekly basis, specified information for each prescription of Schedule II, Schedule III, or Schedule IV controlled substances, to the department, as specified.

This bill would establish the CURES Fund within the State Treasury to receive funds to be allocated, upon appropriation by the Legislature, to the Department of Justice for the purposes of funding CURES, and would make related findings and declarations.

This bill would require ~~the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the Naturopathic Medicine Committee of the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine to charge practitioners under their supervision who are authorized to prescribe, order, administer, furnish, or dispense controlled substances a fee of up to 1.16% of the renewal fee that the licensee was subject to as of July 1, 2013,~~ *an annual fee of $6 to be assessed on specified licensees, including licensees authorized to prescribe, order, administer, furnish, or dispense controlled substances, and require the regulating agency of each of those licensees to bill and collect that fee at the time of license renewal. The bill would authorize the Department of Consumer Affairs to reduce, by regulation, that fee to the reasonable cost of operating and maintaining CURES for the purpose of regulating those licensees, if the reasonable regulatory cost is less than $6 per licensee. The bill would require* the proceeds of ~~which would~~ *the fee to* be deposited into the CURES Fund for *the* support of CURES, as specified. ~~This bill would also require the California State Board of Pharmacy to charge wholesalers, nonresident wholesalers, and veterinary food-animal drug retailers under their supervision a fee of up to 1.16% of the renewal fee that the wholesaler, nonresident wholesaler, or veterinary food-animal drug retailer was subject to as of July 1, 2013, the proceeds of which would be deposited into the CURES Fund for support of CURES, as specified. The bill would require each of these fees to be due and payable at the time the license is renewed and require the fee to be submitted with the renewal fee.~~ The bill would also permit specified insurers, health care service plans, ~~and~~ qualified manufacturers, *and other donors* to voluntarily contribute to the CURES Fund, as described.

(2) Existing law requires the Medical Board of California to periodically develop and disseminate information and educational materials regarding various subjects, including pain management techniques, to each licensed physician and surgeon and to each general acute care hospital in California.

This bill would additionally require the board to periodically develop and disseminate to each licensed physician and surgeon and to each general acute care hospital in California information and educational materials relating to the assessment of a patient's risk of abusing or diverting controlled substances and information relating to CURES.

(3) Existing law permits a licensed health care practitioner, as specified, or a pharmacist to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under his or her care. Existing law also authorizes the Department of Justice to provide the history of controlled substances dispensed to an individual to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

This bill would ~~require licensed health care practitioners,~~ *require, by January 1, 2016, or upon receipt of a federal Drug Enforcement Administration registration, whichever occurs later, health care practitioners authorized to prescribe, order, administer, furnish, or dispense controlled substances,* as specified, and pharmacists to apply to the Department of Justice to obtain approval to access information stored on the Internet regarding the controlled substance history of a patient under ~~his or her care, and, upon the happening of specified events, to be strongly encouraged to access and consult that information prior to prescribing or dispensing Schedule II, Schedule III, or Schedule IV controlled substances.~~ *their care. The bill would require the Department of Justice, in conjunction with the Department of Consumer Affairs and certain licensing boards, to, among other things, develop a streamlined application and approval process to provide access to the CURES database for licensed health care practitioners and pharmacists.* The bill would make other related and conforming changes.

~~(4)This bill would declare that it is to take effect immediately as an urgency statute.~~

Vote: ~~two-thirds~~*majority* Appropriation: no Fiscal Committee: yes Local Program: no

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. The Legislature finds and declares all of the following:

(a) The Controlled Substance Utilization Review and Evaluation System (CURES) is a valuable preventive, investigative, and educational tool for health care providers, ~~regulatory boards,~~ *regulatory agencies,* educational researchers, and law enforcement. Recent budget cuts to the Attorney General's Division of Law Enforcement have resulted in insufficient funding to support ~~the~~ CURES *and its* Prescription Drug Monitoring Program (PDMP). The *CURES* PDMP is necessary to ensure health care professionals have the necessary data to make

informed treatment decisions and to allow law enforcement to investigate diversion of prescription drugs. Without a dedicated funding source, the CURES PDMP is not sustainable.

(b) Each year CURES responds to more than 800,000 requests from practitioners and pharmacists regarding all of the following:

(1) Helping identify and deter drug abuse and diversion of prescription drugs through accurate and rapid tracking of Schedule II, Schedule III, and Schedule IV controlled substances.

(2) Helping practitioners make ~~better~~ prescribing decisions.

(3) Helping reduce misuse, abuse, and trafficking of those drugs.

(c) Schedule II, Schedule III, and Schedule IV controlled substances have had deleterious effects on private and public interests, including the misuse, abuse, and trafficking in dangerous prescription medications resulting in injury and death. It is the intent of the Legislature to work with stakeholders to fully fund the operation of CURES which seeks to mitigate those deleterious effects and serve as a tool for ensuring safe patient care, and which has proven to be a cost-effective tool to help reduce the misuse, abuse, and trafficking of those drugs.

(d) The following goals are critical to increase the effectiveness and functionality of CURES:

(1) Upgrading the *CURES* PDMP so that it is capable of accepting real-time updates and is accessible in real-time, 24 hours a day, seven days a week.

(2) Upgrading ~~all prescription drug monitoring programs~~ *the CURES PDMP* in California so that ~~they are~~ *it is* capable of operating in conjunction with all national prescription drug monitoring programs.

(3) Providing subscribers to prescription drug monitoring programs access to information relating to controlled substances dispensed in California, including those dispensed through the United States Department of Veterans Affairs, the Indian Health Service, the Department of Defense, and any other entity with authority to dispense controlled substances in California.

(4) Upgrading the *CURES* PDMP so that it is capable of accepting *the reporting of* electronic ~~prescriptions,~~ *prescription data,* thereby enabling more reliable, complete, and timely prescription monitoring.

~~SEC. 2.Section 805.8 is added to the Business and Professions Code, to read:805.8.~~
~~(a)(1)In addition to the fees charged for licensure, certification, and renewal, at the time those fees are charged, the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the Naturopathic Medicine Committee of the Osteopathic Medical Board of California, the State Board of Optometry, and the California Board of Podiatric Medicine shall charge each licensee authorized pursuant to Section 11150 of the Health and Safety Code to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances a fee of up to 1.16 percent of the renewal fee that the licensee was subject to as of July 1, 2013, to be assessed annually. This fee shall be due and payable at the time the licensee renews his or her license and shall be submitted with the licensee's renewal fee. In no case shall this fee exceed the reasonable costs associated with operating and maintaining CURES for the purpose of regulating prescribers and dispensers of controlled substances licensed or certificated by these boards.~~

~~(2)In addition to the fees charged for licensure, certification, and renewal, at the time those fees are charged, the California State Board of Pharmacy shall charge wholesalers and nonresident wholesalers of dangerous drugs, licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9, a fee of up to 1.16 percent of the renewal fee that the wholesaler or nonresident wholesaler was subject to as of July 1, 2013, to be assessed annually. This fee shall be due and payable at the time the wholesaler or nonresident wholesaler renews its license and shall be submitted with the wholesaler's or nonresident wholesaler's renewal fee. In no case shall this fee exceed the reasonable costs associated with operating and maintaining CURES for the purpose of regulating wholesalers and nonresident wholesalers of dangerous drugs licensed or certificated by that board.~~

~~(3)In addition to the fees charged for licensure, certification, and renewal, at the time those fees are charged, the California State Board of Pharmacy shall charge veterinary food-animal drug retailers, licensed pursuant to Article 15 (commencing with Section 4196) of Chapter 9, a fee of up to 1.16 percent of the renewal fee that the~~

~~the time the drug retailer renews its license and shall be submitted with the drug retailers' renewal fee. In no case shall this fee exceed the reasonable costs associated with operating and maintaining CURES for the purpose of regulating veterinary food-animal drug retailers licensed or certificated by that board.~~

~~(b)The funds collected pursuant to subdivision (a) shall be deposited in the CURES accounts, which are hereby created, within the Contingent Fund of the Medical Board of California, the State Dentistry Fund, the Pharmacy Board Contingent Fund, the Veterinary Medical Board Contingent Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, the Osteopathic Medical Board of California Contingent Fund, the Optometry Fund, and the Board of Podiatric Medicine Fund. Moneys in the CURES accounts of each of those funds shall, upon appropriation by the Legislature, be available to the Department of Justice solely for operating and maintaining CURES for the purposes of regulating prescribers and dispensers of controlled substances. All moneys received by the Department of Justice pursuant to this section shall be deposited in the CURES Fund described in Section 11165 of the Health and Safety Code.~~

SEC. 2. *Section 208 is added to the Business and Professions Code, to read:*

208. *(a) A CURES fee of six dollars ($6) shall be assessed annually on each of the licensees specified in subdivision (b) to pay the reasonable costs associated with operating and maintaining CURES for the purpose of regulating those licensees. The fee assessed pursuant to this subdivision shall be billed and collected by the regulating agency of each licensee at the time of the licensee's license renewal. If the reasonable regulatory cost of operating and maintaining CURES is less than six dollars ($6) per licensee, the Department of Consumer Affairs may, by regulation, reduce the fee established by this section to the reasonable regulatory cost.*

(b) (1) Licensees authorized pursuant to Section 11150 of the Health and Safety Code to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances or pharmacists licensed pursuant to Chapter 9 (commencing with Section 4000) of Division 2.

(2) Wholesalers and nonresident wholesalers of dangerous drugs licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2.

(3) Nongovernmental clinics licensed pursuant to Article 13 (commencing with Section 4180) and Article 14 (commencing with Section 4190) of Chapter 9 of Division 2.

(4) Nongovernmental pharmacies licensed pursuant to Article 7 (commencing with Section 4110) of Chapter 9 of Division 2.

(c) The funds collected pursuant to subdivision (a) shall be deposited in the CURES Fund, which is hereby created within the State Treasury. Moneys in the CURES Fund shall, upon appropriation by the Legislature, be available to the Department of Consumer Affairs to reimburse the Department of Justice for costs to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

(d) The Department of Consumer Affairs shall contract with the Department of Justice on behalf of the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Board of the Medical Board of California, the Osteopathic Medical Board of California, the Naturopathic Medicine Committee of the Osteopathic Medical Board, the State Board of Optometry, and the California Board of Podiatric Medicine to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

SEC. 3. *Section 209 is added to the Business and Professions Code, to read:*

209. The Department of Justice, in conjunction with the Department of Consumer Affairs and the boards and committees identified in subdivision (d) of Section 208, shall do all of the following:

(a) Identify and implement a streamlined application and approval process to provide access to the CURES Prescription Drug Monitoring Program (PDMP) database for licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and for pharmacists. Every reasonable effort shall be made to implement a streamlined application and approval process that a licensed health care practitioner or pharmacist can complete at the time that he or she is applying for licensure or renewing his or her license.

(b) Identify necessary procedures to enable licensed health care practitioners and pharmacists with access to the CURES PDMP to delegate their authority to order reports from the CURES PDMP.

(c) Develop a procedure to enable health care practitioners who do not have a federal Drug Enforcement Administration (DEA) number to opt out of applying for access to the CURES PDMP.

~~**SEC. 3.**~~***SEC. 4.*** Section 2196.8 is added to the Business and Professions Code, to read:

2196.8. The board shall periodically develop and disseminate information and educational material regarding assessing a patient's risk of abusing or diverting controlled substances and information relating to the Controlled Substance Utilization Review and Evaluation System (CURES), described in Section 11165 of the Health and Safety Code, to each licensed physician and surgeon and to each general acute care hospital in this state. The board shall consult with the State Department of ~~Health Care Services~~ *Public Health, the boards and committees specified in subdivision (d) of Section 208,* and the Department of Justice in developing the materials to be distributed pursuant to this section.

~~**SEC. 4.**~~***SEC. 5.*** Section 11164.1 of the Health and Safety Code is amended to read:

11164.1. (a) ~~(1)~~ Notwithstanding any other provision of law, a prescription for a controlled substance issued by a prescriber in another state for delivery to a patient in another state may be dispensed by a California pharmacy, if the prescription conforms with the requirements for controlled substance prescriptions in the state in which the controlled substance was prescribed.

~~(2)~~

(b) All prescriptions for Schedule ~~II and~~ *II,* Schedule ~~III~~ *III, and Schedule IV* controlled substances dispensed pursuant to this subdivision shall be reported by the dispensing pharmacy to the Department of Justice in the manner prescribed by subdivision ~~(c)~~ *(d)* of Section 11165.

~~(b) Pharmacies may dispense prescriptions for Schedule III, Schedule IV, and Schedule V controlled substances from out-of-state prescribers pursuant to Section 4005 of the Business and Professions Code and Section 1717 of Title 16 of the California Code of Regulations.~~

~~(c) This section shall become operative on January 1, 2005.~~

~~**SEC. 5.**~~***SEC. 6.*** Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in ~~the CURES accounts within the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, the Osteopathic Medical Board of California Contingent Fund, the Veterinary Medical Board Contingent Fund, the Optometry Fund, the Board of Podiatric Medicine Fund, and~~ the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

~~(b)The reporting of Schedule III and Schedule IV controlled substance prescriptions to CURES shall be contingent upon the availability of adequate funds for the Department of Justice for the purpose of funding CURES.~~

~~(c)~~

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES. ~~Grant funds shall not be appropriated from the Contingent Fund of the Medical Board of California, the Pharmacy Board Contingent Fund, the State Dentistry Fund, the Board of Registered Nursing Fund, the Naturopathic Doctor's Fund, the Osteopathic Medical Board of California Contingent Fund, the Veterinary Medical Board Contingent Fund, the Optometry Fund, or the Board of Podiatric Medicine Fund, for the purpose of funding CURES.~~

(d)

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party. The Department of Justice ~~may~~ *shall* establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, *disclosure,* and security of the information within CURES, consistent with this subdivision.

~~(e)~~

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, ~~unless monthly reporting is permitted pursuant to subdivision (f) of Section 11190, and~~ in a format specified by the Department of Justice:

(1) Full name, address, and telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of ~~licensure and license number,~~ *licensure, national provider identifier (NPI) number,* the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, *NPI number,* and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

~~(f)~~

(e) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber *and dispenser* invitees shall be licensed by one of the boards or committees identified in subdivision ~~(a) of Section 805.8~~ *(d) of Section 208* of the Business and Professions Code, in active practice in California, and a regular user of CURES.

~~(g)~~

(f) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision ~~(a) of Section 805.8~~ *(d) of Section 208* of the Business and Professions Code, one or more of the ~~regulatory~~ boards or committees identified in subdivision ~~(a) of Section 805.8~~ *(d) of Section 208* of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES

~~(h)~~

(g) The Department of Justice may establish a process to educate authorized subscribers of *the* CURES *PDMP* on how to access and use *the* CURES *PDMP*.

~~(i) The CURES Fund is hereby established within the State Treasury. The CURES Fund shall consist of all funds made available to the Department of Justice for the purpose of funding CURES. Money in the CURES Fund shall, upon appropriation by the Legislature, be available for allocation to the Department of Justice for the purpose of funding CURES.~~

~~**SEC. 6.**~~***SEC. 7.*** Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) A ~~licensed~~ health care practitioner ~~eligible to prescribe~~ *authorized to prescribe, order, administer, furnish, or dispense* Schedule II, Schedule III, or Schedule IV controlled substances *pursuant to Section 11150* or a pharmacist ~~shall~~ *shall, before January 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later,* submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner or pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(A) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application for a subscriber.

(ii) Failure to maintain effective controls for access to the patient activity report.

(iii) Suspended or revoked federal ~~Drug Enforcement Administration (DEA)~~ *DEA* registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Any subscriber accessing information for any other reason than caring for his or her patients.

(B) Any authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

~~(2)To allow sufficient time for licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and a pharmacist to apply and receive access to PDMP, a written request may be made, until July 1, 2012, and the Department of Justice may release to that practitioner or pharmacist the history of controlled substances dispensed to an individual under his or her care based on data contained in CURES.~~

(2) A health care practitioner authorized to prescribe Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) ~~(1)Until the Department of Justice has issued the notification described in paragraph (3), in~~ *In* order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

~~(2)Upon the Department of Justice issuing the notification described in paragraph (3), licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances and pharmacists shall be strongly encouraged to access and consult the electronic history of controlled substances dispensed to an individual under his or her care prior to prescribing or dispensing a Schedule II, Schedule III, or Schedule IV controlled substances.~~

~~(3) The Department of Justice shall notify licensed health care practitioners and pharmacists who have submitted the application required pursuant to subdivision (a) when the department determines that CURES is capable of accommodating all users, but not before June 1, 2015. The department shall provide a copy of the notification to the Secretary of State, the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel, and shall post the notification on the department's Internet Web site.~~

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section shall be considered medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

~~SEC. 7.~~*SEC. 8.* Section 11165.4 is added to the Health and Safety Code, to read:

11165.4. (a) The Department of Justice may seek *voluntarily contributed* private funds from insurers, health care service plans, ~~and~~ qualified ~~manufacturers~~ *manufacturers, and other donors* for the purpose of supporting CURES. Insurers, health care service plans, ~~and~~ qualified ~~manufacturers~~ *manufacturers, and other donors* may contribute by submitting their payment to the Controller for deposit into the CURES Fund established pursuant to subdivision ~~(c) of Section 11165.~~ *(c) of Section 208 of the Business and Professions Code.* The department shall make information about the amount and the source of all private funds it receives for support of CURES available to the public. Contributions to the CURES Fund pursuant to this subdivision shall be nondeductible for state tax purposes.

(b) For purposes of this section, the following definitions apply:

(1) "Controlled substance" means a drug, substance, or immediate precursor listed in any schedule in Section 11055, 11056, or 11057 of the Health and Safety Code.

(2) "Health care service plan" means an entity licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(3) "Insurer" means an admitted insurer writing health insurance, as defined in Section 106 of the Insurance Code, and an admitted insurer writing workers' compensation insurance, as defined in Section 109 of the Insurance Code.

(4) "Qualified manufacturer" means a manufacturer of a controlled substance, but does not mean a wholesaler or nonresident wholesaler of dangerous drugs, regulated pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2 of the Business and Professions Code, a veterinary food-animal drug retailer, regulated pursuant to Article 15 (commencing with Section 4196) of Chapter 9 of Division 2 of the Business and Professions Code, or an individual regulated by the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, or the California Board of Podiatric Medicine.

~~SEC. 8.This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:~~

~~In order to protect the public from the continuing threat of prescription drug abuse at the earliest possible time, it is necessary that this act take effect immediately.~~

California LEGISLATIVE INFORMATION

SB-809 Controlled substances: reporting. (2013-2014)

Date	Action
08/13/13	From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (August 13). Re-referred to Com. on APPR.
08/05/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B.,P. & C.P.
06/26/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B.,P. & C.P.
06/26/13	From committee: Do pass and re-refer to Com. on B.,P. & C.P. (Ayes 7. Noes 0.) (June 25). Re-referred to Com. on B.,P. & C.P.
06/17/13	Referred to Com. on PUB. S.
05/30/13	In Assembly. Read first time. Held at Desk.
05/30/13	Read third time. Urgency clause adopted. Passed. (Ayes 39. Noes 0. Page 1201.) Ordered to the Assembly.
05/29/13	Read second time. Ordered to third reading.
05/28/13	Ordered to second reading.
05/28/13	Read third time and amended.
05/28/13	Reconsideration granted. (Ayes 39. Noes 0. Page 1115.)
05/28/13	Motion to reconsider made by Senator DeSaulnier.
05/28/13	Read third time. Urgency clause refused adoption. (Ayes 23. Noes 14. Page 1115.)
05/24/13	Read second time and amended. Ordered to third reading.
05/23/13	From committee: Do pass as amended. (Ayes 5. Noes 1. Page 1020.) (May 23).
05/21/13	Set for hearing May 23.
05/20/13	Placed on APPR. suspense file.
05/16/13	Set for hearing May 20.
05/14/13	Read second time and amended. Re-referred to Com. on APPR.
05/13/13	From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 5. Noes 2. Page 882.) (May 8).
05/01/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on GOV. & F.
04/24/13	Set for hearing May 8.
04/16/13	From committee: Do pass and re-refer to Com. on GOV. & F. (Ayes 7. Noes 2. Page 564.) (April 15). Re-referred to Com. on GOV. & F.
03/28/13	Set for hearing April 15.
03/11/13	Referred to Coms. on B., P. & E.D. and GOV. & F.
02/25/13	Read first time.
02/24/13	From printer. May be acted upon on or after March 26.
02/22/13	Introduced. To Com. on RLS. for assignment. To print.

California LEGISLATIVE INFORMATION

SB-809 Controlled substances: reporting. (2013-2014)

Date	Action
08/13/13	From committee: Do pass and re-refer to Com. on APPR. (Ayes 14. Noes 0.) (August 13). Re-referred to Com. on APPR.
08/05/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B.,P. & C.P.
06/26/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on B.,P. & C.P.
06/26/13	From committee: Do pass and re-refer to Com. on B.,P. & C.P. (Ayes 7. Noes 0.) (June 25). Re-referred to Com. on B.,P. & C.P.
06/17/13	Referred to Com. on PUB. S.
05/30/13	In Assembly. Read first time. Held at Desk.
05/30/13	Read third time. Urgency clause adopted. Passed. (Ayes 39. Noes 0. Page 1201.) Ordered to the Assembly.
05/29/13	Read second time. Ordered to third reading.
05/28/13	Ordered to second reading.
05/28/13	Read third time and amended.
05/28/13	Reconsideration granted. (Ayes 39. Noes 0. Page 1115.)
05/28/13	Motion to reconsider made by Senator DeSaulnier.
05/28/13	Read third time. Urgency clause refused adoption. (Ayes 23. Noes 14. Page 1115.)
05/24/13	Read second time and amended. Ordered to third reading.
05/23/13	From committee: Do pass as amended. (Ayes 5. Noes 1. Page 1020.) (May 23).
05/21/13	Set for hearing May 23.
05/20/13	Placed on APPR. suspense file.
05/16/13	Set for hearing May 20.
05/14/13	Read second time and amended. Re-referred to Com. on APPR.
05/13/13	From committee: Do pass as amended and re-refer to Com. on APPR. (Ayes 5. Noes 2. Page 882.) (May 8).
05/01/13	From committee with author's amendments. Read second time and amended. Re-referred to Com. on GOV. & F.
04/24/13	Set for hearing May 8.
04/16/13	From committee: Do pass and re-refer to Com. on GOV. & F. (Ayes 7. Noes 2. Page 564.) (April 15). Re-referred to Com. on GOV. & F.
03/28/13	Set for hearing April 15.
03/11/13	Referred to Coms. on B., P. & E.D. and GOV. & F.
02/25/13	Read first time.
02/24/13	From printer. May be acted upon on or after March 26.
02/22/13	Introduced. To Com. on RLS. for assignment. To print.

Date of Hearing: August 13, 2013

ASSEMBLY COMMITTEE ON BUSINESS, PROFESSIONS AND CONSUMER PROTECTION
Susan A. Bonilla, Chair
SB 809 (Steinberg and DeSaulnier) – As Amended: August 5, 2013

SENATE VOTE: 39-0

SUBJECT: Controlled substances: reporting.

SUMMARY: Establishes a funding mechanism to update and maintain the Controlled Substance Utilization Review and Evaluation System (CURES) and Prescription Drug Monitoring Program (PDMP), requires all prescribing health care practitioners to apply to access CURES information, and establishes processes and procedures for regulating prescribing licensees through CURES and securing private information. Specifically, this bill:

1) Assesses an annual six dollar fee on the following licensees to pay the reasonable costs associated with operating and maintaining CURES for the purpose of regulating those licensees:

   a) Physicians, dentists, podiatrists, veterinarians, naturopathic doctors, pharmacists, registered nurse, certified nurse-midwives, nurse practitioners, physician assistants, and optometrists, as specified;

   b) Wholesalers and nonresident wholesalers of dangerous drugs, as specified;

   c) Nongovernmental clinics, nonprofit clinics, and free clinics, as specified; and,

   d) Nongovernmental pharmacies, as specified.

2) Requires the assessed fee to be billed and collected by the regulating agency of each licensee at the time of the licensee's license renewal, and states that if the reasonable regulatory cost of operating and maintaining CURES is less than six dollars per licensee, the Department of Consumer Affairs (DCA) may, by regulation, reduce the fee to the reasonable regulatory cost.

3) Requires the fees collected to be deposited in the CURES Fund, which is created within the State Treasury.

4) Requires moneys in the CURES Fund to be, upon appropriation by the Legislature, available to DCA to reimburse the Department of Justice (DOJ) for costs to operate and maintain CURES for the purposes of regulating the specified licensees.

5) Requires DCA to contract with DOJ on behalf of the Medical Board of California (MBC), the Dental Board of California, the California State Board of Pharmacy, the Veterinary

the California Board of Podiatric Medicine to operate and maintain CURES for the purposes of regulating licensees.

6) Requires DOJ, in conjunction with DCA and the appropriate boards and committees, to do all of the following:

   a) Identify and implement a streamlined application and approval process to provide access to the CURES PDMP database for pharmacists and licensed health care practitioners eligible to prescribe Schedule II, Schedule III, or Schedule IV controlled substances, and requires every reasonable effort be made to implement a streamlined application and approval process that a licensed health care practitioner or pharmacist can complete at the time that he or she is applying for licensure or renewing his or her license;

   b) Identify necessary procedures to enable licensed health care practitioners and pharmacists with access to the CURES PDMP to delegate their authority to order reports from the CURES PDMP; and,

   c) Develop a procedure to enable health care practitioners who do not have a federal Drug Enforcement Administration (DEA) number to opt out of applying for access to the CURES PDMP.

7) Requires MBC to periodically develop and disseminate information and educational material regarding assessing a patient's risk of abusing or diverting controlled substances and information relating to CURES to each licensed physician and surgeon and to each general acute care hospital in this state; and further requires MBC to consult with the State Department of Public Health, appropriate boards and committees, and DOJ in developing the materials to be distributed.

8) Requires a California pharmacy to report dispensing a Schedule IV controlled substance issued by a prescriber in another state for delivery to a patient in another state to CURES.

9) Requires DOJ to maintain CURES to assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances.

10) Deletes provisions stating that the reporting of Schedules III and IV controlled substances shall be contingent upon the availability of adequate funds from DOJ.

11) Requires DOJ to annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

12) Permits DOJ to seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES.

13) Requires CURES to comply with all applicable federal and state privacy and security laws and regulations.

14) Requires DOJ to establish policies, procedures, and regulations regarding the use, access, evaluation, disclosure, management, implementation, operation, storage, and security of the information within CURES.

15) Requires a pharmacy, clinic, or other dispenser to report specified information, including a prescribers national provider identifier number, to DOJ as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed.

16) Permits DOJ to invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber and dispenser invitees must be licensees, as specified, in active practice in California, and a regular user of CURES.

17) Requires DOJ, prior to upgrading CURES, to consult with prescribers licensed by one of the relevant boards or committees, the boards or committees themselves, and any other stakeholders for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

18) Permits DOJ to establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

19) Requires a health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II-IV controlled substances or a pharmacist to, before January 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application to DOJ to access information online regarding the controlled substance history of a patient, as specified.

20) Requires DOJ, upon approval of an application to access patient information, release to the practitioner or pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

21) States that a health care practitioner authorized to prescribe Schedules II-IV controlled substances, or a pharmacist, shall be deemed to have completed the requirements to access individual patient information if he or she has applied to access CURES PDMP at the time he or she applied for licensure or renewal.

22) Permits DOJ to seek voluntarily contributed private funds from insurers, health care service plans, and qualified manufacturers for the purpose of supporting CURES. Insurers, health care service plans, qualified manufacturers, and other donors may contribute by submitting their payment to the Controller for deposit into the CURES Fund. Contributions to the CURES Fund shall be nondeductible for state tax purposes.

23) Defines the following terms:

a) "Controlled substance" means a drug, substance, or immediate precursor listed in any schedule in Section 11055, 11056, or 11057 of the Health and Safety Code (HSC);

b) "Health care service plan" means an entity licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of HSC);

c) "Insurer" means an admitted insurer writing health insurance, as defined in Section 106 of the Insurance Code, and an admitted insurer writing workers' compensation insurance, as defined in Section 109 of the Insurance Code; and,

d) "Qualified manufacturer" means a manufacturer of a controlled substance, but does not mean a wholesaler or nonresident wholesaler of dangerous drugs, as specified, a veterinary food-animal drug retailer, as specified, or an individual regulated by the MBC, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Committee of the Medical Board of California, the Osteopathic Medical Board of California, the State Board of Optometry, or the California Board of Podiatric Medicine.

24) Makes clarifying and technical amendments.

25) Makes legislative findings and declarations.

EXISTING LAW:

1) Establishes CURES and requires DOJ to maintain CURES for the electronic monitoring of the prescribing and dispensing of Schedule II, III, and IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. (Health and Safety Code (HSC) Section 11165(a))

2) Requires a dispensing pharmacy or clinic to provide specified prescription data for each prescription for a Schedule II, III, or IV controlled substance to DOJ on a weekly basis. (HSC 11165(d))

3) Allows a licensed health care practitioner who is eligible to prescribe Schedule II, III, or IV controlled substances, or a pharmacist, to make a written request to DOJ for the history of controlled substances dispensed to an individual under his or her care, and allows DOJ to provide that information to that health care practitioner or pharmacist. (HSC 11165.1(a))

4) Provides that the history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from DOJ pursuant to this section shall be considered medical information subject to specified confidentiality provisions. (HSC 11165.1(d))

5) Requires every practitioner, other than a pharmacist, who prescribes or administers a controlled substance classified in Schedule II, III or IV to record specified information relating to the transaction. (HSC 11190)

FISCAL EFFECT: Unknown

1) Purpose of this bill. This bill establishes a funding mechanism for DOJ to update and maintain the CURES/PDMP prescription monitoring system for the benefit of DCA prescribing licensees and the public. By doing so, the author aims to increase the quality and usability of the system to improve monitoring for excessive or inappropriate prescribing. This bill is sponsored by the Attorney General's office.

2) Author's statement. According to the author's office, "SB 809 provides essential funding to continue and strengthen the CURES PDMP, a vital resource for medical professionals and law enforcement to detect and prevent prescription drug abuse and addiction, and save lives. Without dedicated funding, the CURES program will be suspended and California will join Missouri as the only state in the nation without a PDMP.

   "Prescription drug abuse is the Nation's fastest-growing drug problem and has been classified as a public health epidemic by the Centers for Disease Control and Prevention. One hundred people die from drug overdoses every day in the United States and prescription painkillers are responsible for 75% of these deaths, claiming more lives than heroin and cocaine combined, and fueling a doubling of drug-related deaths in the United States over the last decade.

   "SB 809 provides sufficient and sustainable revenue to maintain the CURES program operations, sustain full modernization, and improve program participation and utilization by requiring all practitioners and pharmacists to enroll in the CURES PDMP."

3) Background. CURES' predecessor, the California Triplicate Prescription Program (TPP) was created in 1939 and was replaced by CURES in 1998. In 2009, the PDMP system was introduced as a searchable, client-facing component of CURES.

   Presently, the database contains over 100 million entries of controlled substance drugs that have been dispensed in California. In 2012, the program responded to more than 800,000 requests. There are currently 174,338 prescribers registered to use the system, and 38,290 pharmacists.

   Pharmacists are required to report dispensations of Schedules II-IV controlled substances at least weekly, but use of PDMP by prescribers and dispensers for prescription abuse prevention/intervention is voluntary.

   The California Budget Act of 2011 eliminated all General Fund support of CURES and PDMP, which included funding for system support, staff support and related operating expenses. To perform the minimum critical functions and to avoid shutting down the program, the Department opted to assign staff to perform temporary dual job assignments on a part time basis. Although some tasks are being performed, the program is faced with a constant backlog (e.g., four-week backlog on processing new user applications, six-week response time on emails, twelve week backlog on voicemails, etc.)

   CURES is currently overseen by a single employee, and is on a lifeline budget of $400,000. According to a March 2013 article in the Los Angeles Times, doctors requesting information

This bill will require all pharmacists or health care practitioners authorized to prescribe, order, administer, furnish, or dispense Schedule II-IV controlled substances to submit an application to DOJ to access information online regarding the controlled substance history of a patient by January 2016. The updated CURES/PDMP will comply with all state and federal security and privacy issues. Disciplinary, civil or criminal actions will be taken by DOJ and/or the appropriate licensing board for any misuse or inappropriate accessing of patient data.

4) Arguments in support. California Medical Association writes, "Physicians have long been and continue to be strong supporters of the CURES database, which compiles prescription information of Schedule II, III, and IV drugs dispensed in California. We recognize its potential to help ensure appropriate prescribing and as a tool for addressing the abuse and diversion of prescription drugs. CMA supports CURES being upgraded and maintained. Even in its current underfunded and antiquated state, CURES provides valuable information that supports appropriate prescribing of controlled substances. An upgrade that is easy for physicians and other prescribers and dispensers to access, moves closer to real time provision of dispensing data, and that is integrated with other states' PDMPs is welcome."

5) Previous legislation. SB 734 (Torlakson) (Chapter 487, Statutes of 2005) authorized tamper resistant online access to the CURES system for authorized physicians, pharmacists and law enforcement pending the acquisition of private funding.

   SB 1071 (DeSaulnier) of 2010 would have imposed a tax on manufacturers or importers of Schedule II, III and IV controlled substances to pay for ongoing costs of the CURES program, to be collected by the State Board of Equalization at the rate of $0.0025 per pill included in Schedules II, III, and IV. SB 1071 was held in Senate Health Committee.

   SB 360 (DeSaulnier) (Chapter 418, Statutes of 2011) authorized DOJ to initiate administrative enforcement actions to prevent the misuse of confidential information collected through the CURES program.

   SB 616 (DeSaulnier) of 2012 would have increased fees up to $10 per licensee for those licensees authorized to prescribe or dispense controlled substances to pay for CURES. SB 616 was held in the Assembly Business, Professions, and Consumer Protection Committee.

REGISTERED SUPPORT / OPPOSITION:

Support

California Attorney General's Office (sponsor)
ALPHA Fund
American Cancer Society Cancer Action Network
American Medical Association
Association of California Healthcare Districts
Association of California Insurance Companies
Association of California Life and Health Insurance Companies
Association of Northern California Oncologists

California Association of Joint Powers Authorities
California Association of Oral and Maxillofacial Surgeons
California Board of Pharmacy
California Chapter of the American College of Emergency Physicians
California Coalition on Workers' Compensation
California Department of Insurance
California Hospital Association
California JPIA
California Labor Federation
California Medical Association
California Narcotic Officers Association
California Pharmacists Association
California Police Chiefs Association
California Professional Association of Specialty Contractors
California Retailers Association
California Self-Insurers Association
California Society of Health-System Pharmacists
California Special Districts Association
California State Association of Counties
California State Sheriff's Association
Center for Public Interest Law
City and County of San Francisco
CompPharma
County Alcohol and Drug Program Administrators Association of California
County of San Diego
CSAC Excess Insurance Authority
Deputy Sheriffs' Association of San Diego County
Employers Group
Gallagher Bassett Services, Inc.
Golden Oak Cooperative Corporation
Grimmway Farms
Health Officers Association of California
Independent Insurance Agents and Brokers of California
Los Angeles District Attorney's Office
Medical Board of California
Medical Oncology Association of Southern California, Inc.
Metro Risk Management
Michael Sullivan & Associates
National Association of Chain Drug Stores
National Coalition Against Prescription Drug Abuse
Nordstrom
Safeway
Schools Insurance Authority
Schools Insurance Group
Sedgwick Claims Management Services
Shaw, Jacobsmeyer, Crain, and Claffey

Western Occupational & Environmental Medical Association
Western Propane Gas Association

Opposition

California Optometric Association

Analysis Prepared by: Sarah Huchel / B.,P. & C.P. / (916) 319-3301

AGENDA ITEM

10

I ASSISTANT COMMITTEE

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
AL SERVICES								
ARIES AND WAGES								
03 00	CIVIL SERVICE-PERM	188,848	0	158,298	0	158,298	30,550	
33 04	TEMP HELP (907)	0	2,368	27,966	0	27,966	(27,966)	
63 00	STATUTORY-EXEMPT	81,732	0	128,077	0	128,077	(46,345)	
63 03	COMM MEMBER (911)	1,530	0	3,100	0	3,100	(1,570)	
83 00	OVERTIME	0	0	2,477	0	2,477	(2,477)	
AL SALARIES AND WAGES		**272,110**	**2,368**	**319,917**	**0**	**319,917**	**(47,807)**	**-17.57%**
FF BENEFITS								
01 00	STAFF BENEFITS	0	34	34	0	34	(34)	
03 00	OASDI	15,411	0	17,489	0	17,489	(2,078)	
04 00	DENTAL INSURANCE	1,758	0	1,323	0	1,323	435	
05 00	HEALTH/WELFARE INS	38,664	0	14,274	0	14,274	24,390	
06 01	RETIREMENT	53,275	0	47,786	0	47,786	5,489	
25 00	WORKERS' COMPENSAT	4,472	0	0	0	0	4,472	
25 15	SCIF ALLOCATION CO	0	0	1,714	0	1,714	(1,714)	
34 00	OTHER-STAFF BENEFI	0	0	11,470	0	11,470	(11,470)	
34 01	TRANSIT DISCOUNT	0	0	65	0	65	(65)	
35 00	LIFE INSURANCE	0	0	83	0	83	(83)	
36 00	VISION CARE	445	0	363	0	363	82	
37 00	MEDICARE TAXATION	73	0	4,550	0	4,550	(4,477)	
AL STAFF BENEFITS		**114,098**	**34**	**99,152**	**0**	**99,152**	**14,946**	**13.10%**
PERSONAL SERVICES		**386,208**	**2,402**	**419,069**	**0**	**419,069**	**(32,861)**	**-8.51%**
ING EXPENSES & EQUIPMENT								
ERPRINTS								
13 04	FINGERPRINT REPORT	24,890	980	10,927	0	10,927	13,963	
AL FINGERPRINTS		**24,890**	**980**	**10,927**	**0**	**10,927**	**13,963**	**56.10%**
ERAL EXPENSE								
01 00	GENERAL EXPENSE	14,030	0	0	0	0	14,030	
06 00	MISC OFFICE SUPPLI	0	316	2,516	0	2,516	(2,516)	
07 00	FREIGHT & DRAYAGE	0	0	1,296	0	1,296	(1,296)	
13 02	ADMIN OVERHEAD-OTH	0	300	1,788	0	1,788	(1,788)	
17 00	MTG/CONF/EXHIBIT/S	0	0	6,681	212	6,893	(6,893)	
AL GENERAL EXPENSE		**14,030**	**616**	**12,282**	**212**	**12,494**	**1,536**	**10.95%**

ASSISTANT COMMITTEE

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
ITING								
41 00	PRINTING	3,442	0	0	0	0	3,442	
42 02	REPRODUCTION SVS	0	0	27	0	27	(27)	
42 03	COPY COSTS ALLO	0	0	165	0	165	(165)	
42 04	EDD PRODUCTIONS	0	0	564	0	564	(564)	
42 05	METRO PRINT/MAIL	0	0	608	0	608	(608)	
44 00	OFFICE COPIER EXP	0	0	925	395	1,320	(1,320)	
45 00	PRINTED FORM/STATN	0	0	26	0	26	(26)	
AL PRINTING		**3,442**	**0**	**2,315**	**395**	**2,710**	**732**	**21.25%**
IMUNICATIONS								
51 00	COMMUNICATIONS	7,838	0	0	0	0	7,838	
52 00	CELL PHONES,PDA,PA	0	100	823	0	823	(823)	
54 00	FAX	0	0	4	0	4	(4)	
57 00	TELEPHONE	0	0	12	0	12	(12)	
57 01	TELEPHONE EXCHANGE	0	1,000	2,786	0	2,786	(2,786)	
AL COMMUNICATIONS		**7,838**	**1,100**	**3,625**	**0**	**3,625**	**4,213**	**53.75%**
TAGE								
61 00	POSTAGE	8,281	0	0	0	0	8,281	
62 00	STAMPS, STAMP ENVE	0	0	1,795	0	1,795	(1,795)	
63 05	DCA POSTAGE ALLO	0	0	3,713	0	3,713	(3,713)	
63 06	EDD POSTAGE ALLO	0	0	2,007	0	2,007	(2,007)	
AL POSTAGE		**8,281**	**0**	**7,515**	**0**	**7,515**	**766**	**9.24%**
VEL: IN-STATE								
91 00	TRAVEL: IN-STATE	28,299	0	0	0	0	28,299	
92 00	PER DIEM-I/S	0	1,376	5,064	0	5,064	(5,064)	
94 00	COMMERCIAL AIR-I/S	0	0	4,004	0	4,004	(4,004)	
96 00	PRIVATE CAR-I/S	0	0	2,229	0	2,229	(2,229)	
97 00	RENTAL CAR-I/S	0	305	1,829	0	1,829	(1,829)	
AL TRAVEL: IN-STATE		**28,299**	**1,681**	**13,126**	**0**	**13,126**	**15,173**	**53.62%**
INING								
31 00	TRAINING	1,096	0	0	0	0	1,096	
AL TRAINING		**1,096**	**0**	**0**	**0**	**0**	**1,096**	**100.00%**
LITIES OPERATIONS								
11 00	FACILITIES OPERATI	55,958	0	0	0	0	55,958	
13 00	RENT-BLDG/GRND(NON	0	0	44,469	0	44,469	(44,469)	

ASSISTANT COMMITTEE

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
6 00	RECURRING MAINT SV	0	0	272	0	272	(272)	
7 00	FACILITY PLNG-DGS	0	0	823	0	823	(823)	
AL FACILITIES OPERATIONS		**55,958**	**0**	**45,563**	**0**	**45,563**	**10,395**	**18.58%**
SVS - INTERDEPARTMENTAL								
2 00	CONSULT/PROF-INTER	1,899	0	0	0	0	1,899	
AL C/P SVS - INTERDEPARTMENTAL		**1,899**	**0**	**0**	**0**	**0**	**1,899**	**100.00%**
SVS - EXTERNAL								
2 00	CONSULT/PROF SERV-	28,561	0	0	0	0	28,561	
4 05	C&P EXT ADMIN CR C	16,568	0	4	0	4	16,564	
9 00	INFO TECHNOLOGY-EX	0	0	352	0	352	(352)	
8 02	CONS/PROF SVS-EXTR	0	0	35,544	53,622	89,166	(89,166)	
AL C/P SVS - EXTERNAL		**45,129**	**0**	**35,900**	**53,622**	**89,522**	**(44,393)**	**-98.37%**
ARTMENTAL SERVICES								
4 03	OIS PRO RATA	72,509	(6,425)	66,084	0	66,084	6,425	
7 00	INDIRECT DISTRB CO	38,631	(4,916)	33,714	0	33,714	4,917	
7 01	INTERAGENCY SERVS	7,717	0	0	0	0	7,717	
7 02	SHARED SVS-MBC ONL	79,802	27,764	111,054	0	111,054	(31,252)	
7 30	DOI - PRO RATA	1,570	0	1,570	0	1,570	0	
7 34	PUBLIC AFFAIRS PRO	2,202	(270)	1,932	0	1,932	270	
7 35	CCED PRO RATA	2,763	(213)	2,550	0	2,550	213	
AL DEPARTMENTAL SERVICES		**205,194**	**15,940**	**216,904**	**0**	**216,904**	**(11,710)**	**-5.71%**
SOLIDATED DATA CENTERS								
8 00	CONSOLIDATED DATA	4,810	3	1,470	0	1,470	3,340	
AL CONSOLIDATED DATA CENTERS		**4,810**	**3**	**1,470**	**0**	**1,470**	**3,340**	**69.44%**
A PROCESSING								
1 00	INFORMATION TECHNO	3,086	0	0	0	0	3,086	
6 00	SUPPLIES-IT (PAPER	0	0	85	0	85	(85)	
AL DATA PROCESSING		**3,086**	**0**	**85**	**0**	**85**	**3,001**	**97.25%**
TRAL ADMINISTRATIVE SERVICES								
8 00	PRO RATA	68,655	0	68,655	0	68,655	0	
AL CENTRAL ADMINISTRATIVE SERVICES		**68,655**	**0**	**68,655**	**0**	**68,655**	**0**	**0.00%**
ORCEMENT								
6 00	ATTORNEY GENL-INTE	271,418	0	204,305	0	204,305	67,113	
7 00	OFC ADMIN HEARNG-I	75,251	322	42,598	0	42,598	32,653	

I ASSISTANT COMMITTEE

	DESCRIPTION	BUDGET	CURR. MONTH	YR-TO-DATE	ENCUMBRANCE	YTD + ENCUMBRANCE	BALANCE	PCNT REMAIN
14 31	EVIDENCE/WITNESS F	492	1,000	32,930	0	32,930	(32,438)	
18 97	COURT REPORTER SER	0	500	1,613	0	1,613	(1,613)	
27 32	INVEST SVS-MBC ONL	250,122	10,069	92,685	0	92,685	157,437	
AL	ENFORCEMENT	597,283	11,891	374,131	0	374,131	223,152	37.36%
OR EQUIPMENT								
26 00	MINOR EQUIPMENT	5,350	0	0	0	0	5,350	
26 45	MIN EQPMT-DP-REPL	0	0	1,723	0	1,723	(1,723)	
AL	MINOR EQUIPMENT	5,350	0	1,723	0	1,723	3,627	67.79%
OPERATING EXPENSES & EQUIPMEN		1,075,240	32,212	794,221	54,229	848,450	226,790	21.09%
PHYSICIAN ASSISTANT COMMITTEE		1,461,448	34,614	1,213,290	54,229	1,267,519	193,929	13.27%
		1,461,448	34,614	1,213,290	54,229	1,267,519	193,929	13.27%

AGENDA ITEM

13

AGENDA ITEM 13
26 AUGUST 2013

TO: Members of the Physician Assistant Board

FROM:

Glenn L. Mitchell, Jr., Executive Officer
Physician Assistant Board

DATE: 15 August 2013

SUBJECT: Regulatory Proposal - Title 16, California Code of Regulations, section 1399.541 Medical Services Performable

Please see the attached proposed language to amend Title 16 of the California Code of Regulations section 1399.541 regarding the personal presence of the physician while the physician assistant acts as a first or second assistant in surgery. The Medical Board, rather than the Physician Assistant Board (PA Board), has authority to adopt, amend or repeal those regulations that affect the scope of practice of physician assistants. As a result, if approved by the PA Board, the proposed regulatory language will be submitted to the Medical Board for final approval.

The purpose of this regulatory change is to update and clarify supervision requirements while the physician assistant acts as a first or second assistant in surgery. In 2005, the Physician Assistant Committee requested a legal opinion concerning the term "personal presence" as it is used in section 1399.541. On 25 April 2005, legal counsel issued a legal opinion concerning the request. The legal opinion concluded that a physician assistant may not perform opening and closing on a patient without the personal presence of a supervising physician.

In 2011, a concern was raised to the (then) PA Committee and the committee determined that the regulation should be amended to reflect current medical standards with regard to this practice. A prior draft regulation was submitted to the Medical Board in May, 2012, but the Medical Board had concerns about the breadth the regulation, declined to take action, and after considering the concerns raised, PA Board staff worked to significantly revise the language and tailor it more narrowly to the need in light of public safety.

A first draft of the revised regulatory language was presented to the PA Board at its May 2013 meeting. The PA Board members provided feedback and the language was slightly revised. The PA Board's President reviewed the revised language and concurred that the proposed language would address the community concern. In late July, 2013, PA Board staff shared the revised draft language with Medical Board staff to try to anticipate any concerns the members of the Medical Board may have. None were identified.

We are respectfully submitting this language to you for your consideration and approval.

If the language is approved by the board it will then be submitted to the Medical Board of California at a future meeting for their review and, hopefully, to set a regulatory hearing to amend this regulation.

Recommended Action:

Make any necessary amendments to the draft regulatory language, approve it, and direct staff submit the language to the Medical Board for approval to pursue a rulemaking.

Recommended Motion:

"I move to approve the proposed regulatory language [if necessary: as amended] and direct staff to submit the proposal to the Medical Board and respectfully request that it authorize the formal rulemaking process."

Attachments: 2005 Legal opinion
Proposed language

STATE OF CALIFORNIA

Memorandum

To: RICHARD WALLINDER
Executive Officer
Physicians Assistant Committee

Date: April 25, 2005

From: **Department of Consumer Affairs**
Legal Office

Telephone: (916) 322-5252
CalNet: 8-492-5252
FAX: (916) 323-0971

Subject: Title 16, Section 1399.541

INTRODUCTION

You have asked for an interpretation of section 1399.541 of Title 16 of the California Code of Regulations. Specifically, you have inquired as to the term "personal presence" as it is used in subsection (i) of section 1399.541. As we understand the matter, a physician assistant has inquired as to the meaning of the term in relation to performing the opening and closing portions of surgical procedure upon a patient under general anesthesia.

QUESTION PRESENTED

May a physician assistant perform opening and closing surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon?

OPINION

No. A physician assistant may not perform opening and closing surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon.

STATEMENT of FACTS

The Physician Assistant Committee (Committee) licenses physician assistants. (See Bus. & Prof. Code, §§ 3504, 3519.) In accordance with existing statute, the Committee has promulgated regulations that establish the scope of practice for physician assistants. (Cal. Code. Regs., tit. 16, §§ 1999.540, 1399.541.)

Section 1399.541 provides:

> "(i) (1) Perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation

(2) A physician assistant may also act as first or second assistant in surgery under the supervision of an approved supervising physician." (Emphasis added.)

ANALYSIS

The resolution of your inquiry requires an interpretation of section 1399.541. We first note that regulations are examined using the same standards that are used in cases of statutory construction and interpretation. (*Consumer Cause, Inc. v. Weider Nutrition* (2001) 111 Cal.Rptr. 823, 826, citing *Cal. Drive-In Restaurant Assn. v. Clark* (1943) 22 Cal.2d 287, 292.) The foremost concern is to ascertain the purpose of the agency issuing the regulation to effectuate the purpose of the law. (*Taxara v. Gutierrez* (2003) 8 Cal.Rptr.3d 172, 177.) In determining the intent, we must first turn to the words of the regulations themselves. (See *In re Marriage of Bonds* (2000) 99 Cal.Rptr.2d 252, 261.)

Courts often turn to dictionaries to determine the meaning of words. (*Bonds, supra*, at p. 261.) Personal means carried on between individuals directly. (Webster's Third International Dictionary (1993) at p. 1686.) Presence means the fact or condition of being present; the state of being in one place and not elsewhere. (Webster's Third International Dictionary (1993) at p.1793.) Presence is also not mere physical proximity but also includes an awareness of the senses. (*Hamburg v. Wal-Mart Stores, Inc.* (2004) 10 Cal. Rptr.3d 568, 581.)

We think that the plain intent of the regulation is to require that when a physician assistant performs a delegated surgical procedure upon a patient under general anesthesia, his or her supervising physician must be within the same surgical area or theater and in close proximity such that the physician is able to assist the physician assistant immediately and without delay. From a pragmatic perspective, personal presence cannot mean available by telephone or pager or similar device or that the supervising physician is positioned on a different floor of the hospital or involved in another procedure that would render him or her unable to assist the physician assistant virtually instantaneously.

When the agency's intent cannot be discerned directly from the language of the regulation, we may look to a variety of extrinsic aids, including the purpose of the regulation, the legislative history, public policy, and the regulatory scheme. (*Taxara, supra*, at p. 177.) The purpose of the regulation is to clearly specify under what conditions a physician assistant may perform delegated surgical procedures. A physician assistant may perform delegated surgical procedures on a patient under local anesthesia without the personal presence of the supervising physician. (Cal. Code Regs., tit. 16, § 1399.541(i).) Logically, such authority is sound because the patient is alert, awake, and can easily alert the PA of unexpected distress.

General anesthesia, however, is defined as the loss of sensation in the entire body associated with a state of unconsciousness. (*Attorney's Dictionary of Medicine*, (2004), p. A-351.) General anesthesia also invokes a patient's loss of life-preserving protective reflexes. (See Bus. & Prof. Code, § 2216.) Obviously, a patient under general anesthesia requires more vigilance and monitoring than a patient under local anesthesia. In this situation where heightened awareness is

supervising physician – in the same surgical theater or area and within line of sight or earshot – such that assistance to the physician assistant is immediately available.

CONCLUSION

A physician assistant may not perform opening and closing surgical procedures on a patient under general anesthesia without the personal presence of a supervising physician and surgeon.

We trust the foregoing is of assistance.

DOREATHEA JOHNSON
Deputy Director
Legal Affairs

By KURT HEPPLER
Staff Counsel

KH:slb

Proposed Regulatory Amendments
Title 16, C.C.R., § 1399.541
DRAFT - May 22, 2013

Strikeout indicates deletions; underline indicates additions to current text.

1. Amend heading of division 13.8 of title 16 as follows:

Division 13.8. Physician Assistant Board ~~Examining Committee of the Medical Board of California~~

2. Amend section 1399.541 of article 4 of division 13.8 as follows:

§ 1399.541. Medical Services Performable.

Because physician assistant practice is directed by a supervising physician, and a physician assistant acts as an agent for that physician, the orders given and tasks performed by a physician assistant shall be considered the same as if they had been given and performed by the supervising physician. Unless otherwise specified in these regulations or in the delegation or protocols, these orders may be initiated without the prior patient specific order of the supervising physician.

In any setting, including for example, any licensed health facility, out-patient settings, patients' residences, residential facilities, and hospices, as applicable, a physician assistant may, pursuant to a delegation and protocols where present:

(a) Take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans including plans for those services described in Section 1399.541(b) through Section 1399.541(i) inclusive; and record and present pertinent data in a manner meaningful to the physician.

(b) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services.

(c) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures.

(d) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient.

(e) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases.

Proposed Regulatory Amendment
16 CCR § 1399.541
May 22, 2013 DRAFT

(f) Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home.

(g) Initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community.

(h) Administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with the provisions of subdivisions (a)-(f), inclusive, of Section 3502.1 of the Code.

(i)(1) Perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. Prior to delegating any such surgical procedures, the supervising physician shall review documentation which indicates that the physician assistant is trained to perform the surgical procedures. All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of an approved supervising physician.

(2) A physician assistant may also act as first or second assistant in surgery under the supervision of a~~n approved~~ supervising physician. The physician assistant may so act without the personal presence of the supervising physician if the supervising physician is immediately available to the physician assistant. "Immediately available" means able to return to the patient, without delay, upon the request of the physician assistant or to address any situation requiring the supervising physician's services.

Note: Authority cited: Sections 2018, 3502 and 3510, Business and Professions Code. Reference: Sections 2058, 3502 and 3502.1, Business and Professions Code.

AGENDA ITEM

14

STATE OF CALIFORNIA DEPARTMENT OF CONSUMER AFFAIRS
PHYSICIAN ASSISTANT BOARD

To: Board Members

From: Dianne Tincher

Date: August 16, 2013

Subject: Board's Manual of Disciplinary Guidelines and Model Disciplinary Orders Updates to Reflect the Uniform Standards for Substance-Abusing Licensees and Other changes

Background:

The Board's Manual of Disciplinary Guidelines and Model Disciplinary Orders were last updated in 2007. Since then, the board staff has identified changes it seeks to make to the model guidelines and orders. The changes are both to reflect the new Uniform Standards (explained below) and more traditional changes to reflect current laws and regulations and address issues board staff has experienced since the last update.

1. Changes to Reflect the Uniform Standards

In April 2011, as required by SB 1441, chaptered in 2008, the Department of Consumer Affairs (DCA), on behalf of the Substance Abuse Coordination Committee (SACC), published the "Uniform Standards Regarding Substance-Abusing Healing Arts Licenses," casually referred to as simply the "Uniform Standards." The Uniform Standards were a result of the law requiring all healing arts boards to use the Uniform Standards in imposing discipline.

There was much discussion and confusion on the appropriate method of adopting the Uniform Standards by DCA boards. The DCA legal opinion dated April 5, 2012 referenced both a Legislative Counsel and an Attorney General opinion stating that the healing arts boards do not have the discretion to modify the content of the specific terms of conditions of probation that make up the Uniform Standards and must use them in their entirety. The issue is that they only apply to a substance abusing licensee, but there was method identified to determine whether a person is a substance abusing licensee.

The Legal Affairs Division of DCA identified three possible methods for determining whether a licensee is a substance-abusing licensee, which would trigger the application of the Uniform Standards:

Option 1: Using a rebuttable presumption. If the charge involves alcohol or drugs, it will be assumed that the licensee is in fact a substance-abusing licensee and the individual bears the burden of proving that he/she is NOT a substance-abusing licensee at the hearing. Once that finding is assumed, the conditions imposing the Uniform Standards apply.

Option 2: Relying on the clinical diagnostic evaluator's opinion. For any case where the there was a finding of alcohol or drugs involved in the offense, the conditions applying the Uniform Standards are included in a disciplinary order, but permitting the provisions to be

waived contingent on the outcome of a clinical diagnostic evaluation finding that the individual is not a substance-abusing licensee.

Option 3: Bearing the burden. If the charges involve drugs or alcohol, the Board bears the burden of proving (via facts, layperson and expert testimony, etc.) at hearing that the individual is a substance-abusing licensee, at which point the conditions imposing the Uniform Standards may be imposed.

Staff gathered some background information from the public and had discussions before the Board (then Committee). Staff recommended (and continues to recommend), and the prior Board (then Committee) discussion supported, that a clinical evaluation would be ordered in every case to determine whether an individual was a substance abusing licensee (Option 2). In that manner, a neutral expert will decide whether the licensee must be subject to the Uniform Standards. The attached proposed amendments to the text of the regulation and the model guidelines and orders reflect this position, but may be changed by the Board during its consideration of this item or anytime before the regulation is adopted.

2. Other Changes

The attached drafts also contain other, somewhat less complicated, revisions. They include things like:

a. changing Committee to Board
b. adding language from CCR 1399.523 and 1399.523.5 regarding required penalties for sexual misconduct
c. adding clarification language where a license is being issued and condition deadlines should reflect the issuance of the license rather than issuance of the decision.
d. adding language to clarify the consequences for failure to complete or pass the clinical training program and an Option 2 that requires completion of the clinical training program prior to the issuance of a license (Condition Precedent)
e. adding a Prescribing Practices course
f. adding language to clarify that all required logs and medical records must remain at the worksite and be available for inspection by the Board or its designee.
g. combining the language of the two tolling/non practice conditions (out of state and in state) into one condition for non practice.

Action Requested: It is requested that the Board:

1. Identify any necessary changes to the proposal, and,
2. Adopt the proposed amendments (if necessary, as amended,) to the text of the regulation and model disciplinary guidelines and orders and direct staff to proceed with the rulemaking process.

Sample Motion:

"I move that we approve the proposed regulatory language [*if appropriate, add*: as amended during discussion] for publication, and direct staff to proceed with the rulemaking process."

Physician Assistant Board
Proposed Regulatory Amendments
for Discussion at its August 26, 2013, meeting

(Underline indicates additions; ~~strikethrough~~ indicates deletions.)

Amend title 16, California Code of Regulations, § 1399.523, "Disciplinary Guidelines," as follows:

(a) In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Physician Assistant Board[1] shall consider the disciplinary guidelines entitled "Physician Assistant ~~Committee~~ Board Manual of Model Disciplinary Guidelines and Model Disciplinary Orders" ~~3rd~~ 4th Edition 20~~07~~13, which are hereby incorporated by reference. Subject to the limitations of subsection (c), ~~D~~deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the Physician Assistant Board, in its sole discretion, determines that the facts of the particular case warrant such a deviation-for example: the presence of mitigating factors; the age of the case; evidentiary problems.

(b) Notwithstanding the disciplinary guidelines, any proposed decision issued in accordance with the procedures set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code that contains any finding of fact that the licensee engaged in any act of sexual contact, as defined in subdivision (c) of Section 729 of the Code, with a patient, or any finding that the licensee has committed a sex offense or been convicted of a sex offense as defined in Section 44010 of the Education Code, shall contain an order revoking the license. The proposed decision shall not contain an order staying the revocation of the license.

(c) If the conduct found to be a violation involves drugs, alcohol, or both, and the individual is permitted to practice under conditions of probation, a clinical diagnostic evaluation shall be ordered as a condition of probation in every case, without deviation.

(1) Each of the "Conditions Applying the Uniform Standards," as set forth in the model disciplinary orders, shall be included in any order subject to this subsection, but may be imposed contingent upon the outcome of the clinical diagnostic evaluation.

(2) The Substance Abuse Coordination Committee's *Uniform Standards Regarding Substance Abusing Healing Arts Licensees* (4/2011) (Uniform Standards), which are hereby incorporated by reference, shall be used in applying the probationary conditions imposed pursuant to this subsection.

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[1] This draft assumes that non-substantive regulatory changes made in August, 2013 to change the agency's name to the Physician Assistant Board to mirror new statutory provisions have become effective.

(d) Nothing in this section shall prohibit the Board from imposing additional terms or conditions of probation in any order that the Board determines would provide greater public protection.

NOTE: Authority cited: Sections 3510, 3527, 3528, 3529, 3530, 3531, 3532 and 3533, Business and Professions Code; and Section 11400.20, Government Code. Reference: Section 11400.20 and 11425.50(e), Government Code; and Sections 315, 315.2, 315.4, 729, 3527, 3528, 3529, 3530, 3531, 3532, and 3533, Business and Professions Code.

~~STATE OF CALIFORNIA~~

~~MEDICAL BOARD OF CALIFORNIA~~

Comment [pu1]: May delete

PHYSICIAN ASSISTANT ~~COMMITTEE~~ BOARD

Manual of

DISCIPLINARY GUIDELINES

and

MODEL DISCIPLINARY ORDERS

~~3rd Edition, 2007~~

4th Edition 2013

PHYSICIAN ASSISTANT ~~COMMITTEE~~ BOARD

~~MEDICAL BOARD OF CALIFORNIA~~

~~DEPARTMENT OF CONSUMER AFFAIRS~~

~~STATE OF CALIFORNIA~~

Comment [pu2]: May delete

DISCIPLINARY GUIDELINES AND MODEL DISCIPLINARY ORDERS

Introduction

'his *Manual of Disciplinary Guidelines and Model Disciplinary Orders* is intended as a guide to persons ıvolved in setting administrative disciplinary terms and conditions for violations by licensed physician ıssistants of the Physician Assistant Practice Act, and other laws and regulations. Use of these ıuidelines will help ensure that the selected terms and conditions are appropriate and consistent with lecisions reached in comparable disciplinary actions.

ᵊersons directly involved in the administrative disciplinary process of a California licensed physician ıssistant are the intended audience for this booklet. Appropriate users of these guidelines and model ɔrders include administrative law judges, defense attorneys, physician assistant-respondents, trial attorneys from the Attorney General's Office, ~~committee~~ board members (who review proposed decisions and make final decisions), the ~~committee's~~ Board's executive officer, and others.

The Disciplinary Guidelines identify the recommended terms and conditions for each of the listed violations of the Business and Professions Code.

The Model Disciplinary Orders contain ~~three~~ four sections of proposed language for the Disciplinary Order itself, for Optional Conditions, for the Conditions Applying the Uniform Standards Related to Substance Abusing Licensees (Conditions Applying the Uniform Standards) and for Standard Conditions. Optional Conditions should be relevant to the sustained violations and any significant mitigating or aggravating circumstances of the particular case. Conditions Applying the Uniform Standards must be ncluded in all cases in which a licensee is placed on probation due to a violation that involved the use of drugs, alcohol or both. Standard Conditions should appear in all probation cases. All orders should ɔlace the Order(s) first, optional conditions~~(s)~~ second, Conditions Applying the Uniform Standards (if applicable) third and standard conditions ~~third~~ fourth.

ᵊursuant to Business and Professions Code section 3504.1, the Board's highest priority in exercising its disciplinary functions is public protection. The Board and the ALJ are not prohibited from imposing additional terms or conditions of probation that would provide greater public protection.

Special Considerations

Violations Involving Sexual Contact or Offenses:

ᵊursuant to section 1399.523(b) of title 16, California Code of Regulations, a proposed decision that contains any finding of fact that the licensee engaged in any act of sexual contact, as defined in subdivision (c) of Section 729 of the Business and Professions Code, with a patient, or any finding that he licensee has committed a sex offense or been convicted of a sex offense as defined in Section 44010 of the Education Code, shall contain an order revoking the license. The proposed decision shall not contain an order staying the revocation of the license.

Comment [pu3]: Adding sexual misconduct regulation

Violations Involving Drugs, Alcohol, or Both:

Pursuant to section 1399.523 of the Board's Regulations (title 16, California Code of Regulations, Division 13.8), if the conduct found to be a violation involves drugs, alcohol, or both, and the individual is permitted to practice under conditions of probation, a clinical diagnostic evaluation shall be ordered as a condition of probation in every case, without deviation. Each of the "Conditions Applying the Uniform Standards," as set forth in the model disciplinary orders, shall be included in any order subject to this subsection, but may be imposed contingent upon the outcome of the clinical diagnostic evaluation.

The Substance Abuse Coordination Committee's Uniform Standards Regarding Substance Abusing Healing Arts Licensees (4/2011) (Uniform Standards), forms the basis of those probationary conditions and will be consulted in the event of ambiguity.

Violations of the Medical Practice Act:

All concerned individuals, and especially the trier of law, should be aware that any violation of the Medical Practice Act, which would constitute unprofessional conduct by a physician and surgeon is also grounds for a finding of unprofessional conduct for a physician assistant. Furthermore, in addition to the grounds set forth in Business and Professions Code, Chapter 7.7, Section 3527(a), other grounds for action are set forth in California Code of Regulations (CCR), Title 16, Chapter 13.8,~~S~~section 1399.521.

Authority for the ~~committee~~ Board to establish disciplinary guidelines is contained in Government Code Section 11425.50(e). The disciplinary guidelines are incorporated as part of Title 16 CCR 1399.523 and Title 16 CCR 1399.523.5.

If you need additional information or clarification, please contact the Physician Assistant ~~Committee~~ Board at (916) 561-8780.

Title 16, CCR § 1399.523. Disciplinary Guidelines.

[Note to readers of this draft document: Final version of the text of modified section 1399.523 to be copied from adopted text once the rulemaking is final. As of this draft, that text reads:]

(a) In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code Section 11400 et seq.), the Physician Assistant Board[1] shall consider the disciplinary guidelines entitled "Physician Assistant Board Manual of Model Disciplinary Guidelines and Model Disciplinary Orders" 4th Edition 2013, which are hereby incorporated by reference. Subject to the limitations of subsection (c), deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the Physician Assistant Board, in its sole discretion, determines that the facts of the particular case warrant such a deviation-for example: the presence of mitigating factors; the age of the case; evidentiary problems.

(b) Notwithstanding the disciplinary guidelines, any proposed decision issued in accordance with the procedures set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code that contains any finding of fact that the licensee engaged in any act of sexual contact, as defined in subdivision (c) of Section 729 of the Code, with a patient, or any finding that the licensee has committed a sex offense or been convicted of a sex offense as defined in Section 44010 of the Education Code, shall contain an order revoking the license. The proposed decision shall not contain an order staying the revocation of the license.

(c) If the conduct found to be a violation involves drugs, alcohol, or both, and the individual is permitted to practice under conditions of probation, a clinical diagnostic evaluation shall be ordered as a condition of probation in every case, without deviation.

[1] This draft assumes that non-substantive regulatory changes made in August, 2013 to change the agency's name to the Physician Assistant Board to mirror new statutory provisions have become effective.

(1) Each of the "Conditions Applying the Uniform Standards," as set forth in the model disciplinary orders, shall be included in any order subject to this subsection, but may be imposed contingent upon the outcome of the clinical diagnostic evaluation.

(2) The Substance Abuse Coordination Committee's *Uniform Standards Regarding Substance Abusing Healing Arts Licensees* (4/2011) (Uniform Standards), which are hereby incorporated by reference, shall be used in applying the probationary conditions imposed pursuant to this subsection.

(d) Nothing in this section shall prohibit the Board from imposing additional terms or conditions of probation in any order that the Board determines would provide greater public protection.

Disciplinary Guidelines
Index

Comment [pu4]: Page numbers may need to be changed

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726	Sexual Misconduct	~~6~~7
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2241	Furnishing Drugs or Transmitting Drug Orders to Addict	1~~0~~1
2242	Administering or Furnishing Drugs, or Transmitting Drug Orders, Without Prior Good Faith Examination	1~~0~~2
2252	Illegal Cancer Treatment	1~~0~~3
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2262	Alteration of Medical Records	1~~1~~3
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2266	Failure to Maintain Adequate Records	1~~1~~3
2271	Deceptive Advertising	~~6~~7
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Causes for Discipline and License Restriction

Inless otherwise indicated, all Section references are to the Business and Professions :ode Sections.

;141, §2305 & §3527(a) DISCIPLINE BY ANOTHER STATE OR AGENCY

Minimum penalty: Same for similar offense in California
Maximum penalty: Revocation

§651, §2271, & §3527(a) DECEPTIVE ADVERTISING §2285 PRACTICE UNDER FALSE OR FICTITIOUS NAME

Minimum penalty: Stayed Revocation, at least 2 years probation
Maximum penalty: Revocation

1. Suspension of 30 days or more (5)
2. Ethics course (1~~6~~2)

§725 EXCESSIVE TREATMENTS

Minimum penalty: Stayed revocation, at least 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more (5)
2. Controlled drugs - drug order authority (6)
3. Controlled drugs – maintain record (7)
4. Medical record keeping course (~~13~~9)
5. Education course (14~~0~~)
6. Clinical training program (1~~5~~1)
7. Ethics course (1~~6~~2)
8. Prescribing practices course (14)

9~~8~~. Prohibited practice areas (~~21~~8)
10~~9~~ Maintenance of patient medical records (~~22~~19)
1~~0~~1. On-site supervision (~~23~~0)

§726, §729, & §3527(a) SEXUAL MISCONDUCT

Minimum penalty: Stayed revocation, at least 7 years probation
Maximum penalty: Revocation

NOTES: If the individual is required to register as a sex offender pursuant to Section 290 of the Penal Code or the equivalent in another state or territory, or military or federal law, the decision must impose revocation of the license, denial of the application for licensure, or denial of the petition for reinstatement unless the individual who has been relieved under Section 290.5 of the Penal Code or his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law or the law of the jurisdiction that required registration or the individual who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor under Section 314 of the Penal Code, exposing his person or private parts in any public place.

In addition, a proposed decision that contains any finding of fact that the licensee engaged in any act of sexual contact, as defined in subdivision (c) of Section 729 of the Business and Professions Code, with a patient, or any finding that the licensee has committed a sex offense or been convicted of a sex offense as defined in Section 44010 of the Education Code, shall contain an order revoking the license. The proposed decision must not contain an order staying the revocation of the license.

Comment [pu5]: Adding sexual misconduct regulations

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1~~6~~21. Prohibited practice areas (~~2~~18)
~~17~~22. Maintenance of patient medical record (~~22~~19)
~~18~~23. On-site supervision (2~~3~~0)

§820 MENTAL OR PHYSICAL ILLNESS

Minimum penalty: Stayed revocation, at least 5 years probation
Maximum penalty: Revocation

If a licensee has been identified as a substance abusing licensee, then the Conditions Applying the Uniform Standards must be imposed. If a licensee has not yet been identified as a substance-abusing licensee in a case involving drugs or alcohol, a clinical diagnostic evaluation shall be ordered and the remaining provisions of the Uniform Standards may, in the discretion of the Board, be made contingent upon a clinical diagnostic evaluator's report that the individual is a substance-abusing licensee.

1. Controlled drugs – drug order authority (6)
2. Controlled drugs – maintain record (7)
3. ~~Drugs –~~ A~~a~~bstain from the use of controlled substances and dangerous drugs (~~8~~23)
4. ~~Alcohol –~~ A~~a~~bstain from the use of alcohol (~~9~~22)
~~5~~. Biological fluid testing (~~10~~25)
5. Clinical diagnostic evaluation (21)
6. ~~Diversion program~~ Drug and alcohol recovery monitoring program (~~11~~24)
7. Facilitated group support meetings (26)
8. Work site monitor (27)
9. Major violations (28)
10~~7~~. Psychological evaluation/treatment (1~~8~~5)
11~~8~~. Medical evaluation/treatment (1~~9~~6)

12~~9~~. Prohibited practice areas (~~21~~8)
10~~3~~. Maintenance of patient medical records (~~22~~19)
11~~4~~. On-site supervision (23~~0~~)

§2054 & §2278 HOLDING ONESELF OUT AS A PHYSICIAN OR USE OF TITLE "DOCTOR" AND/OR "M.D."

Minimum penalty: Stayed revocation, at least 1 year probation
Maximum penalty: Revocation

1. Suspension of at least 30 days (5)
2. Community service (~~12~~8)
3. Education ~~program~~ course (14~~0~~)
4. Clinical training program (1~~5~~1)
5. Ethics course (16~~2~~)
6. Psychological evaluation/treatment (18~~5~~)
7. Prohibited practice areas (21~~8~~)
8. Maintenance of patient medical records (~~22~~19)
9. On-site supervision (23~~0~~)

§2234(b) GROSS NEGLIGENCE
§2234(c) REPEATED NEGLIGENT ACTS
§2234(d) INCOMPETENCE

Minimum penalty: Stayed revocation, at least 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more (5)
2. Controlled drugs – drug order authority (6)
3. Controlled drugs – maintain record (7)
4. Medical record keeping course (~~13~~9)
5. Education course (14~~0~~)
6. Clinical training program (1~~5~~1)
7. Ethics course (16~~2~~)
8. Prescribing practices course (14)
9~~8~~. Psychological evaluation/treatment (18~~5~~)
10~~9~~. Medical evaluation/treatment (19~~6~~)
10~~1~~. Prohibited practice areas (21~~8~~)
11~~2~~. Maintenance of patient medical records (~~22~~19)
12~~3~~. On-site supervision (23~~0~~)

§2234(e) & §3527(a) DISHONESTY

Minimum penalty: Stayed revocation, at least 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more (5)
2. Controlled drugs – drug order authority (6)
3. Controlled drugs – maintain record (7)
4. Community service (~~12~~8)
5. Ethics course (16~~2~~)
6. Prescribing practices course (14)
~~6~~7. Psychological evaluation/treatment (18~~5~~)

~~7~~8. Prohibited practice areas (~~2~~18)
~~8~~9. Maintenance of patient medical records (~~22~~19)
~~9~~10. On-site supervision (2~~3~~0)

§2235 PROCURING LICENSE BY FRAUD

Minimum penalty: Revocation
Maximum penalty: Revocation

§2236 & §3527(a) CRIMINAL CONVICTION

Minimum penalty: Stayed revocation, at least 5 years probation
Maximum penalty: Revocation

1. Apply appropriate other guidelines depending on nature of criminal offense.
2. Suspension of 60 days or more (5)
3. Ethics course (1~~6~~2)
4. Psychological evaluation/treatment (1~~8~~5)

§2237 & §3527(a) CONVICTION RELATED TO DRUGS
§2238 & §3527(a) VIOLATION OF DRUG STATUTES

Minimum penalty: Stayed revocation 7 years probation
Maximum penalty: Revocation

NOTES: Illegal sales of controlled drugs or dispensing drugs without medical indications warrants revocation unless extensive mitigation appears.

Because the violation involves [OR: If a violation involves the licensee's use of] drugs, alcohol, or both, a clinical diagnostic evaluation must be ordered and the remaining provisions of the Conditions Applying the Uniform Standards may, in the discretion of the Board, be made contingent upon the a clinical diagnostic evaluator's report finding that the individual is a substance-abusing licensee.

Comment [pu6]: Choose language

1. Suspension of 60 days or more (5)
2. Controlled drugs – drug order authority (6)
3. Controlled drugs – maintain record (7)
4. ~~Drugs –~~ Aabstain from the use of controlled substances and dangerous drugs (~~8~~23)
5. ~~Alcohol –~~ Aabstain from the use of alcohol (~~9~~22)
6. Biological fluid testing (~~10~~25)
7. Clinical diagnostic evaluation (21)
~~7~~8. ~~Diversion~~ Drug and alcohol recovery monitoring program (~~11~~24)
9. Facilitated group support meetings (26)
10. Work site monitor (27)
11. Major violations (28)
1~~2~~8. Community service (~~12~~8)
1~~3~~9. Medical record keeping course (~~13~~9)
1~~0~~4. Education course (14~~0~~)
1~~1~~5. Clinical training program (1~~6~~1)
16. Prescribing practices course (14)
1~~2~~7. Psychological evaluation/treatment (1~~8~~5)
1~~3~~8. Medical evaluation/treatment (1~~9~~6)

149. Prohibited practice areas (~~21~~8)
~~15~~20. Maintenance of patient medical records (~~22~~19)
~~16~~21. On-site supervision (~~23~~0)

§2239 & §3527(a) DRUG OR ALCOHOL ABUSE
§2280 INTOXICATION WHILE TREATING PATIENTS

Minimum penalty: Stayed revocation, at least 7 years probation
Maximum penalty: Revocation

NOTE: Because the violation involves [OR: If a violation involves the licensee's use of] drugs, alcohol, or both, a clinical diagnostic evaluation must be ordered and the remaining provisions of the Conditions Applying the Uniform Standards may, in the discretion of the Board, be made contingent upon the a clinical diagnostic evaluator's report finding that the individual is a substance-abusing licensee.

Comment [pu7]: Choose language

1. Suspension of 60 days or more (5)
2. Controlled drugs – drug order authority (6)
3. Controlled drugs – maintain record (7)
4. ~~Drugs –~~ Aabstain from the use of controlled substances and dangerous drugs (~~8~~23)
5. ~~Alcohol –~~ Aabstain from the use of alcohol (~~9~~22)
6. Biological fluid testing (~~10~~25)
7. Clinical diagnostic evaluation (21)
~~7~~8. ~~Diversion~~ Drug and alcohol recovery monitoring program (~~11~~24)
9. Facilitated group support meetings (26)
10. Work site monitor (27)
11. Major violations (28)
12~~8~~. Community service (~~12~~8)
13~~9~~. Medical record keeping course (~~13~~9)
~~10~~4. Education course (14~~0~~)
~~11~~5. Clinical training program (1~~5~~1)
1~~2~~6. Ethics course (1~~6~~2)
17. Prescribing practices course (14)
13~~8~~. Psychological evaluation/treatment (1~~8~~5)
14~~9~~. Medical evaluation/treatment (1~~9~~6)
~~15~~20. Prohibited practice areas (~~2~~18)
~~16~~21. Maintenance of patient medical records (~~22~~19)
~~17~~22. On-site supervision (~~23~~0)

§2241 & §3527(a) FURNISHING DRUGS OR TRANSMITTING DRUG ORDERS TO ADDICT

NOTES: Illegal sales of controlled drugs or dispensing drugs without medical indications warrants revocation unless extensive mitigation appears.

Because the violation involves [OR: If a violation involves the licensee's use of] drugs, alcohol, or both, a clinical diagnostic evaluation must be ordered and the remaining provisions of the Conditions Applying the Uniform Standards may, in the discretion of the Board, be made contingent upon the a clinical diagnostic evaluator's report finding that the individual is a substance-abusing licensee.

Comment [pu8]: Choose language

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more (5)
2. Controlled drugs - drug order authority (6)
3. Controlled drugs - maintain record (7)
4. Abstain from the use of controlled substances and dangerous drugs (23)
5. Abstain from the use of alcohol (22)
6. Biological fluid testing (25)
7. Clinical diagnostic evaluation (21)
8. Drug and alcohol recovery monitoring program (24)
9. Facilitated group support meetings (26)
10. Work site monitor (27)
11. Major violations (28)
412. Community service (~~1~~28)
~~5~~13. Education course (140)
~~6~~14. Clinical training program (1~~5~~1)
~~7~~15. Ethics course (1~~6~~2)
16. Prescribing practices course (14)
17~~8~~. Prohibited practice areas (~~2~~18)
18~~9~~. Maintenance of patient medical records (~~22~~19)
10~~9~~. On-site supervision (2~~3~~0)

§2242 & §3527(a) ADMINISTERING OR FURNISHING DRUGS, OR TRANSMITTING DRUG ORDERS, WITHOUT PRIOR GOOD FAITH EXAMINATION

NOTE: Because the violation involves [OR: If a violation involves the licensee's use of] drugs, alcohol, or both, a clinical diagnostic evaluation must be ordered and the remaining provisions of the Conditions Applying the Uniform Standards may, in the discretion of the Board, be made contingent upon the a clinical diagnostic evaluator's report finding that the individual is a substance-abusing licensee.

Comment [pu9]: Choose language

Minimum penalty: Stayed revocation, at least 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more (5)
2. Controlled drugs - drug order authority (6)
3. Controlled drugs - maintain record (7)
4. Abstain from the use of controlled substances and dangerous drugs (23)
5. Abstain from the use of alcohol (22)
6. Biological fluid testing (25)
7. Clinical diagnostic evaluation (21)
8. Drug and alcohol recovery monitoring program (24)
9. Facilitated group support meetings (26)
10. Work site monitor (27)
11. Major violations (28)
412. Education course (140)
~~5~~13. Clinical training program (1~~5~~1)
~~6~~14. Ethics course (1~~6~~2)
15. Prescribing practices course (14)
16~~7~~. Prohibited practice areas (~~2~~18)
17~~8~~. Maintenance of patient medical records (~~22~~19)
18~~9~~. On-site supervision (2~~3~~0)

§2252 & 3527(a) ILLEGAL CANCER TREATMENT

inimum penalty: Stayed revocation, at least 5 years probation
aximum penalty: Revocation

1. Suspension of 60 days or more (5)
2. Controlled drugs – drug order authority (6)
3. Controlled drugs – maintain record (7)
4. Community service (~~1~~28)
5. Education course (140)
6. Clinical training program (1~~5~~1)
7. Ethics course (1~~6~~2)
8. Prescribing practices course (14)
9~~8~~. Prohibited practice areas (~~2~~18)
10~~9~~. Maintenance of patient medical records (~~22~~19)
1~~0~~1. On-site supervision (2~~3~~0)

§2261 & §3527(a) MAKING OR SIGNING FALSE DOCUMENTS
§2262 ALTERATION OF MEDICAL RECORDS

Minimum penalty: Stayed revocation, at least 3 years probation
Maximum penalty: Revocation

1. Suspension of 30 days or more (5)
2. Controlled drugs – drug order authority (6)
3. Controlled drugs – maintain record (7)
4. Community service (~~1~~28)
5. Medical record keeping course (~~1~~39)
6. Ethics course (1~~6~~2)
7. Prescribing practices course (14)
~~7~~8. Prohibited practice areas (~~2~~18)
~~8~~9. Maintenance of patient medical records (~~22~~19)
~~9~~10. On-site supervision (2~~3~~0)
1~~0~~1. If fraud involved, see "Dishonesty" guidelines

§2264 & §3527(a) AIDING AND ABETTING UNLICENSED PRACTICE

Minimum penalty: Stayed revocation, at least 3 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more (5)
2. Ethics course (1~~6~~2)
3. Prohibited practice areas (~~2~~18)
4. On-site supervision (2~~3~~0)

2266 FAILURE TO MAINTAIN ADEQUATE RECORDS
3527(a) FAILURE TO MAINTAIN REQUIRED PATIENT RECORDS

Minimum penalty: Stayed revocation, at least 3 years probation
Maximum penalty: Revocation

1. Suspension of 30 days or more (5)
2. Controlled drugs – drug order authority (6)
3. Controlled drugs – maintain record (7)

4. Medical record keeping course (~~13~~9)
5. Maintenance of patient medical records (~~22~~19)
6. On-site supervision (~~23~~0)

2288 IMPERSONATION OF APPLICANT IN EXAM

linimum penalty: Revocation
laximum penalty: Revocation

2306 & §3527(a) PRACTICE DURING SUSPENSION

linimum penalty: Revocation
laximum penalty: Revocation

§3502.1 DRUG ORDER AUTHORITY
§3527(a) ADMINISTERING, FURNISHING, OR TRANSMITTING DRUG ORDERS NOT PRESCRIBED BY SUPERVISING PHYSICIAN

NOTE: Because the violation involves [OR: If a violation involves the licensee's use of] drugs, alcohol, or both, a clinical diagnostic evaluation must be ordered and the remaining provisions of the Conditions Applying the Uniform Standards may, in the discretion of the Board, be made contingent upon the a clinical diagnostic evaluator's report finding that the individual is a substance-abusing licensee.

Comment [pu10]: Choose language

Minimum penalty: Stayed Revocation, at least 1 year probation
Maximum penalty: Revocation

1. Suspension of 30 days or more (5)
2. Controlled drugs - drug order authority (6)
3. Controlled drugs - maintain record (7)
4. Abstain from the use of controlled substances and dangerous drugs (23)
5. Abstain from the use of alcohol (22)
6. Biological fluid testing (25)
7. Clinical diagnostic evaluation (21)
8. Drug and alcohol recovery monitoring program (24)
9. Facilitated group support meetings (26)
10. Work site monitor (27)
11. Major violations (28)

~~4~~12. Education course (14~~0~~)
~~5~~13. Clinical training program (1~~5~~1)
~~6~~14. Ethics course (1~~6~~2)
15. Prescribing practices course (14)
~~7~~16. Prohibited practice areas (~~21~~8)
~~8~~17. Maintenance of patient medical records (~~22~~19)
~~9~~18. On-site supervision (~~23~~0)

§3527(a) PRACTICING MEDICINE WITHOUT DELEGATED AUTHORITY FROM A SUPERVISING PHYSICIAN
§3527(a) EXCEEDING DELEGATED SCOPE OF PRACTICE
§3527(a) PRACTICING WITHOUT ADEQUATE SUPERVISION

Minimum penalty: Stayed revocation, at least 3 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more (5)
2. Controlled drugs – drug order authority (6)
3. Controlled drugs – maintain record (7)
4. Education course (14~~0~~)
5. Clinical training program (1~~5~~1)
6. Ethics course (1~~6~~2)
7. Prescribing practices course (14)
~~7~~8. Prohibited practice areas (~~2~~18)
~~8~~9. Maintenance of patient medical records (~~22~~19
~~9~~10. On-site supervision (~~23~~0)

§3527(a) FAILURE TO REPORT CHILD/ELDER/SPOUSAL ABUSE OR OTHER FAILURE TO REPORT UNDER PENAL CODE SECTIONS 11160 OR 11166

Minimum penalty: Stayed revocation, at least 1 year probation
Maximum penalty: Revocation

1. Suspension of 30 days or more (5)
2. Education course (14~~0~~)
3. Clinical training program (1~~5~~1)
4. Ethics course (1~~6~~2)
5. Prohibited practice areas (~~2~~18)
6. Maintenance of patient medical records (~~22~~19)
7. On-site supervision (~~23~~0)

§3527 (a) FAILURE TO FOLLOW GUIDELINES FOR PREVENTION OF BLOOD BORNE PATHOGENS

Minimum penalty: Stayed revocation, at least 1 year probation
Maximum penalty: Revocation

1. Suspension of 30 days or more (5)
2. Education course (14~~0~~)
3. Clinical training program (1~~5~~1)
4. Ethics course (1~~6~~2)
5. Prohibited practice areas (~~2~~18)
6. Maintenance of patient medical records (~~22~~19)
7. On-site supervision (~~23~~0)

§3527(a) & CCR 1399.541(i) PERFORMANCE OF SURGICAL PROCEDURES REQUIRING ANESTHESIA OTHER THAN LOCAL ANESTHESIA WITHOUT PERSONAL PRESENCE OF THE SUPERVISING PHYSICIAN

Minimum penalty: Stayed revocation, 5 years probation
Maximum penalty: Revocation

1. Suspension of 60 days or more (5)
2. Education course (14~~0~~)
3. Clinical training program (1~~5~~1)

4. Ethics course (1~~6~~2)
5. Prohibited practice areas (~~2~~18)
6. Maintenance of patient medical records (~~22~~19)
7. On-site supervision (2~~3~~0)

Government Code 11519(b) VIOLATION OF PROBATION

Minimum penalty: Impose an extension of probation
Maximum penalty: Impose penalty that was stayed

The maximum penalty should be given for repeated similar offenses or for probation violations revealing a cavalier or recalcitrant attitude. Other violations of probation should draw an extension of probation and/or a period of actual suspension.

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Comment [pu11]: Page numbers may need to be changed

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Model Disciplinary Orders

Revocation - single cause

License number_____issued to respondent_____is revoked.

Revocation - multiple causes

License number_____issued to respondent_____is revoked pursuant to Determination of Issues *(e.g. I, II, and III)*, separately and for all of them.

3. Initial Probationary License

The application of _____ for an unrestricted license as a physician assistant is hereby denied. However, a probationary license shall be issued to respondent subject to the following terms and conditions:

1. Respondent is placed on probation for __years, beginning on the date respondent is issued a probationary license.

NOTES: A probationary license may only be issued for an initial license. Distinguish a probationary license from a license issued on probation. The former is not a disciplinary license although the terms of the probationary license would always be disclosed. The latter (where the license is issued, immediately *revoked*, and the revocation stayed) is a disciplinary action and, even after the term of probation is completed, will be reported as a prior disciplinary action.

Where a license is being issued (or reinstated), some conditions may need to be modified to reflect that a deadline commences from issuance of the license rather that issuance of the decision. This is particularly important where there is a condition precedent to issuance of a license.

Comment [pu12]: Clarification language

4. Standard Stay Order

However, the revocation is stayed and respondent is placed on probation for ___ years upon the following terms and conditions.

Optional Conditions

5. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine as a physician assistant for_____beginning the effective date of this decision.

6. Controlled Drugs - Drug Order Authority

Option 1 Total Restriction

Respondent shall not administer, issue a drug order, or hand to a patient or possess any controlled substances as defined by the California Uniform Controlled Substances Act.

Respondent is prohibited from practicing as a physician assistant until respondent provides documentary proof to the ~~committee~~ Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation. Respondent shall surrender all controlled substance order forms to the supervising physician. Thereafter,

respondent shall not reapply for a new DEA permit without the prior written consent of the ~~committee~~ Board or its designee.

Option 2 Partial Restriction

Respondent shall not administer, issue a drug order, or hand to a patient or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedules(s)_____of the Act.

Respondent shall immediately surrender respondent's current DEA permit to the Drug Enforcement Administration for cancellation and re-apply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, respondent shall submit proof that respondent has surrendered respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, the respondent shall submit a true copy of the permit to the ~~committee~~ Board or its designee.

7. Controlled Drugs - Maintain Record

Respondent shall maintain a record of all controlled substances administered, transmitted orally or in writing on a patient's record or handed to a patient by the respondent during probation showing all the following: 1) the name and address of the patient, 2) the date, 3) the character and quantity of controlled substances involved, and 4) the indications and diagnosis for which the controlled substance was furnished, 5) the name of supervising physician prescriber.

Respondent shall keep these records at the worksite in a separate file or ledger, in chronological order, and shall make them available for immediate inspection and copying by the ~~committee~~ Board or its designee on the premises at all times during business hours, upon request and without charge.

Option

The supervising physician shall review, sign, and date the controlled substances record _____(e.g., daily, weekly, monthly).

~~8. Drugs - Abstain from Use~~

Comment [pu13]: #8,9,10, 11 Moved to Uniform Standards

~~Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, and dangerous drugs as defined by Section 4211 of the Business and Professions Code, or any drugs requiring a prescription.~~

~~This condition does not apply to medications lawfully prescribed to respondent for a bona fide illness or condition by another practitioner. However, within 15 calendar days of receiving any lawful prescription medications, respondent shall notify the committee or its designee of the issuing practitioner's name, address, telephone number, medication name, strength, issuing pharmacy name, address, and telephone number.~~

~~9. Alcohol - Abstain from Use~~

~~Respondent shall abstain completely from the use of products or beverages containing alcohol.~~

~~10. Biological Fluid Testing~~

~~Respondent shall immediately submit to biological fluid testing upon the request of the committee or its designee. Respondent shall pay the cost of biological fluid testing.~~

~~11. Diversion Program~~

~~Within 30 days of the effective date of this decision, respondent shall enroll and participate in the committee's Diversion Program until the program determines that further treatment and rehabilitation is no longer necessary. Respondent shall successfully complete the program. The program determines whether or not respondent successfully completes the program.~~

~~Respondent shall pay all costs of the program~~

~~If the program determines that respondent is a danger to the public, upon notification from the program, respondent shall immediately cease practicing as a physician assistant until notified in writing by the committee or its designee that respondent may resume practice. The period of time that respondent is not practicing shall not be counted toward completion of the term of probation.~~

8~~12~~. Community Service

Within 60 days of the effective date of this decision, respondent shall submit to the ~~committee~~ Board or its designee for its prior approval a community service program in which respondent shall, within the first 2 years of probation, provide _____hours of free services (medical or non-medical) to a community or non-profit organization.

Prior to engaging in any community service, respondent shall provide a true copy of the Decision to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where respondent provides community service. Respondent shall submit proof of compliance to the ~~committee~~ Board or its designee within 15 calendar days of completion of the community service. This condition shall also apply to any change(s) in community service.

(NOTE: In quality of care cases, only non-medical community service is allowed.)

9~~13~~. Medical Record Keeping Course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in medical record keeping approved in advance by the ~~committee~~ Board or its designee. The course shall be Category I certified, limited to classroom, conference, or seminar settings. Respondent shall successfully complete the course within the first 6 months of probation.

Respondent shall pay the cost of the course.

Respondent shall submit a certification of successful completion to the ~~committee~~ Board or its designee within 15 days after completing the course.

10. Education Course

Within 60 days of the effective date of the decision, respondent shall submit to the ~~committee~~ Board or its designee for its prior approval an educational program or course from an accredited program which shall not be less than __hours of Category 1 CME. The education course shall be aimed at correcting any areas of deficient practice or knowledge. The course shall be Category I certified, limited to classroom, conference, or seminar settings. Respondent shall successfully complete the course within the first year of probation.

Respondent shall pay the cost of the course.

Respondent shall submit a certification of successful completion to the ~~committee~~ Board or its designee within 15 days after completing the course.

(NOTE: If violations include drug orders, at least one course shall be required in pharmacology and appropriate drug orders.)

1~~5~~. Clinical Training Program

Within 60 days of the effective date of this decision, respondent shall submit to the ~~committee~~ Board or its designee for prior approval, a clinical training or educational program such as the Physician Assessment and Clinical Education Program (PACE) offered by the University of California – San Diego School of Medicine or equivalent program as approved by the ~~committee~~ Board or its designee. The exact number of hours and specific content of the program shall be determined by the ~~committee~~ Board or its designee. The program shall determine whether Respondent has successfully completed and passed the program.

Respondent shall pay the cost of the program.

If the program makes recommendations for the scope and length of any additional educational or clinical training, treatment for any medical or psychological condition, or anything else affecting respondent's practice as a physician assistant, respondent shall comply with the program recommendations and pay all associated costs.

Respondent shall successfully complete and pass the program not later than six months after respondent's initial enrollment. The program determines whether or not the respondent successfully completes the program.

If respondent fails to either 1) complete the program within the designated time period, or 2) to pass the program, as determined by the program, respondent shall cease practicing as a physician assistant immediately after being notified by the ~~committee~~ Board or its designee.

Comment [pu14]: Clarification language

Option 1: Condition Precedent
Respondent shall not practice as a physician assistant until respondent has successfully completed the program and has been so notified by the ~~committee~~ Board or its designee in writing, except that respondent may practice only in the program.

Option 2: Condition Precedent (Applicant, including Reinstatement)
Respondent shall not be issued a license to practice as a physician assistant until respondent has successfully completed and passed the program, as determined by the program, and has been so notified by the Board or its designee in writing, except that respondent may practice only in the program.

Comment [pu15]: New optional condition

(NOTE: This program is for physician assistants who have demonstrated deficiencies in medical skills or knowledge.)

1~~2~~6. Ethics Course

Within 60 days of the effective date of this decision, respondent shall submit to the ~~committee~~ Board or its designee for its prior approval a course in ethics. The course shall be limited to classroom, conference, or seminar settings. Respondent shall successfully complete the course within the first year of probation.

Respondent shall pay the cost of the course.

Respondent shall submit a certification of successful completion to the ~~committee~~ Board or its designee within 15 days after completing the course.

13~~7~~. Professional Boundaries Program

Within 60 calendar days from the effective date of this decision, respondent shall enroll in a professional boundaries program equivalent to the Professional Boundaries Program, Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine ("~~P~~program").

Respondent shall pay the cost of the program.

Respondent shall, at the program's discretion, undergo and complete the program's assessment of respondent's competency, mental health and/or neuropsychological performance, and at a minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the decision, accusation, and any other information that the ~~committee~~ Board or its designee deems relevant. The program shall evaluate respondent at the end of the training and the program shall provide any data from the assessment and training as well as the results of the evaluation to the ~~committee~~ Board or its designee.

Respondent shall successfully complete the entire program not later than six months after respondent's initial enrollment. Based on respondent's performance in and evaluations from the assessment, education, and training, the program shall advise the ~~committee~~ Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with the program recommendations. At the completion of the program, respondent shall submit to a final evaluation. The program shall provide the results of the evaluation to the ~~committee~~ Board or its designee.

The program determines whether or not the respondent successfully completes the program.

If respondent fails to complete the program within the designated time period, respondent shall cease practicing as a physician assistant immediately after being notified by the ~~committee~~ Board or its designee.

Option 1: Condition Precedent
Respondent shall not practice as a physician assistant until respondent has successfully completed the program and has been so notified by the ~~committee~~ Board or its designee in writing.

14. Prescribing Practices Course

Comment [pu16]: Adding prescribing practices course

Within 60 calendar days of the effective date of this decision, respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6 months) after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The

prescribing practices course shall be in additional to the Continuing Medical Education (CME) requirements for renewal of licensure.

Respondent shall pay the cost of the course. The program shall determine whether respondent successfully completes the course.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the decision, whichever is later.

158. Psychological Evaluation/Treatment

Within 60 days of the effective date of this decision, and on a periodic basis thereafter as may be required by the ~~committee~~ Board or its designee, respondent shall undergo a psychological evaluation by a ~~committee~~ Board appointed psychological evaluator who shall furnish a psychological report and recommendations to the ~~committee~~ Board or its designee.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after notification by the ~~committee~~ Board or its designee.

Respondent may, based on the evaluator's report and recommendations, be required by the ~~committee~~ Board or its designee to undergo psychological treatment. Upon notification, respondent shall within 30 days submit for prior approval the name and qualifications of a psychological practitioner of respondent's choice. Upon approval of the treating psychological practitioner, respondent shall undergo and continue psychological treatment until further notice from the ~~committee~~ Board or its designee. Respondent shall have the treating psychological practitioner submit quarterly status reports to the ~~committee~~ Board or its designee indicating whether the respondent is capable of practicing medicine safely.

Respondent shall pay the cost of all psychological evaluations and treatment.

If the evaluator or treating practitioner determines that the respondent is a danger to the public, upon notification, respondent shall immediately cease practicing as a physician assistant until notified in writing by the ~~committee~~ Board or its designee that respondent may resume practice.

Option: Condition Precedent

Respondent shall not practice as a physician assistant until a psychological evaluation has been conducted and respondent is notified in writing by the ~~committee~~ Board or its designee that respondent may resume practice. The period of time that respondent is not practicing shall not be counted toward completion of the term of probation.

(NOTE: This condition is for those cases where the evidence demonstrates that mental illness or disability was a contributing cause of the violations.)

169. Medical Evaluation/Treatment

Within 60 days of the effective date of this decision, and on a periodic basis thereafter as may be required by the ~~committee~~ Board or its designee, respondent shall undergo a medical evaluation by a ~~committee~~ Board appointed physician who shall furnish a medical report and recommendations to the ~~committee~~ Board or its designee.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after notification by the ~~committee~~ Board or its designee.

Respondent may, based on the evaluator's report and recommendations, be required by the ~~committee~~ Board or its designee to undergo medical treatment. Upon notification, respondent shall within 30 days submit for prior approval the name and qualifications of a physician of respondent's choice. Upon approval of the treating physician, respondent shall undergo and continue medical treatment until further notice from the ~~committee~~ Board or its designee. Respondent shall have the treating physician submit quarterly reports to the ~~committee~~ Board or its designee.

Respondent shall pay the cost of all evaluations and treatment.

Option: Condition Precedent

Respondent shall not practice as a physician assistant until the medical evaluation has been conducted and respondent has been notified in writing by the ~~committee~~ Board or its designee that respondent may resume practice. The period of time that respondent is not practicing shall not be counted toward completion of the term of probation.

(NOTE: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.)

17~~20~~. Third Party Chaperone

During probation, respondent shall have a third party present at all time while consulting, examining or treating _____ (e.g. male, female, minor) patients.

It shall be recorded in the patient record that the third party was present at all times during the consultation, treatment and examination of a patient. The notation shall be signed by both the respondent and the third party. The respondent shall also maintain a separate log at the worksite, to be available for immediate inspection on a random and unannounced basis by the ~~committee~~ Board or its designee. The log shall include the names of all patients that the respondent consults, examines and/or treats, the date of examination and/or treatment, and the name of the third party present in the room during the examination and/or treatment. Each entry in the log shall be signed and dated by the respondent and the third party.

(NOTE: *This provision should be included where violations found had a sexual component*)

~~21~~8. Prohibited Practice Areas

During probation, respondent is prohibited from _____(e.g., practicing, performing, or treating)_____(e.g. a specific medical procedure; surgery; on a specific population).

19~~22~~. Maintenance of Patient Medical Records

Option 1
Respondent shall keep written medical records for each patient contact (including all visits and phone calls) at the worksite and shall make them available for immediate inspection by the Board or its designee on the premises at all times during business hours.

Option 2

All medical records originated by the respondent shall be reviewed, initialed, and dated daily by supervising physician.

This condition shall be required for_____(e.g. first/etc. year of probation).

20~~23~~. On-Site Supervision

Option 1
The supervising physician shall be on site at all times respondent is practicing.

Option 2
The supervising physician shall be on site at least 50% of the time respondent is practicing.

Option
Patient's condition shall be reviewed by supervising physician prior to patient leaving facility.
This condition shall be required for_____(e.g., first/etc. year of probation).

Conditions Applying the Uniform Standards Related to Substance Abuse

(TO BE INCLUDED IN ALL CASES RELATED TO SUBSTANCE ABUSE PROBATION)

NOTE: Pursuant to Section 315 of the Business and Professions Code and its regulations, the Physician Assistant Board uses the standards developed by the Substance Abuse Coordination Committee (SACC) for substance abusing licensees. On April 11, 2011, the SACC's Uniform Standards for Substance Abusing Licensees (Uniform Standards) were issued. Administrative law judges, parties and staff are therefore required to use the language below when the violation involved the licensee's use of drugs, alcohol, or both..

To that end, unless the condition is permissive in the Uniform Standards and noted below, each of the following probationary terms and conditions must be used in every case where the violation involved the use of drugs, alcohol, or both. Despite this requirement, , appropriate additional optional conditions should still be used in formulating the penalty and in considering additional optional terms or conditions of probation appropriate for greater public protection.

If the violation did not involve the use of drugs or alcohol, but the facts of the case suggest that the terms are warranted, the conditions may be applied to ensure the public is protected. In a case involving drugs or alcohol, a clinical diagnostic evaluation shall be ordered and the remaining provisions of the Uniform Standards may be made waived upon the clinical diagnostic evaluator's report finding that the individual is not a substance-abusing licensee.

21. Clinical Diagnostic Evaluation (CDE)

Comment [pu17]: Reference Uniform Standards 1 & 2

Within 30 days and thereafter as required by the Board, Respondent shall undergo a CDE from a licensed practitioner who holds a valid, unrestricted license to conduct CDEs, has three (3) years' experience in providing evaluations of health care professionals with substance abuse disorders, and is approved by the Board. The evaluations shall be conducted in accordance with accepted professional standards for conducting a substance abuse CDE.

Respondent shall undergo a CDE to determine whether the Respondent has a substance abuse problem and whether the Respondent is a threat to himself or herself or others. The evaluator

shall make recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the Respondent's rehabilitation and safe practice.

Respondent shall not be evaluated by an evaluator that has a financial, personal, or business relationship with the Respondent within the last five (5) years. The evaluator shall provide an objective, unbiased, and independent evaluation.

During the evaluation, if Respondent is determined to be a threat to himself or herself or others, the evaluator shall notify the Board within 24 hours of such a determination.

For all evaluations, a final written report shall be provided to the Board no later than ten (10) days from the date the evaluator is assigned the matter unless the evaluator requests additional information to complete the evaluation, not to exceed thirty (30) days.

Respondent may return to either full-time or part-time work if the Board determines he or she is fit to do so based upon consideration of the CDE report and the following criteria:

- License type;
- Licensee's history;
- Documented length of sobriety/time that has elapsed since last substance use;
- Scope and pattern of use;
- Treatment history;
- Medical history and current medical condition;
- Nature, duration and severity of substance abuse; and,
- Whether the licensee is a threat to himself or herself or others.

The Board shall determine whether or not the Respondent is safe to return to full-time or part-time work, and what restrictions shall be imposed on the Respondent. However, Respondent shall not return to practice until he or she has thirty days of negative drug tests.

If the Respondent is required to participate in inpatient, outpatient, or any other type of treatment, the Board shall take into consideration the recommendation of the CDE, license type, licensee's history, length of sobriety, scope and pattern of substance abuse, treatment history, medical history, current medical condition, nature, duration and severity of substance abuse and whether the licensee is a threat to himself or herself or others.

In the event that any Condition Applying the Uniform Standards requires interpretation or clarification, the Uniform Standards shall be controlling.

22. Abstain from the Use of Alcohol

Comment [pu18]: Reference Uniform Standards 4 & 8

Respondent shall abstain completely from the use of alcoholic beverages.

[Optional language: This condition may be waived by the board upon a written finding by the CDE that Respondent is not a substance abusing licensee.]

And

23. Abstain from the Use of Controlled Substances and Dangerous Drugs

Comment [pu19]: Reference Uniform Standards 4 & 8

Respondent shall abstain completely from personal use, possession, injection, consumption by any route, including inhalation of all controlled substances as defined in the California Uniform, Controlled Substances Act. This prohibition does not apply to medications lawfully prescribed to Respondent for a bona fide illness or condition by a practitioner licensed to prescribe such medications. Within fifteen (15) calendar days of receiving any lawful prescription medications,

Respondent shall notify the recovery program in writing of the following: prescriber's name, address, and telephone number; medication name and strength, issuing pharmacy name, address, and telephone number. Respondent shall also provide a current list of prescribed medication with the prescriber's name, address, and telephone number on each quarterly report submitted. Respondent shall provide the probation monitor with a signed and dated medical release covering the entire probation period.

Respondent shall identify for the Board's approval a single coordinating physician and surgeon who shall be aware of Respondent's history of substance abuse and who will coordinate and monitor any prescriptions for Respondent for dangerous drugs, and controlled substances. Once a Board-approved physician and surgeon has been identified, Respondent shall provide a copy of the Initial Probationary License Decision and Order, Statement of Issues or Accusation, Decision and Order, or Stipulated Decision and Order to the physician and surgeon. The coordinating physician and surgeon shall report to the Board or its designee on a quarterly basis Respondent's compliance with this condition.

The Board may require that only a physician and surgeon who is a specialist in addictive medicine be approved as the coordinating physician and surgeon.

If Respondent has a positive drug screen for any substance not legally authorized, Respondent shall be contacted and instructed to leave work and ordered by the Board to cease any practice and may not practice unless and until notified by the Board. The Board will notify Respondent's employer, if any, and worksite monitor, if any, that Respondent may not practice. If the Board files a petition to revoke probation or an accusation based upon the positive drug screen, Respondent shall be automatically suspended from practice pending the final decision on the petition to revoke probation or accusation. This period of suspension will not apply to the reduction of this probationary period.

OPTIONAL LANGUAGE: This condition may be waived or modified by the board upon a written finding by the CDE that Respondent is not a substance abusing licensee.

24. Drug and Alcohol Recovery Monitoring Program

Comment [pu20]: Reference Uniform Standard #6

Within fifteen (15) calendar days from the effective date of this Decision and Order, Respondent shall enroll and participate in the Board's drug and alcohol recovery monitoring program at Respondent's cost until the drug and alcohol recovery monitoring program determines that participation in the drug and alcohol recovery monitoring program is no longer necessary.

Respondent shall comply with all components of the drug and alcohol recovery monitoring program. Respondent shall sign a release authorizing the drug & alcohol recovery monitoring program to report all aspects of participation of the drug & alcohol recovery monitoring program as requested by the Board or its designee.

Failure to comply with requirements of the drug and alcohol recovery monitoring program, terminating the program without permission or being expelled for cause shall constitute a violation of probation by Respondent and shall be immediately suspended from the practice of physical therapy.

OPTIONAL LANGUAGE: This condition may be waived or modified by the board or its designee upon a written finding by the CDE that Respondent is not a substance abusing licensee.

25. Biological Fluid Testing

Comment [pu21]: Reference Uniform Standrds 4, 8, & 10

Respondent shall immediately submit to and pay for any random and directed biological fluid or hair sample, breath alcohol or any other mode of testing required by the Board or its designee.

Respondent shall be subject to a minimum of fifty-two (52), but not to exceed one-hundred and four (104) random tests per year within the first year of probation and a minimum of thirty six (36) random tests per year, for the duration of the probationary term up to five years and a minimum of one (1) test per month in each year of probation after the fifth year provided that there have been no positive test results during the previous five (5) years.

The Board or its designee may require less frequent testing if any of the following applies:

- Where respondent has previously participated in a treatment or monitoring program requiring testing, the board or its designee may consider that prior testing record in applying the testing frequency schedule described above;
- Where the basis for probation or discipline is a single incident or conviction involving alcohol or drugs, or two incidents or convictions involving alcohol or drugs that were at least seven (7) years apart, that did not occur at work or on the way to or from work, the board or its designee may skip the first-year testing frequency requirement(s);
- Where respondent is not employed in any health care field, frequency of testing may be reduced to a minimum of twelve (12) tests per year. If respondent wishes to thereafter return to employment in a health care field, respondent shall be required to test at least once a week for a period of sixty (60) days before commencing such employment, and shall thereafter be required to test at least once a week for a full year, before respondent may be reduced to a testing frequency of no less than twenty-four (24) tests per year;
- Where respondent has a demonstrated period of sobriety and/or non-use, the board or its designee may reduce the testing frequency to no less than twenty-four (24) tests per year

Comment [pu22]: Exceptions to testing schedule

Respondent shall make daily contact as directed by the Board to determine if he or she must submit to drug testing. Respondent shall have the test performed by a Board-approved laboratory certified and accredited by the U.S. Department of Health and Human Services on the same day that he or she is notified that a test is required. This shall ensure that the test results are sent immediately to the Board. Failure to comply within the time specified shall be considered an admission of a positive drug screen and constitute a violation of probation. If the test results in a determination that the urine was too diluted for testing, the result shall be considered an admission of a positive urine screen and constitutes a violation of probation. If a positive result is obtained, the Board may require Respondent to immediately undergo a physical examination and to complete laboratory or diagnostic testing to determine if any underlying physical condition has contributed to the diluted result and to suspend Respondent's license to practice. Any such examination or laboratory and testing costs shall be paid by Respondent. A positive result is one which, based on scientific principles, indicates Respondent attempted to alter the test results in order to either render the test invalid or obtain a negative result when a positive result should have been the outcome. If it is determined Respondent altered the test results, the result shall be considered an admission of a positive urine screen and constitutes a violation of probation and Respondent must cease practicing. Respondent shall not resume practice until notified by the Board. If Respondent tests positive for a banned substance, Respondent shall be contacted and instructed to leave work and ordered to cease all practice. Respondent shall not resume practice until notified by the Board. All alternative drug testing sites due to vacation or travel outside of California must be approved by the Board prior to the vacation or travel.

OPTIONAL: This condition may be waived or modified by the Board or its designee upon a written finding by the CDE that Respondent is not a substance abusing licensee.

26. Facilitated Group Support Meetings

Comment [pu23]: Reference Uniform Standard #5

Within fifteen (15) days from the effective date of the decision, Respondent shall submit to the Board or its designee for prior approval the name of one or more meeting facilitators. Respondent shall participate in facilitated group support meetings within fifteen (15) days after notification of the Board's or designee's approval of the meeting facilitator. When determining the type and frequency of required facilitated group support meeting attendance, the Board or its designee shall give consideration to the following:

- The licensee's history;
- The documented length of sobriety/time that has elapsed since substance abuse;
- The recommendation of the clinical evaluator;
- The scope and pattern of use;
- The licensee's treatment history; and ,
- The nature, duration, and severity of substance abuse.

Verified documentation of attendance shall be submitted by Respondent with each quarterly report. Respondent shall continue attendance in such a group for the duration of probation unless notified by the Board that attendance is no longer required.

If a facilitated group support meeting is ordered, the group facilitator shall meet the following qualifications and requirements:

1. The group meeting facilitator shall have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or other nationally certified organizations.
2. The group meeting facilitator shall not have a financial relationship, personal relationship, or business relationship with the licensee in the last five (5) years.
3. The group facilitator shall provide to the Board or its designee a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.
4. The group meeting facilitator shall report any unexcused absence to the Board or its designee within twenty-four (24) hours.

27. Work Site Monitor

Comment [pu24]: Reference Uniform Standard 7

Respondent shall have a worksite monitor as required by this term. The worksite monitor shall not have any current or former financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the Board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the Board. However, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.

The worksite monitor's license scope of practice shall include the scope of practice of the licensee who is being monitored or be another health care professional if no monitor with like scope of practice is available.

The worksite monitor shall have an active unrestricted license, with no disciplinary action within the last five (5) years.

The worksite monitor shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and agrees to monitor the licensee as set forth by the Board.

The worksite monitor must adhere to the following required methods of monitoring the licensee:

a) Have face-to-face contact with the licensee at least once per week in the work environment or more frequently if required by the Board.
b) Interview other staff in the office regarding the licensee's behavior, if applicable.
c) Review the licensee's work attendance.

The worksite monitor shall report to the Board as follows:

☐ Any suspected substance abuse must be verbally reported to the Board and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the Board's normal business hours the verbal report must be within one (1) hour of the next business day. A written report shall be submitted to the Board within 48 hours of occurrence.

☐ The worksite monitor shall complete and submit a written report monthly or as directed by the Board. The report shall include: the licensee's name; license number; worksite monitor's name and signature; worksite monitor's license number; worksite location(s); dates licensee had face-to-face contact with monitor; staff interviewed if applicable; attendance report; any change in behavior and/or personal habits; any indicators leading to suspected substance abuse.

The licensee shall complete the required consent forms and sign an agreement with the worksite monitor and the Board to allow the Board to communicate with the worksite monitor.
If Respondent tests positive for a banned substance, the Board will immediately notify Respondent's employer that the Respondent's license has been ordered to cease practice.

[Optional language: This condition may be waived or modified by the board upon a written finding by the CDE that Respondent is not a substance abusing licensee.]

28. Major Violations

Comment [pu25]: Reference Uniform Standard #10

This provision applies if licensee commits a violation of the drug and alcohol recovery monitoring program or any other condition applying the uniform standards specific to controlled substance.

If Respondent commits a major violation, Respondent shall immediately upon notification by the Board, cease practice until notified otherwise in writing by the Board.

Major Violations include, but are not limited to, the following:

1. Failure to complete a Board-ordered program;
2. Failure to undergo a required CDE;
3. Committing multiple minor violations of probation conditions;
4. Treating a patient while under the influence of drugs or alcohol;
5. Committing any drug or alcohol offense that is a violation of the Business and Professions Code or state or federal law;
6. Failure to obtain biological testing for substance abuse;
7. Testing positive for a banned substance; and

8. Knowingly using, making, altering, or possessing any object or product in such a way as to defraud a drug test designed to detect the presence of alcohol or a controlled substance.

Standard Conditions
(TO BE INCLUDED IN ALL CASES OF PROBATION)

~~24~~9. Approval of Supervising Physician

Within 30 days of the effective date of this decision, respondent shall submit to the ~~committee~~ Board or its designee for its prior approval the name and license number of the supervising physician and a practice plan detailing the nature and frequency of supervision to be provided. Respondent shall not practice until the supervising physician and practice plan are approved by the ~~committee~~ Board or its designee.

The supervising physician may also serve as the worksite monitor.

Respondent shall have the supervising physician submit quarterly reports to the ~~committee~~ Board or its designee.

If the supervising physician resigns or is no longer available, respondent shall, within 15 days, submit the name and license number of a new supervising physician for approval. Respondent shall not practice until a new supervising physician has been approved by the Board or its designee.

~~25~~30. Notification of Employer and Supervising Physician

Comment [pu26]: Reference Uniform Standard #3

Respondent shall notify his/her current and any subsequent employer, contractor and supervising physician(s) of the discipline and provide a copy of the accusation, decision, and order to each employer and supervising physician(s) during his/her period of probation, before accepting or continuing employment ~~at onset of that employment~~. Respondent shall ensure that each employer informs the ~~committee~~ Board or its designee, in writing within 30 days, verifying that the employer and supervising physician(s) have received a copy of Accusation, Decision, and Order.

This condition shall apply to any change(s) in place of employment.

The Respondent shall provide to the Board or its designee the names, physical addresses, mailing addresses, and telephone numbers of all employers, supervising physicians, and work site monitor, and shall inform the Board or its designee in writing of the facility or facilities at which the person practices as a physician assistant.

Respondent shall give specific, written consent to the Board or its designee to allow the Board or its designee to communicate with the employer, supervising physician, or work site monitor regarding the licensee's work status, performance, and monitoring.

~~26~~31. Obey All Laws

Respondent shall obey all federal, state, and local laws, and all rules governing the practice of medicine as a physician assistant in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

~~27~~32. Quarterly Reports

Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the ~~committee~~ Board or its designee, stating whether there has been compliance with all the conditions of probation.

33~~28~~. Other Probation Requirements

Respondent shall comply with the ~~committee's~~ Board's probation unit. Respondent shall, at all times, keep the ~~committee~~ Board and probation unit informed of respondent's business and residence addresses. Changes of such addresses shall be immediately communicated in writing to the ~~committee~~ Board and probation unit. Under no circumstances shall a post office box serve as an address of record, except as allowed by California Code of Regulations 1399.523.

Respondent shall appear in person for an initial probation interview with ~~committee~~ Board or its designee within 90 days of the decision. Respondent shall attend the initial interview at a time and place determined by the ~~committee~~ Board or its designee.

Respondent shall, at all times, maintain a current and renewed physician assistant license.

Respondent shall also immediately inform probation unit, in writing, of any travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) days.

34~~29~~. Interview with Medical Consultant

Respondent shall appear in person for interviews with the ~~committee's~~ Board's medical or expert physician assistant consultant upon request at various intervals and with reasonable notice.

~~30~~5. ~~Tolling for Out-of-State Practice or Residence~~ Non-practice While on Probation

Comment [pu27]: Combining both tolling /non practice conditions into one

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not practicing as a physician assistant. Respondent shall not return to practice until the supervising physician is approved by the Board or its designee.

~~The period of probation shall not run during the time respondent is residing or practicing outside the jurisdiction of California~~. If, during probation, respondent moves out of the jurisdiction of California to reside or practice elsewhere, including federal facilities, respondent is required to immediately notify the ~~committee~~ Board in writing of the date or departure, and the date or return, if any.

Practicing as a physician assistant in another state of the United States or federal jurisdiction while on active probation with the physician assistant licensing authority of that state or jurisdiction shall not be considered non-practice.

All time spent in a clinical training program that has been approved by the Board or its designee, shall not be considered non-practice. Non-practice due to a Board ordered suspension or in compliance with any other condition or probation, shall not be considered a period of non-practice.

Any period of non-practice, as defined in this condition, will not apply to the reduction of the probationary term.

Periods of non-practice do not relieve respondent of the responsibility to comply with the terms and conditions of probation.

Respondent's license shall be automatically canceled if for a total of two years, respondent~~'s period of temporary or permanent residence or practice outside California totals two years~~ fails to

practice as a physician assistant. Respondent's license shall not be canceled as long as respondent is residing and practicing as a physician assistant in another state of the United States and is on active probation with the physician assistant licensing authority of that state, in which case the two year period shall begin on the date probation is completed or terminated in that state.

~~31. Failure to Practice as a Physician Assistant – California Resident~~

~~In the event respondent resides in California and for any reason respondent stops practicing as a physician assistant in California, respondent shall notify the committee or its designee in writing within 30 calendar days prior to the dates of non-practice and return to practice. Any period of non-practice within California, as defined in this condition, will not apply to the reduction of the probationary term and does not relieve respondent of the responsibility to comply with the terms and conditions of probation. Non-practice is defined as any period of time exceeding 30 calendar days in which respondent is not practicing as a physician assistant.~~

~~All time spent in a clinical training program that has been approved by the committee or its designee, shall be considered time spent in the practice of medicine. For purposes of this condition, non-practice due to a committee ordered suspension or in compliance with any other condition or probation, shall not be considered a period of non-practice.~~

~~Respondent's license shall be automatically canceled if, for a total of two years, respondent resides in California and fails to practice as a physician assistant.~~

~~32~~6. Unannounced Clinical Site Visit

The ~~committee~~ Board or its designee may make unannounced clinical site visits at any time to ensure that respondent is complying with all terms and conditions of probation.

~~33~~7. Condition Fulfillment

A course, evaluation, or treatment completed after the acts that gave rise to the charges in the accusation but prior to the effective date of the decision may, in the sole discretion of the ~~committee~~ Board or its designee, be accepted towards the fulfillment of the condition.

~~34~~8. Completion of Probation

Respondent shall comply with all financial obligations (e.g., cost recovery, probation costs) no later than 60 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's license will be fully restored.

~~35~~9. Violation of Probation

If respondent violates probation in any respect, the ~~committee~~ Board after giving respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an accusation or petition to revoke probation is filed against respondent during probation, the ~~committee~~ Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

~~36~~40. Cost Recovery

The respondent is hereby ordered to reimburse the Physician Assistant ~~Committee~~ Board the amount of $_____ within 90 days from the effective date of this decision for its investigative costs. Failure to reimburse the ~~committee's~~ Board costs for its investigation shall constitute a violation of

the probation order, unless the ~~committee~~ Board agrees in writing to payment by an installment plan because of financial hardship. The filing of bankruptcy by the respondent shall not relieve the respondent of his/her responsibility to reimburse the ~~committee~~ Board for its investigative costs.

(NOTE: Most physician assistant cost recovery orders are paid on an installment plan.)

~~37~~41. Probation Monitoring Costs

Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the ~~committee~~ Board, which may be adjusted on an annual basis. The costs shall be made payable to the Physician Assistant ~~Committee~~ Board and delivered to the ~~committee~~ Board no later than January 31 of each calendar year.

42~~38~~. Voluntary License Surrender

Following the effective date of this probation, if respondent ceases practicing due to retirement, health reasons, or is otherwise unable to satisfy the terms and conditions of probation, respondent may request the voluntarily surrender of respondent's license to the ~~committee~~ Board. The ~~committee~~ Board reserves the right to evaluate the respondent's request and to exercise its discretion whether to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, respondent shall, within 15 days, deliver respondent's wallet and wall certificate to the ~~committee~~ Board or its designee and shall no longer practice as a physician assistant. Respondent will no longer be subject to the terms and conditions of probation and the surrender of respondent's license shall be deemed disciplinary action. If respondent re-applies for a physician assistant license, the application shall be treated as a petition for reinstatement of a revoked license.

BUSINESS AND PROFESSIONS CODE - BPC

DIVISION 1. DEPARTMENT OF CONSUMER AFFAIRS [100. - 472.5.]

(Heading of Division 1 amended by Stats. 1973, Ch. 77.)

CHAPTER 4. Consumer Affairs [300. - 337.]

(Chapter 4 added by Stats. 1970, Ch. 1394.)

ARTICLE 3.6. Uniform Standards Regarding Substance-Abusing Healing Arts Licensees [315. - 315.4.]

(Article 3.6 added by Stats. 2008, Ch. 548, Sec. 3.)

315.

(a) For the purpose of determining uniform standards that will be used by healing arts boards in dealing with substance-abusing licensees, there is established in the Department of Consumer Affairs the Substance Abuse Coordination Committee. The committee shall be comprised of the executive officers of the department's healing arts boards established pursuant to Division 2 (commencing with Section 500), the State Board of Chiropractic Examiners, the Osteopathic Medical Board of California, and a designee of the State Department of Alcohol and Drug Programs. The Director of Consumer Affairs shall chair the committee and may invite individuals or stakeholders who have particular expertise in the area of substance abuse to advise the committee.

(b) The committee shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Division 3 of Title 2 of the Government Code).

(c) By January 1, 2010, the committee shall formulate uniform and specific standards in each of the following areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program:

(1) Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

(2) Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation described in paragraph (1) and any treatment recommended by the evaluator described in paragraph (1) and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

(3) Specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status and condition.

(4) Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomness, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

(5) Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

(6) Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

(7) Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

(8) Procedures to be followed when a licensee tests positive for a banned substance.

(9) Procedures to be followed when a licensee is confirmed to have ingested a banned substance.
(10) Specific consequences for major violations and minor violations. In particular, the committee shall consider the use of a "deferred prosecution" stipulation similar to the stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency unless or until the licensee commits a major violation, in which case it is revived and the license is surrendered.
(11) Criteria that a licensee must meet in order to petition for return to practice on a full-time basis.
(12) Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.
(13) If a board uses a private-sector vendor that provides diversion services, standards for immediate reporting by the vendor to the board of any and all noncompliance with any term of the diversion contract or probation; standards for the vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors; standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and standards for a licensee's termination from the program and referral to enforcement.
(14) If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.
(15) If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor's performance in adhering to the standards adopted by the committee.
(16) Measurable criteria and standards to determine whether each board's method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.
(Amended by Stats. 2009, Ch. 140, Sec. 1. Effective January 1, 2010.)

315.2.
(a) A board, as described in Section 315, shall order a licensee of the board to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or diversion program.
(b) An order to cease practice under this section shall not be governed by the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.
(c) A cease practice order under this section shall not constitute disciplinary action.
(d) This section shall have no effect on the Board of Registered Nursing pursuant to Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2.
(Added by Stats. 2010, Ch. 517, Sec. 2. Effective January 1, 2011.)

315.4.
(a) A board, as described in Section 315, may adopt regulations authorizing the board to order a licensee on probation or in a diversion program to cease practice for major violations and when the board orders a licensee to undergo a clinical diagnostic evaluation pursuant to the uniform and specific standards adopted and authorized under Section 315.

(b) An order to cease practice under this section shall not be governed by the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.
(c) A cease practice order under this section shall not constitute disciplinary action.
(d) This section shall have no effect on the Board of Registered Nursing pursuant to Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2.
(Added by Stats. 2010, Ch. 517, Sec. 3. Effective January 1, 2011.)

§ 1399.523. Disciplinary Guidelines.

In reaching a decision on a disciplinary action under the Administrative Procedures Act (Government Code Section 11400 et seq.), the Physician Assistant Committee shall consider the disciplinary guidelines entitled "Physician Assistant Committee Manual of Model Disciplinary Guidelines and Model Disciplinary Orders" 3rd Edition 2007, which are hereby incorporated by reference. Deviation from these guidelines and orders, including the standard terms of probation, is appropriate where the Physician Assistant Committee, in its sole discretion, determines that the facts of the particular case warrant such a deviation-for example: the presence of mitigating factors; the age of the case; evidentiary problems.

Notwithstanding the disciplinary guidelines, any proposed decision issued in accordance with the procedures set forth in Chapter 5 (commencing with Section11500) of Part 1 of Division 3 of Title 2 of the Government Code that contains any finding of fact that the licensee engaged in any act of sexual contact, as defined in subdivision (c) of Section 729 of the Code, with a patient, or any finding that the licensee has committed a sex offense or been convicted of a sex offense as defined in Section 44010 of the Education Code, shall contain an order revoking the license. The proposed decision shall not contain an order staying the revocation of the license.

Note: Authority cited: Sections 3510, 3527, 3528, 3529, 3530, 3531, 3532 and 3533, Business and Professions Code; and Section 11400.20, Government Code. Reference: Sections 11400.20 and 11425.50(e), Government Code; and Sections 729, 3527, 3528, 3529, 3530, 3531, 3532 and 3533, Business and Professions Code.

§ 1399.523.5. Required Actions Against Registered Sex Offenders.

(a) Except as otherwise provided, if an individual is required to register as a sex offender pursuant to Section 290 of the Penal Code, or the equivalent in another state or territory, or military or federal law, the Committee shall:

(1) Deny an application by the individual for licensure, in accordance with the procedures set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Promptly revoke the license of the individual, in accordance with the procedures set forth in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and shall not stay the revocation nor place the license on probation.

(3) Deny any petition to reinstate or reissue the individual's license.

(b) This section shall not apply to any of the following:

(1) An individual who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law or the law of the jurisdiction that required registration; provided, however, that nothing in this paragraph shall prohibit the Committee from exercising its discretion to deny or discipline a licensee under any other provision of state law.

(2) An individual who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code; provided, however, that nothing in this paragraph shall prohibit the Committee from exercising its discretion to deny or discipline a licensee under any other provision of state law based upon the licensee's conviction under section 314 of the Penal Code.

(3) Any administrative proceeding that is fully adjudicated prior to the effective date of this regulation. A petition for reinstatement of a revoked or surrendered license shall be considered a new proceeding for purposes of this paragraph, and the prohibition in subsection (a) against reinstating a license shall govern.

Note: Authority cited: Section 3510, Business and Professions Code. Reference: Sections 3504.1, 3510, 3527, 3528, 3530 and 3531, Business and Professions Code.

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MEMORANDUM

DATE	April 5, 2012
TO	ALL HEALING ARTS BOARDS
FROM	DOREATHEA JOHNSON Deputy Director, Legal Affairs Department of Consumer Affairs
SUBJECT	Opinion Regarding Uniform Standards for Substance-Abusing Licensees (SB 1441)

This memo addresses a number of questions that have been raised concerning the discretion of healing arts boards, with respect to the Uniform Standards for Substance-Abusing Healing Arts Licensees ("Uniform Standards") that were formulated by the Substance Abuse Coordination Committee and mandated by Business and Professions Code section 315. Previously, there have been discussions and advice rendered, opining that the boards retain the discretion to modify the Uniform Standards. This opinion, largely influenced by the fact that the rulemaking process necessarily involves the exercise of a board's discretion, has been followed by a number of boards as they completed the regulatory process.

Two opinions, one issued by the Legislative Counsel Bureau ("Legislative Counsel") dated October 27, 2011, and an informal legal opinion, rendered by the Government Law Section of the Office of the Attorney General ("Attorney General"), dated February 29, 2012, have been issued and address the discretion of the boards, in adopting the Uniform Standards. This memo is to advise the healing arts boards of this office's opinion regarding the questions raised, after a review of these two opinions. A copy of each opinion is attached for your convenience.

Questions Presented

1. **Do the healing arts boards retain the discretion to modify the content of the specific terms or conditions of probation that make up the Uniform Standards?**

   Both Legislative Counsel and the Attorney General concluded that the healing arts boards do not have the discretion to modify the content of the specific terms or conditions of probation that make up the Uniform Standards. We concur with that conclusion.

2. **Do the healing arts boards have the discretion to determine which of the Uniform Standards apply in a particular case?**

   Legislative Counsel opined that, unless the Uniform Standards specifically so provide, all of the Uniform Standards must be applied to cases involving substance-abusing licensees, as it was their belief that the Legislative intent was to "provide for the full implementation of the Uniform Standards." The Attorney General agreed with Legislative Counsel. Following our review and analysis of Business and Professions Code Section 315, we concur with both the Office of the Attorney General and the Legislative Counsel.

3. **Is the Substance Abuse Coordination Committee (SACC) the entity with rulemaking authority over the uniform standards to be used by the healing arts boards?**

   The Legislative Counsel concluded that the SACC had the authority to promulgate regulations mandating that the boards implement the Uniform Standards. However, the Office of the Attorney General disagreed and concluded that the SACC was not vested with the authority to adopt regulations implementing the uniform standards. We agree with the Office of the Attorney General. It is our opinion that the authority to promulgate the regulations necessary to implement the Uniform Standards, lies with the individual boards that implement, interpret or make specific, the laws administered by those boards. As the SACC is limited to the creation or formulation of the uniform standards, but is not authorized to implement the laws of the healing arts boards, it does not have authority to adopt regulations to implement those standards. Consequently, we agree with the Attorney General's opinion that the SACC is not the rule-making entity with respect to the Uniform Standards, and therefore has no authority to adopt the Uniform Standards as regulations.

It is our recommendation that healing arts boards move forward as soon as possible to

the Uniform Standards. Some of the standards are appropriate for inclusion in an agency's disciplinary guidelines, which necessarily will involve the regulatory process. Others are administrative in nature and not appropriate for inclusion in the disciplinary guidelines. For example, Uniform Standard No. 16 which sets forth reporting requirements would not be appropriate for inclusion in disciplinary guidelines.

Please work with your assigned legal counsel to determine how best to implement the Uniform Standards. This should include a discussion as to whether : (1) the Uniform Standards should be placed in a regulation separate from the disciplinary guidelines; (2) the implementing regulation should include a definition of (or criteria by which to determine) what constitutes a "substance-abusing licensee."

It is hopeful that the foregoing information addresses your concerns with respect to the implementation of the mandatory uniform standards.

Attachments

cc: Denise Brown, DCA Director
Awet Kidane, DCA Chief Deputy Director
DCA Legal Affairs Attorneys

LEGISLATIVE
COUNSEL
BUREAU

October 27, 2011

Honorable Curren D. Price Jr.
Room 2053, State Capitol

HEALING ARTS BOARDS: ADOPTION OF UNIFORM STANDARDS - #1124437

Dear Senator Price:

You have asked two questions with regard to the adoption of uniform standards by the Substance Abuse Coordination Committee pursuant to Section 315 of the Business and Professions Code. You have asked whether the Substance Abuse Coordination Committee is required to adopt the uniform standards pursuant to the rulemaking procedures under the Administrative Procedure Act (Ch. 3.5 (commencing with Sec. 11340), Pt. 1, Div. 3, Title 2, Gov. C.). You have also asked, if the uniform standards are properly adopted by the Substance Abuse Coordination Committee, whether the healing arts boards are required to implement them.

By way of background, Section 315 of the Business and Professions Code[1] provides as follows:

> "315. (a) For the purpose of determining uniform standards that will be used by healing arts boards in dealing with substance-abusing licensees, there is established in the Department of Consumer Affairs the Substance Abuse Coordination Committee. The committee shall be comprised of the executive officers of the department's healing arts boards established pursuant to Division 2 (commencing with Section 500), the State Board of Chiropractic Examiners, the Osteopathic Medical Board of California, and a designee of the State Department of Alcohol and Drug Programs. The Director of Consumer Affairs shall chair the committee and may invite individuals or stakeholders who have particular expertise in the area of substance abuse to advise the committee.

[1] All further section references are to the Business and Professions Code, unless otherwise referenced.

"(b) The committee shall be subject to the Bagley-Keene Open Meeting Act (Article 9 (commencing with Section 11120) of Division 3 of Title 2 of the Government Code).

"(c) By January 1, 2010, the committee shall formulate uniform and specific standards in each of the following areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program:

"(1) Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

"(2) Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation described in paragraph (1) and any treatment recommended by the evaluator described in paragraph (1) and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

"(3) Specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status and condition.

"(4) Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomness, method of notice to the licensee, number of hours between the provision of notice and the test standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

"(5) Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

"(6) Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

"(7) Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

"(8) Procedures to be followed when a licensee tests positive for a banned substance.

"(9) Procedures to be followed when a licensee is confirmed to have [illegible] banned substance.

"(10) Specific consequences for major violations and minor violations. In particular, the committee shall consider the use of a deferred prosecution stipulation similar to the stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency unless or until the licensee commits a major violation, in which case it is revived and the license is surrendered.

"(11) Criteria that a licensee must meet in order to petition for return to practice on a full-time basis.

"(12) Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

"(13) If a board uses a private-sector vendor that provides diversion services, standards for immediate reporting by the vendor to the board of any and all noncompliance with any term of the diversion contract or probation; standards for the vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors; standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and standards for a licensee's termination from the program and referral to enforcement.

"(14) If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

"(15) If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor' performance in adhering to the standards adopted by the committee.

"(16) Measurable criteria and standards to determine whether each board' method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term." (Emphasis added.)

Thus, the Legislature has established in the Department of Consumer Affairs (hereafter department) the Substance Abuse Coordination Committee (subd. (a), Sec. 315, hereafter committee). The committee is comprised of the executive officers of each healing arts board within the department,[1] the State Board of Chiropractic Examiners, and the

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[1] The department's healing arts boards are those boards established under Division 2 (commencing with Section 500) to license and regulate practitioners of the healing arts. Those boards include, among others, the Dental Board of California, the Medical Board of California, the Veterinary Medical Board, and the Board of Registered Nursing.

Osteopathic Medical Board of California (hereafter, collectively, healing arts boards), and a designee of the State Department of Alcohol and Drug Programs (Ibid.). The Director of Consumer Affairs chairs the committee and is authorized to invite individuals or stakeholders who have particular expertise in the area of substance abuse to advise the committee (Ibid.).

The committee is required to formulate uniform and specific standards in each of 16 areas provided by the Legislature, but otherwise has discretion to adopt the uniform standards each healing arts board shall use in dealing with substance-abusing licensees (subd. (c), Sec. 315). The committee adopted its initial set of uniform standards in April 2010, and revised those initial standards as recently as April 2011.[1] Although the committee has adopted the uniform standards pursuant to its own procedures, it has yet to adopt those standards pursuant to the rulemaking procedures of the Administrative Procedure Act (Ch. 3.5 (commencing with Sec. 11340), Pt. 1, Div. 3, Title 2, Gov. C.; hereafter APA).

You have asked whether the committee is required to adopt the uniform standards pursuant to the rulemaking procedures of the APA.

The APA establishes basic minimum procedural requirements for the adoption, amendment, or repeal of administrative regulations by state agencies (subd. (a), Sec. 11346, Gov. C.). The APA is applicable to the exercise of any quasi-legislative power conferred by any statute (Ibid.). Quasi-legislative powers consist of the authority to make rules and regulations having the force and effect of law (*California Advocates for Nursing Home Reform v. Bonta* (2003) 106 Cal.App.4th 498, 517; hereafter *California Advocates*). The APA may not be superseded or modified by any subsequent legislation except to the extent that the legislation does so expressly (subd. (a), Sec. 11346, Gov. C.).

The term "regulation" is defined for purposes of the APA to mean "<u>every</u> rule, regulation, order, or <u>standard of general application</u> or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency <u>to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure</u>" (Sec. 11342.600, Gov. C.; emphasis added). The APA provides that a state agency shall not issue, utilize, enforce, or attempt to enforce any guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation under the APA, unless properly adopted under the procedures set forth in the APA, and the Office of Administrative Law is empowered to determine whether any such guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule is a regulation under the APA (Sec. 11340.5, Gov. C.).

In *Tidewater Marine Western, Inc. v. Bradshaw* (1996) 14 Cal.4th 557, 571 (hereafter *Tidewater*), the California Supreme Court found as follows:

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[1] See http://www.dca.ca.gov/about_dca/sacc/index.shtml (as of September 20, 2011).

"A regulation subject to the APA thus has two principal identifying characteristics. (See *Union of American Physicians & Dentists v. Kizer* (1990) 223 Cal.App.3d 490, 497 [272 Cal.Rptr. 886] [describing two-part test of the Office of Administrative Law].) First, the agency must intend its rule to apply generally, rather than in a specific case. The rule need not, however, apply universally; a rule applies generally so long as it declares how a certain class of cases will be decided. (*Roth v. Department of Veterans Affairs* (1980) 110 Cal.App.3d 622, 630 [167 Cal.Rptr. 552].) Second, the rule must 'implement, interpret, or make specific the law enforced or administered by [the agency], or ... govern [the agency's] procedure.' (Gov. Code, § 11342, subd. (g).)"

If a policy or procedure falls within the definition of a "regulation" within the meaning of the APA, the adopting agency must comply with the procedures for formalizing the regulation, which include public notice and approval by the Office of Administrative Law (*County of Butte v. Emergency Medical Services Authority* (2010) 187 Cal.App.4th 1175, 1200). The Office of Administrative Law is required to review all regulations adopted pursuant to the APA and to make its determinations according to specified standards that include, among other things, assessing the necessity for the regulation and the regulation's consistency with the agency's statutory obligation to implement a statute (subd. (a), Sec. 11349.1, Gov. C.).

Applying these principles to the question presented, the uniform standards are subject to the rulemaking procedures of the APA if the following criteria are met: (1) Section 315 does not expressly preclude application of the APA, (2) the committee is a state agency under the APA, (3) the uniform standards are regulations subject to the APA, and (4) no exemption applies under the APA.

With respect to the first criterion, Section 315 is silent on the application of the APA. Thus, Section 315 does not expressly preclude application of the APA, and the APA will apply to any regulation adopted under Section 315.

We turn next to the second criterion, and whether the committee is an "agency" for purposes of the APA. The word "agency" is defined, for purposes of the APA, by several separate provisions of law. For purposes of the rulemaking procedures of the APA, "agency" is defined to mean a state agency (Sec. 11342.520, Gov. C.). That reference to state agency is defined elsewhere in the Government Code to include every state office, officer, department, division, bureau, board, and commission (subd. (a), Sec. 11000, Gov. C.). The APA does not apply to an agency in the judicial or legislative branch of the state government (subd. (a), Sec. 11340.9, Gov. C.).

Along those lines, the APA is applicable to the exercise of any quasi-legislative power conferred by any statute (subd. (a), Sec. 11346, Gov. C.). Quasi-legislative powers consist of the authority to make rules and regulations having the force and effect of law (*California Advocates*, supra, at p. 517). Thus, for purposes of our analysis, we think that an "agency" means any state office, officer, department, division, bureau, board, or commission that exercises quasi-legislative powers.

Here, the committee is a state office comprised of executive officers of the healing arts boards and the Director of Consumer Affairs. Although the Legislature has set forth 16 areas in which the committee is required to adopt standards, the committee itself is required to exercise quasi-legislative powers and adopt uniform standards within those areas. Those standards shall have the force and effect of law, since the healing arts boards, as discussed more extensively below, are required to use the standards in dealing with substance-abusing licensees and the standards are required to govern matters such as when a licensee is temporarily removed from practice or subject to drug testing or work monitoring (paras. (2), (4), and (7), subd. (c), Sec. 315). Accordingly, we think the committee is an agency to which the APA applies.

As to the third criterion, two elements must be met for the uniform standards at issue to be a regulation: they must apply generally and they must implement, interpret, or make specific a law enforced or administered by the agency or that governs its procedures (*Tidewater*, supra, at p. 571; Sec. 11342.600, Gov. C.). Section 315 requires the committee to formulate uniform and specific standards in specified areas that each healing arts board within the department shall use when dealing with substance-abusing licensees, whether or not the board chooses to have a formal diversion program. The uniform standards will not be limited in application to particular instances or individuals but, instead, will apply generally to those licensees. Further, under this statutory scheme, the uniform standards will implement Section 315 and will be enforced and administered by, and will govern the procedures of, each healing arts board that is a member of the committee. Thus, the uniform standards are, in our view, a regulation under the APA.

Lastly, we turn to the fourth criterion, and whether the regulation is exempt from the APA. Certain policies and procedures are expressly exempted by statute from the requirement that they be adopted as regulations pursuant to the APA. In that regard, Section 11340.9 of the Government Code provides as follows:

> "11340.9. This chapter does not apply to any of the following:
>
> "(a) An agency in the judicial or legislative branch of the state government.
>
> "(b) A legal ruling of counsel issued by the Franchise Tax Board or State Board of Equalization.
>
> "(c) A form prescribed by a state agency or any instructions relating to the use of the form, but this provision is not a limitation on any requirement that a regulation be adopted pursuant to this chapter when one is needed to implement the law under which the form is issued.
>
> "(d) A regulation that relates only to the internal management of the state agency.
>
> "(e) A regulation that establishes criteria or guidelines to be used by the staff of an agency in performing an audit, investigation, examination, or inspection, settling a commercial dispute, negotiating a commercial

arrangement, or in the defense, prosecution, or settlement of a case, if disclosure of the criteria or guidelines would do any of the following:

"(1) Enable a law violator to avoid detection.

"(2) Facilitate disregard of requirements imposed by law.

"(3) Give clearly improper advantage to a person who is in an adverse position to the state.

"(f) A regulation that embodies the only legally tenable interpretation of a provision of law.

"(g) A regulation that establishes or fixes rates, prices, or tariffs.

"(h) A regulation that relates to the use of public works, including streets and highways, when the effect of the regulation is indicated to the public by means of signs or signals or when the regulation determines uniform standards and specifications for official traffic control devices pursuant to Section 21400 of the Vehicle Code.

"(i) A regulation that is directed to a specifically named person or to a group of persons and does not apply generally throughout the state."

None of the exemptions contained in the APA can be reasonably construed to apply to the committee or the uniform standards to be used by the healing arts boards. In addition, we are aware of no other applicable exemption.

Thus, because all four of the criteria are met, it is our opinion that the Substance Abuse Coordination Committee is required to adopt the uniform standards pursuant to the rulemaking procedures under the Administrative Procedure Act (Ch. 3.5 (commencing with Sec. 11340), Pt. 1, Div. 3, Title 2, Gov. C.).

Having reached this conclusion, we next turn to whether the healing arts boards are required to use the uniform standards if those standards are properly adopted. In addressing that question, we apply certain established rules of statutory construction. To ascertain the meaning of a statute, we begin with the language in which the statute is framed (*Leroy T. v. Workmen's Comp. Appeals Bd.* (1974) 12 Cal.3d 434, 438; *Visalia School Dist. v. Workers' Comp. Appeals Bd.* (1995) 40 Cal.App.4th 1211, 1220). Significance should be given to every word, and construction making some words surplusage is to be avoided (*Lambert Steel Co. v. Heller Financial, Inc.* (1993) 16 Cal.App.4th 1034, 1040). In addition, effect should be given to statutes according to the usual, ordinary import of the language employed in framing them (*DuBois v. Workers' Comp. Appeals Bd.* (1993) 5 Cal.4th 382, 388).

As set forth above, subdivision (c) of Section 315 provides that "the committee shall formulate uniform and specific standards in each of the following areas that each healing arts board <u>shall</u> <u>use</u> in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program" (emphasis added). Section 19 provides that "shall" is mandatory and "may" is permissive. The word "may" is ordinarily construed as permissive, whereas the word "shall" is ordinarily construed as mandatory (*Common Cause v. Board of Supervisors* (1989) 49 Cal.3d 432, 443).

Here, in Section 315, the Legislature uses the term "shall" rather than "may" in providing that each healing arts board "shall use" the specific and uniform standards adopted by the committee when dealing with substance-abusing licensees. The Legislature uses the term "shall use" as compared to "shall consider," "may consider," or "may use." The Legislature's use of the term "shall" indicates that the healing arts boards are required to use the standards adopted by the committee rather than being provided the discretion to do so. Moreover, as employed in this context, the word "use" implies that the healing arts boards must implement and apply those standards rather than merely considering them. Finally, the use of the term "uniform" suggests that the Legislature intended each board to apply the same standards. If the healing arts boards were not required to use the standards as adopted by the committee, the standards employed by these boards would vary rather than being "uniform."

Notwithstanding the plain meaning of Section 315, one could argue that the enactment of Section 315.4 indicates that the Legislature intended that implementation of the uniform standards by the boards be discretionary. Section 315.4, which was added by Senate Bill No. 1172 of the 2009-10 Regular Session (Ch. 517, Stats. 2010; hereafter S.B. 1172), provides that a healing arts board "may adopt regulations authorizing the board to order a licensee on probation or in a diversion program to cease practice for major violations and when the board orders a licensee to undergo a clinical diagnostic evaluation pursuant to the uniform and specific standards adopted and authorized under Section 315." Section 315.4 could be read to imply that a healing arts board is not required to implement those uniform standards because the board was given discretion to adopt the regulations that would allow that board to implement the standards, if necessary.

It is a maxim of statutory construction that a statute is to be construed so as to harmonize its various parts within the legislative purpose of the statute as a whole (*Wells v. Marina City Properties, Inc.* (1981) 29 Cal.3d 781, 788). As discussed above, we believe that the plain meaning of Section 315 requires the healing arts boards to implement the uniform standards adopted by the committee. Thus, whether Section 315.4 indicates, to the contrary, that the Legislature intended the boards to have discretion in that regard depends upon whether there is a rational basis for harmonizing the two statutes.

In harmonizing Sections 315 and 315.4, we note that S.B. 1172 did not make any changes to Section 315, such as changing the term "shall" to "may" in subdivision (c) of Section 315 or deleting any subdivisions of Section 315. S.B. 1172 did not diminish the scope of the authority provided to the committee to adopt the uniform standards. In fact, the analysis of the Senate Committee on Business, Professions and Economic Development for S.B. 1172, dated April 19, 2010 (hereafter committee analysis), describes the purpose of S.B. 1172 and the enactment of Section 315.4, as follows:

> "The Author points out that pursuant to SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008), the DCA was required to adopt uniform guidelines on sixteen specific standards that would apply to substance abusing health care licensees, regardless of whether a board has a diversion program. Although most of the adopted guidelines do not need additional statutes for

implementation, there are a couple of changes that must be statutorily adopted to fully implement these standards. This bill seeks to provide the statutory authority to allow boards to order a licensee to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or diversion program, if a major violation is committed and while undergoing clinical diagnostic evaluation." (Committee analysis, at p. 4.)

The committee analysis further provides that the purpose of S.B. 1172 was to grant specific authority to implement those standards and "provide for the full implementation of the Uniform Standards" (committee analysis, at p. 11). The committee analysis at no time implies that the Legislature intended the Section 315 uniform standards to be revised or repealed by S.B. 1172 or that, in enacting Section 315.4, the Legislature intended that the implementation of the uniform standards be subject to the discretion of each healing arts board.

Thus, in our view, Section 315.4 may be reasonably construed in a manner that harmonizes it with Section 315. Specifically, we think that the intent of the Legislature in enacting Section 315.4 was not to make the uniform standards discretionary but to "provide for the full implementation of the Uniform Standards" by providing the authority to adopt regulations where the Legislature believed that further statutory authority was needed. Accordingly, we think implementation by the various healing arts boards of the uniform standards adopted under Section 315 is mandatory.[4]

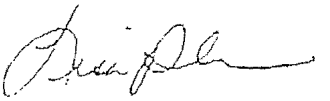
---

[4] Although Section 108 and Division 2 (commencing with Section 500) authorize the healing arts boards to set standards and adopt regulations (see, for example, Secs. 1224, 1614, 2018, 2531.95, 2615, 2715, 2854, 2930, 3025, 3510, and 3546), it is an axiom of statutory construction that a particular or specific provision takes precedence over a conflicting general provision (Sec. 1859, C.C.P.; *Agricultural Labor Relations Bd. v. Superior Court* (1976) 16 Cal.3d 392, 420, app. dism. *Kubo v. Agricultural Relations Bd.* (1976) 429 U.S. 802; see also Sec. 3534, Civ. C.). Thus, in our view, the specific requirement under Section 315 that the uniform standards be adopted supersedes any general provision authorizing the boards to set standards and adopt regulations.

Thus, it is our opinion that, if the uniform standards are properly adopted by the Substance Abuse Coordination Committee, the healing arts boards are required to implement them.

Very truly yours,

Diane F. Boyer-Vine
Legislative Counsel



By
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Uniform Standards Related to Substance-Abusing Licensees (Bus. & Prof. Code, §§ 315 - 315.4)

Executive Summary

Issues

You asked us to review Legislative Counsel's letter of October 27, 2011, which rendered certain opinions regarding the Substance Abuse Coordination Committee (SACC), which was created by Business and Professions Code section 315 to formulate uniform standards for use by the healing arts boards to deal with substance-abusing licensees. Legislative Counsel opined that:

(1) SACC was required to formally promulgate the uniform standards as regulations pursuant to the Administrative Procedures Act (APA), and

(2) the healing arts boards are required to use such standards under Business and Professions Code sections 315.

Summary of Responses

With respect to question (1), we see things differently from Legislative Counsel, in two respects.

First, we believe that SACC's adoption of uniform standards does not need to undergo the formal rule-making process under the APA. While other laws could potentially require the adoption of regulations when the standards are implemented by the boards (such as statutes governing particular boards or the APA's provisions applicable to disciplinary proceedings), we disagree that section 315 itself triggers the need to issue the uniform standards as regulations.

Second, even assuming the uniform standards must be adopted as regulations, we disagree with Legislative Counsel's apparent assumption that SACC would issue the regulations under

individual boards indicate that the boards would issue the regulations to implement the uniform standards.

As to question (2), we agree with Legislative Counsel that the healing arts boards must use the uniform standards under sections 315. A board cannot simply disregard a specific standard because it does not like the standard or because it believes that the standard is too cumbersome. However, some specific uniform standards themselves recognize a board's discretion whether to order a particular action in the first place. Thus, boards still retain authority to determine if they will undertake certain types of actions if permitted under a specific uniform standard.

Statutory Background

In 2008, SACC was legislatively established within the Department of Consumer Affairs to create uniform standards to be used by the healing arts boards when addressing licensees with substance abuse problems. (Bus. & Prof. Code, § 315, subd. (a); Stats. 2008, ch. 548 (SB 1441).) By January 1, 2010, SACC was required to "formulate uniform and specific standards" in 16 identified areas "that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program." (*Id.* at § 315, subd. (c).) These 16 standards include requirements for: clinical diagnostic evaluation of licensees; the temporary removal of the licensee from practice for clinical diagnostic evaluation and any treatment, and criteria before being permitted to return to practice on a full-time or part-time basis; aspects of drug testing; whether inpatient, outpatient, or other type of treatment is necessary; worksite monitoring requirements and standards; consequences for major and minor violations; and criteria for a licensee to return to practice and petition for reinstatement of a full and unrestricted license. (*Ibid.*) SACC meetings to create these standards are subject to Bagley-Keene Act open meeting requirements. (*Id.* at subd. (b).)

On March 3, 2009, SACC conducted its first public hearing, which included a discussion of an overview of the diversion programs, the importance of addressing substance abuse issues for health care professionals, and the impact of allowing health care professionals who are impaired to continue to practice. (Sen. Com. on Business, Professions, and Economic Development, Analysis of SB 1172 (2010-2011 Reg. Sess.), as amended April 12, 2010.) During this meeting, SACC members agreed to draft uniform guidelines for each of the standards, and during subsequent meetings, roundtable discussions were held on the draft uniform standards, including public comments. (*Ibid.*) In December 2009, the Department of Consumer Affairs adopted the uniform guidelines for each of the standards required by SB 1441. (*Ibid.*) These standards have subsequently been amended by SACC, and the current standards were issued in April of 2011.

According to the author of SB 1441 (Ridley-Thomas), the intent of the legislation was to protect the public by ensuring that, at a minimum, a set of best practices or standards were adopted by health-care-related boards to deal with practitioners with alcohol or drug problems. (Sen. Com. on Business and Professions, Analysis of SB 1441 (2008-2009 Reg. Sess.), as

standards established throughout the healing arts licensing boards under the Department of Consumer Affairs. (*Ibid.*) Specifically, the author explains:

> SB 1441 is not attempting to dictate to [the health-related boards] how to run their diversion programs, but instead sets parameters for these boards. The following is true to all of these boards' diversion programs: licensees suffer from alcohol or drug abuse problems, there is a potential threat to allowing licensees with substance abuse problems to continue to practice, actual harm is possible and, sadly, has happened. The failures of the Medical Board of California's (MBC) diversion program prove that there must be consistency when dealing with drug or alcohol issues of licensees.

(Assem. Com. on Business and Professions, Analysis of SB 1441 (2008-2009 Reg. Sess.), as amended June 16, 2008.)

In the view of its author, "[t]his bill allows the boards to continue a measure of self-governance; the standards for dealing with substance-abusing licensees determined by the commission set a floor, and boards are permitted to establish regulations above these levels." (*Ibid.*)

In 2010, additional legislation was enacted to further implement section 315. Specifically, it provided that the healing arts boards, as described in section 315 and with the exception of the Board of Registered Nursing, "may adopt regulations authorizing the board to order a licensee on probation or in a diversion program to cease practice for major violations and when the board orders a licensee to undergo a clinical diagnostic evaluation pursuant to the uniform and specific standards adopted and authorized under Section 315." (Bus. & Prof. Code, § 315.4, subd. (a); Stats. 2010, ch. 517 (SB 1172).) An order to cease practice does not require a formal hearing and does not constitute a disciplinary action. (*Id.* § 315.4 subds. (b), (c).)

According to the author of SB 1172 (Negrete McLoud), this subsequent statute was necessary "because current law does not give boards the authority to order a cease practice." (Sen. Com. on Business, Professions, and Economic Development, Analysis of SB 1172 (2010-2011 Reg. Sess.), as amended April 12, 2010.) The author explains:

> Although most of the adopted guidelines do not need additional statutes for implementation, there are a few changes that must be statutorily adopted to fully implement these standards. [¶] This bill seeks to provide the statutory authority to allow boards to order a licensee to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or diversion program, if a major violation is committed and while undergoing clinical diagnostic evaluation. [¶] The ability of a board to order a licensee to cease practice under these circumstances provides a delicate balance to the inherent confidentiality of diversion programs. The protection of the public remains the top priority of boards when dealing with substance abusing licensees.

(Senate Third Reading, Analysis of SB 1172 (2010-2011 Reg. Sess.), as amended June 22, 2010.)

Legal Analysis

1a. Section 315 should be construed as not requiring that the uniform standards be adopted as regulations.

Legislative Counsel opined that SACC must adopt the uniform standards as regulations under section 315, because (1) the standards meet the definition of regulations, (2) none of the express exemptions under Government Code section 11340.9 remove them from the APA rule-making process, and (3) section 315 contains no express language precluding application of the rulemaking provisions of the APA. (October 27, 2011 Letter, p. 5.) We have a different view on the threshold issue of whether the standards qualify as a regulation under section 315.

Under the APA, a regulation is defined as "every rule, regulation, order, or standard of general application or the amendment, supplement, or revision of any rule, regulation, order, or standard adopted by any state agency to implement, interpret, or make specific the law enforced or administered by it, or to govern its procedure." (Gov. Code, § 11342.600.) "No state agency shall issue, utilize, enforce, or attempt to enforce any guideline, criterion, bulletin, manual, instruction, order, standard of general application, or other rule, which is a regulation as defined in Section 11342.600, unless [it has been adopted in compliance with the APA]." (*Id.* § 11340.5, subd. (a).) This requirement cannot be superseded or modified by subsequent legislation, unless the statute does so expressly. (*Id.* § 11346, subd. (a).)

An agency standard subject to the APA has two identifying characteristics. First, the agency must intend its rule to apply generally, rather than in a specific case. Second, the rule must "implement, interpret, or make specific the law enforced or administered by [the agency], or . . . [illegible]" (*Morning Star Co. v. State Bd. of Equalization* (2006) 38

Cal.4th 324, 333, quoting *Tidewater Marine Western, Inc. et al. v. Bradshaw* (1996) 14 Cal.4th 557, 571.)

Whether a particular standard or rule is a regulation requiring APA compliance depends on the facts of each case, considering the rule in question, and the applicable statutory scheme. Generally speaking, courts tend to readily find the need for such compliance. We understand that certain healing arts boards have already adopted regulations incorporating the uniform standards. (See, e.g., Cal. Code Regs., tit. 16, § 4147 [Board of Occupational Therapy].) This approach is understandable in light of the usually broad requirement that agency rules be adopted as regulations and, as noted below, may be required by other laws when they are implemented by the boards. Here, however, the wording and intent of section 315 indicate the Legislature did not intend that the initial act of formulating and adopting the uniform standards is within the purview of the formal APA rule-making process.

"The fundamental rule of statutory construction is that the court should ascertain the intent of the Legislature so as to effectuate the purpose of the law." (*Bodell Const. Co. v. Trustees of California State University* (1998) 62 Cal.App.4th 1508, 1515.) In determining that intent, courts "first examine the words of the statute itself. Under the so-called 'plain meaning' rule, courts seek to give the words employed by the Legislature their usual and ordinary meaning. If the language of the statute is clear and unambiguous, there is no need for construction. However, the 'plain meaning' rule does not prohibit a court from determining whether the literal meaning of a statute comports with its purpose. If the terms of the statute provide no definitive answer, then courts may resort to extrinsic sources, including the ostensible objects to be achieved and the legislative history." (*Ibid.* [citations omitted].) Courts "must select the construction that comports most closely with the apparent intent of the Legislature, with a view to promoting rather than defeating the general purpose of the statute, and avoid an interpretation that would lead to absurd consequences." (*Ibid.* [citation omitted].) "The legislative purpose will not be sacrificed to a literal construction of any part of the statute." (*Ibid.*)

In *Paleski v. State Department of Health Services* (2006) 144 Cal.App.4th 713, the Court of Appeal applied these rules of statutory construction and found that the challenged agency criteria were not required to be adopted as regulations under the APA. (*Id.* at pp. 728-729.) In *Paleski*, plaintiff challenged an agency's criteria for the prescription of certain drugs because the department had not promulgated them in compliance with the APA. (*Ibid.*) The statute, however, expressly authorized the criteria to be effectuated by publishing them in a manual. (*Ibid.*) According to the court, the "necessary effect" of this language was that the Legislature did not intend for the broader notice procedure of the APA to apply when the agency issued the criteria. (*Ibid.*)

Similar reasoning should apply here. Under the plain meaning of section 315, SACC was legislatively established to create uniform standards to be used by the healing arts boards when addressing licensees with substance abuse problems. (Bus. & Prof. Code, § 315, subd. (a).) [illegible] was to protect the public and to ensure that minimum standards are

licensing boards under the Department of Consumer affairs. (Assem. Com. on Business and Professions, Analysis of SB 1441 (2008-2009 Reg. Sess.), as amended June 16, 2008.) In formulating these uniform standards, SACC was subject to the Bagley-Keene Act, which requires noticed public meetings. Many roundtable discussions were held on the draft uniform standards, including public vetting and public comments. In that way, the affected community learned about the standards and had the opportunity to comment. This is a prime requirement and purpose of the APA rule-making process (see Gov. Code, § 11343 *et seq.*), but it has already been fulfilled by the procedures set forth in section 315. To now require SACC to repeat that process by promulgating the standards as regulations would make little sense and be duplicative.

Nor does the process for the formulation of the standards set forth in section 315 comport with the other purposes and procedures of the APA. During the APA rule-making process, an agency must provide various reasons, justifications, analyses, and supporting evidence for the proposed regulation. (Gov. Code, § 11346.2.) Those provisions and other provisions of the APA are intended to address the proliferation, content, and effect of regulations proposed by administrative agencies. (*Id.* §§ 11340, 11340.1.) Here, the agency is not proposing to adopt the uniform standards. The Legislature has required that the standards adopted by SACC, be uniform, and be used by the boards. Given this statutory mandate that they be implemented, subjecting the uniform standards to substantive review under the APA again makes little sense.[1]

1b. The SACC would not be the rule-making entity, even if the uniform standards would have to be adopted as regulations.

Even assuming that APA compliance was required under section 315, it is doubtful that SACC would carry the responsibility to adopt regulations. The second component of a regulation requires that the rule must "implement, interpret, or make specific the law enforced or administered by [the agency], or . . . govern [the agency's] procedure." (*Morning Star Co.*, *supra*, 38 Cal.4th at p. 333.) Here, SACC was mandated to create the uniform standards to be used by separate boards; the SACC's creation of the uniform standards does not implement,

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[1] Even though the standards do not have to be promulgated as regulations by SACC under section 315, this does not mean that certain regulations would not arguably be required on the part of some or all of the boards under other statutory schemes, such as the laws applicable to a particular board or the APA's provisions on quasi-adjudicatory proceedings. This type of analysis would require a fact specific, case-by-case study of each board's practices and its regulatory scheme and may include consideration of: (1) whether a board's statutory authority requires the adoption of regulations related to actions against substance-abusing licensees, (2) whether current regulations conflict with the standards, and (3) whether in an administrative adjudicative setting, the standards are considered "penalties" and thus must be adopted as

interpret, or make any law more specific. (Bus. & Prof. Code, § 315, subds. (a), (c).) The only express statutory role of the SACC is to determine the uniform standards in the first place.[2]

The boards are then required to use and apply the standards and have much clearer authority to adopt regulations. "Each of the boards [within the Department of Consumer Affairs] exists as a separate unit, and has the function of setting standards, holding meetings, and setting dates thereof, preparing and conducting examinations, passing upon applicants, conducting investigations of violations of laws under its jurisdiction, issuing citations and hold hearings for the revocation of licenses, and the imposing of penalties following such hearings, in so far as these powers are given by statute to each respective board." (Bus. & Prof. Code, § 108.)

The legislative history for section 315 also supports this conclusion. According to its author, section 315 was adopted to protect the public by ensuring that, at a minimum, a set of best practices or standards *were adopted by health care related boards to deal with practitioners with alcohol or drug problems*. (Assem. Com. on Business and Professions, Analysis of SB 1441 (2008-2009 Reg. Sess.), as amended June 16, 2008, emphasis added.)[3] Practically speaking, it would be difficult for the SACC (or the Department of Consumer Affairs) to draft regulations applicable to all boards, given that they are unique and deal with different subject areas, unless such regulations were adopted wholesale, on a one-size-fits-all basis. As explained below, while the healing arts boards must use the standards, they only have to use the ones that apply to their procedures.

Thus, while section 315 does not require regulations to initially adopt the standards, the boards (and not SACC) would more reasonably be tasked with this responsibility.

2. **The healing arts boards must use the uniform standards to the extent that they apply.**

The original language of section 315 is clear that the standards must be used. (Bus. & Prof. Code, § 315, subd. (a) ["uniform standards that will be used by healing arts boards"], subd. (b) ["uniform standards . . . that each healing arts board shall use in dealing with substance-abusing licenses"].) Legislative Counsel was asked to opine on whether subsequent legislation (Bus. & Prof. Code, § 315.4) somehow made these uniform standards discretionary. We agree with

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[2] The SACC is a committee formed by various executive officers of healing arts boards and other public officials formed within the Department of Consumer Affairs. (Bus. & Prof. Code, § 315, subds. (a).)

[3] As discussed shortly, the legislative history for follow-up legislation similarly explains that its purpose was to provide statutory authority for some healing arts boards to issue regulations to implement certain of the uniform standards. (Sen. Com. on Business, Professions, and Economic Development, Analysis of SB 1172 (2010-2011 Reg. Sess.), as amended April 12,

Legislative Counsel's conclusion that section 315.4 did not make the uniform standards optional. (Oct. 27, 2011, Letter, p. 9.)

Section 315.4 was enacted two years after section 315, and provides that that the healing arts boards, as described in section 315 and with the exception of the Board of Registered Nursing, "may adopt regulations authorizing the board to order a licensee on probation or in a diversion program to cease practice for major violations and when the board orders a licensee to undergo a clinical diagnostic evaluation pursuant to the uniform and specific standards adopted and authorized under Section 315." (Bus. & Prof. Code, § 315.4, subd. (a); Stats. 2010, ch. 517, (SB 1172).) If a board adopts such regulations, there is nothing to indicate that use of uniform standards created under section 315 is optional. Such an interpretation would be contrary to the legislative intent. Section 314.5 was enacted for the limited purpose to give boards the authority to order a licensee to cease practice, as this was not provided for in section 315. (Sen. Com. on Business, Professions, and Economic Development, Analysis of SB 1172 (2010-2011 Reg. Sess.), as amended April 12, 2010.) By no means was the intent to transform the mandatory uniform standards of section 315 into optional suggestions. As the author explains:

> Although most of the adopted guidelines do not need additional statutes for implementation, there are a few changes that must be statutorily adopted to fully implement these standards. [¶] This bill seeks to provide the statutory authority to allow boards to order a licensee to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or diversion program, if a major violation is committed and while undergoing clinical diagnostic evaluation.

(Senate Third Reading, Analysis of SB 1172 (2010-2011 Reg. Sess.), as amended June 22, 2010.)

In addition, some specific uniform standards themselves recognize a board's discretion whether to order a particular action in the first place. (See e.g. Uniform Standard # 1 ["If a healing arts board orders a licensee . . . to undergo a clinical diagnosis evaluation, the following applies: ... "].) The standards must be applied, however, if a board undertakes a particular practice or orders an action covered by the standards. A determination regarding a board's specific application (or not) of certain uniform standards would have to be based on a fact specific, case-by-case review of each board and its regulatory scheme. However, once a board implements a procedure covered by the uniform standards, it cannot disregard the applicable uniform standard because it disagrees with the standard's substance.

Conclusion

For the reasons stated above, in our view, section 315 can be read to preclude the necessity to [illegible] the uniform standards are issued initially. And even if regulations were

believe that the healing arts boards must use the uniform standards where an agency undertakes an action covered by the standards.

Please feel free to contact me if you have any questions or would like to discuss the above.

:KAL

cc: Peter K. Southworth, Supervising Deputy Attorney General

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PHYSICIAN ASSISTANT COMMITTEE

IMPLEMENTATION OF UNIFORM STANDARDS AND REVISIONS TO THE DISCIPLINARY GUIDELINES

INTERESTED PARTIES WORKSHOP

MAY 15, 2012

Physician Assistant Committee
2005 Evergreen Street – Hearing Room #1150
Sacramento, CA 95815

AGENDA
10:00 A.M. – 12:00 P.M.

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

The Physician Assistant Committee invites you to an informational meeting to discuss implementation of the Uniform Standards for substance abusing licensees and revisions to the Disciplinary Guidelines. This will provide an opportunity for open discussion on the agenda items identified below. No action will be taken at the May 15, 2012 meeting.

1. Welcome and Introductions

2. Overview and Discussion of Implementation of the Uniform Standards for Substance Abusing Licensees and Revisions to the Disciplinary Guidelines

3. Next Steps

4. Adjournment

Notice: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to participate in the meeting may make a request by contacting Lynn Forsyth at (916) 561-8785 or email Lynn.Forsyth@mbc.ca.gov or send a written request to the Physician Assistant Committee, 2005 Evergreen Street, Suite 1100, Sacramento, California 95815. Providing your request at least five (5) business days before the meeting will help to ensure availability of the request.

Uniform Standards Regarding Substance-Abusing Healing Arts Licensees

Senate Bill 1441 (Ridley-Thomas)

Implementation by
Department of Consumer Affairs,
Substance Abuse Coordination Committee

Brian J. Stiger, Director

STATE OF CALIFORNIA

Substance Abuse Coordination Committee

Brian Stiger, Chair
Director, Department of Consumer Affairs

Elinore F. McCance-Katz, M.D., Ph. D.
CA Department of Alcohol & Drug Programs

Janelle Wedge
Acupuncture Board

Kim Madsen
California Board of Behavioral Sciences

Robert Puleo
Board of Chiropractic Examiners

Lori Hubble
Dental Hygiene Committee of California

Richard De Cuir
Dental Board of California

Linda Whitney
Medical Board of California

Heather Martin
California Board of Occupational Therapy

Mona Maggio
California State Board of Optometry

Teresa Bello-Jones
Board of Vocational Nursing and Psychiatric Technicians

Donald Krpan, D.O.
Osteopathic Medical Board of California

Francine Davies
Naturopathic Medicine Committee

Virginia Herold
California State Board of Pharmacy

Steve Hartzell
Physical Therapy Board of California

Elberta Portman
Physician Assistant Committee

Jim Rathlesberger
Board of Podiatric Medicine

Robert Kahane
Board of Psychology

Louise Bailey
Board of Registered Nursing

Stephanie Nunez
Respiratory Care Board of California

Annemarie Del Mugnaio
Speech-Language Pathology & Audiology & Hearing Aid Dispenser Board

Susan Geranen
Veterinary Medical Board

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#1 SENATE BILL 1441 REQUIREMENT

Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

#1 Uniform Standard

If a healing arts board orders a licensee who is either in a diversion program or whose license is on probation due to a substance abuse problem to undergo a clinical diagnosis evaluation, the following applies:

1. The clinical diagnostic evaluation shall be conducted by a licensed practitioner who:
    - holds a valid, unrestricted license, which includes scope of practice to conduct a clinical diagnostic evaluation;
    - has three (3) years experience in providing evaluations of health professionals with substance abuse disorders; and,
    - is approved by the board.
2. The clinical diagnostic evaluation shall be conducted in accordance with acceptable professional standards for conducting substance abuse clinical diagnostic evaluations.
3. The clinical diagnostic evaluation report shall:
    - set forth, in the evaluator's opinion, whether the licensee has a substance abuse problem;
    - set forth, in the evaluator's opinion, whether the licensee is a threat to himself/herself or others; and,
    - set forth, in the evaluator's opinion, recommendations for substance abuse treatment, practice restrictions, or other recommendations related to the licensee's rehabilitation and safe practice.

The evaluator shall not have a financial relationship, personal relationship, or business relationship with the licensee within the last five years. The evaluator shall provide an objective, unbiased, and independent evaluation.

If the evaluator determines during the evaluation process that a licensee is a threat to himself/herself or others, the evaluator shall notify the board within 24 hours of such a determination.

For all evaluations, a final written report shall be provided to the board no later than ten (10) days from the date the evaluator is assigned the matter unless the evaluator requests additional information to complete the evaluation, not to exceed 30 days.

#2 SENATE BILL 1441 REQUIREMENT

Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation described in subdivision (a) and any treatment recommended by the evaluator described in subdivision (a) and approved by the board, and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

#2 Uniform Standard

The following practice restrictions apply to each licensee who undergoes a clinical diagnostic evaluation:

1. The Board shall order the licensee to cease practice during the clinical diagnostic evaluation pending the results of the clinical diagnostic evaluation and review by the diversion program/board staff.

2. While awaiting the results of the clinical diagnostic evaluation required in Uniform Standard #1, the licensee shall be randomly drug tested at least two (2) times per week.

After reviewing the results of the clinical diagnostic evaluation, and the criteria below, a diversion or probation manager shall determine, whether or not the licensee is safe to return to either part-time or fulltime practice. However, no licensee shall be returned to practice until he or she has at least 30 days of negative drug tests.

- the license type;
- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use
- the scope and pattern of use;
- the treatment history;
- the licensee's medical history and current medical condition;
- the nature, duration and severity of substance abuse, and
- whether the licensee is a threat to himself/herself or the public.

#3 SENATE BILL 1441 REQUIREMENT

Specific requirements that govern the ability of the licensing board to communicate with the licensee's employer about the licensee's status or condition.

#3 Uniform Standard

If the licensee who is either in a board diversion program or whose license is on probation has an employer, the licensee shall provide to the board the names, physical addresses, mailing addresses, and telephone numbers of all employers and supervisors and shall give specific, written consent that the licensee authorizes the board and the employers and supervisors to communicate regarding the licensee's work status, performance, and monitoring.

#4 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of required testing, including, but not limited to, frequency of testing, randomnicity, method of notice to the licensee, number of hours between the provision of notice and the test, standards for specimen collectors, procedures used by specimen collectors, the permissible locations of testing, whether the collection process must be observed by the collector, backup testing requirements when the licensee is on vacation or otherwise unavailable for local testing, requirements for the laboratory that analyzes the specimens, and the required maximum timeframe from the test to the receipt of the result of the test.

#4 Uniform Standard

The following standards shall govern all aspects of testing required to determine abstention from alcohol and drugs for any person whose license is placed on probation or in a diversion program due to substance use:

TESTING FREQUENCY SCHEDULE

A board may order a licensee to drug test at any time. Additionally, each licensee shall be tested RANDOMLY in accordance with the schedule below:

Level	Segments of Probation/Diversion	Minimum Range of Number of Random Tests
I	Year 1	52-104 per year
II*	Year 2+	36-104 per year

*The minimum range of 36-104 tests identified in level II, is for the second year of probation or diversion, and each year thereafter, up to five (5) years. Thereafter, administration of one (1) time per month if there have been no positive drug tests in the previous five (5) consecutive years of probation or diversion.

Nothing precludes a board from increasing the number of random tests for any reason. Any board who finds or has suspicion that a licensee has committed a violation of a board's testing program or who has committed a Major Violation, as identified in Uniform Standard 10, may reestablish the testing cycle by placing that licensee at the beginning of level I, in addition to any other disciplinary action that may be pursued.

EXCEPTIONS TO TESTING FREQUENCY SCHEDULE

I. PREVIOUS TESTING/SOBRIETY
In cases where a board has evidence that a licensee has participated in a treatment or monitoring program requiring random testing, prior to being subject to testing by the board, the board may give consideration to that testing in altering the testing

frequency schedule so that it is equivalent to this standard.

II. VIOLATION(S) OUTSIDE OF EMPLOYMENT
An individual whose license is placed on probation for a single conviction or incident or two convictions or incidents, spanning greater than seven years from each other, where those violations did not occur at work or while on the licensee's way to work, where alcohol or drugs were a contributing factor, may bypass level I and participate in level II of the testing frequency schedule.

III. NOT EMPLOYED IN HEALTH CARE FIELD
A board may reduce testing frequency to a minimum of 12 times per year for any person who is not practicing OR working in any health care field. If a reduced testing frequency schedule is established for this reason, and if a licensee wants to return to practice or work in a health care field, the licensee shall notify and secure the approval of the licensee's board. Prior to returning to any health care employment, the licensee shall be subject to level I testing frequency for at least 60 days. At such time the person returns to employment (in a health care field), if the licensee has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

IV. TOLLING
A board may postpone all testing for any person whose probation or diversion is placed in a tolling status if the overall length of the probationary or diversion period is also tolled. A licensee shall notify the board upon the licensee's return to California and shall be subject to testing as provided in this standard. If the licensee returns to employment in a health care field, and has not previously met the level I frequency standard, the licensee shall be subject to completing a full year at level I of the testing frequency schedule, otherwise level II testing shall be in effect.

V. SUBSTANCE USE DISORDER NOT DIAGNOSED
In cases where no current substance use disorder diagnosis is made, a lesser period of monitoring and toxicology screening may be adopted by the board, but not to be less than 24 times per year.

OTHER DRUG STANDARDS

Drug testing may be required on any day, including weekends and holidays.

The scheduling of drug tests shall be done on a random basis, preferably by a computer program, so that a licensee can make no reasonable assumption of when he/she will be tested again. Boards should be prepared to report data to support back-to-back testing as well as, numerous different intervals of testing.

Licensees shall be required to make daily contact to determine if drug testing is required.

Licensees shall be drug tested on the date of notification as directed by the board.

Specimen collectors must either be certified by the Drug and Alcohol Testing Industry Association or have completed the training required to serve as a collector for the U.S. Department of Transportation.

Specimen collectors shall adhere to the current U.S. Department of Transportation Specimen Collection Guidelines.

Testing locations shall comply with the Urine Specimen Collection Guidelines published by the U.S. Department of Transportation, regardless of the type of test administered.

Collection of specimens shall be observed.

Prior to vacation or absence, alternative drug testing location(s) must be approved by the board.

Laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.

A collection site must submit a specimen to the laboratory within one (1) business day of receipt. A chain of custody shall be used on all specimens. The laboratory shall process results and provide legally defensible test results within seven (7) days of receipt of the specimen. The appropriate board will be notified of non-negative test results within one (1) business day and will be notified of negative test results within seven (7) business days.

A board may use other testing methods in place of, or to supplement biological fluid testing, if the alternate testing method is appropriate.

PETITIONS FOR REINSTATEMENT

Nothing herein shall limit a board's authority to reduce or eliminate the standards specified herein pursuant to a petition for reinstatement or reduction of penalty filed pursuant to Government Code section 11522 or statutes applicable to the board that contains different provisions for reinstatement or reduction of penalty.

OUTCOMES AND AMENDMENTS

For purposes of measuring outcomes and effectiveness, each board shall collect and report historical and post implementation data as follows:

Historical Data - Two Years Prior to Implementation of Standard

Each board should collect the following historical data (as available), for a period of two years, prior to implementation of this standard, for each person subject to testing for banned substances, who has 1) tested positive for a banned substance, 2) failed to

appear or call in, for testing on more than three occasions, 3) failed to pay testing costs, or 4) a person who has given a dilute or invalid specimen.

Post Implementation Data- Three Years

Each board should collect the following data annually, for a period of three years, for every probationer and diversion participant subject to testing for banned substances, following the implementation of this standard.

Data Collection

The data to be collected shall be reported to the Department of Consumer Affairs and the Legislature, upon request, and shall include, but may not be limited to:

Probationer/Diversion Participant Unique Identifier
License Type
Probation/Diversion Effective Date
General Range of Testing Frequency by/for Each Probationer/Diversion Participant
Dates Testing Requested
Dates Tested
Identify the Entity that Performed Each Test
Dates Tested Positive
Dates Contractor (if applicable) was informed of Positive Test
Dates Board was informed of Positive Test
Dates of Questionable Tests (e.g. dilute, high levels)
Date Contractor Notified Board of Questionable Test
Identify Substances Detected or Questionably Detected
Dates Failed to Appear
Date Contractor Notified Board of Failed to Appear
Dates Failed to Call In for Testing
Date Contractor Notified Board of Failed to Call In for Testing
Dates Failed to Pay for Testing
Date(s) Removed/Suspended from Practice (identify which)
Final Outcome and Effective Date (if applicable)

#5 SENATE BILL 1441 REQUIREMENT

Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

#5 Uniform Standard

If a board requires a licensee to participate in group support meetings, the following shall apply:

When determining the frequency of required group meeting attendance, the board shall give consideration to the following:

- the licensee's history;
- the documented length of sobriety/time that has elapsed since substance use;
- the recommendation of the clinical evaluator;
- the scope and pattern of use;
- the licensee's treatment history; and,
- the nature, duration, and severity of substance abuse.

Group Meeting Facilitator Qualifications and Requirements:

1. The meeting facilitator must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse, and shall be licensed or certified by the state or other nationally certified organizations.
2. The meeting facilitator must not have a financial relationship, personal relationship, or business relationship with the licensee within the last year.
3. The group meeting facilitator shall provide to the board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.
4. The facilitator shall report any unexcused absence within 24 hours.

#6 SENATE BILL 1441 REQUIREMENT

Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

#6 Uniform Standard

In determining whether inpatient, outpatient, or other type of treatment is necessary, the board shall consider the following criteria:

- recommendation of the clinical diagnostic evaluation pursuant to Uniform Standard #1;
- license type;
- licensee's history;
- documented length of sobriety/time that has elapsed since substance abuse;
- scope and pattern of substance use;
- licensee's treatment history;
- licensee's medical history and current medical condition;
- nature, duration, and severity of substance abuse, and
- threat to himself/herself or the public.

#7 SENATE BILL 1441 REQUIREMENT

Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

#7 Uniform Standard

A board may require the use of worksite monitors. If a board determines that a worksite monitor is necessary for a particular licensee, the worksite monitor shall meet the following requirements to be considered for approval by the board.

1. The worksite monitor shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the board; however, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.

2. The worksite monitor's license scope of practice shall include the scope of practice of the licensee that is being monitored, be another health care professional if no monitor with like practice is available, or, as approved by the board, be a person in a position of authority who is capable of monitoring the licensee at work.

3. If the worksite monitor is a licensed healthcare professional he or she shall have an active unrestricted license, with no disciplinary action within the last five (5) years.

4. The worksite monitor shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and/or contract and agrees to monitor the licensee as set forth by the board.

5. The worksite monitor must adhere to the following required methods of monitoring the licensee:

    a) Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the board, at least once per week.

    b) Interview other staff in the office regarding the licensee's behavior, if applicable.

    c) Review the licensee's work attendance.

Reporting by the worksite monitor to the board shall be as follows:

1. Any suspected substance abuse must be verbally reported to the board and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the board's normal business hours the verbal report must be within one (1) hour of the next business day. A written report shall be submitted to the board within 48 hours of occurrence.

2. The worksite monitor shall complete and submit a written report monthly or as directed by the board. The report shall include:

   - the licensee's name;
   - license number;
   - worksite monitor's name and signature;
   - worksite monitor's license number;
   - worksite location(s);
   - dates licensee had face-to-face contact with monitor;
   - staff interviewed, if applicable;
   - attendance report;
   - any change in behavior and/or personal habits;
   - any indicators that can lead to suspected substance abuse.

The licensee shall complete the required consent forms and sign an agreement with the worksite monitor and the board to allow the board to communicate with the worksite monitor.

#8 SENATE BILL 1441 REQUIREMENT

Procedures to be followed when a licensee tests positive for a banned substance.

#8 Uniform Standard

When a licensee tests positive for a banned substance:

1. The board shall order the licensee to cease practice;
2. The board shall contact the licensee and instruct the licensee to leave work; and
3. The board shall notify the licensee's employer, if any, and worksite monitor, if any, that the licensee may not work.

Thereafter, the board should determine whether the positive drug test is in fact evidence of prohibited use. If so, proceed to Standard #9. If not, the board shall immediately lift the cease practice order.

In determining whether the positive test is evidence of prohibited use, the board should, as applicable:

1. Consult the specimen collector and the laboratory;
2. Communicate with the licensee and/or any physician who is treating the licensee; and
3. Communicate with any treatment provider, including group facilitator/s.

#9 SENATE BILL 1441 REQUIREMENT

Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

#9 Uniform Standard

When a board confirms that a positive drug test is evidence of use of a prohibited substance, the licensee has committed a major violation, as defined in Uniform Standard #10 and the board shall impose the consequences set forth in Uniform Standard #10.

#10 SENATE BILL 1441 REQUIREMENT

Specific consequences for major and minor violations. In particular, the committee shall consider the use of a "deferred prosecution" stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency until or unless licensee commits a major violation, in which case it is revived and license is surrendered.

#10 Uniform Standard

Major Violations include, but are not limited to:

1. Failure to complete a board-ordered program;
2. Failure to undergo a required clinical diagnostic evaluation;
3. Multiple minor violations;
4. Treating patients while under the influence of drugs/alcohol;
5. Any drug/alcohol related act which would constitute a violation of the practice act or state/federal laws;
6. Failure to obtain biological testing for substance abuse;
7. Testing positive and confirmation for substance abuse pursuant to Uniform Standard #9;
8. Knowingly using, making, altering or possessing any object or product in such a way as to defraud a drug test designed to detect the presence of alcohol or a controlled substance.

Consequences for a major violation include, but are not limited to:

1. Licensee will be ordered to cease practice.
   a) the licensee must undergo a new clinical diagnostic evaluation, and
   b) the licensee must test negative for at least a month of continuous drug testing before being allowed to go back to work.
2. Termination of a contract/agreement.
3. Referral for disciplinary action, such as suspension, revocation, or other action as determined by the board.

Minor Violations include, but are not limited to:

1. Untimely receipt of required documentation;
2. Unexcused non-attendance at group meetings;
3. Failure to contact a monitor when required;
4. Any other violations that do not present an immediate threat to the violator or to the public.

Consequences for minor violations include, but are not limited to:

1. Removal from practice;
2. Practice limitations;
3. Required supervision;
4. Increased documentation;
5. Issuance of citation and fine or a warning notice;
6. Required re-evaluation/testing;
7. Other action as determined by the board.

#11 SENATE BILL 1441 REQUIREMENT

Criteria that a licensee must meet in order to petition for return to practice on a full time basis.

#11 Uniform Standard

"Petition" as used in this standard is an informal request as opposed to a "Petition for Modification" under the Administrative Procedure Act.

The licensee shall meet the following criteria before submitting a request (petition) to return to full time practice:

1. Demonstrated sustained compliance with current recovery program.

2. Demonstrated the ability to practice safely as evidenced by current work site reports, evaluations, and any other information relating to the licensee's substance abuse.

3. Negative drug screening reports for at least six (6) months, two (2) positive worksite monitor reports, and complete compliance with other terms and conditions of the program.

#12 SENATE BILL 1441 REQUIREMENT

Criteria that a licensee must meet in order to petition for reinstatement of a full and unrestricted license.

#12 Uniform Standard

"Petition for Reinstatement" as used in this standard is an informal request (petition) as opposed to a "Petition for Reinstatement" under the Administrative Procedure Act.

The licensee must meet the following criteria to request (petition) for a full and unrestricted license.

1. Demonstrated sustained compliance with the terms of the disciplinary order, if applicable.

2. Demonstrated successful completion of recovery program, if required.

3. Demonstrated a consistent and sustained participation in activities that promote and support their recovery including, but not limited to, ongoing support meetings, therapy, counseling, relapse prevention plan, and community activities.

4. Demonstrated that he or she is able to practice safely.

5. Continuous sobriety for three (3) to five (5) years.

#13 SENATE BILL 1441 REQUIREMENT

If a board uses a private-sector vendor that provides diversion services, (1) standards for immediate reporting by the vendor to the board of any and all noncompliance with process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors; (3) standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services; and (4) standards for a licensee's termination from the program and referral to enforcement.

#13 Uniform Standard

1. A vendor must report to the board any major violation, as defined in Uniform Standard #10, within one (1) business day. A vendor must report to the board any minor violation, as defined in Uniform Standard #10, within five (5) business days.

2. A vendor's approval process for providers or contractors that provide diversion services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors is as follows:

   (a) Specimen Collectors:

   (1) The provider or subcontractor shall possess all the materials, equipment, and technical expertise necessary in order to test every licensee for which he or she is responsible on any day of the week.

   (2) The provider or subcontractor shall be able to scientifically test for urine, blood, and hair specimens for the detection of alcohol, illegal, and controlled substances.

   (3) The provider or subcontractor must provide collection sites that are located in areas throughout California.

   (4) The provider or subcontractor must have an automated 24-hour toll-free telephone system and/or a secure on-line computer database that allows the participant to check in daily for drug testing.

   (5) The provider or subcontractor must have or be subcontracted with operating collection sites that are engaged in the business of collecting urine, blood, and hair follicle specimens for the testing of drugs and alcohol within the State of California.

   (6) The provider or subcontractor must have a secure, HIPAA compliant, website or computer system to allow staff access to drug test results and compliance reporting information that is available 24 hours a day.

(7) The provider or subcontractor shall employ or contract with toxicologists that are licensed physicians and have knowledge of substance abuse disorders and the appropriate medical training to interpret and evaluate laboratory drug test results, medical histories, and any other information relevant to biomedical information.

(8) A toxicology screen will not be considered negative if a positive result is obtained while practicing, even if the practitioner holds a valid prescription for the substance.

(9) Must undergo training as specified in Uniform Standard #4 (6).

(b) Group Meeting Facilitators:

A group meeting facilitator for any support group meeting:

(1) must have a minimum of three (3) years experience in the treatment and rehabilitation of substance abuse;

(2) must be licensed or certified by the state or other nationally certified organization;

(3) must not have a financial relationship, personal relationship, or business relationship with the licensee within the last year;

(4) shall report any unexcused absence within 24 hours to the board, and,

(5) shall provide to the board a signed document showing the licensee's name, the group name, the date and location of the meeting, the licensee's attendance, and the licensee's level of participation and progress.

(c) Work Site Monitors:

The worksite monitor must meet the following qualifications:

(1) Shall not have financial, personal, or familial relationship with the licensee, or other relationship that could reasonably be expected to compromise the ability of the monitor to render impartial and unbiased reports to the board. If it is impractical for anyone but the licensee's employer to serve as the worksite monitor, this requirement may be waived by the board; however, under no circumstances shall a licensee's worksite monitor be an employee of the licensee.

(2) The monitor's licensure scope of practice shall include the scope of practice of the licensee that is being monitored, be another health care professional if no

monitor with like practice is available, or, as approved by the board, be a person in a position of authority who is capable of monitoring the licensee at work.

(3) Shall have an active unrestricted license, with no disciplinary action within the last five (5) years.

(4) Shall sign an affirmation that he or she has reviewed the terms and conditions of the licensee's disciplinary order and/or contract and agrees to monitor the licensee as set forth by the board.

2. The worksite monitor must adhere to the following required methods of monitoring the licensee:

   a) Have face-to-face contact with the licensee in the work environment on a frequent basis as determined by the board, at least once per week.

   b) Interview other staff in the office regarding the licensee's behavior, if applicable.

   c) Review the licensee's work attendance.

3. Any suspected substance abuse must be verbally reported to the contractor, the board, and the licensee's employer within one (1) business day of occurrence. If occurrence is not during the board's normal business hours the verbal report must be within one (1) hour of the next business day. A written report shall be submitted to the board within 48 hours of occurrence.

4. The worksite monitor shall complete and submit a written report monthly or as directed by the board. The report shall include:

   - the licensee's name;
   - license number;
   - worksite monitor's name and signature;
   - worksite monitor's license number;
   - worksite location(s);
   - dates licensee had face-to-face contact with monitor;
   - staff interviewed, if applicable;
   - attendance report;
   - any change in behavior and/or personal habits;

- any indicators that can lead to suspected substance abuse.

(d) Treatment Providers

Treatment facility staff and services must have:

(1) Licensure and/or accreditation by appropriate regulatory agencies;

(2) Sufficient resources available to adequately evaluate the physical and mental needs of the client, provide for safe detoxification, and manage any medical emergency;

(3) Professional staff who are competent and experienced members of the clinical staff;

(4) Treatment planning involving a multidisciplinary approach and specific aftercare plans;

(5) Means to provide treatment/progress documentation to the provider.

(e) General Vendor Requirements

The vendor shall disapprove and discontinue the use of providers or contractors that fail to provide effective or timely diversion services as follows:

(1) The vendor is fully responsible for the acts and omissions of its subcontractors and of persons either directly or indirectly employed by any of them. No subcontract shall relieve the vendor of its responsibilities and obligations. All state policies, guidelines, and requirements apply to all subcontractors.

(2) If a subcontractor fails to provide effective or timely services as listed above, but not limited to any other subcontracted services, the vendor will terminate services of said contractor within 30 business days of notification of failure to provide adequate services.

(3) The vendor shall notify the appropriate board within five (5) business days of termination of said subcontractor.

#14 SENATE BILL 1441 REQUIREMENT

If a board uses a private-sector vendor that provides diversion services, the extent to which licensee participation in that program shall be kept confidential from the public.

#14 Uniform Standard

The board shall disclose the following information to the public for licensees who are participating in a board monitoring/diversion program regardless of whether the licensee is a self-referral or a board referral. However, the disclosure shall not contain information that the restrictions are a result of the licensee's participation in a diversion program.

- Licensee's name;
- Whether the licensee's practice is restricted, or the license is on inactive status;
- A detailed description of any restriction imposed.

#15 SENATE BILL 1441 REQUIREMENT

If a board uses a private-sector vendor that provides diversion services, a schedule for external independent audits of the vendor's performance in adhering to the standards adopted by the committee.

#15 Uniform Standard

1. If a board uses a private-sector vendor to provide monitoring services for its licensees, an external independent audit must be conducted at least once every three (3) years by a qualified, independent reviewer or review team from outside the department with no real or apparent conflict of interest with the vendor providing the monitoring services. In addition, the reviewer shall not be a part of or under the control of the board. The independent reviewer or review team must consist of individuals who are competent in the professional practice of internal auditing and assessment processes and qualified to perform audits of monitoring programs.

2. The audit must assess the vendor's performance in adhering to the uniform standards established by the board. The reviewer must provide a report of their findings to the board by June 30 of each three (3) year cycle. The report shall identify any material inadequacies, deficiencies, irregularities, or other non-compliance with the terms of the vendor's monitoring services that would interfere with the board's mandate of public protection.

3. The board and the department shall respond to the findings in the audit report.

#16 SENATE BILL 1441 Requirement

Measurable criteria and standards to determine whether each board's method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

#16 Uniform Standard

Each board shall report the following information on a yearly basis to the Department of Consumer Affairs and the Legislature as it relates to licensees with substance abuse problems who are either in a board probation and/or diversion program.

- Number of intakes into a diversion program
- Number of probationers whose conduct was related to a substance abuse problem
- Number of referrals for treatment programs
- Number of relapses (break in sobriety)
- Number of cease practice orders/license in-activations
- Number of suspensions
- Number terminated from program for noncompliance
- Number of successful completions based on uniform standards
- Number of major violations; nature of violation and action taken
- Number of licensees who successfully returned to practice
- Number of patients harmed while in diversion

The above information shall be further broken down for each licensing category, specific substance abuse problem (i.e. cocaine, alcohol, Demerol etc.), whether the licensee is in a diversion program and/or probation program.

f the data indicates that licensees in specific licensing categories or with specific substance abuse problems have either a higher or lower probability of success, that information shall be taken into account when determining the success of a program. It may also be used to determine the risk factor when a board is determining whether a license should be revoked or placed on probation.

The board shall use the following criteria to determine if its program protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

- At least 100 percent of licensees who either entered a diversion program or whose license was placed on probation as a result of a substance abuse problem successfully completed either the program or the probation, or had their license to practice revoked or surrendered on a timely basis based on noncompliance of those programs.

- At least 75 percent of licensees who successfully completed a diversion program or probation did not have any substantiated complaints related to substance abuse for at least five (5) years after completion.

AGENDA ITEM

17

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

STATE AND CONSUMER SERVICES AGENCY • GOVERNOR EDMUND G. BROWN JR.
BOARD OF VOCATIONAL NURSING & PSYCHIATRIC TECHNICIANS
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MANDATORY REPORTING REQUIREMENTS & PERFORMANCE ISSUES

CHILD ABUSE OR NEGLECT

Penal Code section 11166 requires certain individuals, including licensed vocational nurses (LVNs) and psychiatric technicians (PTs) and other health care practitioners, to report suspected instances of child abuse or neglect.

Specifically, Penal Code section 11166 requires that any mandatory reporter, **including a licensed vocational nurse or psychiatric technician,** who has knowledge of, or observes, a child in his or her professional capacity or within the scope of his or her employment whom he or she knows or reasonably suspects has been the victim of child abuse or neglect **to report the known or suspected instance of child abuse or neglect immediately, or as soon as practically possible, by telephone and to prepare and send a written report thereof within 36 hours of receiving the information concerning the incident.**

A report of suspected child abuse or neglect must be made to the police department or sheriff's department, not including a school district police or security department, county probation department (if it has been designated by the county to receive mandated reports), or the county welfare department.

"Child abuse or neglect" includes a physical injury inflicted by other than accidental means upon a child by another person, sexual abuse as defined in Penal Code section 11165.1, neglect as defined in Penal Code section 11165.2, willful cruelty or unjustifiable punishment as defined in Penal Code section 11165.3, and unlawful corporal punishment or injury as defined in Penal Code section 11165.4. It includes child abuse or neglect in out-of-home care.

Additionally, any mandatory reporter who has knowledge of or reasonably suspects that unjustifiable mental suffering has been inflicted upon a child or that his or her emotional well being is endangered in any other way may make a report.

Failure to comply with the requirements of Penal Code section 11166 is a misdemeanor, punishable by up to six months in a county jail, by a fine of one thousand dollars ($1,000), or by both the imprisonment and the fine. Failure to make a child abuse or neglect report as required constitutes unprofessional conduct within the meaning of Business and Professions Code sections 2878(a) and 4521(a) pursuant to Title 16, California Code of Regulations sections 2520.1 (vocational nurses) and 2577.2 (psychiatric technicians).

ELDER ABUSE AND DEPENDENT ADULT ABUSE

Section 15630 of the Welfare and Institutions Code requires LVNs and PTs to report any known or suspected instance of elder or dependent adult abuse.

Specifically, Welfare and Institutions Code section 15630 requires that any mandated reporter, who, in his or her professional capacity, or within the scope of his or her employment, has observed or has knowledge of an incident that reasonably appears to be physical abuse, abandonment, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, isolation, financial abuse, or neglect, or reasonably suspects that abuse shall report the known or suspected instance of abuse by telephone immediately or as soon as practically possible, and by written report sent within two working days, as follows:

(A) If the abuse has occurred in a long-term care facility, except a state mental health hospital or a state developmental center, the report shall be made to the local ombudsman or the local law enforcement agency.
(B) If the suspected or alleged abuse occurred in a state mental health hospital or a state developmental center, the report shall be made to designated investigators of the State Department of Mental Health or the State Department of Developmental Services or to the local law enforcement agency.
(C) If the abuse has occurred any place other than one described in subparagraph (A), the report shall be made to the adult protective services agency or the local law enforcement agency.

Failure to make an elder physical abuse or dependent adult physical abuse report as required constitutes unprofessional conduct within the meaning of Business and Professions Code sections 2878(a) and 4521(a), pursuant to Title 16, California Code of Regulations sections 2520.2, 2520.3, 2577.3 and 2577.4.

PERFORMANCE REQUIREMENT

Pursuant to Business and Professions Code (B&P) sections 2878(a) and 4521(a), LVNs and PTs must safeguard patient's/client's health and safety by actions which include but are not limited to reporting to the Board instances of unprofessional conduct by a licensee. The Board has adopted Title 16, California Code of Regulations sections 2518.6 and 2576.6, which increase safeguards to the health, safety, and welfare of California consumers by delineating standards that are expected of its licensees. Failure to report instances of such unprofessional conduct by an LVN or PT itself constitutes unprofessional conduct within the meaning of Business and Professions Code sections 2878(a) and 4521(a).

CONSCIENTIOUS INFECTION CONTROL

Pursuant to Business & Professions Code sections 2878(l) and 4521(n) the Board may revoke a license for the knowing failure to protect patients by failing to follow infection control guidelines of the Board, thereby risking transmission of blood-borne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee.

Licensees are expected to practice professionally including compliance with the guidelines and standards for universal infection control when caring for patients. The purpose of these statutes is to prevent the transmission of HIV, hepatitis B, and other blood-borne pathogens in health care settings. Knowing failure to comply with guidelines for universal precautions may result in disciplinary action against your license.

If you are unclear regarding how to prevent blood-borne pathogen transmission in your specific health care setting, consult with your facility's management, policies and procedures or infection control personnel.

STATE OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

BOARD OF REGISTERED NURSING
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Louise R. Bailey, MEd, RN, Executive Officer

Abuse Reporting Requirements

Website:
http://leginfo.ca.gov/calaw.html
Article 2 Report of Injuries
Article 2.5 Child Abuse and Neglect Reporting Act

http://leginfo.ca.gov/calaw.html
§ 15610.37 "Health Practitioner"

http://leginfo.ca.gov/calaw.html
Article 3 Mandatory and Nonmandatory Reports of Abuse §15630 Welfare and Institutions Code

This information is available in the published California Nursing Practice Act 2010 Edition. This book can be ordered from http://www.lexisnexis.com/bookstore

Registered nurses are among the health practitioners who must report known or observed instances of abuse to the appropriate authorities. This mandate applies to those situations that occur in the RN's professional capacity or within the scope of employment. Registered nurses must also be aware that failure to report as required is also considered unprofessional conduct and can result in disciplinary actions against the RN's license by the BRN.

The California Nursing Practice Act with Rules and Regulations and Related Statutes contains extracted text of abuse reporting statutes. Website: California Legislation Info, http://leginfo.ca.gov to research related statutes on abuse reporting.

Highlights from the Nursing Practice Act abuse reporting laws are noted below.

Article 2 Report of Injuries
Penal Code § 11160 Injuries required to be reported; method of reporting: any health practitioner in a health facility, clinic, physician's office, local or state public health department, or a clinic, or other type of health facility operated by a local or state public health department who, in his or her professional capacity or within the scope of his or her employment, provide medical services for a physical condition to a patient who he or she knows or reasonably suspects is a person described as follows shall immediately make a report to local law enforcement agency (1) report by telephone shall be made immediately or as soon as practically possible and a written report shall be prepared on the standard form developed in compliance with state agencies. The completed forms shall be sent to local law enforcement agency within two working days of receiving the information regarding the person.

Article 2.5 Child Abuse and Neglect Reporting Act
Penal Code §11165.2 "Neglect"; "Severe neglect"; "General neglect"
"Neglect" means the negligent treatment or the maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.

(a) "Severe neglect" means the negligent failure of a person having the care or custody of a child to protect the child from severe malnutrition or medically diagnosed nonorganic failure to thrive. "Severe neglect" also means those situations of neglect where any person having the care or custody of a child willfully causes

or permits the person or health of the child to be placed in a situation such that his or her person or health failure to provide adequate food, clothing, shelter, or medical care.

(b) "General neglect" means the negligent failure of a person having the care or custody of a child to provide adequate food, clothing, shelter, medical care, or supervision where no physical injury to the child has occurred.

For purpose of this chapter, a child receiving treatment by spiritual means as provided in Section 16509.1 of the Welfare and Institutions Code or not receiving specified medical treatment for religious reasons, shall not for that reason alone be considered a neglected child. An informed and appropriate medical decision made by parent or guardian after consultation with a physician or physicians who have examined the minor does not constitute neglect.

Elder Abuse and Dependent Adult Civil Protection Act
Welfare and Institutions Code §15610-15610.65 provides definitions for the following: abandonment, abuse of an elder or dependent adult, adult protective services, adult protective services agency, Bureau of Medi-Cal Fraud , care custodian, clients' rights advocate, dependent adult, developmentally disabled person, elder, financial abuse of dependent adult, goods and services necessary to avoid physical harm or mental suffering, and listings of health practitioner that includes registered nurses, investigation, isolation, long-term care facility, long-term care ombudsman, mental suffering, neglect, patients' rights advocate, physical abuse and reasonable suspicion.

§ 15610.37 "Health Practitioner" means a physician and surgeon, psychiatrist, psychologist, dentist, resident, intern, podiatrist, chiropractor, licensed nurse, dental hygienist, licensed clinical social worker or associate clinical social worker, marriage, family and child counselor, or any other person who is currently licensed under Division 2 (commencing with Section 500) of the Business and Professions Code, any emergency medical technician I or II, paramedic or person certified pursuant to Division 2.5 (commencing with Section 1797) of the Health and Safety Code, a psychological assistant registered pursuant to Section 2913 of Business and Professions Code, a marriage, family, and child counselor trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, or an unlicensed marriage, family, and child counselor intern registered under Section 4980.44 of the Business and Professions Code, state or county public health or social services employee who treats an elder or a dependent adult for any condition, or a coroner.

Article 3 Mandatory and Nonmandatory Reports of Abuse
§15630 Welfare and Institutions Code Duties of mandated reporter; Punishment for failure to report.
Any mandated reporter who, in his or her professional capacity, or within the scope of his or her employment , has observed or has knowledge of an incident that reasonably appears to be physical abuse as defined in 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or is told by an elder or dependent adult that he or she has experienced behavior, including an act or omission, constituting physical abuse, as defined in Section 15610.63 of the Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect, or reasonably suspects that abuse, shall report the known suspect instance of abuse by telephone immediately or as soon as practically possible, and by written report sent within two working days. Specific reporting requirements for long term care facilities, mental health, and clergy are contained in 15630 (A) long term care facilities (B) state mental hospital or state developmental center and
(2) (A) clergy member.

§15630 (3)(A) A mandated reporter, physician and surgeon, registered nurse, or a psychologist shall **not** be required to report as defined in Section 15610.63 Welfare an Institutions Code (i) the mandated reporter has been told by an elder or dependent adult that she/he has experienced behavior constituting physical abuse; (ii) the mandated reporter is not aware of any independent evidence that corroborates the statement that abuse has occurred; (iii) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of court-ordered conservatorship; (iv) in the exercise of clinical judgment, the physician and surgeon, the registered nurse, or the psychotherapist.

§15630 (4)(A) In a long-term care facility, a mandated reporter shall **not** be required to report as a suspected incident of abuse, as defined in Section 15610.07 where all of the following conditions exist: (i) the mandated

reporter is aware that there is a proper plan of care; (ii) the mandated reporter is aware that the plan of care is properly provided and executed; (iii) a physical, mental, or medical injury occurred as a result of care provided pursuant to (i) and (ii); (iv) the mandated reporter reasonably believes that the injury was not the result of abuse.

If the suspected abuse occurred in a long term care facility the report may be made to the long-term ombudsperson program. The local ombudsperson shall report any case of known suspected abuse to the State Department of Public Health and any case of known or suspected criminal activity to the Bureau of Medi-Cal Fraud and Elder Abuse.

If the suspected abuse occurred in a state mental health hospital or a state developmental center, the report may be made to the designated investigator of the State Department of Mental Health or the State Department of Developmental Services or to local law enforcement agency or to the local ombudsperson. If the abuse occurred in other than long-term care or mental health or developmental center the report may be made to the county adult protective services agency.

Failure to report, or impeding or inhibiting a report of, physical abuse defined in Section 15610.63 of Welfare and Institutions Code, abandonment, abduction, isolation, financial abuse, or neglect of an elder or dependent adult, in violation of this section, is a misdemeanor, punishable by not more than six months in county jail, by a fine not more one thousand dollars ($1000) or by both that fine and imprisonment. Any mandated reporter who willfully fails to report and the abuse results in death or great bodily harm, shall be punished by not more than one year in county jail, by a fine of not more than five thousand dollars ($5000), or by both that fines and imprisonment.

The Nursing Practice Act with Regulations and Related Statutes can be obtained from LexisNexis, www.lexisnexis.com , telephone number 800-833-9844. ISBN 978-1-4224-5990-4.

AGENDA ITEM

20

AGENDA ITEM # 20

Physician Assistant Committee

Mission Statement

The mission of the Physician Assistant Committee is to protect and serve consumers through licensing, education and objective enforcement of the Physician Assistant laws and regulations.

Vision Statement:

As a result of our efforts the health care needs of California consumers are met by Physician Assistants in a compassionate, competent, ethical and culturally-sensitive manner.

Values:

- **Accountability**: We are accountable to the people of California and each other as stakeholders. We operate transparently and encourage public participation in our decision-making whenever possible.
- **Efficiency**: We diligently identify the best ways to deliver high-quality services with the most efficient use of our resources.
- **Effectiveness**: We make informed decisions that make a difference and have a positive, measurable impact.
- **Integrity**: We are honest, fair and respectful in our treatment of everyone, which is demonstrated through our decision-making process.
- **Customer Service**: We acknowledge all stakeholders as our customers, listen to them, and take their needs into account.
- **Employees**: We are an employer of choice and strategically recruit, train, and retain employees. We value and recognize employee contributions and talent.
- **Unity**: We draw strength from our organizational diversity as well as California's ever-changing cultural and economic diversity.

Physician Assistant Committee

Goals:

GOAL 1 - Licensing
Protect consumers by licensing qualified applicants using a timely, accurate and cost effective process.

GOAL 2 - Enforcement
To protect consumers through an enforcement process that is timely, fair, and consistent with the applicable laws and regulations.

GOAL 3 – Education & Outreach
Provide education and outreach to consumers, healthcare providers, physician assistant training programs and applicants in an accurate accessible manner, including presentations to diverse, underserved populations.

GOAL 4 – Administrative Efficiency
Utilizing the latest management tools and technology, provide cost-effective, quality administrative services to consumers, applicants and licensees.

GOAL 5 – Legislative & Regulatory
Support legislation; pursue laws and regulations that would better meet the needs of consumers in an ever-changing health care environment.

GOAL 6 - Workforce
Address Physician Assistant workforce needs.

Physician Assistant Committee

Objectives:

GOAL 1 - Licensing
Protect consumers by licensing qualified applicants using a timely, accurate and cost effective process.

Objectives *(not prioritized)*:

- Streamline the regulatory language in regards to licensing schools.
- Improve the Committee's information technology system and support.
- Acquire and maintain adequate staff.
- Consider increasing the length of time between renewals.
- Review application, license, and renewal fees to ensure they are current.
- Develop and transition to an all-electronic processing method for licensing.

GOAL 2 - Enforcement
To protect consumers through an enforcement process that is timely, fair, and consistent with the applicable laws and regulations.

Objectives *(not prioritized)*:

- Identify and use expert witnesses who understand the legal requirements for enforcement.
- Create an enforcement process tree and post it on the Committee's web site.
- Clarify enforcement regulations and statutes.
- Post disciplinary guidelines conspicuously on the web site.
- Reduce the time required to conduct investigations.
- Add requirement for licensees to report any convictions that occur prior to renewal of their license.
- Establish a faster Interim Suspension Order process and use it consistently.
- Increase the number of investigators on staff.

Physician Assistant Committee

Objectives ***(continued)*:**

GOAL 3 – Education & Outreach
Provide education and outreach to consumers, healthcare providers, physician assistant training programs and applicants in an accurate accessible manner, including presentations to diverse, underserved populations.

Objectives ***(not prioritized)*:**

- Arrange for a Twitter account for the Committee executive officer.
- Explore the creation of a blog or other form of "chat" site for Physician's Assistants on the Committee's web site.
- Ensure the views of the profession are represented on national health care issues.
- Create a calendar on the web site that allows PAs and the public to post outreach events.
- Create a newsletter and post it on the Committee's web site.
- Schedule and conduct seminars to increase community/public awareness of the profession.
- Promote the PA career path in high schools and junior colleges.
- Send representatives to present at 4-5 PA schools each year.
- Use electronic venues, such as the Web, Twitter and Facebook to educate stakeholders about new laws.

GOAL 4 – Administrative Efficiency
Utilizing the latest management tools and technology, provide cost-effective, quality administrative services to consumers, applicants and licensees.

Objectives ***(not prioritized)*:**

- Explore setting up a VPN for the Committee.
- Increase the use of electronic, on-line communication to reduce the use of hard-copy.
- Provide electronic access to all electronic data.
- Provide internship opportunities for staff at the Committee.

Physician Assistant Committee

Objectives ***(continued)*:**

GOAL 5 – Legislative & Regulatory
Support legislation; pursue laws and regulations that would better meet the needs of consumers in an ever-changing health care environment.

Objectives ***(not prioritized)*:**

- Stay abreast of updated, changed, and newly enforced laws to make sure we stay compliant.
- Ensure that new legislation and regulations reflect the current needs of Physician Assistant practice.
- Keep regulations current.
- Develop and maintain relationships with legislators.
- Sponsor new legislation to speed up the enforcement process.
- Review the PA school accreditation process.
- Pursue mandatory reporting from hospitals and clinics of disciplinary actions taken against PAs.

GOAL 6 - Workforce
Address Physician Assistant workforce needs.

Objectives ***(not prioritized)*:**

- Collect workforce data every three years and post it on the Committee's web site.
- Inform and educate legislators and the public about the need for more Physician Assistant schools.
- Provide information about the PA career to health sectors of the military branches.