State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

Board Meeting

May 2, 2014

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2014 Legislation

Agenda Item 20

Consideration of Legislation/Regulations

MEDICAL BOARD OF CALIFORNIA - 2014 TRACKER LIST
April 23, 2014

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 186	Maienschein	Professions & Vocations: Military Spouses: Temporary Licenses	Sen. B&P	Support – 2-year Bill	6/24/13
AB 496	Gordon	Task Force: LGBTI Cultural Competency	Inactive File	Support – 2-year Bill	6/25/13
AB 809	Logue	Healing Arts: Telehealth	Sen. Health	Support – 2-year Bill	6/25/13
AB 916	Eggman	Healing Arts: False or Misleading Advertising	Sen. B&P	Support – 2-year Bill	Intro.
AB 1535	Bloom	Pharmacists: Naloxone Hydrochloride	Asm. Approps	Support in Concept Reco: Support	4/1/14
AB 1838	Bonilla	Accelerated Medical School Programs	Sen. B&P	Sponsor/Support	3/5/14
AB 1841	Mullin	Medical Assistants	Asm. B&P	Reco: Neutral	4/21/14
AB 1886	Eggman	Medical Board Internet Posting: 10-year Restriction	Asm. B&P	Sponsor/Support	4/22/14
AB 2139	Eggman	End-of-Life Care: Patient Notification	Asm. Health	Reco: Neutral	4/2/14
AB 2214	Fox	Emergency Room Physicians: CME	Asm. B&P	Reco: Neutral	4/21/14
AB 2232	Gray	UC: Medical Education	Asm. Approps	SPOT	
AB 2346	Gonzalez	NPs, CNMs, and PAs: Supervision	Asm. B&P	Reco: Neutral	
AB 2458	Bonilla	Medical Residency Training Program Grants	Asm. Approps	Reco: Support	4/10/14
SB 491	Hernandez	Nurse Practitioners	Held in Approps.	Oppose – 2-year Bill	8/14/13
SB 492	Hernandez	Optometrist Practice: Licensure	Asm. B&P	OUA – 2-year Bill	8/5/13
SB 500	Lieu	Medical Practice: Pain Management	Assembly	Support	1/9/14
SB 841	Cannella	UC: Medical Education	Sen. Approps	SPOT	3/27/14
SB 966	Lieu	Outpatient Settings: Surgical Clinics	Sen. Health	Reco: Support	4/21/14
SB 1083	Pavley	Physician Assistants:	Senate Floor	Reco: Neutral	

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

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		Disability Certifications			
SB 1116	Torres	Physicians & Surgeons: STLRP	Sen. Approps	Reco: Support	
SB 1258	DeSaulnier	Controlled Substances: Prescriptions: Reporting	Sen. Public Safety	Reco: Support in Concept	3/25/14
SB 1262	Correa	Medical Marijuana	Sen. Health	Reco: Oppose Unless Amended	4/21/14
SB 1466	Sen. B&P	Omnibus	Sen. B&P	Sponsor/Support MBC Provisions	

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

AB 1838 - BONILLA

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1838
Author: Bonilla
Bill Date: March 5, 2014, Amended
Subject: Accelerated Medical School Programs
Sponsor: Medical Board of California and University of California
Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

AB 1838 would allow graduates of accelerated and competency-based medical school programs to be eligible for licensure in California, if the program is accredited by the Liaison Committee on Medical Education (LCME) or the Committee on Accreditation of Canadian Medical Schools (CACMS).

BACKGROUND

The Medical Board of California (Board) raised the issue of accelerated three-year and competency-based medical school programs as a new issue in its Sunset Report. A nationwide physician shortage is projected to reach 90,000+ physicians by the year 2020. Nearly half of that shortage is projected for primary care doctors (family physicians, pediatricians, and family practitioners). The federal Affordable Care Act (ACA) contains provisions to relieve the projected shortage of primary care professionals. Combined with the Prevention and Public Health Fund and the American Recovery and Reinvestment Act, the ACA will provide for the training, development and placement of more than 16,000 primary care providers, including physicians, over the next five years. A significant deterrent to becoming a physician is the substantial cost of medical education. At an estimated cost of $80,000 per year, a medical student can easily accrue a debt of up to $400,000 upon graduation.

In an effort to reduce the nationwide shortage of primary care doctors, as well as lessen burdens on medical students, there is a movement toward an accelerated three-year curriculum. This curriculum would allow medical students to receive the same amount of education in a concentrated, modified year-round education schedule, by eliminating the existing summer breaks, which occur currently in the standard four-year program. Reducing or eliminating the summer breaks allows for an accelerated curriculum completion date.

One such example is the Texas Tech University Health Sciences Center School of Medicine that offers a Family Medicine Accelerated Track (F-MAT) curriculum that provides 10-12 medical students the opportunity to obtain a medical degree in 3 years with 149 contact weeks, as opposed to a traditional four-year program of 160 weeks. In addition, the F-MAT does not require the medical school student to pass USMLE Step 2CS prior to graduation,

unlike most Liaison Committee on Medical Education (LCME) accredited medical schools.

However, the F-MAT students will be required to pass USMLE Step 2CS during their first year of postgraduate training. Normally, LCME accredited medical school graduates are required to pass USMLE Step 2CS as a graduation requirement and must pass USMLE Step 3 during residency training. F-MAT graduates must also pass USMLE Step 3 during residency and successfully complete residency to be eligible for licensure. The F-MAT also has an incentive program where students are given a scholarship in their first year. It is estimated that approximately $50,000 can be saved by the student in an accelerated 3-year program. This is a substantial economic incentive to a potential medical student.

There are also some California Medical School Programs that are proposing or considering competency-based tracks for students that excel and can progress at a faster rate than the standard four-year program. Some accelerated programs will not meet the requirements of Business and Professions Code Sections 2089 – 2091.2, and legislative changes are needed in order to accommodate changes in medical education and to license graduates from the accelerated curriculum programs.

Specifically:

- Section 2089(a) provides "a medical curriculum extending over a period of at least four academic years, or 32 months of actual instruction . . . the total number of hours of all courses shall consist of a minimum of 4,000 hours. At least 80% of actual attendance shall be required."
- Section 2089.5(b) provides "instruction in the clinical courses shall total a minimum of 72 weeks in length."
- Section 2089.5(c) provides "instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length, with a minimum of eight weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine and four weeks in psychiatry."
- Section 2089.5(d) provides "of the instruction . . . 54 weeks shall be performed in a hospital that sponsors the instruction . . ."

ANALYSIS

AB 1838 would allow graduates of accelerated and competency-based medical school programs to be eligible for licensure in California, if the program is accredited by the LCME or the CACMS. This curriculum would allow medical students to receive the same medical education as that received in standard medical programs, but in a concentrated, modified year-round education schedule by eliminating the existing summer breaks, which occur currently in standard medical school programs. Providing this additional pathway for physicians that would like to practice in California will allow more physicians to be eligible for licensure, as

well as reduce debt for medical school students. This bill supports the Board's mission of promoting access to quality medical care.

FISCAL: None

SUPPORT: The Board (Co-Sponsor), University of California (Co-Sponsor), Association of California Healthcare Districts, and Kaiser Permanente

OPPOSITION: None on file

AMENDED IN ASSEMBLY MARCH 5, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1838

Introduced by Assembly Member Bonilla

February 18, 2014

An act to ~~amend Section 901 of~~ *add Section 2084.5 to* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1838, as amended, Bonilla. Healing arts: ~~exemption from licensure.~~ *medical school accreditation.*

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires each applicant for a physician's and surgeon's certificate to show by official transcript or other official evidence satisfactory to the Division of Licensing that he or she has successfully completed a specified medical curriculum that meets certain clinical instruction requirements extending over a period of at least 4 academic years, or 32 months of actual instruction, in a medical school, as specified.

This bill, notwithstanding any other law, would provide that a medical school or medical school program accredited by the Liaison Committee on Medical Education or the Committee on Accreditation of Canadian Medical Schools is deemed to meet the requirements described above.

~~Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law, until January 1, 2018, provides an exemption from the licensure requirement for a health care practitioner licensed or certified and in good standing in another state, district, or territory~~

~~of the United States, when certain requirements are satisfied and health care services are provided under specified circumstances, including that the health care services are provided to uninsured or underinsured persons at a sponsored event not exceeding 10 days.~~

~~This bill would increase the period during which a health care practitioner is exempt from licensure pursuant to these provisions from 10 days to 15 days.~~

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

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

1 *SECTION 1. Section 2084.5 is added to the Business and*
2 *Professions Code, to read:*
3 *2084.5. Notwithstanding any other law, a medical school or*
4 *medical school program accredited by the Liaison Committee on*
5 *Medical Education or the Committee on Accreditation of Canadian*
6 *Medical Schools shall be deemed to meet the requirements of*
7 *Sections 2089 and 2089.5.*
8 ~~SECTION 1. Section 901 of the Business and Professions Code~~
9 ~~is amended to read:~~
10 ~~901. (a) For purposes of this section, the following provisions~~
11 ~~apply:~~
12 ~~(1) "Board" means the applicable healing arts board, under this~~
13 ~~division or an initiative act referred to in this division, responsible~~
14 ~~for the licensure or regulation in this state of the respective health~~
15 ~~care practitioners.~~
16 ~~(2) "Health care practitioner" means any person who engages~~
17 ~~in acts that are subject to licensure or regulation under this division~~
18 ~~or under any initiative act referred to in this division.~~
19 ~~(3) "Sponsored event" means an event, not to exceed 15 calendar~~
20 ~~days, administered by either a sponsoring entity or a local~~
21 ~~government, or both, through which health care is provided to the~~
22 ~~public without compensation to the health care practitioner.~~
23 ~~(4) "Sponsoring entity" means a nonprofit organization~~
24 ~~organized pursuant to Section 501(c)(3) of the Internal Revenue~~
25 ~~Code or a community-based organization.~~
26 ~~(5) "Uninsured or underinsured person" means a person who~~
27 ~~does not have health care coverage, including private coverage or~~
28 ~~coverage through a program funded in whole or in part by a~~

~~governmental entity, or a person who has health care coverage, but the coverage is not adequate to obtain those health care services offered by the health care practitioner under this section.~~

~~(b) A health care practitioner licensed or certified in good standing in another state, district, or territory of the United States who offers or provides health care services for which he or she is licensed or certified is exempt from the requirement for licensure if all of the following requirements are met:~~

~~(1) Prior to providing those services, he or she does all of the following:~~

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

~~(B) Satisfies the following requirements:~~

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

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

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

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

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

~~(A) To uninsured or underinsured persons.~~

~~(B) On a short-term voluntary basis, not to exceed a 15-calendar-day period per sponsored event.~~

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

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

~~(c) The board may deny a health care practitioner authorization to practice without a license if the health care practitioner fails to comply with this section or for any act that would be grounds for denial of an application for licensure.~~

~~(d) A sponsoring entity seeking to provide, or arrange for the provision of, health care services under this section shall do both of the following:~~

~~(1) Register with each applicable board under this division for which an out-of-state health care practitioner is participating in the sponsored event by completing a registration form that shall include all of the following:~~

~~(A) The name of the sponsoring entity.~~

~~(B) The name of the principal individual or individuals who are the officers or organizational officials responsible for the operation of the sponsoring entity.~~

~~(C) The address, including street, city, ZIP Code, and county, of the sponsoring entity's principal office and each individual listed pursuant to subparagraph (B).~~

~~(D) The telephone number for the principal office of the sponsoring entity and each individual listed pursuant to subparagraph (B).~~

~~(E) Any additional information required by the board.~~

~~(2) Provide the information listed in paragraph (1) to the county health department of the county in which the health care services will be provided, along with any additional information that may be required by that department.~~

~~(e) The sponsoring entity shall notify the board and the county health department described in paragraph (2) of subdivision (d) in writing of any change to the information required under subdivision (d) within 30 calendar days of the change.~~

~~(f) Within 15 calendar days of the provision of health care services pursuant to this section, the sponsoring entity shall file a report with the board and the county health department of the~~

~~county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the health care practitioners who participated in providing that care.~~

~~(g) The sponsoring entity shall maintain a list of health care practitioners associated with the provision of health care services under this section. The sponsoring entity shall maintain a copy of each health care practitioner's current license or certification and shall require each health care practitioner to attest in writing that his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The sponsoring entity shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.~~

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

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

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

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

~~(3) A health care practitioner whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless~~

~~and until a subsequent request for authorization has been approved by the board. A health care practitioner who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of the applicable provisions of this division, and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.~~

~~(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.~~

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

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AB 1886 - EGGMAN

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1886
Author: Eggman
Bill Date: April 22, 2014, Amended
Subject: Medical Board Internet Posting: 10-Year Restriction
Sponsor: Medical Board of California (Board)
Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

Currently, public disciplinary information for licensed physicians can only be posted on the Board's website for 10 years. AB 1886 would allow the Board to post this public information on the Board's website for as long as it remains public, with the exception of current accusations, interim suspension orders, temporary restraining orders, and public letters of reprimand; these items would continue to only be posted on the Board's website for 10 years. In addition, if a licensee's hospital staff privileges are restored and the Board is notified, this information would only remain posted on the Board's website for 10 years from the restoration date.

BACKGROUND

The Board raised the 10-year posting restriction as a new issue in its 2012 Sunset Report. Business and Professions Code Section (BPC) 2027 was amended effective January 1, 2003 to require the Board to remove certain public disclosure information from its website. Specifically, the amendment stated:

"From January 1, 2003, the information described in paragraphs (1) (other than whether or not the licensee is in good standing), (2), (4), (5), (7), and (9) of subdivision (a) shall remain posted for a period of 10 years from the date the board obtains possession, custody, or control of the information, and after the end of that period shall be removed from being posted on the board's Internet Website. Information in the possession, custody, or control of the board prior to January 1, 2003, shall be posted for a period of 10 years from January 1, 2003."

The information contained in these subsections pertaining to a physician's license, that would require removal, include: any license or practice suspension/restriction; any enforcement actions (e.g. revocation, probation, public reprimand, etc.); any disciplinary action in California or any other state as described in BPC § 803.1; any current accusations; any malpractice judgment or arbitration award; any misdemeanor conviction that resulted in disciplinary action; and any information required pursuant to 803.1. The only items that would remain on a physician's profile on the Board's website after ten years would be a felony conviction and hospital disciplinary action that resulted in termination or revocation of a physician's hospital staff privileges (unless those privileges were reinstated and then the

information will only remain posted for 10 years from the date of restoration).

ANALYSIS

AB 1886 would allow the Board to post public information on its website for as long as the information is public, with the exception of current accusations, interim suspension orders, temporary restraining orders, and public letters of reprimand; these items would continue to only be posted on the Board's website for 10 years. In addition, if a licensee's hospital staff privileges are restored and the Board is notified, this information would only remain posted on the Board's website for 10 years from the restoration date.

The Board believes that this bill is needed to increase transparency and allow consumers to access public records. This bill does not change what information is available to the public, it simply allows consumers to more easily access information that is already public. Currently, a consumer can call or come to Board offices and request any public documents that have been removed from the Board's website due to the 10-year restriction. However, requiring consumers to call or physically come to the Board's office is burdensome to consumers. The Board believes that not posting these public documents can be misleading to consumers, as they may believe that the physician has no history of discipline, when in fact the public documents have only been removed from the Board's website. In addition, if a consumer were to look up a physician, if the record is removed the website says there are no public documents found. To increase transparency and accessibility, the Board feels it is very important, in the interest of consumer protection, to have all public information available for consumers on the Board's website. This bill will further the Board's mission of consumer protection.

FISCAL: None

SUPPORT: The Board (Sponsor), Center for Public Interest Law, and Consumers Union

OPPOSITION: Association of Northern California Oncologists; California Academy of Cosmetic Surgery; California Academy of Family Physicians; California Medical Association; California Radiological Society; Medical Oncology of Southern Ca, Inc.; Osteopathic Physicians and Surgeons of CA; and Union of American Physicians and Dentists

AMENDED IN ASSEMBLY APRIL 22, 2014

AMENDED IN ASSEMBLY APRIL 2, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1886

Introduced by Assembly Member Eggman

February 19, 2014

An act to amend Sections 2027 and 2233 of the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 1886, as amended, Eggman. Medical Board of California.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires the board to post certain information on the Internet *indefinitely* regarding licensed physicians and surgeons and requires specified information, including any malpractice judgements, arbitration awards, and settlement information, to be posted for a period of 10 years.

This bill would ~~remove the requirement that the specified information be posted on the Internet for a period of 10 years, thereby requiring that information to~~ *require specified information, including enforcement actions, disciplinary actions, malpractice judgments, arbitration awards, and certain misdemeanor convictions, to* be posted indefinitely *on the board's Internet Web site.*

Existing law authorizes the board, by stipulation or settlement with the affected physician and surgeon, to issue a public letter of reprimand after it has conducted an investigation or inspection as specified, rather than filing or prosecuting a formal accusation.

Existing law requires the board to disclose information regarding any enforcement actions taken against a licensee, including, among other things, public letters of reprimand issued, to an inquiring member of the public, as specified.

This bill would make a clarifying and conforming change regarding the disclosure of public letters of reprimand to an inquiring member of the public by deleting a conflicting provision that authorizes, rather than requires, the board to disclose those public letters of reprimand.

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

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

1 SECTION 1. Section 2027 of the Business and Professions
2 Code is amended to read:
3 2027. (a) The board shall post on the Internet the following
4 information in its possession, custody, or control regarding licensed
5 physicians and surgeons:
6 (1) With regard to the status of the license, whether or not the
7 licensee is in good standing, subject to a temporary restraining
8 order (TRO), subject to an interim suspension order (ISO), or
9 subject to any of the enforcement actions set forth in Section 803.1.
10 (2) With regard to prior discipline, whether or not the licensee
11 has been subject to discipline by the board or by the board of
12 another state or jurisdiction, as described in Section 803.1.
13 (3) Any felony convictions reported to the board after January
14 3, 1991.
15 (4) All current accusations filed by the Attorney General,
16 including those accusations that are on appeal. For purposes of
17 this paragraph, "current accusation" shall mean an accusation that
18 has not been dismissed, withdrawn, or settled, and has not been
19 finally decided upon by an administrative law judge and the
20 Medical Board of California unless an appeal of that decision is
21 pending.
22 (5) Any malpractice judgment or arbitration award reported to
23 the board after January 1, 1993.
24 (6) Any hospital disciplinary actions that resulted in the
25 termination or revocation of a licensee's hospital staff privileges
26 for a medical disciplinary cause or reason. The posting shall also
27 provide a link to any additional explanatory or exculpatory

information submitted electronically by the licensee pursuant to subdivision (f) of Section 805.

(7) Any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed.

(8) Appropriate disclaimers and explanatory statements to accompany the above information, including an explanation of what types of information are not disclosed. These disclaimers and statements shall be developed by the board and shall be adopted by regulation.

(9) Any information required to be disclosed pursuant to Section 803.1.

(10) Settlement information, which shall be posted as described in paragraph (2) of subdivision (b) of Section 803.1.

(b) Upon receipt of a certified copy of an expungement order granted pursuant to Section 1203.4 of the Penal Code from a licensee, the board shall, within six months of receipt of the expungement order, post notification of the expungement order and the date thereof on its Internet Web site.

~~(c) If~~

(c) (1) From January 1, 2003, the information described in paragraph (1) of subdivision (a) regarding whether a licensee is subject to a temporary restraining order (TRO) or an interim suspension order (ISO), the information in paragraph (4) of subdivision (a), and information on public letters of reprimand shall remain posted on the board's Internet Web site for a period of 10 years from the date the board obtains possession, custody, or control of the information, and after the end of that period the information shall be removed from the board's Internet Web site.

(2) Except as provided in paragraph (3), if a licensee's hospital staff privileges are restored and the licensee notifies the board of the restoration, the information pertaining to the termination or revocation of those privileges, as described in paragraph (6) of subdivision (a), shall remain posted on the board's Internet Web site for a period of 10 years from the restoration date of the privileges, and at the end of that period the information shall be removed from the board's Internet Web site.

(3) If a court finds, in a final judgment, that peer review resulting in a hospital disciplinary action was conducted in bad faith and the licensee notifies the board of that finding, the information

concerning that hospital disciplinary action posted pursuant to paragraph (6) of subdivision (a) shall be immediately removed from the board's Internet Web site. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(d) The board shall also post on the Internet a factsheet that explains and provides information on the reporting requirements under Section 805.

(e) The board shall provide links to other Web sites on the Internet that provide information on board certifications that meet the requirements of subdivision (b) of Section 651. The board may provide links to other Web sites on the Internet that provide information on health care service plans, health insurers, hospitals, or other facilities. The board may also provide links to any other sites that would provide information on the affiliations of licensed physicians and surgeons.

SEC. 2. Section 2233 of the Business and Professions Code is amended to read:

2233. The board may, by stipulation or settlement with the affected physician and surgeon, issue a public letter of reprimand after it has conducted an investigation or inspection as provided in this article, rather than filing or prosecuting a formal accusation. The public letter of reprimand may, at the discretion of the board, include a requirement for specified training or education. The affected physician and surgeon shall indicate agreement or nonagreement in writing within 30 days of formal notification by the board of its intention to issue the letter. The board, at its option, may extend the response time. Use of a public reprimand shall be limited to minor violations and shall be issued under guidelines established by regulations of the board.

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AB 1535 - BLOOM

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1535
Author:	Bloom
Bill Date:	April 1, 2014, Amended
Subject:	Pharmacists: Naloxone Hydrochloride
Sponsor:	Drug Policy Alliance California Pharmacists Association
Position:	Support in Concept

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow pharmacists to furnish naloxone hydrochloride in accordance with standardized procedures or protocols developed and approved by the Board of Pharmacy (BOP) and the Medical Board of California (Board), in consultation with the California Society of Addiction Medicine, the California Pharmacists Association, and other appropriate entities. This bill would specify that a pharmacist furnishing naloxone hydrochloride shall not permit the person to whom the drug is being furnished to waive the consultation required by the Board and the BOP. This bill would require a pharmacist to complete a training program on the use of opioid antagonists that consists of at least one hour of approved continuing education on the use of naloxone hydrochloride, before furnishing naloxone hydrochloride.

BACKGROUND

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

According to the fact sheet, public health experts agree that increasing access to naloxone is a key strategy in preventing drug overdose deaths. The American Medical Association, the White House Office of National Drug Control Policy, the Director of the National Institutes of Drug Abuse, among others, have called for providing naloxone to at-risk patients, first responders, and persons likely to witness a potentially fatal opioid overdose.

ANALYSIS

AB 635 (Ammiano, Chapter 707, Statutes of 2013) was signed into law by the Governor and was supported by the Board. This new law allows health care providers to prescribe, dispense, and issue standing orders for an opioid antagonist to persons at risk of overdose, or their family member, friend, or other person in a position to assist persons at risk,

without making them professionally, civilly or criminally liable, if acting within reasonable care. It also extends this same liability protection to individuals assisting in dispensing, distributing, or administering the opioid antagonist during an overdose. This law requires a person who is prescribed or possesses an opioid antagonist pursuant to a standing order to receive training provided by an opioid overdose prevention and treatment training program.

This bill would increase access to naloxone by allowing community pharmacists to provide naloxone to at-risk patients in accordance with standardized procedures or protocols developed and approved by BOP and the Board, and in consultation with the California Society of Addiction Medicine, the California Pharmacists Association, and other appropriate entities. The Board and the BOP must include the following when developing the standardized procedures or protocols:

- Procedures to ensure education of the person to whom the drug is furnished, including, but not limited to, opioid overdose prevention, recognition and response, safe administration of naloxone hydrochloride, potential side effect or adverse events, and the importance of seeking emergency medical care for the patient.
- Procedures for the notification of the patient's primary care provider with patient consent of any drugs or devices furnished to the patient, or entry of appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider, and with patient consent.

This bill would specify that a pharmacist furnishing naloxone hydrochloride shall not permit the person to whom the drug is being furnished to waive the consultation required by the Board and the BOP. This bill would require a pharmacist to complete a training program on the use of opioid antagonists that consists of at least one hour of approved continuing education on the use of naloxone hydrochloride, before furnishing naloxone hydrochloride. This bill would authorize BOP and the Board to ensure compliance with this bill by the Boards' respective licensees.

Drug overdoses are now the leading cause of injury death in the United States, surpassing motor vehicle crash deaths. The Board supported AB 635 because it encourages licensed healthcare providers to begin prescribing naloxone to patients on chronic opioid pain medications in order to help address the prescription drug overdose epidemic, furthering the Board's mission of consumer protection.

This bill was amended to address concerns raised by the California Medical Association and now would require the BOP and the Board to include specific procedures in the standardized procedures and protocols to ensure education of the person to whom the naloxone hydrochloride is furnished and would also require procedures to be included for the notification of the patient's primary care provider with patient consent. The amendments require that the patient receive consultation from the pharmacist, and would not allow it to be waived.

This bill will increase at-risk patient's access to naloxone, while at the same time ensuring standardized procedures and protocols are in place. This bill was amended to add requirements that will further consumer protection and address many of the concerns previously raised by the Board. Board staff is suggesting that the Board now take a support position on this bill.

FISCAL: Minimal and absorbable fiscal to develop standardized procedures and protocols with the BOP.

SUPPORT: California Pharmacists Association (Co-Sponsor); Drug Policy Alliance (Co-Sponsor); A New PATH; Addiction Research and Treatment Amity Foundation; Behind the Orange Curtain; Broadway Treatment Center; Broken No More; California Hospital Association; California Mental Health Directors Association; California Narcotic Officers' Association; California Opioid Maintenance Providers; California Retailers Association; California Society of Addiction Medicine; Center for Living and Learning; CRI-HELP, Inc.; Drug and Alcohol Addiction Awareness and Prevention Program; Families ACT!; Fred Brown Recovery Services; Gateways Hospital and Mental Health Center; Grief Recovery After a Substance Passing; Health Officers Association of California; Health Right 360; Hillview Mental Health Center; Hope of the Valley Rescue Mission; In Depth; Legal Services for Prisoners with Children; Los Angeles Centers for Alcohol and Drug Abuse; Los Angeles Community Action Network; Medical Board of California (in concept); Motion Picture Association of America; Not One More; Paving the Way Foundation; Phoenix House of Los Angeles; Primary Purpose Sober Living Homes; SHIELDS For Families; Soberspace; Solace; The County Alcohol and Drug Program Administrators Association of California; The Mary Magdalene Project; and three individuals

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 1, 2014

AMENDED IN ASSEMBLY MARCH 18, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1535

Introduced by Assembly Member Bloom
(Coauthor: Senator Pavley)

January 21, 2014

An act to add Section 4052.01 to the Business and Professions Code, relating to pharmacists.

LEGISLATIVE COUNSEL'S DIGEST

AB 1535, as amended, Bloom. Pharmacists: naloxone hydrochloride.

Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. Existing law, generally, authorizes a pharmacist to dispense or furnish drugs only pursuant to a valid prescription. Existing law authorizes a pharmacist to furnish emergency contraceptives and hormonal contraceptives pursuant to standardized procedures or protocols developed and approved by both the board and the Medical Board of California, as specified, or developed by the pharmacist and an authorized prescriber. Existing law also authorizes a pharmacist to furnish nicotine replacement products pursuant to standardized procedures or protocols developed and approved by both the board and the Medical Board of California, as specified. Existing law authorizes a licensed health care provider who is permitted to prescribe an opioid antagonist and is acting with reasonable care to prescribe and dispense or distribute an opioid antagonist for the treatment of an opioid overdose to a person at risk of an opioid-related overdose or a family member,

friend, or other person in a position to assist a person at risk of an opioid-related overdose.

This bill would authorize a pharmacist to furnish naloxone hydrochloride in accordance with standardized procedures or protocols ~~developed by the pharmacist and an authorized prescriber or~~ developed and approved by both the board and the Medical Board of California, *in consultation with specified entities*. The bill would require the board and the Medical Board of California, in developing those procedures and protocols, to ~~consider~~ *include* procedures *requiring the pharmacist to provide a consultation* to ensure *the* education of the person to whom the drug is furnished, as specified, *and notification of the patient's primary care provider of drugs or devices furnished to the patient, as specified. The bill would prohibit a pharmacist furnishing naloxone hydrochloride pursuant to its provisions from permitting the person to whom the drug is furnished to waive the consultation described above.* The bill would require a pharmacist to complete a training program on the use of opioid antagonists prior to performing this procedure. The bill would require each board to enforce these provisions with respect to its respective licensees.

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

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

1 SECTION 1. Section 4052.01 is added to the Business and
2 Professions Code, to read:
3 4052.01. (a) Notwithstanding any other provision of law, a
4 pharmacist may furnish naloxone hydrochloride in accordance
5 with ~~either of the following:~~
6 ~~(1) Standardized procedures or protocols developed by the~~
7 ~~pharmacist and an authorized prescriber who is acting within his~~
8 ~~or her scope of practice.~~
9 ~~(2) Standardized~~ *standardized* procedures or protocols developed
10 and approved by both the board and the Medical Board of
11 California, *in consultation with the California Society of Addiction*
12 *Medicine, the California Pharmacists Association, and other*
13 *appropriate entities*. In developing *those* standardized procedures
14 or ~~protocols pursuant to this paragraph,~~ *protocols,* the board and
15 the Medical Board of California shall ~~consider procedures~~ *include*
16 *the following:*

(1) Procedures to ensure education of the person to whom the drug is furnished, including, but not limited to, opioid overdose prevention, recognition, and response, safe administration of naloxone hydrochloride, potential side effects or adverse events, and the imperative to seek emergency medical care for the patient.

(2) Procedures to ensure the education of the person to whom the drug is furnished regarding the availability of drug treatment programs.

(3) Procedures for the notification of the patient's primary care provider with patient consent of any drugs or devices furnished to the patient, or entry of appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider, and with patient consent.

(b) A pharmacist furnishing naloxone hydrochloride pursuant to this section shall not permit the person to whom the drug is furnished to waive the consultation required by the board and the Medical Board of California.

~~(b)~~

(c) Prior to performing a procedure authorized under this section, a pharmacist shall complete a training program on the use of opioid antagonists that consists of at least one hour of approved continuing education on the use of naloxone hydrochloride.

~~(c)~~

(d) The board and the Medical Board of California are each authorized to ensure compliance with this section. Each board is specifically charged with enforcing this section with respect to its respective licensees. This section ~~shall~~ *does* not ~~be construed to~~ expand the authority of a pharmacist to prescribe any ~~other drug~~ *prescription medication.*

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AB 1841 - MULLIN

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1841
Author: Mullin
Bill Date: April 21, 2014, Amended
Subject: Medical Assistants
Sponsor: Planned Parenthood

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow medical assistants (MAs) to hand to patients properly labeled and pre-packaged prescription drugs, that have been ordered by a licensed physician, podiatrist, physician assistant (PA), nurse practitioner (NP), or a certified nurse-midwife (CNM). This bill would require the properly labeled and pre-packaged prescription drug to have the patient's name affixed to the package and for the physician, PA, NP, or CNM to verify that it is the correct medication and dosage for that specific patient, prior to the MA handing medication to a patient. This bill would exclude controlled substances.

ANALYSIS

Existing law allows MAs to administer medication (including narcotics) orally, topically or through injection; perform skin tests; apply bandages; remove casts and stitches; perform simple lab/screening tests; and perform technical supportive services upon training and authorization of a licensed physician. However, MAs are not allowed to physically hand over medication to patients. This bill would allow MAs to hand over properly labeled and pre-packaged medication to patients when ordered by a physician or clinician. This bill was also recently amended to require the medication to have the specific patient's name affixed to the package and for the physician or clinician to verify that it is the correct medication and dosage for that specific patient, before the MA can hand over the medication to the patient. These amendments address concerns raised by the California Nurses Association.

According to the author's office, current practice in community health centers relies on the use of MAs to support clinicians. Allowing MAs to hand over medication to patients will increase efficiency and streamline and improve operations, which will allow clinicians to focus on patient care and expand and improve access to care for patients.

Existing law already allows MAs to administer medication orally, topically, or through injection. Allowing MAs to hand over properly labeled, pre-packaged medication seems to be a minor increase in the MAs duties, and one that does not compromise consumer protection, as the physician would have to label the medication for the patient and package the medication. Board staff is suggesting that the Board take a Neutral position on this bill.

FISCAL: None

SUPPORT: Planned Parenthood (Sponsor)
California Family Health Council

OPPOSITION: Service Employees International Union

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 21, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1841

Introduced by Assembly Member Mullin
(Coauthor: Senator Hernandez)

February 18, 2014

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

LEGISLATIVE COUNSEL'S DIGEST

AB 1841, as amended, Mullin. Medical assistants.

Existing law, the Medical Practice Act, provides for the licensure and regulation of the practice of medicine by the Medical Board of California. The act authorizes a medical assistant to administer medication only by intradermal, subcutaneous, or intramuscular injections and to perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife. Existing law defines the term "technical supportive services" to mean 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, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife. Existing law, the Pharmacy Law, prohibits a prescriber, as defined, from dispensing drugs to patients in his or her office unless specified conditions are satisfied, and authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor who functions pursuant to a specified protocol or procedure to hand to a

patient of his or her supervising physician a properly labeled and prepackaged prescription drug.

This bill would specify that the "technical supportive services" a medical assistant may perform also includes handing to a patient a properly labeled and prepackaged prescription drug, other than a controlled substance, ordered by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife, *as specified.*

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

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

1 SECTION 1. Section 2069 of the Business and Professions
2 Code is amended to read:
3 2069. (a) (1) Notwithstanding any other law, a medical
4 assistant may administer medication only by intradermal,
5 subcutaneous, or intramuscular injections and perform skin tests
6 and additional technical supportive services upon the specific
7 authorization and supervision of a licensed physician and surgeon
8 or a licensed podiatrist. A medical assistant may also perform all
9 these tasks and services upon the specific authorization of a
10 physician assistant, a nurse practitioner, or a certified
11 nurse-midwife.
12 (2) The supervising physician and surgeon may, at his or her
13 discretion, in consultation with the nurse practitioner, certified
14 nurse-midwife, or physician assistant, provide written instructions
15 to be followed by a medical assistant in the performance of tasks
16 or supportive services. These written instructions may provide that
17 the supervisory function for the medical assistant for these tasks
18 or supportive services may be delegated to the nurse practitioner,
19 certified nurse-midwife, or physician assistant within the
20 standardized procedures or protocol, and that tasks may be
21 performed when the supervising physician and surgeon is not
22 onsite, if either of the following apply:
23 (A) The nurse practitioner or certified nurse-midwife is
24 functioning pursuant to standardized procedures, as defined by
25 Section 2725, or protocol. The standardized procedures or protocol,
26 including instructions for specific authorizations, shall be

1 developed and approved by the supervising physician and surgeon
2 and the nurse practitioner or certified nurse-midwife.
3 (B) The physician assistant is functioning pursuant to regulated
4 services defined in Section 3502, including instructions for specific
5 authorizations, and is approved to do so by the supervising
6 physician and surgeon.
7 (b) As used in this section and Sections 2070 and 2071, the
8 following definitions apply:
9 (1) "Medical assistant" means a person who may be unlicensed,
10 who performs basic administrative, clerical, and technical
11 supportive services in compliance with this section and Section
12 2070 for a licensed physician and surgeon or a licensed podiatrist,
13 or group thereof, for a medical or podiatry corporation, for a
14 physician assistant, a nurse practitioner, or a certified
15 nurse-midwife as provided in subdivision (a), or for a health care
16 service plan, who is at least 18 years of age, and who has had at
17 least the minimum amount of hours of appropriate training pursuant
18 to standards established by the board. The medical assistant shall
19 be issued a certificate by the training institution or instructor
20 indicating satisfactory completion of the required training. A copy
21 of the certificate shall be retained as a record by each employer of
22 the medical assistant.
23 (2) "Specific authorization" means a specific written order
24 prepared by the supervising physician and surgeon or the
25 supervising podiatrist, or the physician assistant, the nurse
26 practitioner, or the certified nurse-midwife as provided in
27 subdivision (a), authorizing the procedures to be performed on a
28 patient, which shall be placed in the patient's medical record, or
29 a standing order prepared by the supervising physician and surgeon
30 or the supervising podiatrist, or the physician assistant, the nurse
31 practitioner, or the certified nurse-midwife as provided in
32 subdivision (a), authorizing the procedures to be performed, the
33 duration of which shall be consistent with accepted medical
34 practice. A notation of the standing order shall be placed on the
35 patient's medical record.
36 (3) "Supervision" means the supervision of procedures
37 authorized by this section by the following practitioners, within
38 the scope of their respective practices, who shall be physically
39 present in the treatment facility during the performance of those
40 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) (A) "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).

(B) Notwithstanding any other law, "technical supportive services" includes handing to a patient a properly labeled and prepackaged prescription drug, excluding a controlled substance, ordered by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife ~~operative~~ in accordance with subdivision (a). *In every instance, prior to handing the medication to a patient, the properly labeled and prepackaged prescription drug shall have the patient's name affixed to the package and a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife shall verify that it is the correct medication and dosage for that specific patient.*

(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 authorized by Chapter 3 (commencing with Section 1200).

(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.

~~(6) A medical assistant to dispense dangerous drugs or devices to a patient, except as may be authorized by subdivision (a) or by the board in regulations adopted pursuant to Section 2071.~~

1 (d) A nurse practitioner, certified nurse-midwife, or physician
2 assistant shall not authorize a medical assistant to perform any
3 clinical laboratory test or examination for which the medical
4 assistant is not authorized by Chapter 3 (commencing with Section
5 1200). A violation of this subdivision constitutes unprofessional
6 conduct.
7 (e) Notwithstanding any other law, a medical assistant shall not
8 be employed for inpatient care in a licensed general acute care
9 hospital, as defined in subdivision (a) of Section 1250 of the Health
10 and Safety Code.

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AB 2139 - EGGMAN

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2139
Author: Eggman
Bill Date: April 2, 2014, Amended
Subject: End-of-Life Care: Patient Notification
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a health care provider that makes a diagnosis that a patient has a terminal illness, to notify the patient, or when applicable, the patient's agent, of the patient's right to comprehensive information and counseling regarding legal end-of-life options pursuant to existing law.

This bill would define an agent as an individual designated in a power of attorney for health care to make a health care decision for the patient who has been diagnosed with a terminal illness. This bill would define terminal illness as a medical condition resulting in a prognosis of a life expectancy of one year or less, if the disease follows it normal course.

ANALYSIS

Existing law, Business and Professions Code Section 442.5 requires that a health care provider provide a patient diagnosed with a terminal illness, upon request of the patient, with comprehensive information or counseling regarding their end-of-life options, or make other arrangements to accommodate the patient's request. The information required to be provided in law includes information about prognosis, availability of hospice and palliative care, the right to refuse or withdraw from life-sustaining treatment, and the right to provide written health care instructions or appoint a decision maker.

According to the author's office, a recent report from the California Health Care Foundation (CHCF) found that Californians frequently do not receive the care they would prefer at the end of life. According to the CHCF Report, 80% of Californians say they definitely, or probably would, like to talk with a doctor about end-of-life care, yet less than 1 in 10 have had this conversation. Existing law only requires health care providers to give patients this information on end-of-life care if the patient requests this information. According to the author's office, this bill would ensure that all California patients diagnosed with a terminal illness are notified of their right to receive comprehensive information or counseling regarding their end-of-life options.

Existing law already requires health care providers to provide comprehensive information and counseling regarding end-of-life options if the patient requests this information. Requiring a health care provider to notify a patient or the patient's agent of the

patient's right to request this information seems reasonable, as the patient should know that these resources are available. Board staff is suggesting that the Board take a Neutral position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 2, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 2139

Introduced by Assembly Member Eggman

February 20, 2014

An act to ~~add Section 442.4 to~~ *amend Sections 442, 442.5, and 442.7 of* the Health and Safety Code, relating to terminal illness.

LEGISLATIVE COUNSEL'S DIGEST

AB 2139, as amended, Eggman. End-of-life care: patient notification.

Under existing law, the State Department of Public Health licenses and regulates health facilities, including hospice facilities, and the provision of hospice services. Existing law establishes the Medical Practice Act, which provides for the regulation and licensure of physicians and surgeons by the Medical Board of California. *Existing law authorizes an adult to give an individual, known as an agent, authority to make health care decisions for that individual in the event of his or her incapacity pursuant to a power of attorney for health care.*

When a health care provider, as defined, makes a diagnosis that a patient has a terminal illness, existing law requires the health care provider to provide the patient, upon the patient's request, with comprehensive information and counseling regarding legal end-of-life options, as specified, and provide for the referral or transfer of a patient, as provided, if the patient's health care provider does not wish to comply with the patient's request for information on end-of-life options.

~~This~~ *This bill would apply these provisions to an agent under a power of attorney for health care for a patient with a terminal illness diagnosis. The* bill would *additionally* require ~~a~~ *the* health care provider~~, as defined,~~ to notify the patient *or, when applicable, the agent*, when the health

care provider makes a diagnosis that a patient has a terminal illness, of the patient's right to comprehensive information and counseling regarding legal end-of-life care options. *The bill would define the term "terminal illness" for these purposes.*

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

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

1 *SECTION 1. Section 442 of the Health and Safety Code is*
2 *amended to read:*
3 442. For the purposes of this part, the following definitions
4 shall apply:
5 (a) "Actively dying" means the phase of terminal illness when
6 death is imminent.
7 *(b) "Agent" means an individual designated in a power of*
8 *attorney for health care, as provided in Article 1 (commencing*
9 *with Section 4670) and Article 2 (commencing with Section 4680)*
10 *of Chapter 1 of Part 2 of Division 4.7 of the Probate Code, to make*
11 *a health care decision for the patient who has been diagnosed with*
12 *a terminal illness, regardless of whether the person is known as*
13 *an agent or attorney in fact, or by some other term.*
14 ~~(b)~~
15 *(c)* "Disease-targeted treatment" means treatment directed at
16 the underlying disease or condition that is intended to alter its
17 natural history or progression, irrespective of whether or not a cure
18 is a possibility.
19 ~~(c)~~
20 *(d)* "Health care provider" means an attending physician and
21 surgeon. It also means a nurse practitioner or physician assistant
22 practicing in accordance with standardized procedures or protocols
23 developed and approved by the supervising physician and surgeon
24 and the nurse practitioner or physician assistant.
25 ~~(d)~~
26 *(e)* "Hospice" means a specialized form of interdisciplinary
27 health care that is designed to provide palliative care, alleviate the
28 physical, emotional, social, and spiritual discomforts of an
29 individual who is experiencing the last phases of life due to the
30 existence of a terminal disease, and provide supportive care to the
31 primary caregiver and the family of the hospice patient, and that

meets all of the criteria specified in subdivision (b) of Section 1746.

~~(e)~~

(f) "Palliative care" means medical treatment, interdisciplinary care, or consultation provided to a patient or family members, or both, that has as its primary purpose the prevention of, or relief from, suffering and the enhancement of the quality of life, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life as described in subdivision (b) of Section 1339.31. In some cases, disease-targeted treatment may be used in palliative care.

~~(f)~~

(g) "Refusal or withdrawal of life-sustaining treatment" means forgoing treatment or medical procedures that replace or support an essential bodily function, including, but not limited to, cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and any other treatment or discontinuing any or all of those treatments after they have been used for a reasonable time.

(h) "Terminal illness" means a medical condition resulting in a prognosis of a life expectancy of one year or less, if the disease follows its normal course.

SEC. 2. Section 442.5 of the Health and Safety Code is amended to read:

442.5. When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall *notify the patient of his or her right to, or when applicable, the agent of the patient's right to, comprehensive information and counseling regarding legal end-of-life options and*, upon the ~~patient's~~ *patient or agent's* request, provide the patient *or agent* with comprehensive information and counseling regarding legal end-of-life care options pursuant to this section. When a terminally ill patient is in a health facility, as defined in Section 1250, the health care provider, or medical director of the health facility if the patient's health care provider is not available, may refer the patient *or agent* to a hospice provider or private or public agencies and community-based organizations that specialize in end-of-life care case management and consultation to receive comprehensive information and counseling regarding legal end-of-life care options.

(a) If the patient *or agent* indicates a desire to receive the information and counseling, the comprehensive information shall include, but not be limited to, the following:

(1) Hospice care at home or in a health care setting.

(2) A prognosis with and without the continuation of disease-targeted treatment.

(3) The patient's right to refusal of or withdrawal from life-sustaining treatment.

(4) The patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care.

(5) The patient's right to comprehensive pain and symptom management at the end of life, including, but not limited to, adequate pain medication, treatment of nausea, palliative chemotherapy, relief of shortness of breath and fatigue, and other clinical treatments useful when a patient is actively dying.

(6) ~~The~~ *If the patient has not appointed an agent under a power of attorney for health care, the* patient's right to give individual health care instruction pursuant to Section 4670 of the Probate Code, which provides the means by which a patient may provide written health care instruction, such as an advance health care directive, and the patient's right to appoint a legally recognized health care decisionmaker.

(b) The information described in subdivision (a) may, but is not required to, be in writing. Health care providers may utilize information from organizations specializing in end-of-life care that provide information on factsheets and Internet Web sites to convey the information described in subdivision (a).

(c) Counseling may include, but is not limited to, discussions about the outcomes for the patient and his or her family, based on the interest of the patient. Information and counseling, as described in subdivision (a), may occur over a series of meetings with the health care provider or others who may be providing the information and counseling based on the patient's needs.

(d) The information and counseling sessions may include a discussion of treatment options in a manner that the patient and his or her family, *or, when applicable, the agent,* can easily understand. If the patient *or agent* requests information on the costs of treatment options, including the availability of insurance and eligibility of the patient for coverage, the patient *or agent* shall be referred to the appropriate entity for that information.

SEC. 3. Section 442.7 of the Health and Safety Code is amended to read:

442.7. If a health care provider does not wish to comply with his or her patient's request *or, when applicable, the agent's request* for information on end-of-life options, the health care provider shall do both of the following:

(a) Refer or transfer a patient to another health care provider that shall provide the requested information.

(b) Provide the patient *or agent* with information on procedures to transfer to another health care provider that shall provide the requested information.

~~SECTION 1. Section 442.4 is added to the Health and Safety Code, to read:~~

~~442.4. When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall notify the patient of his or her right to comprehensive information and counseling regarding legal end-of-life options pursuant to Section 442.5.~~

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AB 2214 - FOX

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2214
Author: Fox
Bill Date: April 21, 2014, Amended
Subject: Continuing Medical Education: Geriatric Care
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Board, when determining continuing education requirements, to consider including a course in geriatric care for emergency room physicians.

ANALYSIS

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

Existing CME courses approved by the Board's Licensing Program include:

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

CME courses approved by the Board's Licensing Program for CME include programs that are approved by the California Medical Association and the American Medical Association and programs that qualify for prescribed credit from the American Academy of Family Physicians.

This bill would require the Board, when determining continuing education requirements, to consider including a course in geriatric care for emergency room physicians. Although the Board has historically opposed mandated CME, this bill would not mandate particular CME for physicians. This bill would only require the Board to consider a course on

geriatric care for emergency room physicians. The Board does not track employment information for physicians, so the Board would not know which physicians are emergency room physicians. However, if the Board decides that it is important to get out information to physicians on this particular type of CME to encourage attendance in these CME courses, it could include an article in its Newsletter or put information out on the Board's website. Board staff suggests that the Board take a Neutral position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 21, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 2214

Introduced by Assembly Member Fox

February 20, 2014

An act to amend Section 2191 of the Business and Professions Code, relating to physicians *and surgeons*.

LEGISLATIVE COUNSEL'S DIGEST

AB 2214, as amended, Fox. Emergency room ~~physicians:~~ *physicians and surgeons:* continuing medical education: geriatric care.

Existing law, *the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law* requires the Division of Licensing of the Medical Board of California to establish continuing education requirements for physicians and surgeons.

This bill~~, the Dolores H. Fox Act,~~ would require the division, in determining continuing education requirements, to ~~include~~ *consider including* a course in geriatric care for emergency room physicians *and surgeons*.

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

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

1 SECTION 1. This act shall be known and may be cited as the
2 Dolores H. Fox Act.
3 SEC. 2. Section 2191 of the Business and Professions Code is
4 amended to read:

2191. (a) In determining its continuing education requirements, the Division of Licensing shall consider including a course in human sexuality as defined in Section 2090 and nutrition to be taken by those licensees whose practices may require knowledge in those areas.

(b) The division shall consider including a course in child abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected children.

(c) The division shall consider including a course in acupuncture to be taken by those licensees whose practices may require knowledge in the area of acupuncture and whose education has not included instruction in acupuncture.

(d) The division shall encourage every physician and surgeon to take nutrition as part of his or her continuing education, particularly a physician and surgeon involved in primary care.

(e) The division shall consider including a course in elder abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected persons 65 years of age and older.

(f) In determining its continuing education requirements, the division shall consider including a course in the early detection and treatment of substance abusing pregnant women to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these women.

(g) In determining its continuing education requirements, the division shall consider including a course in the special care needs of drug addicted infants to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these infants.

(h) In determining its continuing education requirements, the division shall consider including a course providing training and guidelines on how to routinely screen for signs exhibited by abused women, particularly for physicians and surgeons in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. In the event the division establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(i) In determining its continuing education requirements, the division shall consider including a course in the special care needs of individuals and their families facing end-of-life issues, including, but not limited to, all of the following:

(1) Pain and symptom management.

(2) The psycho-social dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(j) In determining its ~~continuation~~ *continuing* education requirements, the division shall give its highest priority to considering a course on pain management.

(k) In determining its continuing education requirements, the division shall ~~include~~ *consider including* a course in geriatric care for emergency room physicians *and surgeons*.

O

AB 2346 - GONZALEZ

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2346
Author: Gonzalez
Bill Date: February 21, 2014, Introduced
Subject: Physician Supervision Ratios: Mid-Level Practitioners
Sponsor: California Medical Association (CMA)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would increase the ratios of physician supervision from 1:4 to 1:6 for physician assistants (PAs), nurse practitioners (NPs), and Certified Nurse-Midwifes (CNMs).

ANALYSIS

Existing law sets the physician supervision ratio at one physician supervising up to four of each type of mid-level practitioner. This bill would increase the ratio and allow a physician to supervise up to six of each type of mid-level practitioner.

According to the author's office, AB 2346 is intended to increase access to medical care and enable an increase in the medical workforce, while also acting as a cost containing measure. The number of mid-level practitioners is limited by the number of physicians available to provide supervision. The author's office states that by increasing the supervision ratio, more medical professionals will be able to enter the health care field, which will help to solve the workforce shortage and the increased demand for access to care. The author's office also believes that with the higher level of PAs, NPs, and CNMs providing care, hospitals and clinics will see reduced average costs of providing care and fewer physicians will be needed to supervise these professionals.

This bill will increase the total number of mid-level practitioners that a physician can supervise by six. This seems like a modest increase that may help to expand access to care, without significantly compromising consumer protection. Board staff is suggesting that the Board take a Neutral position on this bill.

FISCAL: None

SUPPORT: CMA (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Neutral

ASSEMBLY BILL No. 2346

Introduced by Assembly Member Gonzalez

February 21, 2014

An act to amend Sections 2746.51, 2836.1, and 3516 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2346, as introduced, Gonzalez. Nurse practitioners, certified nurse-midwives, and physician assistants: supervision.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing. Existing law authorizes a nurse practitioner and a certified nurse-midwife to furnish or order drugs or devices under specified circumstances subject to physician and surgeon supervision. Existing law prohibits a physician and surgeon from supervising more than 4 nurse practitioners and certified nurse-midwives at one time for purposes of furnishing drugs or devices. A violation of the Nursing Practice Act is a crime.

This bill would prohibit a physician and surgeon from supervising more than 6 nurse practitioners and certified nurse-midwives at one time for purposes of furnishing drugs or devices.

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. Existing law authorizes a physician assistant to perform certain health care activities subject to physician and surgeon supervision. Existing law prohibits a physician and surgeon from supervising more than 4 physician assistants at one time, except as specified.

This bill would prohibit a physician and surgeon from supervising more than 6 physician assistants at one time, except as specified.

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

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

1 SECTION 1. Section 2746.51 of the Business and Professions
2 Code is amended to read:
3 2746.51. (a) Neither this chapter nor any other provision of
4 law shall be construed to prohibit a certified nurse-midwife from
5 furnishing or ordering drugs or devices, including controlled
6 substances classified in Schedule II, III, IV, or V under the
7 California Uniform Controlled Substances Act (Division 10
8 (commencing with Section 11000) of the Health and Safety Code),
9 when all of the following apply:
10 (1) The drugs or devices are furnished or ordered incidentally
11 to the provision of any of the following:
12 (A) Family planning services, as defined in Section 14503 of
13 the Welfare and Institutions Code.
14 (B) Routine health care or perinatal care, as defined in
15 subdivision (d) of Section 123485 of the Health and Safety Code.
16 (C) Care rendered, consistent with the certified nurse-midwife's
17 educational preparation or for which clinical competency has been
18 established and maintained, to persons within a facility specified
19 in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the
20 Health and Safety Code, a clinic as specified in Section 1204 of
21 the Health and Safety Code, a general acute care hospital as defined
22 in subdivision (a) of Section 1250 of the Health and Safety Code,
23 a licensed *alternative* birth center as defined in Section 1204.3 of
24 the Health and Safety Code, or a special hospital specified as a
25 maternity hospital in subdivision (f) of Section 1250 of the Health
26 and Safety Code.
27 (2) The drugs or devices are furnished or ordered by a certified
28 nurse-midwife in accordance with standardized procedures or
29 protocols. For purposes of this section, standardized procedure
30 means a document, including protocols, developed and approved
31 by the supervising physician and surgeon, the certified
32 nurse-midwife, and the facility administrator or his or her designee.

The standardized procedure covering the furnishing or ordering of drugs or devices shall specify all of the following:

(A) Which certified nurse-midwife may furnish or order drugs or devices.

(B) Which drugs or devices may be furnished or ordered and under what circumstances.

(C) The extent of physician and surgeon supervision.

(D) The method of periodic review of the certified nurse-midwife's competence, including peer review, and review of the provisions of the standardized procedure.

(3) If Schedule II or III controlled substances, as defined in Sections 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician and surgeon. For Schedule II controlled substance protocols, the provision for furnishing the Schedule II controlled substance shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(4) The furnishing or ordering of drugs or devices by a certified nurse-midwife occurs under physician and surgeon supervision. For purposes of this section, ~~no~~ *a* physician and surgeon shall *not* supervise more than ~~four~~ *six* certified nurse-midwives at one time. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

(A) Collaboration on the development of the standardized procedure or protocol.

(B) Approval of the standardized procedure or protocol.

(C) Availability by telephonic contact at the time of patient examination by the certified nurse-midwife.

(b) (1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has successfully completed the requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list

available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section. The board shall establish the requirements for satisfactory completion of this paragraph.

(3) A physician and surgeon may determine the extent of supervision necessary pursuant to this section in the furnishing or ordering of drugs and devices.

(4) A copy of the standardized procedure or protocol relating to the furnishing or ordering of controlled substances by a certified nurse-midwife shall be provided upon request to any licensed pharmacist who is uncertain of the authority of the certified nurse-midwife to perform these functions.

(5) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) under the following conditions:

(1) The drugs and devices are furnished or ordered in accordance with requirements referenced in paragraphs (2) to (4), inclusive, of subdivision (a) and in paragraphs (1) to (3), inclusive, of subdivision (b).

(2) When Schedule II controlled substances, as defined in Section 11055 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific

protocol approved by the treating or supervising physician and surgeon.

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure or protocol. Use of the term "furnishing" in this section shall include the following:

(1) The ordering of a drug or device in accordance with the standardized procedure or protocol.

(2) Transmitting an order of a supervising physician and surgeon.

(e) "Drug order" or "order" for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section 1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 2. Section 2836.1 of the Business and Professions Code is amended to read:

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

(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and

approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.

(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

(e) For purposes of this section, ~~no~~ *a* physician and surgeon shall *not* supervise more than ~~four~~ *six* nurse practitioners at one time.

(f) (1) Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.

(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled

substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

(g) (1) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section.

(2) A physician and surgeon may determine the extent of supervision necessary pursuant to this section in the furnishing or ordering of drugs and devices.

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

(h) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

(i) "Drug order" or "order" for purposes of this section means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section ~~1306.02~~ *1306.03* of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 3. Section 3516 of the Business and Professions Code is amended to read:

3516. (a) Notwithstanding any other provision of law, a physician assistant licensed by the board shall be eligible for employment or supervision by any physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that employment or supervision.

(b) ~~No~~ *A* physician and surgeon shall *not* supervise more than ~~four~~ *six* physician assistants at ~~any~~ one time, except as provided in Section 3502.5.

(c) The Medical Board of California may restrict a physician and surgeon to supervising specific types of physician assistants including, but not limited to, restricting a physician and surgeon from supervising physician assistants outside of the field of specialty of the physician and surgeon.

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AB 2458 - BONILLA

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2458
Author: Bonilla
Bill Date: April 10, 2014, Amended
Subject: Medical Residency Training Program Grants
Sponsor: California Academy of Family Physicians (CAFP, Co-Sponsor)
California Medical Association (CMA, Co-Sponsor)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Graduate Medical Education Fund (GMEF) to finance additional positions at residency programs in California hospitals and teaching health centers. This bill would appropriate $2,840,000 per year for three years from the California Health Data and Planning Fund into the GMEF. This bill would also appropriate $25,000,000 from the General Fund in 2014/15 into the GMEF.

ANALYSIS

Graduate medical education (GME) or residency training, is the second phase of the educational process that prepares physicians for independent practice. Resident physicians typically spend three to seven years in GME training. Medicare has been the largest single funder of GME, but in 1997 Congress capped the number of residency slots for which hospitals could receive Medicare GME funding and has not increased this cap. In California, there are many more individuals that would like a residency slot in California, than there are residency positions available.

According to the author's office, California has a shortage of primary care physicians and one large challenge in California is providing residency slots. Having residency positions in California is important because after residency is concluded, physicians tend to settle in areas where they complete their training. According to the author's office, nearly 70% of residents who train in California remain here to practice after graduation. The Governor's 2014-15 proposed budget includes an allocation of $2.84 million dollars for a term of three years to expand the Song-Brown Primary Care Residency Program. This bill would build on this proposed investment by providing funding for additional GME positions.

Specifically, this bill would do the following: establish the GMEF; direct the Office of Statewide Health, Planning and Development, in consultation with the California Healthcare Workforce Policy Commission, to develop criteria for the distribution of available monies in the GMEF; specify that monies from the GMEF will be used for new GME residency positions; appropriate $2.84 million dollars annually for a period of three years, starting in the 2014/15 fiscal year, from the California Health Data and Planning Fund to

the GMEF; and appropriate $25 million in the 2014/15 fiscal year from the general fund into the GMEF.

This bill would increase funding for residency slots in California, which will help promote the Board's mission of increasing access to care for consumers. This bill would also allow more physicians to receive residency training and potentially end up practicing in California. Board staff is suggesting that the Board take a support position on this bill.

FISCAL: None

SUPPORT: CAFP (Co-Sponsor); CMA (Co-Sponsor); American Academy of Pediatrics, California District IX; American Congress of Obstetricians and Gynecologists, District IX (California); American Federation of State, County and Municipal Employees, AFL-CIO; American Osteopathic Association; Association of California Healthcare Districts; California Chapter of the American College of Emergency Physicians; California Children's Hospital Association; California Hospital Association; California Primary Care Association; and Osteopathic Physicians and Surgeons of California

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 10, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 2458

Introduced by Assembly Member Bonilla

February 21, 2014

An act to add Article 4 (commencing with Section 128310) to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, relating to medical care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2458, as amended, Bonilla. Medical residency training program grants.

Existing law, the Song-Brown Health Care Workforce Training Act, provides for specified training programs for certain health care workers, including family physicians, registered nurses, nurse practitioners, and physician's assistants.

This bill would establish the Graduate Medical Education Fund, to be used to administer and fund grants to graduate medical education residency programs located in California hospitals or teaching health centers, as specified. The bill would appropriate ~~an unspecified amount of money~~ *twenty-five million dollars ($25,000,000)* from the General Fund in the 2014–15 fiscal year for this purpose and $2,840,000 per year for 3 years, commencing with the 2014–15 fiscal year, from the California Health Data and Planning Fund for this purpose.

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

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

SECTION 1. Article 4 (commencing with Section 128310) is added to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, to read:

Article 4. Medical Residency Training Program Grants

128310. (a) The Graduate Medical Education Fund is hereby established in the State Treasury.

(b) Moneys in the fund shall, upon appropriation by the Legislature, be used solely for the purpose of administering and funding grants to graduate medical education residency programs located in California hospitals or teaching health centers.

(c) (1) Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(2) One-time, ongoing, or administrative costs incurred or generated by the implementation of this article, including those that might be incurred by the Office of Statewide Health Planning and Development (OSHPD), shall come directly from the Graduate Medical Education Fund.

(d) The fund shall consist of both of the following:

(1) All assessments, transfers, and appropriations received pursuant to Section 128311.

(2) Interest that accrues on amounts in the fund.

(e) OSHPD, in consultation with the California Healthcare Workforce Policy Commission, shall develop criteria for distribution of available moneys in the fund.

(f) Moneys appropriated from the fund shall be used to fund new graduate medical education residency positions.

(g) Whenever applicable, OSHPD shall utilize moneys appropriated from the fund to provide a match for available federal funds for graduate medical education.

(h) For purposes of this article, the following definitions shall apply:

(1) "Commission" means the California Healthcare Workforce Policy Commission, established pursuant to Section 128215.

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

(3) "Primary care physician" means an allopathic or osteopathic 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. 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.

128311. (a) In the 2014–15 fiscal year, the sum of ~~——~~ *twenty-five million* dollars ~~($——)~~ *($25,000,000)* is hereby appropriated from the General Fund to the Graduate Medical Education Fund established in Section 128310.

(b) Commencing with the 2014–15 fiscal year, the sum of two million eight hundred forty thousand dollars ($2,840,000) per year for three years is hereby appropriated from the California Health Data and Planning Fund ~~into~~ *to* the Graduate Medical Education Fund established in Section 128310.

128312. Funding of this article shall not affect the existing funding for the Song-Brown Health Care Workforce Training Act (Article 1 (commencing with Section 128200)) for family medicine residency or physician assistant, family nurse practitioner, and registered nurse training programs.

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SB 966 - LIEU

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 966
Author: Lieu
Bill Date: April 21, 2014, Amended
Subject: Outpatient Settings: Surgical Clinics
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow outpatient settings owned by physicians or dentists to be licensed by the California Department of Public Health (CDPH) as a surgical clinic. This bill would also subject accredited outpatient settings to data reporting requirements in Health and Safety Code (HSC) Sections 1216, 127280, and 128787; this data would be reported to the Office of Statewide Health Planning and Development (OSHPD). This bill would state that initial certificates of accreditation issued to outpatient settings are valid for two years, and inspections after the initial inspection for accreditation shall be unannounced.

OUTPATIENT SETTINGS BACKGROUND

The Medical Board of California's (Board) role related to outpatient settings is that the Board approves the accreditation agencies (AAs) that accredit outpatient settings. In the Health and Safety Code, there is a distinction between clinics licensed by the CDPH and outpatient settings that are accredited by an outside accrediting agency approved by the Board. Clinics licensed by the CDPH are non-physician owned, while clinics accredited by an AA approved by the Board are owned by a physician, association, corporation, firm, partnership, or individual.

California law prohibits physicians from performing some levels of outpatient surgery, unless it is performed in an accredited or licensed setting. Section 2216 of the Business and Professions Code (B&P) specifies that on or after, July 1, 1996, no physician and surgeon shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, unless the setting is specified in Health and Safety Code Section 1248.1. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

As outlined in Health and Safety Code (H&S) Section 1248.1, certain outpatient surgery settings are excluded from the accreditation requirement, such as ambulatory surgical

centers certified to participate in the Medicare program under Title XVIII, health facilities licensed as general acute care hospitals, federally operated clinics, facilities on recognized tribal reservations, and facilities used by dentists or physicians in compliance with Article 2.7 or Article 2.8 of Chapter 4 of Division 2 of the B&P Code.

Existing law's distinction on which clinics are licensed by CDPH and which fall under the jurisdiction of AAs approved by the Board has been the subject of litigation. In Capen v. Shewry (2007) 147 Cal.App.4th 680, the issue before the court was whether a surgical clinic that is wholly owned and operated by a licensed physician, in which non-owner, non-licensee, physicians will practice, is required to obtain a license from CDPH. The Court concluded that physician-owned-and-operated surgical clinics are not subject to licensing by CDPH and are to be regulated by the Board. In an effort to clarify the Board's authority over outpatient settings after Capen, the Board submitted a letter on October 18, 2007 to Judge Coleman Blease, who issued the opinion in the Capen case. The Board stated that "the law does not give the MBC the authority to regulate clinics owned and operated by physicians. It just gives the MBC the authority to approve accrediting agencies that are in compliance with the standards set forth in Health and Safety Code Section 1248 et.seq."

OUTPATIENT SURGERY SETTINGS (OSS) TASK FORCE BACKGROUND

At the October 2013 Board Meeting, the OSS Task Force was authorized to move forward with its recommended changes after receiving and considering input from the interested parties at the January 22, 2014 meeting. Based upon the comments from the interested parties on January 22, 2014, the OSS Task Force determined three legislative changes could move forward.

Specifically, the OSS Task Force recommended changes to:

1) HSC Section 1248.15(a)(2)(D) – providing some clean up language;
2) HSC Sections 1248.3(a) – requiring initial certifications of accreditation to be valid for only two years, instead of three; and
3) HSC Section 1248.35(b)(2) – requiring inspections, after the initial inspection, to be unannounced.

Also, at the October 2013 Board Meeting, the Board approved staff to move forward with legislation to require accredited outpatient settings to report utilization and patient encounter data to OSHPD. Health and Safety Code Section 1216 requires clinics licensed by CDPH, including surgical clinics, to report aggregate data to OSHPD. This data includes number of patients served and descriptive background, number of patient visits by type of service, patient charges, and any additional information required by CDPH and OSHPD. Before Capen v. Shewry, this data was being collected for the majority of outpatient settings, as they were licensed as surgical clinics. However, when physician-owned outpatient settings fell solely under the jurisdiction of the Board, this reporting was no longer required, which resulted in a serious deficiency of outpatient settings data.

ANALYSIS

This bill includes the Board's data reporting language and the language that came out of the OSS Task force regarding initial two-year inspections and subsequent unannounced inspections. The Board has already voted to support or sponsor these provisions. The Board also has language on peer review reporting for outpatient settings that Board staff will work with the author's office on the possibility of incorporating this language into this bill.

In addition, this bill would allow outpatient settings owned by physicians or dentists to be licensed by CDPH as a surgical clinic. As stated in the outpatient settings background information above, this is how the laws existed before the Capen V. Shewry decision in 2007. This bill would not require outpatient settings to be licensed by CDPH, but would simply give these facilities the option to be licensed by CDPH as a surgical clinic or be accredited by an AA approved by the Board.

Board staff is suggesting that the Board support this bill, it would further consumer protection and the Board has already voted to support the data reporting to OSHPD, and the language that resulted from the OSS Task Force. The other provision in the bill would go back to the outpatient setting structure as it was prior to 2007, and simply allow outpatient settings the option to become accredited or licensed.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE APRIL 21, 2014

SENATE BILL No. 966

Introduced by Senator Lieu

February 10, 2014

~~An act to amend Section 14124.24 of the Welfare and Institutions Code, relating to Medi-Cal.~~ *An act to add Section 2216.5 to the Business and Professions Code, and to amend Sections 1204, 1248.15, 1248.3, and 1248.35 of the Health and Safety Code, relating to outpatient settings.*

LEGISLATIVE COUNSEL'S DIGEST

SB 966, as amended, Lieu. ~~Drug Medi-Cal.~~ *Outpatient settings: surgical clinics.*

Existing law provides for the licensure and regulation of clinics by the State Department of Public Health. A violation of those provisions is a misdemeanor. Existing law provides that certain types of specialty clinics, including surgical clinics, as defined, are eligible for licensure.

This bill would clarify that surgical clinics are eligible for licensure by the department regardless of physician or dentist ownership.

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law provides that it is unprofessional conduct for a physician and surgeon to perform procedures in any outpatient setting except in compliance with specified provisions. Existing law prohibits an association, corporation, firm, partnership, or person from operating, managing, conducting, or maintaining an outpatient setting in the state unless the setting is one of the specified settings, which includes, among others, a surgical clinic licensed by the State Department of Public Health or an outpatient setting accredited by an accreditation agency

approved by the Division of Licensing of the Medical Board of California.

Existing law provides that an outpatient setting that is accredited shall be inspected by the accreditation agency and may be inspected by the Medical Board of California. Existing law requires that the inspections be conducted no less often than once every 3 years by the accreditation agency and as often as necessary by the Medical Board of California to ensure quality of care provided. Existing law requires that certificates for accreditation issued to outpatient settings by an accreditation agency shall be valid for not more than 3 years.

This bill would require that all subsequent inspections after the initial inspection for accreditation be unannounced. This bill would require an outpatient setting accredited by the division to pay certain fees and to comply with certain data submission requirements. The bill would also instead require that initial certificates of accreditation by an accreditation agency be valid for not more than 2 years and that renewal certificates be valid for not more than 3 years.

~~Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal) under which the department is authorized to enter into contracts with counties for the provision of various drug treatment services to Medi-Cal recipients, or is required to directly arrange for the provision of these services if a county elects not to do so. Existing law defines Drug Medi-Cal reimbursable services for purposes of these provisions.~~

~~This bill would make technical, nonsubstantive changes to that definition.~~

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

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

1 *SECTION 1. Section 2216.5 is added to the Business and*
2 *Professions Code, to read:*
3 *2216.5. An outpatient setting accredited pursuant to Section*
4 *1248.1 of the Health and Safety Code is subject to the requirements*

of Section 1216, subdivision (f) of Section 127280, and Section 128737 of the Health and Safety Code.

SEC. 2. Section 1204 of the Health and Safety Code is amended to read:

1204. Clinics eligible for licensure pursuant to this chapter are primary care clinics and specialty clinics.

(a) (1) Only the following defined classes of primary care clinics shall be eligible for licensure:

(A) A "community clinic" means a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. In a community clinic, any charges to the patient shall be based on the patient's ability to pay, utilizing a sliding fee scale. No corporation other than a nonprofit corporation, exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a community clinic; provided, that the licensee of any community clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a community clinic.

(B) A "free clinic" means a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. In a free clinic there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished. No corporation other than a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a free clinic; provided, that the licensee of any free clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a free clinic.

(2) Nothing in this subdivision shall prohibit a community clinic or a free clinic from providing services to patients whose

services are reimbursed by third-party payers, or from entering into managed care contracts for services provided to private or public health plan subscribers, as long as the clinic meets the requirements identified in subparagraphs (A) and (B). For purposes of this subdivision, any payments made to a community clinic by a third-party payer, including, but not limited to, a health care service plan, shall not constitute a charge to the patient. This paragraph is a clarification of existing law.

(b) The following types of specialty clinics shall be eligible for licensure as specialty clinics pursuant to this chapter:

(1) *(A)* A "surgical clinic" means a clinic that is not part of a hospital and that provides ambulatory surgical care for patients who remain less than 24 hours. A surgical clinic does not include any place or establishment owned or leased and operated as a clinic or office by one or more physicians or dentists in individual or group practice, regardless of the name used publicly to identify the place or ~~establishment, provided, however, that physicians or dentists may, at their option, apply for licensure.~~ *establishment.*

(B) Physicians or dentists may, at their option, apply for licensure. Surgical clinics shall be eligible for licensure by the department regardless of physician or dentist ownership.

(2) A "chronic dialysis clinic" means a clinic that provides less than 24-hour care for the treatment of patients with end-stage renal disease, including renal dialysis services.

(3) A "rehabilitation clinic" means a clinic that, in addition to providing medical services directly, also provides physical rehabilitation services for patients who remain less than 24 hours. Rehabilitation clinics shall provide at least two of the following rehabilitation services: physical therapy, occupational therapy, social, speech pathology, and audiology services. A rehabilitation clinic does not include the offices of a private physician in individual or group practice.

(4) An "alternative birth center" means a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility.

SEC. 3. 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~~ *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 Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act. The outpatient setting may, in its discretion, permit anesthesia service by a certified 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.

SEC. 4. Section 1248.3 of the Health and Safety Code is amended to read:

1248.3. (a) ~~Certificates~~ *Initial certificates* of accreditation issued to outpatient settings by an accreditation agency shall be valid for not more than *two years and renewal certificates shall be valid for not more than* three years.

(b) The outpatient setting shall notify the accreditation agency within 30 days of any significant change in ownership, including, but not limited to, a merger, change in majority interest, consolidation, name change, change in scope of services, additional services, or change in locations.

(c) Except for disclosures to the division or to the Division of Medical Quality under this chapter, an accreditation agency shall not disclose information obtained in the performance of accreditation activities under this chapter that individually identifies patients, individual medical practitioners, or outpatient settings. Neither the proceedings nor the records of an accreditation agency or the proceedings and records of an outpatient setting related to performance of quality assurance or accreditation activities under this chapter shall be subject to discovery, nor shall the records or proceedings be admissible in a court of law. The prohibition relating to discovery and admissibility of records and proceedings does not apply to any outpatient setting requesting accreditation in the event that denial or revocation of that outpatient setting's accreditation is being contested. Nothing in this section shall prohibit the accreditation agency from making discretionary

disclosures of information to an outpatient setting pertaining to the accreditation of that outpatient setting.

SEC. 5. Section 1248.35 of the Health and Safety Code is amended to read:

1248.35. (a) Every outpatient setting ~~which~~ *that* is accredited shall be inspected by the accreditation agency and may also be inspected by the Medical Board of California. The Medical Board of California shall ensure that accreditation agencies inspect outpatient settings.

(b) Unless otherwise specified, the following requirements apply to inspections described in subdivision (a).

(1) The frequency of inspection shall depend upon the type and complexity of the outpatient setting to be inspected.

(2) Inspections shall be conducted no less often than once every three years by the accreditation agency and as often as necessary by the Medical Board of California to ensure the quality of care provided. *After the initial inspection for accreditation, all subsequent inspections shall be unannounced.*

(3) The Medical Board of California or the accreditation agency may enter and inspect any outpatient setting that is accredited by an accreditation agency at any reasonable time to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of this chapter.

(c) If an accreditation agency determines, as a result of its inspection, that an outpatient setting is not in compliance with the standards under which it was approved, the accreditation agency may do any of the following:

(1) Require correction of any identified deficiencies within a set timeframe. Failure to comply shall result in the accrediting agency issuing a reprimand or suspending or revoking the outpatient setting's accreditation.

(2) Issue a reprimand.

(3) Place the outpatient setting on probation, during which time the setting shall successfully institute and complete a plan of correction, approved by the board or the accreditation agency, to correct the deficiencies.

(4) Suspend or revoke the outpatient setting's certification of accreditation.

(d) (1) Except as is otherwise provided in this subdivision, before suspending or revoking a certificate of accreditation under this chapter, the accreditation agency shall provide the outpatient setting with notice of any deficiencies and the outpatient setting shall agree with the accreditation agency on a plan of correction that shall give the outpatient setting reasonable time to supply information demonstrating compliance with the standards of the accreditation agency in compliance with this chapter, as well as the opportunity for a hearing on the matter upon the request of the outpatient setting. During the allotted time to correct the deficiencies, the plan of correction, which includes the deficiencies, shall be conspicuously posted by the outpatient setting in a location accessible to public view. Within 10 days after the adoption of the plan of correction, the accrediting agency shall send a list of deficiencies and the corrective action to be taken to the board and to the California State Board of Pharmacy if an outpatient setting is licensed pursuant to Article 14 (commencing with Section 4190) of Chapter 9 of Division 2 of the Business and Professions Code. The accreditation agency may immediately suspend the certificate of accreditation before providing notice and an opportunity to be heard, but only when failure to take the action may result in imminent danger to the health of an individual. In such cases, the accreditation agency shall provide subsequent notice and an opportunity to be heard.

(2) If an outpatient setting does not comply with a corrective action within a timeframe specified by the accrediting agency, the accrediting agency shall issue a reprimand, and may either place the outpatient setting on probation or suspend or revoke the accreditation of the outpatient setting, and shall notify the board of its action. This section shall not be deemed to prohibit an outpatient setting that is unable to correct the deficiencies, as specified in the plan of correction, for reasons beyond its control, from voluntarily surrendering its accreditation prior to initiation of any suspension or revocation proceeding.

(e) The accreditation agency shall, within 24 hours, report to the board if the outpatient setting has been issued a reprimand or if the outpatient setting's certification of accreditation has been suspended or revoked or if the outpatient setting has been placed on probation. If an outpatient setting has been issued a license by the California State Board of Pharmacy pursuant to Article 14

(commencing with Section 4190) of Chapter 9 of Division 2 of the Business and Professions Code, the accreditation agency shall also send this report to the California State Board of Pharmacy within 24 hours.

(f) The accreditation agency, upon receipt of a complaint from the board that an outpatient setting poses an immediate risk to public safety, shall inspect the outpatient setting and report its findings of inspection to the board within five business days. If an accreditation agency receives any other complaint from the board, it shall investigate the outpatient setting and report its findings of investigation to the board within 30 days.

(g) Reports on the results of any inspection shall be kept on file with the board and the accreditation agency along with the plan of correction and the comments of the outpatient setting. The inspection report may include a recommendation for reinspection. All final inspection reports, which include the lists of deficiencies, plans of correction or requirements for improvements and correction, and corrective action completed, shall be public records open to public inspection.

(h) If one accrediting agency denies accreditation, or revokes or suspends the accreditation of an outpatient setting, this action shall apply to all other accrediting agencies. An outpatient setting that is denied accreditation is permitted to reapply for accreditation with the same accrediting agency. The outpatient setting also may apply for accreditation from another accrediting agency, but only if it discloses the full accreditation report of the accrediting agency that denied accreditation. Any outpatient setting that has been denied accreditation shall disclose the accreditation report to any other accrediting agency to which it submits an application. The new accrediting agency shall ensure that all deficiencies have been corrected and conduct a new onsite inspection consistent with the standards specified in this chapter.

(i) If an outpatient setting's certification of accreditation has been suspended or revoked, or if the accreditation has been denied, the accreditation agency shall do all of the following:

(1) Notify the board of the action.

(2) Send a notification letter to the outpatient setting of the action. The notification letter shall state that the setting is no longer allowed to perform procedures that require outpatient setting accreditation.

(3) Require the outpatient setting to remove its accreditation certification and to post the notification letter in a conspicuous location, accessible to public view.

(j) The board may take any appropriate action it deems necessary pursuant to Section 1248.7 if an outpatient setting's certification of accreditation has been suspended or revoked, or if accreditation has been denied.

~~SECTION 1. Section 14124.24 of the Welfare and Institutions Code is amended to read:~~

~~14124.24. (a) For purposes of this section, "Drug Medi-Cal reimbursable services" means the substance use disorder services described in the California State Medicaid Plan and includes, but is not limited to, all of the following services, administered by the department, and to the extent consistent with state and federal law:~~

~~(1) Narcotic treatment program services, as set forth in Section 14021.51.~~

~~(2) Day care rehabilitative services.~~

~~(3) Perinatal residential services for pregnant women and women in the postpartum period.~~

~~(4) Naltrexone services.~~

~~(5) Outpatient drug-free services.~~

~~(6) Other services upon approval of a federal Medicaid state plan amendment or waiver authorizing federal financial participation.~~

~~(b) (1) While seeking federal approval for any federal Medicaid state plan amendment or waiver associated with Drug Medi-Cal services, the department shall consult with the counties and stakeholders in the development of the state plan amendment or waiver.~~

~~(2) Upon federal approval of a federal Medicaid state plan amendment authorizing federal financial participation in the following services, and subject to appropriation of funds, "Drug Medi-Cal reimbursable services" shall also include the following services, administered by the department, and to the extent consistent with state and federal law:~~

~~(A) Notwithstanding subdivision (a) of Section 14132.90, day care habilitative services, which, for purposes of this paragraph, are outpatient counseling and rehabilitation services provided to persons with alcohol or other drug abuse diagnoses.~~

~~(B) Case management services, including supportive services to assist persons with alcohol or other drug abuse diagnoses in gaining access to medical, social, educational, and other needed services.~~

~~(C) Aftercare services.~~

~~(c) (1) The nonfederal share for Drug Medi-Cal services shall be funded through a county's Behavioral Health Subaccount of the Support Services Account of the Local Revenue Fund 2011, and any other available county funds eligible under federal law for federal Medicaid reimbursement. The funds contained in each county's Behavioral Health Subaccount of the Support Services Account of the Local Revenue Fund 2011 shall be considered state funds distributed by the principal state agency for the purposes of receipt of the federal block grant funds for prevention and treatment of substance abuse found at Subchapter XVII of Chapter 6A of Title 42 of the United States Code. Pursuant to applicable federal Medicaid law and regulations including Section 433.51 of Title 42 of the Code of Federal Regulations, counties may claim allowable Medicaid federal financial participation for Drug Medi-Cal services based on the counties certifying their actual total funds expenditures for eligible Drug Medi-Cal services to the department.~~

~~(2) (A) If the director determines that a county's provision of Drug Medi-Cal treatment services are disallowed by the federal government or by state or federal audit or review, the impacted county shall be responsible for repayment of all disallowed federal funds. In addition to any other recovery methods available, including, but not limited to, offset of Medicaid federal financial participation funds owed to the impacted county, the director may offset these amounts in accordance with Section 12419.5 of the Government Code.~~

~~(B) A county subject to an action by the director pursuant to subparagraph (A) may challenge that action by requesting a hearing in writing no later than 30 days from receipt of notice of the department's action. The proceeding shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the director has all the powers granted therein. Upon a county's timely request for hearing, the county's obligation to make payment as determined by the director shall be stayed pending the county's~~

~~exhaustion of administrative remedies provided herein but no longer than will ensure the department's compliance with Section 1903(d)(2)(C) of the federal Social Security Act (42 U.S.C. Sec. 1396b).~~

~~(d) Drug Medi-Cal services are only reimbursable to Drug Medi-Cal providers with an approved Drug Medi-Cal contract.~~

~~(e) Counties shall negotiate contracts only with providers certified to provide Drug Medi-Cal services.~~

~~(f) The department shall develop methods to ensure timely payment of Drug Medi-Cal claims.~~

~~(g) (1) A county or a contracted provider, except for a provider to whom subdivision (h) applies, shall submit accurate and complete cost reports for the previous fiscal year by November 1, following the end of the fiscal year. The department may settle Drug Medi-Cal reimbursable services, based on the cost report as the final amendment to the approved county Drug Medi-Cal contract.~~

~~(2) Amounts paid for services provided to Drug Medi-Cal beneficiaries shall be audited by the department in the manner and form described in Section 14170.~~

~~(3) Administrative appeals to review grievances or complaints arising from the findings of an audit or examination made pursuant to this section shall be subject to Section 14171.~~

~~(h) Certified narcotic treatment program providers that are exclusively billing the state or the county for services rendered to persons subject to Section 1210.1 or 3063.1 of the Penal Code or Section 14021.52 of this code shall submit accurate and complete performance reports for the previous state fiscal year by November 1 following the end of that fiscal year. A provider to which this subdivision applies shall estimate its budgets using the uniform state daily reimbursement rate. The format and content of the performance reports shall be mutually agreed to by the department, the County Alcohol and Drug Program Administrators' Association of California, and representatives of the treatment providers.~~

~~(i) Contracts entered into pursuant to this section shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.~~

~~(j) Annually, the department shall publish procedures for contracting for Drug Medi-Cal services with certified providers~~

1 ~~and for claiming payments, including procedures and specifications~~
2 ~~for electronic data submission for services rendered.~~

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SB 1083 - PAVLEY

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1083
Author: Pavley
Bill Date: February 19, 2014, Introduced
Subject: Physician Assistants: Disability Certifications
Sponsor: California Academy of Physician Assistants (CAPA)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize physician assistants (PAs) to certify claims for disability insurance (DI) with the Employment Development Department (EDD). The PA would first have to perform a physical exam under the supervision of a physician, pursuant to existing law.

ANALYSIS

Existing law does not authorize PAs to certify claims for DI with EDD. Current law authorizes the following practitioners to certify claims for DI: licensed medical or osteopathic physicians; authorized medical officers of a U.S. Government facility; chiropractors; podiatrists; optometrists; dentists; psychologists; nurse practitioners (after examination and collaboration with a physician); licensed midwives; certified nurse midwives; nurse practitioners (for normal pregnancy or child-birth); or accredited religious practitioners.

Existing law allows PAs to perform a variety of medical services under physician supervision, including the following: order medication; conduct physical exams; diagnose and treat illnesses; order and interpret tests; instruct and counsel patient on matters pertaining to their physical and mental health; assist in surgery; and conduct medical exams and sign corresponding certificates or forms for the purposed of issuing disabled person placards.

This bill would allow PAs to certify claims for DI with EDD, if a physical exam is performed by the PA under the supervision of a physician. PAs are already allowed to certify temporary disability and issue disabled person placards. It seems reasonable to also allow PAs to certify claims for DI with EDD and in alignment with the PA scope of practice. The PA is still under a delegated services agreement with a physician, as such, this bill will not compromise consumer protection. Board staff is suggesting that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: CAPA (sponsor) and Kaiser Permanente

OPPOSITION: None on file

POSITION: Recommendation: Neutral

SENATE BILL No. 1083

Introduced by Senator Pavley

February 19, 2014

An act to amend Section 3502.3 of the Business and Professions Code, and to amend Section 2708 of the Unemployment Insurance Code, relating to physician assistants.

LEGISLATIVE COUNSEL'S DIGEST

SB 1083, as introduced, Pavley. Physician assistants: disability certifications.

The Physician Assistant Practice Act authorizes a delegation of services agreement to authorize a physician assistant to engage in specified activities.

Existing law requires a claimant for unemployment compensation disability benefits to establish medical eligibility for each uninterrupted period of disability by filing a first claim for disability benefits supported by the certificate of a treating physician or practitioner that establishes the sickness, injury, or pregnancy of the employee, or the condition of the family member that warrants the care of the employee. Existing law defines the term "practitioner" to mean a person duly licensed or certified in California acting within the scope of his or her license or certification who is a dentist, podiatrist, or a nurse practitioner, as prescribed.

This bill would amend the Physician Assistant Practice Act to authorize a physician assistant to certify disability, after performance of a physical examination by the physician assistant under the supervision of a physician and surgeon consistent with the act. The bill would correspondingly expand the definition of practitioner to include a physician assistant.

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

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

1 SECTION 1. Section 3502.3 of the Business and Professions
2 Code is amended to read:
3 3502.3. (a) Notwithstanding any other provision of law, in
4 addition to any other practices that meet the general criteria set
5 forth in this chapter or the Medical Board of California's
6 regulations for inclusion in a delegation of services agreement, a
7 delegation of services agreement may authorize a physician
8 assistant to do any of the following:
9 (1) Order durable medical equipment, subject to any limitations
10 set forth in Section 3502 or the delegation of services agreement.
11 Notwithstanding that authority, nothing in this paragraph shall
12 operate to limit the ability of a third-party payer to require prior
13 approval.
14 (2) For individuals receiving home health services or personal
15 care services, after consultation with the supervising physician,
16 approve, sign, modify, or add to a plan of treatment or plan of care.
17 *(3) After performance of a physical examination by the physician*
18 *assistant under the supervision of a physician and surgeon*
19 *consistent with this chapter, certify disability pursuant to Section*
20 *2708 of the Unemployment Insurance Code.*
21 (b) Nothing in this section shall be construed to affect the
22 validity of any delegation of services agreement in effect prior to
23 the enactment of this section or those adopted subsequent to
24 enactment.
25 SEC. 2. Section 2708 of the Unemployment Insurance Code,
26 as added by Section 2 of Chapter 350 of the Statutes of 2013, is
27 amended to read:
28 2708. (a) (1) In accordance with the director's authorized
29 regulations, and except as provided in subdivision (c) and Sections
30 2708.1 and 2709, a claimant shall establish medical eligibility for
31 each uninterrupted period of disability by filing a first claim for
32 disability benefits supported by the certificate of a treating
33 physician or practitioner that establishes the sickness, injury, or
34 pregnancy of the employee, or the condition of the family member
35 that warrants the care of the employee. For subsequent periods of

uninterrupted disability after the period covered by the initial certificate or any preceding continued claim, a claimant shall file a continued claim for those benefits supported by the certificate of a treating physician or practitioner. A certificate filed to establish medical eligibility for the employee's own sickness, injury, or pregnancy shall contain a diagnosis and diagnostic code prescribed in the International Classification of Diseases, or, if no diagnosis has yet been obtained, a detailed statement of symptoms.

(2) A certificate filed to establish medical eligibility of the employee's own sickness, injury, or pregnancy shall also contain a statement of medical facts, including secondary diagnoses when applicable, within the physician's or practitioner's knowledge, based on a physical examination and a documented medical history of the claimant by the physician or practitioner, indicating the physician's or practitioner's conclusion as to the claimant's disability, and a statement of the physician's or practitioner's opinion as to the expected duration of the disability.

(b) An employee shall be required to file a certificate to establish eligibility when taking leave to care for a family member with a serious health condition. The certificate shall be developed by the department. In order to establish medical eligibility of the serious health condition of the family member that warrants the care of the employee, the information shall be within the physician's or practitioner's knowledge and shall be based on a physical examination and documented medical history of the family member and shall contain all of the following:

(1) A diagnosis and diagnostic code prescribed in the International Classification of Diseases, or, if no diagnosis has yet been obtained, a detailed statement of symptoms.

(2) The date, if known, on which the condition commenced.

(3) The probable duration of the condition.

(4) An estimate of the amount of time that the physician or practitioner believes the employee needs to care for the child, parent, grandparent, grandchild, sibling, spouse, or domestic partner.

(5) (A) A statement that the serious health condition warrants the participation of the employee to provide care for his or her child, parent, grandparent, grandchild, sibling, spouse, or domestic partner.

(B) "Warrants the participation of the employee" includes, but is not limited to, providing psychological comfort, and arranging "third party" care for the child, parent, grandparent, grandchild, sibling, spouse, or domestic partner, as well as directly providing, or participating in, the medical care.

(c) The department shall develop a certification form for bonding that is separate and distinct from the certificate required in subdivision (a) for an employee taking leave to bond with a minor child within the first year of the child's birth or placement in connection with foster care or adoption.

(d) The first and any continuing claim of an individual who obtains care and treatment outside this state shall be supported by a certificate of a treating physician or practitioner duly licensed or certified by the state or foreign country in which the claimant is receiving the care and treatment. If a physician or practitioner licensed by and practicing in a foreign country is under investigation by the department for filing false claims and the department does not have legal remedies to conduct a criminal investigation or prosecution in that country, the department may suspend the processing of all further certifications until the physician or practitioner fully cooperates, and continues to cooperate, with the investigation. A physician or practitioner licensed by, and practicing in, a foreign country who has been convicted of filing false claims with the department may not file a certificate in support of a claim for disability benefits for a period of five years.

(e) For purposes of this part:

(1) "Physician" has the same meaning as defined in Section 3209.3 of the Labor Code.

(2) "Practitioner" means a person duly licensed or certified in California acting within the scope of his or her license or certification who is a dentist, podiatrist, *physician assistant who has performed a physical examination under the supervision of a physician and surgeon,* or a nurse practitioner, and in the case of a nurse practitioner, after performance of a physical examination by a nurse practitioner and collaboration with a physician and surgeon, or as to normal pregnancy or childbirth, a midwife or nurse midwife, or nurse practitioner.

(f) For a claimant who is hospitalized in or under the authority of a county hospital in this state, a certificate of initial and

continuing medical disability, if any, shall satisfy the requirements of this section if the disability is shown by the claimant's hospital chart, and the certificate is signed by the hospital's registrar. For a claimant hospitalized in or under the care of a medical facility of the United States government, a certificate of initial and continuing medical disability, if any, shall satisfy the requirements of this section if the disability is shown by the claimant's hospital chart, and the certificate is signed by a medical officer of the facility duly authorized to do so.

(g) Nothing in this section shall be construed to preclude the department from requesting additional medical evidence to supplement the first or any continued claim if the additional evidence can be procured without additional cost to the claimant. The department may require that the additional evidence include any or all of the following:

(1) Identification of diagnoses.

(2) Identification of symptoms.

(3) A statement setting forth the facts of the claimant's disability. The statement shall be completed by any of the following individuals:

(A) The physician or practitioner treating the claimant.

(B) The registrar, authorized medical officer, or other duly authorized official of the hospital or health facility treating the claimant.

(C) An examining physician or other representative of the department.

(h) This section shall become operative on July 1, 2014.

O

SB 1116 - TORRES

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1116
Author: Torres
Bill Date: February 19, 2014, Introduced
Subject: Steven M. Thompson Loan Repayment Program
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows physicians to donate an additional $75 to the Medical Board of California (Board), for the purposes of funding the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP).

ANALYSIS:

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

Currently, a physician could donate more than the mandatory $25 to the STLRP, however, this information is not included on the initial licensing or renewal application. This bill would allow physicians to donate an additional $75 to the Board to help fund the STLRP, but this does not mean a physician could not donate more than $75, a physician could still donate any amount they would like to the STLRP. If this bill becomes law, the Board would include specific information on the ability of a physician to donate to the STLRP in any amount and would also include a check box for an additional $75 donation on the initial and renewal application so physicians are aware of their ability to donate additional funding to the STLRP. This bill will allow for additional funding for the STLRP, which will help allow for more loans for the STLRP and more physicians to serve in underserved areas. This bill would further the Board's mission of promoting access to care and staff suggests that the Board take a support position on this bill.

FISCAL: None

SUPPORT: California Primary Care Association

OPPOSITION: California Medical Association (Unless Amended)

POSITION: Recommendation: Support

SENATE BILL No. 1116

Introduced by Senator Torres

February 19, 2014

An act to amend Sections 2436.5 and 2455.1 of the Business and Professions Code, relating to physicians and surgeons, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 1116, as introduced, Torres. Physicians and surgeons.

Under existing law, the Medical Board of California licenses and regulates physicians and surgeons and imposes various fees on those licensees. Under existing law, the Osteopathic Medical Board of California licenses and regulates osteopathic physicians and surgeons and imposes various fees on those licensees. Existing law establishes the Medically Underserved Account for Physicians within the Health Professions Education Fund that is managed by the Health Professions Education Foundation and the Office of Statewide Health Planning and Development. Under existing law, the primary purpose of the account is to fund the Steven M. Thompson Physician Corps Loan Repayment Program, which provides for the repayment of educational loans, as specified, obtained by a physician and surgeon who practices in a medically underserved area of the state, as defined. Under existing law, funds placed in the account for those purposes are continuously appropriated for the repayment of loans and may be used for any other authorized purpose. Physicians and surgeons and osteopathic physicians and surgeons are eligible for the loan repayment program and the board assesses an additional $25 license fee for purposes of the loan repayment program.

This bill would authorize a physician and surgeon and an osteopathic physician and surgeon to pay an additional $75 to the board for those

purposes. By increasing the amount of revenue in a continuously appropriated fund, the bill would make an appropriation.

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

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

1 SECTION 1. Section 2436.5 of the Business and Professions
2 Code is amended to read:
3 2436.5. (a) *(1)* In addition to the fees charged for the initial
4 issuance or biennial renewal of a physician and surgeon's certificate
5 pursuant to Section 2435, and at the time those fees are charged,
6 the board shall charge each applicant or renewing licensee an
7 additional twenty-five-dollar ($25) fee for the purposes of this
8 section.
9 ~~The~~
10 *(2) The* twenty-five-dollar ($25) fee shall be paid at the time of
11 application for initial licensure or biennial renewal and shall be
12 due and payable along with the fee for the initial certificate or
13 biennial renewal.
14 *(3) A physician and surgeon may pay an additional seventy-five*
15 *dollars ($75) to the board for the purposes of this section.*
16 (b) The board shall transfer all funds collected pursuant to this
17 section, on a monthly basis, to the Medically Underserved Account
18 for Physicians created by Section 128555 of the Health and Safety
19 Code for the Steven M. Thompson Physician Corps Loan
20 Repayment Program. Notwithstanding Section 128555 of the
21 Health and Safety Code, these funds shall not be used to provide
22 funding for the Physician Volunteer Program.
23 (c) Up to 15 percent of the funds collected pursuant to this
24 section shall be dedicated to loan assistance for physicians and
25 surgeons who agree to practice in geriatric care settings or settings
26 that primarily serve adults over the age of 65 years or adults with
27 disabilities. Priority consideration shall be given to those physicians
28 and surgeons who are trained in, and practice, geriatrics and who
29 can meet the cultural and linguistic needs and demands of diverse
30 populations of older Californians.
31 SEC. 2. Section 2455.1 of the Business and Professions Code
32 is amended to read:

2455.1. (a) In addition to the fees charged pursuant to Section 2455, and at the time those fees are charged, the board shall charge each applicant for an original or reciprocity certificate or for a biennial license an additional twenty-five-dollar ($25) fee for the purposes of this section. This twenty-five-dollar ($25) fee shall be due and payable along with the fee for the original or reciprocity certificate or the biennial license.

(b) An osteopathic physician and surgeon may pay an additional seventy-five dollars ($75) to the board for the purposes of this section.

~~(b)~~

(c) The board shall transfer all funds collected pursuant to this section, on a monthly basis, to the Medically Underserved Account for Physicians created by Section 128555 of the Health and Safety Code for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Notwithstanding Section 128555 of the Health and Safety Code, these funds shall not be used to provide funding for the Physician Volunteer Program.

O

SB 1258 - DESAULNIER

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1258
Author: DeSaulnier
Bill Date: March 25, 2014, Amended
Subject: Controlled Substances: Prescriptions: Reporting
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would do the following: require controlled substance prescriptions to be made electronically; add Schedule V controlled substances to the Controlled Substance Utilization Review and Evaluation System (CURES) database; establish dispensing limits; and allow an individual designed by a board, bureau, or program within the Department of Consumer Affairs (DCA) to access CURES data for investigation purposes.

BACKGROUND:

The CURES Program is currently housed in the Department of Justice (DOJ) and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) system allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, including the Board, to access patient controlled substance history information through a secure website.

Last year, the 2013/14 Budget Bill and SB 809 (DeSaulnier and Steinberg, Chapter 400) were both signed into law. The Budget Bill required all health boards in DCA to provide funding to upgrade the CURES system. The Medical Board of California (Board) provided $1.638 million. The Budget Bill required, before the funds are appropriated for CURES, for the Feasibility Study Report (FSR) to be approved and mutually agreed upon by DOJ and DCA, and that an interagency agreement be developed between DOJ and DCA on behalf of each board or committee funding the system that includes the roles and responsibilities of each department as to the joint development, implementation, and utilization of CURES. The FSR and Interagency Agreement are currently being drafted and the Board participates in regular meetings with DCA, other boards, and DOJ.

SB 809 established the CURES Fund, which is funded by an annual $6 flat fee for licensees of the boards in DCA that are authorized to prescribe or dispense Schedule II, III, or IV controlled substances, including the Board. This bill makes the money in the CURES Fund available for allocation to DOJ, upon appropriation by the Legislature, for the purposes of funding the CURES Program. This bill specified that the fee

increase shall be due at time of renewal and shall not exceed the reasonable costs associated with maintaining CURES. This bill required 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. This bill also required DOJ to establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, storage, disclosure, and security of the information within CURES. This bill allowed DOJ to invite stakeholders to assist, advise and make recommendations on the establishment of rules and regulations necessary to ensure proper administration and enforcement of the CURES database. This bill required DOJ to consult with prescribers, regulatory boards, and other stakeholders to identify desirable capabilities and upgrades to the CURES system. This bill required DOJ, DCA and the regulatory boards to identify and implement a streamlined application and approval process to provide access to CURES and to make efforts to incorporate the CURES application at the time of license application or renewal. DOJ, DCA and the regulatory boards are required to identify necessary procedures to enable prescribers and dispensers to delegate their authority to order CURES reports, and develop a procedure to enable health care practitioners who do not have a federal DEA number to opt out of applying for access to CURES. This bill required prescribers and dispensers, before January 1, 2016, or upon receipt of a federal DEA number, to submit an application to DOJ to obtain approval to access information online regarding the controlled substance history of a patient from CURES.

It is important to note that both bills affecting CURES were just signed into law last year, so the upgraded CURES system is still in the process of being developed, and almost all of the requirements in SB 809 are dependent on the upgraded system being developed and operational.

ANALYSIS:

SB 1258 would require all prescriptions for Schedule II, III, IV, and V controlled substances to be submitted electronically and to comply with the Drug Enforcement Agency (DEA) regulations. The electronic prescription must meet the following requirements:

- Contain the prescriber's address and telephone number; the name of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services; refill information, such as the number of refills ordered and whether the prescription is a first-time request or refill; and the name, quantity, strength, and directions for use of the controlled substance.
- Contain the address for the person being prescribed the controlled substance. If the prescriber does not specify the address on the prescription, the pharmacist filling the prescription or an employee acting under the direction of the pharmacist must include the address on the prescription or maintain the information in a readily retrievable form in the pharmacy.

This bill would provide an exception to the electronic prescribing requirement if technological failure prevents the electronic transmission of the prescription or if the prescription will be filled by a pharmacist located outside California, but the oral (only for Schedule III, IV, or V) or written prescription must contain all the required

information above and if the prescription is written, it must be signed and dated by the prescriber in ink. This bill would allow an agent of the prescriber, if authorized by the prescriber, to orally transmit a prescription for a controlled substance, if the written record specifies the name of the agent transmitting the prescription.

This bill adds Schedule V controlled substances to those that have to be reported to CURES. According to the DEA's website, Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Schedule V drugs are generally used for antidiarrheal, antitussive, and analgesic purposes. Some examples of Schedule V drugs are: cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC), Lomotil, Motofen, Lyrica, and Parepectolin.

This bill would allow an individual designated by a board, bureau, or program within DCA to access CURES data for investigation purposes if an application is submitted to DOJ to obtain approval to access this information. According to the author's office, this provision would allow designated DCA investigators to access CURES information.

Lastly, this bill would establish controlled substances dispensing limits. This bill would not allow a person to prescribe, fill, compound, or dispense a prescription for a controlled substance in a quantity exceeding a 30-day supply. This bill would provide an exception to this limit and allow for a 90-day supply if the prescription is issued in the treatment of one of the following:

- A panic disorder.
- Attention deficit disorder.
- A chronic debilitating neurologic condition characterized as a movement disorder or exhibiting seizure, convulsive, or spasm activity.
- Pain in patients with conditions or diseases known to be chronic or incurable.
- Narcolepsy.

This bill would not allow a prescription for a controlled substance to be prescribed, filled, compounded or dispensed if another prescription for a controlled substance was issued within the immediate preceding 30 days, until the patient has exhausted all but a seven-day supply of the controlled substance from the previous prescription. This bill would also not allow a prescription for a Schedule II drug to be refilled.

Electronic prescribing is a goal that California should be moving towards in the future. However, this bill may be premature as the upgraded CURES system is not yet up and running. In addition, adding reporting of Schedule V drugs to CURES may be overly inclusive and burdensome to both physicians and the CURES system at this point in time. Although this bill attempts to limit the quantity of controlled substances being dispensed, it does provide many exceptions to the 30-day limit, and may result in an unintended consequence of creating difficulties for both physicians and patients. Board staff suggests that the Board support the concept of electronic prescribing and dispensing limits on controlled substances, but work with the author's office and

interested parties to make the requirements in this bill manageable and workable with the implementation of the requirements that were contained in SB 809 and the upgraded CURES system.

FISCAL: Unknown, but no direct costs to the Board

SUPPORT: California Statewide Law Enforcement Association; National Coalition Against Prescription Drug Abuse; and Troy and Alana Pack Foundation

OPPOSITION: California Hospital Association and California Medical Association

POSITION: Recommendation: Support in Concept

AMENDED IN SENATE MARCH 25, 2014

SENATE BILL No. 1258

Introduced by Senator DeSaulnier

February 21, 2014

An act to amend ~~Section 11165~~ *Sections 4071 and 4072 of the Business and Professions Code, and to amend Sections 11151, 11158, 11164, 11164.1, 11164.5, 11165, 11165.1, 11165.5, 11166, and 11200* of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 1258, as amended, DeSaulnier. Controlled substances: *prescriptions:* 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 specified information regarding prescriptions for Schedule II, Schedule III, and Schedule IV controlled substances, including the ultimate user of the prescribed controlled substance and the National Drug Control number of the controlled substance dispensed, to be reported to the Department of Justice.

This bill would additionally require the prescribing and dispensing of Schedule V controlled substances to be monitored in CURES and would require specified information regarding prescriptions for Schedule V controlled substances to be reported to the Department of Justice.

(2) Existing law requires licensed health care practitioners, as specified, and pharmacists to apply to the Department of Justice to obtain approval to access information contained in the CURES Prescription Drug Monitoring System (PDMP) regarding the controlled substance history of a patient under his or her care. Existing law requires the Department of Justice, upon approval of that application, to provide to that health care practitioner or pharmacist the history of controlled substances dispensed to an individual under his or her care.

This bill would also authorize an individual designated to investigate an applicant for, or a holder of, a professional license to apply to the Department of Justice to obtain approval to access information contained in the CURES PDMP regarding the controlled substance history of an applicant or a licensee for the purpose of investigating the alleged substance abuse of an applicant or a licensee. The bill would, upon approval of that application, require the department to provide to that individual the history of controlled substances dispensed to the applicant or licensee.

(3) Existing law generally requires, subject to specified exceptions, that a prescription for Schedule II, Schedule III, Schedule IV, or Schedule V controlled substances be made on a certain controlled substance prescription form and meet several requirements, including that the prescription be signed and dated by the prescriber in ink. Existing law authorizes, as an exception to that requirement, a Schedule III, Schedule IV, or Schedule V controlled substance to be dispensed upon an oral or electronically transmitted prescription, which must be produced in hard copy form and signed and dated by the pharmacist filling the prescription or another authorized person.

This bill would instead require, subject to specified exceptions, that a prescription for a controlled substance be made by an electronically transmitted prescription that complies with regulations promulgated by the Drug Enforcement Agency, which, except as specified, must be produced in hard copy form and signed and dated by the pharmacist filling the prescription or another authorized person.

(4) Existing law prohibits a prescription for a Schedule II controlled substance from being refilled and prohibits a prescription for a Schedule III or IV controlled substance from being refilled more than 5 times and in an amount, for all refills of that prescription taken together, exceeding a 120-day supply.

This bill would prohibit, subject to specified exceptions, a person from prescribing a controlled substance, or filling, compounding, or

dispensing a prescription for a controlled substance, in a quantity exceeding a 30 day supply. The bill would also prohibit a person from issuing a prescription for a controlled substance, or from filling, compounding, or dispensing a prescription for a controlled substance, for an ultimate user for whom a previous prescription for a controlled substance was issued within the immediately preceding 30 days until the ultimate user has exhausted all but a 7-day supply of the controlled substance filled, compounded, or dispensed from the previous prescription.

~~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 authorizes the Department of Justice to seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES and requires that the operation of CURES comply with all applicable federal and state privacy and security laws and regulations.~~

~~This bill would make technical, nonsubstantive changes to those provisions.~~

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

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

1 *SECTION 1. Section 4071 of the Business and Professions*
2 *Code is amended to read:*
3 4071. Notwithstanding any other provision of law, a prescriber
4 may authorize his or her agent on his or her behalf to orally or
5 electronically transmit a prescription to the furnisher. The furnisher
6 shall make a reasonable effort to determine ~~that~~ *whether* the person
7 who transmits the prescription is authorized to do so and shall
8 record the name of the authorized agent of the prescriber who
9 transmits the order.
10 ~~This section shall not apply to orders for Schedule II controlled~~
11 ~~substances.~~
12 *SEC. 2. Section 4072 of the Business and Professions Code is*
13 *amended to read:*

4072. (a) Notwithstanding any other ~~provision of~~ law, a pharmacist, registered nurse, licensed vocational nurse, licensed psychiatric technician, or other healing arts licentiate, if so authorized by administrative regulation, who is employed by or serves as a consultant for a licensed skilled nursing, intermediate care, or other health care facility, may orally or electronically transmit to the furnisher a prescription lawfully ordered by a person authorized to prescribe drugs or devices pursuant to Sections 4040 and 4070. The furnisher shall take appropriate steps to determine ~~that~~ *whether* the person who transmits the prescription is authorized to do so and shall record the name of the person who transmits the order. This section ~~shall~~ *does* not apply to *oral* orders for Schedule II controlled substances.

(b) In enacting this section, the Legislature recognizes and affirms the role of the State Department of Public Health in regulating drug order processing requirements for licensed health care facilities as set forth in Title 22 of the California Code of Regulations as they may be amended from time to time.

SEC. 3. Section 11151 of the Health and Safety Code is amended to read:

11151. A prescription ~~written~~ *issued* by an unlicensed person lawfully practicing medicine pursuant to Section 2065 of the Business and Professions Code, shall be filled only at a pharmacy maintained in the hospital which employs such unlicensed person.

SEC. 4. Section 11158 of the Health and Safety Code is amended to read:

11158. (a) Except as provided in Section ~~11159~~ *11159, 11159.1, 11159.2, 11167, or 11167.5,* or in subdivision (b) of this section, ~~no~~ *a* controlled substance classified in Schedule II shall *not* be dispensed without a prescription meeting the requirements of this chapter. Except as provided in Section ~~11159~~ *11159, 11159.1, 11159.2, 11167, or 11167.5,* or when dispensed directly to an ultimate user by a practitioner, other than a pharmacist or pharmacy, ~~no~~ *a* controlled substance classified in Schedule III, IV, or V ~~may~~ *shall not* be dispensed without a prescription meeting the requirements of this chapter.

(b) A practitioner specified in Section 11150 may dispense directly to an ultimate user a controlled substance classified in Schedule II in an amount not to exceed a 72-hour supply for the patient in accordance with directions for use given by the

dispensing practitioner only ~~where~~ *if* the patient is not expected to require any additional amount of the controlled substance beyond the 72 hours. ~~Practitioners dispensing drugs pursuant to this subdivision shall meet the requirements of subdivision (f) of Section 11164.~~

(c) Except as otherwise prohibited or limited by law, a practitioner specified in Section 11150, may administer controlled substances in the regular practice of his or her profession.

SEC. 5. Section 11164 of the Health and Safety Code is amended to read:

11164. Except as provided in Section *11158, 11159, 11159.1, 11159.2,* 11167, ~~no~~ *or 11167.5, a* person shall *not* prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

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

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

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

~~(b)~~

(a) (1) ~~Notwithstanding paragraph (1) of subdivision (a) of Section 11162.1, any~~ *A prescription for a* controlled substance classified in Schedule *II,* III, IV, or V ~~be dispensed upon an oral~~

~~or electronically transmitted prescription,~~ *shall be made by an electronically transmitted prescription that complies with regulations promulgated by the Drug Enforcement Agency,* which shall be produced in hard copy form and signed and dated by the pharmacist filling the prescription or by any other person expressly authorized by provisions of the Business and Professions Code. Any person who transmits, maintains, or receives any electronically transmitted prescription shall ensure the security, integrity, authority, and confidentiality of the prescription.

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

(2) A prescription issued pursuant to this subdivision shall meet the following requirements:

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

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

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

(b) (1) A prescription for a controlled substance classified in Schedule II, III, IV, or V, may be written on a controlled substance prescription form as specified in Section 11162.1, or for a controlled substance classified in Schedule III, IV, or V, may be made orally, if technological failure prevents the electronic transmission of a prescription pursuant to subdivision (a) or if the prescription will be filled by a pharmacist located outside of California, provided that the order contains all information required by subdivision (a) and, if the prescription is written on a controlled substance prescription form, is signed and dated by the prescriber in ink.

(2) If a prescriber is permitted to make an oral prescription pursuant to this section, pursuant to an authorization of the prescriber, an agent of the prescriber on behalf of the prescriber may orally transmit a prescription for a controlled substance classified in Schedule II, III, IV, or V, if the written record of the prescription specifies the name of the agent of the prescriber transmitting the prescription.

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

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

~~(e) This section shall become operative on January 1, 2005.~~

SEC. 6. 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) All prescriptions for Schedule II, Schedule III, ~~and~~ Schedule ~~IV~~ *IV, and Schedule V* 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 (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.

SEC. 7. Section 11164.5 of the Health and Safety Code is amended to read:

11164.5. (a) ~~Notwithstanding Section 11164, with the approval of the California State Board of Pharmacy and the Department of Justice, a~~ *A* pharmacy or hospital ~~may~~ *shall* receive electronic data transmission prescriptions or computer entry prescriptions or orders as specified in Section 4071.1 of the Business and Professions Code, for controlled substances in Schedule II, III, IV, or V ~~if authorized by federal law and~~ in accordance with regulations promulgated by the Drug Enforcement Administration. ~~The California State Board of Pharmacy shall maintain a list of all requests and approvals granted pursuant to this subdivision.~~

(b) Notwithstanding *paragraph (1) of subdivision (a) of* Section 11164, ~~if approved pursuant to subdivision (a),~~ a pharmacy or hospital receiving an electronic transmission prescription or a computer entry prescription or order for a controlled substance classified in Schedule II, III, IV, or V ~~shall~~ *is* not ~~be~~ required to reduce that prescription or order to writing or to hard copy form, if for three years from the last day of dispensing that prescription, the pharmacy or hospital is able, upon request of the board or the Department of Justice, to immediately produce a hard copy report that includes for each date of dispensing of a controlled substance in Schedules II, III, IV, and V pursuant to the prescription all of the information described in subparagraphs (A) to (E), inclusive, of paragraph (1) of subdivision (a) of Section 4040 of the Business and Professions Code and the name or identifier of the pharmacist who dispensed the controlled substance.

(c) ~~Notwithstanding Section 11164, if~~ *If* only recorded and stored electronically, on magnetic media, or in any other computerized form, the pharmacy's or hospital's computer system shall not permit the received information or the controlled substance dispensing information required by this section to be changed, obliterated, destroyed, or disposed of, for the record maintenance period required by law, once the information has been received by the pharmacy or the hospital and once the controlled substance has been dispensed, respectively. Once the controlled substance has been dispensed, if the previously created record is

determined to be incorrect, a correcting addition may be made only by or with the approval of a pharmacist. After a pharmacist enters the change or enters his or her approval of the change into the computer, the resulting record shall include the correcting addition and the date it was made to the record, the identity of the person or pharmacist making the correction, and the identity of the pharmacist approving the correction.

(d) Nothing in this section shall be construed to exempt any pharmacy or hospital dispensing Schedule II controlled substances pursuant to electronic transmission prescriptions from existing reporting requirements.

~~SECTION 1.~~

SEC. 8. 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~~ *IV, and Schedule V* controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in 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~~ *IV, and Schedule V* controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(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 the support of CURES.

(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 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 an individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to a third party. The Department of Justice 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.

(d) For each prescription for a Schedule II, Schedule III, ~~or~~ Schedule ~~IV~~ *IV, or Schedule V* controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, ~~and~~ 1308.14, *and 1308.15,* 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, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, 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, license number, national provider identifier (NPI) number, if applicable, 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.

(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 (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or committees identified in subdivision (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 Prescription Drug Monitoring Program (PDMP).

(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.

SEC. 9. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, ~~or~~ Schedule ~~IV~~ *IV, or Schedule V* controlled substances pursuant to Section 11150 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 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).

(ii) A pharmacist shall, before January 1, 2016, or upon licensure, 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 pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(iii) An individual designated by a board, bureau, or program within the Department of Consumer Affairs to investigate an applicant for, or a holder of, a professional license may, for the purpose of investigating the alleged substance abuse of an applicant or a licensee, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of an applicant or a licensee that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that individual the electronic history of controlled substances dispensed to the applicant or licensee based on data contained in the CURES PDMP.

(B) 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 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.

(C) Any authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, ~~or~~ Schedule ~~IV~~ *IV, or Schedule V* 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) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, ~~or~~ Schedule ~~IV~~ *IV, or Schedule V* 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.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by ~~a practitioner or pharmacist~~ *an authorized subscriber* 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~~ *an authorized subscriber* pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, ~~and 1308.14~~ *1308.14, and 1308.15* of Title 21 of the Code of Federal Regulations.

SEC. 10. Section 11165.5 of the Health and Safety Code is amended to read:

11165.5. (a) The Department of Justice may seek voluntarily contributed private funds from insurers, health care service plans, qualified manufacturers, and other donors 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 established pursuant to subdivision (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~~ *11057, or 11058* 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. 11. Section 11166 of the Health and Safety Code is amended to read:

11166. ~~No~~ *A* person shall *not* fill a prescription for a controlled substance after six months has elapsed from the date ~~written on~~ the prescription *was issued* by the prescriber. ~~No~~ *A* person shall *not* knowingly fill a mutilated or forged or altered prescription for a controlled substance except for the addition of the address of the person for whom the controlled substance is prescribed as provided by paragraph ~~(3)~~ *(2)* of subdivision (b) of Section 11164.

SEC. 12. Section 11200 of the Health and Safety Code is amended to read:

11200. (a) ~~No~~ *A* person shall *not* dispense or refill a controlled substance prescription more than six months after the date thereof.

(b) (1) Except as provided in paragraph (2), a person shall not prescribe a controlled substance, nor shall a person fill, compound, or dispense a prescription for a controlled substance, in a quantity exceeding a 30-day supply.

(2) A person may prescribe a controlled substance, and a person may fill, compound, or dispense a prescription for a controlled substance, in a quantity not exceeding a 90-day supply if the prescription is issued in the treatment of one of the following:

(A) A panic disorder.

(B) Attention deficit disorder.

(C) A chronic debilitating neurologic condition characterized as a movement disorder or exhibiting seizure, convulsive, or spasm activity.

(D) Pain in patients with conditions or diseases known to be chronic or incurable.

(E) Narcolepsy.

~~(b) No~~

(c) (1) A prescription for a Schedule III or IV substance ~~may~~ *shall not* be refilled more than five times and in an amount, for all refills of that prescription taken together, exceeding a 120-day supply.

~~(c) No~~

(2) A prescription for a Schedule II substance ~~may~~ *shall not* be refilled.

(d) A person shall not issue a prescription for a controlled substance, nor shall a person fill, compound, or dispense a prescription for a controlled substance, for an ultimate user for whom a previous prescription for a controlled substance was issued within the immediately preceding 30 days until the ultimate user has exhausted all but a seven-day supply of the controlled substance filled, compounded, or dispensed from the previous prescription.

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SB 1262 - CORREA

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1262
Author: Correa
Bill Date: April 21, 2014, Amended
Subject: Medical Marijuana Regulation
Sponsor: California Police Chiefs Association (Co-Sponsor)
League of California Cities (Co-Sponsor)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would put various licensing and enforcement requirements on medical marijuana dispensaries and cultivation facilities and would also put requirements on physicians recommending medical marijuana and on the Medical Board of California (Board). However, this analysis will only cover the portion of the bill related to the requirements on physicians recommending medical marijuana and the Board.

This bill would require physicians to meet specified requirements before recommending medical marijuana and would require the recommendations to include specified information. This bill would require physicians recommending medical marijuana to adhere to financial anti-kickback and advertising requirements. This bill would state that violation of the recommendation and advertising requirements in the bill constitutes unprofessional conduct. Lastly, this bill would require the Board to convene a task force of experts in the use of medical marijuana and to update the Board's statement/guidelines on medical marijuana.

BACKGROUND:

In 1996, California voters approved the Compassionate Use Act (Proposition 215), which allowed Californians access to marijuana for medical purposes, and prohibited punitive action against physicians for making medical marijuana recommendations. SB 420 (Vasconcellos, Chapter 875, Statutes of 2003), the Medical Marijuana Program Act, included issuance of identification cards for qualified patients, and allowed patients and their primary caregivers to collectively or cooperatively cultivate medical marijuana. According to the author's office, no feasible, broad regulatory structure has been established for medical marijuana, and the implementation of the Compassionate Use Act has resulted in conflicting authorities, regulatory chaos, intermittent federal action, and a series of lawsuits. According to the author's office, the purpose of this bill is to put a framework around medical marijuana regulation and address the many associated public safety concerns.

ANALYSIS:

SB 1262 would require physicians, prior to recommending medical marijuana, to meet the following requirements:

- Have a doctor-patient relationship.

- Conduct an appropriate prior examination of the patient to establish that medical use of marijuana is appropriate.
- Consult with the patient as necessary and periodically review the treatment's efficacy.

A physician that recommends marijuana would be required to do all of the following:

- Include a discussion of the side effects.
- Address, in the recommendation, what kind of marijuana to obtain, including high tetrahydrocannabinol (THC) levels, low THC levels, high cannabidiol (CBD) levels, low CBD levels, and explain the reason for recommending that particular strain. Under no circumstances shall a physician recommend butane hash oil.
- Maintain a system of recordkeeping that supports the decision to recommend the use of medical marijuana for individual patients.
- If recommending medical marijuana to a minor (under 21 years of age), the recommendation must be approved by a board-certified pediatrician and must be for high CBD marijuana and for non-smoking delivery.

This bill would make it unprofessional conduct if a physician recommends medical marijuana without an appropriate prior examination and a medical indication, or recommends marijuana for non-medical purposes.

This bill would also subject physicians recommending medical marijuana to the laws in Business and Professions Code Section (BPC) 650.01 and would not allow a physician to accept, solicit, or offer any form of remuneration from or to a licensed dispenser, producer, or processor of cannabis products in which the licensee or his or her immediate family has a financial interest. This bill would not allow a physician to advertise for medical marijuana physician recommendations unless the advertisement contains the following notice and meets the requirements of BPC 651:

> "NOTICE TO CONSUMERS: The Compassionate Use Act of 1996 ensures that seriously ill Californians have the right to obtain and use marijuana for medical purposes where medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana. Physicians arrive at the decision to make this recommendation in accordance with the accepted standards of medical responsibility and are licensed and regulated by the Medical Board of California. California law prohibits advertising that includes statements of bait, discount, premiums, gifts, or any statements of a similar nature."

Lastly, this bill would require the Board, by January 1, 2016, to convene a task force of experts in the use of medical marijuana, to review and update as necessary physician guidelines for recommending medical marijuana to ensure the competent review in cases concerning the recommendation of marijuana for medical purposes.

This bill would give the Board some needed enforcement tools to more efficiently regulate physicians who recommend medical marijuana. This bill expressly spells out

what a physician must do before medical marijuana is recommended, what a physician must do if a medical marijuana recommendation is issued, places appropriate anti-kick back and advertising restrictions on physicians who recommend medical marijuana, and directly ties non-compliance with some of these requirements to unprofessional conduct. These are all tools that will make the Board's enforcement more efficient. However, Board staff does have some concerns with some of the provisions in this bill.

The bill would require a physician to address, in the recommendation, what kind of marijuana to obtain, including high THC levels, low THC levels, high CBD levels, low CBD levels, and explain the reason for recommending that particular strain. Board staff is concerned that until medical marijuana is regulated by the Food and Drug Administration (FDA), physicians may not know the appropriate type of marijuana to recommend, or be able to explain the reason for recommending a particular strain. In addition, the Board's physician experts that review enforcement cases may also not be knowledgeable in the appropriate, particular strain a physician should be recommending, as the FDA does not regulate marijuana at this time.

This bill would require the Board, by January 1, 2016, to convene a task force of experts in the use of medical marijuana, to review and update as necessary physician guidelines for recommending medical marijuana to ensure the competent review in cases concerning the recommendation of marijuana for medical purposes. The Board could convene a task force to look at the current statement adopted by the Board related to medical marijuana, and update that statement with information that will be contained in the revised pain management guidelines and with information on the new laws that are contained in this bill; however, Board staff strongly believes that the guidelines are there to guide physicians recommending marijuana. Board staff believes the competent review portion of this provision should be removed.

Board staff is suggesting the Board oppose this bill unless the portion regarding the recommendation containing a particular strain be amended out of the bill, and the portion that states the purpose of the guidelines is to ensure competent review of cases by the Board.

FISCAL: Minor and absorbable costs related to convening the task force and updating the statement/guidelines for physicians recommending medical marijuana.

SUPPORT: California Police Chiefs Association (Co-Sponsor); League of California Cities (Co-Sponsor); Association for Los Angeles Deputy Sheriffs; Association of Orange County Deputy Sheriffs; California Association of Code Enforcement Officers; California Fraternal Order of Police; City of Adelanto; City of Beaumont; City of Canyon Lake; City of Chowchilla; City of Covina; City of Encinitas; City of Etna; City of Fortuna; City of Gardena; City of Glendora; City of Hemet; City of Highland; City of La Palma; City of Lathrop; City of Lodi; City of Merced; City of Norwalk; City of Rancho Cordova; City of Rancho Cucamonga; City of Rancho Mirage; City of Rosemead; City of Sacramento; City of

San Carlos; City of Woodland; Covina Police Department; El Monte, South El Monte Chamber of Commerce; International Faith Based Coalition; Long Beach Police Officers Association; Los Angeles County Police Professional Peace Officers Association; Los Angeles Police Protective League; Mammoth Lakes Police Department; Riverside Sheriffs Association; Sacramento County Deputy Sheriffs Association; San Diego County District Attorney; San Diego District Attorney; Santa Ana Police Officers Association; Smart Approaches to Marijuana (Project SAM); Town of Colma Police Department; Town of Danville; and Patient Advocacy Network (if amended)

OPPOSITION: Butte County Board of Supervisors

OPPOSE UNLESS AMENDED: American Academy of Cannabinoid Medicine; Americans for Safe Access; California Medical Association; California National Organization for Reform of Marijuana Laws; California National Organization for the Reform of Marijuana Laws (Cal NORML); Drug Policy Alliance; Law Enforcement Against Prohibition; Rural County Representatives of California; The Greater Los Angeles Collective Alliance; and Yolo County

POSITION: Recommendation: Oppose Unless Amended

AMENDED IN SENATE APRIL 21, 2014

SENATE BILL No. 1262

Introduced by Senator Correa

February 21, 2014

An act to add Article 25 (commencing with Section 2525) to Chapter 5 of Division 2 of the Business and Professions Code, and to add Article 7 (commencing with Section 111657) to Chapter 6 of Part 5 of Division 104 of the Health and Safety Code, relating to medical marijuana.

LEGISLATIVE COUNSEL'S DIGEST

SB 1262, as amended, Correa. Medical marijuana: regulation of physicians, dispensaries, and cultivation sites.

(1) Existing law, the Compassionate Use Act of 1996, an initiative measure enacted by the approval of Proposition 215 at the November 6, 1996, statewide general election, authorizes the use of marijuana for medical purposes. Existing law enacted by the Legislature requires the establishment of a program for the issuance of identification cards to qualified patients so that they may lawfully use marijuana for medical purposes, and requires the establishment of guidelines for the lawful cultivation of marijuana grown for medical use.

This bill would require the State Department of Public Health to license dispensing facilities and cultivation sites that provide, process, and grow marijuana for medical use, as specified, and would make these licenses subject to the restrictions of the local jurisdiction in which the facility operates or proposes to operate. The bill would require the department to establish standards for quality assurance testing of medical marijuana and would prohibit the use of nonorganic pesticides in any marijuana cultivation site. The bill would require licensed dispensing facilities and licensed cultivation sites to implement sufficient security

measures to both deter and prevent unauthorized entrance into areas containing marijuana and theft of marijuana at those facilities, including establishing limited access areas accessible only to authorized facility personnel, and would require these facilities to notify appropriate law enforcement authorities within 24 hours after discovering specified breaches in security. *The bill would require licensed dispensing facilities to verify that the recommending physician and surgeon is licensed to practice medicine in California before providing a marijuana product to a patient. This bill would prohibit the distribution of any form of advertising for physician recommendations for medical marijuana unless the advertisement bears a specified notice and requires that the advertisement meet specified requirements and not be fraudulent, deceitful, or misleading, as specified.* The bill would make enforcement of these provisions the responsibility of the county health departments, with oversight by the department. Violation of these provisions would be punishable by a civil fine of up to $35,000 for each individual violation. By expanding the duties of local health officers, this bill would impose a state-mandated local program.

(2) Existing law, the Medical Practice Act, provides for licensure and regulation of physicians and surgeons by the Medical Board of California.

This bill would establish requirements for a physician and surgeon to recommend medical marijuana, including prescribed procedural and recordkeeping requirements, and would require a recommendation for medical marijuana for a ~~minor~~ *person under 21 years of age* to include a specific justification for the recommendation and why the benefit of use is more important than the possible neurological damage that could be caused by the ~~minor~~ *person* using marijuana and to be approved by a board certified pediatrician. ~~The bill would require a physician and surgeon that recommends medical marijuana to report to the board the number of recommendations issued, with supporting documentation on patient medical need.~~

~~This bill would require the board to audit a physician and surgeon who recommends medical marijuana more than 100 times in a year to ensure compliance with existing law and would require the board to establish a certification process for physicians who wish to issue medical marijuana recommendations, including a mandatory training in identifying signs of addiction and ongoing substance abuse.~~

This bill would require the board, by January 1, 2016, to convene a task force of experts in the use of medical marijuana to review and

update, as necessary, guidelines for recommending medical marijuana, as specified.

Violation of these provisions would be punishable by a civil fine not to exceed $5,000. *The bill would make the recommendation of medical marijuana without a prior examination and medical indication and recommendation of medical marijuana for nonmedical purposes unprofessional conduct, to be punished as provided. The bill would also make it a misdemeanor for a physician and surgeon who recommends marijuana to a patient for a medical purpose to accept, solicit, or offer any remuneration from or to a licensed dispensing facility in which the physician and surgeon or his or her immediate family has a financial interest. By creating a new crime, this bill would impose a state-mandated local program.*

~~(3) 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, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.~~

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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) The California Constitution grants cities and counties the
4 authority to make and enforce, within their borders, "all local
5 police, sanitary, and other ordinances and regulations not in conflict

with the general laws." This inherent local police power includes broad authority to determine, for purposes of public health, safety, and welfare, the appropriate uses of land within the local jurisdiction's borders. The police power, therefore, allows each city and county to determine whether or not a medical marijuana dispensary or other facility that makes medical marijuana available may operate within its borders. This authority has been upheld by City of Riverside v. Inland Empire Patients Health & Wellness, Inc. (2013) 56 Cal.4th 729 and County of Los Angeles v. Hill (2011) 192 Cal.App.4th 861.

(b) If, pursuant to this authority, a city or county determines that a dispensary or other facility that makes medical marijuana available may operate within its borders, then there is a need for the state to license these dispensaries and other facilities for the purpose of adopting and enforcing protocols for training and certification of physicians who recommend the use of medical marijuana and for agricultural cultivation practices. This licensing requirement is not intended in any way nor shall it be construed to preempt local ordinances regarding the sale and use of medical marijuana, including, but not limited to, security, signage, lighting, and inspections.

~~(c) Given that the current system of all-cash transactions within the medical marijuana industry is unsustainable in the long term, there is a need to provide a monetary structure, as an alternative to the federal banking system, for the operation, regulation, and taxation of medical marijuana dispensaries.~~

~~(d)~~

(c) All of the following elements are necessary to uphold important state goals:

(1) Strict provisions to prevent the potential diversion of marijuana for recreational use.

(2) Audits to accurately track the volume of both product movement and sales.

(3) An effective means of restricting access to medical marijuana by ~~minors,~~ *persons under 21 years of age* ~~given the medical studies documenting marijuana's harmful and permanent effects on the brain development of youth~~.

~~(4) Stricter provisions relating to physicians and their recommendation procedures in order to address widespread problems of questionable medical marijuana recommendations by~~

~~physicians without a bona-fide doctor-patient relationship with the person to whom they are issuing the recommendation.~~

~~(c)~~

(d) Nothing in this act shall be construed to promote or facilitate the nonmedical, recreational possession, sale, or use of marijuana.

SEC. 2. Article 25 (commencing with Section 2525) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 25. Recommending Medical Marijuana

2525. (a) Prior to recommending marijuana to a patient pursuant to Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the Health and Safety Code, a physician and surgeon shall meet all of the following requirements:

(1) Have a ~~bona fide~~ doctor-patient ~~relationship, with medical marijuana recommendations to be made by a patient's primary care physician or by a physician and surgeon to whom the patient is referred by their primary care physician~~ *relationship*.

(2) Conduct an ~~in-person~~ *appropriate prior* examination *of the patient* to establish ~~the patient's need for medical marijuana~~ *that medical use of marijuana is appropriate*.

(3) Consult with the patient as necessary and periodically review the treatment's efficacy.

(b) A physician and surgeon that recommends medical marijuana shall do all of the following:

(1) ~~Address, in the recommendation, the quantity of use and method of delivery, including~~ *Include* a discussion of side effects. ~~If the recommended method of delivery is smoking, the recommendation shall state the reasons for selecting this method of delivery in the context of health issues created by smoking.~~

(2) Address, in the recommendation, what kind of marijuana to obtain, including high tetrahydrocannabinol (THC) levels, low THC levels, high cannabidiol (CBD) levels, low CBD levels, and explain the reason for recommending the particular strain. Under no circumstances shall a physician and surgeon recommend butane hash oil.

(3) Maintain a system of recordkeeping that supports the decision to recommend the use of medical marijuana for individual patients.

(c) A recommendation for medical marijuana provided to a ~~minor~~ *person under 21 years of age* shall ~~include a specific justification for the recommendation and why the benefit of use is more important than the possible neurological damage that could be caused by the minor using marijuana. A recommendation for a minor shall~~ be approved by a board certified pediatrician. A recommendation for a ~~minor~~ *person under 21 years of age* shall be for high CBD marijuana and all recommendations for ~~minors must~~ *persons under 21 years of age shall* be for nonsmoking delivery.

~~2525.1. (a) A physician and surgeon who recommends medical marijuana shall report to the California Medical Board the number of recommendations issued, with supporting documentation on patient medical need. The board shall forward these reports to the State Department of Public Health.~~

~~(b) A physician and surgeon who makes more than 100 recommendations in a calendar year shall be audited by the California Medical Board to determine compliance with Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the Health and Safety Code.~~

~~2525.2. The California Medical Board shall establish a certification process for physicians who wish to issue medical marijuana recommendations, including a mandatory training in identifying signs of addiction and ongoing substance abuse.~~

2525.1. (a) It is unlawful for a physician and surgeon who recommends marijuana to a patient for a medical purpose to accept, solicit, or offer any form of remuneration from or to a facility licensed pursuant to Article 7 (commencing with Section 111657) of Chapter 6 of Part 5 of Division 104 of the Health and Safety Code if the physician and surgeon or his or her immediate family have a financial interest in that facility.

(b) For the purposes of this section, "financial interest" shall have the same meaning as in Section 650.01.

(c) A violation of this section shall be a misdemeanor.

2525.2. The board, by January 1, 2016, shall convene a task force of experts in the use of medical marijuana to review and update, as necessary, guidelines for recommending medical marijuana to ensure competent review in cases concerning the recommendation of marijuana for medical purposes.

2525.3. *(a)* In addition to all other remedies available pursuant to this chapter, violation of any provision of this article shall be punishable by a civil fine of up to five thousand dollars ($5,000).

(b) Recommending marijuana to a patient for a medical purpose without an appropriate prior examination and a medical indication, or recommending marijuana for a nonmedical purpose shall constitute unprofessional conduct and may be punished pursuant to Article 12 (commencing with Section 2220).

SEC. 3. Article 7 (commencing with Section 111657) is added to Chapter 6 of Part 5 of Division 104 of the Health and Safety Code, to read:

Article 7. Medical Marijuana

111657. For purposes of this article, the following definitions shall apply:

(a) "Department" means the State Department of Public Health.

(b) "Licensed cultivation site" means a facility that grows or grows and processes marijuana for medical use and that is licensed pursuant to Section 111657.1.

(c) "Licensed dispensing facility" means a dispensary, mobile dispensary, marijuana processing facility, or other facility that provides marijuana for medical use that is licensed pursuant to Section 111657.1.

111657.1. (a) Except as provided in Section 11362.5 of, and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of, the Health and Safety Code, a person shall not sell or provide marijuana other than at a licensed dispensing facility.

(b) Except as provided in Section 11362.5 of, and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of, the Health and Safety Code, a person shall not grow or process marijuana other than at a licensed cultivation site.

(c) The department shall require, prior to issuing a license to a dispensing facility or a cultivation site, all of the following:

(1) The name of the owner or owners of the proposed facility.

(2) The address and telephone number of the proposed facility.

(3) A description of the scope of business of the proposed facility.

(4) A certified copy of the local jurisdiction's approval to operate within its borders.

(5) A completed application, as required by the department.

(6) Payment of a fee, in an amount to be determined by the department not to exceed the amount necessary, but that is sufficient to cover, the actual costs of the administration of this article.

(7) Any other information as required by the department.

111657.2. The department shall, after consulting with outside entities as needed, establish standards for quality assurance testing of medical marijuana, to ensure protection against microbiological contaminants. Nonorganic pesticides shall not be used in any marijuana cultivation site, irrespective of size or location.

111657.3. (a) A licensed dispensing facility shall not acquire, possess, cultivate, deliver, transfer, transport, or dispense marijuana for any purpose other than those authorized by Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10.

(b) A licensed dispensing facility shall not acquire marijuana plants or products except through the cultivation of marijuana by that facility, if the facility is a licensed cultivation site, or another licensed cultivation site.

111657.4. A licensed dispensing facility shall not provide a marijuana product to a patient until it verifies that the recommending physician and surgeon is licensed to practice medicine in California.

111657.5. (a) A person shall not distribute any form of advertising for physician recommendations for medical marijuana in California unless the advertisement bears the following notice to consumers:

NOTICE TO CONSUMERS: The Compassionate Use Act of 1996 ensures that seriously ill Californians have the right to obtain and use marijuana for medical purposes where medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana. Physicians are licensed and regulated by the Medical Board of California and arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility. California law prohibits advertising that includes statements of bait, discount, premiums, gifts, or any statements of a similar nature.

(b) Advertising for physician recommendations for medical marijuana shall meet all requirements of Section 651 of the Business and Professions Code. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or statements of a similar nature.

~~111657.4.~~

111657.6. (a) A facility licensed pursuant to this article shall implement sufficient security measures to both deter and prevent unauthorized entrance into areas containing marijuana and theft of marijuana at those facilities. These security measures shall include, but not be limited to, all of the following:

(1) Allow only registered qualifying patients, personal caregivers, and facility agents access to the facility.

(2) Prevent individuals from remaining on the premises of the facility if they are not engaging in activity expressly related to the operations of the facility.

(3) Establish limited access areas accessible only to authorized facility personnel.

(4) Store all finished marijuana in a secure, locked safe or vault and in a manner as to prevent diversion, theft, and loss.

(b) A facility licensed pursuant to this article shall notify appropriate law enforcement authorities within 24 hours after discovering any of the following:

(1) Discrepancies identified during inventory.

(2) Diversion, theft, loss, or any criminal activity involving the facility or a facility agent.

(3) The loss or unauthorized alteration of records related to marijuana, registered qualifying patients, personal caregivers, or facility agents.

(4) Any other breach of security.

(c) A licensed cultivation site shall weigh, inventory, and account for on video, all medical marijuana to be transported prior to its leaving its origination location. Within eight hours after arrival at the destination, the licensed dispensing facility shall re-weigh, re-inventory, and account for on video, all transported marijuana.

~~111657.5.~~

111657.7. (a) Enforcement of this article shall be the responsibility of the county health departments, with oversight by the department.

(b) An enforcement officer may enter a facility licensed pursuant to this article during the facility's hours of operation and other reasonable times to do either of the following:

(1) Conduct inspections, issue citations, and secure samples, photographs, or other evidence from the facility, or a facility suspected of being a dispensing facility or cultivation site.

(2) Secure as evidence documents, or copies of documents, including inventories required pursuant to subdivision (c) of Section ~~111657.4~~ *111657.6*, or any record, file, paper, process, invoice, video, or receipt for the purpose of determining compliance with this chapter.

(c) A written report shall be made and a copy shall be supplied or mailed to the owner of the facility at the completion of an inspection or investigation.

(d) Upon request by the department, local governments shall provide the department with reports on the number and types of facilities operating within their jurisdiction.

~~111657.6.~~

111657.8. In addition to the provisions of this article, a license granted pursuant to this article shall be subject to the restrictions of the local jurisdiction in which the facility operates or proposes to operate. Even if a license has been granted pursuant to this article, a facility shall not operate in a local jurisdiction that prohibits the establishment of that type of business.

~~111657.7.~~

111657.9. Violation of this provision shall be punishable by a civil fine of up to thirty-five thousand dollars ($35,000) for each individual violation.

111657.10. Nothing in this article shall prevent a city or other local governing body from doing any of the following:

(a) Adopting and enforcing local ordinances that regulate the location, operation, or establishment of medical marijuana cooperatives or collectives.

(b) The civil and criminal enforcement of local ordinances described in subdivision (a).

(c) Enacting other laws consistent with this article.

1 ~~SEC. 4. If the Commission on State Mandates determines that~~
2 ~~this act contains costs mandated by the state, reimbursement to~~
3 ~~local agencies and school districts for those costs shall be made~~
4 ~~pursuant to Part 7 (commencing with Section 17500) of Division~~
5 ~~4 of Title 2 of the Government Code.~~
6 *SEC. 4. No reimbursement is required by this act pursuant to*
7 *Section 6 of Article XIII B of the California Constitution for certain*
8 *costs that may be incurred by a local agency or school district*
9 *because, in that regard, this act creates a new crime or infraction,*
10 *eliminates a crime or infraction, or changes the penalty for a crime*
11 *or infraction, within the meaning of Section 17556 of the*
12 *Government Code, or changes the definition of a crime within the*
13 *meaning of Section 6 of Article XIII B of the California*
14 *Constitution.*
15 *However, if the Commission on State Mandates determines that*
16 *this act contains other costs mandated by the state, reimbursement*
17 *to local agencies and school districts for those costs shall be made*
18 *pursuant to Part 7 (commencing with Section 17500) of Division*
19 *4 of Title 2 of the Government Code.*

O

SB 1466 – SEN. B&P

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 1466
Author:	Committee on Business, Professions, and Economic Development
Bill Date:	March 25, 2014, introduced
Subject:	Omnibus
Sponsor:	Committee, Medical Board of California (Board) and other affected regulatory health boards
Position:	Support provisions related to the Board

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business, Professions and Economic Development Committee. This analysis will only include the relevant sections of the bill in the Business and Professions Code (BPC) that are sponsored by and impact the Medical Board of California (Board). The omnibus language would include the American Osteopathic Association-Healthcare Facilities Accreditation Program (AOA-HFAP) as an approved accreditation agency for hospitals offering accredited postgraduate training programs. This bill would also strike "scheduled" from existing law that requires physicians who perform a "scheduled" medical procedure outside of a hospital, that results in a death, to report the occurrence to the Board within 15 days.

ANALYSIS:

BPC Section 2089.5 – AOA-HFAP

Currently, the Board recognizes Accreditation Council Graduate for Medical Education (ACGME) accredited postgraduate training for the purposes of allopathic medical school students' clinical clerkship training and for the required postgraduate training for licensure as a physician and surgeon. ACGME accredited postgraduate training programs are at institutions that are accredited by the Joint Commission. Recently, ACGME has accredited postgraduate training programs in hospitals that are accredited by the AOA-HFAP. However, existing law (B&P Code Section 2089.5) specifically references the "Joint Commission on Accreditation of Hospitals" as the hospital accreditation agency for ACGME postgraduate training programs.

American Osteopathic Association (AOA) accredits postgraduate training for licensure purposes for osteopathic medical school graduates. AOA accredited postgraduate training programs are usually obtained in hospitals that are accredited by the AOA-HFAP. ACGME and AOA have reached an agreement for ACGME to approve all postgraduate training programs for both allopathic medical school (M.D. degrees awarded) and osteopathic medical school (D.O. degrees awarded) graduates.

The language included in the omnibus bill would amend BPC Section 2089.5 to include the AOA-HFAP as an approved accreditation agency for hospitals offering ACGME accredited postgraduate training programs.

BPC Section 2240 – Striking "Scheduled"

Existing law (Business and Professions Code Section 2240 (a)) requires a physician who performs a scheduled medical procedure outside of a general acute care hospital, that results in a death, to report the occurrence to the Board within 15 days. The Board would like to ensure all deaths in outpatient settings are reported to the Board, not just those that resulted from a scheduled medical procedure. As such, the language included in the omnibus bill would strike "scheduled" from this provision.

Both of these proposals have already been approved by the Board to be included in the omnibus bill.

FISCAL: None to the Board

SUPPORT: Medical Board of California and other affected regulatory health boards.

OPPOSITION: None on file

SENATE BILL No. 1466

Introduced by Committee on Business, Professions and Economic Development (Senators Lieu (Chair), Berryhill, Block, Corbett, Galgiani, Hernandez, Hill, Padilla, Wyland, and Yee)

March 25, 2014

An act to amend Sections 27, 2089.5, 2240, 2530.5, 2532.2, 2532.7, 4021.5, 4053, 4980, 4980.36, 4980.37, 4980.399, 4980.41, 4980.43, 4980.55, 4980.72, 4980.78, 4987.5, 4992.09, 4996.23, 4998, 4999.55, 4999.58, 4999.59, 4999.60, and 4999.123 of, and to amend the heading of Chapter 13 (commencing with Section 4980) of Division 2 of, the Business and Professions Code, and to amend Section 14132.55 of the Welfare and Institutions Code, relating to health care professionals.

LEGISLATIVE COUNSEL'S DIGEST

SB 1466, as introduced, Committee on Business, Professions and Economic Development. Health care professionals.

(1) Existing law requires a physician and surgeon who performs a scheduled medical procedure outside of a general acute care hospital that results in the death of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, to report, in writing on a form prescribed by the board, that occurrence to the board within 15 days after the occurrence. A person who violates this requirement is guilty of a misdemeanor.

This bill would make that provision applicable without regard to whether the procedure was scheduled. By expanding the scope of a crime, the bill would impose a state-mandated local program.

(2) Existing law provides for the licensing and regulation of persons who are engaged in the practice of speech-language pathology or audiology, as specified, and vests the enforcement of these provisions

in the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board. Among other requirements, an applicant for licensure as a speech-language pathologist or audiologist is required to submit transcripts from an educational institution approved by the board evidencing completion of specified coursework, and submit evidence of the satisfactory completion of supervised clinical practice with individuals representative of a wide spectrum of ages and communication disorders. Existing law requires the board to establish by regulation the required number of clock hours, not to exceed 300 clock hours, of supervised clinical practice necessary for the applicant.

This bill would delete the requirement that the applicant submit transcripts from an educational institution approved by the board evidencing completion of specified coursework and would increase the maximum number of clock hours that the board may establish by regulation to 375.

(3) Existing law, the Pharmacy Law, governs the regulation of the practice of pharmacy and establishes the California State Board of Pharmacy to administer and enforce these provisions. The law authorizes the board to issue a license to an individual to serve as a designated representative to provide sufficient and qualified supervision in a wholesaler or veterinary food-animal drug retailer, as specified, and requires the licensee to protect the public health and safety in the handling, storage, and shipment of dangerous drugs and dangerous devices in the wholesaler or veterinary food-animal drug retailer. The law also defines a correctional pharmacy to mean a pharmacy, licensed by the board, located within a state correctional facility, as specified.

This bill would require an individual who applies for designated representative license to be at least 18 years of age. The bill would also revise the definition of a correctional pharmacy to mean a pharmacy, licensed by the board, located within a correctional facility, without regard to whether the facility is a state or local correctional facility.

(4) Existing law requires an applicant for a license as marriage and family therapist, social worker, or professional clinical counselor, to participate in and obtain a passing score on a board-administered California law and ethics examination in order to qualify for a license or renewal of a license.

This bill would permit an applicant who holds a registration eligible for renewal, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, if eligible, to renew the registration without first participating in the California law and ethics examination.

The bill would require the applicant to pass that examination prior to lincensure or issuance of a subsequent registration number. The bill would also permit an applicant who holds or has held a registration, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, if eligible, to obtain the subsequent registration number without first passing the California law and ethics examination, if he or she passes the law and ethics examination at the next renewal period or prior to licensure, whichever occurs first.

This bill would make other changes relating to licensed marriage and family therapists and licensed professional clinical counselors.

The bill would also make other technical, conforming, and clarifying changes.

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

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

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

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

1 SECTION 1. Section 27 of the Business and Professions Code
2 is amended to read:
3 27. (a) Each entity specified in subdivisions (c), (d), and (e)
4 shall provide on the Internet information regarding the status of
5 every license issued by that entity in accordance with the California
6 Public Records Act (Chapter 3.5 (commencing with Section 6250)
7 of Division 7 of Title 1 of the Government Code) and the
8 Information Practices Act of 1977 (Chapter 1 (commencing with
9 Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).
10 The public information to be provided on the Internet shall include
11 information on suspensions and revocations of licenses issued by
12 the entity and other related enforcement action, including
13 accusations filed pursuant to the Administrative Procedure Act
14 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
15 Division 3 of Title 2 of the Government Code) taken by the entity
16 relative to persons, businesses, or facilities subject to licensure or
17 regulation by the entity. The information may not include personal
18 information, including home telephone number, date of birth, or

(f) "Internet" for the purposes of this section has the meaning set forth in paragraph (6) of subdivision (f) of Section 17538.

SEC. 2. Section 2089.5 of the Business and Professions Code is amended to read:

2089.5. (a) Clinical instruction in the subjects listed in subdivision (b) of Section 2089 shall meet the requirements of this section and shall be considered adequate if the requirements of subdivision (a) of Section 2089 and the requirements of this section are satisfied.

(b) Instruction in the clinical courses shall total a minimum of 72 weeks in length.

(c) Instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length with a minimum of eight weeks instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry.

(d) Of the instruction required by subdivision (b), including all of the instruction required by subdivision (c), 54 weeks shall be performed in a hospital that sponsors the instruction and shall meet one of the following:

(1) Is a formal part of the medical school or school of osteopathic medicine.

(2) Has a residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC), in family practice or in the clinical area of the instruction for which credit is being sought.

(3) Is formally affiliated with an approved medical school or school of osteopathic medicine located in the United States or Canada. If the affiliation is limited in nature, credit shall be given only in the subject areas covered by the affiliation agreement.

(4) Is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada.

(e) If the institution, specified in subdivision (d), is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada, it shall meet the following:

(1) The formal affiliation shall be documented by a written contract detailing the relationship between the medical school, or a school of osteopathic medicine, and hospital and the responsibilities of each.

(2) The school and hospital shall provide to the board a description of the clinical program. The description shall be in sufficient detail to enable the board to determine whether or not the program provides students an adequate medical education. The board shall approve the program if it determines that the program provides an adequate medical education. If the board does not approve the program, it shall provide its reasons for disapproval to the school and hospital in writing specifying its findings about each aspect of the program that it considers to be deficient and the changes required to obtain approval.

(3) The hospital, if located in the United States, shall be accredited by the Joint Commission on Accreditation of Hospitals, *or the American Osteopathic Association's Healthcare Facilities Accreditation Program,* and if located in another country, shall be accredited in accordance with the law of that country.

(4) The clinical instruction shall be supervised by a full-time director of medical education, and the head of the department for each core clinical course shall hold a full-time faculty appointment of the medical school or school of osteopathic medicine and shall be board certified or eligible, or have an equivalent credential in that specialty area appropriate to the country in which the hospital is located.

(5) The clinical instruction shall be conducted pursuant to a written program of instruction provided by the school.

(6) The school shall supervise the implementation of the program on a regular basis, documenting the level and extent of its supervision.

(7) The hospital-based faculty shall evaluate each student on a regular basis and shall document the completion of each aspect of the program for each student.

(8) The hospital shall ensure a minimum daily census adequate to meet the instructional needs of the number of students enrolled in each course area of clinical instruction, but not less than 15 patients in each course area of clinical instruction.

(9) The board, in reviewing the application of a foreign medical graduate, may require the applicant to submit a description of the

clinical program, if the board has not previously approved the program, and may require the applicant to submit documentation to demonstrate that the applicant's clinical training met the requirements of this subdivision.

(10) The medical school or school of osteopathic medicine shall bear the reasonable cost of any site inspection by the board or its agents necessary to determine whether the clinical program offered is in compliance with this subdivision.

SEC. 3. Section 2240 of the Business and Professions Code is amended to read:

2240. (a) ~~Any~~ *A* physician and surgeon who performs a ~~scheduled~~ medical procedure outside of a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, that results in the death of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, shall report, in writing on a form prescribed by the board, that occurrence to the board within 15 days after the occurrence.

(b) ~~Any~~ *A* physician and surgeon who performs a scheduled medical procedure outside of a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, that results in the transfer to a hospital or emergency center for medical treatment for a period exceeding 24 hours, of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, shall report, in writing, on a form prescribed by the board that occurrence, within 15 days after the occurrence. The form shall contain all of the following information:

(1) Name of the patient's physician in the outpatient setting.

(2) Name of the physician with hospital privileges.

(3) Name of the patient and patient identifying information.

(4) Name of the hospital or emergency center where the patient was transferred.

(5) Type of outpatient procedures being performed.

(6) Events triggering the transfer.

(7) Duration of the hospital stay.

(8) Final disposition or status, if not released from the hospital, of the patient.

(9) Physician's practice specialty and ABMS certification, if applicable.

(c) The form described in subdivision (b) shall be constructed in a format to enable the physician and surgeon to transmit the information in paragraphs (5) to (9), inclusive, to the board in a manner that the physician and surgeon and the patient are anonymous and their identifying information is not transmitted to the board. The entire form containing information described in paragraphs (1) to (9), inclusive, shall be placed in the patient's medical record.

(d) The board shall aggregate the data and publish an annual report on the information collected pursuant to subdivisions (a) and (b).

(e) On and after January 1, 2002, the data required in subdivision (b) shall be sent to the Office of Statewide Health Planning and Development (OSHPD) instead of the board. OSHPD may revise the reporting requirements to fit state and national standards, as applicable. The board shall work with OSHPD in developing the reporting mechanism to satisfy the data collection requirements of this section.

(f) The failure to comply with this section constitutes unprofessional conduct.

SEC. 4. Section 2530.5 of the Business and Professions Code is amended to read:

2530.5. (a) Nothing in this chapter shall be construed as restricting hearing testing conducted by licensed physicians and surgeons or by persons conducting hearing tests under the direct supervision of a physician and surgeon.

(b) Nothing in this chapter shall be construed to prevent a licensed hearing aid dispenser from engaging in testing of hearing and other practices and procedures used solely for the fitting and selling of hearing aids nor does this chapter restrict persons practicing their licensed profession and operating within the scope of their licensed profession or employed by someone operating within the scope of their licensed professions, including persons fitting and selling hearing aids who are properly licensed or registered under the laws of the State of California.

(c) Nothing in this chapter shall be construed as restricting or preventing the practice of speech-language pathology or audiology by personnel holding the appropriate credential from the

MBC TRACKER II BILLS
4/23/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 357	Pan	California Healthy Child Advisory Task Force	2-year	01/16/14
AB 369	Pan	Continuity of Care	Chaptered, #4	02/18/14
AB 395	Fox	Alcoholism and Drug Abuse Treatment Facilities	2-year	07/10/13
AB 467	Stone	Prescription Drugs: Collection and Distribution Program	Chaptered, #10	03/11/14
AB 604	Ammiano	Medical Cannabis: State Regulation and Enforcement	2-year	09/11/13
AB 678	Gordon	Health Care Districts: Community Health Needs Assessment	2-year	04/15/13
AB 889	Frazier	Health Care Coverage: Prescription Drugs	2-year	05/02/13
AB 1153	Eggman	Master Esthetician: License	2-year	01/06/14
AB 1310	Brown	Medi-Cal: Pediatric Subacute Care	2-year	05/24/13
AB 1558	Hernandez	California Health Data Organization	Introduced	
AB 1575	Pan	Public Contracts for Services	Senate	03/20/14
AB 1592	Gaines	California Diabetes Program	Asm. Health	04/02/14
AB 1612	Donnelly	State Government: Regulations	Asm. Account. & Admin. Review	04/02/14
AB 1621	Lowenthal	Emergency Medical Services: Data and Informaiton System	Asm. Health	04/21/14
AB 1650	Jones-Sawyer	Public Contracts: Bidders	Asm. Approps	04/01/14
AB 1683	Jones	Ken Maddy California Cancer Registry	Asm. Approps	04/10/14
AB 1702	Maienschein	Professions and Vocations: Incarceration	Asm. B&P	
AB 1727	Rodriguez	Prescription Drugs: Collection and Distribution Program	Asm. Health	
AB 1743	Ting	Hypodermic Needles and Syringes	Senate	
AB 1755	Gomez	Medical Information	Asm. Health	03/28/14
AB 1758	Patterson	Healing Arts: Initial License Fees: Proration	Asm. B&P	04/03/14
AB 1812	Pan	Health Facilities: Information: Disclosure	Assembly	
AB 1822	Bonta	Tissue Banks	Asm. Approps	
AB 1868	Gomez	Medi-Cal: Optional Benefits: Podiatric Medicine	Asm. Approps	
AB 1890	Chau	Athletic Trainers	Asm. B&P	04/21/14

MBC TRACKER II BILLS
4/23/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1898	Brown	Public Health Records: Reporting: HIV/AIDS	Asm. Judiciary	
AB 1903	Donnelly	Department of Consumer Affairs: Boards: Meetings	Assembly	
AB 1917	Gordon	Outpatient Prescription Drugs: Cost Sharing	Asm. Health	
AB 1921	Holden	Public Contracts for Services: Access to Records	Asm. Account. & Admin. Review	
AB 1923	Daly	State Government: Contracts: Public Records	Asm. Judiciary	
AB 2015	Chau	Health Care Coverage: Discrimination	Asm. Approps	
AB 2058	Wilk	Open Meetings	Asm. Approps	04/09/14
AB 2059	Muratsuchi	Medical Records: Electronic Delivery	Asm. Health	
AB 2062	Hernandez	Health Facilities: Surgical Technologists	Asm. Health	04/10/14
AB 2069	Maienschein	Immunizations: Influenza	Asm. Health	04/21/14
AB 2102	Ting	Licensees: Data Collection	Asm. Approps	03/28/14
AB 2143	Williams	Clinical Laboratories: Chiropractors	Asm. Health	03/28/14
AB 2144	Yamada	Staff-To-Patient Ratios	Asm. Health	4/1014
AB 2165	Patterson	Professions and Vocations: Licenses	Asm. B&P	04/10/14
AB 2198	Levine	Mental Health Professionals: Suicide Prevention Training	Asm. B&P	04/21/14
AB 2278		State Agency Contracts	Assembly	
AB 2336	Grove	Abortion: Gender Selection	Asm. Health	03/28/14
AB 2340	Garcia	State Department of Public Health: Office of Health Equity	Asm. Health	03/28/14
AB 2374	Mansoor	Substance Abuse: Recovery and Treatment Services	Asm. Health	04/08/14
AB 2387	Pan	Commission on Peace Officer Standards and Training	Assembly	04/21/14
AB 2396	Bonta	Convictions: Expungement: Licenses	Asm. B&P	04/21/14
AB 2400	Ridley-Thomas	Health Care Coverage: Physician Contracts	Asm. Health	
AB 2418	Bonilla	Health Care Coverage: Prescription Drug Refills	Asm. Health	
AB 2452	Pan	Advance Health Care Directive Registry	Asm. Health	04/08/14
AB 2482	Wilk	Workers Compensation: Utilization Review	Asm. Insurance	

MBC TRACKER II BILLS
4/23/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2484	Gordon	Healing Arts: Telehealth	Asm. B&P	
AB 2491	Nestande	Alcohol and Drug Abuse Treatment Facilities: Sober Living Homes	Asm. Health	03/28/14
AB 2507	Bocanegra	Public Records Act: Exemptions: Pending Litigation	Asm. Judiciary	04/10/14
AB 2514	Pan	Income Taxes: Credits: Rural Health Care Professionals	Asm. Rev. & Tax	04/01/14
AB 2580	Fox	Medical Licenses	Spot	
AB 2598	Hagman	Department of Consumer Affairs: Administrative Expenses	Asm. B&P	
AB 2605	Bonilla	Pharmacy: Sterile Drug Products	Asm. B&P	03/18/14
AB 2616	Skinner	Workers Compensation: Hospital Employers	Asm. Insurance	04/03/14
AB 2638	Chau	Department of Consumer Affairs	Assembly	
AB 2675	Lowenthal	State Agency: Public Contracts	Asm. Approps	
AB 2720	Ting	State Agencies: Meetings: Record of Action Taken	Asm. Gov. Org.	04/02/14
AB 2723	Medina	Administrative Procedure: Small Business	Assembly	04/09/14
ACA 5	Grove	Abortion: Parental Notification	2-year	01/07/14
ACR 93	Buchanan	Prescription Drug Abuse Awareness Month	Sen. 3rd Reading	03/24/14
ACR 107	Bloom	Year of the Family Physician	Asm. Health	
ACR 110	Fox	Health Care District Month	Asm. 3rd Reading	
ACR 111	Levine	Colorectal Cancer Awareness Month	Sen. 3rd Reading	03/20/14
ACR 125	Perez	Donate Life California Day: Driver's License	Sen. 3rd Reading	04/07/14
SB 18	Hernandez	California Health Benefits Review Program	2-year	04/17/13
SB 20	Hernandez	Health Care Coverage	2-year	04/09/14
SB 22	Beall	Health Care Coverage: Mental Health Parity	2-year	07/02/13
SB 176	Galgiani	Administrative Procedures	2-year	08/07/13
SB 204	Corbett	Prescription Drugs: Labeling	2-year	06/27/13
SB 218	Yee	Healing Arts: Ca Traditional Chinese Medicine Traumatologist	2-year	08/05/13
SB 306	Torres	Nursing: Licensing Criteria	Asm. B&P	01/13/14

MBC TRACKER II BILLS
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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 577	Pavley	Autism & Other Developmental Disabilities: Employment	2-year	01/06/14
SB 830	Galgiani	Health Care: Health Facility Data	Sen. Health	04/07/14
SB 906	Correa	Elective Percutaneous Coronary Intervention Offsite Program	Sen. Health	04/07/14
SB 909	Pavley	Dependent Children: Health Screenings	Sen. Judiciary	04/10/14
SB 973	Hernandez	Narcotic Treatment Programs	Sen. Health	03/28/14
SB 981	Huff	Regulations: Review Process	Sen. Gov. Org.	04/10/14
SB 1014	Jackson	Pharmaceutical Waste: Home Generated	Sen. B&P	04/21/14
SB 1039	Hernandez	Pharmacies: Furnishing Drugs	Sen. Health	04/10/14
SB 1053	Mitchell	Health Care Coverage: Contraceptives	Sen. Health	04/09/14
SB 1135	Jackson	Inmates: Sterilization	Sen. Public Safety	03/24/14
SB 1159	Lara	Professions and Vocations: Federal Tax ID Number	Sen. Approps	04/07/14
SB 1176	Steinberg	Health Care Coverage: Cost Sharing: Tracking	Sen. Health	04/07/14
SB 1215	Hernandez	Heatlhing Arts Licensees: Referrals	Sen. B&P	04/10/14
SB 1238	Hernandez	Health Facilities: Outpatient Care and Patient Assessment	Sen. Health	04/10/14
SB 1241	Leno	Health Care Coverage: Marketplace Transparency	Senate	
SB 1256	Mitchell	Medical Services: Credit	Sen. Judiciary	
SB 1266	Huff	Pupil Health: Epinephrine Auto-Injectors	Sen. Health	04/21/14
SB 1297	Hueso	Hospital Safety and Transparency Act of 2014	Sen. Health	04/02/14
SB 1303	Torres	Public Health: Hepatitis C	Sen. Health	04/02/14
SB 1322	Hernandez	Califonria Health Care Quality Improvement and Cost Containment Commission	Sen. Health	04/01/14
SB 1337	DeSaulnier	Public Records and Reports	Sen. Gov. Org.	04/21/14
SB 1340	Hernandez	Health Care Coverage: Provider Contracts	Sen. 3rd Reading	03/24/14
SB 1357	Wolk	Physician Orders for Life Sustaining Treatment Form: Registry	Sen. Health	04/21/14
SB 1426	De Leon	Breast and Cervical Cancer Treatment Program	Senate	
SB 1429	Steinberg	Civil Damages: Medical Malpractice	Senate	

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BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1438	Pavley	Controlled Substances: Opioid Antagonists	Sen. Health	04/10/14
SB 1457	Evans	Medical Care: Electronic Treatment Authorization Requests	Sen. Approps	03/28/14
SR 36	Walters	Relative to Prescription Drug Abuse Awareness	Adopted	03/25/14