

# MEDICAL BOARD OF CALIFORNIA - 2017 TRACKER LIST

## April 19, 2017

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 40	Santiago	CURES Database: Health Information Technology System	Asm. Public Safety	Support in Concept	
AB 148	Mathis	California Physician Corps: Practice Setting	Assembly	Reco: Neutral	3/27/17
AB 182	Waldron	Heroin and Opioid Public Education (HOPE) Act	Asm. Approps - Suspense	Reco: Support	3/23/17
AB 505	Caballero	Physicians and Surgeons: Probation	Asm. B&P	Reco: Oppose	3/27/17
AB 706	Patterson	Medical Board of California: Licenses	Asm. B&P	Not Moving Forward	
AB 715	Wood	Workgroup Review of Opioid Pain Reliever Use and Abuse	Asm. Approps	Reco: Neutral	4/18/17
AB 845	Wood	Cannabidiol	Asm. Approps	Reco: Neutral	3/28/17
AB 893	Garcia	Healing Arts: Employment	Asm B&P	Reco: Neutral	3/27/17
AB 1048	Arambula	Health Facilities: Pain Management	Asm. Health	Reco: Support	3/21/17
AB 1204	Mayes	Public Health: Emergency Prescriptions	Asm. Health	Reco: Neutral if Amended	3/28/17
AB 1340	Maienschein	Continuing Medical Education: Mental and Physical Health Care Integration	Asm. B&P	Reco: Neutral	3/22/17
AB 1368	Calderon	Medi-Cal: Authorization Requests	Asm. Approps	Reco: Neutral	3/30/17
AB 1512	McCarty	Opioid Addiction Prevention and Rehabilitation Act	Asm. Health	Reco: Support	4/17/17
AB 1560	Friedman	Nurse Practitioners: Supervision	Asm. B&P	Reco: Oppose Unless Amended	3/21/17
AB 1612	Burke	Certified Nurse-Midwives: Physician Supervision	Asm. B&P	Reco: Oppose Unless Amended	4/18/17

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

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<b>AB 1650</b>	Maienschein	Emergency Medical Services: Community Paramedicine	Asm. Approps	Reco: Oppose	4/6/17
<b>SB 241</b>	Monning	Medical Records: Access	Sen. Judiciary	Reco: Support	
<b>SB 419</b>	Portantino	Medical Practice: Pain Management	Sen. B&P	Reco: Support if Amended	4/17/17
<b>SB 457</b>	Bates	Out-of-Hospital Childbirths	Senate		4/17/17
<b>SB 554</b>	Stone	Nurse Practitioners: Physician Assistants: Buprenorphine	Sen. B&P	Reco: Support	4/17/17
<b>SB 641</b>	Lara	CURES: Privacy	Sen. Judiciary	Reco: Neutral if Amended	3/28/17
<b>SB 746</b>	Portantino	Pupil Health: Physical Examinations	Sen. Ed.	Reco: Oppose Unless Amended	
<b>SB 790</b>	McGuire	Health Care Providers: Gifts and Benefits	Sen. Health	Reco: Support	4/17/17
<b>SB 798</b>	Hill	Medical Board of California: Sunset Bill	Sen. B&P – 4/24/17		4/18/17

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

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 40  
**Author:** Santiago  
**Bill Date:** December 5, 2016, Introduced  
**Subject:** CURES Database: Health Information Technology System  
**Sponsor:** California Chapter, American College of Emergency Physicians  
**Position:** Support in Concept

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would allow authorized health information technology systems to integrate with and automatically query the Controlled substances Utilization Review and Evaluation System (CURES) on behalf of an authorized health care practitioner.

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

According to the Centers for Disease Control and Prevention, drug overdoses are the top cause of accidental death in the United States and nearly 23,000 people died from an overdose of pharmaceuticals in 2013, more than 70% of them from opiate prescription painkillers. According to the California Attorney General's Office, if doctors and pharmacies have access to controlled substance history information at the point of care, it will help them make better prescribing decisions and cut down on prescription drug abuse in California.

**ANALYSIS**

This bill requires the Department of Justice (DOJ) to make the electronic controlled substances history data of a patient from CURES available to a practitioner through an

online Internet Web portal or through an authorized health information technology system.

This bill would allow a health information technology system to establish an integration with, and submit queries to, the CURES database on either a user-initiated basis or an automated basis, if the system can certify all of the following:

- It has been authorized to query the CURES database on behalf of an authorized health care practitioner on either a user-initiated basis, an automated basis, or both, for purposes of delivering patient data from the CURES database to assist an authorized health care practitioner with evaluating the need for medical or pharmaceutical treatment or providing medical or pharmaceutical treatment to a patient.
- It will not use or disclose data received from the CURES database for any purpose other than delivering the data to an authorized health care practitioner or performing data processing activities that may be necessary to enable this delivery.
- It will authenticate the identity of any authorized health care practitioner and maintain an audit trail documenting this authentication.
- It will meet applicable patient privacy and information security requirements of state and federal law.

The bill would define a “health information technology system” as an information processing application using hardware and software for the storage, retrieval, sharing of or use of patient data for the communication, decision making, coordination of care, or the quality, safety, or efficiency of the practice of medicine or delivery of health care services, including, but not limited to, electronic medical record application, health information exchange systems, or other interoperable clinical or health care information system.

This bill would define “user-initiated basis” to mean that an authorized health care practitioner has taken an action to initiate the query to the CURES database, such as clicking a button, issuing a voice command, or taking some other action that can be attributed to a specific health care practitioner by an audit trail in the health information technology system.

This bill would define “automated basis” to mean using a predefined criteria established or approved by a health care practitioner to trigger an automated query to the CURES database, which can be attributed to a specific health care practitioner by an audit trail in the health information technology system.

This bill would allow DOJ to determine the best method of system integration between the CURES database and health information technology systems. DOJ would be allowed to require an entity that operates a health information technology system to enter into a memorandum of understanding or other agreement that sets forth terms and conditions for the entity, including, paying a reasonable fee to cover the cost of establishing and maintaining integration with the CURES database; enforcement mechanisms for failure to comply with oversight or audit activities by DOJ; and any other term or condition that DOJ determines is necessary.

This bill contains an urgency clause, so it would become effective immediately once signed into law.

According to the sponsor, allowing CURES to integrate with health information technologies will allow prescription information to be included in the same patient information that physicians receive, without requiring the physician to manually check the CURES database separately. This will help to reduce stress on California's overcrowded emergency departments, allow emergency physicians to more efficiently treat patients, and help to ensure that patients receive timely care.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent doctor shopping. The Board supports the concept of integrating existing health information technology systems with the CURES database, as this will allow CURES to be used more efficiently and effectively, as long as adequate protections are maintained. This efficiency will be important when the law becomes effective that requires all prescribers to consult the CURES database before initially prescribing a Schedule II, III or IV controlled substance. However, the Board believes it important that this integration isn't limited to a small number of health information technology systems, as the Board believes it is important that all physicians have access to the CURES integration and associated efficiency proposed by this bill.

**FISCAL:**                      None to the Board

**SUPPORT:**                      California Chapter, American College of Emergency Physicians  
    (Sponsor)  
    California Access Coalition  
    The Board (in concept)

**OPPOSITION:**                None on file

**ASSEMBLY BILL**

**No. 40**

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**Introduced by Assembly Member Santiago**

December 5, 2016

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An act to amend Sections 11165.1 and 11165.2 of the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

LEGISLATIVE COUNSEL'S DIGEST

AB 40, as introduced, Santiago. CURES database: health information technology system.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a Schedule II, Schedule III, or Schedule IV controlled substance.

This bill would require the Department of Justice to make the electronic history of controlled substances dispensed to an individual under a health care practitioner's care, based on data contained in the CURES database, available to the practitioner through either an online Internet Web portal or an authorized health information technology system, as defined. The bill would authorize a health information technology system to establish an integration with and submit queries to the CURES database if the system can certify, among other requirements, that the data received from the CURES database will not be used for any purpose other than delivering the data to an authorized

health care practitioner or performing data processing activities necessary to enable delivery, and that the system meets applicable patient privacy and information security requirements of state and federal law. The bill would also authorize the Department of Justice to require an entity operating a health information technology system to enter into a memorandum of understanding or other agreement setting forth terms and conditions with which the entity must comply.

Existing law authorizes the Department of Justice to conduct audits of the CURES database and its users.

This bill would authorize the Department of Justice to conduct audits of any authorized health information technology system integrated with the CURES database.

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

Vote:  $\frac{2}{3}$ . 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 11165.1 of the Health and Safety Code,  
2 as amended by Section 2 of Chapter 708 of the Statutes of 2016,  
3 is amended to read:  
4 11165.1. (a) (1) (A) (i) A health care practitioner authorized  
5 to prescribe, order, administer, furnish, or dispense Schedule II,  
6 Schedule III, or Schedule IV controlled substances pursuant to  
7 Section 11150 shall, before July 1, 2016, or upon receipt of a  
8 federal Drug Enforcement Administration (DEA) registration,  
9 whichever occurs later, submit an application developed by the  
10 ~~Department of Justice~~ *department* to obtain approval to access  
11 information ~~online~~ regarding the controlled substance history of  
12 a patient *through an online Internet Web portal that is stored on*  
13 ~~the Internet and maintained within the Department of Justice, by~~  
14 *the department, or through an authorized health information*  
15 *technology system, and, upon approval, the department shall release*  
16 *to that practitioner practitioner, through an online Internet Web*  
17 *portal or an authorized health information technology system, the*  
18 *electronic history of controlled substances dispensed to an*  
19 *individual under his or her care based on data contained in the*  
20 *CURES Prescription Drug Monitoring Program (PDMP).*

1 (ii) A pharmacist shall, before July 1, 2016, or upon licensure,  
2 whichever occurs later, submit an application developed by the  
3 ~~Department of Justice~~ *department* to obtain approval to access  
4 information online regarding the controlled substance history of  
5 a patient that is stored on the Internet and maintained within the  
6 ~~Department of Justice~~, *department*, and, upon approval, the  
7 department shall release to that pharmacist the electronic history  
8 of controlled substances dispensed to an individual under his or  
9 her care based on data contained in the CURES PDMP.

10 (B) An application may be denied, or a subscriber may be  
11 suspended, for reasons which include, but are not limited to, the  
12 following:

13 (i) Materially falsifying an application for a subscriber.

14 (ii) Failure to maintain effective controls for access to the patient  
15 activity report.

16 (iii) Suspended or revoked federal DEA registration.

17 (iv) Any subscriber who is arrested for a violation of law  
18 governing controlled substances or any other law for which the  
19 possession or use of a controlled substance is an element of the  
20 crime.

21 (v) Any subscriber accessing information for any other reason  
22 than caring for his or her patients.

23 (C) Any authorized subscriber shall notify the ~~Department of~~  
24 ~~Justice~~ *department* within 30 days of any changes to the subscriber  
25 account.

26 (D) *A health information technology system may establish an*  
27 *integration with and submit queries to the CURES database on*  
28 *either a user-initiated basis or an automated basis if the system*  
29 *can certify all of the following:*

30 (i) *The health information technology system can establish it*  
31 *has been authorized to query the CURES database on behalf of*  
32 *an authorized health care practitioner on either a user-initiated*  
33 *basis, an automated basis, or both, for purposes of delivering*  
34 *patient data from the CURES database to assist an authorized*  
35 *health care practitioner with evaluating the need for medical or*  
36 *pharmaceutical treatment or providing medical or pharmaceutical*  
37 *treatment to a patient for whom a health care practitioner is*  
38 *providing or has provided care.*

39 (ii) *The health information technology system will not use or*  
40 *disclose data received from the CURES database for any purpose*



1 *other than delivering the data to an authorized health care*  
2 *practitioner or performing data processing activities that may be*  
3 *necessary to enable this delivery.*

4 *(iii) The health information technology system authenticates*  
5 *the identity of any authorized health care practitioner initiating*  
6 *queries to the CURES database on either a user-initiated basis or*  
7 *an automated basis and maintains an audit trail documenting this*  
8 *authentication.*

9 *(iv) The health information technology system meets applicable*  
10 *patient privacy and information security requirements of state and*  
11 *federal law.*

12 *(E) The department may, in its discretion, determine whether*  
13 *to establish a direct system integration between one or more health*  
14 *information technology systems and the CURES database, or*  
15 *whether to develop a gateway system to which multiple health*  
16 *information technology systems can establish an integration for*  
17 *purposes of accessing the CURES database.*

18 *(F) The department may require an entity that operates a health*  
19 *information technology system to enter into a memorandum of*  
20 *understanding or other agreement that sets forth terms and*  
21 *conditions with which the entity shall comply, including, but not*  
22 *limited to, all of the following:*

23 *(i) Paying a reasonable fee to cover the cost of establishing and*  
24 *maintaining integration with the CURES database.*

25 *(ii) Enforcement mechanisms for failure to comply with oversight*  
26 *or audit activities by the department, up to and including*  
27 *termination of access to the CURES database.*

28 *(iii) Any other term or condition that the department may*  
29 *determine in its reasonable discretion is necessary to carry out*  
30 *the intent of this section.*

31 *(2) A health care practitioner authorized to prescribe, order,*  
32 *administer, furnish, or dispense Schedule II, Schedule III, or*  
33 *Schedule IV controlled substances pursuant to Section 11150 or*  
34 *a pharmacist shall be deemed to have complied with paragraph*  
35 *(1) if the licensed health care practitioner or pharmacist has been*  
36 *approved to access the CURES database through the process*  
37 *developed pursuant to subdivision (a) of Section 209 of the*  
38 *Business and Professions Code.*

1 (b) Any request for, or release of, a controlled substance history  
2 pursuant to this section shall be made in accordance with guidelines  
3 developed by the ~~Department of Justice~~. *department*.

4 (c) In order to prevent the inappropriate, improper, or illegal  
5 use of Schedule II, Schedule III, or Schedule IV controlled  
6 substances, the ~~Department of Justice~~ *department* may initiate the  
7 referral of the history of controlled substances dispensed to an  
8 individual based on data contained in CURES to licensed health  
9 care practitioners, pharmacists, or both, providing care or services  
10 to the individual. *An authorized health care practitioner may use*  
11 *a health information technology system, either on a user-initiated*  
12 *basis or an automated basis, to initiate the referral of the history*  
13 *of controlled substances dispensed to an individual based on data*  
14 *contained in CURES to other licensed health care practitioners,*  
15 *pharmacists, or both.*

16 (d) The history of controlled substances dispensed to an  
17 individual based on data contained in CURES that is received by  
18 a practitioner or pharmacist from the ~~Department of Justice~~  
19 *department* pursuant to this section is medical information subject  
20 to the provisions of the Confidentiality of Medical Information  
21 Act contained in Part 2.6 (commencing with Section 56) of  
22 Division 1 of the Civil Code.

23 (e) Information concerning a patient's controlled substance  
24 history provided to a prescriber or pharmacist pursuant to this  
25 section shall include prescriptions for controlled substances listed  
26 in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code  
27 of Federal Regulations.

28 (f) A health care practitioner, pharmacist, and any person acting  
29 on behalf of a health care practitioner or pharmacist, when acting  
30 with reasonable care and in good faith, is not subject to civil or  
31 administrative liability arising from any false, incomplete,  
32 inaccurate, or misattributed information submitted to, reported by,  
33 or relied upon in the CURES database or for any resulting failure  
34 of the CURES database to accurately or timely report that  
35 information.

36 (g) *For purposes of this section, the following terms have the*  
37 *following meanings:*

38 (1) *"Automated basis" means using predefined criteria*  
39 *established or approved by a health care practitioner to trigger*  
40 *an automated query to the CURES database, which can be*

1 *attributed to a specific health care practitioner by an audit trail*  
2 *in the health information technology system.*

3 (2) *“Department” means the Department of Justice.*

4 (3) *“Health information technology system” means an*  
5 *information processing application using hardware and software*  
6 *for the storage, retrieval, sharing of or use of patient data for*  
7 *communication, decisionmaking, coordination of care, or the*  
8 *quality, safety, or efficiency of the practice of medicine or delivery*  
9 *of health care services, including, but not limited to, electronic*  
10 *medical record applications, health information exchange systems,*  
11 *or other interoperable clinical or health care information system.*

12 (4) *“User-initiated basis” means an authorized health care*  
13 *practitioner has taken an action to initiate the query to the CURES*  
14 *database, such as clicking a button, issuing a voice command, or*  
15 *taking some other action that can be attributed to a specific health*  
16 *care practitioner by an audit trail in the health information*  
17 *technology system.*

18 SEC. 2. Section 11165.2 of the Health and Safety Code is  
19 amended to read:

20 11165.2. (a) The Department of Justice may conduct audits  
21 of the CURES Prescription Drug Monitoring Program system and  
22 ~~its—users:~~ *users, including any authorized health information*  
23 *technology system, as defined in subdivision (g) of Section 11165.1,*  
24 *integrated with the CURES database.*

25 (b) The Department of Justice may establish, by regulation, a  
26 system for the issuance to a CURES Prescription Drug Monitoring  
27 Program subscriber of a citation which may contain an order of  
28 abatement, or an order to pay an administrative fine assessed by  
29 the Department of Justice if the subscriber is in violation of any  
30 provision of this chapter or any regulation adopted by the  
31 Department of Justice pursuant to this chapter.

32 (c) The system shall contain the following provisions:

33 (1) Citations shall be in writing and shall describe with  
34 particularity the nature of the violation, including specific reference  
35 to the provision of law or regulation of the department determined  
36 to have been violated.

37 (2) Whenever appropriate, the citation shall contain an order of  
38 abatement establishing a reasonable time for abatement of the  
39 violation.

1 (3) In no event shall the administrative fine assessed by the  
2 department exceed two thousand five hundred dollars (\$2,500) for  
3 each violation. In assessing a fine, due consideration shall be given  
4 to the appropriateness of the amount of the fine with respect to  
5 such factors as the gravity of the violation, the good faith of the  
6 subscribers, and the history of previous violations.

7 (4) An order of abatement or a fine assessment issued pursuant  
8 to a citation shall inform the subscriber that if the subscriber desires  
9 a hearing to contest the finding of a violation, a hearing shall be  
10 requested by written notice to the CURES Prescription Drug  
11 Monitoring Program within 30 days of the date of issuance of the  
12 citation or assessment. Hearings shall be held pursuant to Chapter  
13 5 (commencing with Section 11500) of Part 1 of Division 3 of  
14 Title 2 of the Government Code.

15 (5) In addition to requesting a hearing, the subscriber may,  
16 within 10 days after service of the citation, request in writing an  
17 opportunity for an informal conference with the department  
18 regarding the citation. At the conclusion of the informal conference,  
19 the department may affirm, modify, or dismiss the citation,  
20 including any fine levied or order of abatement issued. The decision  
21 shall be deemed to be a final order with regard to the citation  
22 issued, including the fine levied or the order of abatement which  
23 could include permanent suspension to the system, a monetary  
24 fine, or both, depending on the gravity of the violation. However,  
25 the subscriber does not waive its right to request a hearing to  
26 contest a citation by requesting an informal conference. If the  
27 citation is affirmed, a formal hearing may be requested within 30  
28 days of the date the citation was affirmed. If the citation is  
29 dismissed after the informal conference, the request for a hearing  
30 on the matter of the citation shall be deemed to be withdrawn. If  
31 the citation, including any fine levied or order of abatement, is  
32 modified, the citation originally issued shall be considered  
33 withdrawn and a new citation issued. If a hearing is requested for  
34 a subsequent citation, it shall be requested within 30 days of service  
35 of that subsequent citation.

36 (6) Failure of a subscriber to pay a fine within 30 days of the  
37 date of assessment or comply with an order of abatement within  
38 the fixed time, unless the citation is being appealed, may result in  
39 disciplinary action taken by the department. If a citation is not

1 contested and a fine is not paid, the subscriber account will be  
2 terminated:

3 (A) A citation may be issued without the assessment of an  
4 administrative fine.

5 (B) Assessment of administrative fines may be limited to only  
6 particular violations of law or department regulations.

7 (d) Notwithstanding any other provision of law, if a fine is paid  
8 to satisfy an assessment based on the finding of a violation,  
9 payment of the fine shall be represented as a satisfactory resolution  
10 of the matter for purposes of public disclosure.

11 (e) Administrative fines collected pursuant to this section shall  
12 be deposited in the CURES Program Special Fund, available upon  
13 appropriation by the Legislature. These special funds shall provide  
14 support for costs associated with informal and formal hearings,  
15 maintenance, and updates to the CURES Prescription Drug  
16 Monitoring Program.

17 (f) The sanctions authorized under this section shall be separate  
18 from, and in addition to, any other administrative, civil, or criminal  
19 remedies; however, a criminal action may not be initiated for a  
20 specific offense if a citation has been issued pursuant to this section  
21 for that offense, and a citation may not be issued pursuant to this  
22 section for a specific offense if a criminal action for that offense  
23 has been filed.

24 (g) Nothing in this section shall be deemed to prevent the  
25 department from serving and prosecuting an accusation to suspend  
26 or revoke a subscriber if grounds for that suspension or revocation  
27 exist.

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

32 In order to ensure that information in the CURES database is  
33 available to prescribing physicians so they may prevent the  
34 dangerous abuse of prescription drugs and to safeguard the health  
35 and safety of the people of this state, it is necessary that this act  
36 take effect immediately.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 148  
**Author:** Mathis  
**Bill Date:** March 27, 2017, Amended  
**Subject:** California Physician Corps Program: Practice Setting  
**Sponsor:** Author

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would revise the definition of “practice setting” for purposes of eligibility under the Physician Corps Loan Repayment Program (Program), which includes the Steven M. Thompson Loan Repayment Program (STLRP) and the Physician Volunteer Program, for community clinics and physician offices by allowing settings to participate in the program if 30% of their patient population qualifies as medically underserved and if the setting is in a rural area.

**BACKGROUND:**

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

**ANALYSIS**

This bill would revise the definition of a practice setting for the purposes of Program eligibility to allow community clinics and physician offices that are in rural areas to be eligible if 30% of their patient population qualifies as medically underserved. The current practice setting definition specifies that community clinics and physician offices are eligible for the Program if 50% of their patient population qualifies as medically underserved. This bill only changes the definition for rural areas, urban areas still must meet the 50% threshold in order to be eligible. This bill would also specify that the revised definition only applies to program participants that enroll in the Program on or after January 1, 2018.

According to the author, rural areas struggle to incentivize quality physicians to take up residency in these areas, and this bill is designed to give rural areas a greater chance to obtain the benefits of the STLRP and recruit physicians to these areas. According to a report submitted by HPEF, only 15 of the total 126 STLRP awardees were in rural areas

in 2015/16. Supporters of this bill state that access to high quality health care in rural areas is dependent upon an adequate supply of health care providers and loan repayment programs are a great way to attract high quality physicians with diverse qualifications. This bill has the potential to expand the number of rural practice settings eligible for this Program.

Although the Board supported the bill in 2013 that originally added the 50% medically underserved patient population requirement for practice settings, AB 565 (Salas, Chapter 378), it appears that some rural areas cannot meet this requirement and as a result are not eligible for the Program. This bill will not increase the funding for the Program, but it will expand eligibility for practice settings in rural areas, which may help to incentivize physicians to practice in those areas. For this reason, staff is suggesting that the Board take a neutral position on this bill.

**FISCAL:** None

**SUPPORT:** California Hospital Association  
California Medical Association  
Rural County Representative of California  
Tenet Healthcare

**OPPOSITION:** None on file

**POSITION:** Recommendation: Neutral

AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

## ASSEMBLY BILL

**No. 148**

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**Introduced by Assembly Member Mathis**  
**(Coauthors: Assembly Members Cunningham, Gallagher, Lackey,**  
**Waldron, and Wood)**  
(Coauthors: Senators Berryhill and Fuller)

January 10, 2017

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An act to amend Section 128552 of the Health and Safety Code, relating to physicians and surgeons, and making an appropriation therefor.

### LEGISLATIVE COUNSEL'S DIGEST

AB 148, as amended, Mathis. California Physician Corps Program: practice setting.

Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program (program) in the California Physician Corps Program within the Health Professions Education Foundation, which provides financial incentives, including repayment of educational loans, to a physician and surgeon who practices in a medically underserved area, as defined. Existing law establishes the Medically Underserved Account for Physicians, a continuously appropriated account, within the Health Professions Education Fund, to primarily provide funding for the ongoing operations of the program. Existing law requires the foundation and the Office of Statewide Health Planning and Development to develop guidelines using specified criteria for selection and placement of applicants.

Existing law defines “practice setting,” for these purposes, to include a community clinic, as defined, a clinic owned or operated by a public



hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role to serve its indigent population, that is located in a medically underserved area and at least 50% of whose patients are from a medically underserved population. Existing law also defines "practice setting," for these purposes, to include a physician owned and operated medical practice setting that provides primary care located in a medically underserved area and has a minimum of 50% of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250% of the federal poverty level.

This bill would instead require, for purposes of this definition, *and only for program participants who enroll in the program on or after January 1, 2018, as specified*, that the clinic or the physician owned and operated medical practice setting have at least 30% of patients, if the area is rural, or at least 50% of patients, if the area is urban, who are from the above-described populations. By expanding the authorization for the use of moneys in the Medically Underserved Account for Physicians, this bill would make an appropriation.

Vote:  $\frac{2}{3}$ . 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 128552 of the Health and Safety Code
- 2 is amended to read:
- 3 128552. For purposes of this article, the following definitions
- 4 shall apply:
- 5 (a) "Account" means the Medically Underserved Account for
- 6 Physicians established within the Health Professions Education
- 7 Fund pursuant to this article.
- 8 (b) "Foundation" means the Health Professions Education
- 9 Foundation.
- 10 (c) "Fund" means the Health Professions Education Fund.
- 11 (d) "Medi-Cal threshold languages" means primary languages
- 12 spoken by limited-English-proficient (LEP) population groups
- 13 meeting a numeric threshold of 3,000, eligible LEP Medi-Cal
- 14 beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP
- 15 beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal
- 16 beneficiaries residing in two contiguous ZIP Codes.

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

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

9 (g) “Office” means the Office of Statewide Health Planning and  
10 Development (OSHPD).

11 (h) “Physician Volunteer Program” means the Physician  
12 Volunteer Registry Program established by the Medical Board of  
13 California.

14 (i) “Practice setting,” for the purposes of this article only, means  
15 either of the following:

16 (1) A community clinic as defined in subdivision (a) of Section  
17 1204 and subdivision (c) of Section 1206, a clinic owned or  
18 operated by a public hospital and health system, or a clinic owned  
19 and operated by a hospital that maintains the primary contract with  
20 a county government to fulfill the county’s role pursuant to Section  
21 17000 of the Welfare and Institutions Code, which is located in a  
22 medically underserved area and ~~has~~ *meets the following conditions:*

23 (A) *For program participants who enrolled in the program*  
24 *before January 1, 2018, and who continue to participate in the*  
25 *program on or after that date, the clinic has at least 50 percent of*  
26 *patients who are from a medically underserved population.*

27 (B) *For program participants who enroll in the program on or*  
28 *after January 1, 2018, the clinic has at least 30 percent of patients,*  
29 *if the area is rural, or at least 50 percent of patients, if the area is*  
30 *urban, who are from a medically underserved population.*

31 (2) A physician owned and operated medical practice setting  
32 that provides primary care located in a medically underserved area  
33 and ~~has~~ *meets the following conditions:*

34 (A) *For program participants who enrolled in the program*  
35 *before January 1, 2018, and who continue to participate in the*  
36 *program on or after that date, the medical practice setting has a*  
37 *minimum of 50 percent of patients who are uninsured, Medi-Cal*  
38 *beneficiaries, or beneficiaries of another publicly funded program*  
39 *that serves patients who earn less than 250 percent of the federal*  
40 *poverty level.*

1     (B) *For program participants who enroll in the program on or*  
2 *after January 1, 2018, the medical practice setting has at least 30*  
3 *percent of patients, if the area is rural, or at least 50 percent of*  
4 *patients, if the area is urban, who are uninsured, Medi-Cal*  
5 *beneficiaries, or beneficiaries of another publicly funded program*  
6 *that serves patients who earn less than 250 percent of the federal*  
7 *poverty level.*

8     (j) “Primary specialty” means family practice, internal medicine,  
9 pediatrics, or obstetrics/gynecology.

10    (k) “Program” means the Steven M. Thompson Physician Corps  
11 Loan Repayment Program.

12    (l) “Selection committee” means a minimum three-member  
13 committee of the board, that includes a member that was appointed  
14 by the Medical Board of California.

15  
16  
17 **CORRECTIONS:** \_\_\_\_\_

18 **Heading—Line 2.**  
19 \_\_\_\_\_

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 182  
**Author:** Waldron  
**Bill Date:** March 23, 2017, Amended  
**Subject:** Heroin and Opioid Public Education Act  
**Sponsor:** Author

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would require the Department of Health Care Services (DHCS) to develop, coordinate, implement and oversee a comprehensive multicultural public awareness campaign, to be known as the Heroin and Opioid Public Education (HOPE) Program, to combat the growing heroin and opioid medication epidemic in California.

**BACKGROUND:**

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

According to the Centers for Disease Control, every day, 44 people in the U.S. die from overdose of prescription painkillers and many more become addicted.

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

In 2014, the Director of CDPH launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) to share information and develop collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in California. The Workgroup started as a multi-sector group consisting of more than 10 state agencies, including CDPH, Department of Justice, DHCS, Department of Managed Health Care, Department of Education, Department of Industrial Relations, Department of Corrections and Rehabilitation, Department of Consumer Affairs (including the Board, Dental Board of California, Board of Pharmacy, and Board of Registered Nursing), Emergency Medical Services Authority, and others. The Workgroup initially commenced a multi-phase plan involving enhancement of the state's Prescription Drug Monitoring Program (PDMP), promoting the release and adoption of the Board's revised Guidelines for Prescribing Controlled Substances for Pain, and development of a comprehensive public education campaign to increase public awareness about the potential dangers of opioid medications and to create better understanding and expectations among the public regarding proper prescribing, use, storage and disposal of opioids.

## **ANALYSIS**

This bill makes findings and declarations regarding the epidemic in California stemming from the use of heroin and the abuse of opioid medications and the need for awareness and dissemination of information. This bill would require DHCS, in consultation with stakeholders, as appropriate, to develop, coordinate, implement and oversee a comprehensive multicultural public awareness campaign, to be known as the HOPE Program, to combat the growing heroin and opioid medication epidemic in California.

This bill would require the HOPE Program to provide for the coordinated and widespread public dissemination of individual case stories and other generalized information using appropriate types of media, including new technologies in media, print media, television and radio, Internet and social media. This dissemination of information shall be designed to do the following:

- Identify the pathways that can lead to opioid medication abuse and heroin use.
- Show the many faces of addiction and rebut the commonly accepted myths and stereotypes about heroin users and opioid medication abusers.
- Condemn and stigmatize the abuse and diversion of opioid medication, while recognizing the legitimate use of opioids.
- Describe the effects and warning signs of heroin use and opioid medication abuse to enable members of the public to know when help is needed.
- Show the link that exists between heroin and opioid medication addiction and suicidal behavior.
- Identify pathways that are available for individuals to seek help, including telephone hotline systems for persons who wish to report cases of drug abuse or engage in substance abuse treatment.
- Highlight the availability of naloxone hydrochloride as a means to avert death from a heroin or opioid medication overdose, identify pathways for members of the public to obtain naloxone and training, and promote the proper use of naloxone.
- Highlight the benefits of substance abuse treatment.

- Highlight the benefits of medication-assisted therapy using medications approved by the federal Food and Drug Administration, such as methadone, buprenorphine, extended-release injectable naltrexone, or other similar drugs, and destigmatize the use of the medication-assisted therapy.
- Identify the methods that can be used by an individual to help finance the costs of substance abuse treatment.
- Identify the steps that individuals can take to prevent and deter others from misusing opioid medications.
- Identify the proper methods for safeguarding and disposing of opioid medications.
- Address any other issue that DHCS may deem appropriate and necessary to proactively educate the public about the state's heroin or opioid medication addiction.

In disseminating this information, the HOPE program shall employ a variety of complementary educational themes and messages that shall be tailored to appeal to different target audiences. At a minimum, the HOPE program shall incorporate all of the following:

- At least one message directed at individuals who are personally at risk of heroin use or opioid medication abuse or who have already started down a pathway of addiction.
- At least one message directed at family members and friends of addicted persons, teachers, school nurses, medical practitioners, and employers.
- At least one message that is directed at the dangers of teen drug pilfering from the household medicine cabinet and how this could be avoided through the use of safe storage products.

This bill would require information under the HOPE Program to be disseminated using culturally and linguistically appropriate means, and when feasible and appropriate, the information shall be made available in a variety of languages.

This bill would allow DHCS to enter into public-private partnerships with pharmaceutical or health care insurance companies, nonprofit social services organizations, mental health service providers and clinics, law enforcement, health care agencies, and school districts, that provide services in the state in order to facilitate the dissemination of information under the HOPE Program.

This bill would require DHCS to submit a report to the Governor and the Legislature on at least an annual basis that summarizes the actions undertaken by DHCS to implement this bill and to include an assessment of the effectiveness of the HOPE Program, including, but not limited to, effects on the rate of new opioid and heroin addictions by populations, mitigation of the effects of opioid or heroin addiction, crime rates, hospitalization rates, death rates, and other calculable results as determined by DHCS. The report shall provide any recommendations for legislative or executive action that may be necessary to facilitate the ongoing success of the HOPE Program.

According to the author, there is an epidemic in California of heroin use stemming from the abuse of opioid medications and this epidemic demands our attention. The author believes that in order for California to combat this epidemic, citizens must be armed with information that will allow them to recognize and undertake appropriate actions when they or their loved ones are at risk of succumbing to a heroin or opioid medication addiction.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill will increase awareness and provide education to help prevent heroin use and opioid medication abuse. This bill furthers the Board’s mission of consumer protection and Board staff recommends that the Board support this bill.

- |                           |  |
|---------------------------|--|
| <b><u>FISCAL:</u></b>     | None to the Board  |
| <b><u>SUPPORT:</u></b>    | American Academy of Pediatrics, California<br>Biocom<br>California Police Chiefs Association<br>California State Parent Teacher Association<br>California Special Districts Association<br>Gatekeeper Innovation |
| <b><u>OPPOSITION:</u></b> | None on file   |
| <b><u>POSITION:</u></b>   | Recommendation: Support  |

AMENDED IN ASSEMBLY MARCH 23, 2017

AMENDED IN ASSEMBLY MARCH 9, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

## ASSEMBLY BILL

**No. 182**

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**Introduced by Assembly Member Waldron**  
**(Coauthors: Assembly Members Baker, Mayes, and Wood)**  
(Coauthors: Senators Bates and Glazer)

January 19, 2017

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An act to add Article 5 (commencing with Section 11774) to Chapter 1 of Part 2 of Division ~~70.5~~ *10.5* of the Health and Safety Code, relating to drug abuse.

### LEGISLATIVE COUNSEL'S DIGEST

AB 182, as amended, Waldron. Heroin and Opioid Public Education (HOPE) Act.

Existing law vests the State Department of Health Care Services with duties, powers, purposes, functions, responsibilities, and jurisdiction of alcohol and drug programs in the state, including narcotic treatment programs that use narcotic replacement therapy for maintenance or detoxification of opioid medication dependence. Existing law requires the department to develop and implement a statewide prevention campaign designed to deter the abuse of methamphetamine in California, and authorizes the department to develop and implement a mass media alcohol and other drug education program in order to provide community education, develop public awareness, and motivate community action in alcohol and other drug abuse prevention, treatment, and rehabilitation.

This bill would require the department, in consultation with ~~specified entities~~, *stakeholders*, to develop, coordinate, implement, and oversee



a comprehensive multicultural public awareness campaign, to be known as “Heroin and Opioid Public Education (HOPE).” The bill would require the HOPE program to provide for the coordinated and widespread public dissemination of individual case stories and other generalized information that is designed to, among other things, describe the effects and warning signs of heroin use and opioid medication abuse, so as to better enable members of the public to determine when help is needed and identify the pathways that are available for individuals to seek help. The bill would require the HOPE program to effectuate the dissemination of information by using appropriate types of media, as specified, employing a variety of complementary educational themes and messages that are tailored to appeal to different target audiences, and using culturally and linguistically appropriate means.

The bill would require the department to submit a report to the Governor and Legislature on at least an annual basis, that summarizes the actions that have been undertaken by the department to implement the bill and includes an assessment of the effectiveness of the HOPE program, as specified.

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 “HOPE Act.”
- 3 SEC. 2. Article 5 (commencing with Section 11774) is added
- 4 to Chapter 1 of Part 2 of Division 10.5 of the Health and Safety
- 5 Code, to read:
- 6
- 7 Article 5. Heroin and Opioid Public Education (HOPE)
- 8
- 9 11774. The Legislature finds and declares all of the following:
- 10 (a) There is an epidemic in this state stemming from the use of
- 11 heroin and the abuse of opioid medications.
- 12 (b) In order for the state to combat this epidemic, citizens in all
- 13 walks of life shall be alerted to the problem, and shall be armed
- 14 with information that will allow them to recognize, and undertake
- 15 appropriate actions, when they or their loved ones are at risk of,
- 16 or are succumbing to, a heroin or opioid medication addiction.

1 (c) The widespread dissemination of information necessary to  
2 combat the state's heroin and opioid medication epidemic could  
3 be successfully achieved through the institution and maintenance  
4 of a multicultural statewide public awareness campaign, which  
5 would be carefully coordinated through all available multimedia  
6 channels to reach a wide variety of audiences, including drug users,  
7 their family members and friends, medical practitioners and nurses,  
8 emergency personnel, and employers.

9 (d) Prescription drug overdoses now kill more people than car  
10 accidents.

11 (e) Every day, 2,500 children 12 to 17 years of age abuse a  
12 prescription painkiller for the first time, and more people are  
13 becoming addicted to prescription drugs.

14 (f) Data from the federal Centers for Disease Control and  
15 Prevention suggests that the nonmedical use of prescription  
16 painkillers costs public and private health insurers seventy-two  
17 billion eight hundred million dollars (\$72,800,000,000) annually.

18 (g) As abuse rates have risen, the functions of the State  
19 Department of Alcohol and Drug Programs have been transferred  
20 to the State Department of Health Care Services.

21 (h) In order to be more successful in combating drug abuse,  
22 while addressing the current opioid and heroin epidemic, the  
23 department's current public awareness campaign is being used to  
24 combat the state's growing heroin and opioid medication epidemic  
25 shall be designed to do all of the following:

26 (1) Educate the public as to the reasons why ordinary people  
27 may engage in the abuse of opioid medications and the associated  
28 use of heroin.

29 (2) Rebut the commonly accepted myths and stereotypes  
30 associated with heroin use and opioid medication abuse.

31 (3) Stigmatize and condemn the abuse and diversion of opioid  
32 medication, while still recognizing the legitimate use of those  
33 opioid drugs as medications.

34 11774.1. (a) The department, in consultation with ~~the Coalition~~  
35 ~~for a Drug Free California and, as appropriate, the federal Drug~~  
36 ~~Enforcement Administration, stakeholders, as appropriate,~~ shall  
37 develop, coordinate, implement, and oversee a comprehensive  
38 multicultural public awareness campaign, to be known as "Heroin  
39 and Opioid Public Education (HOPE)," which shall allow for the  
40 coordinated and widespread dissemination of information designed

1 to combat the growing heroin and opioid medication epidemic in  
2 the state.

3 (b) Using the means described in subdivision (c), HOPE shall  
4 provide for the coordinated and widespread public dissemination  
5 of individual case stories and other generalized information that  
6 is designed to do all of the following:

7 (1) Identify the pathways that can lead to opioid medication  
8 abuse and heroin use, and the reasons why opioid medication abuse  
9 may evolve into heroin use.

10 (2) Show the many faces of heroin and opioid medication  
11 addiction, and rebut the commonly accepted myths and stereotypes  
12 about heroin users and opioid medication abusers.

13 (3) Condemn and stigmatize the abuse and diversion of opioid  
14 medication, while recognizing the legitimate use of those same  
15 opioid drugs as medications.

16 (4) Describe the effects and warning signs of heroin use and  
17 opioid medication abuse, so as to better enable members of the  
18 public to determine when help is needed.

19 (5) Show the link that exists between heroin and opioid  
20 medication addiction and suicidal behavior.

21 (6) Identify the pathways that are available for individuals to  
22 seek help in association with their own, or another person's, heroin  
23 or opioid medication addiction, and indicate the various telephone  
24 hotline systems that exist in the state for persons who wish to report  
25 a case of drug abuse or engage in substance abuse treatment.

26 (7) Highlight the availability of naloxone hydrochloride as a  
27 means to avert death from a heroin or opioid medication overdose,  
28 identify pathways for members of the public to obtain a prescription  
29 for naloxone hydrochloride and training in the emergency  
30 administration of naloxone hydrochloride, and promote the proper  
31 use of naloxone hydrochloride in crisis situations.

32 (8) Highlight the benefits of substance abuse treatment and the  
33 potential for treatment to allow for the reclaiming of lives that  
34 have been upset by addiction, and underscore the fact that relapses  
35 occur not because treatment is ineffective, but because of the nature  
36 of addiction, which is a recurring and relapsing disorder.

37 (9) Highlight the benefits of medication-assisted therapy using  
38 medications approved by the federal Food and Drug  
39 Administration, such as methadone, buprenorphine,

1 extended-release injectable naltrexone, or other similar drugs, and  
2 destigmatize the use of that medication-assisted therapy.

3 (10) Identify the methods that can be used by an individual to  
4 help finance the costs of substance abuse treatment.

5 (11) Identify the steps that individuals can take to prevent and  
6 deter family members, friends, students, patients, coworkers, and  
7 others from first experimenting with inappropriately obtained  
8 opioid medications, and from misusing or mismanaging lawful  
9 opioid medications.

10 (12) Identify the proper methods for safeguarding, and for safely  
11 disposing of, legitimate opioid medications.

12 (13) Address any other issues that the department may deem  
13 appropriate and necessary to proactively educate the public about  
14 the state's heroin and opioid medication epidemic and the actions  
15 that can be taken by members of the public to reduce the likelihood  
16 of heroin or opioid medication addiction, or to otherwise respond  
17 to, or mitigate the effects of, heroin or opioid medication addiction  
18 in cases in which it is present.

19 (c) (1) The HOPE program shall effectuate the dissemination  
20 of information described in subdivision (b) by using appropriate  
21 types of media to achieve the goal efficiently and effectively,  
22 including new technologies in media, print media, television and  
23 radio, Internet and social media.

24 (2) In disseminating the information described in subdivision  
25 (b), the HOPE program shall employ a variety of complementary  
26 educational themes and messages that shall be tailored to appeal  
27 to different target audiences in the state. At a minimum, the HOPE  
28 program shall incorporate all of the following:

29 (A) At least one message that is directed at, and is tailored to  
30 influence and resonate with, individuals who are personally at risk  
31 of heroin use or opioid medication abuse or who have already  
32 started down a pathway to addiction.

33 (B) At least one message that is directed at, and is tailored to  
34 influence and resonate with, the family members and friends of  
35 addicted persons, teachers, school nurses, medical practitioners,  
36 and employers.

37 (C) At least one message that is directed at the dangers of teen  
38 drug pilfering from the *household* medicine cabinet and how this  
39 could be avoided through the use of safe storage products.

1 (3) Information under the HOPE program shall be disseminated  
2 using culturally and linguistically appropriate means, in a manner  
3 that demonstrates respect for individual dignity and cultural  
4 differences. Where feasible and appropriate, the information shall  
5 be made available in a variety of languages.

6 (4) The department may enter into public-private partnerships  
7 with pharmaceutical or health care insurance companies, nonprofit  
8 social services organizations, mental health services providers and  
9 clinics, law enforcement, health care agencies, and school districts,  
10 that provide services in the state in order to facilitate the  
11 dissemination of information under the HOPE program.

12 11774.2. (a) The department shall submit to the Governor and  
13 the Legislature on at least an annual basis, a report that summarizes  
14 the actions that have been undertaken by the department to  
15 implement this article and includes an assessment of the  
16 effectiveness of the program, including, but not limited to, effects  
17 on the rate of new opioid and heroin addictions by populations,  
18 mitigation of the effects of opioid or heroin addiction, crime rates,  
19 hospitalization rates, death rates, and other calculable results as  
20 determined by the department. The report shall provide any  
21 recommendations for legislative or executive action that may be  
22 necessary to facilitate the ongoing success of the program.

23 (b) A report to be submitted to the Legislature pursuant to this  
24 section shall be submitted in compliance with Section 9795 of the  
25 Government Code.

26 11774.3. The department may adopt regulations in accordance  
27 with the rulemaking provisions of the Administrative Procedure  
28 Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of  
29 Division 3 of Title 2 of the Government Code) as necessary to  
30 implement this article.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 505  
**Author:** Caballero  
**Bill Date:** March 27, 2017, Amended  
**Subject:** Physicians and Surgeons: Probation  
**Sponsor:** California Medical Association

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would prohibit the Medical Board of California (Board) from entering into a stipulation for disciplinary action if the stipulation places a licensee on probation and the operative accusation includes specified charges.

**BACKGROUND:**

The Board uses its Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines) (16 CCR section 1361) and the Uniform Standards for Substance-Abusing Licensees (Uniform Standards) (16 CCR section 1361.5) as the framework for determining the appropriate penalty for charges filed against a physician. Business and Professions (B&P) Code section 2229 identifies that protection of the public shall be the highest priority for the Board, but also requires that wherever possible, the actions should be calculated to aid in the rehabilitation of the licensee. While the Disciplinary Guidelines and Uniform Standards frame the recommended penalty, the facts of each individual case may support a deviation from the guidelines. After the filing of an accusation and/or petition to revoke probation, a respondent physician must file a notice of defense within 15 days indicating they intend to present a defense to the accusation and/or petition to revoke probation or that they are interested in a settlement agreement. If the individual requests a hearing, existing law (Government Code sections 11511.5 and 11511.7) requires that a prehearing conference be held to explore settlement possibilities and prepare stipulations, as well as schedule a mandatory settlement conference, in an attempt to resolve the case through a stipulated settlement before proceeding to the administrative hearing.

The assigned deputy attorney general (DAG) reviews the case, any mitigation provided, the strengths and weaknesses of the case, the Board's Disciplinary Guidelines, and, when applicable, any prior disciplinary action against the respondent physician, and drafts a settlement recommendation that frames the recommended penalty. In addition, this settlement recommendation takes into account consumer protection and B&P Code section 2229(b). The DAG's recommendation is then reviewed and either approved or edited by the supervising DAG. Once that approval is received, the DAG submits the settlement recommendation to the Board's Executive Director for review and consideration.

The Board's Executive Director reviews the settlement recommendation using the same criteria as the DAG and either approves or changes the settlement recommendation. The DAG then negotiates with the respondent physician and/or their counsel to settle the

case with the recommended penalty. Both the prehearing settlement conference and the mandatory settlement conference have the assistance of an administrative law judge (ALJ). This ALJ reviews the case and hears information from the DAG and the respondent physician and/or their counsel and then assists in negotiating the settlement. During the settlement conference, the Board representative must be available to authorize any change to the previously agreed settlement recommendation.

If a settlement agreement is reached, the stipulated settlement document must be approved by a panel of the Board, unless the settlement is for a stipulated surrender. The Board then has the ability to adopt the settlement as written, request changes to the settlement, or request the matter go to hearing. In the process to settle a case, public protection is the first priority, and must be weighed with rehabilitation of the physician. When making a decision on a stipulation, the panel members are provided the strengths and weaknesses of the case, and weigh all factors.

### **ANALYSIS**

This bill would prohibit the Board from entering into a stipulation for disciplinary action if the stipulation places a licensee on probation and the operative accusation includes any of the following:

- Felony conviction involving harm to patient safety or health.
- Drug or alcohol abuse directly resulting in harm to patient safety or health.
- Sexual act or sexual exploitation as defined in Section 726 and subdivision (a) of Section 729.

Any settlement recommendation stipulated to by the Board must provide an appropriate level of public protection and rehabilitation. Settling cases by stipulations that are agreed to by both sides facilitates consumer protection by rehabilitating the physician in a more expeditious manner. By entering into a stipulation, it puts the individual on probation or restriction sooner and the public is able to see the action taken by the Board more timely than if the matter went to hearing. In addition, the Board may get more terms and conditions through the settlement process than would have been achieved if the matter went to hearing.

If the Board is required to go to hearing for certain cases, there will be a significant fiscal impact to the Board and it will also significantly increase the Board's enforcement timelines. This bill will not enhance consumer protection, as it will result in physicians practicing longer with no monitoring or restrictions by the Board. The Board's primary mission is consumer protection and this bill does not further that mission, as such, Board staff suggests that the Board oppose this bill,

### **FISCAL:**

Using the categories specified in this bill and comparing them to the categories of discipline in the Board's 15/16 Annual Report, minus the number of proposed decisions in that same time frame with the same categories, Board staff estimates that 95 cases will not be allowed to settle and will have to go to hearing. It is important to note that the Board had to use all cases in those categories, as the Board will not know beforehand which cases

will have the disciplinary outcome of probation. In the probation notification bill from last year, Board staff estimated the cost of going to hearing at \$35,000 per case. With the estimated 95 cases, times the hearing cost, this would result in a cost of \$3,325,000 to the Board. It is possible that a fee increase may be needed if this bill were to be enacted. The Board would have to contract for a fee audit to confirm any possible fee increase.

**SUPPORT:**

California Medical Association (Sponsor)

**OPPOSITION:**

None on file

**POSITION:**

Recommendation: Oppose



AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

**ASSEMBLY BILL**

**No. 505**

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**Introduced by Assembly Member Caballero**

February 13, 2017

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An act to add Section 2227.1 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL’S DIGEST

AB 505, as amended, Caballero. Physicians and surgeons: probation.

Under existing law, a physician and surgeon whose matter has been heard by an administrative law judge, or whose default has been entered, and who is found guilty, or who has entered into a stipulation for disciplinary action with the Medical Board of California, is authorized to be subject to, among other things, license revocation, suspension, or probation, as specified. Existing law authorizes the board to discipline a licensee by placing him or her on probation subject to specified conditions.

This bill would prohibit the board from entering into any stipulation for disciplinary action, ~~including placing~~ *action if the stipulation places* a licensee on ~~probation, if probation and~~ the operative accusation includes specified acts.

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 2227.1 is added to the Business and
- 2 Professions Code, to read:

1     2227.1. Notwithstanding Sections 2227 and 2228, the board  
2     may not enter into any stipulation for disciplinary ~~action, which~~  
3     ~~includes placing~~ *action if the stipulation places* a licensee on  
4     ~~probation, if probation and~~ the operative accusation includes any  
5     of the following:  
6     (a) Felony conviction involving harm to patient safety or health.  
7     (b) Drug or alcohol abuse directly resulting in harm to patient  
8     safety or health.  
9     (c) Sexual act or sexual exploitation as defined in Section 726  
10    and subdivision (a) of Section 729.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 706  
**Author:** Patterson  
**Bill Date:** February 15, 2017: Introduced  
**Subject:** Medical Board of California: Licenses  
**Sponsor:** Author  
**Position:** Support

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would require licenses issued by the Medical Board of California (Board) to be valid for two years from issuance.

**BACKGROUND**

The Board currently utilizes a physician's birth date to calculate license expiration dates. The purpose of the birth date renewal initially was to ensure that the Board did not have to process a large number of renewals during peak times. However, with the intensive licensing outreach performed by the Board's Licensing Outreach Manager to potential licensees, licenses are not issued only during certain months, but are spread out throughout the year.

The Board does give applicants the option of waiting until their birth month for their physician and surgeon license to be issued. However, if an applicant cannot wait until their birth month to receive their license, the initial license will not be valid for a full two years, resulting in overpayment to the Board.

**ANALYSIS**

This bill would resolve the same overpayment issue that AB 483 (Patterson, 2015) would have addressed for licenses issued by specified Department of Consumer Affairs boards. AB 483 would have required these boards to prorate the initial licensing fees to ensure that licensees are not overcharged. However, the proration requirement would result in delays in issuing licenses and increased workload. AB 483 was vetoed by the Governor. AB 773 (Baker, 2015) would have required the Board of Psychology and the Board to issue licenses that are valid for two-years from the time of issuance. However, the Board was pulled out of the bill in Senate Appropriations Committee on the suspense file and the bill that was signed into law only included the Board of Psychology.

Board staff believes that a two-year license would be a better way to resolve the issue of license fee overpayment. The Board does not have any issues with peak times, so a two-year license will ensure that applicants are not overcharged and will not create any additional steps in the licensure process. The Board took a support position on AB 773 in 2015. In addition,

the Board included this as a new issue in its 2016 Sunset Report. As such, the Board already is supportive of the language in this bill.

**FISCAL:** Minimal and absorbable workload to change the Board's licensing process from a birth month expiration to a straight two-year license.

**SUPPORT:** Medical Board of California

**OPPOSITION:** None on file

**ASSEMBLY BILL**

**No. 706**

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**Introduced by Assembly Member Patterson**

February 15, 2017

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An act to amend Section 2423 of, and to repeal Section 2422 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 706, as introduced, Patterson. Medical Board of California: licenses.

Existing law provides for the licensure and regulation of specific health care professions by the Medical Board of California or a licensing and regulatory authority within the jurisdiction of that board. The Medical Practice Act determines the expiration of, and governs the renewal of, certificates, licenses, registrations, and permits issued by or under the Medical Board of California, including physician and surgeon's certificates, certificates to practice podiatric medicine, physical therapy licenses and approvals, registrations of research psychoanalysts, registrations of dispensing opticians, registrations of nonresident contact lens sellers, registrations of spectacle lens dispensers, registrations of contact lens dispensers, certificates to practice midwifery, and fictitious-name permits. Under the act, physician and surgeon's certificates, certificates to practice podiatric medicine, registrations of spectacle lens dispensers and contact lens dispensers, and certificates to practice midwifery expire on the last day of the birth month of the licensee during the 2nd year of a 2-year term. Under that act, registrations of dispensing opticians expire on the last day of the month in which the license was issued during the 2nd year of a 2-year term.

This bill would instead have all of the above licenses expire at the end, as provided, of a 2-year period from the date the license was issued.

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 2422 of the Business and Professions  
2 Code is repealed.

3 ~~2422. All licenses expire and become invalid at 12 midnight~~  
4 ~~on the last day of February of each even-numbered year if not~~  
5 ~~renewed.~~

6 ~~To renew an unexpired license, a licensee shall, on or before the~~  
7 ~~date it would otherwise expire, apply for renewal on a form~~  
8 ~~prescribed by the licensing authority and pay the prescribed renewal~~  
9 ~~fee.~~

10 SEC. 2. Section 2423 of the Business and Professions Code is  
11 amended to read:

12 ~~2423. (a) Notwithstanding Section 2422: All physician and~~  
13 ~~surgeon's certificates, certificates to practice podiatric medicine,~~  
14 ~~registrations of dispensing opticians, spectacle lens dispensers,~~  
15 ~~and contact lens dispensers, and certificates to practice midwifery~~  
16 ~~shall expire at 12 midnight on the last day of the month in which~~  
17 ~~the license was issued during the second year of a two-year term~~  
18 ~~commencing from the date of issuance.~~

19 ~~(1) All physician and surgeon's certificates, certificates to~~  
20 ~~practice podiatric medicine, registrations of spectacle lens~~  
21 ~~dispensers and contact lens dispensers, and certificates to practice~~  
22 ~~midwifery shall expire at 12 midnight on the last day of the birth~~  
23 ~~month of the licensee during the second year of a two-year term~~  
24 ~~if not renewed.~~

25 ~~(2) Registrations of dispensing opticians will expire at midnight~~  
26 ~~on the last day of the month in which the license was issued during~~  
27 ~~the second year of a two-year term if not renewed.~~

28 ~~(b) The Division of Licensing shall establish by regulation~~  
29 ~~procedures for the administration of a birth date renewal program,~~  
30 ~~including, but not limited to, the establishment of a system of~~  
31 ~~staggered license expiration dates such that a relatively equal~~  
32 ~~number of licenses expire monthly.~~

33 ~~(c)~~

1     (b) To renew an unexpired license, the ~~licensee shall~~, *licensee*,  
2     on or before the ~~dates~~ *date* on which it would otherwise expire,  
3     *shall* apply for renewal on a form prescribed by the licensing  
4     authority and pay the prescribed renewal fee.

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MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 715  
**Author:** Wood  
**Bill Date:** April 18, 2017, Amended  
**Subject:** Workgroup Review of Opioid Pain Reliever Use and Abuse  
**Sponsor:** Author

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would require the California Department of Public Health (CDPH) to convene a workgroup to review existing prescription guidelines and develop a recommended statewide guideline addressing best practices for prescribing opioids.

**BACKGROUND:**

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

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

In 2014, the Director of CDPH launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) to share information and develop collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in California. The Workgroup started as a multi-sector group consisting of more than 10



state agencies, including CDPH, Department of Justice, DHCS, Department of Managed Health Care, Department of Education, Department of Industrial Relations, Department of Corrections and Rehabilitation, Department of Consumer Affairs (including the Board, Dental Board of California, Board of Pharmacy, and Board of Registered Nursing), Emergency Medical Services Authority, and others. The Workgroup initially commenced a multi-phase plan involving enhancement of the state's Prescription Drug Monitoring Program (PDMP), promoting the release and adoption of the Board's revised Guidelines for Prescribing Controlled Substances for Pain, and development of a comprehensive public education campaign to increase public awareness about the potential dangers of opioid medications and to create better understanding and expectations among the public regarding proper prescribing, use, storage and disposal of opioids.

In 2016, the Centers for Disease Control (CDC) developed and published the CDC Guidelines for Prescribing Opioids for Chronic Pain to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care. These Guidelines address clinical practices on determining when to initiate or continue opioids for chronic pain outside of active cancer treatment, palliative care, and end-of-life care; opioid selection, dosage, duration, follow-up, and discontinuation; and assessing risk and addressing harms of opioid use.

## **ANALYSIS**

This bill makes findings and declarations regarding the epidemic of opioid abuse in the United States. This bill would require CDPH to convene a workgroup to do all of the following:

- Review existing prescription guidelines, including, but not limited to, guidelines developed by the CDC and the Board.
- Develop a recommended statewide guideline addressing best practices for prescribing opioid pain relievers for instances of acute, short-term pain. In developing the statewide guideline, the workgroup may consider, among other things, evidence-based, peer-reviewed research, lessons learned from demonstration pilot projects, or other policies that have been successful in reducing opioid use and abuse. The guidelines shall include, but not be limited to, the appropriateness of limiting initial prescription duration and the appropriateness of a differing prescribing protocol for individuals under 21 years of age.

This bill would require CDPH to determine the membership of the workgroup, ensuring an open and inclusive process. Members of the workgroup shall include, but not be limited to, family practitioners, emergency room physicians, dentists, surgeons, pain management experts, and experts in the field of substance abuse prevention and treatment.

This bill would require CDPH to submit a report to the Legislature, on or before March 1, 2019, which shall contain the workgroup’s conclusions and required recommendations, and any other recommendations made by the workgroup. This bill would sunset the workgroup on January 1, 2020.

The author believes that while several multi-agency efforts are underway related to public education, safe storage, and treatment for opioid misuse, the response to the crisis has not been sufficiently aggressive in efforts to intervene and change existing prescribing practice related to the appropriateness of use and initial dosage of opioid prescriptions. Although there are numerous guidelines and recommendations for opioid prescribers, the author believes it is prudent to conduct an extensive review of these guidelines by healthcare professionals, experts in the fields of pain management and addiction, and other credible stakeholders to develop a single set of recommendations for practitioners to use in prescribing opioids.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. Although the Board has already drafted guidelines on this issue through a very extensive process that included stakeholder and expert input, a third party review of all existing guidelines may allow for additional input and updates for state guidelines. Board staff recommends that the Board take a neutral position on this bill.

- FISCAL:** None
- SUPPORT:** California State Sheriffs’ Association
- OPPOSITION:** None on file
- POSITION:** Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 18, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

**ASSEMBLY BILL**

**No. 715**

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**Introduced by Assembly Member Wood**

February 15, 2017

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An act to add and repeal Part 6.3 (commencing with Section 1179.90) of Division 1 of the Health and Safety Code, relating to public health.

LEGISLATIVE COUNSEL’S DIGEST

AB 715, as amended, Wood. Workgroup review of opioid pain reliever use and abuse.

Existing law creates the State Department of Public Health and vests it with duties, powers, functions, jurisdiction, and responsibilities with regard to the advancement of public health.

This bill would require the department to convene a workgroup, comprised of members selected by the department, to review existing prescription guidelines and develop a recommended statewide guideline addressing best practices for prescribing opioid pain relievers. The bill would require the department, on or before March 1, 2019, to report the workgroup’s conclusions and recommendations to the Legislature. The bill would repeal its provisions on January 1, 2020.

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

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

1     SECTION 1. The Legislature finds and declares all of the  
2     following:

1 (a) Opioid abuse is a serious problem that affects the health,  
2 social, and economic welfare of the state.

3 (b) After alcohol, prescription drugs are the most commonly  
4 abused substances by Americans over 12 years of age.

5 (c) Almost 2 million people in the United States suffer from  
6 substance use disorders related to prescription opioid pain relievers.

7 (d) Deaths involving prescription opioid pain relievers represent  
8 the largest portion of drug overdose deaths involving heroin or  
9 cocaine.

10 (e) The number of unintentional overdose deaths involving  
11 prescription opioid pain relievers has more than quadrupled since  
12 1999.

13 SEC. 2. Part 6.3 (commencing with Section 1179.90) is added  
14 to Division 1 of the Health and Safety Code, to read:

15  
16 PART 6.3 WORKGROUP REVIEW OF OPIOID PAIN  
17 RELIEVER USE AND ABUSE  
18

19 1179.90. (a) The State Department of Public Health shall  
20 convene a workgroup to do all of the following:

21 (1) Review existing prescription guidelines, including, but not  
22 limited to, guidelines developed by the federal Centers for Disease  
23 Control and Prevention and the Medical Board of California.

24 (2) Develop a recommended statewide guideline addressing  
25 best practices for prescribing opioid pain-relievers. *relievers for*  
26 *instances of acute, short-term pain.* In developing the statewide  
27 guideline, the workgroup may consider, among other things,  
28 evidence-based, peer-reviewed research, lessons learned from  
29 demonstration pilot projects, or other policies that have been  
30 successful in reducing opioid use and abuse. *The guidelines shall*  
31 *include, but not be limited to, the appropriateness of limiting initial*  
32 *prescription duration and the appropriateness of a differing*  
33 *prescribing protocol for individuals under 21 years of age.*

34 (b) The State Department of Public Health shall determine the  
35 membership of the ~~workgroup~~. *workgroup, ensuring an open and*  
36 *inclusive process.* Members of the workgroup ~~may include~~  
37 ~~multidisciplinary experts from the fields of pain management and~~  
38 ~~substance abuse prevention and treatment.~~ *shall include, but not*  
39 *be limited to, family practitioners, emergency room physicians,*

1 *dentists, surgeons, pain management experts, and experts in the*  
2 *field of substance abuse prevention and treatment.*

3 1179.91. On or before March 1, 2019, the State Department  
4 of Public Health shall submit to the Legislature a report of the  
5 workgroup's conclusions and recommendations pursuant to  
6 paragraphs (1) and (2) of subdivision (a) of Section 1179.90 and  
7 any other recommendations made by the workgroup. The report  
8 shall be submitted in compliance with Section 9795 of the  
9 Government Code.

10 1179.92. This part shall remain in effect only until January 1,  
11 2020, and as of that date is repealed.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 845  
**Author:** Wood  
**Bill Date:** March 28, 2017, Amended  
**Subject:** Cannabidiol  
**Sponsor:** Epilepsy Foundation of Greater Los Angeles

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would allow a physician to prescribe and a pharmacist to dispense cannabidiol, if it is removed from Schedule 1 of the federal Controlled Substances Act (Act) and placed on a schedule other than Schedule I, or if a product composed of cannabidiol is approved by the federal Food and Drug Administration (FDA) and either placed on a schedule of the Act other than Schedule I or is exempted from the Act. If a physician and pharmacist prescribes and dispenses cannabidiol in accordance with federal law, they shall be deemed to be in compliance with state law.

**BACKGROUND (taken from the fact sheet):**

Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into five designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I. Existing law places marijuana in Schedule I and cannabidiol is a compound found in marijuana.

Epilepsy is a medical condition that produces seizures affecting a variety of mental and physical functions. Approximately 1 in 26 Americans will develop epilepsy at some point in their lifetime. There is no “one size fits all” treatment option and about one million people live with uncontrolled or intractable seizures. Access to new treatment is particularly important for these individuals, who live with the continual risk of serious injuries and loss of life.

The FDA is currently reviewing at least one cannabidiol or CBD derived therapy (Epidiolex) that shows promise for the treatment of Dravet and Lennox Gastaut syndromes (LGS), tuberous sclerosis complex (TSC) and potentially other rare epilepsies. This potential treatment option has both Orphan Drug Designation from the FDA for Dravet syndrome and also Orphan Drug Designation for LGS and TSC, other rare types of epilepsy. Given the fast track designation, this potential treatment option could be available as soon as early 2018.

**ANALYSIS**

This bill would allow a physician to prescribe and a pharmacist to dispense cannabidiol, if it is removed from Schedule 1 of the federal Act and placed on a schedule other than Schedule I, or if a product composed of cannabidiol is approved by the federal Food and Drug Administration (FDA) and either placed on a schedule of the Act other than Schedule I or is exempted from the Act. If a physician and pharmacist prescribes and

dispenses cannabidiol in accordance with federal law, they shall be deemed to be in compliance with state law.

This bill would state that upon the effective date of one of the federal changes specified in this bill, notwithstanding any other state law, the prescription, furnishing, dispensing, possession, or use of a product composed of cannabidiol, in accordance with federal law, is for a legitimate medical purpose and is authorized pursuant to state law. This bill is an urgency statute and will take effect immediately upon being signed into law.

Per the author's office, currently any product that contains any quantity of marijuana is considered a Schedule I controlled substance, unless specifically exempted. Under current law, should a product be derived from cannabidiol, it would still be considered a Schedule I controlled substance and therefore could not be prescribed by a physician. According to the author, the purpose of this bill is to ensure Californians with uncontrolled seizures will have continued access to FDA approved epilepsy treatments derived from cannabidiol.

This bill would ensure that if the federal government approves cannabidiol treatment, then California physicians and pharmacists can prescribe and dispense cannabidiol in accordance with federal law. This bill merely aligns revises state law with federal law to allow treatments authorized by the federal government in the future. Board staff suggests the Board take a neutral position on this bill.

**FISCAL:** None

**SUPPORT:** Epilepsy Foundation of Greater Los Angeles (Sponsor)

**OPPOSITION:** None on file

**POSITION:** Recommendation: Neutral

AMENDED IN ASSEMBLY MARCH 28, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

## ASSEMBLY BILL

**No. 845**

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**Introduced by Assembly Member Wood**

February 16, 2017

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An act to add Section 11150.2 to the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

### LEGISLATIVE COUNSEL’S DIGEST

AB 845, as amended, Wood. Cannabidiol.

Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I, and the least restrictive limitations generally placed on controlled substances classified in Schedule V. Existing law places marijuana in Schedule I. Cannabidiol is a compound found in marijuana.

Existing law restricts the prescription, furnishing, possession, sale, and use of controlled substances, including marijuana and synthetic cannabinoid compounds, and makes a violation of those laws a crime, except as specified.

~~This bill would authorize, if federal law authorizes the prescription of a controlled substance containing cannabidiol, a physician to prescribe that substance in accordance with federal law. The bill would also provide that upon the enactment of federal law authorizing the prescription or the furnishing, transferring, possession, or use of a prescription for a controlled substance containing cannabidiol, notwithstanding any other state law, the prescription, furnishing,~~



~~transferring, possession, or use of that controlled substance in accordance with federal law is for a legitimate medical purpose and is authorized pursuant to state law.~~

*This bill, if one of specified changes in federal law regarding the controlled substance cannabidiol occurs, would provide that a physician who prescribes and a pharmacist who dispenses a product composed of cannabidiol, in accordance with federal law, is in compliance with state law governing those acts. The bill would also provide that upon the effective date of one of those changes in federal law regarding cannabidiol, the prescription, furnishing, dispensing, transfer, possession, or use of that product in accordance with federal law is for a legitimate medical purpose and is authorized pursuant to state law.*

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

Vote:  $\frac{2}{3}$ . Appropriation: no. Fiscal committee: yes.  
State-mandated local program: no.

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

1 SECTION 1. The Legislature finds and declares that both  
2 children and adults with epilepsy are in desperate need of new  
3 treatment options and that cannabidiol is showing potential as one  
4 of these treatments. If federal laws prohibiting the prescription of  
5 medications ~~containing~~ *composed of* cannabidiol are repealed or  
6 if an exception from the general prohibition is enacted permitting  
7 the prescription of drugs ~~containing~~ *composed of* cannabidiol,  
8 patients should have rapid access to this treatment option. The  
9 availability of this new prescription medication is intended to  
10 augment, not to restrict or otherwise amend, other cannabinoid  
11 treatment modalities currently available under state law.

12 SEC. 2. ~~Section 11150.2 is added to the Health and Safety~~  
13 ~~Code, to read:~~

14 11150.2. ~~Notwithstanding any other law, if federal law~~  
15 ~~authorizes the prescription of a controlled substance containing~~  
16 ~~cannabidiol, a physician may prescribe that substance in accordance~~  
17 ~~with federal law. For purposes of this chapter, including, but not~~  
18 ~~limited to, Sections 11153 and 11153.5, upon the enactment of~~  
19 ~~federal law authorizing the prescription or the furnishing,~~  
20 ~~transferring possession, or use of a prescription for a controlled~~  
21 ~~substance containing cannabidiol, notwithstanding any other state~~

1 ~~law, the prescription, furnishing, transferring, possession, or use~~  
2 ~~of that controlled substance in accordance with federal law is for~~  
3 ~~a legitimate medical purpose and is authorized pursuant to state~~  
4 ~~law.~~

5 *SEC. 2. Section 11150.2 is added to the Health and Safety*  
6 *Code, to read:*

7 *11150.2. (a) Notwithstanding any other law, if cannabidiol is*  
8 *removed from Schedule I of the federal Controlled Substances Act*  
9 *and placed on a schedule of the act other than Schedule I, or if a*  
10 *product composed of cannabidiol is approved by the federal Food*  
11 *and Drug Administration and either placed on a schedule of the*  
12 *act other than Schedule I, or exempted from one or more provisions*  
13 *of the act, so as to permit a physician to prescribe and a pharmacist*  
14 *to dispense that product, a physician who prescribes, and a*  
15 *pharmacist who dispenses, that product in accordance with federal*  
16 *law shall be deemed to be in compliance with state law governing*  
17 *those acts.*

18 *(b) For purposes of this chapter, including, but not limited to,*  
19 *Sections 11153 and 11153.5, upon the effective date of one of the*  
20 *changes in federal law described in subdivision (a),*  
21 *notwithstanding any other state law, the prescription, furnishing,*  
22 *dispensing, transfer, possession, or use of a product composed of*  
23 *cannabidiol in accordance with federal law is for a legitimate*  
24 *medical purpose and is authorized pursuant to state law.*

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

29 *In order to ensure that patients are able to obtain access to a new*  
30 *treatment modality as soon as federal law makes it available, it is*  
31 *necessary that this act take effect immediately.*

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 893  
**Author:** Garcia, E.  
**Bill Date:** March 27, 2017, Amended  
**Subject:** Healing Arts: Employment: Pioneers Memorial Health Care District  
**Sponsor:** Pioneers Memorial Health Care District

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would authorize, until January 1, 2022, Pioneers Memorial Health Care District (District) to employ physicians and charge for professional services. The District can only employ physicians if the medical staff concurs by an affirmative vote that employing physicians is in the best interest of the communities served by the District and if the District does not interfere with, control or otherwise direct the professional judgement of a physician in a manner prohibited by Business and Professions Code Section 2400 or any other law. This bill would require the District to submit reports to the Office of Statewide Health Planning and Development (OSHPD) on an annual basis.

**BACKGROUND:**

Current law (commonly referred to as the "ban on the corporate practice of medicine" – Business and Professions Code section 2400) generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine, to ensure that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians.

Most states, including California, allow exemptions for some professional medical corporations to employ physicians. For example, California allows physician employees at teaching hospitals, some community clinics, and certain non-profit organizations. California is one of only a few states that prohibits the employment of physicians by hospitals.

SB 376 (Chesbro, Chapter 411, Statutes of 2003) directed the Board to establish a pilot program to provide for the direct employment of physicians by qualified district hospitals. The bill was sponsored by the Association of California Healthcare Districts to enable qualified district hospitals to recruit, hire, and employ physicians as full-time, paid staff in rural or underserved communities meeting specified criteria. The goal of the legislation was to improve the ability of district hospitals to attract physicians. However, participation in the pilot was very limited, with only five participating hospitals and six participating physicians, and the Board was hindered in making a full evaluation due to lack of participation. The pilot expired on January 1, 2011.

AB 2024 (Wood, Chapter 496, Statutes of 2016) authorizes, until January 1, 2024, a federally certified critical access hospital (CAH) to employ physicians and charge for professional services. A CAH can only employ physicians if the medical staff concurs by an affirmative vote that employing physicians is in the best interest of the communities served by the CAH and if the CAH does not interfere with, control or otherwise direct the professional judgement of a physician. This bill requires OSHPD, on or before July 1, 2023, to provide a report to the Legislature regarding the impact of CAH's employing physicians and their ability to recruit and retain physicians between January 1, 2017 and January 1, 2023, inclusive. This bill requires the CAHs to also submit reports to OSHPD on an annual basis. The Board took a neutral position on this bill.

### **ANALYSIS**

This bill would establish a pilot program for the District to employ physicians if the medical staff concurs by an affirmative vote that employing physicians is in the best interest of the communities served by the District and if the District does not interfere with, control or otherwise direct the professional judgement of a physician. This bill would require the District to report to OSHPD on an annual basis on an after July 1, 2018, until this bill sunsets in 2022.

The District includes one hospital, Pioneers Memorial Hospital, and one health center in Calexico. The hospital is a 107 bed acute care facility located in Imperial Valley. According to the author, a large segment of the population in Pioneers' service area are Medi-Cal members, which makes it difficult to recruit new physicians. This bill would authorize a three-year pilot program to expand on AB 2024 from last year and allow the District, which is a rural healthcare district, to better recruit and employ physicians, in order to assure physician retention in a rural setting.

The Board has always believed that the ban on the corporate practice of medicine provides a very important protection for patients and physicians from inappropriate intrusions into the practice of medicine. That being said, this bill only applies to one hospital and one health center and this bill would help this hospital to recruit and retain physicians, which will improve access to care in these rural communities. In addition, this bill is a pilot program that will be evaluated and the bill makes it clear that the District must not interfere with, control or otherwise direct the professional judgement of a physician. In addition, this bill is modeled after AB 2024 from last year in which the Board took a neutral position. As such, staff is recommending that the Board take a neutral position on this bill.

**FISCAL:** None

**SUPPORT:** Pioneers Memorial Health Care District (Sponsor)

**OPPOSITION:** None on file

**POSITION:** Recommendation: Neutral

AMENDED IN ASSEMBLY MARCH 27, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

**ASSEMBLY BILL**

**No. 893**

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**Introduced by Assembly Member Eduardo Garcia**

February 16, 2017

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*An act to add Section 2401.1 to the Business and Professions Code, relating to healing arts.*

LEGISLATIVE COUNSEL’S DIGEST

AB 893, as amended, Eduardo Garcia. ~~Healing arts: employment.~~  
*arts: employment: Pioneers Memorial Health Care District.*

Existing law, the Medical Practice Act, restricts the employment of physicians and surgeons or doctors of podiatric medicine by a corporation or other artificial legal entity to entities that do not charge for professional services rendered to patients and are approved by the Medical Board of California, subject to specified exemptions. Existing law, until January 1, 2024, also authorizes a federally certified critical access hospital to employ those medical professionals and to charge for professional services rendered by those medical professionals if the medical staff concur by an affirmative vote that the professional’s employment is in the best interest of the communities served by the hospital and the hospital does not direct or interfere with the professional judgment of a physician and surgeon, as specified. Existing law requires, on and after July 1, 2017, and until July 1, 2023, ~~require~~ a federally certified critical access hospital employing those medical professionals under this authorization to submit a report, on or before July 1 of each year, to the ~~office~~ *Office of Statewide Health Planning and Development*, as specified.

~~This bill would state the intent of the Legislature to subsequently amend this bill to include provisions that would authorize rural hospitals to employ physicians and surgeons or doctors of podiatric medicine and to charge for professional services rendered by those medical professionals.~~

*This bill would authorize the Pioneers Memorial Health Care District, until January 1, 2022, to conduct a pilot program pursuant to which it also may employ licensees and charge for professional services rendered by those licensees if the medical staff concur by an affirmative vote that the professional's employment is in the best interest of the communities served by the district and the district does not direct or interfere with the professional judgment of a physician and surgeon, as specified. The bill would require the district to submit a report to the office containing data elements required by the office.*

*This bill would make legislative findings and declarations as to the necessity of a special statute for the Pioneers Memorial Health Care District.*

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 2401.1 is added to the Business and
- 2     Professions Code, to read:
- 3     2401.1. (a) Notwithstanding Sections 2400 and 2401, the
- 4     Pioneers Memorial Health Care District, until January 1, 2022,
- 5     is authorized to conduct a pilot program pursuant to which it may
- 6     employ licensees and charge for professional services rendered
- 7     by those licensees to patients, provided that both of the following
- 8     conditions are met:
- 9         (1) The medical staff concur by an affirmative vote that the
- 10        licensee's employment is in the best interest of the communities
- 11        served by the district.
- 12        (2) The district does not interfere with, control, or otherwise
- 13        direct a physician and surgeon's professional judgment in a
- 14        manner prohibited by Section 2400 or any other law.
- 15     (b) On and after July 1, 2018, the Pioneers Memorial Health
- 16     Care District shall submit to the Office of Statewide Health
- 17     Planning and Development, on or before July 1 of each year, a
- 18     report for any year in which it has employed or is employing

1 *licensees and charging for professional services rendered by those*  
2 *licensees to patients. The report shall include data elements as*  
3 *required by the office and shall be submitted in a format as*  
4 *required by the office. This report shall be submitted in compliance*  
5 *with Section 9795 of the Government Code. The requirement for*  
6 *submitting a report imposed under this subdivision is inoperative*  
7 *on July 1, 2022.*

8 *SEC. 2. The Legislature finds and declares that a special statute*  
9 *is necessary and that a general statute cannot be made applicable*  
10 *within the meaning of Section 16 of Article IV of the California*  
11 *Constitution because of the particular need for Pioneers Memorial*  
12 *Health Care District to better recruit and employ physicians, and*  
13 *to ensure the continued presence of those professionals in a rural*  
14 *setting.*

15 ~~SECTION 1. It is the intent of the Legislature to subsequently~~  
16 ~~amend this measure to include provisions that would authorize~~  
17 ~~rural hospitals to employ physicians and surgeons or doctors of~~  
18 ~~podiatric medicine and to charge for professional services rendered~~  
19 ~~by those medical professionals.~~

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1048  
**Author:** Arambula  
**Bill Date:** March 21, 2017, Amended  
**Subject:** Health Care: Pain Management and Schedule II Drug Prescriptions  
**Sponsor:** California Medical Association

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would authorize a pharmacist to dispense opioids as partial fills if requested by the prescribing physician or patient. This bill would remove the requirement that pain be assessed at the same time as vital signs. Lastly, this bill would prohibit health facilities from in any way conditioning or basing executive compensation to chief officers, executives, managers and administrators on patient satisfaction measurements for pain management.

**BACKGROUND:**

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

According to the Centers for Disease Control, every day, 44 people in the U.S. die from overdose of prescription painkillers and many more become addicted.

Until 2016, federal law limited partially filling a Schedule II controlled substance to narrow circumstances. Section 702 of the Comprehensive Addiction and Recover Act (CARA) expanded the allowable circumstances for a Schedule II partial fill.

AB 791, which was signed into law in 1991, required that all health care staff record pain assessment each time that vital signs are recorded for each patient, making it the fifth vital sign. In 2016, both the American Medical Association and the Physicians at the American Academy of Family Physicians dropped pain as the fifth vital sign. Veterans Affairs, which was used as the model for AB 791, has also stopped requiring that pain be assessed as the fifth vital sign.



## ANALYSIS

This bill would authorize a pharmacist to dispense a Schedule II controlled substance, including opioids, as a partial fill if requested by the patient or the prescribing physician. This bill would specify that subsequent fills, until the original prescription is completely dispensed, shall occur at the pharmacy where the original prescription was partially filled. This bill would require the full prescription to be dispensed not more than 30 days after the first partial fill. Thirty-one days after the initial partial fill, the prescription shall expire and no more of the drug shall be dispensed without a subsequent prescription. This bill would require the pharmacist to record in the state prescription drug monitoring program only the actual amounts of the drug dispensed. This bill would require the pharmacist to notify the prescriber that the prescription was partially filled and the amount of the drug that was dispensed in one of the following ways:

- A notation in the patient's interoperable electronic health record.
- An electric or facsimile transmission.
- A notation in the patient's record at the pharmacy that is available to the prescriber upon request.

This bill would require the pharmacy to collect the copayment, if any, for the entire prescription at the time of the first partial fill. No additional money shall be collected for later dispensing, up to the full prescription amount. This bill would prohibit a pharmacist from charging an additional fee, service fee, or a higher rate of copayment for prescriptions that are dispensed as partial fills.

This bill would remove the requirement that pain be assessed at the same time as vital signs, and would instead include pain as an item to be assessed, which shall be noted in the patient's chart.

Lastly, this bill would prohibit health facilities from, in any way, conditioning or basing executive compensation, as specified, to chief officers, executives, managers and administrators of hospitals on patient satisfaction measurements for pain management. This bill would define a patient satisfaction measurement as a survey, questionnaire, poll, audit, or other instrument or process that collects or measures patient-reported outcomes or patient feelings about the medical care provided at the hospital, including, but not limited to, satisfaction with professional staff, service and facilities.

Per the author's office, this bill seeks to update California statute to reflect the new partial fill authority created by CARA. Allowing for partial fills will give the patient confidence that should his/her pain continue beyond the expected duration, he/she will be able to access appropriate pain relief without unnecessary delay. Conversely, should the patient only require the lowest dosage at the shortest duration, it will reduce the supply of unused medication available for misuse or diversion. In addition, this bill removes pain as the fifth vital sign, but maintains a requirement to assess pain in a manner that allows organizations and hospitals to set their own policies regarding which patient should have pain assessed based on the population served and services delivered. Lastly, this bill has put limitations on executive compensation so hospital systems will

not feel pressured to encourage opioid prescribing as a consequence of lower satisfaction scores by patients.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill will increase consumer protection by allowing for partial fills of opioids, which will likely reduce the supply of opioids that could potentially be misused or diverted. This bill takes reasonable steps to address the opioid epidemic and will further the Board's mission of consumer protection. Board staff recommends that the Board support this bill.

**FISCAL:**                      None to the Board

**SUPPORT:**                      California Medical Association (Sponsor)

**OPPOSITION:**                      None on file

**POSITION:**                      Recommendation: Support

AMENDED IN ASSEMBLY MARCH 21, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

## ASSEMBLY BILL

**No. 1048**

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**Introduced by Assembly Member Arambula**

February 16, 2017

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An act to *add Section 4052.10 to the Business and Professions Code, and to amend Section 1254.7 of of, and to add Section 1254.8 to, the Health and Safety Code, relating to health care.*

### LEGISLATIVE COUNSEL’S DIGEST

AB 1048, as amended, Arambula. ~~Health facilities: pain management.~~ *Health care: pain management and Schedule II drug prescriptions.*

*(1) The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy in the Department of Consumer Affairs. The law specifies the functions pharmacists are authorized to perform, including to administer, orally or topically, drugs and biologicals pursuant to a prescriber’s order; and to administer immunizations pursuant to a protocol with a prescriber. A violation of the Pharmacy Law is a crime.*

*This bill would authorize a pharmacist to dispense a Schedule II controlled substance as a partial fill if requested by the patient or the prescribing physician. The bill would require the pharmacy to retain the original prescription, with a notation of how much of the prescription has been filled, until the prescription has been fully dispensed, and would impose notification requirements on the pharmacy. The bill would require the pharmacy to collect the copayment, if any, for the entire prescription at the time of the first partial fill and would prohibit a pharmacy from charging an additional fee, service fee, or a higher rate or copayment for prescriptions that are dispensed as partial fills. By*

*creating a new crime, this bill would impose a state-mandated local program.*

**Existing**

(2) *Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health of health facilities. Health. Existing law requires a health facility to, as a condition of licensure, include pain as an item to be assessed at the same time vital signs are taken and to ensure that pain assessment is performed in a consistent manner that is appropriate to the patient. Violation of these provisions is a crime.*

*This bill would remove the requirement that pain be assessed at the same time as vital signs. The bill would also prohibit a general acute care hospital or acute psychiatric hospital from in any way conditioning or basing executive compensation, as defined, on patient satisfaction measurements for pain management. By creating a new crime, this bill would impose a state-mandated local program.*

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

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

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

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

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

- 1     SECTION 1. Section 4052.10 is added to the Business and
- 2     Professions Code, to read:
- 3     4052.10. (a) A pharmacist may dispense a Schedule II
- 4     controlled substance, as listed in Section 11055 of the Health and
- 5     Safety Code, as a partial fill if requested by the patient or the
- 6     prescribing physician.
- 7     (b) If a pharmacist dispenses a partial fill on a prescription
- 8     pursuant to this section, the pharmacy shall retain the original
- 9     prescription, with a notation of how much of the prescription has
- 10    been filled, until the prescription has been fully dispensed. The

1 *total quantity dispensed shall not exceed the total quantity*  
2 *prescribed.*

3 *(c) Subsequent fills, until the original prescription is completely*  
4 *dispensed, shall occur at the pharmacy where the original*  
5 *prescription was partially filled. The full prescription shall be*  
6 *dispensed not more than 30 days after the first partial fill.*  
7 *Thirty-one days after the initial partial fill on a prescription, the*  
8 *prescription shall expire and no more of the drug shall be*  
9 *dispensed without a subsequent prescription.*

10 *(d) The pharmacist shall record in the state prescription drug*  
11 *monitoring program only the actual amounts of the drug dispensed.*

12 *(e) The pharmacist shall notify the prescriber that the*  
13 *prescription was partially filled and the amount of the drug that*  
14 *was dispensed in one of the following ways:*

15 *(1) A notation in the patient's interoperable electronic health*  
16 *record.*

17 *(2) An electronic or facsimile transmission.*

18 *(3) A notation in the patient's record at the pharmacy that is*  
19 *available to the prescriber upon request.*

20 *(f) (1) A pharmacy shall collect the copayment, if any, for the*  
21 *entire prescription at the time of the first partial fill. No additional*  
22 *money shall be collected for later dispensing, up to the full*  
23 *prescription amount.*

24 *(2) A pharmacist shall not charge an additional fee, service fee,*  
25 *or a higher rate or copayment for prescriptions that are dispensed*  
26 *as partial fills.*

27 *(g) This section is not intended to conflict with or supersede*  
28 *any other requirement established for the prescription of a*  
29 *Schedule II controlled substance.*

30 *(h) For purposes of this section, the following definitions apply:*

31 *(1) "Original prescription" means the prescription presented*  
32 *by the patient to the pharmacy or submitted electronically to the*  
33 *pharmacy.*

34 *(2) "Partial fill" means a part of a prescription filled that is of*  
35 *a quantity less than the entire prescription.*

36 **SECTION 1.**

37 **SEC. 2.** Section 1254.7 of the Health and Safety Code is  
38 amended to read:

1 1254.7. (a) It is the intent of the Legislature that pain be  
2 assessed and treated promptly, effectively, and for as long as pain  
3 persists.

4 (b) A health facility licensed pursuant to this chapter shall, as  
5 a condition of licensure, include pain as an item to be assessed at  
6 ~~the same time vital signs are taken.~~ *assessed.* The health facility  
7 shall ensure that pain assessment is performed in a consistent  
8 manner that is appropriate to the patient. The pain assessment shall  
9 be noted in the patient's ~~chart in a manner consistent with other~~  
10 ~~vital signs.~~ *chart.*

11 *SEC. 3. Section 1254.8 is added to the Health and Safety Code,*  
12 *to read:*

13 *1254.8. (a) A health facility shall not in any way condition or*  
14 *base executive compensation on patient satisfaction measurements*  
15 *for pain management.*

16 *(b) A scheme or artifice that has the purpose of avoiding the*  
17 *limitation established in subdivision (a) shall be a violation of this*  
18 *section.*

19 *(c) For purposes of this section, the following definitions shall*  
20 *apply:*

21 *(1) (A) "Executive compensation" means compensation or any*  
22 *tangible employment benefit to chief executive officers, executives,*  
23 *managers, and administrators of hospitals, including, but not*  
24 *limited to, wages; salary; paid time off; bonuses; incentive*  
25 *payments; lump-sum cash payments; below market rate loans or*  
26 *loan forgiveness; payments for transportation, travel, meals, or*  
27 *other expenses in excess of actual documented expenses incurred*  
28 *in the performance of duties; payments or reimbursement for*  
29 *entertainment or social club memberships; housing, automobiles,*  
30 *parking, or similar benefits; scholarships or fellowships; payment*  
31 *for dependent care or adoption assistance; payment of personal*  
32 *legal or financial services; stock options or awards; and deferred*  
33 *compensation earned or accrued, even if not yet vested or paid.*

34 *(B) "Executive compensation" does not include a benefit or*  
35 *remuneration to the extent that the inclusion of that benefit or*  
36 *remuneration is preempted by federal law or violates the state or*  
37 *federal constitution.*

38 *(2) "Pain management" means the prevention, diagnosis, and*  
39 *treatment of pain.*

1     (3) “*Patient satisfaction measurement*” means a survey,  
2     questionnaire, poll, audit, or other instrument or process that  
3     collects or measures patient-reported outcomes or patient feelings  
4     about the medical care provided at the hospital, including, but not  
5     limited to, satisfaction with professional staff, service, and  
6     facilities.

7     SEC. 4. No reimbursement is required by this act pursuant to  
8     Section 6 of Article XIII B of the California Constitution because  
9     the only costs that may be incurred by a local agency or school  
10    district will be incurred because this act creates a new crime or  
11    infraction, eliminates a crime or infraction, or changes the penalty  
12    for a crime or infraction, within the meaning of Section 17556 of  
13    the Government Code, or changes the definition of a crime within  
14    the meaning of Section 6 of Article XIII B of the California  
15    Constitution.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1204  
**Author:** Mayes  
**Bill Date:** March 28, 2017, Amended  
**Subject:** Public Health: Emergency Prescriptions  
**Sponsor:** Author

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would allow a physician to prescribe a one-month supply of a life-saving medication, as defined, to a patient to be stored for the use of that patient in case of a natural disaster or other emergency.

**ANALYSIS**

This bill would define life-saving medication to include, but is not limited to, medication necessary to save the life of a patient whose life is at risk due to illnesses such as cancer, heart disease, diabetes, stroke, and other illnesses in which the failure to administer the medication can result in the death of the patient. A life-saving medication does not include medications that are primarily prescribed to relieve pain.

According to the author's office this bill is a district bill and the purpose is to ensure that once a year a doctor can prescribe a life-saving medication, over and above what is normally prescribed, so the patient can store that medication at home in case of a natural disaster or other emergency that prevents the individual from going to the pharmacy and having their prescription filled.

Ensuring that patients have access to life-saving medications is important and will ensure that these patient's lives are not at risk. However, the bill as written does not make it clear that the 30-day supply is in addition to their regularly prescribed dosage. In addition, although this bill does say that life-saving medications do not include medications that are primarily prescribed to relieve pain, this bill should specifically prohibit controlled substances used for pain management. Board staff suggests that the Board be neutral on the bill if these amendments are made.

**FISCAL:** None

**SUPPORT:** None on file

**OPPOSITION:** None on file

**POSITION:** Recommendation: Neutral if Amended



AMENDED IN ASSEMBLY MARCH 28, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

## ASSEMBLY BILL

**No. 1204**

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**Introduced by Assembly Member Mayes**

February 17, 2017

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An act to ~~amend Section 1797.1 of~~ *add Chapter 13 (commencing with Section 1799.300) to Division 2.5 of the Health and Safety Code,* relating to emergency medical services.

### LEGISLATIVE COUNSEL'S DIGEST

AB 1204, as amended, Mayes. Public health: emergency ~~medical services; prescriptions.~~

*Existing law governs the practice of medicine and the issuance of prescription drugs.*

*Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, states that it is the policy of the State of California to ensure the provision of effective and efficient emergency medical care.*

*This bill would authorize a licensed physician to prescribe a one-month supply of a life-saving medication, as described, to a patient to be stored for the use of that patient in case of a natural disaster or other emergency.*

~~Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, makes findings and declarations regarding the establishment of the Emergency Medical Services Authority.~~

~~This bill would make a technical, nonsubstantive change to these provisions.~~

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. Chapter 13 (commencing with Section 1799.300)  
2     is added to Division 2.5 of the Health and Safety Code, to read:

3  
4             CHAPTER 13. EMERGENCY PRESCRIPTIONS  
5

6     1799.300. For purposes of this chapter, a “life-saving  
7     medication” includes, but is not limited to, medication necessary  
8     to save the life of a patient whose life is at risk due to illnesses  
9     such as cancer, heart disease, diabetes, stroke, and other illnesses  
10    in which the failure to administer the medication can result in the  
11    death of the patient. A life-saving medication does not include  
12    medications that are primarily prescribed to relieve pain.

13    1799.301. Notwithstanding any other law, a licensed physician  
14    may prescribe a one-month supply of a life-saving medication to  
15    a patient to be stored for the use of that patient in case of a natural  
16    disaster or other emergency.

17    SECTION 1. ~~Section 1797.1 of the Health and Safety Code is~~  
18    ~~amended to read:~~

19    ~~1797.1. The Legislature finds and declares that it is the intent~~  
20    ~~of this act to provide the state with a statewide system for~~  
21    ~~emergency medical services by establishing within the California~~  
22    ~~Health and Human Services Agency, the Emergency Medical~~  
23    ~~Services Authority, which is responsible for the coordination and~~  
24    ~~integration of all state activities concerning emergency medical~~  
25    ~~services.~~

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1340  
**Author:** Maienschein  
**Bill Date:** March 22, 2017, Amended  
**Subject:** Continuing Medical Education: Mental and Physical Health Care  
Integration  
**Sponsor:** The Steinberg Institute

**DESCRIPTION OF LEGISLATION:**

This bill would allow for an optional continuing medical education (CME) course in integrating mental and physical health care in primary care settings, especially at it pertains to early identification of mental health issues in children and young adults and their appropriate care and treatment.

**BACKGROUND**

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

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

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

**ANALYSIS**

This bill requires the Board, when determining CME requirements, to consider including a course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues in children and young adults and their appropriate care and treatment. According to the sponsor, it is imperative that all medical

professionals are trained in recognizing the early signs of mental health issues in children and young adults. The sponsor believes this is especially important for pediatricians and general practitioners to ensure they are fully educated in identifying mental health concerns and appropriately treating them. The sponsor states that 50 percent of all cases of mental illness begin by age 14 and by age 24 the rate is 75 percent, so the need to equip physicians with the tools and knowledge to meet the demands of these young people is paramount.

Although the Board has historically opposed mandated CME, this bill would not mandate particular CME for physicians. This bill only requires the Board to consider a course on integrating mental and physical health care in primary care settings. The Board does not track employment information for physicians, so the Board would not know which physicians practice in primary care settings. 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:** The Steinberg Institute

**OPPOSITION:** None on file

**POSITION:** Recommendation: Neutral

**ASSEMBLY BILL**

**No. 1340**

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**Introduced by Assembly Member Maienschein**  
*(Principal coauthor: Assembly Member Thurmond)*  
*(Coauthors: Assembly Members Gallagher and Mathis)*  
*(Coauthors: Senators Bates and Hertzberg)*

February 17, 2017

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An act to amend Section 2191 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL’S DIGEST

AB 1340, as introduced, Maienschein. Continuing medical education: mental and physical health care integration.

The Medical Practice Act requires the Medical Board of California to adopt and administer standards for the continuing education of licensed physicians and surgeons and requires the board to require each licensed physician and surgeon to demonstrate satisfaction of the continuing education requirements at specified intervals. The act requires the board, in determining its continuing education requirements, to consider including courses on specified matters.

This bill would require the board to consider including in its continuing education requirements a course in integrating mental and physical health care in primary care settings, especially as it pertains to early identification of mental health issues in children and young adults and their appropriate care and treatment.

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

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

SECTION 1. Section 2191 of the Business and Professions Code is amended to read:

2191. (a) In determining its continuing education requirements, the board 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 board 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 board 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 board 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 board 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 board 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 board 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 board 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 board establishes a requirement for continuing education coursework in spousal or partner abuse

1 detection or treatment, that requirement shall be met by each  
2 licensee within no more than four years from the date the  
3 requirement is imposed.

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

8 (1) Pain and symptom management.

9 (2) The psycho-social dynamics of death.

10 (3) Dying and bereavement.

11 (4) Hospice care.

12 (j) In determining its continuing education requirements, the  
13 board shall give its highest priority to considering a course on pain  
14 management.

15 (k) In determining its continuing education requirements, the  
16 board shall consider including a course in geriatric care for  
17 emergency room physicians and surgeons.

18 *(l) In determining its continuing education requirements, the*  
19 *board shall consider including a course in integrating mental and*  
20 *physical health care in primary care settings, especially as it*  
21 *pertains to early identification of mental health issues in children*  
22 *and young adults and their appropriate care and treatment.*

23  
24  
25 **REVISIONS:**

26 **Heading—Line 2.**  
27

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1368  
**Author:** Calderon  
**Bill Date:** March 30, 2017, Amended  
**Subject:** Medi-Cal: Authorization Requests  
**Sponsor:** California Academy of Physician Assistants (CAPA)

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would authorize a physician to designate a physician assistant (PA) to sign any authorization form required for benefits and services under the Medi-Cal Program, provided that the physician and the PA are each enrolled as Medi-Cal providers.

**BACKGROUND:**

The Physician Assistant Practice Act (Act) was established to encourage the utilization of PAs by physicians, and by physicians and podiatrists practicing in the same medical group, and to provide that existing legal constraints should not be an unnecessary hindrance to the more effective provision of health care services. It is also the purpose of the Act to allow for innovative development of programs for the education, training, and utilization of PAs. There are approximately 10,000 PAs practicing in California.

Existing law allows two mechanisms to ensure proper supervision of PAs by physicians. The first requires a supervising physician to review, countersign, and date a sample consisting of, at a minimum, five percent of the medical records of patients treated by a PA within 30 days of the date of treatment. The supervising physician is required to select for review those cases that by diagnosis, problem, treatment, or procedure represent the most significant risk to the patient. The second allows for medical records review meetings, which is a meeting between the supervising physician and the PA during which medical records are reviewed to ensure adequate supervision of the PA. The supervising physician must review a sample of at least 10 medical records per month, for at least 10 months during the year, using a combination of the countersignature mechanism and the medical records review mechanism.

Existing law requires a supervising physician who delegates the authority to issue a drug order to a PA to prepare and adopt a formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. Existing law allows two mechanisms for reviewing and signing off on medical charts for Schedule II drug orders. The first requires the medical charts for these drug orders to be countersigned within seven days by the supervising physician. The second is only allowed if the PA has



documentation evidencing the successful completion of an education course that covers prescribing controlled substances and meets specified standards. This mechanism requires the supervising physician to review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the PA for whom the PA's Schedule II drug order has been issued or carried out.

### **ANALYSIS**

According to the sponsor, current law recognizes PAs as licensed health care providers that practice medicine under the supervision of a physician and act as an agent of the supervising physician when performing any authorized medical services. Specifically, Medi-Cal recognizes PAs as non-physician providers that render medical services under the general supervision of a physician. PAs must be enrolled with the Department of Health Care Services Provider Enrollment Division for reimbursement, ordering, referring and prescribing purposes. Further, the Medi-Cal program recognizes PAs as primary care providers. However, there are many Medi-Cal forms that require a physician (M.D. or D.O) signature, even when a PA has performed the medical services. Requiring a physician signature on authorization forms creates delays in access to care and supplies to meet basic health care needs such as: incontinence supplies, non-urgent medical transport, physical therapy and other critical patient needs.

Allowing PAs to sign off on authorization forms for Medi-Cal seems reasonable, as PAs are already recognized as primary care providers in Medi-Cal. This bill would only allow PAs to sign off on authorization forms if their physician supervisor has designated them to do so. This may prevent delays in access to care for Medi-Cal patients and will not compromise consumer protection. Board staff suggests the Board take a neutral position on this bill.

**FISCAL:** None

**SUPPORT:** CAPA (sponsor)

**OPPOSITION:** None on File

**POSITION:** Recommendation: Neutral

AMENDED IN ASSEMBLY MARCH 30, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1368**

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**Introduced by Assembly Member Calderon**

February 17, 2017

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*An act to add Section 14133.91 to the Welfare and Institutions Code, relating to Medi-Cal.*

LEGISLATIVE COUNSEL'S DIGEST

AB 1368, as amended, Calderon. Medi-Cal: authorization requests.

Existing law establishes 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. Existing law provides for a schedule of benefits and services under the Medi-Cal program, subject to utilization controls. Existing law provides that specified utilization controls may be applied to any specific service or group of services that are subject to utilization controls, including prior authorization requirements.

This bill would ~~declare the intent of the Legislature to enact legislation to~~ authorize a physician to designate a physician assistant to sign any authorization form required by the ~~State Department of Health Care Services~~ department for benefits and services under the Medi-Cal program, provided that the physician and the designated physician assistant are each enrolled as a Medi-Cal provider.

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 14133.91 is added to the Welfare and*  
2     *Institutions Code, immediately following Section 14133.9, to read:*

3     *14133.91. A physician may designate a physician assistant to*  
4     *sign any authorization form required by the department for benefits*  
5     *and services under this chapter, provided that the physician and*  
6     *the designated physician assistant are each enrolled as a Medi-Cal*  
7     *provider pursuant to Article 1.3 (commencing with Section 14043).*

8     ~~SECTION 1. It is the intent of the Legislature to enact~~  
9     ~~legislation to authorize a physician to designate a physician~~  
10    ~~assistant to sign any authorization form required by the State~~  
11    ~~Department of Health Care Services for benefits and services under~~  
12    ~~the Medi-Cal program, provided that the physician and the~~  
13    ~~designated physician assistant are each enrolled as a Medi-Cal~~  
14    ~~provider.~~

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1512  
**Author:** McCarty  
**Bill Date:** April 17, 2017, Amended  
**Subject:** Opioid Addiction Prevention and Rehabilitation Act  
**Sponsor:** California Council of Community Behavioral Health Agencies

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would create the Opioid Addiction Prevention and Rehabilitation Act, which will be funded through a one cent per milligram surcharge on opioid sales in California.

**BACKGROUND:**

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

According to the Centers for Disease Control, every day, 44 people in the U.S. die from overdose of prescription painkillers and many more become addicted.

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

In 2014, the Director of CDPH launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) to share information and develop

collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in California. The Workgroup started as a multi-sector group consisting of more than 10 state agencies, including CDPH, Department of Justice, DHCS, Department of Managed Health Care, Department of Education, Department of Industrial Relations, Department of Corrections and Rehabilitation, Department of Consumer Affairs (including the Board, Dental Board of California, Board of Pharmacy, and Board of Registered Nursing), Emergency Medical Services Authority, and others. The Workgroup initially commenced a multi-phase plan involving enhancement of the state's Prescription Drug Monitoring Program (PDMP), promoting the release and adoption of the Board's revised Guidelines for Prescribing Controlled Substances for Pain, and development of a comprehensive public education campaign to increase public awareness about the potential dangers of opioid medications and to create better understanding and expectations among the public regarding proper prescribing, use, storage and disposal of opioids.

## **ANALYSIS**

This bill would create the Opioid Prevention and Rehabilitation Program Fund (Fund) in the State Treasury. All moneys deposited in the Fund, upon appropriation by the Legislature, will be transferred to Department of Health Care Services (DHCS), which shall allocate the moneys to counties to provide critical resources for addiction prevention and rehabilitation programs. This bill would state that it is the intent of the Legislature that these funds be distributed based on need and population.

This bill would create the Opioid Addiction Prevention and Rehabilitation Act (Act), which would, on and after January 1, 2018, impose a tax upon the distribution of opioids by every person, including, but not limited to, a manufacturer or wholesaler, that makes the first sale of opioids in California, where the sale is for the purpose of resale in the regular course of business, at the rate of one cent per milligram of active opioid ingredient. The Board of Equalization (BOE) would collect the tax pursuant to existing law. The tax imposed would be due and payable to the BOE on or before the last day of the month next succeeding each calendar quarter. All taxes, interest, penalties, and other amounts collected shall be deposited in the Fund.

According to the author, addiction is an issue that affects all types of people regardless of their ethnicity, age, social class, gender, or where they live. The barriers of access to treatment are unique to every patient and every county. Despite the high level of need, California's capacity for treatment services is not keeping pace. From 2010-2014, more than 87% of those dependent on or abusing illicit drugs did not have access to the care they needed. Despite more Californians enrolled in healthcare programs, millions go unserved and cannot access drug treatment programs. This bill would allocate funds to substance abuse treatment and prevention and education campaigns on the risks of opioids. The funds will be distributed to counties based on a per capita and need formula.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill will tax the wholesalers and manufacturers of opioids, which seems to

be a reasonable funding source to contribute to the growing opioid abuse epidemic. This bill will ensure that these funds go to the counties to provide resources for addiction prevention and rehabilitation programs, which is much needed in California. This bill will increase awareness and help to treat and rehabilitate individuals in California. This bill furthers the Board’s mission of consumer protection and Board staff recommends that the Board support this bill.

**FISCAL:**                      None to the Board

**SUPPORT:**                      California Council of Community Behavioral Health Agencies  
(Sponsor)

**OPPOSITION:**                      California Chamber of Commerce; California Hospice and Palliative Care Association; California Life Sciences Association; California Taxpayers Association; Healthcare Distribution Alliance; Pharmaceutical Research and Manufacturers of America; and TEVA Pharmaceuticals

**POSITION:**                      Recommendation: Support

AMENDED IN ASSEMBLY APRIL 17, 2017

AMENDED IN ASSEMBLY MARCH 28, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

## ASSEMBLY BILL

**No. 1512**

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**Introduced by Assembly Member McCarty**

February 17, 2017

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An act to add Division 10.4 (commencing with Section 11740) to the Health and Safety Code, and to add Part 14.3 (commencing with Section 33001) to Division 2 of the Revenue and Taxation Code, relating to ~~taxation, to take effect immediately, tax levy:~~ *taxation*.

### LEGISLATIVE COUNSEL'S DIGEST

AB 1512, as amended, McCarty. Opioid Addiction Prevention and Rehabilitation Act.

Existing law imposes various fees and taxes, including taxes on the privilege of engaging in certain activities. The Fee Collection Procedures Law, the violation of which is a crime, provides procedures for the collection of certain fees and surcharges.

~~This~~

*Under this bill*, the Opioid Addiction Prevention and Rehabilitation ~~Act~~, *Act* would impose a tax *on and after January 1, 2018*, upon the distribution of opioids by every person including, but not limited to, a manufacturer or wholesaler, that makes the first sale in this state of opioids, where the sale is for the purpose of resale in the regular course of business, at the rate of \$0.01 per milligram of active opioid ingredient. The tax would be administered by the State Board of Equalization and would be collected pursuant to the procedures set forth in the Fee Collection Procedures Law, which sets forth requirements for

registration, returns, payments, penalties, interest, determinations and redeterminations, collections, overpayments and refunds, administration and confidentiality, and violations. By expanding the application of the Fee Collection Procedures Law, the violation of which is a crime, this bill would impose a state-mandated local program.

~~The~~

*This bill would require the board to deposit all taxes, interest, penalties, and other amounts collected, less refunds, in the Opioid Prevention and Rehabilitation Program Fund, which this bill would create. The bill would require all moneys in the fund, upon appropriation by the Legislature, to be transferred to the State Department of ~~Public Health~~, Health Care Services, which would allocate the moneys to counties to provide critical resources for addiction prevention and rehabilitation programs. The bill would state the intent of the Legislature that the funds be distributed based on need and population.*

This bill would include a change in state statute that would result in a taxpayer paying a higher tax within the meaning of Section 3 of Article XIII A of the California Constitution, and thus would require for passage the approval of  $\frac{2}{3}$  of the membership of each house of the Legislature.

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.

~~This bill would take effect immediately as a tax levy, but its operative date would depend on its effective date.~~

Vote:  $\frac{2}{3}$ . Appropriation: no. Fiscal committee: yes.  
State-mandated local program: yes.

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

1 SECTION 1. Division 10.4 (commencing with Section 11740)  
2 is added to the Health and Safety Code, to read:

3

4 DIVISION 10.4. OPIOID PREVENTION AND  
5 REHABILITATION PROGRAM FUND

6

7 11740. (a) There is hereby created in the State Treasury the  
8 Opioid Prevention and Rehabilitation Program Fund.



(b) All moneys deposited in the Opioid Prevention and Rehabilitation Program Fund, upon appropriation by the Legislature, shall be transferred to the ~~State Department of Public Health~~, *State Department of Health Care Services*, which shall allocate the moneys to counties to provide critical resources for addiction prevention and rehabilitation programs.

(c) *It is the intent of the Legislature that these funds be distributed based on need and population.*

SEC. 2. Part 14.3 (commencing with Section 33001) is added to Division 2 of the Revenue and Taxation Code, to read:

PART 14.3. OPIOID ADDICTION PREVENTION AND  
REHABILITATION ACT

33001. This part shall be known and may be cited as the Opioid Addiction Prevention and Rehabilitation Act.

33002. For purposes of this part:

(a) “Active opioid ingredient” means that portion of a product that is an opioid.

(b) “Distribution” means the sale of untaxed opioids in this state.

(c) “In this state” means within the exterior limits of the State of California and includes all territory within these limits owned by or ceded to the United States.

(d) “Opiate” means the dried, condensed juice of a poppy, *Papaver somniferum*, that has a narcotic, soporific, analgesic, and astringent effect.

(e) “Opioid” means an opiate or any synthetic or semisynthetic narcotic that has opiatelike activities but is not derived from opium and has effects similar to natural opium alkaloids, and any derivatives thereof.

(f) “Person” means person as defined in Section 55002.

(g) “Sale” means any transfer of title or possession for a consideration, exchange, or barter, in any manner or by any means.

(h) “Untaxed opioid” means any opioid which has not yet been distributed in a manner as to result in a tax liability under this part.

33003. ~~A~~*On and after January 1, 2018, a tax is hereby imposed upon the distribution of opioids by every person including, but not limited to, a manufacturer or wholesaler, that makes the first sale in this state of opioids, where the sale is for the purpose*

1 of resale in the regular course of business, at the rate of one cent  
2 (\$0.01) per milligram of active opioid ingredient.

3 33004. There shall be exempt from the taxes imposed by this  
4 part the distribution to a person if the state is prohibited from taxing  
5 that sale under the Constitution or laws of the United States or  
6 under the Constitution of this state.

7 33005. (a) The board shall collect the tax pursuant to the Fee  
8 Collection Procedures Law (Part 30 (commencing with Section  
9 55001) of Division 2 of the Revenue and Taxation Code). For  
10 purposes of administration of the tax pursuant to this part,  
11 references in the Fee Collection Procedures Law to “feepayer”  
12 and “fee” shall include “taxpayer” and “tax.”

13 (b) The board may adopt any regulations necessary or  
14 appropriate to carry out the purposes of this part.

15 (c) The tax imposed by this part shall be due and payable to the  
16 board on or before the last day of the month next succeeding each  
17 calendar quarter, together with a return for that calendar quarter.

18 33006. All taxes, interest, penalties, and other amounts  
19 collected pursuant to this part, less refunds, shall be deposited into  
20 the Opioid Prevention and Rehabilitation Program Fund—~~created~~  
21 ~~in~~ *established* by Section 11740 of the Health and Safety Code.

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

31 ~~SEC. 4. This act provides for a tax levy within the meaning of~~  
32 ~~Article IV of the California Constitution and shall go into~~  
33 ~~immediate effect. However, the provisions of this act shall become~~  
34 ~~operative on the first day of the first calendar quarter commencing~~  
35 ~~more than 90 days after the effective date of this act.~~

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1560  
**Author:** Friedman  
**Bill Date:** March 21, 2017, Amended  
**Subject:** Nurse Practitioners: Supervision  
**Sponsor:** California Association for Nurse Practitioners (CANP)

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would eliminate the ratio for physicians supervising nurse practitioners (NPs).

**ANALYSIS:**

Existing law, Business and Professions Code Section 2836.1 (e) limits the number of NPs who are furnishing or ordering drugs, that may be supervised by a physician, to four. This bill would eliminate that cap entirely allowing physicians to supervise as many NPs as they choose.

According to the author's office, in many clinic systems where there are multiple clinic sites but only one medical director on staff, this severely limits the number of NPs who can provide patient care. The author's office believes this bill will increase essential health care availability and improve efficiency.

Allowing physicians to have no limits in the number of NPs they supervise could be problematic, as it may lead to physicians supervising too many NPs at one time, and may result in consumer harm due to a lack of supervision. NPs are well qualified to provide medical care when practicing under standardized procedures and physician supervision. The standardized procedures and physician supervision, collaboration, and consultation are in existing law to ensure that the patient care provided by an NP includes physician involvement and oversight, as physicians should be participating in the patient's care in order to ensure consumer protection. If the cap were to be removed, it may lead to less physician involvement and oversight, which could impact consumer protection. As such, Board staff suggests the Board oppose this bill unless it is amended to include a reasonable cap on the number of NPs a physician can supervise.

**FISCAL:** None

**SUPPORT:** CANP (Sponsors)

**OPPOSITION:** None on file

**POSITION:** Recommendation: Oppose Unless Amended

AMENDED IN ASSEMBLY MARCH 21, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1560**

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**Introduced by Assembly Member Friedman**

February 17, 2017

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An act to amend Section ~~500~~ 2836.1 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1560, as amended, Friedman. ~~Healing arts: records. Nurse practitioners: supervision.~~

*The Nursing Practice Act provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing. The act authorizes a nurse practitioner to furnish or order drugs or devices under specified circumstances subject to physician and surgeon supervision. The act prohibits a physician and surgeon from supervising more than 4 nurse practitioners at one time for purposes of furnishing drugs or devices.*

*This bill would delete that cap on the number of nurse practitioners a physician and surgeon may supervise at one time for purposes of furnishing drugs or devices.*

~~Existing law permits the Medical Board of California, the Dental Board of California, and the California State Board of Pharmacy to reproduce records that they have a duty to keep, if those records are destroyed by fire or public calamity.~~

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

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 2836.1 of the Business and Professions*  
2     *Code is amended to read:*

3     2836.1. Neither this chapter nor any other provision of law  
4     shall be construed to prohibit a nurse practitioner from furnishing  
5     or ordering drugs or devices when all of the following apply:

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

13    (b) The nurse practitioner is functioning pursuant to standardized  
14    procedure, as defined by Section 2725, or protocol. The  
15    standardized procedure or protocol shall be developed and  
16    approved by the supervising physician and surgeon, the nurse  
17    practitioner, and the facility administrator or the designee.

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

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

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

1 ~~(e) For purposes of this section, no physician and surgeon shall~~  
2 ~~supervise more than four nurse practitioners at one time.~~

3 ~~(f)~~

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

11 (2) When Schedule II or III controlled substances, as defined  
12 in Sections 11055 and 11056, respectively, of the Health and Safety  
13 Code, are furnished or ordered by a nurse practitioner, the  
14 controlled substances shall be furnished or ordered in accordance  
15 with a patient-specific protocol approved by the treating or  
16 supervising physician. A copy of the section of the nurse  
17 practitioner's standardized procedure relating to controlled  
18 substances shall be provided, upon request, to any licensed  
19 pharmacist who dispenses drugs or devices, when there is  
20 uncertainty about the nurse practitioner furnishing the order.

21 ~~(g)~~

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

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

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

38 ~~(h)~~

39 (g) Use of the term "furnishing" in this section, in health  
40 facilities defined in Section 1250 of the Health and Safety Code,

1 shall include (1) the ordering of a drug or device in accordance  
2 with the standardized procedure and (2) transmitting an order of  
3 a supervising physician and surgeon.

4 (i)

5 (h) “Drug order” or “order” for purposes of this section means  
6 an order for medication which is dispensed to or for an ultimate  
7 user, issued by a nurse practitioner as an individual practitioner,  
8 within the meaning of Section ~~1306.02~~ 1306.03 of Title 21 of the  
9 Code of Federal Regulations. Notwithstanding any other provision  
10 of law, (1) a drug order issued pursuant to this section shall be  
11 treated in the same manner as a prescription of the supervising  
12 physician; (2) all references to “prescription” in this code and the  
13 Health and Safety Code shall include drug orders issued by nurse  
14 practitioners; and (3) the signature of a nurse practitioner on a drug  
15 order issued in accordance with this section shall be deemed to be  
16 the signature of a prescriber for purposes of this code and the  
17 Health and Safety Code.

18 SECTION 1. ~~Section 500 of the Business and Professions Code~~  
19 ~~is amended to read:~~

20 500. ~~If the register or book of registration of the Dental Board~~  
21 ~~of California, the Medical Board of California, or the California~~  
22 ~~State Board of Pharmacy is destroyed by fire or other public~~  
23 ~~calamity, the board, whose duty it is to keep the register or book,~~  
24 ~~may reproduce it so that there may be shown as nearly as possible~~  
25 ~~the record existing in the original at the time of destruction.~~

AMENDED IN ASSEMBLY MARCH 20, 2017

CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

## ASSEMBLY BILL

**No. 1612**

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**Introduced by Assembly Member Burke**

February 17, 2017

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An act to amend Section 2746.2 of the Business and Professions Code, relating to nursing.

### LEGISLATIVE COUNSEL'S DIGEST

AB 1612, as amended, Burke. Nursing: nurse-midwives.

The Nursing Practice Act provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing, which is within the Department of Consumer Affairs, and requires the board to issue a certificate to practice nurse-midwifery to a licensee who meets specified qualifications. That act *requires each applicant for a certificate to show evidence satisfactory to the board that the applicant has met educational standards established by the board or has at least the equivalent thereof* and authorizes the board to appoint a committee of qualified physicians and nurses to develop the necessary standards relating to educational requirements, ratios of nurse-midwives to supervising physicians, and associated matters.

This bill would *specify that evidence satisfactory to the board includes evidence of current advanced level national certification by a certifying body that meets standards established and approved by the board and would remove from the authority of the committee the development of standards relating to ratios of nurse-midwives to supervising physicians.*

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 2746.2 of the Business and Professions  
2     Code is amended to read:  
3     2746.2. Each applicant shall show by evidence satisfactory to  
4     the board that he or she has met the educational standards  
5     established by the board or has at least the equivalent ~~thereof.~~  
6     *thereof, including evidence of current advanced level national*  
7     *certification by a certifying body that meets standards established*  
8     *and approved by the board.* The board is authorized to appoint a  
9     committee of qualified physicians and nurses, including, but not  
10    limited to, obstetricians and nurse-midwives, to develop the  
11    necessary standards relating to educational requirements and  
12    associated matters.

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MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** AB 1650  
**Author:** Maienschein  
**Bill Date:** April 6, 2017, Amended  
**Subject:** Emergency Medical Services: Community Paramedicine  
**Sponsor:** California Ambulance Association

**DESCRIPTION OF LEGISLATION:**

This bill would create the Community Paramedic Program in the Emergency Medical Services Authority (EMSA).

**BACKGROUND**

Under existing law, a paramedic is limited to providing care in emergency situations, during ambulance transports, and while working in a hospital. Beginning in late 2014, thirteen community paramedicine pilot projects began in California, testing six concepts as part of the Health Workforce Pilot Project (HWPP) #173. These HWPP pilot projects are coordinated through the Office of Statewide Health Planning and Development (OSHPD). This bill would authorize four of the original six concepts allowed for in the pilot project.

**ANALYSIS**

This bill would create a statewide Community Paramedic Program (Program) in EMSA. This bill would allow the Program to authorize a local emergency medical services (EMS) agency that opts to participate in the Program to provide, through a local community paramedic program, any of the following services:

- Post-discharge follow up services for targeted and eligible patients recently discharged from a hospital participating in the Program, which is intended to provide short-term assistance in order to reduce hospital admission and shall not replace home health care or any other services available.
- Directly observed therapy for eligible patients undergoing tuberculosis treatment in partnership with a county public health department. This therapy service is intended as a supplement to provide for after-hours availability or to reach patients who are difficult to serve, and shall not replace community health workers or public health nurses.
- Hospice rapid response service for eligible and enrolled patients to administer comfort care, coordinate services with the hospice nurse, and, as appropriate, avoid patient transport to an acute care hospital emergency department.
- Case management services and linkage to non-emergency services for frequent EMS system users, for the purpose of reducing dependence of those users on the EMS system and acute care hospital emergency departments to provide primary medical care.

This bill would require EMSA to develop criteria that qualifies local community paramedic services to participate in the Program. The criteria must include training and certification requirements for a community paramedic and regulations for the initiation, operation, and evaluation of a local community paramedic program. This bill would also require EMSA to develop an application and application process to be used by a local EMS agency that seeks to participate in the Program and to review and approve these applications. EMSA would be required to consult with OSHPD on the implementation of this Program.

This bill would specify that a local EMS agency can opt to participate in the Program as long as they meet the criteria and submit an application to EMSA. This bill would require a community paramedic service plan developed by a local EMS agency that seeks to participate in the Program to demonstrate it will be able to meet all the requirements of the Program and include specified information.

According to the author, a report published in January 2017 concluded that the HWPP pilot projects resulted in improved health care for the targeted patients, as well as a reduction in health care costs. The intent of this bill, according to the author, is to permanently authorize the expanded role of paramedics and to establish parameters for community paramedicine programs.

Board staff, working with a Board Member who is a physician, provided input to OSHPD on HWPP #173 and raised patient safety concerns. One of these concerns being that persons recently discharged from the hospital should be seen by their primary care physician for follow up care. Any additional training that would be required would not be sufficient enough to teach paramedics the basics of disease management or how to diagnose and treat medical conditions. The other concern raised was that the pilot project did not specifically delineate what services will be allowed to be performed by community paramedics as part of the post-discharge follow up services and case management services; the same is true for this bill. This bill could have a negative impact on consumer protection and Board staff recommends that the Board take an oppose position on this bill.

**FISCAL:** None

**SUPPORT:** California Ambulance Association (Sponsor)

**OPPOSITION:** None on file

**POSITION:** Recommendation: Oppose

AMENDED IN ASSEMBLY APRIL 6, 2017  
AMENDED IN ASSEMBLY MARCH 29, 2017  
CALIFORNIA LEGISLATURE—2017–18 REGULAR SESSION

**ASSEMBLY BILL**

**No. 1650**

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**Introduced by Assembly Member Maienschein**  
**(Coauthors: Assembly Members Chávez and Mathis)**  
(Coauthor: Senator Wilk)

February 17, 2017

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An act to ~~amend Section 1797.218~~ *add Chapter 13 (commencing with Section 1800) to Division 2.5* of the Health and Safety Code, relating to emergency medical services.

LEGISLATIVE COUNSEL'S DIGEST

AB 1650, as amended, Maienschein. Emergency medical services: community paramedicine.

Existing law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of all state agencies concerning emergency medical services. Among other duties, the authority ~~regulates the training and scope of practice of prehospital emergency medical care personnel, including, but not limited to, emergency medical technician-II (EMT-II) and emergency medical technician-paramedic (EMT-P). The local EMS agency is responsible for implementation of advanced life support systems and limited advanced life support systems and for the monitoring of training programs.~~ Existing law specifies the situations in which the local EMS agency may authorize an advanced life support

~~or limited advanced life support program that provides services utilizing EMT-H and EMT-P personnel. is required to develop planning and implementation guidelines for emergency medical services systems, provide technical assistance to existing agencies, counties, and cities for the purpose of developing the components of emergency medical services systems, and receive plans for the implementation of emergency medical services and trauma care systems from local EMS agencies.~~

~~This bill would additionally authorize a local EMS agency to authorize a community paramedicine program that provides services utilizing EMT-P personnel for the delivery of medical care and is consistent with a specified community paramedicine pilot project authorized by the Office of Statewide Health Planning and Development. The bill would specify the goals of a community paramedicine program, would specify the types of program services that a local EMS agency may authorize, and would require a local EMS agency to specify patient safeguards and appropriate training requirements for EMT-P personnel under an authorized program.~~ *create the Community Paramedic Program in the authority. The bill would authorize the authority to authorize a local EMS agency that opts to participate in the program to provide specified services, such as case management services and linkage to nonemergency services for frequent EMS system users, through a local community paramedic program. The bill would require the authority, in consultation with the Office of Statewide Health Planning and Development, to develop criteria to qualify services for participation in the program, develop an application and application process for local EMS agencies seeking to participate in the program, and to review and approve applications for participation in the program as a component of the local EMS agency's EMS plan. The bill would authorize a local EMS agency to opt to participate in the program if it meets the criteria established by the authority and completes the application process developed by the criteria. The bill would specify the necessary components of a community paramedic service plan to be included in the local EMS agency's application. The bill would require the medical director of the local EMS agency to oversee the local community paramedic program.*

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. Chapter 13 (commencing with Section 1800) is*  
2     *added to Division 2.5 of the Health and Safety Code, to read:*

3  
4             *CHAPTER 13. COMMUNITY PARAMEDIC PROGRAM*

5  
6                     *Article 1. General Provisions*

7  
8     1800. *This chapter shall be known, and may be cited, as the*  
9     *Community Paramedic Program Act.*

10    1802. *Unless the context requires otherwise, the following*  
11    *definitions shall apply to this chapter:*

12    (a) *“Community paramedic” means an individual who is*  
13    *educated and trained in community paramedicine, whose scope*  
14    *of practice is in accordance with standards established by the*  
15    *authority, who holds a current certification as a mobile integrated*  
16    *health community paramedic by the International Board of*  
17    *Specialty Certification or equivalent, who has a valid license issued*  
18    *pursuant to this chapter, and who is accredited by a local EMS*  
19    *agency.*

20    (b) *“Program” means the Community Paramedic Program*  
21    *established by this chapter.*

22    1804. *Within the authority there is the statewide Community*  
23    *Paramedic Program. The program may authorize a local EMS*  
24    *agency that opts to participate in the program to provide, through*  
25    *a local community paramedic program, any of the following*  
26    *services:*

27    (a) (1) *Postdischarge followup services for targeted and eligible*  
28    *patients recently discharged from a hospital participating in the*  
29    *program.*

30    (2) *A postdischarge service authorized pursuant to this*  
31    *subdivision is intended to provide short-term assistance in order*  
32    *to reduce hospital admissions and shall not replace home health*  
33    *care or any other services available to patients.*

34    (b) (1) *Directly observed therapy for eligible patients*  
35    *undergoing tuberculosis treatment in partnership with a county*  
36    *public health department.*

37    (2) *A directly observed therapy service authorized pursuant to*  
38    *this subdivision is intended as a supplement to provide for*

1 *after-hours availability or to reach patients who are difficult to*  
2 *serve, and shall not replace home community health workers or*  
3 *public health nurses.*

4 *(c) Hospice rapid response service for eligible and enrolled*  
5 *patients to administer comfort care, coordinate services with the*  
6 *hospice nurse, and, as appropriate, avoid patient transport to an*  
7 *acute care hospital emergency department.*

8 *(d) Case management services and linkage to nonemergency*  
9 *services for frequent EMS system users, for the purpose of reducing*  
10 *dependence of those users on the EMS system and acute care*  
11 *hospital emergency departments to provide primary medical care.*

12  
13 *Article 2. Duties and Powers of the Authority*  
14

15 *1810. (a) To implement the program, the authority shall do*  
16 *all of the following:*

17 *(1) Develop criteria that qualify local community paramedic*  
18 *services to participate in the program.*

19 *(2) Develop an application and application process to be used*  
20 *by a local EMS agency that seeks to participate in the program.*  
21 *The application process shall provide for the submission of a local*  
22 *community paramedic service plan described in Section 1820 that*  
23 *shall be a component of the local EMS agency's local EMS plan.*

24 *(3) Review and approve applications for the implementation of*  
25 *local community paramedic services as a component of the local*  
26 *EMS agency's EMS plan in accordance with Section 1797.105.*

27 *(b) Criteria described in paragraph (1) of subdivision (a) shall*  
28 *include, but not be limited to, the following:*

29 *(1) Training and certification requirements for a community*  
30 *paramedic.*

31 *(2) Regulations for the initiation, operation, and evaluation of*  
32 *a local community paramedic program.*

33 *1812. The authority shall consult with the Office of Statewide*  
34 *Health Planning and Development in performing its duties required*  
35 *by this chapter.*  
36

37 *Article 3. Local EMS Agency Participation*  
38

39 *1820. (a) A local EMS agency may opt to participate in the*  
40 *program by meeting the criteria and completing the application*

1 and application process established by the authority pursuant to  
2 Section 1810.

3 (b) A community paramedic service plan developed by a local  
4 EMS agency that seeks to participate in the program shall  
5 demonstrate that the local EMS agency will be able to meet the  
6 requirements of the program and shall include, but not be limited  
7 to, all of the following:

8 (1) Agreements between local agencies and service providers  
9 participating or partnering in the local community paramedic  
10 program.

11 (2) A description of the local community paramedic program.

12 (3) A description of existing problems that the local community  
13 paramedic program is intended to address.

14 (4) Criteria for the enrollment or inclusion of patients in the  
15 local community paramedic program.

16 (5) Goals and intended results of the local community paramedic  
17 program.

18 (6) Criteria for patient and provider safety.

19 (7) Estimated costs and savings attributable to the local  
20 community paramedic program.

21 (8) Data to be collected for the purpose of evaluating the  
22 effectiveness of the local community paramedic program.

23 (9) Criteria and processes for evaluating the effectiveness of  
24 the local community paramedic program.

25 (10) Protocols, policies, and procedures for the implementation  
26 and operation of local community paramedic program services  
27 by a community paramedic.

28 (11) Protocols for the assessment of patients served by the local  
29 community paramedic program.

30 (12) Any other information or plan component required by the  
31 authority pursuant to Section 1810.

32 1822. The local EMS agency medical director shall oversee a  
33 local community paramedic program participating in the program.

34 SECTION 1. Section 1797.218 of the Health and Safety Code  
35 is amended to read:

36 1797.218. ~~(a) A local EMS agency may authorize an advanced~~  
37 ~~life support or limited advanced life support program that provides~~  
38 ~~services utilizing EMT-H, EMT-P, or both, for the delivery of~~  
39 ~~emergency medical care to the sick and injured at the scene of an~~  
40 ~~emergency, during transport to a general acute care hospital, during~~



1 interfacility transfer, while in the emergency department of a  
2 general acute care hospital until care responsibility is assumed by  
3 the regular staff of that hospital, and during training within the  
4 facilities of a participating general acute care hospital.

5 (b) A local EMS agency may authorize a community  
6 paramedicine program that provides services utilizing EMT-P  
7 personnel for the delivery of medical care, and is consistent with  
8 the community paramedicine pilot project authorized by the Office  
9 of Statewide Health Planning and Development's Health  
10 Workforce Pilot Projects Program in 2014. The goals of a  
11 community paramedicine program authorized under this  
12 subdivision shall include, but not be limited to, all of the following:

13 (1) Providing more effective, efficient, and timely health care.  
14 (2) Avoiding unnecessary transports to hospital emergency  
15 departments.

16 (3) Relieving emergency department overcrowding.

17 (4) Reducing hospital readmissions.

18 (5) Lowering health care costs.

19 (c) A community paramedicine program authorized pursuant  
20 to subdivision (b) shall be limited to the following:

21 (1) Postdischarge, short-term followup home care visits for  
22 individuals suffering from chronic conditions.

23 (2) Case management services for frequent "911" emergency  
24 service callers.

25 (3) Directly observed therapy for tuberculosis in coordination  
26 with a local public health department.

27 (4) Hospice care in coordination with a hospice agency.

28 (d) In authorizing a community paramedicine program pursuant  
29 to subdivision (b), a local EMS agency shall specify appropriate  
30 training required for EMT-P personnel and safeguards for patient  
31 safety.

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 241  
**Author:** Monning  
**Bill Date:** February 6, 2017, Introduced  
**Subject:** Medical Records: Access  
**Sponsor:** Author

**DESCRIPTION OF LEGISLATION:**

This bill would revise existing law regarding the rights of patients to access and copy their medical records.

**BACKGROUND**

Existing law, the Patient Access to Health Records (PAHR) law, specifies that any adult patient of a health care provider, or any minor patient authorized by law to consent to medical treatment, or any patient representative, is entitled to inspect patient records upon presenting a health care provider with a written request for those records and upon payment of reasonable clerical costs incurred in locating and making those records available.

Existing law establishes the federal Health Information Portability and Accountability Act of 1996 (HIPAA), which provides federal protections for patients' health information held by "covered entities" and any "business associates" that a covered entity engages to help it carry out its health care activities. A covered entity can be a provider, a health plan, or a health care clearinghouse that processes health information it receives from another entity. While HIPAA establishes a federal baseline for minimum privacy protections of individually identifiable health information, states are permitted to enact laws that provide greater privacy protections or rights.

**ANALYSIS**

This bill would conform existing PAHR law to HIPAA and would describe what costs a health care provider could charge patients or their representative for medical records. This bill would also repeal the requirement in existing law that requests by patients for their records be "written" requests. This bill would clarify that a patient or patient representative is entitled to a paper or electronic copy of their records.

This bill would conform existing PAHR law to HIPAA, as it would require a health care provider, if the requested patient records are maintained electronically and if the patient or their representative requests an electronic copy of those records, to provide them in the electronic format requested if they are readily producible in that format, or, if not, in a readable electronic format as agreed to by the health care provider and the patient or their representative.

This bill would revise existing PAHR law and conform it with HIPAA relating to what a health care provider can charge a patient or their representative and would allow a health care provider to impose a reasonable cost-based fee for providing a paper or electronic copy or summary of patient records, provided the fee only includes the cost of the following:

- Labor for copying the patient records requested by the patient or their representative, whether in paper or electronic form.
- Supplies for creating the paper copy or electronic media if the patient or their representative requests that the electronic copy be provided on portable media.
- Postage, if the patient or their representative has requested the copy, or the summary or explanation, be mailed.
- Time for preparing an explanation or summary of the patient's record, if agreed to by the patient or their representative.

This bill would retain the existing maximum limit cost for copies at 25 cents per page or 50 cents per page for copies from microfilm.

According to the author, patients and their representatives have rights to access their medical records, and these rights need to be understandable if they are to be exercised and followed. The purpose for access to medical records includes tracking care between different health care providers and verifying accurate records. Because of differences with federal law, this bill seeks to align and better clarify state law in areas where federal law preempts or is more detailed. The author believes these changes will reduce confusion among patients and providers and may allow for better adherence to laws among all health care providers.

This bill would conform existing PAHR law with HIPAA and update the law to allow for electronic requests for patient records and would allow patients and their representatives to receive electronic copies of those records. This bill would also make it clear that any fee imposed must be reasonable and cost-based, which may help to clarify what actual costs can be charged. This bill would also help ensure that patients have better access to their medical records. As such, Board staff suggests that the Board take a support position on this bill.

**FISCAL:** None

**SUPPORT:** California Association of Health Facilities  
California Hospital Association  
Los Angeles County Professional Peace Officers Association  
Organization of SMUD Employees  
San Diego County Court Employees Association  
San Luis Obispo County Employees Association  
Western Center on Law and Poverty

**OPPOSITION:** None on file

**POSITION:** Recommendation: Support

**Introduced by Senator Monning**

February 6, 2017

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An act to amend Section 123110 of the Health and Safety Code, and to amend Section 5328 of the Welfare and Institutions Code, relating to medical records.

**LEGISLATIVE COUNSEL'S DIGEST**

SB 241, as introduced, Monning. Medical records: access.

Existing law governs a patient's access to his or her health records. Existing law requires a health care provider to provide a patient or his or her representative with all or any part of the patient's medical records that the patient has a right to inspect, subject to the payment of clerical costs incurred in locating and making the records available, following a written request from the patient. If the patient or patient's representative presents proof to the provider that the records are needed to support an appeal regarding eligibility for a public benefit program, as defined, the health care provider must provide one copy of the relevant portion of the patient's record at no charge under specified circumstances. Existing law makes a violation of these provisions by specified health care providers an infraction.

This bill would change the basis of the fee that a health care provider is authorized to charge from clerical costs to specified costs for labor, supplies, postage, and preparing an explanation or summary of the patient record. The bill would require the health care provider to provide the patient or patient's personal representative with a copy of the records in a paper or electronic copy, in the form or format requested if the records are readily producible in that form or format.

Existing law provides that information and records obtained in the course of providing mental health and developmental services are

confidential, but allows disclosure of communications under specified circumstances.

This bill would allow disclosure to a business associate or for health care operations purposes, as specified.

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 123110 of the Health and Safety Code  
2 is amended to read:

3 123110. (a) Notwithstanding Section 5328 of the Welfare and  
4 Institutions Code, and except as provided in Sections 123115 and  
5 123120, any adult patient of a health care provider, any minor  
6 patient authorized by law to consent to medical treatment, and any  
7 patient *personal* representative shall be entitled to inspect patient  
8 records upon presenting to the health care provider a ~~written~~ request  
9 for those records and upon payment of reasonable ~~clerical costs~~  
10 ~~incurred in locating and making the records available. costs as~~  
11 ~~specified in subdivision (k).~~ However, a patient who is a minor  
12 shall be entitled to inspect patient records pertaining only to health  
13 care of a type for which the minor is lawfully authorized to consent.  
14 A health care provider shall permit this inspection during business  
15 hours within five working days after receipt of the ~~written~~ request.  
16 The inspection shall be conducted by the patient or patient's  
17 *personal* representative requesting the inspection, who may be  
18 accompanied by one other person of his or her choosing.

19 (b) (1) Additionally, any patient or patient's *personal*  
20 representative shall be entitled to ~~copies a paper or electronic copy~~  
21 of all or any portion of the patient records that he or she has a right  
22 to inspect, upon presenting a ~~written~~ request to the health care  
23 provider specifying the records to be copied, together with a fee  
24 to defray the ~~cost of copying, that shall not exceed twenty-five~~  
25 ~~cents (\$0.25) per page or fifty cents (\$0.50) per page for records~~  
26 ~~that are copied from microfilm and any additional reasonable~~

1 ~~clerical costs incurred in making the records available; costs of~~  
2 ~~producing the copy or summary, as specified in subdivision (k).~~  
3 The health care provider shall ensure that the copies are transmitted  
4 within 15 days after receiving the ~~written~~ request.

5 (2) *The health care provider shall provide the patient or*  
6 *patient's personal representative with a copy of the record in the*  
7 *form and format requested if it is readily producible in the*  
8 *requested form and format, or, if not, in a readable paper copy*  
9 *form or other form and format as agreed to by the health care*  
10 *provider and the patient or patient's personal representative. If*  
11 *the requested patient records are maintained electronically and*  
12 *if the patient or patient's personal representative requests an*  
13 *electronic copy of those records, the health care provider shall*  
14 *provide them in the electronic form and format requested if they*  
15 *are readily producible in that form and format, or, if not, in a*  
16 *readable electronic form and format as agreed to by the health*  
17 *care provider and the patient or patient's personal representative.*

18 (c) Copies of X-rays or tracings derived from  
19 electrocardiography, electroencephalography, or electromyography  
20 need not be provided to the patient or patient's *personal*  
21 representative under this section, if the original X-rays or tracings  
22 are transmitted to another health care provider upon written request  
23 of the patient or patient's *personal* representative and within 15  
24 days after receipt of the request. The request shall specify the name  
25 and address of the health care provider to whom the records are  
26 to be delivered. All reasonable costs, not exceeding actual costs,  
27 incurred by a health care provider in providing copies pursuant to  
28 this subdivision may be charged to the patient or representative  
29 requesting the copies.

30 (d) (1) Notwithstanding any provision of this section, and  
31 except as provided in Sections 123115 and 123120, any patient or  
32 former patient or the patient's *personal* representative shall be  
33 entitled to a copy, at no charge, of the relevant portion of the  
34 patient's records, upon presenting to the provider a written request,  
35 and proof that the records are needed to support an appeal regarding  
36 eligibility for a public benefit program. These programs shall be  
37 the Medi-Cal program, social security disability insurance benefits,  
38 and Supplemental Security Income/State Supplementary Program  
39 for the Aged, Blind and Disabled (SSI/SSP) benefits. For purposes  
40 of this subdivision, "relevant portion of the patient's records"

1 means those records regarding services rendered to the patient  
2 during the time period beginning with the date of the patient's  
3 initial application for public benefits up to and including the date  
4 that a final determination is made by the public benefits program  
5 with which the patient's application is pending.

6 (2) Although a patient shall not be limited to a single request,  
7 the patient or patient's *personal* representative shall be entitled to  
8 no more than one copy of any relevant portion of his or her record  
9 free of charge.

10 (3) This subdivision shall not apply to any patient who is  
11 represented by a private attorney who is paying for the costs related  
12 to the patient's appeal, pending the outcome of that appeal. For  
13 purposes of this subdivision, "private attorney" means any attorney  
14 not employed by a nonprofit legal services entity.

15 (e) If the patient's appeal regarding eligibility for a public  
16 benefit program specified in subdivision (d) is successful, the  
17 hospital or other health care provider may bill the patient, at the  
18 rates specified in subdivisions (b) and (c), for the copies of the  
19 medical records previously provided free of charge.

20 (f) If a patient or his or her *personal* representative requests a  
21 record pursuant to subdivision (d), the health care provider shall  
22 ensure that the copies are transmitted within 30 days after receiving  
23 the written request.

24 (g) This section shall not be construed to preclude a health care  
25 provider from requiring reasonable verification of identity prior  
26 to permitting inspection or copying of patient records, provided  
27 this requirement is not used oppressively or discriminatorily to  
28 frustrate or delay compliance with this section. Nothing in this  
29 chapter shall be deemed to supersede any rights that a patient or  
30 *personal* representative might otherwise have or exercise under  
31 Section 1158 of the Evidence Code or any other provision of law.  
32 Nothing in this chapter shall require a health care provider to retain  
33 records longer than required by applicable statutes or administrative  
34 regulations.

35 (h) This chapter shall not be construed to render a health care  
36 provider liable for the quality of his or her records or the copies  
37 provided in excess of existing law and regulations with respect to  
38 the quality of medical records. A health care provider shall not be  
39 liable to the patient or any other person for any consequences that  
40 result from disclosure of patient records as required by this chapter.

1 A health care provider shall not discriminate against classes or  
2 categories of providers in the transmittal of X-rays or other patient  
3 records, or copies of these X-rays or records, to other providers as  
4 authorized by this section.

5 Every health care provider shall adopt policies and establish  
6 procedures for the uniform transmittal of X-rays and other patient  
7 records that effectively prevent the discrimination described in  
8 this subdivision. A health care provider may establish reasonable  
9 conditions, including a reasonable deposit fee, to ensure the return  
10 of original X-rays transmitted to another health care provider,  
11 provided the conditions do not discriminate on the basis of, or in  
12 a manner related to, the license of the provider to which the X-rays  
13 are transmitted.

14 (i) Any health care provider described in paragraphs (4) to (10),  
15 inclusive, of subdivision (a) of Section 123105 who willfully  
16 violates this chapter is guilty of unprofessional conduct. Any health  
17 care provider described in paragraphs (1) to (3), inclusive, of  
18 subdivision (a) of Section 123105 that willfully violates this chapter  
19 is guilty of an infraction punishable by a fine of not more than one  
20 hundred dollars (\$100). The state agency, board, or commission  
21 that issued the health care provider's professional or institutional  
22 license shall consider a violation as grounds for disciplinary action  
23 with respect to the licensure, including suspension or revocation  
24 of the license or certificate.

25 (j) This section shall be construed as prohibiting a health care  
26 provider from withholding patient records or summaries of patient  
27 records because of an unpaid bill for health care services. Any  
28 health care provider who willfully withholds patient records or  
29 summaries of patient records because of an unpaid bill for health  
30 care services shall be subject to the sanctions specified in  
31 subdivision (i).

32 (k) (1) *Except as provided in subdivision (d), a health care*  
33 *provider may impose a reasonable, cost-based fee for providing*  
34 *a paper or electronic copy or summary of patient records, provided*  
35 *the fee includes only the cost of the following:*

36 (A) *Labor for copying the patient records requested by the*  
37 *patient or patient's personal representative, whether in paper or*  
38 *electronic form.*



1     (B) *Supplies for creating the paper copy or electronic media if*  
2     *the patient or patient's personal representative requests that the*  
3     *electronic copy be provided on portable media.*

4     (C) *Postage, if the patient or patient's personal representative*  
5     *has requested the copy, or the summary or explanation, be mailed.*

6     (D) *Preparing an explanation or summary of the patient record,*  
7     *if agreed to by the patient or patient's personal representative.*

8     (2) *The fee from a health care provider shall not exceed*  
9     *twenty-five cents (\$0.25) per page for paper copies or fifty cents*  
10    *(\$0.50) per page for records that are copied from microfilm.*

11    SEC. 2. Section 5328 of the Welfare and Institutions Code is  
12    amended to read:

13    5328. All information and records obtained in the course of  
14    providing services under Division 4 (commencing with Section  
15    4000), Division 4.1 (commencing with Section 4400), Division  
16    4.5 (commencing with Section 4500), Division 5 (commencing  
17    with Section 5000), Division 6 (commencing with Section 6000),  
18    or Division 7 (commencing with Section 7100), to either voluntary  
19    or involuntary recipients of services shall be confidential.  
20    Information and records obtained in the course of providing similar  
21    services to either voluntary or involuntary recipients prior to 1969  
22    shall also be confidential. Information and records shall be  
23    disclosed only in any of the following cases:

24    (a) In communications between qualified professional persons  
25    in the provision of services or appropriate referrals, or in the course  
26    of conservatorship proceedings. The consent of the patient, or his  
27    or her guardian or conservator, shall be obtained before information  
28    or records may be disclosed by a professional person employed  
29    by a facility to a professional person not employed by the facility  
30    who does not have the medical or psychological responsibility for  
31    the patient's care.

32    (b) When the patient, with the approval of the physician and  
33    surgeon, licensed psychologist, social worker with a master's  
34    degree in social work, licensed marriage and family therapist, or  
35    licensed professional clinical counselor, who is in charge of the  
36    patient, designates persons to whom information or records may  
37    be released, except that nothing in this article shall be construed  
38    to compel a physician and surgeon, licensed psychologist, social  
39    worker with a master's degree in social work, licensed marriage  
40    and family therapist, licensed professional clinical counselor, nurse,

1 attorney, or other professional person to reveal information that  
2 has been given to him or her in confidence by members of a  
3 patient's family. Nothing in this subdivision shall be construed to  
4 authorize a licensed marriage and family therapist or licensed  
5 professional clinical counselor to provide services or to be in charge  
6 of a patient's care beyond his or her lawful scope of practice.

7 (c) To the extent necessary for a recipient to make a claim, or  
8 for a claim to be made on behalf of a recipient for aid, insurance,  
9 or medical assistance to which he or she may be entitled.

10 (d) If the recipient of services is a minor, ward, dependent, or  
11 conservatee, and his or her parent, guardian, guardian ad litem,  
12 conservator, or authorized representative designates, in writing,  
13 persons to whom records or information may be disclosed, except  
14 that nothing in this article shall be construed to compel a physician  
15 and surgeon, licensed psychologist, social worker with a master's  
16 degree in social work, licensed marriage and family therapist,  
17 licensed professional clinical counselor, nurse, attorney, or other  
18 professional person to reveal information that has been given to  
19 him or her in confidence by members of a patient's family.

20 (e) For research, provided that the Director of Health Care  
21 Services, the Director of State Hospitals, the Director of Social  
22 Services, or the Director of Developmental Services designates  
23 by regulation, rules for the conduct of research and requires the  
24 research to be first reviewed by the appropriate institutional review  
25 board or boards. The rules shall include, but need not be limited  
26 to, the requirement that all researchers shall sign an oath of  
27 confidentiality as follows:

28  
29  
30 \_\_\_\_\_  
Date

31  
32 As a condition of doing research concerning persons who have  
33 received services from \_\_\_\_ (fill in the facility, agency or person),  
34 I, \_\_\_\_, agree to obtain the prior informed consent of such persons  
35 who have received services to the maximum degree possible as  
36 determined by the appropriate institutional review board or boards  
37 for protection of human subjects reviewing my research, and I  
38 further agree not to divulge any information obtained in the course  
39 of such research to unauthorized persons, and not to publish or  
40 otherwise make public any information regarding persons who

1 have received services such that the person who received services  
2 is identifiable.

3 I recognize that the unauthorized release of confidential  
4 information may make me subject to a civil action under provisions  
5 of the Welfare and Institutions Code.

6  
7 (f) To the courts, as necessary to the administration of justice.

8 (g) To governmental law enforcement agencies as needed for  
9 the protection of federal and state elective constitutional officers  
10 and their families.

11 (h) To the Senate Committee on Rules or the Assembly  
12 Committee on Rules for the purposes of legislative investigation  
13 authorized by the committee.

14 (i) If the recipient of services who applies for life or disability  
15 insurance designates in writing the insurer to which records or  
16 information may be disclosed.

17 (j) To the attorney for the patient in any and all proceedings  
18 upon presentation of a release of information signed by the patient,  
19 except that when the patient is unable to sign the release, the staff  
20 of the facility, upon satisfying itself of the identity of the attorney,  
21 and of the fact that the attorney does represent the interests of the  
22 patient, may release all information and records relating to the  
23 patient except that nothing in this article shall be construed to  
24 compel a physician and surgeon, licensed psychologist, social  
25 worker with a master's degree in social work, licensed marriage  
26 and family therapist, licensed professional clinical counselor, nurse,  
27 attorney, or other professional person to reveal information that  
28 has been given to him or her in confidence by members of a  
29 patient's family.

30 (k) Upon written agreement by a person previously confined in  
31 or otherwise treated by a facility, the professional person in charge  
32 of the facility or his or her designee may release any information,  
33 except information that has been given in confidence by members  
34 of the person's family, requested by a probation officer charged  
35 with the evaluation of the person after his or her conviction of a  
36 crime if the professional person in charge of the facility determines  
37 that the information is relevant to the evaluation. The agreement  
38 shall only be operative until sentence is passed on the crime of  
39 which the person was convicted. The confidential information  
40 released pursuant to this subdivision shall be transmitted to the

1 court separately from the probation report and shall not be placed  
2 in the probation report. The confidential information shall remain  
3 confidential except for purposes of sentencing. After sentencing,  
4 the confidential information shall be sealed.

5 (l) (1) Between persons who are trained and qualified to serve  
6 on multidisciplinary personnel teams pursuant to subdivision (d)  
7 of Section 18951. The information and records sought to be  
8 disclosed shall be relevant to the provision of child welfare services  
9 or the investigation, prevention, identification, management, or  
10 treatment of child abuse or neglect pursuant to Chapter 11  
11 (commencing with Section 18950) of Part 6 of Division 9.  
12 Information obtained pursuant to this subdivision shall not be used  
13 in any criminal or delinquency proceeding. Nothing in this  
14 subdivision shall prohibit evidence identical to that contained  
15 within the records from being admissible in a criminal or  
16 delinquency proceeding, if the evidence is derived solely from  
17 means other than this subdivision, as permitted by law.

18 (2) As used in this subdivision, “child welfare services” means  
19 those services that are directed at preventing child abuse or neglect.

20 (m) To county patients’ rights advocates who have been given  
21 knowing voluntary authorization by a client or a guardian ad litem.  
22 The client or guardian ad litem, whoever entered into the  
23 agreement, may revoke the authorization at any time, either in  
24 writing or by oral declaration to an approved advocate.

25 (n) To a committee established in compliance with Section  
26 14725.

27 (o) In providing information as described in Section 7325.5.  
28 Nothing in this subdivision shall permit the release of any  
29 information other than that described in Section 7325.5.

30 (p) To the county behavioral health director or the director’s  
31 designee, or to a law enforcement officer, or to the person  
32 designated by a law enforcement agency, pursuant to Sections  
33 5152.1 and 5250.1.

34 (q) If the patient gives his or her consent, information  
35 specifically pertaining to the existence of genetically handicapping  
36 conditions, as defined in Section 125135 of the Health and Safety  
37 Code, may be released to qualified professional persons for  
38 purposes of genetic counseling for blood relatives upon request of  
39 the blood relative. For purposes of this subdivision, “qualified  
40 professional persons” means those persons with the qualifications

1 necessary to carry out the genetic counseling duties under this  
2 subdivision as determined by the genetic disease unit established  
3 in the State Department of Health Care Services under Section  
4 125000 of the Health and Safety Code. If the patient does not  
5 respond or cannot respond to a request for permission to release  
6 information pursuant to this subdivision after reasonable attempts  
7 have been made over a two-week period to get a response, the  
8 information may be released upon request of the blood relative.

9 (r) When the patient, in the opinion of his or her psychotherapist,  
10 presents a serious danger of violence to a reasonably foreseeable  
11 victim or victims, then any of the information or records specified  
12 in this section may be released to that person or persons and to  
13 law enforcement agencies and county child welfare agencies as  
14 the psychotherapist determines is needed for the protection of that  
15 person or persons. For purposes of this subdivision,  
16 “psychotherapist” means anyone so defined within Section 1010  
17 of the Evidence Code.

18 (s) (1) To the designated officer of an emergency response  
19 employee, and from that designated officer to an emergency  
20 response employee regarding possible exposure to HIV or AIDS,  
21 but only to the extent necessary to comply with provisions of the  
22 federal Ryan White Comprehensive AIDS Resources Emergency  
23 Act of 1990 (Public Law 101-381; 42 U.S.C. Sec. 201).

24 (2) For purposes of this subdivision, “designated officer” and  
25 “emergency response employee” have the same meaning as these  
26 terms are used in the federal Ryan White Comprehensive AIDS  
27 Resources Emergency Act of 1990 (Public Law 101-381; 42 U.S.C.  
28 Sec. 201).

29 (3) The designated officer shall be subject to the confidentiality  
30 requirements specified in Section 120980, and may be personally  
31 liable for unauthorized release of any identifying information about  
32 the HIV results. Further, the designated officer shall inform the  
33 exposed emergency response employee that the employee is also  
34 subject to the confidentiality requirements specified in Section  
35 120980, and may be personally liable for unauthorized release of  
36 any identifying information about the HIV test results.

37 (t) (1) To a law enforcement officer who personally lodges with  
38 a facility, as defined in paragraph (2), a warrant of arrest or an  
39 abstract of such a warrant showing that the person sought is wanted  
40 for a serious felony, as defined in Section 1192.7 of the Penal

Code, or a violent felony, as defined in Section 667.5 of the Penal Code. The information sought and released shall be limited to whether or not the person named in the arrest warrant is presently confined in the facility. This paragraph shall be implemented with minimum disruption to health facility operations and patients, in accordance with Section 5212. If the law enforcement officer is informed that the person named in the warrant is confined in the facility, the officer may not enter the facility to arrest the person without obtaining a valid search warrant or the permission of staff of the facility.

(2) For purposes of paragraph (1), a facility means all of the following:

(A) A state hospital, as defined in Section 4001.

(B) A general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, solely with regard to information pertaining to a person with mental illness subject to this section.

(C) An acute psychiatric hospital, as defined in subdivision (b) of Section 1250 of the Health and Safety Code.

(D) A psychiatric health facility, as described in Section 1250.2 of the Health and Safety Code.

(E) A mental health rehabilitation center, as described in Section 5675.

(F) A skilled nursing facility with a special treatment program for individuals with mental illness, as described in Sections 51335 and 72445 to 72475, inclusive, of Title 22 of the California Code of Regulations.

(u) Between persons who are trained and qualified to serve on multidisciplinary personnel teams pursuant to Section 15610.55, 15753.5, or 15761. The information and records sought to be disclosed shall be relevant to the prevention, identification, management, or treatment of an abused elder or dependent adult pursuant to Chapter 13 (commencing with Section 15750) of Part 3 of Division 9.

(v) The amendment of subdivision (d) enacted at the 1970 Regular Session of the Legislature does not constitute a change in, but is declaratory of, the preexisting law.

(w) This section shall not be limited by Section 5150.05 or 5332.

(x) (1) When an employee is served with a notice of adverse action, as defined in Section 19570 of the Government Code, the following information and records may be released:

(A) All information and records that the appointing authority relied upon in issuing the notice of adverse action.

(B) All other information and records that are relevant to the adverse action, or that would constitute relevant evidence as defined in Section 210 of the Evidence Code.

(C) The information described in subparagraphs (A) and (B) may be released only if both of the following conditions are met:

(i) The appointing authority has provided written notice to the consumer and the consumer's legal representative or, if the consumer has no legal representative or if the legal representative is a state agency, to the clients' rights advocate, and the consumer, the consumer's legal representative, or the clients' rights advocate has not objected in writing to the appointing authority within five business days of receipt of the notice, or the appointing authority, upon review of the objection has determined that the circumstances on which the adverse action is based are egregious or threaten the health, safety, or life of the consumer or other consumers and without the information the adverse action could not be taken.

(ii) The appointing authority, the person against whom the adverse action has been taken, and the person's representative, if any, have entered into a stipulation that does all of the following:

(I) Prohibits the parties from disclosing or using the information or records for any purpose other than the proceedings for which the information or records were requested or provided.

(II) Requires the employee and the employee's legal representative to return to the appointing authority all records provided to them under this subdivision, including, but not limited to, all records and documents from any source containing confidential information protected by this section, and all copies of those records and documents, within 10 days of the date that the adverse action becomes final except for the actual records and documents or copies thereof that are no longer in the possession of the employee or the employee's legal representative because they were submitted to the administrative tribunal as a component of an appeal from the adverse action.



1 (III) Requires the parties to submit the stipulation to the  
2 administrative tribunal with jurisdiction over the adverse action  
3 at the earliest possible opportunity.

4 (2) For the purposes of this subdivision, the State Personnel  
5 Board may, prior to any appeal from adverse action being filed  
6 with it, issue a protective order, upon application by the appointing  
7 authority, for the limited purpose of prohibiting the parties from  
8 disclosing or using information or records for any purpose other  
9 than the proceeding for which the information or records were  
10 requested or provided, and to require the employee or the  
11 employee's legal representative to return to the appointing authority  
12 all records provided to them under this subdivision, including, but  
13 not limited to, all records and documents from any source  
14 containing confidential information protected by this section, and  
15 all copies of those records and documents, within 10 days of the  
16 date that the adverse action becomes final, except for the actual  
17 records and documents or copies thereof that are no longer in the  
18 possession of the employee or the employee's legal representatives  
19 because they were submitted to the administrative tribunal as a  
20 component of an appeal from the adverse action.

21 (3) Individual identifiers, including, but not limited to, names,  
22 social security numbers, and hospital numbers, that are not  
23 necessary for the prosecution or defense of the adverse action,  
24 shall not be disclosed.

25 (4) All records, documents, or other materials containing  
26 confidential information protected by this section that have been  
27 submitted or otherwise disclosed to the administrative agency or  
28 other person as a component of an appeal from an adverse action  
29 shall, upon proper motion by the appointing authority to the  
30 administrative tribunal, be placed under administrative seal and  
31 shall not, thereafter, be subject to disclosure to any person or entity  
32 except upon the issuance of an order of a court of competent  
33 jurisdiction.

34 (5) For purposes of this subdivision, an adverse action becomes  
35 final when the employee fails to answer within the time specified  
36 in Section 19575 of the Government Code, or, after filing an  
37 answer, withdraws the appeal, or, upon exhaustion of the  
38 administrative appeal or of the judicial review remedies as  
39 otherwise provided by law.



1 (y) To the person appointed as the developmental services  
2 decisionmaker for a minor, dependent, or ward pursuant to Section  
3 319, 361, or 726.

4 (z) *To a business associate or for health care operations*  
5 *purposes, in accordance with Part 160 (commencing with Section*  
6 *160.101) and Part 164 (commencing with Section 164.102) of*  
7 *Subchapter C of Subtitle A of Title 45 of the Code of Federal*  
8 *Regulations.*

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

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 419  
**Author:** Portantino  
**Bill Date:** April 17, 2017, Amended  
**Subject:** Medical Practice: Pain Management  
**Sponsor:** Author

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would require the Medical Board of California (Board) to update standards on a continuous basis for review of pain management cases. This bill would also require education for guardians of minors being prescribed specified controlled substances for pain and would require a reevaluation before a subsequent prescription is made for that controlled substance.

**BACKGROUND:**

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

According to the Centers for Disease Control, every day, 44 people in the U.S. die from overdose of prescription painkillers and many more become addicted.

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

In 2014, the Director of CDPH launched a state agency Prescription Opioid Misuse and Overdose Prevention Workgroup (Workgroup) to share information and develop collaborative strategies to curb prescription drug misuse, abuse, and overdose deaths in California. The Workgroup started as a multi-sector group consisting of more than 10 state agencies, including CDPH, Department of Justice, DHCS, Department of Managed Health Care, Department of Education, Department of Industrial Relations, Department of Corrections and Rehabilitation, Department of Consumer Affairs (including the Board, Dental Board of California, Board of Pharmacy, and Board of Registered Nursing), Emergency Medical Services Authority, and others. The Workgroup initially commenced a multi-phase plan involving enhancement of the state's Prescription Drug Monitoring Program (PDMP), promoting the release and adoption of the Board's revised Guidelines for Prescribing Controlled Substances for Pain, and development of a comprehensive public education campaign to increase public awareness about the potential dangers of opioid medications and to create better understanding and expectations among the public regarding proper prescribing, use, storage and disposal of opioids.

## **ANALYSIS**

This bill would require the Board to update the standards in existing law regarding competent review in cases concerning the management, including, but not limited to, the under treatment, under medication, and overmedication of a patient's pain. These standards were first required in 2002. This bill would update references in existing law regarding who the Board can consult with on this issue. This bill would require the Board to update these standards on or before July 1, 2018, and on or before July 1 each fifth year thereafter. This bill would require the Board to convene a task force to develop and recommend the updated standards to the Board and would require the task force to consult with the specified entities in existing law and others.

This bill would require a health care practitioner who is authorized to prescribe, order, administer, or furnish oxycodone, hydrocodone, hydromorphone, morphine, codeine, oxymorphone, fentanyl, methadone, tramadol, or tapentadol, before prescribing, ordering, administering, or furnishing these medication to a minor, to educate the guardian on all of the following:

- All other available medical treatments, other than the medication to be prescribed.
- Non-opioid treatment alternatives to be tried before and alongside opioid therapy, unless there is a specific adverse reaction or contraindication.
- The risks and benefits of narcotic medications and alternatives.
- The safe storage of opioid medications.
- The proper disposal of unused medications.
- The illegality of sharing or misusing prescribed medications.

This bill would define a minor as a person under 18 years of age who is not: a cancer patient; a patient in hospice or palliative care; or a patient who has been diagnosed with a terminal illness.

This bill would require the discussion and counseling to be memorialized in a document printed on a secure prescription pad and signed by the minor, if he or she was counseled, the guardian, and the prescriber. This bill would require a pharmacist to review and verify the disclosure and counseling document described before dispensing a prescription for a minor for any pain medication specified in this bill.

This bill would specify that a subsequent prescription for the pain medications specified in the bill shall not be made until the minor is reevaluated by a pain management specialist or a pediatrician.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill is currently referencing some outdated standards regarding pain management. However, the Board has already convened a Prescribing Task Force that led the charge in updating the Board’s Guidelines for Prescribing Controlled Substances for Pain in November 2014. The Board could continue to look at the Guidelines to see if they should be updated on a regular basis. Educating guardians of minors on other non-opioid medical treatment, the risks and benefits of narcotic treatment and alternatives, the safe storage of opioid medications, and the proper disposal of medications, all help to increase awareness and prevent opioid medication abuse. As such, this bill would help further the Board’s mission of consumer protection. If technical amendments are made to refer to the correct guidelines, to not mandate updates at specific time periods or mandate who the Board consults, Board staff recommends that the Board support this bill.

- FISCAL:**                      None to the Board
- SUPPORT:**                      None on file
- OPPOSITION:**                      None on file
- POSITION:**                      Recommendation: Support if Amended

AMENDED IN SENATE APRIL 17, 2017  
AMENDED IN SENATE MARCH 20, 2017

**SENATE BILL**

**No. 419**

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**Introduced by Senator Portantino**

February 15, 2017

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*An act to add Section 2242.3 to the Business and Professions Code, relating to controlled substances. An act to amend Section 2241.6 of, and to add Section 4075.7 to, the Business and Professions Code, and to add Section 11167.7 to the Health and Safety Code, relating to healing arts.*

LEGISLATIVE COUNSEL'S DIGEST

SB 419, as amended, Portantino. ~~Oxycodone: prescriptions. Medical practice: pain management.~~

*Existing law, the Controlled Substances Act, prohibits a person other than a physician, dentist, podiatrist, veterinarian, or certain other health care practitioners, in specified circumstances, from writing or issuing a prescription. That act requires a prescription for specified controlled substances to be made on a specified controlled substance prescription form, to be signed and dated by the prescriber in ink, and to contain specified information. That act requires a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance to consult the Controlled Substance Utilization Review and Evaluation System database to review a patient's controlled substance history before prescribing specified controlled substances to the patient for the first time, and at least once every 4 months thereafter if the substance remain part of the treatment of the patient, except as specified. That act prohibits a person from prescribing, administering, or dispensing a controlled substance to an addict or any person*

*representing himself or herself as an addict, except as specified. That act defines “addict” for this purpose, and excludes from the definition a person whose drug-seeking behavior is primarily due to the inadequate control of pain. Existing law, the Pharmacy Law, imposes various requirements on the dispensing by prescription of dangerous drugs, including controlled substances. That law prohibits furnishing a prescription for a controlled substance transmitted by means of an oral or electronically transmitted order to any person unknown and unable to properly establish his or her identity. Existing law makes a violation of these provisions a crime.*

*This bill would require a specified health care practitioner, before prescribing, ordering, or furnishing specified narcotic pain medications, including controlled substances, to a minor, as defined, to educate the guardian of the minor on all other available medical treatments, specified nonopioid treatment alternatives to be tried before and alongside opioid therapy, the risks and benefits of narcotic medications and alternatives to narcotic medications, the safe storage of opioid medications, the proper disposal of unused medications, and the illegality of sharing or misusing prescribed medications. The bill would also require this discussion and counseling to be memorialized in a document printed on a secure prescription pad and signed by the minor, if he or she was counseled, the guardian, and the prescriber. The bill would require a pharmacist to review and verify the document before dispensing the medication. The bill would prohibit a subsequent prescription of those medications from being made until the minor is reevaluated by a pain management specialist or a pediatrician. By adding these new requirements to the Controlled Substances Act and the Pharmacy Law, the violation of which would be a crime, this bill would impose a state-mandated local program.*

*Existing law establishes the Medical Board of California within the Department of Consumer Affairs. Existing law, among other things, required the board to develop standards before June 1, 2002, to ensure the competent review in cases concerning the management, including, but not limited to, the undertreatment, undermedication, and overmedication of a patient’s pain.*

*This bill would require the board, on or before July 1, 2018, to update those standards. The bill would also require the board to update those standards on or before July 1 each 5th year thereafter. The bill would require the board to convene a task force to develop and recommend the updated standards to the board. The bill would require the task*

*force, in developing the updated standards, to consult with specified entities.*

*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.*

~~Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I, and the least restrictive limitations generally placed on controlled substances classified in Schedule V. Existing law places oxycodone within Schedule II. Existing law requires a prescription for a controlled substance to only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice.~~

~~Existing law, the Medical Practice Act, provides for the licensing and regulation of physicians and surgeons by the Medical Board of California. Among other things, the act regulates the prescribing, dispensing, or furnishing of dangerous drugs, including oxycodone, by a licensee, and provides, under certain circumstances, for the imposition of an administrative fine pursuant to a citation by the board, or the imposition of a civil penalty for a violation of these provisions. A violation of designated provisions of the act is a crime.~~

~~This bill would prohibit a person from prescribing oxycodone, by whatever official, common, usual, chemical, or trade name designated, to a patient under 21 years of age, except as specified. The bill would make a violation of this prohibition subject to a civil penalty, as specified. The bill would also authorize a patient who was prescribed oxycodone in violation of the prohibition, and who sustained economic loss or personal injury as a result of that violation, to bring a civil action to recover compensatory damages, reasonable attorney's fees, and litigation costs.~~

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

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

1     *SECTION 1. Section 2241.6 of the Business and Professions*  
2     *Code is amended to read:*

3     ~~2241.6. The Division of Medical Quality shall develop~~  
4     ~~standards before June 1, 2002, to assure the competent review in~~  
5     ~~cases concerning the management, including, but not limited to,~~  
6     ~~the undertreatment, undermedication, and overmedication of a~~  
7     ~~patient's pain. The division~~

8     2241.6. (a) (1) *The board shall develop standards before June*  
9     *1, 2002, to ensure the competent review in cases concerning the*  
10    *management, including, but not limited to, the undertreatment,*  
11    *undermedication, and overmedication of a patient's pain.*

12    (2) *The board may consult with entities such as the American*  
13    *Pain Society, the American Academy of Pain Medicine, the*  
14    *California Society of Anesthesiologists, the California Chapter of*  
15    *the American College of Emergency Physicians, and any other*  
16    *medical entity specializing in pain control therapies to develop the*  
17    *standards utilizing, to the extent they are applicable, current*  
18    *authoritative clinical practice guidelines.*

19    (b) *The board shall update the standards adopted pursuant to*  
20    *subdivision (a) on or before July 1, 2018, and on or before July 1*  
21    *each fifth year thereafter.*

22    (c) *The board shall convene a task force to develop and*  
23    *recommend the updated standards to the board. The task force, in*  
24    *developing the updated standards, shall consult with the entities*  
25    *specified in paragraph (2) of subdivision (a), the American Cancer*  
26    *Society, and specialists in pharmacology and addiction medicine.*

27    SEC. 2. *Section 4075.7 is added to the Business and Professions*  
28    *Code, to read:*

29    4075.7. (a) *Before dispensing a prescription for a minor for*  
30    *a pain medication listed in Section 11167.7 of the Health and*  
31    *Safety Code, the pharmacist shall review and verify the disclosure*  
32    *and counseling document described in subdivision (c) of Section*  
33    *11167.7 of the Health and Safety Code.*

34    (b) *For purposes of this section, "minor" shall have the same*  
35    *meaning as in Section 11167.7 of the Health and Safety Code.*

36    SEC. 3. *Section 11167.7 is added to the Health and Safety*  
37    *Code, to read:*



1 11167.7. (a) For purposes of this section, the following  
2 definitions shall apply:

3 (1) “Minor” means a person under 18 years of age who is not  
4 any of the following:

5 (A) A cancer patient.

6 (B) A patient in hospice or palliative care.

7 (C) A patient who has been diagnosed with a terminal illness.

8 (2) “Guardian” means the legal guardian of the minor.

9 (b) A health care practitioner, except a veterinarian, authorized  
10 to prescribe, order, administer, or furnish oxycodone, hydrocodone,  
11 hydromorphone, morphine, codeine, oxymorphone, fentanyl,  
12 methadone, tramadol, or tapentadol to a minor shall, before  
13 prescribing, ordering, administering, or furnishing those  
14 medications, educate the guardian on all of the following:

15 (1) All other available medical treatments, other than the  
16 medication to be prescribed.

17 (2) Nonopioid treatment alternatives to be tried before and  
18 alongside opioid therapy, unless there is a specific adverse reaction  
19 or contraindication.

20 (3) The risks and benefits of narcotic medications and  
21 alternatives.

22 (4) The safe storage of opioid medications.

23 (5) The proper disposal of unused medications.

24 (6) The illegality of sharing or misusing prescribed medications.

25 (c) The discussion and counseling provided in subdivision (b)  
26 shall be memorialized in a document printed on a secure  
27 prescription pad and signed by the minor, if he or she was  
28 counseled, the guardian, and the prescriber.

29 (d) A subsequent prescription for the pain medications listed in  
30 subdivision (b) shall not be made until the minor is reevaluated  
31 by a pain management specialist or a pediatrician.

32 SEC. 4. No reimbursement is required by this act pursuant to  
33 Section 6 of Article XIII B of the California Constitution because  
34 the only costs that may be incurred by a local agency or school  
35 district will be incurred because this act creates a new crime or  
36 infraction, eliminates a crime or infraction, or changes the penalty  
37 for a crime or infraction, within the meaning of Section 17556 of  
38 the Government Code, or changes the definition of a crime within  
39 the meaning of Section 6 of Article XIII B of the California  
40 Constitution.

1     SECTION 1. ~~Section 2242.3 is added to the Business and~~  
2     ~~Professions Code, to read:~~

3     ~~2242.3. (a) (1) Notwithstanding any other law, a person shall~~  
4     ~~not prescribe oxycodone, by whatever official, common, usual,~~  
5     ~~chemical, or trade name designated, to a patient under 21 years of~~  
6     ~~age.~~

7     ~~(2) Paragraph (1) does not apply with respect to a patient of any~~  
8     ~~age who is any of the following:~~

9     ~~(A) A cancer patient.~~

10    ~~(B) A patient in hospice or palliative care.~~

11    ~~(C) A patient who has been diagnosed with a terminal illness.~~

12    ~~(b) (1) Notwithstanding Section 2314 or any other law, a~~  
13    ~~violation of this section may subject the person who has committed~~  
14    ~~the violation to either a fine of up to five thousand dollars (\$5,000)~~  
15    ~~per violation pursuant to a citation issued by the board or a civil~~  
16    ~~penalty of up to five thousand dollars (\$5,000) per violation.~~

17    ~~(2) The Attorney General may bring an action to enforce this~~  
18    ~~section and to collect the fines or civil penalties authorized by~~  
19    ~~paragraph (1).~~

20    ~~(c) In addition to the penalties described in paragraph (1) of~~  
21    ~~subdivision (b), a patient who was prescribed oxycodone in~~  
22    ~~violation of subdivision (a), and who sustained economic loss or~~  
23    ~~personal injury as a result of that violation, may bring an action~~  
24    ~~to recover compensatory damages, as well as reasonable attorney's~~  
25    ~~fees and costs.~~

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 457  
**Author:** Bates  
**Bill Date:** April 17, 2017, Amended  
**Subject:** Out-of-Hospital Childbirths: Physicians and Surgeons: Licensed  
Midwives: Certified Nurse-Midwives  
**Sponsor:** California Medical Association (CMA)

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would set standard conditions and requirements for out-of-hospital births, regardless of who is attending the birth, a physician, licensed midwife (LM), or certified nurse-midwife (CNM). This bill would remove the physician supervision requirement for CNMs for out-of-hospital births, and would allow CNMs to provide prenatal, intrapartum, and postpartum care related to the out-of-hospital birth for the client, and immediate care for the newborn, related to the out-of-hospital birth.

**BACKGROUND**

AB 1308 (Bonilla, Chapter 665, Statutes of 2013) removed the physician supervision requirement for LMs and required LMs to only accept clients that meet the criteria for normal pregnancy and childbirth, as specified in this bill. If a potential client does not meet the criteria for normal pregnancy and childbirth, then the LM can refer that client to a physician trained in obstetrics and gynecology for examination; the LM can only accept the client if the physician examines the client and determines that the risk factors are not likely to significantly affect the course of pregnancy and childbirth. This bill required the Medical Board of California (Board) to develop regulations specifying preexisting maternal diseases or conditions likely to affect the pregnancy and significant diseases arising from the pregnancy. This bill allowed LMs to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with the LMs' scope of practice. This bill required LMs to provide records and speak to the receiving physician if the client is transferred to a hospital. This bill required the hospital to report each transfer of a planned out-of-hospital birth to the Board and the California Maternal Quality Care Collaborative, using a form developed by the Board. Lastly, this bill allowed LMs to attend births in alternative birth centers (ABCs) and changed the standards of certification that must be met by an ABC to those established by the American Association of Birth Centers.

The Board has held interested parties meetings in an effort to develop regulations to define "normal," by specifying preexisting maternal diseases or conditions likely to affect the pregnancy and significant diseases arising from the pregnancy. While the interested parties

were able to reach consensus on most issues, agreement has not been reached around the issue of allowing LMs to attend homebirths for women who want a vaginal birth after cesarean section (VBAC) without a physician consult and approval, if certain conditions are met. The Board created a task force to further consider this issue and to work toward proceeding with the rulemaking process.

In March 2017, the Members of the Midwifery Task Force, Dr. Bholat and Dr. Levine, met with Board staff and interested parties. The parties discussed the challenges created by the current language under Business and Professions Code (BPC) Section 2507(b)(2) requiring a licensed midwife to refer a client with a preexisting maternal disease or condition likely to affect the pregnancy or a significant disease arising from the pregnancy, to a physician and surgeon for an examination and a determination by the physician that the risk factors presented by the client's disease or condition are not likely to significantly affect the course of pregnancy and childbirth. The task force was informed that requiring physicians to make this determination puts physicians in a difficult position causing reluctance and challenges for collaboration and access to care for midwifery clients.

It was acknowledged that this issue could not be resolved through regulations, and a statutory change is necessary. Proposed language was discussed at the Midwifery Task Force meeting. Board staff then prepared a draft, and circulated it to interested parties and the task force members.

Under Board staff's proposed changes to BPC section 2507, if the client has a preexisting maternal disease or condition likely to affect the pregnancy, or a significant disease arising from the pregnancy, the midwife will still be required to refer the client to a physician trained in obstetrics for an assessment of the risk factors that may adversely affect the outcome of the pregnancy or childbirth. The midwife would have to include the physician's assessment in evaluating whether the client's disease or condition are likely to significantly affect the course of the pregnancy or childbirth. It would ultimately be the midwife making the determination within the midwifery standard of care, rather than the physician, as to whether the client should continue with midwifery care.

If Board staff's proposed amendments are made to the statute, then Board staff will move forward with the regulatory process to define "preexisting maternal disease or condition likely to affect the pregnancy," and "significant disease arising from the pregnancy." Conditions falling within the definitions put forth in regulations, which would include prior cesarean section, would prompt the referral to the physician for the assessment of the risk factors, and when appropriate, for the transfer of care.

## **ANALYSIS**

This bill would set standard conditions and requirements for out-of-hospital births, regardless of who is attending the birth, a physician, LM, or CNM and would make them similar to what is in existing law for LMs, but would not require the Board to develop regulations.

This bill would specify that both LMs and CNMs can attend cases of out-of-hospital childbirth, pursuant to this bill, and they can provide prenatal, intrapartum, and postpartum care, related to the out-of-hospital childbirth for the client, and immediate care for the newborn, without physician supervision. This bill would specify that the practice of midwifery for LMs constitutes the furthering or undertaking by any midwife to assist a client in an out-of-hospital birth, pursuant to this bill.

This bill would allow licensed physicians, CNMs and LMs to attend cases of pregnancy and out-of-hospital births, only when all of the following conditions apply:

- There is no increased risk to the client because of a disease or condition that could adversely affect the pregnancy and childbirth.
- The patient or client has not had prior uterine or abdominal surgery, including, but not limited to, myomectomy, hysterotomy, or prior caesarian section.
- There is a singleton fetus.
- There is a cephalic presentation by 36 0/7 completed weeks of pregnancy.
- The gestational age of the fetus is greater than 37 0/7 weeks and less than 42 0/7 completed weeks of pregnancy.
- Labor is spontaneous or manually induced after 39 weeks gestation.
- Transfer to a hospital setting can occur within 20 minutes from the initiation of the transfer (this is a new requirement).

This bill would require the physician, CNM, or LM, acting within their scope of practice, to use a self-screening form to identify client risk factors for out-of-hospital childbirth.

This bill would specify that if a potential patient or client meets the conditions required in the bill, but has an increased risk because of a disease or condition that could adversely affect the pregnancy and childbirth, or has had a prior uterine or abdominal surgery, based on the risk factors identified by the self-screening tool, the client must obtain a medical examination by a licensed physician with privileges to practice obstetrics and/or gynecology. The bill would only allow the physician, CNM, or LM to attend that out-of-hospital birth if the physician who performs the medical examination determines, at the time of the examination, that the client is not at an increased risk due to a disease or condition, that could adversely affect the pregnancy and childbirth. This bill would specify that it would constitute unprofessional conduct for a physician, LM, or CNM to attend a case of out-of-hospital childbirth after the physician who performs the examination determines that the patient or client is at an increased risk due to a disease or condition that could adversely affect the pregnancy and childbirth.

This bill would require the physician, CNM, or LM attending the planned out-of-hospital birth and related pregnancy to continuously assess the client for any evidence of a disease or condition that could adversely affect the pregnancy or childbirth. If evidence is found, the client must obtain a medical examination by a physician with privileges to practice obstetrics and/or gynecology, or appropriate interventions, including transfer, first-responder care, and/or emergency transport must be initiated.

For CNMs and LMs, this bill would specify that if a physician determines that the client's condition or concern has been resolved such that the client is not at an increased risk due to a disease or condition, that could adversely affect the pregnancy and childbirth, the midwife may resume care of the client and resume assisting the client during the pregnancy, out-of-hospital childbirth, or postpartum care.

This bill would also specify for CNMs and LMs, if a physician determines the client's condition or concern has not been resolved and is at an increased risk due to a disease or condition that could adversely affect the pregnancy and childbirth, the midwife may provide concurrent care with a physician and, if authorized by the client, be present during the labor and childbirth, and resume postpartum care, if appropriate. An LM shall not attend an out-of-hospital childbirth of the client and a CNM can only attend an out-of-hospital birth under the supervision of a physician.

This bill would specify that a CNM or LM shall not provide or continue to provide midwifery care to a client if a licensed physician with privileges to practice obstetrics and/or gynecology determines, at the time of the examination, that the client is at an increased risk due to a disease or condition, that could adversely affect the pregnancy and childbirth pursuant to this bill, regardless of whether the client has consented to this care or refused care by a physician.

For purposes of attending an out-of-hospital birth, this bill would specify the drugs and tests that a CNM or LM can administer or perform, as follows:

- Postpartum antihemorrhagic drugs.
- Prophylactic ophthalmic antibiotics.
- Vitamin K.
- RhoGAM.
- Local anesthetic medications.
- Intravenous fluids limited to lactated ringers, 5 percent dextrose with lactated ringers, and heparin and 0.9 percent sodium chloride for use in intravenous locks.
- Epinephrine for use in maternal anaphylaxis pending emergency transport.
- HBIG and GBV for neonates born to hepatitis B mothers, per current Centers for Disease Control Guidelines.
- Antibiotics for intrapartum prophylaxis of Group B Betahemolytic Streptococcus (GBBS) per current Centers for Disease Control Guidelines.
- Equipment incidental to the practice of out-of-hospital childbirth, specifically, dopplers, syringes, needles, phlebotomy equipment, suture, urinary catheters, intravenous equipment, amnihooks, airway suction devices, neonatal and adult resuscitation equipment, glucometer, and centrifuge.
- Equipment incidental to maternal care, specifically, compression stockings, maternity belts, breast pumps, diaphragms, and cervical caps.

As existing law already requires for LMs, this bill would require physicians, CNMs and LMs to obtain specific informed consent, orally and in writing, which must be signed and be part of the client's medical record. This bill would require the client to also be provided with the most

recent versions of the following:

- The American College of Nurse Midwives Clinical Bulletin – “Midwifery Provision of Home Birth Services.”
- The American College of Obstetricians and Gynecologists on Obstetric Practice Committee Opinion #669 – Planned Home Birth.
- Society of Maternal Fetal Medicine and the American College of Obstetricians and Gynecologists document entitled “Obstetrics Care Consensus – Levels of Maternal Care.”

This bill would require the Board and the Board of Registered Nursing (BRN) to make the most recent version of these documents publicly available on their websites.

This bill would require alternative birth centers to inform the client orally and in writing if no licensed physician is present during birth.

If a client is transferred to a hospital, this bill would require the physician, CNM, or LM to provide records, including prenatal records, and speak to the receiving physician about labor up to the point of transfer. This bill would specify that failure to comply with this would constitute unprofessional conduct.

This bill would now require the Office of Statewide Health Planning Development (OSHDP), instead of the Board, to develop a form for the hospitals to report each transfer of a patient who attempted a planned out-of-hospital birth, but was transferred to a hospital. The form shall be submitted by the hospital to OSHDP within 30 days of the transfer. The standardized form must include the following:

- Name and license number of the physician, CNM, or LM who attended or attempted to attend, the planned out-of-hospital birth;
- Name and license number of the accepting or admitting physician or CNM who assumed care of the patient;
- Name of the patient and patient identifying information;
- Name of the hospital or emergency center where the patient was transferred;
- Date of report;
- Whether the person(s) admitted was pregnant, the delivered mother, or newborn(s);
- Whether there was a verbal handoff or if any prenatal records were obtained from the out-of-hospital birth attendant;
- Gestational age of the fetus or newborn in weeks and method of determination;
- Events triggering the transfer including, but not limited to, pain management, excessive bleeding, fetal intolerance of labor, prolonged or non-progressive labor with time in labor, maternal request for transfer, or the clinical judgment of the out-of-hospital childbirth attendant;
- Presence of significant history and risk factors, including specified factors;
- Method of delivery;
- Whether a cesarean section was performed;

- Place of delivery;
- FHR tracing on admission;
- Fetal presentation on admission;
- APGAR score of the newborn;
- Cord gases;
- Whether the newborn suffered any complications and was placed in the NICU;
- Whether the mother suffered any complications and was placed in the ICU; and
- Duration of hospital stay for the mother and the newborn(s) as of the date of the report and final disposition or status, if not released from the hospital, of the mother and newborn.

The hospital transfer form would be required to be constructed in a format to enable the hospital to transmit the information to OSHPD in a manner that the licensees and the patient are anonymous and their identifying information is not transmitted to OSHPD. The entire form is required to be placed in the patient's medical record. This bill would allow OSHPD to revise the reporting requirement to fit state and national standards.

This bill would require each licensee who attends an out-of-hospital birth to submit, within 30 days of initial acceptance of a client, a form to OSHPD indicating the initiation of care and would require OSHPD to develop this standardized form.

As existing law already requires for LMs, this bill would require each licensee who attends an out-of-hospital childbirth, including supervising a student midwife, to annually report to OSHPD. The report would be required to be submitted no later than March 30, for the prior calendar year, in a form specified by OSHPD, instead of the Board. The information that would be required to be submitted is the same information that is currently included in the LM annual report. This bill would require OSHPD to report to the appropriate board, by April 30, those licensees who have met the reporting requirements for that year. OSHPD would be required to report the aggregate information collected to the appropriate board by July 30 of each year. This bill would require the Board and the BRN to include this information in their annual reports to the Legislature. This bill would allow OSHPD, with input from both boards, to adjust the data elements required to be reported to better coordinate with other reporting systems. This bill would specify that failure to report would be unprofessional conduct.

This bill would standardize the requirements for out-of-hospital births. The language in this bill would require the physician who conducts the medical examination to determine, at the time of the examination, that the client is not at an increased risk due to a disease or condition that could adversely affect the pregnancy and childbirth. The physician determination language is included in current law and has been problematic for liability reasons and Board staff has drafted alternative language. In addition, this bill adds abdominal surgery as one the factors that could prohibit a licensee from attending an out-of-hospital birth; this is broader than what is included in current law. This bill would also prohibit a licensee from attending an out-of-hospital birth if transfer to a hospital setting cannot occur within 20 minutes from the initiation of the transfer; this is a new requirement. There is also some conflicting language in



this bill regarding whether a CNM can attend an out-of-hospital birth once the physician determines the client is at an increased risk due to a disease or condition that could adversely affect the pregnancy and childbirth; this would need to be clarified. This bill would no longer require the Board to develop regulations, and would make it clear in statute what requirements and conditions must be met for out-of-hospital births. This bill would also require all licensees to annually report data on out-of-hospital births, would expand the information that must be reported by hospitals when a transfer occurs, and would require the hospital transfer form to be included in the patient's medical record.

**FISCAL:** Minimal and absorbable

**SUPPORT:** CMA (Sponsor)

**OPPOSITION:** None on File

AMENDED IN SENATE APRIL 17, 2017

**SENATE BILL**

**No. 457**

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**Introduced by Senator Bates**

February 16, 2017

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~~An act to amend Section 1248 of the Health and Safety Code, relating to health facilities.~~ *An act to amend Section 2507 of, to add Section 2746.54 to, to add Article 17 (commencing with Section 880) to Chapter 1 of Division 2 of, and to repeal Sections 2508, 2510, 2516 of, the Business and Professions Code, and to amend Section 1204.3 of the Health and Safety Code, relating to out-of-hospital childbirths.*

LEGISLATIVE COUNSEL'S DIGEST

SB 457, as amended, Bates. ~~Health facilities: outpatient settings.~~ *Out-of-Hospital Childbirths: physicians and surgeons: licensed midwives: certified nurse-midwives.*

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

*Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensure and regulation of midwives by the Medical Board of California. A violation of the act is a crime. Existing law authorizes a licensed midwife to attend cases of normal pregnancy and childbirth, but requires a midwife to immediately refer or transfer a client to a physician and surgeon if there are complications. Under the act, if a client of a licensed midwife is transferred to a hospital, the licensed midwife is required to provide records and speak with the receiving physician and surgeon about labor up to the point of the transfer. The act requires a hospital to report each transfer of a planned out-of-hospital birth to the Medical Board of California and the*

*California Maternal Quality Care Collaborative using a standardized form developed by the board. Under existing law, a midwife is authorized to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with his or her scope of practice.*

*Existing law, the Nursing Practice Act, provides for the licensure and regulation of certified nurse-midwives by the Board of Registered Nursing. A violation of the act is a crime. Existing law authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn, and provides that the practice of nurse-midwifery constitutes the furthering or undertaking by a certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal. Existing law authorizes a certified nurse-midwife to furnish and order drugs or devices incidentally to the provision of family planning services, routine health care or perinatal care, and care rendered consistent with the certified nurse-midwife's educational preparation or clinical competence to specified persons, and only in accordance with standardized procedures and protocols developed and approved by, among others, the supervising physician and surgeon.*

*Existing law establishes the Office of Statewide Health Planning and Development in state government and it has jurisdiction over health planning and research development.*

*This bill would revise and recast these provisions by requiring that a licensed physician and surgeon, a licensed midwife, and a certified nurse-midwife only attend cases of pregnancy and out-of-hospital childbirth, as defined, when specified conditions are met. For purposes of determining whether a patient or client satisfies these conditions, the bill would require the licensed physician and surgeon, licensed certified nurse midwife, or licensed midwife to use a self-screening form to identify patient or client risk factors for out-of-hospital childbirth. The bill would specify those circumstances when a medical examination by a licensed physician and surgeon is required, when a licensed physician and surgeon, a licensed midwife, and a certified nurse-midwife is prohibited from attending cases of pregnancy and out-of-hospital childbirth, and when a licensed physician and surgeon, a licensed*

midwife, and a certified nurse-midwife would be required to initiate appropriate interventions, including transfer to a hospital, when a patient or client's health status changes. The bill would make it unprofessional conduct for a licensed physician and surgeon, licensed midwife, or licensed certified nurse-midwife to attend to a case of out-of-hospital childbirth after a licensed physician and surgeon determines that the patient or client is at an increased risk due to her health status, as provided.

This bill would require licensed physician and surgeon, licensed midwife, or a licensed certified nurse-midwife attending to cases of out-of-hospital childbirths to make specified disclosures to a prospective patient or client and obtain consent, as provided. The bill would also require these licensees to provide the patient or client with the most recent versions of specified documents concerning out-of-hospital childbirths. The bill would also require the Medical Board of California and the Board of Registered Nursing to make those same documents publicly available on their Internet Web sites.

If a patient or client is transferred to a hospital, this bill would require the licensee to provide specified records and speak with the receiving physician and surgeon about the labor up to the point of the transfer. The bill would provide that the failure to comply with this requirement shall constitute unprofessional conduct. The bill would also require the hospital, within a specified period of time, to report to the Office of Statewide Health Planning and Development each transfer of a patient, as specified. The bill would require the Office of Statewide Health Planning and Development to develop a form, subject to specified criteria, including that patient identifying information is protected, for purposes of implementing the hospital reporting requirement.

This bill would require each licensee caring for a patient or client planning an out-of-hospital birth to submit, within a specified period of time, a form to the Office of Statewide Health Planning and Development indicating the initiation of care. The bill would also require each licensee who attends an out-of-hospital childbirth to annually submit a specified report to the Office of Statewide Health Planning and Development. The bill would require the Office of Statewide Health Planning and Development to, among other things, maintain the confidentiality of this information.

For consistency with the above provisions governing out-of-hospital childbirths, the bill would make conforming changes to the Licensed Midwifery Practice Act of 1993 and the Nursing Practice Act. The bill

would specify that a certified nurse-midwife is authorized to attend cases of out-of-hospital childbirth without physician and surgeon supervision when the provisions governing out-of-hospital childbirths are complied with. The bill would also authorize a licensed midwife and a certified nurse-midwife to administer, order, or use certain drugs and equipment. Because a violation of these requirements by a licensed midwife or certified nurse-midwife would be a crime under their respective acts, the bill would impose a state-mandated local program.

(2) Under existing law, an alternative birth center that is licensed as an alternative birth center specialty clinic is required to, as a condition of licensure, and a primary care clinic providing services as an alternative birth center is required to, meet specified certain requirements including requiring the presence of at least 2 attendants at all times during birth, one of whom is required to be a licensed physician and surgeon, licensed midwife, or a certified nurse-midwife.

This bill would require the client to be informed orally and in writing when no licensed physician and surgeon is present.

(3) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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

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

~~Existing law provides for the licensure and regulation of health facilities by the State Department of Public Health. Existing law prohibits the operation, management, conduct, or maintenance of an outpatient setting unless the outpatient setting is accredited by an accreditation agency that is approved by the Medical Board of California, licensed by the State Department of Public Health, as specified, or meets other criteria. Existing law defines an outpatient setting, in part, as a facility, clinic, unlicensed clinic, center, office, or other setting that is not part of a general acute care facility, as defined, that uses anesthesia, as specified.~~

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

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

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

1     SECTION 1. Article 17 (commencing with Section 880) is  
2     added to Chapter 1 of Division 2 of the Business and Professions  
3     Code, to read:

4  
5                     Article 17. Out-of-Hospital Childbirths  
6

7     880. (a) Notwithstanding any other law and except as provided  
8     in subdivisions (c) and (d), a licensed physician and surgeon, a  
9     licensed midwife, and a certified nurse-midwife shall only attend  
10    cases of pregnancy and out-of-hospital childbirth when all of the  
11    following conditions are met:

12    (1) There is no increased risk to the patient or client because  
13    of a disease or condition that could adversely affect the pregnancy  
14    and childbirth.

15    (2) The patient or client has not had prior uterine or abdominal  
16    surgery, including, but not limited to, myomectomy, hysterotomy,  
17    or prior caesarian section.

18    (3) There is a singleton fetus.

19    (4) There is a cephalic presentation by 36<sup>0</sup>/<sub>7</sub> completed weeks  
20    of pregnancy.

21    (5) The gestational age of the fetus is greater than 37<sup>0</sup>/<sub>7</sub> weeks  
22    and less than 42<sup>0</sup>/<sub>7</sub> completed weeks of pregnancy.

23    (6) Labor is spontaneous or manually induced after 39 weeks  
24    gestation.

25    (7) Transfer to a hospital setting can occur within 20 minutes  
26    from the initiation of the transfer.

27    (b) The licensed physician and surgeon, licensed certified nurse  
28    midwife, or licensed midwife, acting within their scope of practice,  
29    shall use a self-screening form to identify patient or client risk  
30    factors for out-of-hospital childbirth.

31    (c) If the patient or client meets the conditions specified in  
32    paragraphs (3) to (7), inclusive, of subdivision (a), but fails to  
33    meet the conditions specified in paragraph (1) or (2) of subdivision

1 (a) based on the risk factors identified by the self-screening form,  
2 the patient or client shall obtain a medical examination by a  
3 licensed physician and surgeon with privileges to practice  
4 obstetrics or gynecology. Under these circumstances, the licensed  
5 physician and surgeon, licensed midwife, or certified nurse midwife  
6 may only attend cases of out-of-hospital childbirth if a licensed  
7 physician and surgeon with privileges to practice obstetrics or  
8 gynecology determines, at the time of the examination, that the  
9 patient or client is not at an increased risk due to a disease or  
10 condition, that could adversely affect the pregnancy and childbirth.

11 (d) The licensed physician and surgeon, licensed midwife, or  
12 licensed certified nurse-midwife attending cases of pregnancy and  
13 out-of-hospital childbirth under this article shall continuously  
14 assess the patient or client for any evidence of a disease or  
15 condition that could adversely affect the pregnancy and childbirth.  
16 If any evidence of a disease or condition that could adversely affect  
17 the pregnancy and childbirth arise, the patient or client shall obtain  
18 a medical examination by a licensed physician and surgeon with  
19 privileges to practice obstetrics or gynecology or the licensed  
20 physician and surgeon, licensed midwife, or licensed certified  
21 nurse-midwife, shall initiate appropriate interventions, including  
22 transfer, first-responder emergency care or emergency transport.

23 (e) For the purposes of this article, “out-of-hospital childbirth”  
24 means childbirth in the home setting, an alternative birth center  
25 pursuant to paragraph (4) of subdivision (b) of Section  
26 1204 of the Health and Safety Code, or any other setting other  
27 than a facility as described in Chapter 2 (commencing with Section  
28 1250) of Division 2 of the Health and Safety Code, or a facility as  
29 described in Chapter 2.5 (commencing with Section 1440) of  
30 Division 2 of the Health and Safety Code.

31 (f) It shall constitute unprofessional conduct for a licensed  
32 physician and surgeon, licensed midwife, or licensed certified  
33 nurse-midwife to attend to a case of out-of-hospital childbirth after  
34 a licensed physician and surgeon with privileges in obstetrics or  
35 gynecology, pursuant to a medical examination under subdivision  
36 (c) or (d), determines that the patient or client is at an increased  
37 risk due to a disease or condition, that could adversely affect the  
38 pregnancy and childbirth. Notwithstanding any other law, a  
39 violation of this section shall not be a crime.

1     880.2. (a) A licensed physician and surgeon, licensed midwife,  
2     or a licensed certified nurse-midwife authorized to attend to cases  
3     of out-of-hospital childbirths pursuant to this article shall disclose  
4     in oral and written form to a prospective patient or client seeking  
5     care for a planned out-of-hospital childbirth, and obtain consent  
6     for, all of the following:

7     (1) All of the provisions of Section 880.

8     (2) The type of license held by the licensee and licensee number.

9     (3) A licensed midwife or certified nurse-midwife who attends  
10    cases of out-of-hospital childbirth without physician and surgeon  
11    supervision shall provide notice that the care being provided is  
12    not being supervised by a physician and surgeon.

13    (4) The practice settings in which the licensee practices.

14    (5) If the licensee does not have professional liability coverage  
15    for the care being provided in an out-of-hospital birth setting, he  
16    or she shall disclose that fact.

17    (6) The acknowledgment that if the patient or client is required  
18    to obtain an examination with a licensed physician and surgeon  
19    pursuant to subdivision (c) or (d) of Section 880, failure to do so  
20    may affect the patient or client's legal rights in any professional  
21    negligence actions against a physician and surgeon, a healing arts  
22    licensee, or hospital.

23    (7) There are conditions that will result in an examination from,  
24    or transfer of care to, a licensed physician and surgeon and if  
25    these conditions exist, the licensee will no longer be able to care  
26    for the patient or client in an out-of-hospital setting, beyond  
27    continuing care during the transition period to the physician and  
28    surgeon.

29    (8) The specific arrangements for examination by a physician  
30    and surgeon with privileges in obstetrics or gynecology for  
31    examination. The licensee shall not be required to identify a  
32    specific physician and surgeon.

33    (9) The specific arrangements for the transfer of care during  
34    the prenatal period, hospital transfer during the intrapartum and  
35    postpartum periods, and access to appropriate emergency medical  
36    services for patient or client and newborn, if necessary, and  
37    recommendations for preregistration at a hospital that has obstetric  
38    emergency services and is most likely to receive the transfer.



1     (10) If, during the course of care, the patient or client has or  
2     may have a condition indicating the need for a transfer to a  
3     hospital, that the licensee shall initiate the transfer.

4     (11) The availability of the text of laws regulating out-of-hospital  
5     childbirth and the procedure for reporting complaints to the  
6     appropriate licensing entity.

7     (12) Consultation by a licensee with a consulting physician and  
8     surgeon does not alone create a physician-patient relationship or  
9     any other relationship with the consulting physician and surgeon.  
10    The licensee shall inform the patient or client that he or she is an  
11    independent healing arts licensee and is solely responsible for the  
12    services he or she provides.

13    (b) The disclosure and consent form shall be signed by both the  
14    licensee and patient or client and a copy of the signed disclosure  
15    and consent form shall be placed in the patient or client's medical  
16    record.

17    (c) (1) The licensee shall provide the patient or client with the  
18    most recent versions of the following documents:

19    (A) The American College of Nurse-Midwives Clinical Bulletin  
20    entitled "Midwifery Provision of Home Birth Services."

21    (B) The American College of Obstetricians and Gynecologists  
22    on Obstetric Practice Committee Opinion #669: Planned Home  
23    Birth.

24    (C) Society of Maternal Fetal Medicine and the American  
25    College of Obstetricians and Gynecologists document entitled  
26    "Obstetrics Care Consensus: Levels of Maternal Care."

27    (2) The Medical Board of California and the Board of Registered  
28    Nursing shall make the most recent version of the documents  
29    specified in paragraph (1) publicly available on their Internet Web  
30    sites.

31    880.4. (a) If a patient or client is transferred to a hospital, the  
32    licensee shall provide records, including prenatal records, and  
33    speak with the receiving physician and surgeon about the labor  
34    up to the point of the transfer. The failure to comply with this  
35    section shall constitute unprofessional conduct. Notwithstanding  
36    any other law, a violation of this section shall not be a crime.

37    (b) The hospital shall report, in writing on a form developed  
38    by the Office of Statewide Health Planning and Development,  
39    within 30 days, each transfer of a patient who attempted a planned

1 *out-of-hospital childbirth to the Office of Statewide Health*  
2 *Planning and Development. The standardized form shall include:*

3 *(1) Name and license number of the licensed physician and*  
4 *surgeon, certified nurse-midwife, or licensed midwife who attended*  
5 *the patient's planned out-of-hospital childbirth or out-of-hospital*  
6 *childbirth attempt.*

7 *(2) Name and license number of the accepting or admitting*  
8 *physician and surgeon or certified nurse midwife who assumed*  
9 *care of the patient.*

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

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

13 *(5) Date of report.*

14 *(6) Whether the person or persons admitted was pregnant, the*  
15 *delivered mother, or newborn newborns.*

16 *(7) Whether there was a verbal handoff or if any prenatal*  
17 *records were obtained from the out-of-hospital childbirth attendant.*

18 *(8) Gestational age of the fetus or newborn in weeks and method*  
19 *of determination.*

20 *(9) Events triggering transfer including, but not limited to, pain*  
21 *management, excessive bleeding, fetal intolerance of labor,*  
22 *prolonged or nonprogressive labor with time in labor, maternal*  
23 *request for transfer, or the clinical judgment of the out-of-birth*  
24 *childbirth attendant.*

25 *(10) Presence of significant history and risk factors including,*  
26 *but not limited to, preterm less than 37<sup>0</sup>/<sub>7</sub>, postterm greater than*  
27 *42<sup>0</sup>/<sub>7</sub>, prior uterine or abdominal surgery including prior cesarean*  
28 *section, Group B strep, multiple births, IUGR, IUFD,*  
29 *chorioamnionitis, bleeding, noncephalic presentation, gestational*  
30 *diabetes, morbid obesity (BMI >40), or preeclampsia.*

31 *(11) Method of delivery.*

32 *(12) Whether a caesarian section was performed.*

33 *(13) Place of delivery.*

34 *(14) FHR tracing on admission.*

35 *(15) Fetal presentation on admission.*

36 *(16) APGAR score of the newborn.*

37 *(17) Cord gases.*

38 *(18) Whether the newborn suffered any complications and was*  
39 *placed in the NICU.*

1     (19) Whether the mother suffered any complications and was  
2     placed in the ICU.

3     (20) Duration of hospital stay for the mother and the newborn  
4     and newborns as of the date of the report and final disposition or  
5     status, if not released from the hospital, of the mother and newborn  
6     or newborns.

7     (c) The form described in subdivision (b) shall be constructed  
8     in a format to enable the hospital to transmit the information in  
9     paragraphs (4) to (20), inclusive, to the Office of Statewide Health  
10    Planning and Development in a manner that the licensees and the  
11    patient are anonymous and their identifying information is not  
12    transmitted to the office. The entire form containing information  
13    described in paragraphs (1) to (20), inclusive, of subdivision (b)  
14    shall be placed in the patient's medical record.

15    (d) The Office of Statewide Health Planning and Development  
16    may revise the reporting requirements for consistency with national  
17    and standards, as applicable.

18    880.6. (a) Each licensee caring for a patient or client planning  
19    an out-of-hospital birth shall submit, within 30 days of initial  
20    acceptance of a patient or client, a form indicating the initiation  
21    of care to the Office of Statewide Health Planning and  
22    Development. The office shall develop a standardized form.

23    (b) Each licensee who attends an out-of-hospital childbirth,  
24    including supervising a student midwife, shall annually report to  
25    the Office of Statewide Health Planning and Development. The  
26    report shall be submitted no later than March 30, for the prior  
27    calendar year, in a form specified by the office and shall contain  
28    all of the following:

29    (1) The licensee's name and license number.

30    (2) The calendar year being reported.

31    (3) The following information with regard to cases in California  
32    in which the licensee, or the student midwife supervised by a  
33    licensee, attended or assisted during the previous year when the  
34    intended place of birth at the onset of care was an out-of-hospital  
35    setting:

36    (A) The total number of patients or clients served as primary  
37    caregiver at the onset of prenatal care.

38    (B) The number by county of live births attended as primary  
39    caregiver.

1     (C) *The number, by county, of cases of fetal demise, infant*  
2 *deaths, and maternal deaths attended as primary caregiver at the*  
3 *discovery of the demise or death.*

4     (D) *The number of patients or clients whose primary care was*  
5 *transferred to another health care practitioner during the*  
6 *antepartum period, and the reason for each transfer.*

7     (E) *The number, reason, and outcome for each elective hospital*  
8 *transfer during the intrapartum or postpartum period.*

9     (F) *The number, reason, and outcome for each urgent or*  
10 *emergency transport of an expectant mother in the antepartum*  
11 *period.*

12     (G) *The number, reason, and outcome for each urgent or*  
13 *emergency transport of an infant or mother during the intrapartum*  
14 *or immediate postpartum period.*

15     (H) *The number of planned out-of-hospital births at the onset*  
16 *of labor and the number of births completed in an out-of-hospital*  
17 *setting.*

18     (I) *The number of planned out-of-hospital births completed in*  
19 *an out-of-hospital setting that were any of the following:*

20         (i) *Twin births.*

21         (ii) *Multiple births other than twin births.*

22         (iii) *Presentations other than cephalic.*

23         (iv) *Vaginal births after cesarean section (VBAC).*

24     (J) *A brief description of any complications resulting in the*  
25 *morbidity or mortality of a mother or a neonate.*

26     (K) *Any other information prescribed by the Office of Statewide*  
27 *Health Planning and Development in regulations.*

28     (c) *The Office of Statewide Health Planning and Development*  
29 *shall maintain the confidentiality of the information submitted*  
30 *pursuant to this section, and shall not permit any law enforcement*  
31 *or regulatory agency to inspect or have copies made of the contents*  
32 *of any reports submitted pursuant to subdivisions (a) and (b) for*  
33 *any purpose, including, but not limited to, investigations for*  
34 *licensing, certification, or any other regulatory purposes.*

35     (d) *The Office of Statewide Health Planning and Development*  
36 *shall report to the appropriate board, by April 30, those licensees*  
37 *who have met the requirements of this section for that year.*

38     (e) *The Office of Statewide Health Planning and Development*  
39 *shall report the aggregate information collected pursuant to this*  
40 *section to the appropriate board by July 30 of each year. The*

1 *Medical Board of California and the Board of Registered Nursing*  
2 *shall include this information in its annual report to the*  
3 *Legislature.*

4 *(f) The Office of Statewide Health Planning and Development,*  
5 *with input from the appropriate licensing boards, may adjust the*  
6 *data elements required to be reported to better coordinate with*  
7 *other reporting systems, including the reporting system of the*  
8 *Midwives Alliance of North America (MANA), while maintaining*  
9 *the data elements unique to California. To better capture data*  
10 *needed for the report required by this section, the concurrent use*  
11 *of systems, including MANA's, by licensed midwives is encouraged.*

12 *(g) A failure to report under this section shall constitute*  
13 *unprofessional conduct. Notwithstanding any other law, a violation*  
14 *of this section shall not be a crime.*

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

17 2507. (a) ~~The~~ *Notwithstanding any other law, the license to*  
18 *practice midwifery authorizes the holder to attend cases of normal*  
19 *pregnancy and childbirth, as defined in paragraph (1) of subdivision*  
20 *(b), out-of-hospital childbirth pursuant to Article 17 (commencing*  
21 *with Section 880), and to provide prenatal, intrapartum, and*  
22 *postpartum care, including family planning care, for the mother,*  
23 *care related to the out-of-hospital childbirth for the client and*  
24 *immediate care for the newborn.*

25 (b) *As used in this article, the practice of midwifery constitutes*  
26 *the furthering or undertaking by any licensed midwife to assist a*  
27 *woman in childbirth as long as progress meets criteria accepted*  
28 *as normal: client in an out-of-hospital childbirth pursuant to*  
29 *pursuant to Article 17 (commencing with Section 880).*

30 ~~(1) Except as provided in paragraph (2), a licensed midwife~~  
31 ~~shall only assist a woman in normal pregnancy and childbirth,~~  
32 ~~which is defined as meeting all of the following conditions:~~

33 ~~(A) There is an absence of both of the following:~~

34 ~~(i) Any preexisting maternal disease or condition likely to affect~~  
35 ~~the pregnancy.~~

36 ~~(ii) Significant disease arising from the pregnancy.~~

37 ~~(B) There is a singleton fetus.~~

38 ~~(C) There is a cephalic presentation.~~

39 ~~(D) The gestational age of the fetus is greater than 37  $\frac{0}{7}$  weeks~~  
40 ~~and less than 42  $\frac{0}{7}$  completed weeks of pregnancy.~~

1 ~~(E) Labor is spontaneous or induced in an outpatient setting.~~

2 ~~(2) If a potential midwife client meets the conditions specified~~  
3 ~~in subparagraphs (B) to (E), inclusive, of paragraph (1), but fails~~  
4 ~~to meet the conditions specified in subparagraph (A) of paragraph~~  
5 ~~(1), and the woman still desires to be a client of the licensed~~  
6 ~~midwife, the licensed midwife shall provide the woman with a~~  
7 ~~referral for an examination by a physician and surgeon trained in~~  
8 ~~obstetrics and gynecology. A licensed midwife may assist the~~  
9 ~~woman in pregnancy and childbirth only if an examination by a~~  
10 ~~physician and surgeon trained in obstetrics and gynecology is~~  
11 ~~obtained and the physician and surgeon who examined the woman~~  
12 ~~determines that the risk factors presented by her disease or~~  
13 ~~condition are not likely to significantly affect the course of~~  
14 ~~pregnancy and childbirth.~~

15 ~~(3) The board shall adopt regulations pursuant to the~~  
16 ~~Administrative Procedure Act (Chapter 3.5 (commencing with~~  
17 ~~Section 11340) of Part of 1 of Division 3 of Title 2 of the~~  
18 ~~Government Code) specifying the conditions described in~~  
19 ~~subparagraph (A) of paragraph (1).~~

20 ~~(c) (1) If at any point during pregnancy, childbirth, or~~  
21 ~~postpartum care a client's condition deviates from normal, the~~  
22 ~~licensed midwife shall immediately refer or transfer the client to~~  
23 ~~a physician and surgeon: care, there is any evidence of a disease~~  
24 ~~or condition that could adversely affect the pregnancy and~~  
25 ~~childbirth arise, the client shall obtain a medical examination by~~  
26 ~~a licensed physician and surgeon with privileges to practice~~  
27 ~~obstetrics or gynecology pursuant to paragraph (b) of Section 880,~~  
28 ~~or the licensed midwife shall initiate appropriate interventions,~~  
29 ~~including immediate transfer, first-responder emergency care, or~~  
30 ~~emergency transport. The licensed midwife may consult and~~  
31 ~~remain in consultation with the physician and surgeon after the~~  
32 ~~referral or transfer.~~

33 ~~(2) If a physician and surgeon determines that the client's~~  
34 ~~condition or concern has been resolved such that the risk factors~~  
35 ~~presented by a woman's disease or condition are not likely to~~  
36 ~~significantly affect the course of pregnancy or childbirth, client is~~  
37 ~~not at an increased risk due to a disease or condition, that could~~  
38 ~~adversely affect the pregnancy and childbirth, the licensed midwife~~  
39 ~~may resume primary care of the client and resume assisting the~~  
40 ~~client during her the pregnancy, childbirth, or postpartum care.~~

(3) If a physician and surgeon determines the client's condition or concern has not been resolved as specified in paragraph ~~(2)~~; (2) *and is at an increased risk due to a disease or condition, that could adversely affect the pregnancy and childbirth*, the licensed midwife may provide concurrent care with a physician and surgeon and, if authorized by the client, be present during the labor and childbirth, and resume postpartum care, if appropriate. A licensed midwife shall ~~not resume primary care of the client. attend an out-of-hospital childbirth of the client.~~

(d) A licensed midwife shall not provide or continue to provide midwifery care to a ~~woman with a risk factor that will significantly affect the course of client~~ *if a licensed physician and surgeon with privileges to practice obstetrics or gynecology determines, at the time of the examination, that the client is at an increased risk due to a disease or condition, that could adversely affect the pregnancy and childbirth as described in Article 17 (commencing with Section 880) pregnancy and childbirth, regardless of whether the woman client* has consented to this care or refused care by a physician or surgeon, except as provided in paragraph (3) of subdivision (c).

(e) The practice of midwifery does not include the assisting of childbirth by any artificial, forcible, or mechanical means, nor the performance of any version of these means.

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

(f) *A licensed midwife may administer, order, or use any of the following:*

- (1) *Postpartum antihemorrhagic drugs.*
- (2) *Prophylactic ophthalmic antibiotics.*
- (3) *Vitamin K.*
- (4) *RhoGAM.*
- (5) *Local anesthetic medications.*
- (6) *Intravenous fluids limited to lactated ringers, 5 percent dextrose with lactated ringers, and heparin and 0.9 percent sodium chloride for use in intravenous locks.*
- (7) *Epinephrine for use in maternal anaphylaxis pending emergency transport.*
- (8) *HBIG and GBV for neonates born to hepatitis B mothers, per current Centers for Disease Control guidelines.*

1 (9) Antibiotics for intrapartum prophylaxis of Group B  
2 Betahemolytic Streptococcus (GBBS), per current Centers For  
3 Disease Control guidelines.

4 (10) Equipment incidental to the practice of out-of-hospital  
5 childbirth, specifically, dopplers, syringes, needles, phlebotomy  
6 equipment, suture, urinary catheters, intravenous equipment,  
7 amnihooks, airway suction devices, neonatal and adult  
8 resuscitation equipment, glucometer, and centrifuge.

9 (11) Equipment incidental to maternal care, specifically,  
10 compression stockings, maternity belts, breast pumps, diaphragms,  
11 and cervical caps.

12 (g) This article does not authorize a midwife to practice medicine  
13 or to perform surgery.

14 SEC. 3. Section 2508 of the Business and Professions Code is  
15 repealed.

16 2508. (a) ~~A licensed midwife shall disclose in oral and written~~  
17 ~~form to a prospective client as part of a client care plan, and obtain~~  
18 ~~informed consent for, all of the following:~~

19 ~~(1) All of the provisions of Section 2507.~~

20 ~~(2) The client is retaining a licensed midwife, not a certified~~  
21 ~~nurse-midwife, and the licensed midwife is not supervised by a~~  
22 ~~physician and surgeon.~~

23 ~~(3) The licensed midwife's current licensure status and license~~  
24 ~~number.~~

25 ~~(4) The practice settings in which the licensed midwife practices.~~

26 ~~(5) If the licensed midwife does not have liability coverage for~~  
27 ~~the practice of midwifery, he or she shall disclose that fact. The~~  
28 ~~licensed midwife shall disclose to the client that many physicians~~  
29 ~~and surgeons do not have liability insurance coverage for services~~  
30 ~~provided to someone having a planned out-of-hospital birth.~~

31 ~~(6) The acknowledgment that if the client is advised to consult~~  
32 ~~with a physician and surgeon, failure to do so may affect the~~  
33 ~~client's legal rights in any professional negligence actions against~~  
34 ~~a physician and surgeon, licensed health care professional, or~~  
35 ~~hospital.~~

36 ~~(7) There are conditions that are outside of the scope of practice~~  
37 ~~of a licensed midwife that will result in a referral for a consultation~~  
38 ~~from, or transfer of care to, a physician and surgeon.~~



1     ~~(8) The specific arrangements for the referral of complications~~  
2 ~~to a physician and surgeon for consultation. The licensed midwife~~  
3 ~~shall not be required to identify a specific physician and surgeon.~~

4     ~~(9) The specific arrangements for the transfer of care during the~~  
5 ~~prenatal period, hospital transfer during the intrapartum and~~  
6 ~~postpartum periods, and access to appropriate emergency medical~~  
7 ~~services for mother and baby if necessary, and recommendations~~  
8 ~~for preregistration at a hospital that has obstetric emergency~~  
9 ~~services and is most likely to receive the transfer.~~

10    ~~(10) If, during the course of care, the client is informed that she~~  
11 ~~has or may have a condition indicating the need for a mandatory~~  
12 ~~transfer, the licensed midwife shall initiate the transfer.~~

13    ~~(11) The availability of the text of laws regulating licensed~~  
14 ~~midwifery practices and the procedure for reporting complaints to~~  
15 ~~the Medical Board of California, which may be found on the~~  
16 ~~Medical Board of California's Internet Web site.~~

17    ~~(12) Consultation with a physician and surgeon does not alone~~  
18 ~~create a physician-patient relationship or any other relationship~~  
19 ~~with the physician and surgeon. The informed consent shall~~  
20 ~~specifically state that the licensed midwife and the consulting~~  
21 ~~physician and surgeon are not employees, partners, associates,~~  
22 ~~agents, or principals of one another. The licensed midwife shall~~  
23 ~~inform the patient that he or she is independently licensed and~~  
24 ~~practicing midwifery and in that regard is solely responsible for~~  
25 ~~the services he or she provides.~~

26    ~~(b) The disclosure and consent shall be signed by both the~~  
27 ~~licensed midwife and the client and a copy of the disclosure and~~  
28 ~~consent shall be placed in the client's medical record.~~

29    ~~(c) The Medical Board of California may prescribe the form for~~  
30 ~~the written disclosure and informed consent statement required to~~  
31 ~~be used by a licensed midwife under this section.~~

32    ~~SEC. 4. Section 2510 of the Business and Professions Code is~~  
33 ~~repealed.~~

34    ~~2510. If a client is transferred to a hospital, the licensed~~  
35 ~~midwife shall provide records, including prenatal records, and~~  
36 ~~speak with the receiving physician and surgeon about labor up to~~  
37 ~~the point of the transfer. The hospital shall report each transfer of~~  
38 ~~a planned out-of-hospital birth to the Medical Board of California~~  
39 ~~and the California Maternal Quality Care Collaborative using a~~  
40 ~~standardized form developed by the board.~~

1     *SEC. 5. Section 2516 of the Business and Professions Code is*  
2     *repealed.*

3     ~~2516. (a) Each licensed midwife who assists, or supervises a~~  
4     ~~student midwife in assisting, in childbirth that occurs in an~~  
5     ~~out-of-hospital setting shall annually report to the Office of~~  
6     ~~Statewide Health Planning and Development. The report shall be~~  
7     ~~submitted no later than March 30, for the prior calendar year, in a~~  
8     ~~form specified by the board and shall contain all of the following:~~

9     ~~(1) The midwife's name and license number.~~

10    ~~(2) The calendar year being reported.~~

11    ~~(3) The following information with regard to cases in California~~  
12    ~~in which the midwife, or the student midwife supervised by the~~  
13    ~~midwife, assisted during the previous year when the intended place~~  
14    ~~of birth at the onset of care was an out-of-hospital setting:~~

15    ~~(A) The total number of clients served as primary caregiver at~~  
16    ~~the onset of care.~~

17    ~~(B) The number by county of live births attended as primary~~  
18    ~~caregiver.~~

19    ~~(C) The number, by county, of cases of fetal demise, infant~~  
20    ~~deaths, and maternal deaths attended as primary caregiver at the~~  
21    ~~discovery of the demise or death.~~

22    ~~(D) The number of women whose primary care was transferred~~  
23    ~~to another health care practitioner during the antepartum period,~~  
24    ~~and the reason for each transfer.~~

25    ~~(E) The number, reason, and outcome for each elective hospital~~  
26    ~~transfer during the intrapartum or postpartum period.~~

27    ~~(F) The number, reason, and outcome for each urgent or~~  
28    ~~emergency transport of an expectant mother in the antepartum~~  
29    ~~period.~~

30    ~~(G) The number, reason, and outcome for each urgent or~~  
31    ~~emergency transport of an infant or mother during the intrapartum~~  
32    ~~or immediate postpartum period.~~

33    ~~(H) The number of planned out-of-hospital births at the onset~~  
34    ~~of labor and the number of births completed in an out-of-hospital~~  
35    ~~setting.~~

36    ~~(I) The number of planned out-of-hospital births completed in~~  
37    ~~an out-of-hospital setting that were any of the following:~~

38    ~~(i) Twin births.~~

39    ~~(ii) Multiple births other than twin births.~~

40    ~~(iii) Breech births.~~

1     ~~(iv) Vaginal births after the performance of a cesarean section.~~  
2     ~~(J) A brief description of any complications resulting in the~~  
3     ~~morbidity or mortality of a mother or a neonate.~~

4     ~~(K) Any other information prescribed by the board in~~  
5     ~~regulations.~~

6     ~~(b) The Office of Statewide Health Planning and Development~~  
7     ~~shall maintain the confidentiality of the information submitted~~  
8     ~~pursuant to this section, and shall not permit any law enforcement~~  
9     ~~or regulatory agency to inspect or have copies made of the contents~~  
10    ~~of any reports submitted pursuant to subdivision (a) for any~~  
11    ~~purpose, including, but not limited to, investigations for licensing,~~  
12    ~~certification, or regulatory purposes.~~

13    ~~(c) The office shall report to the board, by April 30, those~~  
14    ~~licensees who have met the requirements of subdivision (a) for~~  
15    ~~that year.~~

16    ~~(d) The board shall send a written notice of noncompliance to~~  
17    ~~each licensee who fails to meet the reporting requirement of~~  
18    ~~subdivision (a). Failure to comply with subdivision (a) will result~~  
19    ~~in the midwife being unable to renew his or her license without~~  
20    ~~first submitting the requisite data to the Office of Statewide Health~~  
21    ~~Planning and Development for the year for which that data was~~  
22    ~~missing or incomplete. The board shall not take any other action~~  
23    ~~against the licensee for failure to comply with subdivision (a).~~

24    ~~(e) The board, in consultation with the office and the Midwifery~~  
25    ~~Advisory Council, shall devise a coding system related to data~~  
26    ~~elements that require coding in order to assist in both effective~~  
27    ~~reporting and the aggregation of data pursuant to subdivision (f).~~  
28    ~~The office shall utilize this coding system in its processing of~~  
29    ~~information collected for purposes of subdivision (f).~~

30    ~~(f) The office shall report the aggregate information collected~~  
31    ~~pursuant to this section to the board by July 30 of each year. The~~  
32    ~~board shall include this information in its annual report to the~~  
33    ~~Legislature.~~

34    ~~(g) The board, with input from the Midwifery Advisory Council,~~  
35    ~~may adjust the data elements required to be reported to better~~  
36    ~~coordinate with other reporting systems, including the reporting~~  
37    ~~system of the Midwives Alliance of North America (MANA);~~  
38    ~~while maintaining the data elements unique to California. To better~~  
39    ~~capture data needed for the report required by this section, the~~

1 concurrent use of systems, including MANA's, by licensed  
2 midwives is encouraged.

3 ~~(h) Notwithstanding any other law, a violation of this section~~  
4 ~~shall not be a crime.~~

5 SEC. 6. Section 2746.54 is added to the Business and  
6 Professions Code, to read:

7 2746.54. (a) Notwithstanding Section 2746.5 or any other law,  
8 a certified nurse-midwife may attend cases of out-of-hospital  
9 childbirth pursuant to Article 17 (commencing with Section 880),  
10 and to provide prenatal, intrapartum, and postpartum care, related  
11 to the out-of-hospital childbirth, for the client and immediate care  
12 for the newborn without physician and surgeon supervision.

13 (b) (1) If at any point during pregnancy, childbirth, or  
14 postpartum care there is any evidence of a disease or condition  
15 that could adversely affect the pregnancy and childbirth arise, the  
16 client shall obtain a medical examination by a licensed physician  
17 and surgeon with privileges to practice obstetrics or gynecology  
18 as described in Article 17 (commencing with Section 880), or the  
19 certified nurse midwife shall initiate appropriate interventions,  
20 including immediate transfer, first-responder emergency care, or  
21 emergency transport. The certified nurse-midwife may consult and  
22 remain in consultation with the physician and surgeon after the  
23 referral or transfer.

24 (2) If a physician and surgeon determines that the client's  
25 condition or concern has been resolved such that the risk factors  
26 presented by a client's disease or condition does not adversely  
27 affect the pregnancy or childbirth, the certified nurse midwife may  
28 resume care of the client and resume assisting the client during  
29 the pregnancy, out-of-hospital childbirth, or postpartum care.

30 (3) If a physician and surgeon determines the client's condition  
31 or concern has not been resolved as specified in paragraph (2),  
32 and is at an increased risk due to a disease or condition, that could  
33 adversely affect the pregnancy and childbirth, the certified  
34 nurse-midwife may provide concurrent care with a physician and  
35 surgeon and, if authorized by the client, be present during the  
36 labor and childbirth, and resume postpartum care, if appropriate.  
37 Notwithstanding any other law, under the circumstances described  
38 in this paragraph, a certified nurse-midwife shall not attend an  
39 out-of-hospital birth of the client unless under the supervision of  
40 a physician and surgeon pursuant to Section 2746.5.

1 (c) A certified nurse-midwife shall not provide or continue to  
2 provide care to a client if a licensed physician and surgeon with  
3 privileges to practice obstetrics or gynecology determines, at the  
4 time of the examination, that there is an increased risk to the client  
5 because of a disease or condition that could adversely affect the  
6 pregnancy and childbirth, as described in Article 17 (commencing  
7 with Section 880), regardless of whether the client has consented  
8 to this care or refused care by a physician or surgeon, except as  
9 provided in paragraph (3) of subdivision (b).

10 (d) This section does not include the assisting of childbirth by  
11 any artificial, forcible, or mechanical means, nor the performance  
12 of any version of these means.

13 (e) For purposes of attending an out-of-hospital childbirth  
14 pursuant to this section, and notwithstanding Section 2746.51, a  
15 certified nurse-midwife may administer, order, or use any of the  
16 following:

17 (1) Postpartum antihemorrhagic drugs.

18 (2) Prophylactic ophthalmic antibiotics.

19 (3) Vitamin K.

20 (4) RhoGAM.

21 (5) Local anesthetic medications.

22 (6) Intravenous fluids limited to lactated ringers, 5 percent  
23 dextrose with lactated ringers, and heparin and 0.9 percent sodium  
24 chloride for use in intravenous locks.

25 (7) Epinephrine for use in maternal anaphylaxis pending  
26 emergency transport.

27 (8) HBIG and GBV for neonates born to hepatitis B mothers,  
28 per current Centers for Disease Control guidelines.

29 (9) Antibiotics for intrapartum prophylaxis of Group B  
30 Betahemolytic Streptococcus (GBBS), per current Centers For  
31 Disease Control guidelines.

32 (10) Equipment incidental to the practice of out-of-hospital  
33 childbirth, specifically, dopplers, syringes, needles, phlebotomy  
34 equipment, suture, urinary catheters, intravenous equipment,  
35 amnihooks, airway suction devices, neonatal and adult  
36 resuscitation equipment, glucometer, and centrifuge.

37 (11) Equipment incidental to maternal care, specifically,  
38 compression stockings, maternity belts, breast pumps, diaphragms,  
39 and cervical caps.

1     (f) *This section does not authorize a nurse midwife to practice*  
2     *medicine or to perform surgery.*

3     SEC. 7. *Section 1204.3 of the Health and Safety Code is*  
4     *amended to read:*

5     1204.3. (a) An alternative birth center that is licensed as an  
6     alternative birth center specialty clinic pursuant to paragraph (4)  
7     of subdivision (b) of Section 1204 shall, as a condition of licensure,  
8     and a primary care clinic licensed pursuant to subdivision (a) of  
9     Section 1204 that provides services as an alternative birth center  
10    shall, meet all of the following requirements:

11    (1) Be a provider of comprehensive perinatal services as defined  
12    in Section 14134.5 of the Welfare and Institutions Code.

13    (2) Maintain a quality assurance program.

14    (3) Meet the standards for certification established by the  
15    American Association of Birth Centers, or at least equivalent  
16    standards as determined by the state department.

17    (4) In addition to standards of the American Association of Birth  
18    Centers regarding proximity to hospitals and presence of attendants  
19    at births, meet both of the following conditions:

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

25    (B) Require the presence of at least two attendants at all times  
26    during birth, one of whom shall be a physician and surgeon, a  
27    licensed midwife, or a certified nurse-midwife. *If no licensed*  
28    *physician and surgeon is present, the client shall be informed*  
29    *orally and in writing that no licensed physician and surgeon is*  
30    *present.*

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

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

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

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

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

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

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

22 *SEC. 8. The Legislature finds and declares that Section 1 of*  
23 *this act, which adds Section 880.6 to the Business and Professions*  
24 *Code, imposes a limitation on the public's right of access to the*  
25 *meetings of public bodies or the writings of public officials and*  
26 *agencies within the meaning of Section 3 of Article I of the*  
27 *California Constitution. Pursuant to that constitutional provision,*  
28 *the Legislature makes the following findings to demonstrate the*  
29 *interest protected by this limitation and the need for protecting*  
30 *that interest:*

31 *In order to allow the Office of Statewide Health Planning and*  
32 *Development to fully accomplish its goals, it is imperative to*  
33 *protect the interests of those persons submitting information to*  
34 *the office to ensure that any personal or sensitive information that*  
35 *this act requires those persons to submit is protected as confidential*  
36 *information.*

37 *SEC. 9. No reimbursement is required by this act pursuant to*  
38 *Section 6 of Article XIII B of the California Constitution because*  
39 *the only costs that may be incurred by a local agency or school*  
40 *district will be incurred because this act creates a new crime or*

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

6 ~~SECTION 1. Section 1248 of the Health and Safety Code is~~  
7 ~~amended to read:~~

8 ~~1248. For purposes of this chapter, the following definitions~~  
9 ~~shall apply:~~

10 ~~(a) “Division” means the Medical Board of California. All~~  
11 ~~references in this chapter to the division, the Division of Licensing~~  
12 ~~of the Medical Board of California, or the Division of Medical~~  
13 ~~Quality shall be deemed to refer to the Medical Board of California~~  
14 ~~pursuant to Section 2002 of the Business and Professions Code.~~

15 ~~(b) (1) “Outpatient setting” means a facility, clinic, unlicensed~~  
16 ~~clinic, center, office, or other setting that is not part of a general~~  
17 ~~acute care facility, as defined in Section 1250, that uses anesthesia,~~  
18 ~~except local anesthesia or peripheral nerve blocks, or both, in~~  
19 ~~compliance with the community standard of practice, in doses that,~~  
20 ~~when administered, have the probability of placing a patient at risk~~  
21 ~~for loss of the patient’s life-preserving protective reflexes.~~

22 ~~(2) “Outpatient setting” also means a facility that offers in vitro~~  
23 ~~fertilization, as defined in subdivision (b) of Section 1374.55.~~

24 ~~(3) “Outpatient setting” does not include, among other settings,~~  
25 ~~a setting where anxiolytics and analgesics are administered, when~~  
26 ~~done so in compliance with the community standard of practice,~~  
27 ~~in doses that do not have the probability of placing the patient at~~  
28 ~~risk for loss of the patient’s life-preserving protective reflexes.~~

29 ~~(c) “Accreditation agency” means a public or private~~  
30 ~~organization that is approved to issue certificates of accreditation~~  
31 ~~to outpatient settings by the board pursuant to Sections 1248.15~~  
32 ~~and 1248.4.~~



MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 554  
**Author:** Stone  
**Bill Date:** April 17, 2017, Amended  
**Subject:** Nurse Practitioners: Physician Assistants: Buprenorphine  
**Sponsor:** Author

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would allow nurse practitioners (NPs) and physician assistants (PAs) to administer or provide buprenorphine to a patient when done in compliance with the provisions of the federal Comprehensive Addiction Recovery Act (CARA), as enacted on July 22, 2016.

**BACKGROUND:**

In 2010, approximately 38,329 unintentional drug overdose deaths occurred in the United States, one death every 14 minutes. Of this number, 22,134 of these deaths were attributed to prescription drugs (16,651 or 75.2% attributed to opioid overdoses). Prescription drug abuse is the fastest growing drug problem in the United States.

According to the California Department of Public Health (CDPH), 2,024 deaths related to pharmaceutical opioids occurred in California in 2014; 4,106 non-fatal ED visits related to all opioids in the same timeframe; 4,482 opioid related hospitalizations in the same timeframe; and 619 opioids were prescribed per 1,000 residents in 2015.

According to the Centers for Disease Control, every day, 44 people in the U.S. die from overdose of prescription painkillers and many more become addicted.

Buprenorphine was approved by the Food and Drug Administration in 2002 for the treatment (alone or in combination with naloxone) of opioid dependence. The efficacy of buprenorphine in the treatment of opioid dependence has consistently been demonstrated, and its use has been associated with new types of patients receiving addiction treatment. Similar to other opioids, buprenorphine produces euphoria and respiratory depression in a dose-dependent manner. However, unique to buprenorphine, these effects increase until, at moderate doses, the effects reach a plateau and no longer continue to increase, making respiratory depression less likely in a habituated opioid user.

**ANALYSIS**

This bill would specify that an NP is not prohibited from furnishing or ordering buprenorphine when done in compliance with the provisions of CARA, as enacted on July 22, 2016. This bill would also specify that a PA is not prohibited from administering or providing buprenorphine to a patient, or transmitting orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully

furnish buprenorphine, when done in compliance with the provisions of CARA. Both NPs and PAs must comply with the following CARA requirements:

- The requirement that the NP or PA complete not fewer than 24 hours of initial training provided by the American Society of Addiction Medicine, the American Academy of Addiction Psychiatry, the American Medical Association, the American Osteopathic Association, the American Nurses Credentialing Center, the American Psychiatric Association, the American Association of Nurse Practitioners, the American Academy of Physician Assistants, or any other organization that addresses the following:
  - Opioid maintenance and detoxification.
  - Appropriate clinical use of all drugs approved by the Food and Drug Administration for the treatment of opioid use disorder.
  - Initial and periodic patient assessments, including substance use monitoring.
  - Individualized treatment planning, overdose reversal, and relapse prevention.
  - Counseling and recovery support services.
  - Staffing roles and considerations.
  - Diversion control.
  - Other best practices, as identified by the United States Secretary of Health and Human Services.
- The requirement that the NP or PA have other training or experience that the United States Secretary of Health and Human Services determines will demonstrate the ability of the NP or PA to treat and manage opiate-dependent patients.
- The requirement that the NP or PA be supervised by, or work in collaboration with, a licensed physician and surgeon.

The growing opioid abuse epidemic remains a matter of concern for the Board and it is a priority for the Board to help prevent inappropriate prescribing and misuse and abuse of opioids. This bill would conform California law to federal law enacted in 2016. This bill would allow NPs and PAs to administer or provide buprenorphine, as long as they meet the requirements specified in this bill and in federal law. This would help to ensure expanded access to buprenorphine, which is used to treat opioid addiction. This expansion seems reasonable and is in line with federal law. As such, this bill will help further the Board's mission of consumer protection and Board staff recommends that the Board support this bill.

**FISCAL:**                      None to the Board

**SUPPORT:**                      None on file

**OPPOSITION:**                      None on file

**POSITION:**                      Recommendation: Support

AMENDED IN SENATE APRIL 17, 2017  
AMENDED IN SENATE MARCH 27, 2017

**SENATE BILL**

**No. 554**

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**Introduced by Senator Stone**

February 16, 2017

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An act to add ~~Article 8.5 (commencing with Section 2837.50) to Chapter 6 of Division 2 of Sections 2836.4 and 3502.1.5~~ to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 554, as amended, Stone. Nurse practitioners: ~~independent practice.~~  
*physician assistants: buprenorphine.*

*Existing federal law requires practitioners, as defined, who dispense narcotic drugs to individuals for maintenance treatment or detoxification treatment to obtain annually a separate registration with the United States Attorney General for that purpose. Existing federal law authorizes waiver of the registration requirement for a qualifying practitioner who submits specified information to the United States Secretary of Health and Human Services. Existing federal law, the Comprehensive Addiction Recovery Act of 2016, defines a qualifying practitioner for these purposes to include, among other practitioners, a nurse practitioner or physician assistant who, among other requirements, has completed not fewer than 24 hours of initial training, as specified, and is supervised by, or works in collaboration with, a qualifying physician, if the nurse practitioner or physician assistant is required by state law to prescribe medications for the treatment of opioid use disorder in collaboration with or under the supervision of a physician.*

*Existing state law, the Nursing Practice Act, establishes the Board of Registered Nursing in the Department of Consumer Affairs for the*

*licensure and regulation of nurse practitioners. The act authorizes a nurse practitioner to furnish or order drugs or devices under specified circumstances subject to physician and surgeon supervision.*

*This bill would prohibit construing the Nursing Practice Act or any provision of state law from prohibiting a nurse practitioner from furnishing or ordering buprenorphine when done in compliance with the provisions of the Comprehensive Addiction Recovery Act, as specified.*

*Existing state law, the Physician Assistant Practice Act, establishes the Physician Assistant Board within the jurisdiction of the Medical Board of California for the licensure and regulation of physician assistants. The act authorizes a physician assistant, while under the supervision of a licensed physician authorized to supervise a physician assistant, to administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication, as specified.*

*This bill would prohibit construing the Physician Assistant Practice Act or any provision of state law from prohibiting a physician assistant from administering or providing buprenorphine to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order for buprenorphine to a person who may lawfully furnish buprenorphine when done in compliance with the provisions of the Comprehensive Addiction Recovery Act, as specified.*

~~Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including ordering durable medical equipment in accordance with standardized procedures, certifying disability for purposes of unemployment insurance after physical examination and collaboration with a physician and surgeon, and, for an individual receiving home health services or personal care services, approving, signing, modifying, or adding to a plan of treatment or plan of care after consultation with a physician and surgeon. A violation of these provisions is a crime.~~

~~This bill would authorize a nurse practitioner who holds a certification from a national certifying body, recognized by the board, to be certified by the board as an independent nurse practitioner and to perform certain nursing functions without the supervision of a physician and surgeon, if the independent nurse practitioner meets specified requirements and practices in medically underserved areas or with medically underserved~~

populations, as defined by the federal Health Resources and Services Administration.

The bill would prohibit a person from advertizing or hold himself or herself out as an “independent nurse practitioner” unless the person is certified by the board as an independent nurse practitioner pursuant to this bill. By expanding the scope of an existing crime, this bill would impose a state-mandated local program.

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

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

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

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

- 1     SECTION 1. Section 2836.4 is added to the Business and
- 2     Professions Code, to read:
- 3     2836.4. Neither this chapter nor any other provision of law
- 4     shall be construed to prohibit a nurse practitioner from furnishing
- 5     or ordering buprenorphine when done in compliance with the
- 6     provisions of the Comprehensive Addiction Recovery Act (P.L.
- 7     114-198), as enacted on July 22, 2016, including the following:
- 8     (a) The requirement that the nurse practitioner complete not
- 9     fewer than 24 hours of initial training provided by the American
- 10    Society of Addiction Medicine, the American Academy of Addiction
- 11    Psychiatry, the American Medical Association, the American
- 12    Osteopathic Association, the American Nurses Credentialing
- 13    Center, the American Psychiatric Association, the American
- 14    Association of Nurse Practitioners, the American Academy of
- 15    Physician Assistants, or any other organization that addresses the
- 16    following:
- 17     (1) Opioid maintenance and detoxification.
- 18     (2) Appropriate clinical use of all drugs approved by the Food
- 19     and Drug Administration for the treatment of opioid use disorder.
- 20     (3) Initial and periodic patient assessments, including substance
- 21     use monitoring.
- 22     (4) Individualized treatment planning, overdose reversal, and
- 23     relapse prevention.

1     (5) *Counseling and recovery support services.*

2     (6) *Staffing roles and considerations.*

3     (7) *Diversion control.*

4     (8) *Other best practices, as identified by the United States*  
5 *Secretary of Health and Human Services.*

6     (b) *The requirement that the nurse practitioner have other*  
7 *training or experience that the United States Secretary of Health*  
8 *and Human Services determines will demonstrate the ability of*  
9 *the nurse practitioner to treat and manage opiate-dependent*  
10 *patients.*

11     (c) *The requirement that the nurse practitioner be supervised*  
12 *by, or work in collaboration with, a licensed physician and*  
13 *surgeon.*

14  
15     SEC. 2. *Section 3502.1.5 is added to the Business and*  
16 *Professions Code, to read:*

17     3502.1.5. *Neither this chapter nor any other provision of law*  
18 *shall be construed to prohibit a physician assistant from*  
19 *administering or providing buprenorphine to a patient, or*  
20 *transmitting orally, or in writing on a patient's record or in a drug*  
21 *order, an order to a person who may lawfully furnish*  
22 *buprenorphine when done in compliance with the provisions of*  
23 *the Comprehensive Addiction Recovery Act (P.L. 114-198), as*  
24 *enacted on July 22, 2016, including the following:*

25     (a) *The requirement that the physician assistant complete not*  
26 *fewer than 24 hours of initial training provided by the American*  
27 *Society of Addiction Medicine, the American Academy of Addiction*  
28 *Psychiatry, the American Medical Association, the American*  
29 *Osteopathic Association, the American Nurses Credentialing*  
30 *Center, the American Psychiatric Association, the American*  
31 *Association of Nurse Practitioners, the American Academy of*  
32 *Physician Assistants, or any other organization that addresses the*  
33 *following:*

34     (1) *Opioid maintenance and detoxification.*

35     (2) *Appropriate clinical use of all drugs approved by the Food*  
36 *and Drug Administration for the treatment of opioid use disorder.*

37     (3) *Initial and periodic patient assessments, including substance*  
38 *use monitoring.*

39     (4) *Individualized treatment planning, overdose reversal, and*  
40 *relapse prevention.*

1     (5) *Counseling and recovery support services.*

2     (6) *Staffing roles and considerations.*

3     (7) *Diversion control.*

4     (8) *Other best practices, as identified by the United States*  
5 *Secretary of Health and Human Services.*

6     (b) *The requirement that the physician assistant have other*  
7 *training or experience that the United States Secretary of Health*  
8 *and Human Services determines will demonstrate the ability of*  
9 *the nurse practitioner to treat and manage opiate-dependent*  
10 *patients.*

11     (c) *The requirement that the physician assistant be supervised*  
12 *by, or work in collaboration with, a licensed physician and*  
13 *surgeon.*

14     ~~SECTION 1. Article 8.5 (commencing with Section 2837.50)~~  
15 ~~is added to Chapter 6 of Division 2 of the Business and Professions~~  
16 ~~Code, to read:~~

17  
18             ~~Article 8.5. Independent Nurse Practitioners~~  
19

20     ~~2837.50. (a) The board shall establish the category of~~  
21 ~~independent nurse practitioner and shall establish the qualifications~~  
22 ~~and the scope of independent practice as set forth in this article.~~

23     ~~(b) The qualifications for a certification by the board as an~~  
24 ~~independent nurse practitioner shall include compliance with all~~  
25 ~~of the following:~~

26     ~~(1) Meeting all of the licensing requirements of Article 8~~  
27 ~~(commencing with Section 2834).~~

28     ~~(2) Holding a certificate of independent nurse practitioner issued~~  
29 ~~by a national certifying agency recognized by the board.~~

30     ~~(c) Notwithstanding any law, the board shall specify the scope~~  
31 ~~of practice of an independent nurse practitioner to include all of~~  
32 ~~the following:~~

33     ~~(1) The nursing practice of a nurse practitioner as set forth in~~  
34 ~~Article 8 (commencing with Section 2834) performed under the~~  
35 ~~supervision of a supervising physician and surgeon as set forth in~~  
36 ~~that article.~~

37     ~~(2) Specific aspects of the nursing practice of a nurse practitioner~~  
38 ~~as set forth in Article 8 (commencing with Section 2834),~~  
39 ~~including, but not limited to, standardized procedures, as set forth~~  
40 ~~in Section 2725, that may be independently performed by an~~

1 independent nurse practitioner. Functions identified by the board  
2 pursuant to this paragraph may be performed by an independent  
3 nurse practitioner, certified pursuant to this article, without the  
4 supervision of a physician and surgeon. An independent nurse  
5 practitioner shall be authorized to practice independently pursuant  
6 to this paragraph only in medically underserved areas or with  
7 medically underserved populations, as defined by the federal Health  
8 Resources and Services Administration.

9 (d) No person shall advertise or hold himself or herself out as  
10 an “independent nurse practitioner” unless the person is certified  
11 by the board as an independent nurse practitioner pursuant to this  
12 article.

13 SEC. 2. No reimbursement is required by this act pursuant to  
14 Section 6 of Article XIII B of the California Constitution because  
15 the only costs that may be incurred by a local agency or school  
16 district will be incurred because this act creates a new crime or  
17 infraction, eliminates a crime or infraction, or changes the penalty  
18 for a crime or infraction, within the meaning of Section 17556 of  
19 the Government Code, or changes the definition of a crime within  
20 the meaning of Section 6 of Article XIII B of the California  
21 Constitution.



MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 641  
**Author:** Lara  
**Bill Date:** March 28, 2017, Amended  
**Subject:** CURES: Privacy  
**Sponsor:** California Medical Association

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would specify that the Department of Justice (DOJ) shall only provide data obtained from the Controlled Substance Utilization Review and Evaluation System (CURES) to a federal, state, or local law enforcement agency pursuant to a valid court order or warrant based on probable cause and issued at the request of the law enforcement agency engaged in an open and active investigation regarding prescription drug abuse or diversion of controlled substances involving the individual to whom the requested information pertains.

**BACKGROUND:**

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

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

SB 482 (Lara, Chapter 708) was signed into law in 2016 and requires a health care practitioner that is authorized to prescribe, order, administer or furnish a controlled substance to consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every four months thereafter, if the prescribed controlled substance remains part of the patient's treatment, with specified exceptions. This bill requires a health care practitioner to obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before the medication is prescribed, ordered, administered, furnished or dispensed. If a health care practitioner is exempted

from checking CURES before prescribing a controlled substance for the first time pursuant to this bill, they are required to consult CURES before subsequently prescribing a controlled substance to the patient at least every four months thereafter if the substance remains part of the treatment of the patient. This bill specifies that it is not operative until six months after DOJ certifies that the CURES database is ready for statewide use and that DOJ has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in the Budget Act of 2016. This bill requires DOJ to notify the Secretary of State and the Office of Legislative Counsel of the date of that certification. DOJ has not yet certified that the CURES database is ready for statewide use and the DOJ has adequate staff.

### **ANALYSIS**

This bill would not change the Medical Board of California's (Board) access to CURES, although the original version of this bill would have. Now this bill only affects law enforcement agencies. Although the Department of Consumer Affairs, Health Quality Investigation Unit (HQIU) investigators that perform the Board's investigations are peace officers, they are performing the investigations on behalf of a regulatory board, so this bill would not apply to the Board's administrative investigations. However, there are a small portion of criminal investigations performed by HQIU investigators on behalf of the Board. This bill would impact those investigations, but there are only approximately 20 criminal investigations per year conducted on behalf of the Board.

Board staff believes that a technical amendment may be necessary to ensure that this bill only applies to criminal investigations. According to the sponsor and the author, this is their intent, but it may be helpful to clarify this in case any questions arise if this bill were to be signed into law. As such, Board staff suggests the Board take a neutral position on this bill if a technical amendment is made to clarify that the provision in this bill only applies to criminal investigations.

**FISCAL:** Minimal and absorbable fiscal impact

**SUPPORT:** California Medical Association (Sponsor)

**OPPOSITION:** None on file

**POSITION:** Recommendation: Neutral if Amended

AMENDED IN SENATE MARCH 28, 2017

**SENATE BILL**

**No. 641**

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**Introduced by Senator Lara**

February 17, 2017

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An act to amend ~~Sections~~ *Section* 11165 and 11165.1 of, and to add ~~Section 11165.6 to,~~ *of* the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 641, as amended, Lara. Controlled Substance Utilization Review and Evaluation System: privacy.

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 the operation of CURES to comply with all applicable federal and state privacy and security laws and regulations. Under existing law, data obtained from CURES may 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, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Existing law allows data obtained from CURES to be provided to public or private entities for statistical or research purposes, as approved by the department.

~~This bill would revise and recast the CURES privacy provisions. The bill would specify that, except as specified, information within CURES is confidential, not subject to discovery or admissible in any civil or~~

~~administrative action, and exempt from public inspection, copying, and disclosure pursuant to the California Public Records Act. The bill would specify to whom the information within CURES may be disclosed or released, including, among others, to a health care practitioner providing care to a current patient, to a pharmacist dispensing a controlled substance to a current patient, and, upon a written request, to certain regulatory boards. The bill would require a pharmacy to provide a specific notification about CURES to each patient who is dispensed a Schedule II, Schedule III, or Schedule IV controlled substance.~~

~~Existing law authorizes the department to invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database.~~

~~The bill would instead require the department to appoint a multidisciplinary advisory committee, as specified, to assist, advise, and make recommendations for the establishment of rules and regulations relating to the proper administration and enforcement of the CURES database.~~

~~Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.~~

~~This bill would make legislative findings to that effect.~~

~~*This bill would prohibit the release of data obtained from CURES to a law enforcement agency except pursuant to a valid court order, as specified.*~~

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 11165 of the Health and Safety Code is
- 2 amended to read:
- 3 11165. (a) To assist health care practitioners in their efforts
- 4 to ensure appropriate prescribing, ordering, administering,
- 5 furnishing, and dispensing of controlled substances, law
- 6 enforcement and regulatory agencies in their efforts to control the
- 7 diversion and resultant abuse of Schedule II, Schedule III, and
- 8 Schedule IV controlled substances, and for statistical analysis,

education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations. ~~Information within CURES pertaining to a patient or a patient's representative, health care practitioner, dispenser, an employee of the health care practitioner acting on behalf of and at the direction of the practitioner, a pharmacist, or a pharmacy is confidential and may only be used, accessed, or disclosed pursuant to Section 11165.1.~~

(2) (A) *CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations.*

(B) *The Department of Justice shall only provide data obtained from CURES to a federal, state, or local law enforcement agency pursuant to a valid court order or warrant based on probable cause and issued at the request of a federal, state, or local law*

1 *enforcement agency engaged in an open and active investigation*  
2 *regarding prescription drug abuse or diversion of prescription of*  
3 *controlled substances involving the individual to whom the*  
4 *requested information pertains.*

5 (2)

6 (C) The Department of Justice shall establish policies,  
7 procedures, and regulations regarding the use, access, evaluation,  
8 management, implementation, operation, storage, disclosure, and  
9 security of the information within CURES, consistent with Section  
10 11165.1.

11 ~~(3) Information within CURES is not subject to discovery and~~  
12 ~~is not admissible in any civil or administrative action, except in~~  
13 ~~an investigation and disciplinary proceeding by the appropriate~~  
14 ~~regulatory board responsible for licensure, regulation, or discipline~~  
15 ~~of health care practitioners and pharmacists authorized to prescribe,~~  
16 ~~order, administer, furnish, or dispense controlled substances. A~~  
17 ~~regulatory board whose licensees do not prescribe, order,~~  
18 ~~administer, furnish, or dispense controlled substances shall not be~~  
19 ~~provided data obtained from CURES.~~

20 ~~(4) All information within CURES, including records related~~  
21 ~~to the requests for accessor disclosure, or both, of information and~~  
22 ~~data, is confidential and exempt from public inspection, copying,~~  
23 ~~and disclosure pursuant to the California Public Records~~  
24 ~~Act(Chapter 3.5 (commencing Section 6250) of Division 7 of Title~~  
25 ~~1) of the Government Code.~~

26 (D) *Notwithstanding subparagraph (A), a regulatory board*  
27 *whose licensees do not prescribe, order, administer, furnish, or*  
28 *dispense controlled substances shall not be provided data obtained*  
29 *from CURES.*

30 (3) *In accordance with federal and state privacy laws and*  
31 *regulations, a health care practitioner may provide a patient with*  
32 *a copy of the patient's CURES patient activity report as long as*  
33 *no additional CURES data is provided and keep a copy of the*  
34 *report in the patient's medical record in compliance with*  
35 *subdivision (d) of Section 11165.1.*

36 (d) For each prescription for a Schedule II, Schedule III, or  
37 Schedule IV controlled substance, as defined in the controlled  
38 substances schedules in federal law and regulations, specifically  
39 Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21  
40 of the Code of Federal Regulations, the dispensing pharmacy,

1 clinic, or other dispenser shall report the following information to  
2 the Department of Justice as soon as reasonably possible, but not  
3 more than seven days after the date a controlled substance is  
4 dispensed, in a format specified by the Department of Justice:

5 (1) Full name, address, and, if available, telephone number of  
6 the ultimate user or research subject, or contact information as  
7 determined by the Secretary of the United States Department of  
8 Health and Human Services, and the gender, and date of birth of  
9 the ultimate user.

10 (2) The prescriber's category of licensure, license number,  
11 national provider identifier (NPI) number, if applicable, the federal  
12 controlled substance registration number, and the state medical  
13 license number of any prescriber using the federal controlled  
14 substance registration number of a government-exempt facility.

15 (3) Pharmacy prescription number, license number, NPI number,  
16 and federal controlled substance registration number.

17 (4) National Drug Code (NDC) number of the controlled  
18 substance dispensed.

19 (5) Quantity of the controlled substance dispensed.

20 (6) International Statistical Classification of Diseases, 10th  
21 revision (ICD-10) Code, if available.

22 (7) Number of refills ordered.

23 (8) Whether the drug was dispensed as a refill of a prescription  
24 or as a first-time request.

25 (9) Date of origin of the prescription.

26 (10) Date of dispensing of the prescription.

27 *(e) The Department of Justice may invite stakeholders to assist,*  
28 *advise, and make recommendations on the establishment of rules*  
29 *and regulations necessary to ensure the proper administration*  
30 *and enforcement of the CURES database. All prescriber and*  
31 *dispenser invitees shall be licensed by one of the boards or*  
32 *committees identified in subdivision (d) of Section 208 of the*  
33 *Business and Professions Code, in active practice in California,*  
34 *and a regular user of CURES.*

35 ~~(e)~~

36 *(f) The Department of Justice shall, prior to upgrading CURES,*  
37 *consult with prescribers licensed by one of the boards or*  
38 *committees identified in subdivision (d) of Section 208 of the*  
39 *Business and Professions Code, one or more of the boards or*  
40 *committees identified in subdivision (d) of Section 208 of the*

1 Business and Professions Code, and any other stakeholder  
2 identified by the department, for the purpose of identifying  
3 desirable capabilities and upgrades to the CURES Prescription  
4 Drug Monitoring Program (PDMP).

5 (f)

6 (g) The Department of Justice may establish a process to educate  
7 authorized subscribers of the CURES PDMP on how to access and  
8 use the CURES PDMP.

9 ~~(g) The Department of Justice shall appoint a multidisciplinary~~  
10 ~~advisory committee to assist, advise, and make recommendations~~  
11 ~~for the establishment of rules and regulations necessary to insure~~  
12 ~~the proper administration and enforcement of the CURES database.~~  
13 ~~Appointments shall be made from lists of nominees solicited by~~  
14 ~~the department and shall provide adequate and proper~~  
15 ~~representation of all licensees affected by this chapter and a person~~  
16 ~~who administers addiction services. All members shall be licensed,~~  
17 ~~in active practice in California, and a regular user of the CURES~~  
18 ~~database. Subcommittees of the committee may be appointed~~  
19 ~~consisting of committee members and consultants having particular~~  
20 ~~knowledge in a subject area for the purpose of assisting the~~  
21 ~~department on special administrative problems and in making~~  
22 ~~recommendations to the committee for consideration in the~~  
23 ~~establishment of rules and regulations.~~

24 SEC. 2. ~~Section 11165.1 of the Health and Safety Code is~~  
25 ~~amended to read:~~

26 ~~11165.1. (a) (1) (A) (i) A health care practitioner authorized~~  
27 ~~to prescribe, order, administer, furnish, or dispense Schedule II,~~  
28 ~~Schedule III, or Schedule IV controlled substances pursuant to~~  
29 ~~Section 11150 shall, upon receipt of a federal Drug Enforcement~~  
30 ~~Administration (DEA) registration, submit an application~~  
31 ~~developed by the Department of Justice to obtain approval to access~~  
32 ~~information regarding the controlled substance history of a patient~~  
33 ~~that is stored and maintained by the Department of Justice, and,~~  
34 ~~upon approval, the department shall release to that practitioner the~~  
35 ~~electronic history of controlled substances dispensed to an~~  
36 ~~individual under his or her care based on data contained in the~~  
37 ~~CURES Prescription Drug Monitoring Program (PDMP).~~

38 ~~(ii) A pharmacist shall, upon licensure, submit an application~~  
39 ~~developed by the Department of Justice to obtain approval to access~~  
40 ~~information regarding the controlled substance history of a patient~~



1 that is stored and maintained by the Department of Justice, and,  
2 upon approval, the department shall release to that pharmacist the  
3 electronic history of controlled substances dispensed to an  
4 individual under his or her care based on data contained in the  
5 CURES PDMP.

6 (B) An application may be denied, or a subscriber's access may  
7 be suspended or terminated, for reasons which include, but are not  
8 limited to, the following:

9 (i) Materially falsifying an application for a subscriber.

10 (ii) Failure to maintain effective controls for access to the patient  
11 activity report.

12 (iii) Suspended or revoked federal DEA registration.

13 (iv) Any subscriber who is arrested for a violation of law  
14 governing controlled substances or any other law for which the  
15 possession or use of a controlled substance is an element of the  
16 crime.

17 (v) Any subscriber accessing information for any other reason  
18 than caring for his or her patients.

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

21 (2) A health care practitioner authorized to prescribe, order,  
22 administer, furnish, or dispense Schedule II, Schedule III, or  
23 Schedule IV controlled substances pursuant to Section 11150 or  
24 a pharmacist shall be deemed to have complied with paragraph  
25 (1) if the licensed health care practitioner or pharmacist has been  
26 approved to access the CURES database through the process  
27 developed pursuant to subdivision (a) of Section 209 of the  
28 Business and Professions Code.

29 (b) All information within CURES is confidential, subject to  
30 all applicable federal and state privacy and security laws and  
31 regulations, including, but not limited to, regulations promulgated  
32 pursuant to the Health Insurance Portability and Accountability  
33 Act of 1996 (Parts 160 and 164 of Title 45 of the Code of Federal  
34 Regulations) and the Confidentiality of Medical Information Act  
35 (Part 2.6 (commencing with Section 56) of Division 1 of the Civil  
36 Code), and shall only be disclosed or released as follows:

37 (1) The Department of Justice shall allow the following  
38 individuals to directly access information within the CURES  
39 database for purposes of reviewing a patient's controlled substance  
40 prescription history:

1     ~~(A) A health care practitioner who is providing care to a current~~  
2     ~~patient and who has obtained approval to access CURES pursuant~~  
3     ~~to subdivision (a).~~

4     ~~(B) A pharmacist who is dispensing a controlled substance to~~  
5     ~~a current patient and who has obtained approval to access CURES~~  
6     ~~pursuant to subdivision (a).~~

7     ~~(2) Upon a written request, the Department of Justice shall~~  
8     ~~disclose information within CURES relating to a patient or patient's~~  
9     ~~representative, health care practitioner, dispenser, an employee of~~  
10    ~~the health care practitioner acting on behalf of and at the direction~~  
11    ~~of the practitioner, a pharmacist, or a pharmacy to any of the~~  
12    ~~following entities:~~

13    ~~(A) Relevant regulatory boards responsible for the licensure,~~  
14    ~~regulation, or discipline of health care practitioners and pharmacists~~  
15    ~~authorized to prescribe, order, administer, furnish, or dispense~~  
16    ~~controlled substances that certify that the requested information~~  
17    ~~is necessary for an active investigation relating to prescribed~~  
18    ~~controlled substances involving a designated applicant or licensee.~~

19    ~~(B) Federal, state, or local law enforcement pursuant to a valid~~  
20    ~~court order or warrant based on probable cause and issued at the~~  
21    ~~request of a federal, state, or local law enforcement agency engaged~~  
22    ~~in an open and active investigation regarding prescription drug~~  
23    ~~abuse or diversion of prescription controlled substances involving~~  
24    ~~the individual to whom the requested information pertains.~~

25    ~~(C) A medical examiner, forensic pathologist, or coroner who~~  
26    ~~is an officer of or employed by a state or local government,~~  
27    ~~pursuant to his or her official duties.~~

28    ~~(3) The Department of Justice may disclose information within~~  
29    ~~CURES that does not identify a patient or practitioner and is fully~~  
30    ~~deidentified to entities approved by the department for educational,~~  
31    ~~peer review, statistical, research, or public health purposes.~~

32    ~~(4) A health care practitioner may provide a patient with a copy~~  
33    ~~of the patient's CURES patient activity report as long as no~~  
34    ~~additional CURES data is provided and the practitioner keeps a~~  
35    ~~copy of the report in the patient's medical record in compliance~~  
36    ~~with subdivision (d).~~

37    ~~(e) In order to prevent the inappropriate, improper, or illegal~~  
38    ~~use of Schedule II, Schedule III, or Schedule IV controlled~~  
39    ~~substances, the Department of Justice may initiate the referral of~~  
40    ~~the history of controlled substances dispensed to an individual~~

1 based on data contained in CURES to licensed health care  
2 practitioners, pharmacists, or both, providing care or services to  
3 the individual.

4 (d) (1) The history of controlled substances dispensed to an  
5 individual based on data contained in CURES that is received by  
6 a practitioner or pharmacist from the Department of Justice  
7 pursuant to this section is medical information subject to the  
8 provisions of the Confidentiality of Medical Information Act  
9 contained in Part 2.6 (commencing with Section 56) of Division  
10 1 of the Civil Code.

11 (2) Any person or entity that obtains or accesses confidential  
12 CURES information pursuant to this section shall maintain its  
13 confidentiality under applicable federal and state privacy laws and  
14 shall not further disclose, sell, or transfer the information to any  
15 third party, unless authorized by, or pursuant to, this section or  
16 applicable state and federal privacy and security laws and  
17 regulations.

18 (e) Information concerning a patient's controlled substance  
19 history provided to a prescriber or pharmacist pursuant to this  
20 section shall include prescriptions for controlled substances listed  
21 in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code  
22 of Federal Regulations.

23 (f) A health care practitioner, pharmacist, and any person acting  
24 on behalf of a health care practitioner or pharmacist, when acting  
25 with reasonable care and in good faith, is not subject to civil or  
26 administrative liability arising from any false, incomplete,  
27 inaccurate, or misattributed information submitted to, reported by,  
28 or relied upon in the CURES database or for any resulting failure  
29 of the CURES database to accurately or timely report that  
30 information.

31 SEC. 3. Section 11165.6 is added to the Health and Safety  
32 Code, to read:

33 11165.6. A pharmacy shall notify each patient who is dispensed  
34 a Schedule II, Schedule III, or Schedule IV controlled substance  
35 about CURES before, or at the time of, dispensing the controlled  
36 substance to the patient. The notification shall state the following,  
37 in at least 14-point font:

38 -

39 "California's Controlled Substance Utilization Review and  
40 Evaluation System (CURES) is the state prescription drug

1 monitoring program to help health care providers and pharmacists  
2 provide better patient care in managing patients' prescriptions.  
3 They can access the CURES database to view more complete  
4 patient prescription information. Information about this prescription  
5 will be reported to CURES by the pharmacy, as required by law.  
6 For more information, visit <https://oag.ca.gov/eures-pdmp> or call  
7 (916) 227-3843.

8 SEC. 4. ~~The Legislature finds and declares that Section 1 of~~  
9 ~~this act, which amends Section 11165 of the Health and Safety~~  
10 ~~Code, and Section 2, which amends Section 11165.1 of the Health~~  
11 ~~and Safety Code, impose a limitation on the public's right of access~~  
12 ~~to the meetings of public bodies or the writings of public officials~~  
13 ~~and agencies within the meaning of Section 3 of Article I of the~~  
14 ~~California Constitution. Pursuant to that constitutional provision,~~  
15 ~~the Legislature makes the following findings to demonstrate the~~  
16 ~~interest protected by this limitation and the need for protecting~~  
17 ~~that interest:~~

18 ~~In order to preserve patients' right to privacy in their medical~~  
19 ~~information, it is necessary for information in the Controlled~~  
20 ~~Substance Utilization Review and Evaluation System to remain~~  
21 ~~confidential.~~

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 746  
**Author:** Portantino  
**Bill Date:** February 17, 2017, Introduced  
**Subject:** Pupil Health: Physical Examinations  
**Sponsor:** California Chiropractic Association

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would allow doctors of chiropractic, naturopathic doctors, and nurse practitioners (NPs) to perform physical examinations for students in interscholastic athletic programs.

**BACKGROUND:**

The California Interscholastic Federation (CIF) oversees the protocols related to physical examinations for school interscholastic athletic programs. Existing law only allows these exams to be performed by a physician or a physician assistant in Section 49458 of the Education Code. In the past, schools have allowed chiropractors to execute sports physical forms. However, the Schools Insurance Authority published an Informational Review of the “Use of Chiropractors in School Sports Programs” and raised concerns about the use of chiropractors for these physical exams, as the examinations may exceed the chiropractic scope. The review also brings up a concern that for sports injuries an injury could have possibly been avoided through an examination by a physician, so the school may have liability if it has accepted a sports physical form from a chiropractor. Because of this review, the CIF bylaws define a health care provider as a physician or osteopathic physician, so schools in California currently do not allow chiropractors to perform sports physicals.

As noted by the California Attorney General, a chiropractor must not engage in any care or treatment that is not based on “...a system of treatment by manipulation of the joints of the human body, by manipulation of anatomical displacements, articulation of the spinal column, including its vertebrae and cord, and he may use all necessary, mechanical, hygienic and sanitary measures incident to the care of the body in connection with said system of treatment, but not for the purpose of treatment, and not including measures as would constitute the practice of medicine, surgery, osteopathy, dentistry, or optometry, and without the use of any drug or medicine included in materia medica.” 59 Op.Atty.Gen 420, 8-26-76, citing *Crees* at p. 214.

AB 1992 (Jones, 2016) included the exact same language as this bill. The Board took an oppose unless amended position on that bill, with the amendment being to only add NPs to the list of providers who can perform the physical examinations for student athletes.

**ANALYSIS:**

Chiropractors are authorized to perform certain types of limited examinations and evaluations, but there is currently no specific authorization for a chiropractor to perform sports physicals for student athletes. Existing law only allows physician assistants and physician and surgeons to perform physical examinations for interscholastic athletic programs. These sports physicals require a review of cardiac, neurologic and internal organ functioning, which is outside of the chiropractic and naturopathic scope of practice.

According to the author, “Under current law, doctors of chiropractic have been legally performing pre-participation sports physicals in California for over 30 years. An outdated section of the Education Code does not list all health care providers qualified to perform these physicals. Some school districts are only accepting these physicals when performed by a health care provider listed in the Education Code, for fear of a perceived increase in potential liability.”

Allowing a chiropractor or naturopathic doctor to perform and sign off on these physical examinations, which include an evaluation and possible diagnosis, could negatively impact the students receiving these examinations, as chiropractors do not receive the same level of medical education and training as physicians. The Board’s primary mission is consumer protection and the Board should oppose this change. However, allowing an NP, who is under the supervision of a physician, to perform these examinations seems reasonable. Physician assistants are already allowed to perform these examinations in existing law. Board staff suggests that the Board oppose this bill unless it is amended to only add NPs to the list of providers who can perform physical examinations for student athletes

**FISCAL:** None

**SUPPORT:** California Chiropractic Association (Sponsor)  
California Naturopathic Doctors Association  
Southern California University of Health Sciences

**OPPOSITION:** California Academy of Family Physicians  
California Academy of Pediatrics  
American College of Emergency Physicians, California Chapter  
California Medical Association

**POSITION:** Recommendation: Oppose Unless Amended

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**Introduced by Senator Portantino**

February 17, 2017

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An act to amend Section 49458 of the Education Code, relating to pupil health.

LEGISLATIVE COUNSEL'S DIGEST

SB 746, as introduced, Portantino. Pupil health: physical examinations.

Existing law authorizes a physician and surgeon or physician assistant to perform a physical examination that is required for a pupil to participate in an interscholastic athletic program of a school.

This bill would additionally authorize a doctor of chiropractic, naturopathic doctor, or nurse practitioner practicing in compliance with the respective laws governing their profession to perform that physical examination.

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 49458 of the Education Code is amended
- 2 to read:
- 3 49458. When a school district or a county superintendent of
- 4 schools requires a physical examination as a condition of
- 5 participation in an interscholastic athletic program, the physical
- 6 examination may be performed by a physician and ~~surgeon or~~
- 7 ~~surgeon~~, physician assistant practicing in compliance with Chapter
- 8 7.7 (commencing with Section 3500) of Division 2 of the Business
- 9 and Professions ~~Code~~. *Code, doctor of chiropractic practicing in*

1 *compliance with Chapter 2 (commencing with Section 1000) of*  
2 *Division 2 of the Business and Professions Code, naturopathic*  
3 *doctor practicing in compliance with Chapter 8.2 (commencing*  
4 *with Section 3610) of Division 2 of the Business and Professions*  
5 *Code, or nurse practitioner practicing in compliance with Article*  
6 *8 (commencing with Section 2834) of Chapter 6 of Division 2 of*  
7 *the Business and Professions Code.*

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MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 790  
**Author:** McGuire  
**Bill Date:** April 17, 2017, Amended  
**Subject:** Health Care Providers: Gifts and Benefits  
**Sponsor:** Author

**DESCRIPTION OF CURRENT LEGISLATION:**

This bill would prohibit a manufacturer of a prescribed product or a wholesale distributor of medical devices from offering or giving a gift to a health care provider. This bill would prohibit a manufacturer of a prescribed product or an entity on behalf of a manufacturer of a prescribed product from providing a fee, payment, subsidy, or other economic benefit to a health care provider in connection with the provider's participation in research. This bill would authorize the Attorney General (AG) to bring an action to enforce a violation of these prohibitions and to seek injunctive relief and imposition of a civil penalty for each violation.

**BACKGROUND:**

The Physician Payments Sunshine Act is a 2010 federal healthcare law to increase transparency of financial relationships between health care providers and pharmaceutical manufacturers. The Sunshine Act requires manufacturers of drugs, medical devices, and biological and medical supplies, covered by the three federal health care programs Medicare, Medicaid, and State Children's Health Insurance Program, to collect and track all financial relationships with physicians and teaching hospitals and to report this data to the federal Centers for Medicare and Medicaid Services. The goal of the law is to increase the transparency of financial relationships between health care providers and pharmaceutical manufacturers and to uncover potential conflicts of interest.

Data from 2014 shows that California physicians received the highest number of payments from pharmaceutical companies than any state (\$1.44B) compared to the second and third ranking states, New York (\$517M) and Texas (\$435M), with Alaska at the bottom, receiving the lowest amount (\$1.8M). 2014 data also revealed almost 280,000 doctors received a total of more than 60,000 payments associated with four target drugs.

Nationally, about three quarters of doctors across five common medical specialties received at least one payment from a company in 2014. In Nevada, that number was over 90 percent. In Vermont, the state with the strictest gift regulations, the number fell below 24 percent.

The Office of the Inspector General of the U.S. Department of Health and Human Services cautioned drug companies about making excessive payments to physicians for consulting and offering inappropriate gifts.

California's largest hospitals such as Kaiser, the University of California Medical Centers, and Stanford have implemented policies restricting pharma gifts to doctors. Eight other states and the District of Columbia have also adopted gift bans and restrictions.

## **ANALYSIS**

This bill would define an allowable expenditure as any of the following:

- A payment by a manufacturer of a prescribed product or a wholesale distributor of medical services to the sponsor of a significant educational, medical, scientific, or policy making conference or seminar, provided that the payment is not made directly to a health care professional or pharmacist. The funding must be used solely for bona fide educational purposes (can be used for meals and other food for conference participants), and all program content is objective, free from industry control, and does not promote specific products.
- Honoraria and payment of the expenses of a health care professional who serves on the faculty at a bona fide educational, medical, scientific, or policy making conference or seminar, if the honoraria or payment is governed by an explicit contract with specific deliverables that are restricted to medical issues, and the content of the presentation is determined by the health care professional.
- For a bona fide clinical trial, the annual direct salary support for principal investigators and other health care professionals.
- For a research project that constitutes a systematic investigation, is designed to develop or contribute to general knowledge, and reasonably can be considered to be of significant interest or value to scientists or health care professionals working in the particular field of inquiry. It can include gross compensation, direct salary support per health care professional, and expenses paid on behalf of each health care professional.
- Payment or reimbursement for reasonable expenses, including travel expenses, necessary for technical training of individual health care professionals on the use of a medical device, if the commitment to provide those expenses are described in a written agreement between the provider and the manufacturer.
- Provision of meals for a health care provider that do not exceed \$250 per person, per year in value.

This bill would define a gift as anything of value provided for free to a health care provider, or a payment, food, entertainment, travel, subscription, advance, service, or anything else of value provided to a health care provider, unless it is an allowable expenditure.

This bill would define a health care provider as a health care professional, hospital, nursing home, pharmacist, health benefit plan administrator, or any other person authorized to dispense, or purchase for distribution, prescribed products in California.

This bill would define a manufacturer as a pharmaceutical, biological product or medical device manufacturer, or any other person who is engaged in the production, preparation, propagation, compounding, processing, marketing, packaging, repackaging, distributing, or

labeling of prescribed products. This bill would specify that it does not include a wholesaler distributor of biological products, a retailer, or a pharmacist.

This bill would expressly prohibit a manufacturer of a prescribed product or a wholesale distributor of medical devices, or an agent thereof, from offering or giving a gift to a health care provider. This bill would also prohibit a manufacturer or an entity on behalf of a manufacturer from providing a fee, payment, subsidy, or other economic benefit, with the exception of allowable expenditures, to a health care provider in connection with the provider's participation in research. This bill would specify that these prohibitions do not apply to the following:

- Samples of a prescribed product or reasonable quantities of an over-the-counter drug, a non-prescription medical device, an item of non-prescription durable medical equipment, an item of medical food as defined in federal law, or infant formula, that are provided to a health care provider for free distribution to patients.
- The loan of a medical device for a short-term trial period, not to exceed 120 days, to permit evaluation of the device by a health care provider or patient.
- The provision of reasonable quantities of medical device demonstration or evaluation units to a health care provider to assess the appropriate use and function of the product and determine whether and when to use or recommend the product.
- The provision, distribution, dissemination, or receipt of peer-reviewed academic, scientific, or other clinical articles or journals and other items that serve an educational function for the benefit of patients.
- Scholarship or other support for medical students, residents and fellows to attend a significant educational, scientific, or policy making conference or seminar.
- Rebates and discounts for prescribed products provided in the normal course of business.
- Labels approved by the federal Food and Drug Administration for prescribed products.
- The provision to a free clinic of financial donations or of free prescription drugs, over-the-counter drugs, medical devices, biological products, combination products, medical food, infant formula, medical equipment, or medical supplies.
- Prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded patient assistance program.
- Fellowship salary support provided to fellows through grants for manufacturers of prescribed products, if the following apply: the grants are applied for by an academic institution or hospital; the institution or hospital selects the recipient fellows; the manufacturer imposes no further demands or limits on the use of the funds; and the fellowships are not named for a manufacturer, and no individual recipient's fellowship is attributed to a particular manufacturer.

This bill would allow the AG to bring an action seeking injunctive relief, costs, attorney's fees, and imposition of a civil penalty of up to \$10,000. Each unlawful gift offered or given or each fee, subsidy, payment or other economic benefit given in violation of this bill would constitute a separate violation. This bill would give the AG, in connection with an action brought pursuant to this bill, the same powers to investigate

and obtain remedies that are granted to the Director of Consumer Affairs under existing law in Chapter 4 of Division 1 of the Business and Professions Code, commencing with Section 300.

This bill would state that it is the intent of the Legislature that the requirements and prohibitions in this bill would complement and operate in conjunction with the federal Physician Payments Sunshine Act. If the Physician Payments Sunshine Act is repealed or becomes inoperative, it is the intent of the Legislature to enact similar legislation requiring manufacturers to disclose payments or other transfers of value made to health care providers in California.

According to the author, studies have shown that interaction with the pharmaceutical industry is associated with substantially negative consequences that include risks to patient safety associated with unnecessary drug prescriptions, drug cost increases borne by the patient, less availability of generic drugs, and less attention paid to evidence-based prescribing. The author believes that the pervasive use of gifts is of special concern to vulnerable populations and that physicians prescribing in the California's foster care system in recent years have received, on average, more than twice the amount in payments and incentives from drug companies when compared with the typical California physician. The author introduced this bill because he believes the time has come for California to join the largest hospitals, eight other states and the District of Columbia in providing regulations on pharma gifts.

The Medical Board of California's (Board) primary mission is consumer protection. This bill would ensure that physicians are not influenced by gifts or economic benefits when deciding what brand of drug to prescribe, but would still allow for some reasonable expenditures. This bill would further the Board's mission of consumer protection and Board staff recommends that the Board take a support position on this bill.

**FISCAL:** None to the Board

**SUPPORT:** None on file

**OPPOSITION:** Pharmaceutical Research and Manufacturers of America

**POSITION:** Recommendation: Support

AMENDED IN SENATE APRIL 17, 2017  
AMENDED IN SENATE MARCH 29, 2017

**SENATE BILL**

**No. 790**

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**Introduced by Senator McGuire**

February 17, 2017

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An act to ~~add Article 16 (commencing with Section 870) to Chapter 1 of Division 2 of the Business and Professions Code, and to add Division 117 (commencing with Section 150300) to the Health and Safety Code, relating to health care providers.~~

LEGISLATIVE COUNSEL'S DIGEST

SB 790, as amended, McGuire. Health care providers: gifts and benefits.

The Sherman Food, Drug, and Cosmetic Law, administered by the *State* Department of Public Health, regulates the packaging, labeling, and advertising of drugs and devices, and requires a manufacturer of any drug or device in the state to be licensed by the department. Existing law imposes various requirements on persons engaged in the provision of health care services in the state.

This bill would prohibit a manufacturer of a prescribed product or a wholesale distributor of medical devices, as defined, from offering or giving a gift to a health care provider. The bill would define a gift as anything of value provided for free to a health care provider, or a payment, food, entertainment, travel, subscription, advance, service, or anything else of value provided to a health care provider, unless it is a specified allowable expenditure or the health care provider reimburses the cost at fair market value. The bill would prohibit a manufacturer of a prescribed product or an entity on behalf of a manufacturer of a prescribed product from providing a fee, payment, subsidy, or other

economic benefit to a health care provider in connection with the provider's participation in research. The bill would specify circumstances to which these prohibitions do not apply. The bill would authorize the Attorney General to bring an action to enforce a violation of these prohibitions and to seek injunctive relief and imposition of a civil penalty for each violation, as specified. ~~The bill would require a health care professional, as defined, who is a member of a committee that sets formularies or develops clinical guidelines and who also serves as a speaker or commercial consultant for a manufacturer of prescribed products to disclose to the committee his or her relationship with the manufacturer, as specified.~~

*Existing federal law, the Physician Payments Sunshine Act (Sunshine Act), requires manufacturers of specified drugs, devices, biologicals, or medical supplies to disclose to the federal Centers for Medicare and Medicaid Services payments or other transfers of value made to physicians or teaching hospitals.*

*This bill would state the intent of the Legislature that the prohibitions and requirements described above complement and operate in conjunction with the Sunshine Act. The bill would state the intent of the Legislature to enact legislation similar to the Sunshine Act if the Sunshine Act is repealed or becomes inoperative.*

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. Article 16 (commencing with Section 870) is~~  
2     ~~added to Chapter 1 of Division 2 of the Business and Professions~~  
3     ~~Code, to read:~~

4  
5     ~~Article 16. Disclosure of Relationship with Manufacturer of~~  
6                     ~~Prescribed Products~~

7  
8     ~~870. (a) A health care professional, as defined in subdivision~~  
9     ~~(g) of Section 150300 of the Health and Safety Code, who is a~~  
10    ~~member of a committee that sets formularies or develops clinical~~  
11    ~~guidelines and who also serves as a speaker or commercial~~  
12    ~~consultant for a manufacturer, as defined in subdivision (i) of~~  
13    ~~Section 150300, shall disclose to the committee his or her~~  
14    ~~relationship with the manufacturer.~~

1 ~~(b) A health care professional shall make the disclosure required~~  
2 ~~by subdivision (a) during and for a period of two years after the~~  
3 ~~termination of his or her relationship with a manufacturer.~~

4 ~~SEC. 2.~~

5 *SECTION 1.* Division 117 (commencing with Section 150300)  
6 is added to the Health and Safety Code, to read:

7  
8 DIVISION 117. EXPENDITURES BY MANUFACTURERS  
9 OF PRESCRIBED PRODUCTS

10  
11 150300. For the purposes of this division, the following  
12 definitions shall apply:

13 (a) "Allowable expenditure" means any of the following:

14 (1) Payment by a manufacturer of a prescribed product or a  
15 wholesale distributor of medical devices to the sponsor of a  
16 significant educational, medical, scientific, or policymaking  
17 conference or seminar, provided that all of the following conditions  
18 are satisfied:

19 (A) The payment is not made directly to a health care  
20 professional or pharmacist.

21 (B) Funding is used solely for bona fide educational purposes,  
22 except that the sponsor may, in the sponsor's discretion, apply  
23 some or all of the funding to provide meals and other food for all  
24 conference participants.

25 (C) All program content is objective, free from industry control,  
26 and does not promote specific products.

27 (2) Honoraria and payment of the expenses of a health care  
28 professional who serves on the faculty at a bona fide educational,  
29 medical, scientific, or policymaking conference or seminar,  
30 provided that all of the following conditions are satisfied:

31 (A) The honoraria or payment is governed by an explicit contract  
32 with specific deliverables which are restricted to medical issues,  
33 not marketing activities.

34 (B) Consistent with federal law, the content of the presentation,  
35 including slides and written materials, is determined by the health  
36 care professional.

37 (3) For a bona fide clinical trial, the annual direct salary support  
38 for principal investigators and other health care professionals.

39 (4) For a research project that constitutes a systematic  
40 investigation, is designed to develop or contribute to general

1 knowledge, and reasonably can be considered to be of significant  
2 interest or value to scientists or health care professionals working  
3 in the particular field of inquiry, all of the following:

4 (A) Gross compensation.

5 (B) Direct salary support per health care professional.

6 (C) Expenses paid on behalf of each health care professional.

7 (5) Payment or reimbursement for reasonable expenses,  
8 including travel and lodging-related expenses, necessary for  
9 technical training of individual health care professionals on the  
10 use of a medical device, if the commitment to provide those  
11 expenses and the amounts or categories of reasonable expenses to  
12 be paid are described in a written agreement between the health  
13 care provider and the manufacturer.

14 (6) Royalties and licensing fees paid to health care providers in  
15 return for contractual rights to use or purchase a patented or  
16 otherwise legally recognized discovery for which the health care  
17 provider holds an ownership right.

18 (7) The payment of reasonable expenses of an individual related  
19 to the interview of the individual by a manufacturer of prescribed  
20 products in connection with a bona fide employment opportunity  
21 or for health care services on behalf of an employee of the  
22 manufacturer.

23 (8) Provision of meals for a health care provider that do not  
24 exceed two hundred fifty dollars (\$250) per person, per year in  
25 value.

26 (b) “Bona fide clinical trial” means an FDA-reviewed clinical  
27 trial that constitutes research as defined in Section 46.102 of Title  
28 45 of the Code of Federal Regulations that can be reasonably  
29 considered to be of interest to scientists or health care professionals  
30 working in the particular field of inquiry.

31 (c) “Clinical trial” means a study that does either of the  
32 following:

33 (1) Assesses the safety or efficacy of prescribed products  
34 administered alone or in combination with other prescribed  
35 products or other therapies.

36 (2) Assesses the relative safety or efficacy of prescribed products  
37 in comparison with other prescribed products or therapies.

38 (d) “Free clinic” means a health care facility operated by a  
39 nonprofit private entity that satisfies all of the following conditions:



1 (1) In providing health care, the health care facility does not  
2 accept reimbursement from any third-party payer, including  
3 reimbursement from any insurance policy, health plan, or federal  
4 or state health benefits program that is individually determined.

5 (2) In providing health care, the health care facility either does  
6 not impose charges on patients to whom service is provided, or  
7 imposes charges on patients according to their ability to pay.

8 (3) The health care facility may accept voluntary donations from  
9 patients for the provision of health care services.

10 (4) The health care facility is licensed or certified to provide  
11 health services under applicable law.

12 (e) “Gift” means either of the following:

13 (1) Anything of value provided for free to a health care provider.

14 (2) A payment, food, entertainment, travel, subscription,  
15 advance, service, or anything else of value provided to a health  
16 care provider, unless it is an allowable expenditure as defined in  
17 subdivision (a) or the health care provider reimburses the cost at  
18 fair market value.

19 (f) “Health benefit plan administrator” means the person or  
20 entity who sets formularies on behalf of an employer or health  
21 insurer.

22 (g) “Health care professional” means any of the following:

23 (1) A person who is authorized by law to prescribe or to  
24 recommend prescribed products, who regularly practices in the  
25 state, and who is either licensed by the state to provide or is  
26 otherwise lawfully providing health care in the state.

27 (2) A partnership or corporation made up of the persons  
28 described in paragraph (1).

29 (3) An officer, employee, agent, or contractor of a person  
30 described in paragraph (1) who is acting in the course and scope  
31 of employment, of an agency, or of a contract related to or  
32 supportive of the provision of health care to individuals.

33 (h) “Health care provider” means a health care professional,  
34 hospital, nursing home, pharmacist, health benefit plan  
35 administrator, or any other person authorized to dispense or  
36 purchase for distribution prescribed products in the state. “Health  
37 care provider” does not include a hospital foundation that is  
38 organized as a nonprofit entity separate from a hospital.

39 (i) “Manufacturer” means a pharmaceutical manufacturer,  
40 biological product manufacturer, or medical device manufacturer

1 or any other person who is engaged in the production, preparation,  
2 propagation, compounding, processing, marketing, packaging,  
3 repackaging, distributing, or labeling of prescribed products.  
4 “Manufacturer” does not include a wholesale distributor of  
5 biological products, a retailer, or a pharmacist.

6 (j) “Marketing” means promoting, detailing, or any activity that  
7 is intended to be used or is used to influence sales or market share  
8 or to evaluate the effectiveness of a professional sales force.

9 (k) “Pharmaceutical manufacturer” means either of the  
10 following:

11 (1) An entity that is engaged in the production, preparation,  
12 propagation, compounding, conversion, or processing of  
13 prescription drugs, whether directly or indirectly by extraction  
14 from substances of natural origin, independently by means of  
15 chemical synthesis, or by a combination of extraction and chemical  
16 synthesis.

17 (2) An entity engaged in the packaging, repackaging, labeling,  
18 relabeling, or distribution of prescription drugs.

19 (l) “Prescribed product” means a drug or device as defined in  
20 Section 321 of Title 21 of the United States Code, a compounded  
21 drug or drugs, a biological product as defined in Section 262 of  
22 Title 42 of the United States Code for human use, or a combination  
23 product as defined in subdivision (e) of Section 3.2 of Title 21 of  
24 the Code of Federal Regulations, but shall not include prescription  
25 eyeglasses, prescription sunglasses, or other prescription eyewear.

26 (m) “Sample” means a unit of a prescription drug, biological  
27 product, or medical device that is not intended to be sold and is  
28 intended to promote the sale of the drug, product, or device, and  
29 includes starter packs and coupons or other vouchers that enable  
30 an individual to receive a prescribed product free of charge or at  
31 a discounted price. “Sample” does not include prescribed products  
32 distributed free of charge or at a discounted price pursuant to a  
33 manufacturer-sponsored or manufacturer-funded patient assistance  
34 program.

35 (n) “Significant educational, scientific, or policymaking  
36 conference or seminar” means an educational, scientific, or  
37 policymaking conference or seminar that satisfies both of the  
38 following:

39 (1) The conference or seminar is accredited by the Accreditation  
40 Council for Continuing Medical Education or a comparable

1 organization or is presented by an approved sponsor of continuing  
2 education, provided that the sponsor is not a manufacturer of  
3 prescribed products.

4 (2) The conference or seminar offers continuing education credit,  
5 features multiple presenters on scientific research, or is authorized  
6 by the sponsor to recommend or make policy.

7 150302. A manufacturer of a prescribed product or a wholesale  
8 distributor of medical devices, or an agent thereof, shall not offer  
9 or give a gift to a health care provider.

10 150304. Except as described in paragraph (3) of subdivision  
11 (a) of Section 150300, a manufacturer or an entity on behalf of a  
12 manufacturer shall not provide a fee, payment, subsidy, or other  
13 economic benefit to a health care provider in connection with the  
14 provider's participation in research.

15 150306. Sections 150302 and 150304 shall not apply to the  
16 following:

17 (a) Samples of a prescribed product or reasonable quantities of  
18 an over-the-counter drug, a nonprescription medical device, an  
19 item of nonprescription durable medical equipment, an item of  
20 medical food as defined in Section 360ee of Title 21 of the United  
21 States Code, or infant formula as defined in Section 321 of Title  
22 21 of the United States Code, that are provided to a health care  
23 provider for free distribution to patients.

24 (b) The loan of a medical device for a short-term trial period,  
25 not to exceed 120 days, to permit evaluation of the device by a  
26 health care provider or patient.

27 (c) The provision of reasonable quantities of medical device  
28 demonstration or evaluation units to a health care provider to assess  
29 the appropriate use and function of the product and determine  
30 whether and when to use or recommend the product in the future.

31 (d) The provision, distribution, dissemination, or receipt of  
32 peer-reviewed academic, scientific, or clinical articles or journals  
33 and other items that serve a genuine educational function provided  
34 to a health care provider for the benefit of patients.

35 (e) Scholarship or other support for medical students, residents,  
36 and fellows to attend a significant educational, scientific, or  
37 policymaking conference or seminar of a national, regional, or  
38 specialty medical or other professional association if the recipient  
39 of the scholarship or other support is selected by the association.

(f) Rebates and discounts for prescribed products provided in the normal course of business.

(g) Labels approved by the federal Food and Drug Administration for prescribed products.

(h) The provision to a free clinic of financial donations or of free prescription drugs, over-the-counter drugs, medical devices, biological products, combination products, medical food, infant formula, medical equipment, or medical supplies.

(i) Prescribed products distributed free of charge or at a discounted price pursuant to a manufacturer-sponsored or manufacturer-funded patient assistance program.

(j) Fellowship salary support provided to fellows through grants for manufacturers of prescribed products, provided that all of the following conditions are satisfied:

(1) The grants are applied for by an academic institution or hospital.

(2) The institution or hospital selects the recipient fellows.

(3) The manufacturer imposes no further demands or limits on the institution's, hospital's, or fellow's use of the funds.

(4) Fellowships are not named for a manufacturer and no individual recipient's fellowship is attributed to a particular manufacturer of prescribed products.

150308. (a) The Attorney General may bring an action seeking injunctive relief, costs, attorney's fees, and imposition of a civil penalty of up to ten thousand dollars (\$10,000) for each violation of Section 150302 or 150304.

(b) For purposes of this section, each unlawful gift offered or given in violation of Section 150302, or each fee, subsidy, payment or other economic benefit given in violation of Section 150304 shall constitute a separate violation.

(c) In connection with an action brought pursuant to this section, the Attorney General shall, in addition to the powers granted to him or her by law, have the same powers to investigate and obtain remedies as are granted to the Director of Consumer Affairs pursuant to Chapter 4 (commencing with Section 300) of Division 1 of the Business and Professions Code.

150310. *It is the intent of the Legislature that the requirements and prohibitions of this division complement and operate in conjunction with the federal Physician Payments Sunshine Act (42 U.S.C. Sec. 1320a-7h). If the Physician Payments Sunshine Act is*

1 *repealed or becomes inoperative, it is the intent of the Legislature*  
2 *to enact similar legislation requiring manufacturers to disclose*  
3 *payments or other transfers of value made to health care providers*  
4 *in the state.*

O

MEDICAL BOARD OF CALIFORNIA  
LEGISLATIVE ANALYSIS

**Bill Number:** SB 798  
**Author:** Hill  
**Bill Date:** April 18, 2017, Amended  
**Subject:** Healing Arts: Boards  
**Sponsor:** Author

**DESCRIPTION OF CURRENT LEGISLATION:**

This is the Medical Board of California's (Board) sunset bill, which includes language on a portion of the new issues from the Board's 2016 Sunset Review Report, and will extend the Board's sunset date for four years, until January 1, 2022.

There are some issues that are included in this bill that are not issues raised in the Board's sunset report. This bill would move research psychoanalysts to the Board of Psychology. This bill would allow the Board to recover costs for investigations and prosecutions for disciplinary proceedings. This bill would require physicians to notify patients that they are on probation and would require the Board to post specified information on the physician's profile on the Board's website. This bill would include licensed midwives (LMs) in the peer review sections and the medical corporation law. This bill would allow a doctor of podiatric medicine (DPM) to advertise and use the phrase, "podiatric physician and surgeon" and would allow a DPM to advertise as, "podiatric physician", "podiatric surgeon", "podiatric physician and surgeon", and "foot and ankle physician and surgeon". Lastly this bill would repeal the vertical enforcement and prosecution model.

**ANALYSIS:**

The Board included new issues in its 2016 Sunset Review Report to the Legislature. This report was submitted to the Legislature and the Legislature prepared a background paper that raised 30 issues, some of them related to the new issues included in the Board's Sunset Review Report. Here are the new issues that were included in the Board's Sunset Review Report and are included in this bill:

- Allow the Board to issue a two-year license to its licensees, instead of using a physician's birth date to calculate license expiration dates - **This bill includes language for a two-year license for all of the Board's licensees. It also includes technical language to clean-up existing law for licensees not under the purview of the Board.**
- Change the postgraduate training requirement from one or two years to three years for all applicants, regardless of where they went to medical school. Create a postgraduate training license to allow an individual in a postgraduate training program to continue in

that program without violating the law. Delete the requirement for the Board to approve international medical schools. - **This bill includes language that would require an applicant to complete three years of postgraduate training in order to be eligible for licensure. This bill includes some exceptions for applicants who have a medical degree from a combined dental and medical degree program. This bill would create a postgraduate training license with specified application requirements that must be obtained within 180 days after enrollment in a postgraduate training program and would be valid until 90 days after the holder has completed 36 months of postgraduate training. This bill would delete the requirement for the Board to approve international medical schools. This bill would determine that an international medical school is recognized if they are listed on the World Federation for Medical Education and the Foundation for Advancement of International Medical Education and Research World Directory of Medical Schools joint directory or the World Directory of Medical Schools.**

- Require data reporting for accredited outpatient settings and revise the adverse events that outpatient settings are required to report to the Board. **This bill includes language largely based on what was included in previous legislation and existing law regarding data that surgical clinics are required to report to OSHPD. This bill would also revise the adverse events that are required to be reported to the Board in existing law to only include those that relate to outpatient settings.**
- Amend existing law to allow the Board to require more information about the Board in a more consumer friendly manner on notice to consumers' postings. – **This bill adds Business and Professions Code (BPC) Section 2026 to allow the Board to require changes and more information in the notice to consumers posting.**
- Amend BPC Code section 805.01 to allow the Board to fine an entity up to \$50,000 per violation for failing to submit an 805.01 report to the Board, or \$100,000 per violation if it is determined that the failure to report was willful.– **This bill includes this language.**
- Require state agencies and hospital accrediting agencies to report to the Board any peer review incidents subject to 805 reporting that are found during an inspection of a health care facility or clinic. – **This bill includes this language.**
- Amend existing law regarding the Health Professions Education Foundation (HPEF) to require two members to be appointed by the Board, as was previously required. –**This bill includes this language.**
- The Board recommended in its previous sunset report that the provision in existing law that requires the Board to approve non-ABMS specialty boards be deleted. The Board suggested that the law should continue to require physicians to advertise as board certified only if they have been certified by ABMS boards and any additional boards

previously approved by the Board. – **This bill includes this language.**

- Make technical, clarifying changes to make it clear that the Board of Podiatric Medicine (BPM) is its own board that performs its own licensing functions. – **This bill includes this language.**
- Delete the requirement in existing law that the Board president cannot be on a disciplinary panel. – **This bill includes this language.**
- Amend existing law regarding the prompt revocation of physicians who are required to register as sex offenders, and change it to an automatic revocation to allow the revocations to be processed in a more expeditious manner. – **This bill includes this language.**
- Amend BPC Section 2225 to make it clear that invocation of the psychotherapist-patient privilege is not a barrier to the Board obtaining psychotherapy records via a subpoena upon a showing of good cause. – **This bill includes this language.**
- Allow the Board to issue a cease practice order in cases where a licensee delays or does not comply with an order to undergo a physical or mental health examination. – **This bill includes this language.**
- Amend existing law related to expert witness reports, to include additional information that the reports must include and to ensure the Board receives these reports in a timely manner. – **This bill includes this language.**
- Existing law, Government Code Section 11529 requires that if the Board pursues and obtains an Interim Suspension Order (ISO), it has 30 days to file an accusation. A petition to revoke probation is very similar to an accusation in that it is still the charging document identifying what the physician has done to violate the law. The Board is recommending an amendment to add petitions to revoke probation. – **This bill includes this language.**
- Delete outdated sections of law related to the Board's Licensing Program. – **This bill repeals these outdated sections.**

There some issues that are included in this bill that are not issues raised in the Board's sunset report. They are as follows:

This bill would require, on and after July 1, 2018, the Board to require a licensee on probation, pursuant to a probationary order made on or after July 1, 2018, before a patient's first visit following the probationary order, to provide the patient or the patient's guardian or health care surrogate, with a separate disclosure containing all the following information:

- The licensee's probationary status.



- The length of the probation and the end date.
- All practice restrictions placed on the licensee by the Board.
- The Board's telephone number.
- An explanation of how the patient can find further information on the licensee's probation on the licensee's profile page on the Board's online license information site.

This bill would specify that a licensee required to provide a disclosure shall obtain from the patient, or the patient's guardian or health care surrogate, a separate, signed copy of the disclosure.

This bill would specify that a licensee on probation is not required to provide a disclosure if any of the following applies:

- The patient is unconscious or otherwise unable to comprehend the disclosure and sign the copy of the disclosure and a guardian or health care surrogate is unavailable. In that instance, the licensee shall disclose his or her status as soon as the patient can comprehend and sign the disclosure, or a guardian or health care surrogate is available.
- The visit occurs in an emergency room or an urgent care facility or the visit is unscheduled.
- The licensee who will be treating the patient during the visit is not known to the patient until immediately prior to the start of the visit.

This bill would require the Board, on and after July 1, 2018, to provide the following information for licensees on probation and licensees practicing under probationary licenses, in plain view on the licensee's profile page on the Board's website:

- For probation imposed pursuant to a stipulated settlement, the causes alleged in the operative accusation along with a designation identifying those causes by which the licensee has expressly admitted guilt and a statement that acceptance of the settlement is not an admission of guilt.
- For probation imposed by an adjudicated decision of the Board, the causes for probation stated in the final probationary order.
- For a licensee granted a probationary license, the causes by which a probationary license was imposed.
- The length of the probation and end date.
- All practice restrictions placed on the license by the Board.

This bill would repeal the existing vertical enforcement and prosecution model (VE). Although VE is an issue that the Board has reported on in the past, the Board has not yet offered any suggested language.

This bill would allow a DPM to advertise and use the phrase, "podiatric physician and surgeon" and would allow a DPM to advertise as, "podiatric physician," "podiatric surgeon," "podiatric physician and surgeon," and "foot and ankle physician and surgeon." This bill would also add DPMs to the definition of "attending physician" in Health and Safety Code Section 11362.7, which would allow DPMs to recommend medical cannabis.

The Board is currently prohibited from recovering costs for investigations and prosecutions for disciplinary proceedings. This bill would allow the Board to recover these costs from licensees.

In response to stakeholder feedback, this bill would include LMs in the peer review reporting requirements and provisions in existing law. This bill would also add LMs to the listing of medical corporations.

This bill would transfer research psychoanalysts to the Board of Psychology. This was brought up in the background paper, as psychoanalysis is a discipline of psychology.

This bill would extend the Board's sunset date for another four years and would address many of the new issues raised in the Board's 2016 Sunset Review Report. This bill includes language to make the legislative changes suggested by the Board to accommodate the continuing evolution of medical training and testing, to improve the efficiencies of the Board's Licensing and Enforcement Programs, and most importantly, to enhance consumer protection. The Board should support this bill unless it has concerns with any of the provisions that are included in this bill and were not included as new issues in the Board's sunset report.

**FISCAL:** Minimal and absorbable fiscal impact

**SUPPORT:** None on File

**OPPOSITION:** None on File

AMENDED IN SENATE APRIL 18, 2017

**SENATE BILL**

**No. 798**

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**Introduced by Senator Hill**

February 17, 2017

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An act to amend Sections 115.6, 125.3, 144, 146, 328, 651, 656, 683, 800, 803.1, 805, 805.01, 805.1, 805.5, 805.6, 810, 2001, 2006, 2008, 2020, ~~and 2450 of~~ 2054, 2064, 2065, 2066.5, 2082, 2084, 2084.5, 2087, 2096, 2105, 2111, 2112, 2113, 2135, 2135.5, 2143, 2168.4, 2191, 2216.3, 2220.05, 2221, 2225, 2232, 2334, 2415, 2421, 2423, 2435, 2435.2, 2450, 2454.5, 2460, 2461, 2472, 2474, 2475, 2479, 2486, 2488, 2492, 2499, 2525.2, 4170, and 4175 of, to amend and renumber Sections 2529, 2529.1, 2529.5, and 2529.6 of, to add Sections 2026, 2064.5, 2216. 5, 2228.1, 2499.7, and 2566.2 to, to add the heading of Article 3.5 (commencing with Section 2950) to Chapter 6.6 of Division 2 of, to repeal Sections 2052.5, 2066, 2067, 2072, 2073, 2085, 2089, 2089.5, 2089.7, 2090, 2091, 2091.1, 2091.2, 2100, 2102, 2103, 2104, 2104.5, 2107, 2115, 2135.7, 2420, and 2422 of, and to repeal the heading of Chapter 5.1 (commencing with Section 2529) of Division 2 of, the Business and Professions Code, to amend Section 43.7 and 43.8 of the Civil Code, to amend Sections 13401 and 13401.5 of the Corporations Code, to amend Section 1157 of the Evidence Code, to amend Section 11529 of, and to repeal Section 12529.6 of, the Government Code, and to amend Sections 11362.7 and 128335 of the Health and Safety Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 798, as amended, Hill. Healing arts: boards.

Existing

(1) *Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensure and regulation of physicians and surgeons. Existing law requires the Governor to appoint members to the board, as provided. Existing law authorizes the board to employ an executive director, investigators, legal counsel, medical consultants, and other assistance as specified. Existing law requires the Attorney General to act as legal counsel for the board, as specified. Existing law provides that those provisions will be repealed on January 1, 2018.*

*This bill would instead repeal those provisions on January 1, 2022.*

(2) *Existing law relating to research psychoanalysts authorizes certain students and graduates in psychoanalysis to engage in psychoanalysis under prescribed circumstances if they register with the Medical Board of California and present evidence of their student or graduate status. Existing law authorizes that board to suspend or revoke the exemption of those persons from licensure for unprofessional conduct, as specified. Existing law requires a registrant to pay into the Contingent Fund of the Medical Board of California a fee fixed by that board, as specified. Existing law, the Psychology Law, makes a violation of its provisions a crime.*

*This bill would transfer the administration and enforcement duties of those provisions from the Medical Board of California to the Board of Psychology. The bill would require that any moneys within the Contingent Fund of the Medical Board of California collected pursuant to those provisions be deposited in the Psychology Fund, and would require a registrant to pay into the Psychology Fund a fee fixed by the Board of Psychology. The bill would authorize the Board of Psychology to employ, subject to civil service regulations, whatever additional clerical assistance is necessary for the administration of these provisions. By placing these provisions in the Psychology Law, the bill would expand the definition of a crime, thereby imposing a state-mandated local program.*

(3) *Existing law establishes a peer review process for certain healing arts licensees and requires peer review bodies to review licensee conduct under specified circumstances. Existing law makes the willful failure of a peer review body to make specified reports a crime. Existing law provides that there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, certain health related professional societies or its members for act performed within the scope of the functions of peer review, as provided.*

*This bill would apply these provisions to licensed midwives. Because the willful failure of such a peer review body to make specified reports would be punishable as a crime, the bill would impose a state-mandated local program.*

*Existing law prohibits the proceedings and records of organized committees of healing arts professions or of a peer review body from being subject to discovery, except as specified.*

*This bill would apply these provisions to the proceedings and records of committees or peer review bodies of licensed midwives, except as specified.*

*The Moscone-Knox Professional Corporation Act provides for the organization of a corporation under certain existing law for the purposes of qualifying as a professional corporation under that act and rendering professional services. The act authorizes specified healing arts practitioners to be shareholders, officers, directors, or professional employees of a designated professional corporation, subject to certain limitations relating to ownership of shares.*

*This bill would add licensed midwives to the lists of healing arts practitioners who may be shareholders, officers, directors, or professional employees of a medical corporation, a psychological corporation, a nursing corporation, a marriage and family therapist corporation, a licensed clinical social worker corporation, a physician assistants corporation, a chiropractic corporation, an acupuncture corporation, a naturopathic doctor corporation, a professional clinical counselor corporation, a physical therapy corporation, and a registered dental hygienist in alternative practice corporation. The bill would also add a licensed midwives corporation to the list of professional corporations, and would authorize licensed physicians and surgeons, licensed psychologists, registered nurses, licensed marriage and family therapists, licensed clinical social workers, licensed physician assistants, licensed chiropractors, licensed acupuncturists, licensed naturopathic doctors, licensed professional clinical counselors, and licensed physical therapists to be shareholders, officers, directors, or professional employees, subject to those limitations relating to ownership of shares.*

*(4) Existing law, the Medical Practice Act, creates, within the Department of Consumer Affairs, the Medical Board of California consisting of 15 members. The act requires the board to elect a president from its members, and authorizes the board to appoint panels from its members for the purpose of fulfilling specified obligations. The act*

*prohibits the president of the board from being a member of any panel unless there is a vacancy in the membership of the board.*

*This bill would discontinue that prohibition on the president being a member of a panel.*

*Existing law requires the Office of Statewide Health Planning and Development to establish a nonprofit public benefit corporation known as the Health Professions Education Foundation to perform various duties with respect to implementing health professions scholarship and loan programs. Existing law requires the foundation to be governed by a board consisting of 9 members appointed by the Governor, one member appointed by the Speaker of the Assembly, and one member appointed by the Senate Committee on Rules. Existing law requires the Governor to appoint the president of the board of trustees from among those members appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules. Existing law requires the members of the board to serve without compensation but requires that they be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the board.*

*This bill would add to that governing board of the foundation 2 members appointed by the Medical Board of California. The bill would include these members in the list of members from which the Governor is required to appoint the president of the board. The bill would require the Medical Board of California to reimburse its 2 appointed member for any actual and necessary expenses incurred in connection with their duties as member of the board. The bill would require the Medical Board of California to reimburse its 2 appointed foundation board members for any actual and necessary expenses incurred in connection with their duties as members of the foundation board.*

*Existing law, the Medical Practice Act, requires the Medical Board of California to post on the Internet certain information regarding licensed physicians and surgeons.*

*This bill would require the board to initiate the process of adopting regulations on or before January 1, 2019, to require its licentiates and registrants to provide notice to their clients or patients that the practitioner is licensed or registered in this state by the board, that the practitioner's license can be checked, and that complaints against the practitioner can be made through the board's Internet Web site or by the contracting the board.*

*Existing law makes it unlawful for a healing arts practitioner to disseminate or cause to be disseminated any form of public*

*communication containing a false, fraudulent, misleading, or deceptive statement, claim, or image for the purpose of or likely to induce, directly or indirectly, the rendering of professional services or furnishing of products in connection with the professional practice or business for which he or she is licensed. Existing law prohibits a physician and surgeon from including a statement that he or she is certified or eligible for certification by a private or public board or parent association, including a multidisciplinary board or association, as defined, unless that board or association is one of a specified list of boards and associations, including a board or association with equivalent requirements approved by that physician and surgeon's licensing board. Existing law requires the Medical Board of California to adopt regulations to establish and collect a reasonable fee from each board or association applying for recognition.*

*This bill would discontinue the Medical Board of California approval of a board or association. The bill would continue to authorize a physician and surgeon to make a statement that he or she is certified or eligible for certification by a board or association with equivalent requirements approved by that physician and surgeon's licensing board prior to January 1, 2018.*

*Existing law requires each applicant for a physician's and surgeon's certificate to show by official transcript or other official evidence that he or she has successfully completed a medical curriculum meeting specified requirements.*

*This bill would remove these medical curriculum requirements.*

*Existing law requires an applicant to show by evidence satisfactory to the board that he or she has satisfactorily completed at least one year of postgraduate training. Existing law requires the postgraduate training to be obtained in a postgraduate training program approved by the Accreditation Council for Graduate Medical Education or the Royal College of Physicians and Surgeons of Canada.*

*This bill would instead require an applicant to show by evidence satisfactory to the board that he or she has satisfactorily completed at least 36 months of board-approved postgraduate training. The bill would authorize an applicant to obtain postgraduate training in a postgraduate training program approved by the College of Family Physicians of Canada. The bill would make eligible for licensure an applicant who has completed at least 36 months of board-approved postgraduate training, not less than 24 months of which was completed as a resident after receiving a medical degree from a combined dental*



*and medical degree program accredited by the Commission on Dental Accreditation or approved by the board.*

*Existing law authorizes a graduate of an approved medical school who is enrolled in a postgraduate training program approved by the board to engage in the practice of medicine whenever and wherever required as part of the program under specified conditions.*

*This bill would add to these conditions a requirement that the medical school graduate obtain a postgraduate training license, as specified.*

*Existing law requires an applicant for a physician's and surgeon's certificate whose professional instruction was acquired in a country other than the United States or Canada to provide evidence satisfactory to the board of satisfactory completion of various requirements, including showing by evidence satisfactory to the board that he or she has satisfactorily completed at least two years of postgraduate training.*

*This bill would recast some of those provisions and make conforming changes to other provisions. The bill would require those applicants to show by evidence satisfactory to the board that he or she has satisfactorily completed at least 36 months of board-approved postgraduate training.*

*Existing law authorizes the holder of a special faculty permit to practice medicine, without a physician's and surgeon's certificate, within a medical school and certain affiliated institutions. Under existing law, a special faculty permit expires and becomes invalid at midnight on the last day of the permitholder's birth month during the 2nd year of a 2-year term, if not renewed.*

*The bill would instead specify that a special faculty permit expires and becomes invalid at midnight on the last day of the month in which the permit was issued during the 2nd year of a 2-year term commencing from the date of issuance, if not renewed.*

*The Medical Practice Act creates, within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine. Under the act, certificates to practice podiatric medicine expire on a certain date during the 2nd year of a 2-year term if not renewed. The act authorizes a doctor of podiatric medicine who is ankle certified, as specified, to perform certain services and procedures.*

*This bill would instead create the California Board of Podiatric Medicine in the Department of Consumer Affairs, and would make conforming and related changes. This bill would discontinue the ankle certification requirement for a doctor of podiatric medicine to perform those services and procedures.*



*Under the act, certificates to practice podiatric medicine and registrations of spectacle lens dispensers and contact lens dispensers, among others, expire on a certain date during the second year of a 2-year term if not renewed.*

*This bill would discontinue the requirement for the expiration of the registrations of spectacle lens dispensers and contact lens dispensers.*

*Existing law requires the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of a peer review body, as defined, and the chief executive officer or administrator of a licensed health care facility or clinic to file reports with the applicable state licensing agency of specified health care practitioners upon the occurrence of specified events. Existing law also requires those individuals.*

*This bill would additionally require state agencies and hospitals to report to the Medical Board of California any peer review incidents subject to those provisions that are found during an inspection of a health care facility or clinic. The bill would impose a \$100,000 fine for a willful failure to file a specified report and a \$50,000 fine for all other failures to file the report.*

*Existing law requires an accredited outpatient setting to report an adverse event, as defined, to the Medical Board of California no later than 5 days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected.*

*This bill would redefine adverse event for those purposes and would require the outpatient setting to inform the patient or the party responsible for the patient of the adverse event by the time the report is made. The bill would require an accredited outpatient setting to annually file a specified report with the Office of Statewide Health Planning and Development. The bill would also require an accredited outpatient setting to file an Ambulatory Surgery Data Record, as specified, for each patient encounter during which at least one ambulatory surgery procedure is performed. The bill would subject accredited outpatient settings to specified fee for freestanding ambulatory surgery clinics.*

*Existing law requires the board to promptly revoke the license of any person who has been required to register as a sex offender.*

*This bill would instead require the board to make the revocation automatically, regardless of whether the related conviction has been*

*appealed. The bill would require the board to notify the licensee of the license revocation and of his or her right to elect to have a hearing. The bill would authorize the holder of the physician's and surgeon's certificate to request a hearing, as specified, within 30 days of the revocation. The bill would require the revocation to cease automatically if the conviction is overturned on appeal.*

*Existing law makes certain privileged communication provisions not applicable to investigations or proceedings related to violations of the Medical Practices Act.*

*This bill would specify that provisions pertaining to the psychotherapist-patient privilege are also not applicable to those investigations or proceedings.*

*Existing law authorizes the administrative law judge of the Medical Quality Hearing Panel to issue an interim order suspending a license or imposing license restrictions, as specified. Existing law requires the order to be dissolved if an accusation is not filed and served, as specified, within 30 days of the date on which the parties to the hearing on the order have submitted the matter.*

*This bill would also require the order to be dissolved if a petition to revoke probation is not filed and served, as specified, within 30 days of the date on which the parties to the hearing on the order have submitted the matter.*

*Existing law prohibits a party's use of expert testimony in matters brought by the Medical Board of California unless specified information, including a brief narrative statement of the general substance of the testimony that the expert is expected to give, is exchanged in written form with the counsel for the other party. Existing law requires the exchange of information to be completed at least 30 days prior to the commencement date of the hearing.*

*This bill would instead require the exchange of information to be completed either within 90 days from the filing of an accusation or petition to revoke probation or 30 calendar days prior to the originally scheduled commencement date of the hearing, whichever occurs first, or as determined by an administrative law judge, as specified. The bill would replace the requirement that a brief narrative statement be exchanged with the requirement that a complete expert witness report, as specified, be exchanged.*

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

*specified professionals. Existing law specifies that a licentiate's failure to comply with this order constitutes grounds for the suspension or revocation of the licentiate's certificate or license.*

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

*Existing law establishes the Health Quality Enforcement Section within the Department of Justice to investigate and prosecute proceedings against licensees and applicants within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine, the Board of Psychology, or any committee under the jurisdiction of the Medical Board of California. Existing law requires each complaint that is referred to a district office of one of these boards for investigation to be jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section of the Department of Justice responsible for prosecuting the case if the investigation results in the filing of an accusation.*

*This bill would remove this requirement, and make conforming changes.*

*Existing law establishes the State Board of Chiropractic Examiners, the Medical Board of California, the California Board of Podiatric Medicine within the Medical Board of California, the Osteopathic Medical Board of California, the Naturopathic Medicine Committee, and the Acupuncture Board for the licensure and regulation of chiropractors, physicians and surgeons, podiatrists, osteopathic physicians and surgeons, naturopathic doctors, and acupuncturists, respectively. Existing law authorizes each of those regulatory entities to discipline its licensee by placing that licensee on probation, as specified. Existing law also requires 3 of those regulatory entities, the Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine, to disclose to an inquiring member of the public and to post on their Internet Web sites specified information concerning licensees including revocations, suspensions, probations, and limitations on practice.*

*This bill, on and after July 1, 2018, would require each of those regulatory entities to require a licensee on probation pursuant to a probationary order made on or after July 1, 2018, to provide a patient,*

*or the patient's guardian or health care surrogate, with a separate disclosure containing specified information relating to the licensee's probationary status, with certain exceptions, and would require the licensee to obtain a signed copy of that disclosure from the patient, or the patient's guardian or health care surrogate. The bill would further require each of those regulatory entities, on and after July 1, 2018, to provide certain information regarding licensees on probation and licensees practicing under probationary licenses to an inquiring member of the public, on any of the regulatory entity's documents informing the public of individual probation orders and probationary licenses, and in plain view on the licensee's profile page on the regulatory entity's online license information site.*

*Existing law, in any order issued in resolution of a disciplinary proceeding before any board within the Department of Consumer Affairs or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding unless the entity is the Medical Board of California, authorizes the administrative law judge to direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, as specified. Existing law requires the Medical Board of California to ensure that any loss of revenue or increases in costs incurred pursuant to its inability to request and obtain investigation and prosecution costs for a disciplinary proceeding is offset by initial license and renewal fees.*

*This bill would authorize the Medical Board of California to request and obtain from a physician and surgeon the investigation and prosecution costs for a disciplinary proceeding and would make related and conforming changes.*

Existing law, the Osteopathic Act, establishes the Osteopathic Medical Board of California, which issues certificates to, and regulates, osteopathic physicians and surgeons and requires that the powers and duties of the board in that regard be subject to review by the appropriate committees of the Legislature. Existing law requires that review to be performed as if those provisions were scheduled to be repealed as of January 1, 2018.

This bill would instead require that review to be performed as if those provisions were scheduled to be repealed as of January 1, 2022.

*Existing law requires the Osteopathic Medical Board of California to require each licensed osteopathic physician and surgeon to demonstrate satisfaction of continuing education requirements as a*

*condition for the renewal of a license at intervals of not less than one year nor more than three years. Existing law requires the board to require each licensed osteopathic physician and surgeon to complete a minimum of 150 hours of American Osteopathic Association continuing education hours during each three-year cycle, of which 60 hours must be completed in American Osteopathic Association Category 1 continuing education hours as a condition for renewal of an active license.*

*This bill would instead require the board to require satisfaction of the continuing education requirements not less than one year nor more than two years. The bill would require each licensed osteopathic physician and surgeon to complete a minimum of 100 hours of American Osteopathic Association continuing education hours during each two-year cycle, of which 40 hours must be completed in American Osteopathic Association Category 1 continuing education hours and the remaining 60 hours shall be either American Osteopathic Association or American Medical Association accredited.*

*Existing law authorizes a list of specified boards to request and receive from a local or state agency certified records of all arrests and convictions, certified records regarding probation, and any and all other documentation needed to complete an applicant or licensee investigation.*

*This bill would add the California Board of Podiatric Medicine and the Osteopathic Medical Board of California to that list of specified boards.*

*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: ~~no~~-yes.

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

- 1     SECTION 1. Section 115.6 of the Business and Professions
- 2     Code is amended to read:
- 3     115.6. (a) A board within the department shall, after
- 4     appropriate investigation, issue the following eligible temporary

1 licenses to an applicant if he or she meets the requirements set  
2 forth in subdivision (c):

3 (1) Registered nurse license by the Board of Registered Nursing.

4 (2) Vocational nurse license issued by the Board of Vocational  
5 Nursing and Psychiatric Technicians of the State of California.

6 (3) Psychiatric technician license issued by the Board of  
7 Vocational Nursing and Psychiatric Technicians of the State of  
8 California.

9 (4) Speech-language pathologist license issued by the  
10 Speech-Language Pathology and Audiology and Hearing Aid  
11 Dispensers Board.

12 (5) Audiologist license issued by the Speech-Language  
13 Pathology and Audiology and Hearing Aid Dispensers Board.

14 (6) Veterinarian license issued by the Veterinary Medical Board.

15 (7) All licenses issued by the Board for Professional Engineers,  
16 Land Surveyors, and Geologists.

17 (8) All licenses issued by the Medical Board of California.

18 (9) *All licenses issued by the California Board of Podiatric*  
19 *Medicine.*

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

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

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

31 (2) The applicant shall hold a current, active, and unrestricted  
32 license that confers upon him or her the authority to practice, in  
33 another state, district, or territory of the United States, the  
34 profession or vocation for which he or she seeks a temporary  
35 license from the board.

36 (3) The applicant shall submit an application to the board that  
37 shall include a signed affidavit attesting to the fact that he or she  
38 meets all of the requirements for the temporary license and that  
39 the information submitted in the application is accurate, to the best  
40 of his or her knowledge. The application shall also include written



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

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

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

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

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

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

28 (f) An applicant seeking a temporary license as a civil engineer,  
29 geotechnical engineer, structural engineer, land surveyor,  
30 professional geologist, professional geophysicist, certified  
31 engineering geologist, or certified hydrogeologist pursuant to this  
32 section shall successfully pass the appropriate California-specific  
33 examination or examinations required for licensure in those  
34 respective professions by the Board for Professional Engineers,  
35 Land Surveyors, and Geologists.

36 (g) A temporary license issued pursuant to this section shall  
37 expire 12 months after issuance, upon issuance of an expedited  
38 license pursuant to Section 115.5, or upon denial of the application  
39 for expedited licensure by the board, whichever occurs first.

1     *SEC. 2. Section 125.3 of the Business and Professions Code*  
2     *is amended to read:*

3     125.3. (a) Except as otherwise provided by law, in any order  
4     issued in resolution of a disciplinary proceeding before any board  
5     within the department or before the Osteopathic Medical Board,  
6     upon request of the entity bringing the proceeding, the  
7     administrative law judge may direct a licentiate found to have  
8     committed a violation or violations of the licensing act to pay a  
9     sum not to exceed the reasonable costs of the investigation and  
10    enforcement of the case.

11    (b) In the case of a disciplined licentiate that is a corporation or  
12    a partnership, the order may be made against the licensed corporate  
13    entity or licensed partnership.

14    (c) A certified copy of the actual costs, or a good faith estimate  
15    of costs where actual costs are not available, signed by the entity  
16    bringing the proceeding or its designated representative shall be  
17    prima facie evidence of reasonable costs of investigation and  
18    prosecution of the case. The costs shall include the amount of  
19    investigative and enforcement costs up to the date of the hearing,  
20    including, but not limited to, charges imposed by the Attorney  
21    General.

22    (d) The administrative law judge shall make a proposed finding  
23    of the amount of reasonable costs of investigation and prosecution  
24    of the case when requested pursuant to subdivision (a). The finding  
25    of the administrative law judge with regard to costs shall not be  
26    reviewable by the board to increase the cost award. The board may  
27    reduce or eliminate the cost award, or remand to the administrative  
28    law judge if the proposed decision fails to make a finding on costs  
29    requested pursuant to subdivision (a).

30    (e) If an order for recovery of costs is made and timely payment  
31    is not made as directed in the board's decision, the board may  
32    enforce the order for repayment in any appropriate court. This  
33    right of enforcement shall be in addition to any other rights the  
34    board may have as to any licentiate to pay costs.

35    (f) In any action for recovery of costs, proof of the board's  
36    decision shall be conclusive proof of the validity of the order of  
37    payment and the terms for payment.

38    (g) (1) Except as provided in paragraph (2), the board shall not  
39    renew or reinstate the license of any licentiate who has failed to  
40    pay all of the costs ordered under this section.



(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licentiate who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

~~(k) Notwithstanding the provisions of this section, the Medical Board of California shall not request nor obtain from a physician and surgeon, investigation and prosecution costs for a disciplinary proceeding against the licentiate. The board shall ensure that this subdivision is revenue neutral with regard to it and that any loss of revenue or increase in costs resulting from this subdivision is offset by an increase in the amount of the initial license fee and the biennial renewal fee, as provided in subdivision (e) of Section 2435.~~

*SEC. 3. Section 144 of the Business and Professions Code is amended to read:*

144. (a) Notwithstanding any other law, an agency designated in subdivision (b) shall require an applicant to furnish to the agency a full set of fingerprints for purposes of conducting criminal history record checks. Any agency designated in subdivision (b) may obtain and receive, at its discretion, criminal history information from the Department of Justice and the United States Federal Bureau of Investigation.

(b) Subdivision (a) applies to the following:

(1) California Board of Accountancy.

(2) State Athletic Commission.

(3) Board of Behavioral Sciences.

(4) Court Reporters Board of California.

(5) State Board of Guide Dogs for the Blind.

- 1 (6) California State Board of Pharmacy.
- 2 (7) Board of Registered Nursing.
- 3 (8) Veterinary Medical Board.
- 4 (9) Board of Vocational Nursing and Psychiatric Technicians.
- 5 (10) Respiratory Care Board of California.
- 6 (11) Physical Therapy Board of California.
- 7 (12) Physician Assistant Committee of the Medical Board of
- 8 California.
- 9 (13) Speech-Language Pathology and Audiology and Hearing
- 10 Aid Dispenser Board.
- 11 (14) Medical Board of California.
- 12 (15) State Board of Optometry.
- 13 (16) Acupuncture Board.
- 14 (17) Cemetery and Funeral Bureau.
- 15 (18) Bureau of Security and Investigative Services.
- 16 (19) Division of Investigation.
- 17 (20) Board of Psychology.
- 18 (21) California Board of Occupational Therapy.
- 19 (22) Structural Pest Control Board.
- 20 (23) Contractors' State License Board.
- 21 (24) Naturopathic Medicine Committee.
- 22 (25) Professional Fiduciaries Bureau.
- 23 (26) Board for Professional Engineers, Land Surveyors, and
- 24 Geologists.
- 25 (27) Bureau of Medical Cannabis Regulation.
- 26 (28) *California Board of Podiatric Medicine.*
- 27 (29) *Osteopathic Medical Board of California.*
- 28 (c) For purposes of paragraph (26) of subdivision (b), the term
- 29 "applicant" shall be limited to an initial applicant who has never
- 30 been registered or licensed by the board or to an applicant for a
- 31 new licensure or registration category.
- 32 *SEC. 4. Section 146 of the Business and Professions Code is*
- 33 *amended to read:*
- 34 146. (a) Notwithstanding any other provision of law, a
- 35 violation of any code section listed in subdivision (c) is an
- 36 infraction subject to the procedures described in Sections 19.6 and
- 37 19.7 of the Penal Code when either of the following applies:
- 38 (1) A complaint or a written notice to appear in court pursuant
- 39 to Chapter 5c (commencing with Section 853.5) of Title 3 of Part
- 40 2 of the Penal Code is filed in court charging the offense as an

1 infraction unless the defendant, at the time he or she is arraigned,  
2 after being advised of his or her rights, elects to have the case  
3 proceed as a misdemeanor.

4 (2) The court, with the consent of the defendant and the  
5 prosecution, determines that the offense is an infraction in which  
6 event the case shall proceed as if the defendant has been arraigned  
7 on an infraction complaint.

8 (b) Subdivision (a) does not apply to a violation of the code  
9 sections listed in subdivision (c) if the defendant has had his or  
10 her license, registration, or certificate previously revoked or  
11 suspended.

12 (c) The following sections require registration, licensure,  
13 certification, or other authorization in order to engage in certain  
14 businesses or professions regulated by this code:

15 (1) *Section 2474.*

16 ~~(1)~~

17 (2) Sections 2052 and 2054.

18 ~~(2)~~

19 (3) Section 2630.

20 ~~(3)~~

21 (4) Section 2903.

22 ~~(4)~~

23 (5) Section 3575.

24 ~~(5)~~

25 (6) Section 3660.

26 ~~(6)~~

27 (7) Sections 3760 and 3761.

28 ~~(7)~~

29 (8) Section 4080.

30 ~~(8)~~

31 (9) Section 4825.

32 ~~(9)~~

33 (10) Section 4935.

34 ~~(10)~~

35 (11) Section 4980.

36 ~~(11)~~

37 (12) Section 4989.50.

38 ~~(12)~~

39 (13) Section 4996.

40 ~~(13)~~

1    (14) Section 4999.30.  
2    ~~(14)~~  
3    (15) Section 5536.  
4    ~~(15)~~  
5    (16) Section 6704.  
6    ~~(16)~~  
7    (17) Section 6980.10.  
8    ~~(17)~~  
9    (18) Section 7317.  
10   ~~(18)~~  
11   (19) Section 7502 or 7592.  
12   ~~(19)~~  
13   (20) Section 7520.  
14   ~~(20)~~  
15   (21) Section 7617 or 7641.  
16   ~~(21)~~  
17   (22) Subdivision (a) of Section 7872.  
18   ~~(22)~~  
19   (23) Section 8016.  
20   ~~(23)~~  
21   (24) Section 8505.  
22   ~~(24)~~  
23   (25) Section 8725.  
24   ~~(25)~~  
25   (26) Section 9681.  
26   ~~(26)~~  
27   (27) Section 9840.  
28   ~~(27)~~  
29   (28) Subdivision (c) of Section 9891.24.  
30   ~~(28)~~  
31   (29) Section 19049.  
32   (d) Notwithstanding any other law, a violation of any of the  
33 sections listed in subdivision (c), which is an infraction, is  
34 punishable by a fine of not less than two hundred fifty dollars  
35 (\$250) and not more than one thousand dollars (\$1,000). No portion  
36 of the minimum fine may be suspended by the court unless as a  
37 condition of that suspension the defendant is required to submit  
38 proof of a current valid license, registration, or certificate for the  
39 profession or vocation that was the basis for his or her conviction.

SEC. 5. *Section 328 of the Business and Professions Code is amended to read:*

328. (a) In order to implement the Consumer Protection Enforcement Initiative of 2010, the director, through the Division of Investigation, shall implement “Complaint Prioritization Guidelines” for boards to utilize in prioritizing their respective complaint and investigative workloads. The guidelines shall be used to determine the referral of complaints to the division and those that are retained by the health care boards for investigation.

~~(b) The—Neither the Medical Board of California nor the California Board of Podiatric Medicine shall not~~ be required to utilize the guidelines implemented pursuant to subdivision (a).

SEC. 6. *Section 651 of the Business and Professions Code is amended to read:*

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

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

(1) Contains a misrepresentation of fact.

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

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

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

1 fact that the photograph or image is of a model is a violation of  
2 subdivision (a). For purposes of this paragraph, a model is anyone  
3 other than an actual patient, who has undergone the procedure  
4 being advertised, of the licensee who is advertising for his or her  
5 services.

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

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

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

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

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

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

31 (c) Any price advertisement shall be exact, without the use of  
32 phrases, including, but not limited to, “as low as,” “and up,”  
33 “lowest prices,” or words or phrases of similar import. Any  
34 advertisement that refers to services, or costs for services, and that  
35 uses words of comparison shall be based on verifiable data  
36 substantiating the comparison. Any person so advertising shall be  
37 prepared to provide information sufficient to establish the accuracy  
38 of that comparison. Price advertising shall not be fraudulent,  
39 deceitful, or misleading, including statements or advertisements  
40 of bait, discount, premiums, gifts, or any statements of a similar

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

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

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

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

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

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

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

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

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

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

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

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

1 (C) A physician and surgeon licensed under Chapter 5  
2 (commencing with Section 2000) by the Medical Board of  
3 California may include a statement that he or she limits his or her  
4 practice to specific fields, but shall not include a statement that he  
5 or she is certified or eligible for certification by a private or public  
6 board or parent association, including, but not limited to, a  
7 multidisciplinary board or association, unless that board or  
8 association is (i) an American Board of Medical Specialties  
9 member board, (ii) a board or association with equivalent  
10 requirements approved by that physician and surgeon's licensing  
11 ~~board~~, *board prior to January 1, 2018*, or (iii) a board or  
12 association with an Accreditation Council for Graduate Medical  
13 Education approved postgraduate training program that provides  
14 complete training in that specialty or subspecialty. A physician  
15 and surgeon licensed under Chapter 5 (commencing with Section  
16 2000) by the Medical Board of California who is certified by an  
17 organization other than a board or association referred to in clause  
18 (i), (ii), or (iii) shall not use the term "board certified" in reference  
19 to that certification, unless the physician and surgeon is also  
20 licensed under Chapter 4 (commencing with Section 1600) and  
21 the use of the term "board certified" in reference to that certification  
22 is in accordance with subparagraph (A). A physician and surgeon  
23 licensed under Chapter 5 (commencing with Section 2000) by the  
24 Medical Board of California who is certified by a board or  
25 association referred to in clause (i), (ii), or (iii) shall not use the  
26 term "board certified" unless the full name of the certifying board  
27 is also used and given comparable prominence with the term "board  
28 certified" in the statement.

29 For purposes of this subparagraph, a "multidisciplinary board  
30 or association" means an educational certifying body that has a  
31 psychometrically valid testing process, as determined by the  
32 Medical Board of California, for certifying medical doctors and  
33 other health care professionals that is based on the applicant's  
34 education, training, and experience. *A multidisciplinary board or*  
35 *association approved by the Medical Board of California prior to*  
36 *January 1, 2018, shall retain that approval.*

37 For purposes of the term "board certified," as used in this  
38 subparagraph, the terms "board" and "association" mean an  
39 organization that is an American Board of Medical Specialties  
40 member board, an organization with equivalent requirements



1 approved by a physician and surgeon's licensing ~~board~~, *board*  
2 *prior to January 1, 2018*, or an organization with an Accreditation  
3 Council for Graduate Medical Education approved postgraduate  
4 training program that provides complete training in a specialty or  
5 subspecialty.

6 ~~The Medical Board of California shall adopt regulations to~~  
7 ~~establish and collect a reasonable fee from each board or~~  
8 ~~association applying for recognition pursuant to this subparagraph.~~  
9 ~~The fee shall not exceed the cost of administering this~~  
10 ~~subparagraph. Notwithstanding Section 2 of Chapter 1660 of the~~  
11 ~~Statutes of 1990, this subparagraph shall become operative July~~  
12 ~~1, 1993. However, an administrative agency or accrediting~~  
13 ~~organization may take any action contemplated by this~~  
14 ~~subparagraph relating to the establishment or approval of specialist~~  
15 ~~requirements on and after January 1, 1991.~~

16 (D) A doctor of podiatric medicine licensed under ~~Chapter 5~~  
17 ~~(commencing with Section 2000) by the Medical Board of Article~~  
18 ~~22 (commencing with Section 2460) of Chapter 5 by the California~~  
19 ~~Board of Podiatric Medicine~~ may include a statement that he or  
20 she is certified or eligible or qualified for certification by a private  
21 or public board or parent association, including, but not limited  
22 to, a multidisciplinary board or association, if that board or  
23 association meets one of the following requirements: (i) is approved  
24 by the Council on Podiatric Medical Education, (ii) is a board or  
25 association with equivalent requirements approved by the  
26 California Board of Podiatric Medicine, or (iii) is a board or  
27 association with the Council on Podiatric Medical Education  
28 approved postgraduate training programs that provide training in  
29 podiatric medicine and podiatric surgery. A doctor of podiatric  
30 medicine licensed under ~~Chapter 5 (commencing with Section~~  
31 ~~2000) by the Medical Board of Article 22 (commencing with~~  
32 ~~Section 2460) of Chapter 5 by the California Board of Podiatric~~  
33 ~~Medicine~~ who is certified by a board or association referred to in  
34 clause (i), (ii), or (iii) shall not use the term "board certified" unless  
35 the full name of the certifying board is also used and given  
36 comparable prominence with the term "board certified" in the  
37 statement. A doctor of podiatric medicine licensed under ~~Chapter~~  
38 ~~5 (commencing with Section 2000) by the Medical Board of Article~~  
39 ~~22 (commencing with Section 2460) of Chapter 5 by the California~~  
40 ~~Board of Podiatric Medicine~~ who is certified by an organization

1 other than a board or association referred to in clause (i), (ii), or  
2 (iii) shall not use the term “board certified” in reference to that  
3 certification.

4 For purposes of this subparagraph, a “multidisciplinary board  
5 or association” means an educational certifying body that has a  
6 psychometrically valid testing process, as determined by the  
7 California Board of Podiatric Medicine, for certifying doctors of  
8 podiatric medicine that is based on the applicant’s education,  
9 training, and experience. For purposes of the term “board certified,”  
10 as used in this subparagraph, the terms “board” and “association”  
11 mean an organization that is a Council on Podiatric Medical  
12 Education approved board, an organization with equivalent  
13 requirements approved by the California Board of Podiatric  
14 Medicine, or an organization with a Council on Podiatric Medical  
15 Education approved postgraduate training program that provides  
16 training in podiatric medicine and podiatric surgery.

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

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

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

28 (8) A statement of publications authored by the practitioner.

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

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

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

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

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

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

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

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

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

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

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

38 (j) The Attorney General shall commence legal proceedings in  
39 the appropriate forum to enjoin advertisements disseminated or  
40 about to be disseminated in violation of this section and seek other

1 appropriate relief to enforce this section. Notwithstanding any  
2 other provision of law, the costs of enforcing this section to the  
3 respective licensing boards or committees may be awarded against  
4 any licensee found to be in violation of any provision of this  
5 section. This shall not diminish the power of district attorneys,  
6 county counsels, or city attorneys pursuant to existing law to seek  
7 appropriate relief.

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

17 *SEC. 7. Section 656 of the Business and Professions Code is*  
18 *amended to read:*

19 656. Whenever any person has engaged, or is about to engage,  
20 in any acts or practices that constitute, or will constitute, a violation  
21 of this article, the superior court in and for the county wherein the  
22 acts or practices take place, or are about to take place, may issue  
23 an injunction, or other appropriate order, restraining the conduct  
24 on application of the State Board of Optometry, the Medical Board  
25 of California, *the California Board of Podiatric Medicine*, the  
26 Osteopathic Medical Board of California, the Attorney General,  
27 or the district attorney of the county.

28 The proceedings under this section shall be governed by Chapter  
29 3 (commencing with Section 525) of Title 7 of Part 2 of the Code  
30 of Civil Procedure.

31 The remedy provided for in this section shall be in addition to,  
32 and not a limitation upon, the authority provided by any other  
33 provision of this code.

34 *SEC. 8. Section 683 of the Business and Professions Code is*  
35 *amended to read:*

36 683. (a) A board shall report, within 10 working days, to the  
37 State Department of Health Care Services the name and license  
38 number of a person whose license has been revoked, suspended,  
39 surrendered, made inactive by the licensee, or placed in another  
40 category that prohibits the licensee from practicing his or her

profession. The purpose of the reporting requirement is to prevent reimbursement by the state for Medi-Cal and Denti-Cal services provided after the cancellation of a provider's professional license.

(b) "Board," as used in this section, means the Dental Board of California, the Medical Board of California, the Board of Psychology, the State Board of Optometry, the California State Board of Pharmacy, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Behavioral Sciences, *the California Board of Podiatric Medicine*, and the California Board of Occupational Therapy.

(c) This section shall become operative on January 1, 2015.

*SEC. 9. Section 800 of the Business and Professions Code is amended to read:*

800. (a) The Medical Board of California, *the California Board of Podiatric Medicine*, the Board of Psychology, the Dental Board of California, the Dental Hygiene Committee of California, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the State Board of Optometry, the Veterinary Medical Board, the Board of Behavioral Sciences, the Physical Therapy Board of California, the California State Board of Pharmacy, the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, the California Board of Occupational Therapy, the Acupuncture Board, and the Physician Assistant Board shall each separately create and maintain a central file of the names of all persons who hold a license, certificate, or similar authority from that board. Each central file shall be created and maintained to provide an individual historical record for each licensee with respect to the following information:

(1) Any conviction of a crime in this or any other state that constitutes unprofessional conduct pursuant to the reporting requirements of Section 803.

(2) Any judgment or settlement requiring the licensee or his or her insurer to pay any amount of damages in excess of three thousand dollars (\$3,000) for any claim that injury or death was proximately caused by the licensee's negligence, error or omission in practice, or by rendering unauthorized professional services, pursuant to the reporting requirements of Section 801 or 802.

1 (3) Any public complaints for which provision is made pursuant  
2 to subdivision (b).

3 (4) Disciplinary information reported pursuant to Section 805,  
4 including any additional exculpatory or explanatory statements  
5 submitted by the licensee pursuant to subdivision (f) of Section  
6 805. If a court finds, in a final judgment, that the peer review  
7 resulting in the 805 report was conducted in bad faith and the  
8 licensee who is the subject of the report notifies the board of that  
9 finding, the board shall include that finding in the central file. For  
10 purposes of this paragraph, “peer review” has the same meaning  
11 as defined in Section 805.

12 (5) Information reported pursuant to Section 805.01, including  
13 any explanatory or exculpatory information submitted by the  
14 licensee pursuant to subdivision (b) of that section.

15 (b) (1) Each board shall prescribe and promulgate forms on  
16 which members of the public and other licensees or certificate  
17 holders may file written complaints to the board alleging any act  
18 of misconduct in, or connected with, the performance of  
19 professional services by the licensee.

20 (2) If a board, or division thereof, a committee, or a panel has  
21 failed to act upon a complaint or report within five years, or has  
22 found that the complaint or report is without merit, the central file  
23 shall be purged of information relating to the complaint or report.

24 (3) Notwithstanding this subdivision, the Board of Psychology,  
25 the Board of Behavioral Sciences, and the Respiratory Care Board  
26 of California shall maintain complaints or reports as long as each  
27 board deems necessary.

28 (c) (1) The contents of any central file that are not public  
29 records under any other provision of law shall be confidential  
30 except that the licensee involved, or his or her counsel or  
31 representative, shall have the right to inspect and have copies made  
32 of his or her complete file except for the provision that may  
33 disclose the identity of an information source. For the purposes of  
34 this section, a board may protect an information source by  
35 providing a copy of the material with only those deletions necessary  
36 to protect the identity of the source or by providing a  
37 comprehensive summary of the substance of the material.  
38 Whichever method is used, the board shall ensure that full  
39 disclosure is made to the subject of any personal information that  
40 could reasonably in any way reflect or convey anything detrimental,



1 disparaging, or threatening to a licensee's reputation, rights,  
2 benefits, privileges, or qualifications, or be used by a board to  
3 make a determination that would affect a licensee's rights, benefits,  
4 privileges, or qualifications. The information required to be  
5 disclosed pursuant to Section 803.1 shall not be considered among  
6 the contents of a central file for the purposes of this subdivision.

7 (2) The licensee may, but is not required to, submit any  
8 additional exculpatory or explanatory statement or other  
9 information that the board shall include in the central file.

10 (3) Each board may permit any law enforcement or regulatory  
11 agency when required for an investigation of unlawful activity or  
12 for licensing, certification, or regulatory purposes to inspect and  
13 have copies made of that licensee's file, unless the disclosure is  
14 otherwise prohibited by law.

15 (4) These disclosures shall effect no change in the confidential  
16 status of these records.

17 *SEC. 10. Section 803.1 of the Business and Professions Code*  
18 *is amended to read:*

19 803.1. (a) Notwithstanding any other ~~provision of~~ law, the  
20 Medical Board of California, the Osteopathic Medical Board of  
21 California, the California Board of Podiatric Medicine, and the  
22 Physician Assistant Board shall disclose to an inquiring member  
23 of the public information regarding any enforcement actions taken  
24 against a licensee, including a former licensee, by the board or by  
25 another state or jurisdiction, including all of the following:

26 (1) Temporary restraining orders issued.

27 (2) Interim suspension orders issued.

28 (3) Revocations, suspensions, probations, or limitations on  
29 practice ordered by the board, including those made part of a  
30 probationary order or stipulated agreement.

31 (4) Public letters of reprimand issued.

32 (5) Infractions, citations, or fines imposed.

33 (b) Notwithstanding any other ~~provision of~~ law, in addition to  
34 the information provided in subdivision (a), the Medical Board of  
35 California, the Osteopathic Medical Board of California, the  
36 California Board of Podiatric Medicine, and the Physician Assistant  
37 Board shall disclose to an inquiring member of the public all of  
38 the following:

39 (1) Civil judgments in any amount, whether or not vacated by  
40 a settlement after entry of the judgment, that were not reversed on

1 appeal and arbitration awards in any amount of a claim or action  
2 for damages for death or personal injury caused by the physician  
3 and surgeon's negligence, error, or omission in practice, or by his  
4 or her rendering of unauthorized professional services.

5 (2) (A) All settlements in the possession, custody, or control  
6 of the board shall be disclosed for a licensee in the low-risk  
7 category if there are three or more settlements for that licensee  
8 within the last 10 years, except for settlements by a licensee  
9 regardless of the amount paid where (i) the settlement is made as  
10 a part of the settlement of a class claim, (ii) the licensee paid in  
11 settlement of the class claim the same amount as the other licensees  
12 in the same class or similarly situated licensees in the same class,  
13 and (iii) the settlement was paid in the context of a case where the  
14 complaint that alleged class liability on behalf of the licensee also  
15 alleged a products liability class action cause of action. All  
16 settlements in the possession, custody, or control of the board shall  
17 be disclosed for a licensee in the high-risk category if there are  
18 four or more settlements for that licensee within the last 10 years  
19 except for settlements by a licensee regardless of the amount paid  
20 where (i) the settlement is made as a part of the settlement of a  
21 class claim, (ii) the licensee paid in settlement of the class claim  
22 the same amount as the other licensees in the same class or  
23 similarly situated licensees in the same class, and (iii) the  
24 settlement was paid in the context of a case where the complaint  
25 that alleged class liability on behalf of the licensee also alleged a  
26 products liability class action cause of action. Classification of a  
27 licensee in either a "high-risk category" or a "low-risk category"  
28 depends upon the specialty or subspecialty practiced by the licensee  
29 and the designation assigned to that specialty or subspecialty by  
30 the Medical Board of California, as described in subdivision (f).  
31 For the purposes of this paragraph, "settlement" means a settlement  
32 of an action described in paragraph (1) entered into by the licensee  
33 on or after January 1, 2003, in an amount of thirty thousand dollars  
34 (\$30,000) or more.

35 (B) The board shall not disclose the actual dollar amount of a  
36 settlement but shall put the number and amount of the settlement  
37 in context by doing the following:

38 (i) Comparing the settlement amount to the experience of other  
39 licensees within the same specialty or subspecialty, indicating if



1 it is below average, average, or above average for the most recent  
2 10-year period.

3 (ii) Reporting the number of years the licensee has been in  
4 practice.

5 (iii) Reporting the total number of licensees in that specialty or  
6 subspecialty, the number of those who have entered into a  
7 settlement agreement, and the percentage that number represents  
8 of the total number of licensees in the specialty or subspecialty.

9 (3) Current American Board of Medical Specialties certification  
10 or board equivalent as certified by the Medical Board of California,  
11 the Osteopathic Medical Board of California, or the California  
12 Board of Podiatric Medicine.

13 (4) Approved postgraduate training.

14 (5) Status of the license of a licensee. By January 1, 2004, the  
15 Medical Board of California, the Osteopathic Medical Board of  
16 California, and the California Board of Podiatric Medicine shall  
17 adopt regulations defining the status of a licensee. The board shall  
18 employ this definition when disclosing the status of a licensee  
19 pursuant to Section 2027.

20 (6) Any summaries of hospital disciplinary actions that result  
21 in the termination or revocation of a licensee's staff privileges for  
22 medical disciplinary cause or reason, unless a court finds, in a final  
23 judgment, that the peer review resulting in the disciplinary action  
24 was conducted in bad faith and the licensee notifies the board of  
25 that finding. In addition, any exculpatory or explanatory statements  
26 submitted by the licensee electronically pursuant to subdivision  
27 (f) of that section shall be disclosed. For purposes of this paragraph,  
28 "peer review" has the same meaning as defined in Section 805.

29 (c) Notwithstanding any other ~~provision of~~ law, the Medical  
30 Board of California, the Osteopathic Medical Board of California,  
31 the California Board of Podiatric Medicine, and the Physician  
32 Assistant Board shall disclose to an inquiring member of the public  
33 information received regarding felony convictions of a physician  
34 and surgeon or doctor of podiatric medicine.

35 (d) The Medical Board of California, the Osteopathic Medical  
36 Board of California, the California Board of Podiatric Medicine,  
37 and the Physician Assistant Board may formulate appropriate  
38 disclaimers or explanatory statements to be included with any  
39 information released, and may by regulation establish categories  
40 of information that need not be disclosed to an inquiring member

1 of the public because that information is unreliable or not  
2 sufficiently related to the licensee's professional practice. The  
3 Medical Board of California, the Osteopathic Medical Board of  
4 California, the California Board of Podiatric Medicine, and the  
5 Physician Assistant Board shall include the following statement  
6 when disclosing information concerning a settlement:

7  
8 “Some studies have shown that there is no significant correlation  
9 between malpractice history and a doctor's competence. At the  
10 same time, the State of California believes that consumers should  
11 have access to malpractice information. In these profiles, the State  
12 of California has given you information about both the malpractice  
13 settlement history for the doctor's specialty and the doctor's history  
14 of settlement payments only if in the last 10 years, the doctor, if  
15 in a low-risk specialty, has three or more settlements or the doctor,  
16 if in a high-risk specialty, has four or more settlements. The State  
17 of California has excluded some class action lawsuits because  
18 those cases are commonly related to systems issues such as product  
19 liability, rather than questions of individual professional  
20 competence and because they are brought on a class basis where  
21 the economic incentive for settlement is great. The State of  
22 California has placed payment amounts into three statistical  
23 categories: below average, average, and above average compared  
24 to others in the doctor's specialty. To make the best health care  
25 decisions, you should view this information in perspective. You  
26 could miss an opportunity for high-quality care by selecting a  
27 doctor based solely on malpractice history.

28 When considering malpractice data, please keep in mind:

29 Malpractice histories tend to vary by specialty. Some specialties  
30 are more likely than others to be the subject of litigation. This  
31 report compares doctors only to the members of their specialty,  
32 not to all doctors, in order to make an individual doctor's history  
33 more meaningful.

34 This report reflects data only for settlements made on or after  
35 January 1, 2003. Moreover, it includes information concerning  
36 those settlements for a 10-year period only. Therefore, you should  
37 know that a doctor may have made settlements in the 10 years  
38 immediately preceding January 1, 2003, that are not included in  
39 this report. After January 1, 2013, for doctors practicing less than  
40 10 years, the data covers their total years of practice. You should

1 take into account the effective date of settlement disclosure as well  
2 as how long the doctor has been in practice when considering  
3 malpractice averages.

4 The incident causing the malpractice claim may have happened  
5 years before a payment is finally made. Sometimes, it takes a long  
6 time for a malpractice lawsuit to settle. Some doctors work  
7 primarily with high-risk patients. These doctors may have  
8 malpractice settlement histories that are higher than average  
9 because they specialize in cases or patients who are at very high  
10 risk for problems.

11 Settlement of a claim may occur for a variety of reasons that do  
12 not necessarily reflect negatively on the professional competence  
13 or conduct of the doctor. A payment in settlement of a medical  
14 malpractice action or claim should not be construed as creating a  
15 presumption that medical malpractice has occurred.

16 You may wish to discuss information in this report and the  
17 general issue of malpractice with your doctor.”  
18

19 (e) The Medical Board of California, the Osteopathic Medical  
20 Board of California, the California Board of Podiatric Medicine,  
21 and the Physician Assistant Board shall, by regulation, develop  
22 standard terminology that accurately describes the different types  
23 of disciplinary filings and actions to take against a licensee as  
24 described in paragraphs (1) to (5), inclusive, of subdivision (a). In  
25 providing the public with information about a licensee via the  
26 Internet pursuant to Section 2027, the Medical Board of California,  
27 the Osteopathic Medical Board of California, the California Board  
28 of Podiatric Medicine, and the Physician Assistant Board shall not  
29 use the terms “enforcement,” “discipline,” or similar language  
30 implying a sanction unless the physician and surgeon has been the  
31 subject of one of the actions described in paragraphs (1) to (5),  
32 inclusive, of subdivision (a).

33 (f) The Medical Board of California shall adopt regulations no  
34 later than July 1, 2003, designating each specialty and subspecialty  
35 practice area as either high risk or low risk. In promulgating these  
36 regulations, the board shall consult with commercial underwriters  
37 of medical malpractice insurance companies, health care systems  
38 that self-insure physicians and surgeons, and representatives of  
39 the California medical specialty societies. The board shall utilize  
40 the carriers’ statewide data to establish the two risk categories and

1 the averages required by subparagraph (B) of paragraph (2) of  
2 subdivision (b). Prior to issuing regulations, the board shall  
3 convene public meetings with the medical malpractice carriers,  
4 self-insurers, and specialty representatives.

5 (g) The Medical Board of California, the Osteopathic Medical  
6 Board of California, the California Board of Podiatric Medicine,  
7 and the Physician Assistant Board shall provide each licensee,  
8 including a former licensee under subdivision (a), with a copy of  
9 the text of any proposed public disclosure authorized by this section  
10 prior to release of the disclosure to the public. The licensee shall  
11 have 10 working days from the date the board provides the copy  
12 of the proposed public disclosure to propose corrections of factual  
13 inaccuracies. Nothing in this section shall prevent the board from  
14 disclosing information to the public prior to the expiration of the  
15 10-day period.

16 (h) Pursuant to subparagraph (A) of paragraph (2) of subdivision  
17 (b), the specialty or subspecialty information required by this  
18 section shall group physicians by specialty board recognized  
19 pursuant to paragraph (5) of subdivision (h) of Section 651 unless  
20 a different grouping would be more valid and the board, in its  
21 statement of reasons for its regulations, explains why the validity  
22 of the grouping would be more valid.

23 (i) *On and after July 1, 2018, the Medical Board of California*  
24 *and the Osteopathic Medical Board of California shall provide*  
25 *the information described in subdivision (d) of Section 2228.1,*  
26 *with respect to licensees on probation and licensees practicing*  
27 *under probationary licenses, to an inquiring member of the public*  
28 *and on any board documents, such as newsletters, informing the*  
29 *public of individual probation orders and probationary licenses.*

30 *SEC. 11. Section 805 of the Business and Professions Code is*  
31 *amended to read:*

32 805. (a) As used in this section, the following terms have the  
33 following definitions:

34 (1) (A) “Peer review” means both of the following:

35 (i) A process in which a peer review body reviews the basic  
36 qualifications, staff privileges, employment, medical outcomes,  
37 or professional conduct of licentiates to make recommendations  
38 for quality improvement and education, if necessary, in order to  
39 do either or both of the following:

(I) Determine whether a licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, to determine the parameters of that practice.

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

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

(B) “Peer review body” includes:

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

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

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

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

(2) “Licentiate” means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, *licensed midwife*, or physician assistant. “Licentiate” also includes a person authorized to practice medicine pursuant to Section 2113 or 2168.

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

(4) “Staff privileges” means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not

1 limited to, full staff privileges, active staff privileges, limited staff  
2 privileges, auxiliary staff privileges, provisional staff privileges,  
3 temporary staff privileges, courtesy staff privileges, locum tenens  
4 arrangements, and contractual arrangements to provide professional  
5 services, including, but not limited to, arrangements to provide  
6 outpatient services.

7 (5) “Denial or termination of staff privileges, membership, or  
8 employment” includes failure or refusal to renew a contract or to  
9 renew, extend, or reestablish any staff privileges, if the action is  
10 based on medical disciplinary cause or reason.

11 (6) “Medical disciplinary cause or reason” means that aspect  
12 of a licentiate’s competence or professional conduct that is  
13 reasonably likely to be detrimental to patient safety or to the  
14 delivery of patient care.

15 (7) “805 report” means the written report required under  
16 subdivision (b).

17 (b) The chief of staff of a medical or professional staff or other  
18 chief executive officer, medical director, or administrator of any  
19 peer review body and the chief executive officer or administrator  
20 of any licensed health care facility or clinic shall file an 805 report  
21 with the relevant agency within 15 days after the effective date on  
22 which any of the following occur as a result of an action of a peer  
23 review body:

24 (1) A licentiate’s application for staff privileges or membership  
25 is denied or rejected for a medical disciplinary cause or reason.

26 (2) A licentiate’s membership, staff privileges, or employment  
27 is terminated or revoked for a medical disciplinary cause or reason.

28 (3) Restrictions are imposed, or voluntarily accepted, on staff  
29 privileges, membership, or employment for a cumulative total of  
30 30 days or more for any 12-month period, for a medical disciplinary  
31 cause or reason.

32 (c) If a licentiate takes any action listed in paragraph (1), (2),  
33 or (3) after receiving notice of a pending investigation initiated  
34 for a medical disciplinary cause or reason or after receiving notice  
35 that his or her application for membership or staff privileges is  
36 denied or will be denied for a medical disciplinary cause or reason,  
37 the chief of staff of a medical or professional staff or other chief  
38 executive officer, medical director, or administrator of any peer  
39 review body and the chief executive officer or administrator of  
40 any licensed health care facility or clinic where the licentiate is



1 employed or has staff privileges or membership or where the  
2 licentiate applied for staff privileges or membership, or sought the  
3 renewal thereof, shall file an 805 report with the relevant agency  
4 within 15 days after the licentiate takes the action.

5 (1) Resigns or takes a leave of absence from membership, staff  
6 privileges, or employment.

7 (2) Withdraws or abandons his or her application for staff  
8 privileges or membership.

9 (3) Withdraws or abandons his or her request for renewal of  
10 staff privileges or membership.

11 (d) For purposes of filing an 805 report, the signature of at least  
12 one of the individuals indicated in subdivision (b) or (c) on the  
13 completed form shall constitute compliance with the requirement  
14 to file the report.

15 (e) An 805 report shall also be filed within 15 days following  
16 the imposition of summary suspension of staff privileges,  
17 membership, or employment, if the summary suspension remains  
18 in effect for a period in excess of 14 days.

19 (f) A copy of the 805 report, and a notice advising the licentiate  
20 of his or her right to submit additional statements or other  
21 information, electronically or otherwise, pursuant to Section 800,  
22 shall be sent by the peer review body to the licentiate named in  
23 the report. The notice shall also advise the licentiate that  
24 information submitted electronically will be publicly disclosed to  
25 those who request the information.

26 The information to be reported in an 805 report shall include the  
27 name and license number of the licentiate involved, a description  
28 of the facts and circumstances of the medical disciplinary cause  
29 or reason, and any other relevant information deemed appropriate  
30 by the reporter.

31 A supplemental report shall also be made within 30 days  
32 following the date the licentiate is deemed to have satisfied any  
33 terms, conditions, or sanctions imposed as disciplinary action by  
34 the reporting peer review body. In performing its dissemination  
35 functions required by Section 805.5, the agency shall include a  
36 copy of a supplemental report, if any, whenever it furnishes a copy  
37 of the original 805 report.

38 If another peer review body is required to file an 805 report, a  
39 health care service plan is not required to file a separate report  
40 with respect to action attributable to the same medical disciplinary

1 cause or reason. If the Medical Board of California or a licensing  
2 agency of another state revokes or suspends, without a stay, the  
3 license of a physician and surgeon, a peer review body is not  
4 required to file an 805 report when it takes an action as a result of  
5 the revocation or suspension. *If the California Board of Podiatric*  
6 *Medicine or a licensing agency of another state revokes or*  
7 *suspends, without a stay, the license of a doctor of podiatric*  
8 *medicine, a peer review body is not required to file an 805 report*  
9 *when it takes an action as a result of the revocation or suspension.*

10 (g) The reporting required by this section shall not act as a  
11 waiver of confidentiality of medical records and committee reports.  
12 The information reported or disclosed shall be kept confidential  
13 except as provided in subdivision (c) of Section 800 and Sections  
14 803.1 and 2027, provided that a copy of the report containing the  
15 information required by this section may be disclosed as required  
16 by Section 805.5 with respect to reports received on or after  
17 January 1, 1976.

18 (h) The Medical Board of California, *the California Board of*  
19 *Podiatric Medicine*, the Osteopathic Medical Board of California,  
20 and the Dental Board of California shall disclose reports as required  
21 by Section 805.5.

22 (i) An 805 report shall be maintained electronically by an agency  
23 for dissemination purposes for a period of three years after receipt.

24 (j) No person shall incur any civil or criminal liability as the  
25 result of making any report required by this section.

26 (k) A willful failure to file an 805 report by any person who is  
27 designated or otherwise required by law to file an 805 report is  
28 punishable by a fine not to exceed one hundred thousand dollars  
29 (\$100,000) per violation. The fine may be imposed in any civil or  
30 administrative action or proceeding brought by or on behalf of any  
31 agency having regulatory jurisdiction over the person regarding  
32 whom the report was or should have been filed. If the person who  
33 is designated or otherwise required to file an 805 report is a  
34 licensed physician and surgeon, the action or proceeding shall be  
35 brought by the Medical Board of California. *If the person who is*  
36 *designated or otherwise required to file an 805 report is a licensed*  
37 *doctor of podiatric medicine, the action or proceeding shall be*  
38 *brought by the California Board of Podiatric Medicine.* The fine  
39 shall be paid to that agency but not expended until appropriated  
40 by the Legislature. A violation of this subdivision may constitute



unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available at law. As used in this subdivision, “willful” means a voluntary and intentional violation of a known legal duty.

(l) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that under no circumstances shall exceed fifty thousand dollars (\$50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. *If the person who is designated or otherwise required to file an 805 report is a licensed doctor of podiatric medicine, the action or proceeding shall be brought by the California Board of Podiatric Medicine.* The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars (\$50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

(m) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when

1 determining participation with the plan or insurer, shall evaluate,  
2 on a case-by-case basis, licentiates who are the subject of an 805  
3 report, and not automatically exclude or deselect these licentiates.

4 *(n) State agencies and hospital accrediting agencies shall report*  
5 *to the Medical Board of California any peer review incidents*  
6 *subject to 805 reporting that are found during an inspection of a*  
7 *health care facility or clinic.*

8 *SEC. 12. Section 805.01 of the Business and Professions Code*  
9 *is amended to read:*

10 805.01. (a) As used in this section, the following terms have  
11 the following definitions:

12 (1) “Agency” has the same meaning as defined in Section 805.

13 (2) “Formal investigation” means an investigation performed  
14 by a peer review body based on an allegation that any of the acts  
15 listed in paragraphs (1) to (4), inclusive, of subdivision (b)  
16 occurred.

17 (3) “Licentiate” has the same meaning as defined in Section  
18 805.

19 (4) “Peer review body” has the same meaning as defined in  
20 Section 805.

21 (b) The chief of staff of a medical or professional staff or other  
22 chief executive officer, medical director, or administrator of any  
23 peer review body and the chief executive officer or administrator  
24 of any licensed health care facility or clinic shall file a report with  
25 the relevant agency within 15 days after a peer review body makes  
26 a final decision or recommendation regarding the disciplinary  
27 action, as specified in subdivision (b) of Section 805, resulting in  
28 a final proposed action to be taken against a licentiate based on  
29 the peer review body’s determination, following formal  
30 investigation of the licentiate, that any of the acts listed in  
31 paragraphs (1) to (4), inclusive, may have occurred, regardless of  
32 whether a hearing is held pursuant to Section 809.2. The licentiate  
33 shall receive a notice of the proposed action as set forth in Section  
34 809.1, which shall also include a notice advising the licentiate of  
35 the right to submit additional explanatory or exculpatory statements  
36 electronically or otherwise.

37 (1) Incompetence, or gross or repeated deviation from the  
38 standard of care involving death or serious bodily injury to one or  
39 more patients, to the extent or in such a manner as to be dangerous  
40 or injurious to any person or to the public. This paragraph shall

1 not be construed to affect or require the imposition of immediate  
2 suspension pursuant to Section 809.5.

3 (2) The use of, or prescribing for or administering to himself or  
4 herself, any controlled substance; or the use of any dangerous drug,  
5 as defined in Section 4022, or of alcoholic beverages, to the extent  
6 or in such a manner as to be dangerous or injurious to the licentiate,  
7 any other person, or the public, or to the extent that such use  
8 impairs the ability of the licentiate to practice safely.

9 (3) Repeated acts of clearly excessive prescribing, furnishing,  
10 or administering of controlled substances or repeated acts of  
11 prescribing, dispensing, or furnishing of controlled substances  
12 without a good faith effort prior examination of the patient and  
13 medical reason therefor. However, in no event shall a physician  
14 and surgeon prescribing, furnishing, or administering controlled  
15 substances for intractable pain, consistent with lawful prescribing,  
16 be reported for excessive prescribing and prompt review of the  
17 applicability of these provisions shall be made in any complaint  
18 that may implicate these provisions.

19 (4) Sexual misconduct with one or more patients during a course  
20 of treatment or an examination.

21 (c) The relevant agency shall be entitled to inspect and copy the  
22 following documents in the record of any formal investigation  
23 required to be reported pursuant to subdivision (b):

24 (1) Any statement of charges.

25 (2) Any document, medical chart, or exhibit.

26 (3) Any opinions, findings, or conclusions.

27 (4) Any certified copy of medical records, as permitted by other  
28 applicable law.

29 (d) The report provided pursuant to subdivision (b) and the  
30 information disclosed pursuant to subdivision (c) shall be kept  
31 confidential and shall not be subject to discovery, except that the  
32 information may be reviewed as provided in subdivision (c) of  
33 Section 800 and may be disclosed in any subsequent disciplinary  
34 hearing conducted pursuant to the Administrative Procedure Act  
35 (Chapter 5 (commencing with Section 11500) of Part 1 of Division  
36 3 of Title 2 of the Government Code).

37 (e) The report required under this section shall be in addition  
38 to any report required under Section 805.

39 (f) A peer review body shall not be required to make a report  
40 pursuant to this section if that body does not make a final decision

1 or recommendation regarding the disciplinary action to be taken  
2 against a licentiate based on the body's determination that any of  
3 the acts listed in paragraphs (1) to (4), inclusive, of subdivision  
4 (b) may have occurred.

5 (g) *A willful failure to file a report pursuant to this section by*  
6 *any person who is designated or otherwise required by law to file*  
7 *a report is punishable by a fine not to exceed one hundred thousand*  
8 *dollars (\$100,000) per violation. The fine may be imposed in any*  
9 *civil or administrative action or proceeding brought by or on*  
10 *behalf of any agency having regulatory jurisdiction over the person*  
11 *who filed or should have filed the report. If the person who is*  
12 *designated or otherwise required to file a report is a licensed*  
13 *physician and surgeon, the action or proceeding shall be brought*  
14 *by the Medical Board of California. The fine shall be paid to that*  
15 *agency. A violation of this subdivision may constitute*  
16 *unprofessional conduct by the licentiate. A person who is alleged*  
17 *to have violated this subdivision may assert any defense available*  
18 *at law. As used in this subdivision, "willful" means a voluntary*  
19 *and intentional violation of a known legal duty.*

20 (h) *Except as otherwise provided in subdivision (g), any failure*  
21 *by the administrator of any peer review body, the chief executive*  
22 *officer or administrator of any health care facility, or any person*  
23 *who is designated or otherwise required by law to file a report*  
24 *pursuant to this section, shall be punishable by a fine that under*  
25 *no circumstances shall exceed fifty thousand dollars (\$50,000)*  
26 *per violation. The fine may be imposed in any civil or*  
27 *administrative action or proceeding brought by or on behalf of*  
28 *any agency having regulatory jurisdiction over the person who*  
29 *filed or should have filed the report. If the person who is designated*  
30 *or otherwise required to file a report is a licensed physician and*  
31 *surgeon, the action or proceeding shall be brought by the Medical*  
32 *Board of California. The fine shall be paid to that agency. The*  
33 *amount of the fine imposed, not exceeding fifty thousand dollars*  
34 *(\$50,000) per violation, shall be proportional to the severity of*  
35 *the failure to report and shall differ based upon written findings,*  
36 *including (i) whether the failure to file caused harm to a patient*  
37 *or created a risk to patient safety, (ii) whether the administrator*  
38 *of any peer review body, the chief executive officer or administrator*  
39 *of any health care facility, or any person who is designated or*  
40 *otherwise required by law to file a report exercised due diligence*

1 *despite the failure to file or whether they knew or should have*  
 2 *known that a report would not be filed, and (3) whether there has*  
 3 *been a prior failure to file a report. The amount of the fine imposed*  
 4 *may also differ based on whether a health care facility is a small*  
 5 *or rural hospital as defined in Section 124840 of the Health and*  
 6 *Safety Code.*

7 *(i) State agencies and hospital accrediting agencies shall report*  
 8 *to the Medical Board of California any peer review incidents*  
 9 *subject to 805.01 reporting that are found during an inspection of*  
 10 *a health care facility or clinic.*

11 *SEC. 13. Section 805.1 of the Business and Professions Code*  
 12 *is amended to read:*

13 805.1. (a) The Medical Board of California, the California  
 14 Board of Podiatric Medicine, the Osteopathic Medical Board of  
 15 California, and the Dental Board of California shall be entitled to  
 16 inspect and copy the following documents in the record of any  
 17 disciplinary proceeding resulting in action that is required to be  
 18 reported pursuant to Section 805:

- 19 (1) Any statement of charges.
- 20 (2) Any document, medical chart, or exhibits in evidence.
- 21 (3) Any opinion, findings, or conclusions.
- 22 (4) Any certified copy of medical records, as permitted by other  
 23 applicable law.

24 (b) The information so disclosed shall be kept confidential and  
 25 not subject to discovery, in accordance with Section 800, except  
 26 that it may be reviewed, as provided in subdivision (c) of Section  
 27 800, and may be disclosed in any subsequent disciplinary hearing  
 28 conducted pursuant to the Administrative Procedure Act (Chapter  
 29 5 (commencing with Section 11500) of Part 1 of Division 3 of  
 30 Title 2 of the Government Code).

31 *SEC. 14. Section 805.5 of the Business and Professions Code*  
 32 *is amended to read:*

33 805.5. (a) Prior to granting or renewing staff privileges for  
 34 any physician and surgeon, psychologist, podiatrist, or dentist, any  
 35 health facility licensed pursuant to Division 2 (commencing with  
 36 Section 1200) of the Health and Safety Code, any health care  
 37 service plan or medical care foundation, the medical staff of the  
 38 institution, a facility certified to participate in the federal Medicare  
 39 Program as an ambulatory surgical center, or an outpatient setting  
 40 accredited pursuant to Section 1248.1 of the Health and Safety

1 Code shall request a report from the Medical Board of California,  
2 the Board of Psychology, *the California Board of Podiatric*  
3 *Medicine*, the Osteopathic Medical Board of California, or the  
4 Dental Board of California to determine if any report has been  
5 made pursuant to Section 805 indicating that the applying physician  
6 and surgeon, psychologist, podiatrist, or dentist has been denied  
7 staff privileges, been removed from a medical staff, or had his or  
8 her staff privileges restricted as provided in Section 805. The  
9 request shall include the name and California license number of  
10 the physician and surgeon, psychologist, podiatrist, or dentist.  
11 Furnishing of a copy of the 805 report shall not cause the 805  
12 report to be a public record.

13 (b) Upon a request made by, or on behalf of, an institution  
14 described in subdivision (a) or its medical staff the board shall  
15 furnish a copy of any report made pursuant to Section 805 as well  
16 as any additional exculpatory or explanatory information submitted  
17 electronically to the board by the licensee pursuant to subdivision  
18 (f) of that section. However, the board shall not send a copy of a  
19 report (1) if the denial, removal, or restriction was imposed solely  
20 because of the failure to complete medical records, (2) if the board  
21 has found the information reported is without merit, (3) if a court  
22 finds, in a final judgment, that the peer review, as defined in  
23 Section 805, resulting in the report was conducted in bad faith and  
24 the licensee who is the subject of the report notifies the board of  
25 that finding, or (4) if a period of three years has elapsed since the  
26 report was submitted. This three-year period shall be tolled during  
27 any period the licensee has obtained a judicial order precluding  
28 disclosure of the report, unless the board is finally and permanently  
29 precluded by judicial order from disclosing the report. If a request  
30 is received by the board while the board is subject to a judicial  
31 order limiting or precluding disclosure, the board shall provide a  
32 disclosure to any qualified requesting party as soon as practicable  
33 after the judicial order is no longer in force.

34 If the board fails to advise the institution within 30 working days  
35 following its request for a report required by this section, the  
36 institution may grant or renew staff privileges for the physician  
37 and surgeon, psychologist, podiatrist, or dentist.

38 (c) Any institution described in subdivision (a) or its medical  
39 staff that violates subdivision (a) is guilty of a misdemeanor and



1 shall be punished by a fine of not less than two hundred dollars  
2 (\$200) nor more than one thousand two hundred dollars (\$1,200).

3 *SEC. 15. Section 805.6 of the Business and Professions Code*  
4 *is amended to read:*

5 805.6. (a) The Medical Board of California, *California Board*  
6 *of Podiatric Medicine*, the Osteopathic Medical Board, and the  
7 Dental Board of California shall establish a system of electronic  
8 notification that is either initiated by the board or can be accessed  
9 by qualified subscribers, and that is designed to achieve early  
10 notification to qualified recipients of the existence of new reports  
11 that are filed pursuant to Section 805.

12 (b) The State Department of Health Services shall notify the  
13 appropriate licensing agency of any reporting violations pursuant  
14 to Section 805.

15 (c) The Department of Managed Health Care shall notify the  
16 appropriate licensing agency of any reporting violations pursuant  
17 to Section 805.

18 *SEC. 16. Section 810 of the Business and Professions Code is*  
19 *amended to read:*

20 810. (a) It shall constitute unprofessional conduct and grounds  
21 for disciplinary action, including suspension or revocation of a  
22 license or certificate, for a health care professional to do any of  
23 the following in connection with his or her professional activities:

24 (1) Knowingly present or cause to be presented any false or  
25 fraudulent claim for the payment of a loss under a contract of  
26 insurance.

27 (2) Knowingly prepare, make, or subscribe any writing, with  
28 intent to present or use the same, or to allow it to be presented or  
29 used in support of any false or fraudulent claim.

30 (b) It shall constitute cause for revocation or suspension of a  
31 license or certificate for a health care professional to engage in  
32 any conduct prohibited under Section 1871.4 of the Insurance Code  
33 or Section 549 or 550 of the Penal Code.

34 (c) (1) It shall constitute cause for automatic suspension of a  
35 license or certificate issued pursuant to Chapter 4 (commencing  
36 with Section 1600), Chapter 5 (commencing with Section 2000),  
37 Chapter 6.6 (commencing with Section 2900), Chapter 7  
38 (commencing with Section 3000), or Chapter 9 (commencing with  
39 Section 4000), or pursuant to the Chiropractic Act or the  
40 Osteopathic Act, if a licensee or certificate holder has been

1 convicted of any felony involving fraud committed by the licensee  
2 or certificate holder in conjunction with providing benefits covered  
3 by worker's compensation insurance, or has been convicted of any  
4 felony involving Medi-Cal fraud committed by the licensee or  
5 certificate holder in conjunction with the Medi-Cal program,  
6 including the Denti-Cal element of the Medi-Cal program, pursuant  
7 to Chapter 7 (commencing with Section 14000), or Chapter 8  
8 (commencing with Section 14200), of Part 3 of Division 9 of the  
9 Welfare and Institutions Code. The board shall convene a  
10 disciplinary hearing to determine whether or not the license or  
11 certificate shall be suspended, revoked, or some other disposition  
12 shall be considered, including, but not limited to, revocation with  
13 the opportunity to petition for reinstatement, suspension, or other  
14 limitations on the license or certificate as the board deems  
15 appropriate.

16 (2) It shall constitute cause for automatic suspension and for  
17 revocation of a license or certificate issued pursuant to Chapter 4  
18 (commencing with Section 1600), Chapter 5 (commencing with  
19 Section 2000), Chapter 6.6 (commencing with Section 2900),  
20 Chapter 7 (commencing with Section 3000), or Chapter 9  
21 (commencing with Section 4000), or pursuant to the Chiropractic  
22 Act or the Osteopathic Act, if a licensee or certificate holder has  
23 more than one conviction of any felony arising out of separate  
24 prosecutions involving fraud committed by the licensee or  
25 certificate holder in conjunction with providing benefits covered  
26 by worker's compensation insurance, or in conjunction with the  
27 Medi-Cal program, including the Denti-Cal element of the  
28 Medi-Cal program pursuant to Chapter 7 (commencing with  
29 Section 14000), or Chapter 8 (commencing with Section 14200),  
30 of Part 3 of Division 9 of the Welfare and Institutions Code. The  
31 board shall convene a disciplinary hearing to revoke the license  
32 or certificate and an order of revocation shall be issued unless the  
33 board finds mitigating circumstances to order some other  
34 disposition.

35 (3) It is the intent of the Legislature that paragraph (2) apply to  
36 a licensee or certificate holder who has one or more convictions  
37 prior to January 1, 2004, as provided in this subdivision.

38 (4) Nothing in this subdivision shall preclude a board from  
39 suspending or revoking a license or certificate pursuant to any  
40 other provision of law.



(5) “Board,” as used in this subdivision, means the Dental Board of California, the Medical Board of California, *the California Board of Podiatric Medicine*, the Board of Psychology, the State Board of Optometry, the California State Board of Pharmacy, the Osteopathic Medical Board of California, and the State Board of Chiropractic Examiners.

(6) “More than one conviction,” as used in this subdivision, means that the licensee or certificate holder has one or more convictions prior to January 1, 2004, and at least one conviction on or after that date, or the licensee or certificate holder has two or more convictions on or after January 1, 2004. However, a licensee or certificate holder who has one or more convictions prior to January 1, 2004, but who has no convictions and is currently licensed or holds a certificate after that date, does not have “more than one conviction” for the purposes of this subdivision.

(d) As used in this section, health care professional means any person licensed or certified pursuant to this division, or licensed pursuant to the Osteopathic Initiative Act, or the Chiropractic Initiative Act.

#### SECTION 1.

SEC. 17. Section 2001 of the Business and Professions Code is amended to read:

2001. (a) There is in the Department of Consumer Affairs a Medical Board of California that consists of 15 members, 7 of whom shall be public members.

(b) The Governor shall appoint 13 members to the board, subject to confirmation by the Senate, 5 of whom shall be public members. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.

(c) This section shall remain in effect only until January 1, 2022, and as of that date is repealed. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 18. Section 2006 of the Business and Professions Code is amended to read:

2006. (a) Any reference in this chapter to an investigation by the board shall be deemed to refer to a joint investigation conducted by employees of the Department of Justice and the Health Quality Investigation Unit under the vertical enforcement and prosecution

1 ~~model, as specified in Section 12529.6 of the Government Code.~~  
2 ~~an investigation conducted by employees of the Health Quality~~  
3 ~~Investigation Unit within the Department of Consumer Affairs~~  
4 ~~Division of Investigation.~~

5 ~~(b) This section shall become operative on July 1, 2014.~~

6 SEC. 19. *Section 2008 of the Business and Professions Code*  
7 *is amended to read:*

8 2008. The board may appoint panels from its members for the  
9 purpose of fulfilling the obligations established in subdivision (c)  
10 of Section 2004. Any panel appointed under this section shall at  
11 no time be comprised of less than four members and the number  
12 of public members assigned to the panel shall not exceed the  
13 number of licensed physician and surgeon members assigned to  
14 the panel. ~~The president of the board shall not be a member of any~~  
15 ~~panel unless there is a vacancy in the membership of the board.~~  
16 Each panel shall annually elect a chair and a vice chair.

17 ~~SEC. 2.~~

18 SEC. 20. *Section 2020 of the Business and Professions Code*  
19 *is amended to read:*

20 2020. (a) The board, by and with the approval of the director,  
21 may employ an executive director exempt from the provisions of  
22 the Civil Service Act and may also employ investigators, legal  
23 counsel, medical consultants, and other assistance as it may deem  
24 necessary to carry this chapter into effect. The board may fix the  
25 compensation to be paid for services subject to the provisions of  
26 applicable state laws and regulations and may incur other expenses  
27 as it may deem necessary. Investigators employed by the board  
28 shall be provided special training in investigating medical practice  
29 activities.

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

33 (c) This section shall remain in effect only until January 1, 2022,  
34 and as of that date is repealed.

35 SEC. 21. *Section 2026 is added to the Business and Professions*  
36 *Code, to read:*

37 2026. *The board shall initiate the process of adopting*  
38 *regulations on or before January 1, 2019, to require its licentiates*  
39 *and registrants to provide notice to their clients or patients that*  
40 *the practitioner is licensed or registered in this state by the board,*

1 *that the practitioner's license can be checked, and that complaints*  
2 *against the practitioner can be made through the board's Internet*  
3 *Web site or by contacting the board.*

4 *SEC. 22. Section 2052.5 of the Business and Professions Code*  
5 *is repealed.*

6 ~~2052.5.—(a) The proposed registration program developed~~  
7 ~~pursuant to subdivision (b) shall provide that, for purposes of the~~  
8 ~~proposed registration program:~~

9 ~~(1) A physician and surgeon practices medicine in this state~~  
10 ~~across state lines when that person is located outside of this state~~  
11 ~~but, through the use of any medium, including an electronic~~  
12 ~~medium, practices or attempts to practice, or advertises or holds~~  
13 ~~himself or herself out as practicing, any system or mode of treating~~  
14 ~~the sick or afflicted in this state, or diagnoses, treats, operates for,~~  
15 ~~or prescribes for any ailment, blemish, deformity, disease,~~  
16 ~~disfigurement, disorder, injury, or other physical or mental~~  
17 ~~condition of any person in this state.~~

18 ~~(2) A doctor of podiatric medicine practices podiatric medicine~~  
19 ~~in this state across state lines when that person is located outside~~  
20 ~~of this state but, through the use of any medium, including an~~  
21 ~~electronic medium, practices or attempts to practice podiatric~~  
22 ~~medicine, as defined in Section 2472, in this state.~~

23 ~~(3) The proposed registration program shall not apply to any~~  
24 ~~consultation described in Section 2060.~~

25 ~~(b) The board may, at its discretion, develop a proposed~~  
26 ~~registration program to permit a physician and surgeon, or a doctor~~  
27 ~~of podiatric medicine, located outside this state to register with~~  
28 ~~the board to practice medicine or podiatric medicine in this state~~  
29 ~~across state lines.~~

30 ~~(1) The proposed registration program shall include proposed~~  
31 ~~requirements for registration, including, but not limited to, licensure~~  
32 ~~in the state or country where the physician and surgeon, or the~~  
33 ~~doctor of podiatric medicine, resides, and education and training~~  
34 ~~requirements.~~

35 ~~(2) The proposed registration program may also include all of~~  
36 ~~the following: (A) standards for confidentiality, format, and~~  
37 ~~retention of medical records, (B) access to medical records by the~~  
38 ~~board, (C) registration fees, renewal fees, delinquency fees, and~~  
39 ~~replacement document fees in an amount not to exceed the actual~~  
40 ~~cost of administering the registration program, and (D) provisions~~

1 ensuring that enforcement and consumer education shall be integral  
2 parts of administering the registration program.

3 (3) ~~The proposed registration program may also provide all of~~  
4 ~~the following:~~

5 (A) ~~All laws, rules, and regulations that govern the practice of~~  
6 ~~medicine or podiatric medicine in this state, including, but not~~  
7 ~~limited to, confidentiality and reporting requirements, shall apply~~  
8 ~~to a physician and surgeon, or a doctor of podiatric medicine, who~~  
9 ~~is registered by the board to practice medicine or podiatric medicine~~  
10 ~~in this state across state lines.~~

11 (B) ~~The board may deny an application for registration or may~~  
12 ~~suspend, revoke, or otherwise discipline a registrant for any of the~~  
13 ~~following: (i) on any ground prescribed by this chapter, (ii) failure~~  
14 ~~to possess or to maintain a valid license in the state where the~~  
15 ~~registrant resides, or (iii) if the applicant or registrant is not licensed~~  
16 ~~by the state or country in which he or she resides, and that state or~~  
17 ~~country prohibits the practice of medicine or podiatric medicine~~  
18 ~~from that state or country into any other state or country without~~  
19 ~~a valid registration or license issued by the state or country in~~  
20 ~~which the applicant or registrant practices. Action to deny or~~  
21 ~~discipline a registrant shall be taken in the manner provided for in~~  
22 ~~this chapter.~~

23 (C) ~~Any of the following shall be grounds for discipline of a~~  
24 ~~registrant: (i) to allow any person to engage in the practice of~~  
25 ~~medicine or podiatric medicine in this state across state lines under~~  
26 ~~his or her registration, including, but not limited to, any nurse,~~  
27 ~~physician assistant, medical assistant, or other person, (ii) to fail~~  
28 ~~to include his or her registration number on any invoice or other~~  
29 ~~type of billing statement submitted for care or treatment provided~~  
30 ~~to a patient located in this state, (iii) to practice medicine or~~  
31 ~~podiatric medicine in any other state or country without meeting~~  
32 ~~the legal requirements to practice medicine or podiatric medicine~~  
33 ~~in that state or country, or (iv) to fail to notify the board, in a~~  
34 ~~manner prescribed by the board, of any restrictions placed on his~~  
35 ~~or her medical license, or podiatric medical license, in any state.~~

36 (D) ~~A registration issued pursuant to the registration program~~  
37 ~~shall automatically be suspended upon receipt of a copy, from the~~  
38 ~~state that issued the license, of the surrender, revocation,~~  
39 ~~suspension, or other similar type of action taken by another state~~  
40 ~~or country against a medical license, or podiatric medical license,~~

1 issued to a registrant. The board shall notify the registrant in writing  
2 of the suspension and of the registrant's right to a hearing.

3 ~~(4) Section 2314 shall not apply to the registration program.~~

4 ~~(e) This section shall not be construed to authorize the board to~~  
5 ~~implement a registration program for physicians and surgeons or~~  
6 ~~doctors of podiatric medicine located outside this state. This section~~  
7 ~~is intended to authorize the board to develop a proposed registration~~  
8 ~~program to be authorized for implementation by future legislation.~~

9 *SEC. 23. Section 2054 of the Business and Professions Code*  
10 *is amended to read:*

11 2054. (a) Any person who uses in any sign, business card, or  
12 letterhead, or, in an advertisement, the words "doctor" or  
13 "physician," the letters or prefix "Dr.," the initials "M.D.," or any  
14 other terms or letters indicating or implying that he or she is a  
15 physician and surgeon, physician, surgeon, or practitioner under  
16 the terms of this or any other law, or that he or she is entitled to  
17 practice hereunder, or who represents or holds himself or herself  
18 out as a physician and surgeon, physician, surgeon, or practitioner  
19 under the terms of this or any other law, without having at the time  
20 of so doing a valid, unrevoked, and unsuspended certificate as a  
21 physician and surgeon under this chapter, is guilty of a  
22 misdemeanor.

23 ~~(b) A holder of a valid, unrevoked, and unsuspended certificate~~  
24 ~~to practice podiatric medicine may use the phrases "doctor of~~  
25 ~~podiatric medicine," "doctor of podiatry," and "podiatric doctor,"~~  
26 ~~or the initials "D.P.M.," and shall not be in violation of subdivision~~  
27 ~~(a).~~

28 ~~(e)~~

29 (b) Notwithstanding subdivision (a), any of the following  
30 persons may use the words "doctor" or "physician," the letters or  
31 prefix "Dr.," or the initials "M.D.":

32 (1) A graduate of a medical school approved or recognized by  
33 the board while enrolled in a postgraduate training program  
34 approved by the board.

35 (2) A graduate of a medical school who does not have a  
36 certificate as a physician and surgeon under this chapter if he or  
37 she meets all of the following requirements:

38 (A) If issued a license to practice medicine in any jurisdiction,  
39 has not had that license revoked or suspended by that jurisdiction.

1 (B) Does not otherwise hold himself or herself out as a physician  
2 and surgeon entitled to practice medicine in this state except to  
3 the extent authorized by this chapter.

4 (C) Does not engage in any of the acts prohibited by Section  
5 2060.

6 (3) A person authorized to practice medicine under Section 2111  
7 or 2113 subject to the limitations set forth in those sections.

8 *SEC. 24. Section 2064 of the Business and Professions Code*  
9 *is amended to read:*

10 2064. Nothing in this chapter shall be construed to prevent a  
11 regularly matriculated student undertaking a course of professional  
12 instruction in an approved medical school, or to prevent a foreign  
13 medical student who is enrolled in an approved medical school or  
14 clinical training program in this state, ~~or to prevent students~~  
15 ~~enrolled in a program of supervised clinical training under the~~  
16 ~~direction of an approved medical school pursuant to Section 2104,~~  
17 from engaging in the practice of medicine whenever and wherever  
18 prescribed as a part of his or her course of study.

19 *SEC. 25. Section 2064.5 is added to the Business and*  
20 *Professions Code, to read:*

21 2064.5. (a) Within 180 days after enrollment in a board  
22 approved postgraduate training program pursuant to Section 2065,  
23 medical school graduates shall obtain a physician's and surgeon's  
24 postgraduate training license. To be considered for a postgraduate  
25 training license, the applicant shall submit the application forms  
26 and primary source documents required by the board, shall  
27 successfully pass all required licensing examinations, shall pay  
28 the reduced licensing fee, and shall not have committed any act  
29 that would be grounds for denial.

30 (1) Each application submitted pursuant to this section shall  
31 be made upon a form provided by the board, and each application  
32 form shall contain a legal verification to be signed by the applicant  
33 verifying under penalty of perjury that the information provided  
34 by the applicant is true and correct and that any information in  
35 supporting documents provided by the applicant is true and correct.

36 (2) Each application shall include the following:

37 (A) A diploma issued by a board-approved medical school. The  
38 requirements of the school shall not have been less than those  
39 required under this chapter at the time the diploma was granted  
40 or by any preceding medical practice act at the time that the



1 *diploma was granted. In lieu of a diploma, the applicant may*  
2 *submit evidence satisfactory to the board of having possessed the*  
3 *same.*

4 *(B) An official transcript or other official evidence satisfactory*  
5 *to the board showing each approved medical school in which a*  
6 *resident course of professional instruction was pursued covering*  
7 *the minimum requirements for certification as a physician and*  
8 *surgeon, and that a diploma and degree were granted by the*  
9 *school.*

10 *(C) Other information concerning the professional instruction*  
11 *and preliminary education of the applicant as the board may*  
12 *require.*

13 *(D) An affidavit showing to the satisfaction of the board that*  
14 *the applicant is the person named in each diploma and transcript*  
15 *that he or she submits, that he or she is the lawful holder thereof,*  
16 *and that the diploma or transcript was procured in the regular*  
17 *course of professional instruction and examination without fraud*  
18 *or misrepresentation.*

19 *(E) Either fingerprint cards or a copy of a completed Live Scan*  
20 *form from the applicant in order to establish the identity of the*  
21 *applicant and in order to determine whether the applicant has a*  
22 *record of any criminal convictions in this state or in any other*  
23 *jurisdiction, including foreign countries. The information obtained*  
24 *as a result of the fingerprinting of the applicant shall be used in*  
25 *accordance with Section 11105 of the Penal Code, and to*  
26 *determine whether the applicant is subject to denial of licensure*  
27 *under the provisions of Division 1.5 (commencing with Section*  
28 *475) and Section 2221.*

29 *(F) If the medical school graduate graduated from a foreign*  
30 *medical school approved by the board pursuant to Section 2084,*  
31 *an official Educational Commission for Foreign Medical*  
32 *Graduates (ECFMG) Certification Status Report confirming the*  
33 *graduate is ECFMG certified.*

34 *(b) The physician's and surgeon's postgraduate training license*  
35 *shall be valid until 90 days after the holder has completed 36*  
36 *months of board-approved postgraduate training. The physician's*  
37 *and surgeon's postgraduate training licensee may engage in the*  
38 *practice of medicine only in connection with his or her duties as*  
39 *an intern or resident physician in a board approved program,*  
40 *including its affiliated sites, or under those conditions as are*

1 *approved in writing and maintained in the postgraduate training*  
2 *licensee's file by the director of his or her program.*

3 *(c) The postgraduate training licensee may engage in the*  
4 *practice of medicine in locations authorized by subdivision (b),*  
5 *and as permitted by the Medical Practice Act and other applicable*  
6 *statutes and regulations, including, but not limited to, the*  
7 *following:*

8 *(1) Diagnose and treat patients.*

9 *(2) Prescribe medications without a cosigner, including*  
10 *prescriptions for controlled substances, if the training licensee*  
11 *has the appropriate Drug Enforcement Agency registration/permit*  
12 *and is registered with the Department of Justice CURES program.*

13 *(3) Sign birth certificates without a cosigner.*

14 *(4) Sign death certificates without a cosigner.*

15 *(d) The postgraduate training licensee may be disciplined by*  
16 *the board at any time for any of the grounds that would subject*  
17 *the holder of a physician's and surgeon's certificate to discipline.*

18 *(e) If the medical school graduate fails to obtain a postgraduate*  
19 *training license within 180 days after enrollment in a board*  
20 *approved postgraduate training program or if the board denies*  
21 *his or her application for a postgraduate training license, all*  
22 *privileges and exemptions under this section shall automatically*  
23 *cease.*

24 *SEC. 26. Section 2065 of the Business and Professions Code*  
25 *is amended to read:*

26 *2065. (a) Unless otherwise provided by law, no postgraduate*  
27 *trainee, intern, resident, postdoctoral fellow, or instructor may*  
28 *engage in the practice of medicine, or receive compensation*  
29 *therefor, or offer to engage in the practice of medicine unless he*  
30 *or she holds a valid, unrevoked, and unsuspended physician's and*  
31 *surgeon's certificate issued by the board. However, a graduate of*  
32 *an approved medical school, who is registered with the board and*  
33 *who is enrolled in a postgraduate training program approved by*  
34 *the board, school may engage in the practice of medicine whenever*  
35 *and wherever required as a part of the a postgraduate training*  
36 *program under the following conditions:*

37 *(1) The medical school graduate has taken and passed the*  
38 *board-approved medical licensing examinations required to qualify*  
39 *the applicant to participate in an approved postgraduate training*  
40 *program.*



1     (2) *The medical school graduate is registered with the board.*

2     (3) *If the medical school graduate graduated from a foreign*  
3 *medical school approved by the board pursuant to Section 2084,*  
4 *the Educational Commission for Foreign Medical Graduates*  
5 *(ECFMG) has submitted an official ECFMG Certification Status*  
6 *Report directly to the board confirming the graduate is ECFMG*  
7 *certified.*

8     (4) *The medical school graduate is enrolled in a postgraduate*  
9 *training program approved by the board.*

10    (5) *The board-approved postgraduate training program has*  
11 *submitted the required board approved form to the board*  
12 *documenting the medical school graduate is enrolled in an*  
13 *approved postgraduate training program.*

14    (6) *The medical school graduate obtains a physician's and*  
15 *surgeon's postgraduate training license in accordance with Section*  
16 *2064.5.*

17    (a)

18    (b) *A medical school graduate enrolled in an approved first-year*  
19 *postgraduate training program in accordance with this section may*  
20 *so engage in the practice of medicine for a period not to exceed*  
21 *one year whenever and wherever required as a part of the training*  
22 *program, and may receive compensation for that practice; practice*  
23 *not to exceed 12 months.*

24    (b)

25    (c) *A graduate who has completed the first year of postgraduate*  
26 *training may, in an approved residency or fellowship, engage in*  
27 *the practice of medicine whenever and wherever required as part*  
28 *of that residency or fellowship, and may receive compensation for*  
29 *that practice; practice not to exceed 27 months. The resident or*  
30 *fellow shall qualify for, take, and pass the next succeeding written*  
31 *examination for licensure, or shall qualify for and receive a*  
32 *physician's and surgeon's certificate by one of the other methods*  
33 *specified in this chapter; licensure. If the resident or fellow fails*  
34 *to receive a license to practice medicine under this chapter within*  
35 *one year 27 months from the commencement of the residency or*  
36 *fellowship or if the board denies his or her application for licensure,*  
37 *all privileges and exemptions under this section shall automatically*  
38 *cease.*

1 (d) All approved postgraduate training the medical school  
2 graduate has participated in the United States or Canada shall  
3 count toward the 39-month license exemption.

4 (e) A medical school graduate from a medical school approved  
5 by the board shall have successfully completed a minimum of 36  
6 months of approved postgraduate training with at least 24  
7 consecutive months in the same program, to be eligible for a  
8 California physician's and surgeon's certificate.

9 SEC. 27. Section 2066 of the Business and Professions Code  
10 is repealed.

11 2066. (a) ~~Nothing in this chapter shall be construed to prohibit~~  
12 ~~a foreign medical graduate from engaging in the practice of~~  
13 ~~medicine whenever and wherever required as a part of a clinical~~  
14 ~~service program under the following conditions:~~

15 (1) ~~The clinical service is in a postgraduate training program~~  
16 ~~approved by the Division of Licensing.~~

17 (2) ~~The graduate is registered with the division for the clinical~~  
18 ~~service.~~

19 (b) ~~A graduate may engage in the practice of medicine under~~  
20 ~~this section until the receipt of his or her physician and surgeon's~~  
21 ~~certificate. If the graduate fails to pass the examination and receive~~  
22 ~~a certificate by the completion of the graduate's third year of~~  
23 ~~postgraduate training or if the division denies his or her application~~  
24 ~~for licensure, all privileges and exemptions under this section shall~~  
25 ~~automatically cease.~~

26 (c) ~~Nothing in this section shall preclude a foreign medical~~  
27 ~~graduate from engaging in the practice of medicine under any other~~  
28 ~~exemption contained in this chapter.~~

29 SEC. 28. Section 2066.5 of the Business and Professions Code  
30 is amended to read:

31 2066.5. (a) The pilot program authorized by this section shall  
32 be known and may be cited as the University of California at Los  
33 Angeles David Geffen School of Medicine's International Medical  
34 Graduate Pilot Program.

35 (b) Nothing in this chapter shall be construed to prohibit a  
36 foreign medical graduate from engaging in the practice of medicine  
37 when required as part of the pilot program authorized by this  
38 section.

39 (c) There is currently a preresidency training program at the  
40 University of California, Los Angeles David Geffen School of

Medicine, Department of Family Medicine, hereafter referred to as UCLA, for selected international medical graduates (IMGs). Participation in the pilot program authorized by this section shall be at the option of UCLA. This section authorizes those IMGs, through the new pilot program authorized by this section, to receive, through the existing program, hands-on clinical instruction in the courses specified in subdivision (c) of Section 2089.5. *instruction*. The pilot program, as administered by UCLA, shall include all of the following elements:

(1) Each pilot program participant shall have done all of the following:

(A) Graduated from a medical school recognized by the Medical Board of California at the time of selection.

(B) Taken and passed the United States Medical Licensing Examination Steps 1 and 2 (Clinical Knowledge and Clinical Science).

(C) Submitted an application and materials to the Educational Commission for Foreign Medical Graduates.

(2) A pilot program participant shall receive all clinical instruction at health care facilities operated by the University of California, Los Angeles, or other approved UCLA-designated teaching sites, which shall be hospitals or clinics with either a signed formal affiliation agreement with UCLA or a signed letter of agreement.

(3) Participation of a trainee in clinical instruction offered by the pilot program shall not generally exceed 16 weeks. However, at the discretion of UCLA, an additional eight weeks of clinical instruction may be granted. In no event shall a participant receive more than 24 weeks of clinical instruction under the pilot program.

(4) The clinical instruction shall be supervised by licensed physicians on faculty at UCLA or faculty affiliated with UCLA as specified in an approved affiliation agreement between UCLA and the affiliated entity.

(5) The clinical instruction shall be provided pursuant to written affiliation agreements for clinical instruction of trainees established by UCLA.

(6) The supervising faculty shall evaluate each participant on a regular basis and shall document the completion of each aspect of the clinical instruction portion of the program for each participant.

(d) UCLA shall provide the board with the names of the participants in the pilot program on an annual basis, or more frequently if necessary to maintain accuracy. Upon a reasonable request of the board, UCLA shall provide additional information such as the courses successfully completed by program participants, the dates of instruction, and other relevant information.

~~(e) Nothing in this section shall be construed to alter the requirements for licensure set forth in Sections 2089 and 2089.5. The board may consider participation in the clinical instruction portion of the pilot program as remediation for medical education deficiencies identified in a participant's application for licensure or authorization for postgraduate training should such a deficiency apply to that applicant.~~

(f) On or before January 1, 2018, UCLA is requested to prepare a report for the board and the Legislature. Topics to be addressed in the report shall include the number of participants in the pilot program, the number of participants in the pilot program who were issued physician's and surgeon's certificates by the board, the number of participants who practice in designated medically underserved areas, and the potential for retention or expansion of the pilot program.

(g) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

*SEC. 29. Section 2067 of the Business and Professions Code is repealed.*

~~2067. An applicant for a physician's and surgeon's certificate who is found by the Division of Licensing to be deficient in the education and clinical instruction required by Sections 2089 and 2089.5 or who is required pursuant to Section 2185 to complete additional medical instruction may engage in the practice of medicine in this state in any setting approved by the Division of Licensing for the period of time prescribed by the Division of Licensing.~~

*SEC. 30. Section 2072 of the Business and Professions Code is repealed.*

~~2072. Notwithstanding any other provision of law and subject to the provisions of the State Civil Service Act, any person who~~

1 is licensed to practice medicine in any other state, who meets the  
2 requirements for application set forth in this chapter and who  
3 registers with and is approved by the Division of Licensing, may  
4 be appointed to the medical staff within a state institution and,  
5 under the supervision of a physician and surgeon licensed in this  
6 state, may engage in the practice of medicine on persons under the  
7 jurisdiction of any state institution. Qualified physicians and  
8 surgeons licensed in this state shall not be recruited pursuant to  
9 this section.

10 No person appointed pursuant to this section shall be employed  
11 in any state institution for a period in excess of two years from the  
12 date the person was first employed, and the appointment shall not  
13 be extended beyond the two-year period. At the end of the two-year  
14 period, the physician shall have been issued a physician's and  
15 surgeon's certificate by the board in order to continue employment.  
16 Until the physician has obtained a physician's and surgeon's  
17 certificate from the board, he or she shall not engage in the practice  
18 of medicine in this state except to the extent expressly permitted  
19 herein.

20 *SEC. 31. Section 2073 of the Business and Professions Code*  
21 *is repealed.*

22 2073. Notwithstanding any other provision of law, any person  
23 who is licensed to practice medicine in any other state who meets  
24 the requirements for application set forth in this chapter, and who  
25 registers with and is approved by the Division of Licensing, may  
26 be employed on the resident medical staff within a county general  
27 hospital and, under the supervision of a physician and surgeon  
28 licensed in this state, may engage in the practice of medicine on  
29 persons within the county institution. Employment pursuant to this  
30 section is authorized only when an adequate number of qualified  
31 resident physicians cannot be recruited from intern staffs in this  
32 state.

33 No person appointed pursuant to this section shall be employed  
34 in any county general hospital for a period in excess of two years  
35 from the date the person was first employed, and the employment  
36 shall not be extended beyond the two-year period. At the end of  
37 the two-year period, the physician shall have been issued a  
38 physician's and surgeon's certificate by the board in order to  
39 continue as a member of the resident staff. Until the physician has  
40 obtained a physician's and surgeon's certificate from the board,

1 he or she shall not engage in the practice of medicine in this state  
2 except to the extent expressly permitted herein.

3 *SEC. 32. Section 2082 of the Business and Professions Code*  
4 *is amended to read:*

5 2082. Each application shall include the following:

6 (a) A diploma issued by an approved medical school. The  
7 requirements of the school shall have been at the time of granting  
8 the diploma in no degree less than those required under this chapter  
9 or by any preceding medical practice act at the time that the  
10 diploma was granted. In lieu of a diploma, the applicant may  
11 submit evidence satisfactory to the ~~Division of Licensing~~ board  
12 of having possessed the same.

13 (b) An official transcript or other official evidence satisfactory  
14 to the ~~division~~ board showing each approved medical school in  
15 which a resident course of professional instruction was pursued  
16 covering the minimum requirements for certification as a physician  
17 and surgeon, and that a diploma and degree were granted by the  
18 school.

19 (c) Other information concerning the professional instruction  
20 and preliminary education of the applicant as the ~~division~~ board  
21 may require.

22 (d) *Proof of passage of the written examinations as provided*  
23 *under Article 9 (commencing with Section 2170) with a score*  
24 *acceptable to the board.*

25 (e) *Proof of satisfactory completion of the postgraduate training*  
26 *required under Section 2096 on a form approved by the board.*

27 ~~(d)~~

28 (f) An affidavit showing to the satisfaction of the ~~division~~ board  
29 that the applicant is the person named in each diploma and  
30 transcript that he or she submits, that he or she is the lawful holder  
31 thereof, and that the diploma or transcript was procured in the  
32 regular course of professional instruction and examination without  
33 fraud or misrepresentation.

34 ~~(e)~~

35 (g) Either fingerprint cards or a copy of a completed Live Scan  
36 form from the applicant in order to establish the identity of the  
37 applicant and in order to determine whether the applicant has a  
38 record of any criminal convictions in this state or in any other  
39 jurisdiction, including foreign countries. The information obtained  
40 as a result of the fingerprinting of the applicant shall be used in



accordance with Section 11105 of the Penal Code, and to determine whether the applicant is subject to denial of licensure under the provisions of Division 1.5 (commencing with Section 475) and Section 2221.

(h) *If the applicant attended a foreign medical school approved by the board pursuant to Section 2084, an official Educational Commission for Foreign Medical Graduates (ECFMG) Certification Status Report submitted by the Educational Commission for Foreign Medical Graduates confirming the graduate is ECFMG certified.*

(i) *If the applicant attended a foreign medical school approved by the board pursuant to Section 2084, official evidence satisfactory to the board of completion of all formal requirements of the medical school for graduation, except the applicant shall not be required to have completed an internship or social service or be admitted or licensed to practice medicine in the country in which the professional instruction was completed.*

SEC. 33. *Section 2084 of the Business and Professions Code is amended to read:*

~~2084. The Division of Licensing may approve every school which substantially complies with the requirements of this chapter for resident courses of professional instruction. Graduates of medical schools approved under this section shall be deemed to meet the requirements of Section 2089. (a) Medical schools accredited by a national accrediting agency approved by the division board and recognized by the United States Department of Education shall be deemed approved by the division under this section. Nothing in this chapter prohibits the division from considering the quality of the resident courses of professional instruction required for certification as a physician and surgeon.~~

*board.*

(b) *The board shall determine a foreign medical school to be a recognized medical school if the foreign medical school meets any of the following requirements:*

(1) *The foreign medical school has been evaluated by the Educational Commission for Foreign Medical Graduates (ECFMG) or one of the ECFMG authorized foreign medical school accreditation agencies and deemed to meet the minimum requirements substantially equivalent to the requirements of medical schools accredited by the Liaison Committee on Medical*

1 *Education, the Committee on Accreditation of Canadian Medical*  
2 *Schools, or the Commission on Osteopathic College Accreditation.*

3 (2) *The foreign medical school is listed on the World Federation*  
4 *for Medical Education (WFME) and the Foundation for*  
5 *Advancement of International Medical Education and Research*  
6 *(FAIMER) World Directory of Medical Schools joint directory or*  
7 *the World Directory of Medical Schools.*

8 (3) *The foreign medical school had been previously approved*  
9 *by the board. The prior approval shall only be valid for a maximum*  
10 *of seven years from the date of enactment of this section.*

11 *SEC. 34. Section 2084.5 of the Business and Professions Code*  
12 *is amended to read:*

13 2084.5. Notwithstanding any other law, a medical school or  
14 medical school program accredited by the Liaison Committee on  
15 Medical Education, the Committee on Accreditation of Canadian  
16 Medical Schools, or the Commission on Osteopathic College  
17 Accreditation shall be deemed to meet the requirements of Sections  
18 ~~2089 and 2089.5.~~ *Section 2084.*

19 *SEC. 35. Section 2085 of the Business and Professions Code*  
20 *is repealed.*

21 ~~2085. (a) Notwithstanding Section 2084, a graduate of an~~  
22 ~~approved medical school located in the United States or Canada~~  
23 ~~who has graduated from a special medical school program that~~  
24 ~~does not substantially meet the requirements of Section 2089 with~~  
25 ~~respect to any aspect of curriculum length or content may be~~  
26 ~~approved by the Division of Licensing if the division determines~~  
27 ~~that the applicant has otherwise received adequate instruction in~~  
28 ~~the subjects listed in subdivision (b) of Section 2089.~~

29 ~~“Adequate instruction” means the applicant has received~~  
30 ~~instruction adequate to prepare the applicant to engage in the~~  
31 ~~practice of medicine in the United States. This definition applies~~  
32 ~~to the sufficiency of instruction of the following courses:~~

33 ~~(1) Anatomy, including gross anatomy, embryology, histology,~~  
34 ~~and neuroanatomy.~~

35 ~~(2) Bacteriology and immunology.~~

36 ~~(3) Biochemistry.~~

37 ~~(4) Pathology.~~

38 ~~(5) Pharmacology.~~

39 ~~(6) Physiology.~~



1   ~~The division may require an applicant under this section to~~  
2   ~~undertake additional education to bring up to standard, instruction~~  
3   ~~in the subjects listed in subdivision (b) of Section 2089 as a~~  
4   ~~condition of issuing a physician and surgeon's certificate. In~~  
5   ~~approving an applicant under this section, the division may take~~  
6   ~~into account the applicant's total relevant academic experience,~~  
7   ~~including performance on standardized national examinations.~~

8   ~~(b) (1) Notwithstanding subdivision (a) or Sections 2084 and~~  
9   ~~2089, an applicant who is a graduate of an approved medical school~~  
10   ~~located in the United States or Canada who has graduated from a~~  
11   ~~special medical school program that does not substantially meet~~  
12   ~~the requirements of Section 2089 with respect to any aspect of~~  
13   ~~curriculum length or content shall be presumed to meet the~~  
14   ~~requirements of Sections 2084 and 2089 if the special medical~~  
15   ~~school program has been reviewed and approved by a national~~  
16   ~~accrediting agency approved by the division and recognized by~~  
17   ~~the United States Department of Education.~~

18   ~~(2) This presumption may be overcome upon a finding by the~~  
19   ~~division that the medical education received by the applicant is~~  
20   ~~not the educational equivalent of the medical education received~~  
21   ~~by graduates of medical schools approved pursuant to subdivision~~  
22   ~~(a) or Section 2084. In making its finding, the division shall~~  
23   ~~consider, at a minimum, the applicant's total academic and medical~~  
24   ~~training experience prior to, and following, as well as during,~~  
25   ~~medical school, the applicant's performance on standardized~~  
26   ~~national examinations, including the National Board Examinations,~~  
27   ~~the applicant's achievements as a house staff officer, and the~~  
28   ~~number of years of postgraduate medical training completed by~~  
29   ~~the applicant.~~

30   ~~(3) An applicant under this subdivision who (A) has~~  
31   ~~satisfactorily completed at least two years of postgraduate clinical~~  
32   ~~training approved by the Accreditation Council for Graduate~~  
33   ~~Medical Education or the Coordinating Council of Medical~~  
34   ~~Education of the Canadian Medical Association and whose~~  
35   ~~postgraduate training has included at least one year of clinical~~  
36   ~~contact with patients and (B) has achieved a passing score on the~~  
37   ~~written examination required for licensure, satisfies the~~  
38   ~~requirements of Sections 2084 and 2089. For purposes of this~~  
39   ~~subdivision, an applicant who has satisfactorily completed at least~~  
40   ~~two years of approved postgraduate clinical training on or before~~

1 July 1, 1987, shall not be required to have at least one year of  
2 clinical contact with patients.

3 (4) Applicants under this subdivision who apply after  
4 satisfactorily completing one year of approved postgraduate  
5 training shall have their applications reviewed by the division and  
6 shall be informed by the division either that satisfactory completion  
7 of a second year of approved postgraduate training will result in  
8 their being deemed to meet the requirements of Sections 2084 and  
9 2089, or informed of any deficiencies in their qualifications or  
10 documentation and the specific remediation, if any, required by  
11 the division to meet the requirements of Sections 2084 and 2089.  
12 Upon satisfactory completion of the specified remediation, the  
13 division shall promptly issue a license to the applicant.

14 *SEC. 36. Section 2087 of the Business and Professions Code*  
15 *is amended to read:*

16 2087. If any medical school is not approved by the Division  
17 of Licensing or any applicant for licensure is rejected by it, the  
18 board, then the school or the applicant may commence an action  
19 in the superior court as provided in Section 2019 against the  
20 division board to compel it to approve the school or to issue the  
21 applicant a certificate or for any other appropriate relief. If the  
22 applicant is denied a certificate on the grounds of unprofessional  
23 conduct, the provisions of Article 12 (commencing with Section  
24 2220) shall apply. In such an action the court shall proceed under  
25 Section 1094.5 of the Code of Civil Procedure, except that the  
26 court may not exercise an independent judgment on the evidence.  
27 The action shall be speedily determined by the court and shall take  
28 precedence over all matters pending therein except criminal cases,  
29 applications for injunction, or other matters to which special  
30 precedence may be given by law.

31 *SEC. 37. Section 2089 of the Business and Professions Code*  
32 *is repealed.*

33 2089. (a) Each applicant for a physician's and surgeon's  
34 certificate shall show by official transcript or other official evidence  
35 satisfactory to the Division of Licensing that he or she has  
36 successfully completed a medical curriculum extending over a  
37 period of at least four academic years, or 32 months of actual  
38 instruction, in a medical school or schools located in the United  
39 States or Canada approved by the division, or in a medical school  
40 or schools located outside the United States or Canada which

1 otherwise meets the requirements of this section. The total number  
2 of hours of all courses shall consist of a minimum of 4,000 hours.  
3 At least 80 percent of actual attendance shall be required. If an  
4 applicant has matriculated in more than one medical school, the  
5 applicant must have matriculated in the medical school awarding  
6 the degree of doctor of medicine or its equivalent for at least the  
7 last full academic year of medical education received prior to the  
8 granting of the degree.

9 (b) The curriculum for all applicants shall provide for adequate  
10 instruction in the following subjects:

11 Alcoholism and other chemical substance dependency, detection  
12 and treatment.

13 Anatomy, including embryology, histology, and neuroanatomy.

14 Anesthesia.

15 Biochemistry.

16 Child abuse detection and treatment.

17 Dermatology.

18 Geriatric medicine.

19 Human sexuality.

20 Medicine, including pediatrics.

21 Neurology.

22 Obstetrics and gynecology.

23 Ophthalmology.

24 Otolaryngology.

25 Pain management and end-of-life care.

26 Pathology, bacteriology, and immunology.

27 Pharmacology.

28 Physical medicine.

29 Physiology.

30 Preventive medicine, including nutrition.

31 Psychiatry.

32 Radiology, including radiation safety.

33 Spousal or partner abuse detection and treatment.

34 Surgery, including orthopedic surgery.

35 Therapeutics.

36 Tropical medicine.

37 Urology.

38 (c) The requirement that an applicant successfully complete a  
39 medical curriculum that provides instruction in pain management

1 and end-of-life care shall only apply to a person entering medical  
2 school on or after June 1, 2000.

3 *SEC. 38. Section 2089.5 of the Business and Professions Code*  
4 *is repealed.*

5 2089.5. (a) Clinical instruction in the subjects listed in  
6 subdivision (b) of Section 2089 shall meet the requirements of this  
7 section and shall be considered adequate if the requirements of  
8 subdivision (a) of Section 2089 and the requirements of this section  
9 are satisfied.

10 (b) Instruction in the clinical courses shall total a minimum of  
11 72 weeks in length.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9 *SEC. 39. Section 2089.7 of the Business and Professions Code*  
10 *is repealed.*

11 2089.7. (a) The requirement of four weeks of clinical course  
12 instruction in family medicine shall apply only to those applicants  
13 for licensure who graduate from medical school or a school of  
14 osteopathic medicine after May 1, 1998.

15 (b) This section shall become operative on June 30, 1999.

16 *SEC. 40. Section 2090 of the Business and Professions Code*  
17 *is repealed.*

18 2090. "Human sexuality" as used in Sections 2089 and 2191  
19 means the study of a human being as a sexual being and how he  
20 or she functions with respect thereto.

21 *SEC. 41. Section 2091 of the Business and Professions Code*  
22 *is repealed.*

23 2091. The requirement that instruction in child abuse detection  
24 and treatment be provided shall apply only to applicants who  
25 matriculate on or after September 1, 1979.

26 *SEC. 42. Section 2091.1 of the Business and Professions Code*  
27 *is repealed.*

28 2091.1. The requirement that instruction in alcoholism and  
29 other chemical substance dependency be provided applies only to  
30 applicants who matriculate on or after September 1, 1985.

31 *SEC. 43. Section 2091.2 of the Business and Professions Code*  
32 *is repealed.*

33 2091.2. The requirements that instruction in spousal or partner  
34 abuse detection and treatment be provided shall apply only to  
35 applicants who matriculate on or after September 1, 1994. The  
36 requirement for coursework in spousal or partner abuse detection  
37 and treatment shall be satisfied by, and the board shall accept in  
38 satisfaction of the requirement, a certification from the chief  
39 academic officer of the educational institution from which the

1 applicant graduated that the required coursework is included within  
2 the institution's required curriculum for graduation.

3 *SEC. 44. Section 2096 of the Business and Professions Code*  
4 *is amended to read:*

5 2096. (a) In addition to other requirements of this chapter,  
6 before a physician's and surgeon's license may be issued, each  
7 applicant, including an applicant applying pursuant to Article 5  
8 (commencing with Section 2100), ~~except as provided in subdivision~~  
9 ~~(b)~~, shall show by evidence satisfactory to the board that he or she  
10 has satisfactorily completed at least ~~one year~~ 36 months of  
11 board-approved postgraduate training.

12 ~~(b) An applicant applying pursuant to Section 2102 shall show~~  
13 ~~by evidence satisfactory to the board that he or she has~~  
14 ~~satisfactorily completed at least two years of postgraduate training.~~

15 ~~(e)~~

16 (b) The postgraduate training required by this section shall  
17 include at least four months of general medicine and shall be  
18 obtained in a postgraduate training program approved by the  
19 Accreditation Council for Graduate Medical Education ~~(ACGME)~~  
20 ~~or (ACGME)~~, the Royal College of Physicians and Surgeons of  
21 Canada ~~(RCPSC)~~, (RCPSC), or the College of Family Physicians  
22 of Canada (CFPC).

23 (c) An applicant who has completed at least 36 months of  
24 board-approved postgraduate training, not less than 24 months  
25 of which was completed as a resident after receiving a medical  
26 degree from a combined dental and medical degree program  
27 accredited by the Commission on Dental Accreditation (CODA)  
28 or approved by the board, shall be eligible for licensure.

29 ~~(d) The amendments made to this section at the 1987 portion~~  
30 ~~of the 1987-88 session of the Legislature shall not apply to~~  
31 ~~applicants who completed their one year of postgraduate training~~  
32 ~~on or before July 1, 1990.~~

33 *SEC. 45. Section 2100 of the Business and Professions Code*  
34 *is repealed.*

35 2100. ~~The provisions of this article shall apply to all~~  
36 ~~applications of graduates of medical schools located outside the~~  
37 ~~United States or Canada. Such applicants shall otherwise comply~~  
38 ~~with the provisions of this chapter, except where such provisions~~  
39 ~~are in conflict with or inconsistent with the provisions of this~~  
40 ~~article.~~



1     ~~SEC. 46. Section 2102 of the Business and Professions Code~~  
2     ~~is repealed.~~

3     ~~2102. An applicant whose professional instruction was acquired~~  
4     ~~in a country other than the United States or Canada shall provide~~  
5     ~~evidence satisfactory to the board of compliance with the following~~  
6     ~~requirements to be issued a physician's and surgeon's certificate:~~

7     ~~(a) Completion in a medical school or schools of a resident~~  
8     ~~course of professional instruction equivalent to that required by~~  
9     ~~Section 2089 and issuance to the applicant of a document~~  
10    ~~acceptable to the board that shows final and successful completion~~  
11    ~~of the course. However, nothing in this section shall be construed~~  
12    ~~to require the board to evaluate for equivalency any coursework~~  
13    ~~obtained at a medical school disapproved by the board pursuant~~  
14    ~~to this section.~~

15    ~~(b) Certification by the Educational Commission for Foreign~~  
16    ~~Medical Graduates, or its equivalent, as determined by the board.~~  
17    ~~This subdivision shall apply to all applicants who are subject to~~  
18    ~~this section and who have not taken and passed the written~~  
19    ~~examination specified in subdivision (d) prior to June 1, 1986.~~

20    ~~(c) Satisfactory completion of the postgraduate training required~~  
21    ~~under subdivision (b) of Section 2096. An applicant shall be~~  
22    ~~required to have substantially completed the professional~~  
23    ~~instruction required in subdivision (a) and shall be required to~~  
24    ~~make application to the board and have passed steps 1 and 2 of~~  
25    ~~the written examination relating to biomedical and clinical sciences~~  
26    ~~prior to commencing any postgraduate training in this state. In its~~  
27    ~~discretion, the board may authorize an applicant who is deficient~~  
28    ~~in any education or clinical instruction required by Sections 2089~~  
29    ~~and 2089.5 to make up any deficiencies as a part of his or her~~  
30    ~~postgraduate training program, but that remedial training shall be~~  
31    ~~in addition to the postgraduate training required for licensure.~~

32    ~~(d) Passage of the written examination as provided under Article~~  
33    ~~9 (commencing with Section 2170). An applicant shall be required~~  
34    ~~to meet the requirements specified in subdivision (b) prior to being~~  
35    ~~admitted to the written examination required by this subdivision.~~

36    ~~(e) Nothing in this section prohibits the board from disapproving~~  
37    ~~a foreign medical school or from denying an application if, in the~~  
38    ~~opinion of the board, the professional instruction provided by the~~  
39    ~~medical school or the instruction received by the applicant is not~~



1 equivalent to that required in Article 4 (commencing with Section  
2 2080).

3 *SEC. 47. Section 2103 of the Business and Professions Code*  
4 *is repealed.*

5 2103. ~~An applicant shall be eligible for a physician's and~~  
6 ~~surgeon's certificate if he or she has completed the following~~  
7 ~~requirements:~~

8 (a) ~~Submitted official evidence satisfactory to the board of~~  
9 ~~completion of a resident course or professional instruction~~  
10 ~~equivalent to that required in Section 2089 in a medical school~~  
11 ~~located outside the United States or Canada. However, nothing in~~  
12 ~~this section shall be construed to require the board to evaluate for~~  
13 ~~equivalency any coursework obtained at a medical school~~  
14 ~~disapproved by the board pursuant to Article 4 (commencing with~~  
15 ~~Section 2080).~~

16 (b) ~~Submitted official evidence satisfactory to the board of~~  
17 ~~completion of all formal requirements of the medical school for~~  
18 ~~graduation, except the applicant shall not be required to have~~  
19 ~~completed an internship or social service or be admitted or licensed~~  
20 ~~to practice medicine in the country in which the professional~~  
21 ~~instruction was completed.~~

22 (c) ~~Attained a score satisfactory to an approved medical school~~  
23 ~~on a qualifying examination acceptable to the board.~~

24 (d) ~~Successfully completed one academic year of supervised~~  
25 ~~clinical training in a program approved by the board pursuant to~~  
26 ~~Section 2104. The board shall also recognize as compliance with~~  
27 ~~this subdivision the successful completion of a one-year supervised~~  
28 ~~clinical medical internship operated by a medical school pursuant~~  
29 ~~to Chapter 85 of the Statutes of 1972 and as amended by Chapter~~  
30 ~~888 of the Statutes of 1973 as the equivalent of the year of~~  
31 ~~supervised clinical training required by this section.~~

32 (1) ~~Training received in the academic year of supervised clinical~~  
33 ~~training approved pursuant to Section 2104 shall be considered as~~  
34 ~~part of the total academic curriculum for purposes of meeting the~~  
35 ~~requirements of Sections 2089 and 2089.5.~~

36 (2) ~~An applicant who has passed the basic science and English~~  
37 ~~language examinations required for certification by the Educational~~  
38 ~~Commission for Foreign Medical Graduates may present evidence~~  
39 ~~of those passing scores along with a certificate of completion of~~  
40 ~~one academic year of supervised clinical training in a program~~

1 approved by the board pursuant to Section 2104 in satisfaction of  
2 the formal certification requirements of subdivision (b) of Section  
3 2102.

4 (e) Satisfactorily completed the postgraduate training required  
5 under Section 2096.

6 (f) Passed the written examination required for certification as  
7 a physician and surgeon under this chapter.

8 *SEC. 48. Section 2104 of the Business and Professions Code*  
9 *is repealed.*

10 2104. The Division of Licensing shall approve programs of  
11 supervised clinical training in hospitals for the purpose of providing  
12 basic clinical training to students who are graduates of foreign  
13 medical schools or have completed all the formal requirements for  
14 graduation except for internship or social service and who intend  
15 to apply for licensure as a physician and surgeon pursuant to  
16 Section 2103. Such programs shall be under the direction of  
17 approved medical schools.

18 *SEC. 49. Section 2104.5 of the Business and Professions Code*  
19 *is repealed.*

20 2104.5. The board, in consultation with various medical schools  
21 located in California, the Office of Statewide Health Planning and  
22 Development, and executive directors and medical directors of  
23 nonprofit community health centers, hospital administrators, and  
24 medical directors with experience hiring graduates of the Fifth  
25 Pathway Program or foreign medical school graduates shall study  
26 methods to reactivate the Fifth Pathway Program in medical  
27 schools located in this state. The executive directors and medical  
28 directors of nonprofit community health centers, the hospital  
29 administrators, and the medical directors should serve or work  
30 with underserved populations or in facilities located in medically  
31 underserved communities or in health professional shortage areas.  
32 The board shall submit a report to the Legislature on or before July  
33 1, 2003, that shall include options for the Legislature to consider  
34 in order to facilitate the establishment of one or more Fifth Pathway  
35 Programs in medical schools located in California. The study shall  
36 focus on whether the Fifth Pathway Program can address the needs  
37 of areas where a shortage of providers exists, communities with a  
38 non-English speaking population in need of medical providers  
39 who speak their native language and understand their culture, and

1 ~~whether it can provide greater provider stability in these~~  
2 ~~communities.~~

3 *SEC. 50. Section 2105 of the Business and Professions Code*  
4 *is amended to read:*

5 2105. No hospital licensed by this state, or operated by the  
6 state or a political subdivision thereof, or which receives state  
7 financial assistance, directly or indirectly, shall require an  
8 individual who at the time of his or her enrollment in a medical  
9 school outside the United States is a citizen of the United States,  
10 to satisfy any requirements other than those contained in  
11 subdivisions (a), (b), (c), (d), and (e) of Section 2103 *paragraph*  
12 *(1) of subdivision (a) of Section 2065* prior to commencing the  
13 postgraduate training ~~required by subdivision (f)~~ which are not  
14 required for graduates of approved medical schools located in the  
15 United States or Canada.

16 *SEC. 51. Section 2107 of the Business and Professions Code*  
17 *is repealed.*

18 ~~2107. (a) The Legislature intends that the board shall have the~~  
19 ~~authority to substitute postgraduate education and training to~~  
20 ~~remedy deficiencies in an applicant's medical school education~~  
21 ~~and training. The Legislature further intends that applicants who~~  
22 ~~substantially completed their clinical training shall be granted that~~  
23 ~~substitute credit if their postgraduate education took place in an~~  
24 ~~accredited program.~~

25 ~~(b) To meet the requirements for licensure set forth in Sections~~  
26 ~~2089 and 2089.5, the board may require an applicant under this~~  
27 ~~article to successfully complete additional education and training.~~  
28 ~~In determining the content and duration of the required additional~~  
29 ~~education and training, the board shall consider the applicant's~~  
30 ~~medical education and performance on standardized national~~  
31 ~~examinations, and may substitute approved postgraduate training~~  
32 ~~in lieu of specified undergraduate requirements. Postgraduate~~  
33 ~~training substituted for undergraduate training shall be in addition~~  
34 ~~to the postgraduate training required by Sections 2102 and 2103.~~

35 *SEC. 52. Section 2111 of the Business and Professions Code*  
36 *is amended to read:*

37 2111. (a) Physicians who are not citizens but who meet the  
38 requirements of subdivision (b) and who seek postgraduate study  
39 in an approved medical school may, after receipt of an appointment  
40 from the dean of the California medical school and application to

1 and approval by the ~~Division of Licensing~~, *board*, be permitted to  
2 participate in the professional activities of the department or  
3 division in the medical school to which they are appointed. The  
4 physician shall be under the direction of the head of the department  
5 to which he or she is appointed, supervised by the staff of the  
6 medical school's medical center, and known for these purposes as  
7 a "visiting fellow." The visiting fellow shall wear a visible name  
8 tag containing the title "visiting fellow" when he or she provides  
9 clinical services.

10 (b) (1) Application for approval shall be made on a form  
11 prescribed by the division and shall be accompanied by a fee fixed  
12 by the ~~division~~ *board* in an amount necessary to recover the actual  
13 application processing costs of the program. The application shall  
14 show that the person does not immediately qualify for a physician's  
15 and surgeon's certificate under this chapter and that the person has  
16 completed at least three years of postgraduate basic residency  
17 requirements. The application shall include a written statement of  
18 the recruitment procedures followed by the medical school before  
19 offering the appointment to the applicant.

20 (2) Approval shall be granted only for appointment to one  
21 medical school, and no physician shall be granted more than one  
22 approval for the same period of time.

23 (3) Approval may be granted for a maximum of three years and  
24 shall be renewed annually. The medical school shall submit a  
25 request for renewal on a form prescribed by the ~~division~~, *board*,  
26 which shall be accompanied by a renewal fee fixed by the ~~division~~  
27 *board* in a amount necessary to recover the actual application  
28 processing costs of the program.

29 (c) Except to the extent authorized by this section, the visiting  
30 fellow may not engage in the practice of medicine. Neither the  
31 visiting fellow nor the medical school may assess any charge for  
32 the medical services provided by the visiting fellow, and the  
33 visiting fellow may not receive any other compensation therefor.

34 (d) The time spent under appointment in a medical school  
35 pursuant to this section may not be used to meet the requirements  
36 ~~for licensure under Section 2102.~~ *license*.

37 (e) The ~~division~~ *board* shall notify both the visiting fellow and  
38 the dean of the appointing medical school of any complaint made  
39 about the visiting fellow.

The ~~division~~ board may terminate its approval of an appointment for any act that would be grounds for discipline if done by a licensee. The ~~division~~ board shall provide both the visiting fellow and the dean of the medical school with a written notice of termination including the basis for that termination. The visiting fellow may, within 30 days after the date of the notice of termination, file a written appeal to the ~~division~~ board. The appeal shall include any documentation the visiting fellow wishes to present to the ~~division~~ board.

(f) Nothing in this section shall preclude any United States citizen who has received his or her medical degree from a medical school located in a foreign country and recognized by the ~~division~~ board from participating in any program established pursuant to this section.

*SEC. 53. Section 2112 of the Business and Professions Code is amended to read:*

2112. (a) Physicians who are not citizens and who seek postgraduate study, may, after application to and approval by the ~~Division of Licensing~~ board, be permitted to participate in a fellowship program in a specialty or subspecialty field, providing the fellowship program is given in a hospital in this state which is approved by the ~~Joint Committee on Accreditation of Hospitals Commission~~ and providing the service is satisfactory to the ~~division~~ board. Such physicians shall at all times be under the direction and supervision of a licensed, board-certified physician and surgeon who is recognized as a clearly outstanding specialist in the field in which the foreign fellow is to be trained. The supervisor, as part of the application process, shall submit his or her curriculum vitae and a protocol of the fellowship program to be completed by the foreign fellow. Approval of the program and supervisor is for a period of one year, but may be renewed annually upon application to and approval by the ~~division~~ board. The approval may not be renewed more than four times. The ~~division~~ board may determine a fee, based on the cost of operating this program, which shall be paid by the applicant at the time the application is filed.

(b) Except to the extent authorized by this section, no such visiting physician may engage in the practice of medicine or receive compensation therefor. The time spent under appointment in a medical school pursuant to this section may not be used to meet

1 the requirements for licensure under Section 2101 or 2102.  
2 *licensure.*

3 (c) Nothing in this section shall preclude any United States  
4 citizen who has received his or her medical degree from a medical  
5 school located in a foreign country from participating in any  
6 program established pursuant to this section.

7 *SEC. 54. Section 2113 of the Business and Professions Code*  
8 *is amended to read:*

9 2113. (a) Any person who does not immediately qualify for  
10 a physician's and surgeon's certificate under this chapter and who  
11 is offered by the dean of an approved medical school in this state  
12 a full-time faculty position may, after application to and approval  
13 by the ~~Division of Licensing,~~ *board*, be granted a certificate of  
14 registration to engage in the practice of medicine only to the extent  
15 that the practice is incident to and a necessary part of his or her  
16 duties as approved by the ~~division~~ *board* in connection with the  
17 faculty position. A certificate of registration does not authorize a  
18 registrant to admit patients to a nursing or a skilled or assisted  
19 living facility unless that facility is formally affiliated with the  
20 sponsoring medical school. A clinical fellowship shall not be  
21 submitted as a faculty service appointment.

22 (b) Application for a certificate of registration shall be made on  
23 a form prescribed by the ~~division~~ *board* and shall be accompanied  
24 by a registration fee fixed by the ~~division in a board in an~~ amount  
25 necessary to recover the actual application processing costs of the  
26 program. To qualify for the certificate, an applicant shall submit  
27 all of the following:

28 (1) If the applicant is a graduate of a medical school other than  
29 in the United States or Canada, documentary evidence satisfactory  
30 to the ~~division~~ *board* that he or she has been licensed to practice  
31 medicine and surgery for not less than four years in another state  
32 or country whose requirements for licensure are satisfactory to the  
33 ~~division,~~ *board*, or has been engaged in the practice of medicine  
34 in the United States for at least four years in approved facilities,  
35 or has completed a combination of that licensure and training.

36 (2) If the applicant is a graduate of ~~an approved~~ a medical school  
37 in the United States or Canada, documentary evidence that ~~he or~~  
38 ~~she has completed a resident course of professional instruction as~~  
39 ~~required in Section 2089.~~ *the medical school is approved by the*  
40 *board.*



1 (3) Written certification by the head of the department in which  
2 the applicant is to be appointed of all of the following:

3 (A) The applicant will be under his or her direction.

4 (B) The applicant will not be permitted to practice medicine  
5 unless incident to and a necessary part of his or her duties as  
6 approved by the ~~division~~ *board* in subdivision (a).

7 (C) The applicant will be accountable to the medical school's  
8 department chair or division chief for the specialty in which the  
9 applicant will practice.

10 (D) The applicant will be proctored in the same manner as other  
11 new faculty members, including, as appropriate, review by the  
12 medical staff of the school's medical center.

13 (E) The applicant will not be appointed to a supervisory position  
14 at the level of a medical school department chair or division chief.

15 (4) Demonstration by the dean of the medical school that the  
16 applicant has the requisite qualifications to assume the position to  
17 which he or she is to be appointed and that shall include a written  
18 statement of the recruitment procedures followed by the medical  
19 school before offering the faculty position to the applicant.

20 (c) A certificate of registration shall be issued only for a faculty  
21 position at one approved medical school, and no person shall be  
22 issued more than one certificate of registration for the same period  
23 of time.

24 (d) (1) A certificate of registration is valid for one year from  
25 its date of issuance and may be renewed twice.

26 A request for renewal shall be submitted on a form prescribed  
27 by the ~~division~~ *board* and shall be accompanied by a renewal fee  
28 fixed by the ~~division~~ *board* in an amount necessary to recover the  
29 actual application processing costs of the program.

30 (2) The dean of the medical school may request renewal of the  
31 registration by submitting a plan at the beginning of the third year  
32 of the registrant's appointment demonstrating the registrant's  
33 continued progress toward licensure and, if the registrant is a  
34 graduate of a medical school other than in the United States or  
35 Canada, that the registrant has been issued a certificate by the  
36 Educational Commission for Foreign Medical Graduates. The  
37 ~~division~~ *board* may, in its discretion, extend the registration for a  
38 two-year period to facilitate the registrant's completion of the  
39 licensure process.

(e) If the registrant is a graduate of a medical school other than in the United States or Canada, he or she shall meet the requirements of Section ~~2102~~ 2065 or 2135, as appropriate, in order to obtain a physician's and surgeon's certificate. Notwithstanding any other provision of law, the ~~division may accept clinical practice in an appointment pursuant to this section as qualifying time to meet the postgraduate training requirements in Section 2102,~~ and board may, in its discretion, waive the examination and the Educational Commission for Foreign Medical Graduates certification requirements specified in ~~Section 2102 paragraph (3) of subdivision (a) of Section 2065~~ in the event the registrant applies for a physician's and surgeon's certificate. As a condition to waiving any examination or the Educational Commission for Foreign Medical Graduates certification requirement, the ~~division~~ board in its discretion, may require an applicant to pass ~~the a clinical competency examination referred to in subdivision (d) of Section 2135.~~ The ~~division~~ approved by the board. The board shall not waive any examination for an applicant who has not completed at least one year in the faculty position.

(f) Except to the extent authorized by this section, the registrant shall not engage in the practice of medicine, bill individually for medical services provided by the registrant, or receive compensation therefor, unless he or she is issued a physician's and surgeon's certificate.

(g) When providing clinical services, the registrant shall wear a visible name tag containing the title "visiting professor" or "visiting faculty member," as appropriate, and the institution at which the services are provided shall obtain a signed statement from each patient to whom the registrant provides services acknowledging that the patient understands that the services are provided by a person who does not hold a physician's and surgeon's certificate but who is qualified to participate in a special program as a visiting professor or faculty member.

(h) The ~~division~~ board shall notify both the registrant and the dean of the medical school of a complaint made about the registrant. The ~~division~~ board may terminate a registration for any act that would be grounds for discipline if done by a licensee. The ~~division~~ board shall provide both the registrant and the dean of the medical school with written notice of the termination and the



basis for that termination. The registrant may, within 30 days after the date of the notice of termination, file a written appeal to the ~~division: board~~. The appeal shall include any documentation the registrant wishes to present to the ~~division: board~~.

*SEC. 55. Section 2115 of the Business and Professions Code is repealed.*

~~2115.—(a) Physicians who are not citizens and who seek postgraduate study may, after application to and approval by the Division of Licensing, be permitted to participate in a fellowship program in a specialty or subspecialty field, providing the fellowship program is given in a clinic or hospital in a medically underserved area of this state that is licensed by the State Department of Health Services or is exempt from licensure pursuant to subdivision (b) or (c) of Section 1206 of the Health and Safety Code, and providing service is satisfactory to the division. These physicians shall at all times be under the direction and supervision of a licensed, board-certified physician and surgeon who has an appointment with a medical school in California and is a specialist in the field in which the fellow is to be trained. The supervisor, as part of the application process, shall submit his or her curriculum vitae and a protocol of the fellowship program to be completed by the foreign fellow. Approval of the program and supervisor is for a period of one year, but may be renewed annually upon application to and approval by the division. The approval may not be renewed more than four times. The division may determine a fee, based on the cost of operating this program, which shall be paid by the applicant at the time the application is filed.~~

~~(b) Except to the extent authorized by this section, no visiting physician may engage in the practice of medicine or receive compensation therefor. The time spent under appointment in a clinic pursuant to this section may not be used to meet the requirements for licensure under Section 2102.~~

~~(c) Nothing in this section shall preclude any United States citizen who has received his or her medical degree from a medical school located in a foreign country from participating in any program established pursuant to this section.~~

~~(d) For purposes of this section, a medically underserved area means a federally designated Medically Underserved Area, a federally designated Health Professional Shortage Area, and any other clinic or hospital determined by the board to be medically~~

underserved. Clinics or hospitals determined by the board pursuant to this subdivision shall be reported to the Office of Statewide Health Planning and Development.

SEC. 56. Section 2135 of the Business and Professions Code is amended to read:

2135. The board shall issue a physician and surgeon's certificate to an applicant who meets all of the following requirements:

(a) The applicant holds an unlimited license as a physician and surgeon in another state or states, or in a Canadian province or Canadian provinces, which was issued upon:

(1) Successful completion of a resident course of professional instruction leading to a degree of medical doctor equivalent to that specified in Section 2089. However, nothing in this section shall be construed to require the board to evaluate for equivalency any coursework obtained at a medical school disapproved by the board pursuant to Article 4 (commencing with Section 2080); from a board-approved medical school pursuant to Section 2084.

(2) Taking and passing a written examination that is recognized by the board to be equivalent in content to that administered in California.

(b) The applicant has held an unrestricted license to practice medicine, in a state or states, in a Canadian province or Canadian provinces, or as a member of the active military, United States Public Health Services, or other federal program, for a period of at least four years. Any time spent by the applicant in an approved postgraduate training program or clinical fellowship acceptable to the board shall not be included in the calculation of this four-year period.

(c) The board determines that no disciplinary action has been taken against the applicant by any medical licensing authority and that the applicant has not been the subject of adverse judgments or settlements resulting from the practice of medicine that the board determines constitutes evidence of a pattern of negligence or incompetence.

(d) The applicant (1) has satisfactorily completed at least one year of approved postgraduate training and is certified by a specialty board approved by the American Board of Medical Specialties or approved by the board pursuant to subdivision (h) of Section 651; (2) has satisfactorily completed at least two years

1 of approved postgraduate training; or (3) has satisfactorily  
2 completed at least one year of approved postgraduate training and  
3 takes and passes the clinical competency written examination. 651.

4 (e) The applicant has not committed any acts or crimes  
5 constituting grounds for denial of a certificate under Division 1.5  
6 (commencing with Section 475) or Article 12 (commencing with  
7 Section 2220).

8 (f) Any application received from an applicant who has held an  
9 unrestricted license to practice medicine, in a state or states, or  
10 Canadian province or Canadian provinces, or as a member of the  
11 active military, United States Public Health Services, or other  
12 federal program for four or more years shall be reviewed and  
13 processed pursuant to this section. Any time spent by the applicant  
14 in an approved postgraduate training program or clinical fellowship  
15 acceptable to the board shall not be included in the calculation of  
16 this four-year period. This subdivision does not apply to  
17 applications that may be reviewed and processed pursuant to  
18 Section 2151.

19 *SEC. 57. Section 2135.5 of the Business and Professions Code*  
20 *is amended to read:*

21 2135.5. Upon review and recommendation, the ~~Division of~~  
22 ~~Licensing board~~ may determine that an applicant for a physician's  
23 and surgeon's certificate has satisfied the medical curriculum  
24 education requirements of Section 2089, the clinical instruction  
25 requirements of Sections 2089.5 and 2089.7, 2135, and the  
26 examination requirements of Section 2170 if the applicant meets  
27 all of the following criteria:

28 (a) He or she holds an unlimited and unrestricted license as a  
29 physician and surgeon in another state and has held that license  
30 continuously for a minimum of four years prior to the date of  
31 application.

32 (b) He or she is certified by a specialty board that is a member  
33 board of the American Board of Medical Specialties.

34 (c) He or she is not subject to denial of licensure under Division  
35 1.5 (commencing with Section 475) or Article 12 (commencing  
36 with Section 2220).

37 (d) ~~He or she has not graduated from a medical school that has~~  
38 ~~been disapproved by the division or that does not provide a resident~~  
39 ~~course of instruction.~~

1     ~~(e) He or she has graduated from a medical school recognized~~  
2     ~~by the division. If the applicant graduated from a medical school~~  
3     ~~that the division recognized after the date of the applicant's~~  
4     ~~graduation, the division may evaluate the applicant under its~~  
5     ~~regulations.~~

6     ~~(f)~~

7     ~~(d) He or she has not been the subject of a disciplinary action~~  
8     ~~by a medical licensing authority or of an adverse judgment or~~  
9     ~~settlement resulting from the practice of medicine that, as~~  
10    ~~determined by the division, board, constitutes a pattern of~~  
11    ~~negligence or incompetence.~~

12    ~~SEC. 58. Section 2135.7 of the Business and Professions Code~~  
13    ~~is repealed.~~

14    ~~2135.7. (a) Upon review and recommendation, the board may~~  
15    ~~determine that an applicant for a physician and surgeon's certificate~~  
16    ~~who acquired his or her medical education or a portion thereof at~~  
17    ~~a foreign medical school that is not recognized or has been~~  
18    ~~previously disapproved by the board is eligible for a physician and~~  
19    ~~surgeon's certificate if the applicant meets all of the following~~  
20    ~~criteria:~~

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

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

30    ~~(ii) For an applicant who acquired any part of his or her~~  
31    ~~professional instruction from a foreign medical school that was~~  
32    ~~disapproved by the board at the time he or she attended the school,~~  
33    ~~he or she holds an unlimited and unrestricted license as a physician~~  
34    ~~and surgeon in another state, a federal territory, or a Canadian~~  
35    ~~province and has held that license and continuously practiced for~~  
36    ~~a minimum of 12 years prior to the date of application.~~

37    ~~(B) For the purposes of clauses (i) and (ii) of subparagraph (A),~~  
38    ~~the board may combine the period of time that the applicant has~~  
39    ~~held an unlimited and unrestricted license in other states, federal~~  
40    ~~territories, or Canadian provinces and continuously practiced~~

1 therein, but each applicant under this section shall have a minimum  
2 of two years continuous licensure and practice in a single state,  
3 federal territory, or Canadian province. For purposes of this  
4 paragraph, continuous licensure and practice includes any  
5 postgraduate training after 24 months in a postgraduate training  
6 program that is accredited by the Accreditation Council for  
7 Graduate Medical Education (ACGME) or postgraduate training  
8 completed in Canada that is accredited by the Royal College of  
9 Physicians and Surgeons of Canada (RCPSC).

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

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

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

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

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

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

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

37 (c) This section shall not apply to a person seeking to participate  
38 in a program described in Section 2072, 2073, 2111, 2112, 2113,  
39 2115, or 2168, or seeking to engage in postgraduate training in  
40 this state.

1     *SEC. 59. Section 2143 of the Business and Professions Code*  
2     *is amended to read:*

3     2143. An applicant for a reciprocity certificate need not have  
4     completed the ~~first year of~~ postgraduate training required in Section  
5     2096 prior to the issuance of a license in another state, if the  
6     applicant complies with the requirements of Section 2096 before  
7     application is made to the ~~Division of Licensing~~ board for a  
8     reciprocity certificate.

9     *SEC. 60. Section 2168.4 of the Business and Professions Code*  
10    *is amended to read:*

11    2168.4. (a) A special faculty permit expires and becomes  
12    invalid at midnight on the last day of the ~~permitholder's birth~~  
13    ~~month during the second year of a two-year term, month in which~~  
14    ~~the permit was issued during the second year of a two-year term~~  
15    commencing from the date of issuance, if not renewed.

16    (b) A person who holds a special faculty permit shall show at  
17    the time of license renewal that he or she continues to meet the  
18    eligibility criteria set forth in Section 2168.1. After the first renewal  
19    of a special faculty permit, the permitholder shall not be required  
20    to hold a full-time faculty position, and may instead be employed  
21    part-time in a position that otherwise meets the requirements set  
22    forth in paragraph (1) of subdivision (a) of Section 2168.1.

23    (c) A person who holds a special faculty permit shall show at  
24    the time of license renewal that he or she meets the continuing  
25    medical education requirements of Article 10 (commencing with  
26    Section 2190).

27    (d) In addition to the requirements set forth above, a special  
28    faculty permit shall be renewed in accordance with Article 19  
29    (commencing with Section 2420) in the same manner as a  
30    physician's and surgeon's certificate.

31    (e) Those fees applicable to a physician's and surgeon's  
32    certificate shall also apply to a special faculty permit and shall be  
33    paid into the State Treasury and credited to the Contingent Fund  
34    of the Medical Board of California.

35    *SEC. 61. Section 2191 of the Business and Professions Code*  
36    *is amended to read:*

37    2191. (a) In determining its continuing education requirements,  
38    the board shall consider including a course in human ~~sexuality as~~  
39    ~~defined in Section 2090~~ *sexuality, defined as the study of a human*  
40    *being as a sexual being and how he or she functions with respect*

1 *thereto*, and nutrition to be taken by those licensees whose practices  
2 may require knowledge in those areas.

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

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

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

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

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

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

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

38 (i) In determining its continuing education requirements, the  
39 board shall consider including a course in the special care needs



1 of individuals and their families facing end-of-life issues, including,  
2 but not limited to, all of the following:

- 3 (1) Pain and symptom management.
- 4 (2) The psycho-social dynamics of death.
- 5 (3) Dying and bereavement.
- 6 (4) Hospice care.

7 (j) In determining its continuing education requirements, the  
8 board shall give its highest priority to considering a course on pain  
9 management.

10 (k) In determining its continuing education requirements, the  
11 board shall consider including a course in geriatric care for  
12 emergency room physicians and surgeons.

13 *SEC. 62. Section 2216.3 of the Business and Professions Code*  
14 *is amended to read:*

15 2216.3. (a) An outpatient setting accredited pursuant to Section  
16 1248.1 of the Health and Safety Code shall report an adverse event  
17 to the board no later than five days after the adverse event has been  
18 detected, or, if that event is an ongoing urgent or emergent threat  
19 to the welfare, health, or safety of patients, personnel, or visitors,  
20 not later than 24 hours after the adverse event has been detected.  
21 Disclosure of individually identifiable patient information shall  
22 be consistent with applicable law.

23 (b) For the purposes of this section, “adverse event” ~~has the~~  
24 ~~same meaning as in subdivision (b) of Section 1279.1 of the Health~~  
25 ~~and Safety Code.~~ *includes any of the following:*

26 *(1) Surgical or other invasive procedures, including the*  
27 *following:*

28 *(A) Surgical or other invasive procedure performed on a wrong*  
29 *body part that is inconsistent with the documented informed*  
30 *consent for that patient. A reportable event under this*  
31 *subparagraph does not include a situation requiring prompt action*  
32 *that occurs in the course of surgery or a situation that is so urgent*  
33 *as to preclude obtaining informed consent.*

34 *(B) Surgical or other invasive procedure performed on the*  
35 *wrong patient.*

36 *(C) The wrong surgical or other invasive procedure performed*  
37 *on a patient, which is a procedure performed on a patient that is*  
38 *inconsistent with the documented informed consent for that patient.*  
39 *A reportable event under this subparagraph does not include a*  
40 *situation requiring prompt action that occurs in the course of*



1 *surgery, or a situation that is so urgent as to preclude the obtaining*  
2 *of informed consent.*

3 *(D) Retention of a foreign object in a patient after surgery or*  
4 *other procedure, excluding objects intentionally implanted as part*  
5 *of a planned intervention and objects present prior to surgery that*  
6 *are intentionally retained.*

7 *(E) Death of a patient during or up to 24 hours after admittance*  
8 *of a patient to an outpatient setting.*

9 *(F) Transfer of a patient to a hospital or emergency center for*  
10 *medical treatment for a period exceeding 24 hours.*

11 *(2) Product or device events, including the following:*

12 *(A) Patient death or serious disability associated with the use*  
13 *of a contaminated drug, device, or biologic provided by the*  
14 *outpatient setting when the contamination is the result of generally*  
15 *detectable contaminants in the drug, device, or biologic, regardless*  
16 *of the source of the contamination or the product.*

17 *(B) Patient death or serious disability associated with the use*  
18 *or function of a device in patient care in which the device is used*  
19 *or functions other than as intended. For purposes of this*  
20 *subparagraph, “device” includes, but is not limited to, a catheter;*  
21 *drain, or other specialized tube, infusion pump, or ventilator.*

22 *(C) Patient death or serious disability associated with*  
23 *intravascular air embolism that occurs while being cared for in*  
24 *an outpatient setting, excluding deaths associated with*  
25 *neurosurgical procedures known to present a high risk of*  
26 *intravascular air embolism.*

27 *(3) Patient protection events, including the following:*

28 *(A) A minor discharged to the wrong person.*

29 *(B) A patient suicide or attempted suicide resulting in serious*  
30 *disability while being cared for in an outpatient setting due to*  
31 *patient actions after admission to the outpatient setting.*

32 *(4) Care management events, including the following:*

33 *(A) A patient death or serious disability associated with a*  
34 *medication error, including, but not limited to, an error involving*  
35 *the wrong drug, the wrong dose, the wrong patient, the wrong*  
36 *time, the wrong rate, the wrong preparation, or the wrong route*  
37 *of administration, excluding reasonable differences in clinical*  
38 *judgment on drug selection and dose.*

1 (B) A patient death or serious disability associated with a  
2 hemolytic reaction due to the administration of ABO-incompatible  
3 blood or blood products.

4 (C) Patient death or serious disability directly related to  
5 hypoglycemia, the onset of which occurs while the patient is being  
6 cared for in an outpatient setting.

7 (D) Death or serious disability, including kernicterus, associated  
8 with failure to identify and treat hyperbilirubinemia in neonates  
9 during the first 28 days of life. For purposes of this subparagraph,  
10 “hyperbilirubinemia” means bilirubin levels greater than 30  
11 milligrams per deciliter.

12 (E) A patient death or serious disability due to spinal  
13 manipulative therapy performed at the outpatient setting.

14 (5) Environmental events, including the following:

15 (A) A patient death or serious disability associated with an  
16 electric shock while being cared for in an outpatient setting,  
17 excluding events involving planned treatments, such as electric  
18 countershock.

19 (B) Any incident in which a line designated for oxygen or other  
20 gas to be delivered to a patient contains the wrong gas or is  
21 contaminated by a toxic substance.

22 (C) A patient death or serious disability associated with a burn  
23 incurred from any source while being cared for in an outpatient  
24 setting.

25 (D) A patient death associated with a fall while being cared for  
26 in an outpatient setting.

27 (E) A patient death or serious disability associated with the use  
28 of restraints or bed rails while being cared for in an outpatient  
29 setting.

30 (6) Criminal events, including the following:

31 (A) Any instance of care ordered by or provided by someone  
32 impersonating a physician, nurse, pharmacist, or other licensed  
33 health care provider.

34 (B) The abduction of a patient of any age.

35 (C) The sexual assault on a patient within or on the grounds of  
36 an outpatient setting.

37 (D) The death or significant injury of a patient or staff member  
38 resulting from a physical assault that occurs within or on the  
39 grounds of an outpatient setting.

1 (7) *An adverse event or series of adverse events that cause the*  
2 *death or serious disability of a patient, personnel, or visitor.*

3 (c) *The outpatient setting shall inform the patient or the party*  
4 *responsible for the patient of the adverse event by the time the*  
5 *report is made.*

6 (d) *“Serious disability” means a physical or mental impairment*  
7 *that substantially limits one or more of the major life activities of*  
8 *an individual, or the loss of bodily function, if the impairment or*  
9 *loss lasts more than seven days or is still present at the time of*  
10 *discharge from an inpatient health care facility, or the loss of a*  
11 *body part.*

12 (e) *“Surgical or other invasive procedures” are defined for the*  
13 *purposes of this section as operative procedures in which skin or*  
14 *mucous membranes and connective tissue are incised or an*  
15 *instrument is introduced through a natural body orifice. They*  
16 *include all procedures described by the codes in the surgery section*  
17 *of the 2017 Current Procedural Terminology.*

18 SEC. 63. *Section 2216.5 is added to the Business and*  
19 *Professions Code, to read:*

20 2216.5. (a) *An outpatient setting accredited pursuant to Section*  
21 *1248.1 of the Health and Safety Code shall, on or before February*  
22 *15 of each year, file with the Office of Statewide Health Planning*  
23 *and Development upon forms to be furnished by the office, a*  
24 *verified report showing the following information relating to the*  
25 *previous calendar year:*

26 (1) *Number of patients served and descriptive information,*  
27 *including age, gender, race, and ethnic background of patients.*

28 (2) *Number of patient visits by type of service.*

29 (3) *Number of hospital transfers and admissions.*

30 (4) *Number of postoperative wound infections.*

31 (5) *Number of patient falls.*

32 (6) *Number of patient burns.*

33 (7) *Number of medication errors.*

34 (8) *Number of emergency room visits within 48 hours of*  
35 *discharge.*

36 (9) *Number of procedures performed on the wrong patient.*

37 (10) *Number of wrong procedures performed.*

38 (11) *Number of wrong site surgeries.*

39 (12) *Number of patients returned to surgery for reasons other*  
40 *than bleeding.*

1     (13) Number of patients who had excessive bleeding that  
2     required the patient to return to the operating room or transfer.

3     (14) Number of patients who had cardiac or respiratory arrest.

4     (15) Number of medical device errors.

5     (16) Number of procedures that resulted in a retained foreign  
6     body in the patient.

7     (17) Number of patient deaths.

8     (b) An outpatient setting accredited pursuant to Section 1248.1  
9     of the Health and Safety Code shall file with the Office of Statewide  
10    Health Planning and Development an Ambulatory Surgery Data  
11    Record for each patient encounter during which at least one  
12    ambulatory surgery procedure is performed. The Ambulatory  
13    Surgery Data Record shall include all of the following:

14    (1) Date of birth.

15    (2) Sex.

16    (3) Race.

17    (4) Ethnicity.

18    (5) Principal language spoken.

19    (6) ZIP Code.

20    (7) Patient social security number, if it is contained in the  
21    patient's medical record.

22    (8) Service date.

23    (9) Principal diagnosis.

24    (10) Other diagnoses.

25    (11) Principal procedure.

26    (12) Other procedures.

27    (13) Principal external cause of injury, if known.

28    (14) Other external cause of injury, if known.

29    (15) Disposition of patient.

30    (c) Outpatient settings accredited pursuant to Section 1248.1  
31    of the Health and Safety Code shall be subject to the fees required  
32    in subdivision (f) of Section 127280 of the Health and Safety Code.  
33    Any fees collected pursuant to subdivision (f) of Section 127280  
34    of the Health and Safety Code shall not exceed the reasonable  
35    costs incurred by the Office of Statewide Health Planning and  
36    Development.

37    (d) It is the expressed intent of the Legislature that the patient's  
38    rights of confidentiality shall not be violated in any manner. Patient  
39    social security numbers and any other data elements that the office  
40    believes could be used to determine the identity of an individual

1 *patient shall be exempt from the disclosure requirements of the*  
 2 *California Public Records Act (Chapter 3.5 (commencing with*  
 3 *Section 6250) of Division 7 of Title 1 of the Government Code).*

4 *(e) No person reporting data pursuant to this section shall be*  
 5 *liable for damages in any action based on the use or misuse of*  
 6 *patient-identifiable data that has been mailed or otherwise*  
 7 *transmitted to the office pursuant to the requirements of this*  
 8 *section.*

9 *SEC. 64. Section 2220.05 of the Business and Professions Code*  
 10 *is amended to read:*

11 2220.05. (a) In order to ensure that its resources are maximized  
 12 for the protection of the public, the Medical Board of California  
 13 *and the California Board of Podiatric Medicine* shall prioritize ~~its~~  
 14 *their* investigative and prosecutorial resources to ensure that  
 15 physicians and surgeons *and doctors of podiatric medicine*  
 16 representing the greatest threat of harm are identified and  
 17 disciplined expeditiously. Cases involving any of the following  
 18 allegations shall be handled on a priority basis, as follows, with  
 19 the highest priority being given to cases in the first paragraph:

20 (1) Gross negligence, incompetence, or repeated negligent acts  
 21 that involve death or serious bodily injury to one or more patients,  
 22 such that the physician and surgeon *or the doctor of podiatric*  
 23 *medicine* represents a danger to the public.

24 (2) Drug or alcohol abuse by a physician and surgeon *or a doctor*  
 25 *of podiatric medicine* involving death or serious bodily injury to  
 26 a patient.

27 (3) Repeated acts of clearly excessive prescribing, furnishing,  
 28 or administering of controlled substances, or repeated acts of  
 29 prescribing, dispensing, or furnishing of controlled substances  
 30 without a good faith prior examination of the patient and medical  
 31 reason therefor. However, in no event shall a physician and surgeon  
 32 prescribing, furnishing, or administering controlled substances for  
 33 intractable pain consistent with lawful prescribing, including, but  
 34 not limited to, Sections 725, 2241.5, and 2241.6 of this code and  
 35 Sections 11159.2 and 124961 of the Health and Safety Code, be  
 36 prosecuted for excessive prescribing and prompt review of the  
 37 applicability of these provisions shall be made in any complaint  
 38 that may implicate these provisions.

39 (4) Repeated acts of clearly excessive recommending of cannabis  
 40 to patients for medical purposes, or repeated acts of recommending

1 cannabis to patients for medical purposes without a good faith  
2 prior examination of the patient and a medical reason for the  
3 recommendation.

4 (5) Sexual misconduct with one or more patients during a course  
5 of treatment or an examination.

6 (6) Practicing medicine while under the influence of drugs or  
7 alcohol.

8 (7) Repeated acts of clearly excessive prescribing, furnishing,  
9 or administering psychotropic medications to a minor without a  
10 good faith prior examination of the patient and medical reason  
11 therefor.

12 (b) The board may by regulation prioritize cases involving an  
13 allegation of conduct that is not described in subdivision (a). Those  
14 cases prioritized by regulation shall not be assigned a priority equal  
15 to or higher than the priorities established in subdivision (a).

16 (c) The Medical Board of California shall indicate in its annual  
17 report mandated by Section 2312 the number of temporary  
18 restraining orders, interim suspension orders, and disciplinary  
19 actions that are taken in each priority category specified in  
20 subdivisions (a) and (b).

21 *SEC. 65. Section 2221 of the Business and Professions Code*  
22 *is amended to read:*

23 2221. (a) The board may deny a physician's and surgeon's  
24 certificate or postgraduate training authorization letter to an  
25 applicant guilty of unprofessional conduct or of any cause that  
26 would subject a licensee to revocation or suspension of his or her  
27 license. The board in its sole discretion, may issue a probationary  
28 physician's and surgeon's certificate to an applicant subject to  
29 terms and conditions, including, but not limited to, any of the  
30 following conditions of probation:

31 (1) Practice limited to a supervised, structured environment  
32 where the licensee's activities shall be supervised by another  
33 physician and surgeon.

34 (2) Total or partial restrictions on drug prescribing privileges  
35 for controlled substances.

36 (3) Continuing medical or psychiatric treatment.

37 (4) Ongoing participation in a specified rehabilitation program.

38 (5) Enrollment and successful completion of a clinical training  
39 program.

40 (6) Abstention from the use of alcohol or drugs.



1 (7) Restrictions against engaging in certain types of medical  
2 practice.

3 (8) Compliance with all provisions of this chapter.

4 (9) Payment of the cost of probation monitoring.

5 (b) The board may modify or terminate the terms and conditions  
6 imposed on the probationary certificate upon receipt of a petition  
7 from the *licensee; however, the requirements of Section 2228.1*  
8 *are mandatory with any probationary licensee.* The board may  
9 assign the petition to an administrative law judge designated in  
10 Section 11371 of the Government Code. After a hearing on the  
11 petition, the administrative law judge shall provide a proposed  
12 decision to the board.

13 (c) The board shall deny a physician's and surgeon's certificate  
14 to an applicant who is required to register pursuant to Section 290  
15 of the Penal Code. This subdivision does not apply to an applicant  
16 who is required to register as a sex offender pursuant to Section  
17 290 of the Penal Code solely because of a misdemeanor conviction  
18 under Section 314 of the Penal Code.

19 (d) An applicant shall not be eligible to reapply for a physician's  
20 and surgeon's certificate for a minimum of three years from the  
21 effective date of the denial of his or her application, except that  
22 the board may, in its discretion and for good cause demonstrated,  
23 permit reapplication after not less than one year has elapsed from  
24 the effective date of the denial.

25 *SEC. 66. Section 2225 of the Business and Professions Code*  
26 *is amended to read:*

27 2225. (a) Notwithstanding Section 2263 and any other ~~law~~  
28 *law, including laws pertaining to the psychotherapist-patient*  
29 *privilege*, making a communication between a physician and  
30 surgeon or a doctor of podiatric medicine and his or her patients  
31 a privileged communication, those provisions shall not apply to  
32 investigations or proceedings conducted under this chapter.  
33 Members of the board, the Senior Assistant Attorney General of  
34 the Health Quality Enforcement Section, members of the California  
35 Board of Podiatric Medicine, and deputies, employees, agents, and  
36 representatives of the board or the California Board of Podiatric  
37 Medicine and the Senior Assistant Attorney General of the Health  
38 Quality Enforcement Section shall keep in confidence during the  
39 course of investigations, the names of any patients whose records  
40 are reviewed and shall not disclose or reveal those names, except

1 as is necessary during the course of an investigation, unless and  
2 until proceedings are instituted. The authority of the board or the  
3 California Board of Podiatric Medicine and the Health Quality  
4 Enforcement Section to examine records of patients in the office  
5 of a physician and surgeon or a doctor of podiatric medicine is  
6 limited to records of patients who have complained to the board  
7 or the California Board of Podiatric Medicine about that licensee.

8 (b) Notwithstanding any other law, the Attorney General and  
9 his or her investigative agents, and investigators and representatives  
10 of the board or the California Board of Podiatric Medicine, may  
11 inquire into any alleged violation of the Medical Practice Act or  
12 any other federal or state law, regulation, or rule relevant to the  
13 practice of medicine or podiatric medicine, whichever is applicable,  
14 and may inspect documents relevant to those investigations in  
15 accordance with the following procedures:

16 (1) Any document relevant to an investigation may be inspected,  
17 and copies may be obtained, where patient consent is given.

18 (2) Any document relevant to the business operations of a  
19 licensee, and not involving medical records attributable to  
20 identifiable patients, may be inspected and copied if relevant to  
21 an investigation of a licensee.

22 (c) (1) Notwithstanding subdivision (b) or any other law, in  
23 any investigation that involves the death of a patient, the board  
24 may inspect and copy the medical records of the deceased patient  
25 without the authorization of the beneficiary or personal  
26 representative of the deceased patient or a court order solely for  
27 the purpose of determining the extent to which the death was the  
28 result of the physician and surgeon's conduct in violation of the  
29 Medical Practice Act, if the board provides a written request to  
30 either the physician and surgeon or the facility where the medical  
31 records are located or the care to the deceased patient was provided,  
32 that includes a declaration that the board has been unsuccessful in  
33 locating or contacting the deceased patient's beneficiary or personal  
34 representative after reasonable efforts. Nothing in this subdivision  
35 shall be construed to allow the board to inspect and copy the  
36 medical records of a deceased patient without a court order when  
37 the beneficiary or personal representative of the deceased patient  
38 has been located and contacted but has refused to consent to the  
39 board inspecting and copying the medical records of the deceased  
40 patient.



(2) The Legislature finds and declares that the authority created in the board pursuant to this section, and a physician and surgeon's compliance with this section, are consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA).

(d) In all cases in which documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

*SEC. 67. Section 2228.1 is added to the Business and Professions Code, to read:*

*2228.1. (a) On and after July 1, 2018, except as otherwise provided in subdivision (c), the board shall require a licensee on probation pursuant to a probationary order made on or after July 1, 2018, before a patient's first visit following the probationary order, to provide the patient, or the patient's guardian or health care surrogate, with a separate disclosure containing all of the following information:*

*(1) The licensee's probationary status.*

*(2) The length of the probation and the end date.*

*(3) All practice restrictions placed on the licensee by the board.*

1     (4) *The board's telephone number, if the probation was imposed*  
2 *by the board.*

3     (5) *An explanation of how the patient can find further*  
4 *information on the licensee's probation on the licensee's profile*  
5 *page on the board's online license information site, if the probation*  
6 *was imposed by the board.*

7     (b) *A licensee required to provide a disclosure pursuant to*  
8 *subdivision (a) shall obtain from the patient, or the patient's*  
9 *guardian or health care surrogate, a separate, signed copy of that*  
10 *disclosure.*

11     (c) *A licensee shall not be required to provide a disclosure*  
12 *pursuant to subdivision (a) if any of the following applies:*

13     (1) *The patient is unconscious or otherwise unable to*  
14 *comprehend the disclosure and sign the copy of the disclosure*  
15 *pursuant to subdivision (b) and a guardian or health care surrogate*  
16 *is unavailable to comprehend the disclosure and sign the copy. In*  
17 *that instance, the licensee shall disclose her or his status as soon*  
18 *as either the patient can comprehend the disclosure and sign the*  
19 *copy or a guardian or health care surrogate is available to*  
20 *comprehend the disclosure and sign the copy.*

21     (2) *The visit occurs in an emergency room or an urgent care*  
22 *facility or the visit is unscheduled.*

23     (3) *The licensee who will be treating the patient during the visit*  
24 *is not known to the patient until immediately prior to the start of*  
25 *the visit.*

26     (d) *On and after July 1, 2018, the board shall provide the*  
27 *following information, with respect to licensees on probation and*  
28 *licensees practicing under probationary licenses, in plain view on*  
29 *the licensee's profile page on the board's online license*  
30 *information site.*

31     (1) *For probation imposed pursuant to a stipulated settlement,*  
32 *the causes alleged in the operative accusation along with a*  
33 *designation identifying those causes by which the licensee has*  
34 *expressly admitted guilt and a statement that acceptance of the*  
35 *settlement is not an admission of guilt.*

36     (2) *For probation imposed by an adjudicated decision of the*  
37 *board, the causes for probation stated in the final probationary*  
38 *order.*

39     (3) *For a licensee granted a probationary license, the causes*  
40 *by which the probationary license was imposed.*

1     (4) *The length of the probation and end date.*

2     (5) *All practice restrictions placed on the license by the board.*

3     (e) *Section 2314 shall not apply to this section.*

4     SEC. 68. *Section 2232 of the Business and Professions Code*  
5 *is amended to read:*

6     2232. (a) Except as provided in subdivisions ~~(b), (c), and (d)~~, and (c),  
7 (d), and (e), the board shall ~~promptly~~ automatically revoke the  
8 license of any person who, at any time after January 1, 1947, has  
9 been required to register as a sex offender pursuant to the  
10 provisions of Section 290 of the Penal ~~Code~~. *Code, regardless of*  
11 *whether the related conviction has been appealed. The board shall*  
12 *notify the licensee of the license revocation and of his or her right*  
13 *to elect to have a hearing as provided in subdivision (b).*

14     (b) *Upon revocation of the physician's and surgeon's certificate,*  
15 *the holder of the certificate may request a hearing within 30 days*  
16 *of the revocation. The proceeding shall be conducted in accordance*  
17 *with the Administrative Procedure Act (Chapter 5 (commencing*  
18 *with Section 11500) of Part 1 of Division 3 of Title 2 of the*  
19 *Government Code).*

20     ~~(b)~~

21     (c) This section shall not apply to a person who is required to  
22 register as a sex offender pursuant to Section 290 of the Penal  
23 Code solely because of a misdemeanor conviction under Section  
24 314 of the Penal Code.

25     ~~(e)~~

26     (d) (1) Five years after the effective date of the revocation and  
27 three years after successful discharge from parole, probation, or  
28 both parole and probation if under simultaneous supervision, an  
29 individual who after January 1, 1947, and prior to January 1, 2005,  
30 was subject to subdivision (a), may petition the superior court, in  
31 the county in which the individual has resided for, at minimum,  
32 five years prior to filing the petition, to hold a hearing within one  
33 year of the date of the petition, in order for the court to determine  
34 whether the individual no longer poses a possible risk to patients.  
35 The individual shall provide notice of the petition to the Attorney  
36 General and to the board at the time of its filing. The Attorney  
37 General and the board may present written and oral argument to  
38 the court on the merits of the petition.

39     (2) If the court finds that the individual no longer poses a  
40 possible risk to patients, and there are no other underlying reasons

1 for which the board pursued disciplinary action, the court shall  
2 order, in writing, the board to reinstate the individual's license  
3 within 180 days of the date of the order. The board may issue a  
4 probationary license to a person subject to this paragraph subject  
5 to terms and conditions, including, but not limited to, any of the  
6 conditions of probation specified in Section 2221.

7 (3) If the court finds that the individual continues to pose a  
8 possible risk to patients, the court shall deny relief. The court's  
9 decision shall be binding on the individual and the board, and the  
10 individual shall be prohibited from filing a subsequent petition  
11 under this section based on the same conviction.

12 ~~(d)~~

13 (e) This section shall not apply to a person who has been relieved  
14 under Section 290.5 of the Penal Code of his or her duty to register  
15 as a sex offender, or whose duty to register has otherwise been  
16 formally terminated under California law.

17 (f) *If the related conviction of the certificate holder is overturned*  
18 *on appeal, the revocation ordered pursuant to this section shall*  
19 *automatically cease. Nothing in this subdivision shall prohibit the*  
20 *board from pursuing disciplinary action based on any cause other*  
21 *than the overturned conviction.*

22 (g) *The other provisions of this article setting forth a procedure*  
23 *for the revocation of a physician's and surgeon's certificate shall*  
24 *not apply to proceedings conducted pursuant to this section.*

25 SEC. 69. *Section 2291.5 is added to the Business and*  
26 *Professions Code, to read:*

27 2291.5. *A physician and surgeon's failure to comply with an*  
28 *order issued under Section 820 shall result in the issuance of*  
29 *notification from the board to cease the practice of medicine within*  
30 *three calendar days after being so notified. The physician and*  
31 *surgeon shall cease the practice of medicine until the ordered*  
32 *examinations have been completed. A physician and surgeon's*  
33 *continued failure to comply with an order issued under Section*  
34 *820 shall constitute grounds for the suspension or revocation of*  
35 *his or her certificate.*

36 SEC. 70. *Section 2334 of the Business and Professions Code*  
37 *is amended to read:*

38 2334. (a) Notwithstanding any other provision of law, with  
39 respect to the use of expert testimony in matters brought by the  
40 Medical Board of California, no expert testimony shall be permitted

1 by any party unless the following information is exchanged in  
2 written form with counsel for the other party, as ordered by the  
3 Office of Administrative Hearings:

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

6 (2) ~~A brief narrative statement of the general substance of the~~  
7 ~~testimony that the expert is expected to give, including any opinion~~  
8 ~~testimony and its basis.~~ *complete expert witness report, which must*  
9 *include the following:*

10 (A) *A complete statement of all opinions the expert will express*  
11 *and the bases and reasons for each opinion.*

12 (B) *The facts or data considered by the expert in forming the*  
13 *opinions.*

14 (C) *Any exhibits that will be used to summarize or support the*  
15 *opinions.*

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

18 (4) A statement of the expert's hourly and daily fee for providing  
19 testimony and for consulting with the party who retained his or  
20 her services.

21 (b) The exchange of the information described in subdivision  
22 (a) shall be completed ~~at least~~ *no later than 90 days from the filing*  
23 *of an accusation or petition to revoke probation or 30 calendar*  
24 *days prior to the commencement date of the* ~~hearing.~~ *hearing,*  
25 *whichever occurs first, or as determined by an administrative law*  
26 *judge when Section 11529 of the Government Code applies.*

27 (c) The Office of Administrative Hearings may adopt regulations  
28 governing the required exchange of the information described in  
29 this section.

30 *SEC. 71. Section 2415 of the Business and Professions Code*  
31 *is amended to read:*

32 2415. (a) Any physician and surgeon or any doctor of podiatric  
33 medicine, as the case may be, who as a sole proprietor, or in a  
34 partnership, group, or professional corporation, desires to practice  
35 under any name that would otherwise be a violation of Section  
36 2285 may practice under that name if the proprietor, partnership,  
37 group, or corporation obtains and maintains in current status a  
38 fictitious-name permit issued by the Division of Licensing, or, in  
39 the case of doctors of podiatric medicine, the California Board of  
40 Podiatric Medicine, under the provisions of this section.

(b) The division or the board shall issue a fictitious-name permit authorizing the holder thereof to use the name specified in the permit in connection with his, her, or its practice if the division or the board finds to its satisfaction that:

(1) The applicant or applicants or shareholders of the professional corporation hold valid and current licenses as physicians and surgeons or doctors of podiatric medicine, as the case may be.

(2) The professional practice of the applicant or applicants is wholly owned and entirely controlled by the applicant or applicants.

(3) The name under which the applicant or applicants propose to practice is not deceptive, misleading, or confusing.

(c) Each permit shall be accompanied by a notice that shall be displayed in a location readily visible to patients and staff. The notice shall be displayed at each place of business identified in the permit.

(d) This section shall not apply to licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services under Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code or any medical school approved by the division or a faculty practice plan connected with that medical school.

(e) Fictitious-name permits issued under this section shall be subject to Article 19 (commencing with Section ~~2420~~ 2421) pertaining to renewal of licenses, ~~except the division shall establish procedures for the renewal of fictitious-name permits every two years on an anniversary basis. For the purpose of the conversion of existing permits to this schedule the division may fix prorated renewal fees.~~ licenses.

(f) The division or the board may revoke or suspend any permit issued if it finds that the holder or holders of the permit are not in compliance with the provisions of this section or any regulations adopted pursuant to this section. A proceeding to revoke or suspend a fictitious-name permit shall be conducted in accordance with Section 2230.

(g) A fictitious-name permit issued to any licensee in a sole practice is automatically revoked in the event the licensee's certificate to practice medicine or podiatric medicine is revoked.

(h) The division or the board may delegate to the executive director, or to another official of the board, its authority to review



1 and approve applications for fictitious-name permits and to issue  
2 those permits.

3 (i) The California Board of Podiatric Medicine shall administer  
4 and enforce this section as to doctors of podiatric medicine and  
5 shall adopt and administer regulations specifying appropriate  
6 podiatric medical name designations.

7 *SEC. 72. Section 2420 of the Business and Professions Code*  
8 *is repealed.*

9 ~~2420. The provisions of this article apply to, determine the~~  
10 ~~expiration of, and govern the renewal of, each of the following~~  
11 ~~certificates, licenses, registrations, and permits issued by or under~~  
12 ~~the Medical Board of California: physician's and surgeon's~~  
13 ~~certificates, certificates to practice podiatric medicine, physical~~  
14 ~~therapy licenses and approvals, registrations of research~~  
15 ~~psychoanalysts, registrations of dispensing opticians, registrations~~  
16 ~~of nonresident contact lens sellers, registrations of spectacle lens~~  
17 ~~dispensers, registrations of contact lens dispensers, certificates to~~  
18 ~~practice midwifery, and fictitious-name permits.~~

19 *SEC. 73. Section 2421 of the Business and Professions Code*  
20 *is amended to read:*

21 2421. As used in this article, the terms:

22 (a) "License" includes "certificate," "permit," and "registration."

23 (b) "Licensee" includes the holder of a license.

24 (c) "Licensing authority" means ~~the appropriate division or~~  
25 ~~examining committee, under the board, which has jurisdiction over~~  
26 ~~a particular licensee.~~

27 *SEC. 74. Section 2423 of the Business and Professions Code*  
28 *is amended to read:*

29 2423. (a) Notwithstanding Section 2422:

30 (1) All physician and surgeon's ~~certificates, certificates to~~  
31 ~~practice podiatric medicine, registrations of spectacle lens~~  
32 ~~dispensers and contact lens dispensers, certificates, and certificates~~  
33 ~~to practice midwifery~~ *midwifery, research psychoanalyst*  
34 *registrations, polysomnographic trainee, technician, and*  
35 *technologist registrations, and fictitious name permits* shall expire  
36 at 12 midnight on the last day of the birth month of the licensee  
37 during the second year of a two-year term if not renewed.

38 (2) Registrations of dispensing opticians will expire at midnight  
39 on the last day of the month in which the license was issued during  
40 the second year of a two-year term if not renewed.

(b) ~~The Division of Licensing~~ *board* shall establish by regulation procedures for the administration of a birth date renewal program, including, but not limited to, the establishment of a system of staggered license expiration dates such that a relatively equal number of licenses expire monthly.

(c) To renew an unexpired license, the licensee shall, on or before the dates on which it would otherwise expire, apply for renewal on a form prescribed by the licensing authority and pay the prescribed renewal fee.

*SEC. 75. Section 2435 of the Business and Professions Code is amended to read:*

2435. The following fees apply to the licensure of physicians and surgeons:

(a) Each applicant for a certificate based upon a national board diplomate certificate, each applicant for a certificate based on reciprocity, and each applicant for a certificate based upon written examination, shall pay a nonrefundable application and processing fee, as set forth in subdivision (b), at the time the application is filed.

(b) The application and processing fee shall be fixed by the board by May 1 of each year, to become effective on July 1 of that year. The fee shall be fixed at an amount necessary to recover the actual costs of the licensing program as projected for the fiscal year commencing on the date the fees become effective.

(c) Each applicant who qualifies for a certificate, as a condition precedent to its issuance, in addition to other fees required herein, shall pay an initial license fee, if any, in an amount fixed by the board consistent with this section. The initial license fee shall not exceed seven hundred ninety dollars (\$790). An applicant enrolled in an approved postgraduate training program shall be required to pay only 50 percent of the initial license fee.

(d) The biennial renewal fee shall be fixed by the board consistent with this section and shall not exceed seven hundred ninety dollars (\$790).

~~(e) Notwithstanding subdivisions (c) and (d), and to ensure that subdivision (k) of Section 125.3 is revenue neutral with regard to the board, the board may, by regulation, increase the amount of the initial license fee and the biennial renewal fee by an amount required to recover both of the following:~~



1     ~~(1) The average amount received by the board during the three~~  
2     ~~fiscal years immediately preceding July 1, 2006, as reimbursement~~  
3     ~~for the reasonable costs of investigation and enforcement~~  
4     ~~proceedings pursuant to Section 125.3.~~

5     ~~(2) Any increase in the amount of investigation and enforcement~~  
6     ~~costs incurred by the board after January 1, 2006, that exceeds the~~  
7     ~~average costs expended for investigation and enforcement costs~~  
8     ~~during the three fiscal years immediately preceding July 1, 2006.~~  
9     ~~When calculating the amount of costs for services for which the~~  
10    ~~board paid an hourly rate, the board shall use the average number~~  
11    ~~of hours for which the board paid for those costs over these prior~~  
12    ~~three fiscal years, multiplied by the hourly rate paid by the board~~  
13    ~~for those costs as of July 1, 2005. Beginning January 1, 2009, the~~  
14    ~~board shall instead use the average number of hours for which it~~  
15    ~~paid for those costs over the three-year period of fiscal years~~  
16    ~~2005–06, 2006–07, and 2007–08, multiplied by the hourly rate~~  
17    ~~paid by the board for those costs as of July 1, 2005. In calculating~~  
18    ~~the increase in the amount of investigation and enforcement costs,~~  
19    ~~the board shall include only those costs for which it was eligible~~  
20    ~~to obtain reimbursement under Section 125.3 and shall not include~~  
21    ~~probation monitoring costs and disciplinary costs, including those~~  
22    ~~associated with the citation and fine process and those required to~~  
23    ~~implement subdivision (b) of Section 12529 of the Government~~  
24    ~~Code.~~

25    ~~(f)~~  
26    ~~(e) Notwithstanding Section 163.5, the delinquency fee shall~~  
27    ~~be 10 percent of the biennial renewal fee.~~

28    ~~(g)~~  
29    ~~(f) The duplicate certificate and endorsement fees shall each be~~  
30    ~~fifty dollars (\$50), and the certification and letter of good standing~~  
31    ~~fees shall each be ten dollars (\$10).~~

32    ~~(h)~~  
33    ~~(g) It is the intent of the Legislature that, in setting fees pursuant~~  
34    ~~to this section, the board shall seek to maintain a reserve in the~~  
35    ~~Contingent Fund of the Medical Board of California in an amount~~  
36    ~~not less than two nor more than four months' operating~~  
37    ~~expenditures.~~

38    ~~(i)~~  
39    ~~(h) Not later than January 1, 2012, the Office of State Audits~~  
40    ~~and Evaluations within the Department of Finance shall commence~~

1 a preliminary review of the board's financial status, including, but  
2 not limited to, its projections related to expenses, revenues, and  
3 reserves, and the impact of the loan from the Contingent Fund of  
4 the Medical Board of California to the General Fund made pursuant  
5 to the Budget Act of 2008. The office shall make the results of this  
6 review available upon request by June 1, 2012. This review shall  
7 be funded from the existing resources of the office during the  
8 2011–12 fiscal year.

9 *SEC. 76. Section 2435.2 of the Business and Professions Code*  
10 *is amended to read:*

11 2435.2. (a) Notwithstanding any other provision of law, if  
12 Article 14 (commencing with Section 2340) becomes inoperative  
13 or the diversion program described in that article is discontinued,  
14 the board shall reduce the amount of the following fees:

15 (1) The initial license fee, as described in subdivision (c) of  
16 Section 2435.

17 (2) The biennial renewal fee, as described in subdivision (d) of  
18 Section 2435.

19 ~~(3) An increase in the fees established pursuant to subdivision~~  
20 ~~(e) of Section 2435.~~

21 (b) The amount of the reductions made pursuant to subdivision  
22 (a) shall equal the board's cost of operating the diversion program.

23 (c) The board shall not make the reductions described in  
24 subdivision (a) if a diversion program is established by statute and  
25 requires the board to fund it in whole or in part from licensure  
26 fees.

27 ~~SEC. 3.~~

28 *SEC. 77. Section 2450 of the Business and Professions Code*  
29 *is amended to read:*

30 2450. There is a Board of Osteopathic Examiners of the State  
31 of California, established by the Osteopathic Act, which shall be  
32 known as the Osteopathic Medical Board of California which  
33 enforces this chapter relating to persons holding or applying for  
34 physician's and surgeon's certificates issued by the Osteopathic  
35 Medical Board of California under the Osteopathic Act.

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

Notwithstanding any other law, the powers and duties of the Osteopathic Medical Board of California, as set forth in this article and under the Osteopathic Act, shall be subject to review by the appropriate policy committees of the Legislature. The review shall be performed as if this chapter were scheduled to be repealed as of January 1, 2022.

*SEC. 78. Section 2454.5 of the Business and Professions Code is amended to read:*

2454.5. In order to ensure the continuing competence of licensed osteopathic physicians and surgeons, the board shall adopt and administer standards for the continuing education of those licensees. The board shall require each licensed osteopathic physician and surgeon to demonstrate satisfaction of the continuing education requirements as a condition for the renewal of a license at intervals of not less than one year nor more than ~~three~~ two years. Commencing January 1, ~~1995~~, 2018, the board shall require each licensed osteopathic physician and surgeon to complete a minimum of ~~150~~ 100 hours of American Osteopathic Association continuing education hours during each ~~three-year~~ two-year cycle, of which ~~60~~ 40 hours ~~must~~ shall be completed in American Osteopathic Association Category 1 continuing education hours and the remaining 60 hours shall be either American Osteopathic Association or American Medical Association accredited as a condition for renewal of an active license.

For purposes of this section, “American Osteopathic Association Category 1” means continuing education activities and programs approved for Category 1 credit by the Committee on Continuing Medical Education of the American Osteopathic Association.

*SEC. 79. Section 2460 of the Business and Professions Code is amended to read:*

2460. (a) ~~There is created within the jurisdiction of the Medical Board of California in the Department of Consumer Affairs the California Board of Podiatric Medicine.~~

(b) This section shall remain in effect only until January 1, 2021, and as of that date is repealed. Notwithstanding any other law, the repeal of this section renders the California Board of Podiatric Medicine subject to review by the appropriate policy committees of the Legislature.

*SEC. 80. Section 2461 of the Business and Professions Code is amended to read:*

1     2461. As used in this article:

2     (a) ~~“Division” means the Division of Licensing of the Medical~~  
3 ~~Board of California.~~

4     (b)

5     (a) “Board” means the California Board of Podiatric Medicine.

6     (e)

7     (b) “Podiatric licensing authority” refers to any officer, board,  
8 commission, committee, or department of another state that may  
9 issue a license to practice podiatric medicine.

10     SEC. 81. *Section 2472 of the Business and Professions Code*  
11 *is amended to read:*

12     2472. (a) The certificate to practice podiatric medicine  
13 authorizes the holder to practice podiatric medicine.

14     (b) As used in this chapter, “podiatric medicine” means the  
15 diagnosis, medical, surgical, mechanical, manipulative, and  
16 electrical treatment of the human foot, including the ankle and  
17 tendons that insert into the foot and the nonsurgical treatment of  
18 the muscles and tendons of the leg governing the functions of the  
19 foot.

20     (c) A doctor of podiatric medicine may not administer an  
21 anesthetic other than local. If an anesthetic other than local is  
22 required for any procedure, the anesthetic shall be administered  
23 by another licensed health care practitioner who is authorized to  
24 administer the required anesthetic within the scope of his or her  
25 practice.

26     (d) (1) A doctor of podiatric medicine ~~who is ankle-certified~~  
27 ~~by the board on and after January 1, 1984,~~ may do the following:

28     (A) Perform surgical treatment of the ankle and tendons at the  
29 level of the ankle pursuant to subdivision (e).

30     (B) Perform services under the direct supervision of a physician  
31 and surgeon, as an assistant at surgery, in surgical procedures that  
32 are otherwise beyond the scope of practice of a doctor of podiatric  
33 medicine.

34     (C) Perform a partial amputation of the foot no further proximal  
35 than the Chopart’s joint.

36     (2) Nothing in this subdivision shall be construed to permit a  
37 doctor of podiatric medicine to function as a primary surgeon for  
38 any procedure beyond his or her scope of practice.

1 (e) A doctor of podiatric medicine may perform surgical  
2 treatment of the ankle and tendons at the level of the ankle only  
3 in the following locations:

4 (1) A licensed general acute care hospital, as defined in Section  
5 1250 of the Health and Safety Code.

6 (2) A licensed surgical clinic, as defined in Section 1204 of the  
7 Health and Safety Code, if the doctor of podiatric medicine has  
8 surgical privileges, including the privilege to perform surgery on  
9 the ankle, in a general acute care hospital described in paragraph  
10 (1) and meets all the protocols of the surgical clinic.

11 (3) An ambulatory surgical center that is certified to participate  
12 in the Medicare program under Title XVIII (42 U.S.C. Sec. 1395  
13 et seq.) of the federal Social Security Act, if the doctor of podiatric  
14 medicine has surgical privileges, including the privilege to perform  
15 surgery on the ankle, in a general acute care hospital described in  
16 paragraph (1) and meets all the protocols of the surgical center.

17 (4) A freestanding physical plant housing outpatient services  
18 of a licensed general acute care hospital, as defined in Section  
19 1250 of the Health and Safety Code, if the doctor of podiatric  
20 medicine has surgical privileges, including the privilege to perform  
21 surgery on the ankle, in a general acute care hospital described in  
22 paragraph (1). For purposes of this section, a “freestanding physical  
23 plant” means any building that is not physically attached to a  
24 building where inpatient services are provided.

25 (5) An outpatient setting accredited pursuant to subdivision (g)  
26 of Section 1248.1 of the Health and Safety Code.

27 *SEC. 82. Section 2474 of the Business and Professions Code*  
28 *is amended to read:*

29 2474. (a) Any person who uses in any sign or in any  
30 advertisement or otherwise, the word or words “*podiatric*  
31 *physician*,” “*podiatric surgeon*,” “*podiatric physician and*  
32 *surgeon*,” “*foot and ankle physician and surgeon*,” “*foot and*  
33 *ankle doctor*,” “*doctor of podiatric medicine*,” “*doctor of podiatry*,”  
34 “*podiatric doctor*,” “*D.P.M.*,” “*podiatrist*,” “*foot specialist*,” or any  
35 other term or terms or any letters indicating or implying that he or  
36 she is a doctor of podiatric medicine, or that he or she practices  
37 podiatric medicine, or holds himself out as practicing podiatric  
38 medicine or foot correction as defined in Section 2472, without  
39 having at the time of so doing a valid, unrevoked, and unsuspended

1 certificate as provided for in this chapter, is guilty of a  
2 misdemeanor.

3 *(b) A holder of a valid, unrevoked, and unsuspended certificate*  
4 *to practice podiatric medicine may use the phrases “doctor of*  
5 *podiatric medicine,” “podiatric physician and surgeon,” “doctor*  
6 *of podiatry,” and “podiatric doctor, or the initials “D.P.M.,” and*  
7 *shall not be in violation of subdivision (a) of Section 2054*

8 SEC. 83. Section 2475 of the Business and Professions Code  
9 is amended to read:

10 2475. Unless otherwise provided by law, no postgraduate  
11 trainee, intern, resident postdoctoral fellow, or instructor may  
12 engage in the practice of podiatric medicine, or receive  
13 compensation therefor, or offer to engage in the practice of  
14 podiatric medicine unless he or she holds a valid, unrevoked, and  
15 unsuspended certificate to practice podiatric medicine issued by  
16 ~~the division:~~ board. However, a graduate of an approved college  
17 or school of podiatric medicine upon whom the degree doctor of  
18 podiatric medicine has been conferred, who is issued a resident’s  
19 license, which may be renewed annually for up to eight years for  
20 this purpose by ~~the division upon recommendation of the board,~~  
21 and who is enrolled in a postgraduate training program approved  
22 by the board, may engage in the practice of podiatric medicine  
23 whenever and wherever required as a part of that program and may  
24 receive compensation for that practice under the following  
25 conditions:

26 (a) A graduate with a resident’s license in an approved  
27 internship, residency, or fellowship program may participate in  
28 training rotations outside the scope of podiatric medicine, under  
29 the supervision of a physician and surgeon who holds a medical  
30 doctor or doctor of osteopathy degree wherever and whenever  
31 required as a part of the training program, and may receive  
32 compensation for that practice. If the graduate fails to receive a  
33 license to practice podiatric medicine under this chapter within  
34 three years from the commencement of the postgraduate training,  
35 all privileges and exemptions under this section shall automatically  
36 cease.

37 (b) Hospitals functioning as a part of the teaching program of  
38 an approved college or school of podiatric medicine in this state  
39 may exchange instructors or resident or assistant resident doctors  
40 of podiatric medicine with another approved college or school of

1 podiatric medicine not located in this state, or those hospitals may  
2 appoint a graduate of an approved school as such a resident for  
3 purposes of postgraduate training. Those instructors and residents  
4 may practice and be compensated as provided in this section, but  
5 that practice and compensation shall be for a period not to exceed  
6 two years.

7 *SEC. 84. Section 2479 of the Business and Professions Code*  
8 *is amended to read:*

9 ~~2479. The division shall issue, upon the recommendation of~~  
10 ~~the board,~~ *board shall issue* a certificate to practice podiatric  
11 medicine to each applicant who meets the requirements of this  
12 chapter. Every applicant for a certificate to practice podiatric  
13 medicine shall comply with the provisions of Article 4  
14 (commencing with Section 2080) which are not specifically  
15 applicable to applicants for a physician's and surgeon's certificate,  
16 in addition to the provisions of this article.

17 *SEC. 85. Section 2486 of the Business and Professions Code*  
18 *is amended to read:*

19 ~~2486. The Medical Board of California shall issue, upon the~~  
20 ~~recommendation of the board,~~ *board shall issue* a certificate to  
21 practice podiatric medicine if the applicant has submitted directly  
22 to the board from the credentialing organizations verification that  
23 he or she meets all of the following requirements:

24 (a) The applicant has graduated from an approved school or  
25 college of podiatric medicine and meets the requirements of Section  
26 2483.

27 (b) The applicant, within the past 10 years, has passed parts I,  
28 II, and III of the examination administered by the National Board  
29 of Podiatric Medical Examiners of the United States or has passed  
30 a written examination that is recognized by the board to be the  
31 equivalent in content to the examination administered by the  
32 National Board of Podiatric Medical Examiners of the United  
33 States.

34 (c) The applicant has satisfactorily completed the postgraduate  
35 training required by Section 2484.

36 (d) The applicant has passed within the past 10 years any oral  
37 and practical examination that may be required of all applicants  
38 by the board to ascertain clinical competence.



1 (e) The applicant has committed no acts or crimes constituting  
2 grounds for denial of a certificate under Division 1.5 (commencing  
3 with Section 475).

4 (f) The board determines that no disciplinary action has been  
5 taken against the applicant by any podiatric licensing authority  
6 and that the applicant has not been the subject of adverse judgments  
7 or settlements resulting from the practice of podiatric medicine  
8 that the board determines constitutes evidence of a pattern of  
9 negligence or incompetence.

10 (g) A disciplinary databank report regarding the applicant is  
11 received by the board from the Federation of Podiatric Medical  
12 Boards.

13 *SEC. 86. Section 2488 of the Business and Professions Code*  
14 *is amended to read:*

15 2488. ~~Notwithstanding any other provision of law, the Medical~~  
16 ~~Board of California shall issue, upon the recommendation of the~~  
17 ~~board,~~ *The board shall issue* a certificate to practice podiatric  
18 medicine by credentialing if the applicant has submitted directly  
19 to the board from the credentialing organizations verification that  
20 he or she is licensed as a doctor of podiatric medicine in any other  
21 state and meets all of the following requirements:

22 (a) The applicant has graduated from an approved school or  
23 college of podiatric medicine.

24 (b) The applicant, within the past 10 years, has passed either  
25 part III of the examination administered by the National Board of  
26 Podiatric Medical Examiners of the United States or a written  
27 examination that is recognized by the board to be the equivalent  
28 in content to the examination administered by the National Board  
29 of Podiatric Medical Examiners of the United States.

30 (c) The applicant has satisfactorily completed a postgraduate  
31 training program approved by the Council on Podiatric Medical  
32 Education.

33 (d) The applicant, within the past 10 years, has passed any oral  
34 and practical examination that may be required of all applicants  
35 by the board to ascertain clinical competence.

36 (e) The applicant has committed no acts or crimes constituting  
37 grounds for denial of a certificate under Division 1.5 (commencing  
38 with Section 475).

39 (f) The board determines that no disciplinary action has been  
40 taken against the applicant by any podiatric licensing authority



1 and that the applicant has not been the subject of adverse judgments  
2 or settlements resulting from the practice of podiatric medicine  
3 that the board determines constitutes evidence of a pattern of  
4 negligence or incompetence.

5 (g) A disciplinary databank report regarding the applicant is  
6 received by the board from the Federation of Podiatric Medical  
7 Boards.

8 *SEC. 87. Section 2492 of the Business and Professions Code*  
9 *is amended to read:*

10 2492. (a) The board shall examine every applicant for a  
11 certificate to practice podiatric medicine to ensure a minimum of  
12 entry-level competence at the time and place designated by the  
13 board in its discretion, but at least twice a year.

14 (b) Unless the applicant meets the requirements of Section 2486,  
15 applicants shall be required to have taken and passed the  
16 examination administered by the National Board of Podiatric  
17 Medical Examiners.

18 (c) The board may appoint qualified persons to give the whole  
19 or any portion of any examination as provided in this article, who  
20 shall be designated as examination commissioners. The board may  
21 fix the compensation of those persons subject to the provisions of  
22 applicable state laws and regulations.

23 (d) The provisions of Article 9 (commencing with Section 2170)  
24 shall apply to examinations administered by the board except where  
25 those provisions are in conflict with or inconsistent with the  
26 provisions of this article. ~~In respect to applicants under this article~~  
27 ~~any references to the "Division of Licensing" or "division" shall~~  
28 ~~be deemed to apply to the board.~~

29 *SEC. 88. Section 2499 of the Business and Professions Code*  
30 *is amended to read:*

31 2499. There is in the State Treasury the Board of Podiatric  
32 Medicine Fund. Notwithstanding Section 2445, ~~the division~~ board  
33 shall report to the Controller at the beginning of each calendar  
34 month for the month preceding the amount and source of all  
35 revenue received by it on behalf of the board, pursuant to this  
36 chapter, and shall pay the entire amount thereof to the Treasurer  
37 for deposit into the fund. All revenue received by the board and  
38 the division from fees authorized to be charged relating to the  
39 practice of podiatric medicine shall be deposited in the fund as  
40 provided in this section, and shall be available, upon appropriation

1 of the Legislature, to carry out the provisions of this chapter  
2 relating to the regulation of the practice of podiatric medicine.

3 *SEC. 89. Section 2499.7 is added to the Business and*  
4 *Professions Code, to read:*

5 *2499.7. (a) Certificates to practice podiatric medicine shall*  
6 *expire at 12 midnight on the last day of the birth month of the*  
7 *licensee during the second year of a two-year term.*

8 *(b) To renew an unexpired certificate, the licensee, on or before*  
9 *the date on which the certificate would otherwise expire, shall*  
10 *apply for renewal on a form prescribed by the board and pay the*  
11 *prescribed renewal fee.*

12 *SEC. 90. Section 2525.2 of the Business and Professions Code*  
13 *is amended to read:*

14 *2525.2. An individual who possesses a license in good standing*  
15 *to practice medicine or osteopathy issued by the Medical Board*  
16 *of—California California, the California Board of Podiatric*  
17 *Medicine, or the Osteopathic Medical Board of California shall*  
18 *not recommend medical cannabis to a patient, unless that person*  
19 *is the patient’s attending physician, as defined by subdivision (a)*  
20 *of Section 11362.7 of the Health and Safety Code.*

21 *SEC. 91. The heading of Chapter 5.1 (commencing with Section*  
22 *2529) of Division 2 of the Business and Professions Code is*  
23 *repealed.*

24  
25 ~~CHAPTER 5.1. RESEARCH PSYCHOANALYSTS~~

26  
27 *SEC. 92. Section 2529 of the Business and Professions Code*  
28 *is amended and renumbered to read:*

29 ~~2529.~~

30 *2950. (a) Graduates of the Southern California Psychoanalytic*  
31 *Institute, the Los Angeles Psychoanalytic Society and Institute,*  
32 *the San Francisco Psychoanalytic Institute, the San Diego*  
33 *Psychoanalytic Center, or institutes deemed equivalent by the*  
34 ~~*Medical Board of California*~~ *board who have completed clinical*  
35 *training in psychoanalysis may engage in psychoanalysis as an*  
36 *adjunct to teaching, training, or research and hold themselves out*  
37 *to the public as psychoanalysts, and students in those institutes*  
38 *may engage in psychoanalysis under supervision, if the students*  
39 *and graduates do not hold themselves out to the public by any title*  
40 *or description of services incorporating the words “psychological,”*

1 “psychologist,” “psychology,” “psychometrists,” “psychometrics,”  
2 or “psychometry,” or that they do not state or imply that they are  
3 licensed to practice psychology.

4 (b) Those students and graduates seeking to engage in  
5 psychoanalysis under this ~~chapter~~ *article* shall register with the  
6 ~~Medical Board of California, board,~~ presenting evidence of their  
7 student or graduate status. The board may suspend or revoke the  
8 exemption of those persons for unprofessional conduct as defined  
9 in Sections 726, ~~2234, 2235, and 2529.1~~ 2960, 2960.6, 2969, and  
10 2996.

11 *SEC. 93. Section 2529.1 of the Business and Professions Code*  
12 *is amended and renumbered to read:*

13 ~~2529.1.~~

14 2951. (a) The use of any controlled substance or the use of  
15 any of the dangerous drugs specified in Section 4022, or of  
16 alcoholic beverages, to the extent, or in such a manner as to be  
17 dangerous or injurious to the registrant, or to any other person or  
18 to the public, or to the extent that this use impairs the ability of  
19 the registrant to practice safely or more than one misdemeanor or  
20 any felony conviction involving the use, consumption, or  
21 self-administration of any of the substances referred to in this  
22 section, or any combination thereof, constitutes unprofessional  
23 conduct. The record of the conviction is conclusive evidence of  
24 this unprofessional conduct.

25 (b) A plea or verdict of guilty or a conviction following a plea  
26 of nolo contendere is deemed to be a conviction within the meaning  
27 of this section. The board may order discipline of the registrant in  
28 accordance with ~~Section 2227~~ *Article 4 (commencing with Section*  
29 *2960)* or may order the denial of the registration when the time  
30 for appeal has elapsed or the judgment of conviction has been  
31 affirmed on appeal or when an order granting probation is made  
32 suspending imposition of sentence, irrespective of a subsequent  
33 order under the provisions of Section 1203.4 of the Penal Code  
34 allowing this person to withdraw his or her plea of guilty and to  
35 enter a plea of not guilty, or setting aside the verdict of guilty, or  
36 dismissing the accusation, complaint, information, or indictment.

37 *SEC. 94. Section 2529.5 of the Business and Professions Code*  
38 *is amended and renumbered to read:*

1     ~~2529.5.~~

2     2952. (a) Each person to whom registration is granted under  
3 the provisions of this chapter shall pay into the Contingent Fund  
4 of the Medical Board of California a fee to be fixed by the ~~Medical~~  
5 ~~Board of California~~ board at a sum not in excess of one hundred  
6 dollars (\$100).

7     ~~The~~

8     (b) *The* registration shall expire after two years. The registration  
9 may be renewed biennially at a fee to be fixed by the board at a  
10 sum not in excess of fifty dollars (\$50). Students seeking to renew  
11 their registration shall present to the board evidence of their  
12 continuing student status.

13     ~~The~~

14     (c) *The* money in the Contingent Fund of the Medical Board of  
15 California shall be used for the administration of this chapter. *Any*  
16 *moneys within the Contingent Fund of the Medial Board of*  
17 *California collected pursuant to Chapter 5.1 (commencing with*  
18 *Section 2529) as it read before the enactment of the statute that*  
19 *amended and renumbered this section, shall be deposited in the*  
20 *Psychology Fund.*

21     (d) *The board may employ, subject to civil service regulations,*  
22 *whatever additional clerical assistance is necessary for the*  
23 *administration of this article.*

24     SEC. 95. *Section 2529.6 of the Business and Professions Code*  
25 *is amended and renumbered to read:*

26     ~~2529.6.~~

27     2953. (a) Except as provided in subdivisions (b) and (c), the  
28 board shall revoke the registration of any person who has been  
29 required to register as a sex offender pursuant to Section 290 of  
30 the Penal Code for conduct that occurred on or after January 1,  
31 2017.

32     (b) This section shall not apply to a person who is required to  
33 register as a sex offender pursuant to Section 290 of the Penal  
34 Code solely because of a misdemeanor conviction under Section  
35 314 of the Penal Code.

36     (c) This section shall not apply to a person who has been relieved  
37 under Section 290.5 of the Penal Code of his or her duty to register  
38 as a sex offender, or whose duty to register has otherwise been  
39 formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section 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.

SEC. 96. *The heading of Article 3.5 (commencing with Section 2950) is added to Chapter 6.6 of Division 2 of the Business and Professions Code, to read:*

*Article 3.5. Research Psychoanalysts*

SEC. 97. *Section 2566.2 is added to the Business and Professions Code, to read:*

2566.2. *Every registration issued to a dispensing optician, contact lens dispenser, and spectacle lens dispenser shall expire 24 months after the initial date of issuance. To renew an unexpired registration, the registrant shall, before the time at which the license would otherwise expire, apply for renewal on a form prescribed by the board, and pay the renewal fee prescribed by this chapter.*

SEC. 98. *Section 43.7 of the Civil Code is amended to read:*

43.7. (a) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any member of a duly appointed mental health professional quality assurance committee that is established in compliance with Section 14725 of the Welfare and Institutions Code, for any act or proceeding undertaken or performed within the scope of the functions of the committee which is formed to review and evaluate the adequacy, appropriateness, or effectiveness of the care and treatment planned for, or provided to, mental health patients in order to improve quality of care by mental health professionals if the committee member acts without malice, has made a reasonable effort to obtain the facts of the matter as to which he or she acts, and acts in reasonable belief that the action taken by him or her is warranted by the facts known to him or her after the reasonable effort to obtain facts.

(b) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any professional society, any member of a duly appointed committee of a medical specialty society, or any member of a duly appointed committee of a state or local professional society, or duly appointed member

1 of a committee of a professional staff of a licensed hospital  
2 (provided the professional staff operates pursuant to written bylaws  
3 that have been approved by the governing board of the hospital),  
4 for any act or proceeding undertaken or performed within the scope  
5 of the functions of the committee which is formed to maintain the  
6 professional standards of the society established by its bylaws, or  
7 any member of any peer review committee whose purpose is to  
8 review the quality of medical, dental, dietetic, chiropractic,  
9 optometric, acupuncture, psychotherapy, *midwifery*, or veterinary  
10 services rendered by physicians and surgeons, dentists, dental  
11 hygienists, podiatrists, registered dietitians, chiropractors,  
12 optometrists, acupuncturists, veterinarians, marriage and family  
13 therapists, professional clinical counselors, *licensed midwives*, or  
14 psychologists, which committee is composed chiefly of physicians  
15 and surgeons, dentists, dental hygienists, podiatrists, registered  
16 dietitians, chiropractors, optometrists, acupuncturists, veterinarians,  
17 marriage and family therapists, professional clinical counselors,  
18 *licensed midwives* or psychologists for any act or proceeding  
19 undertaken or performed in reviewing the quality of medical,  
20 dental, dietetic, chiropractic, optometric, acupuncture,  
21 psychotherapy, *midwifery*, or veterinary services rendered by  
22 physicians and surgeons, dentists, dental hygienists, podiatrists,  
23 registered dietitians, chiropractors, optometrists, acupuncturists,  
24 veterinarians, marriage and family therapists, professional clinical  
25 counselors, *midwifery*, or psychologists or any member of the  
26 governing board of a hospital in reviewing the quality of medical  
27 services rendered by members of the staff if the professional  
28 society, committee, or board member acts without malice, has  
29 made a reasonable effort to obtain the facts of the matter as to  
30 which he, she, or it acts, and acts in reasonable belief that the action  
31 taken by him, her, or it is warranted by the facts known to him,  
32 her, or it after the reasonable effort to obtain facts. "Professional  
33 society" includes legal, medical, psychological, dental, dental  
34 hygiene, dietetic, accounting, optometric, acupuncture, podiatric,  
35 pharmaceutical, chiropractic, physical therapist, veterinary, licensed  
36 marriage and family therapy, licensed clinical social work, licensed  
37 professional clinical counselor, and engineering organizations  
38 having as members at least 25 percent of the eligible persons or  
39 licentiates in the geographic area served by the particular society.  
40 However, if the society has fewer than 100 members, it shall have

1 as members at least a majority of the eligible persons or licentiates  
2 in the geographic area served by the particular society.

3 “Medical specialty society” means an organization having as  
4 members at least 25 percent of the eligible physicians and surgeons  
5 within a given professionally recognized medical specialty in the  
6 geographic area served by the particular society.

7 (c) This section does not affect the official immunity of an  
8 officer or employee of a public corporation.

9 (d) There shall be no monetary liability on the part of, and no  
10 cause of action for damages shall arise against, any physician and  
11 surgeon, podiatrist, or chiropractor who is a member of an  
12 underwriting committee of an interindemnity or reciprocal or  
13 interinsurance exchange or mutual company for any act or  
14 proceeding undertaken or performed in evaluating physicians and  
15 surgeons, podiatrists, or chiropractors for the writing of  
16 professional liability insurance, or any act or proceeding undertaken  
17 or performed in evaluating physicians and surgeons for the writing  
18 of an interindemnity, reciprocal, or interinsurance contract as  
19 specified in Section 1280.7 of the Insurance Code, if the evaluating  
20 physician and surgeon, podiatrist, or chiropractor acts without  
21 malice, has made a reasonable effort to obtain the facts of the  
22 matter as to which he or she acts, and acts in reasonable belief that  
23 the action taken by him or her is warranted by the facts known to  
24 him or her after the reasonable effort to obtain the facts.

25 (e) This section shall not be construed to confer immunity from  
26 liability on any quality assurance committee established in  
27 compliance with Section 14725 of the Welfare and Institutions  
28 Code or hospital. In any case in which, but for the enactment of  
29 the preceding provisions of this section, a cause of action would  
30 arise against a quality assurance committee established in  
31 compliance with Section 14725 of the Welfare and Institutions  
32 Code or hospital, the cause of action shall exist as if the preceding  
33 provisions of this section had not been enacted.

34 *SEC. 99. Section 43.8 of the Civil Code is amended to read:*

35 43.8. (a) In addition to the privilege afforded by Section 47,  
36 there shall be no monetary liability on the part of, and no cause of  
37 action for damages shall arise against, any person on account of  
38 the communication of information in the possession of that person  
39 to any hospital, hospital medical staff, veterinary hospital staff,  
40 professional society, medical, dental, podiatric, psychology,



1 marriage and family therapy, professional clinical counselor,  
2 *midwifery*, or veterinary school, professional licensing board or  
3 division, committee or panel of a licensing board, the Senior  
4 Assistant Attorney General of the Health Quality Enforcement  
5 Section appointed under Section 12529 of the Government Code,  
6 peer review committee, quality assurance committees established  
7 in compliance with Sections 4070 and 5624 of the Welfare and  
8 Institutions Code, or underwriting committee described in Section  
9 43.7 when the communication is intended to aid in the evaluation  
10 of the qualifications, fitness, character, or insurability of a  
11 practitioner of the healing or veterinary arts.

12 (b) The immunities afforded by this section and by Section 43.7  
13 shall not affect the availability of any absolute privilege that may  
14 be afforded by Section 47.

15 (c) Nothing in this section is intended in any way to affect the  
16 California Supreme Court's decision in *Hassan v. Mercy American*  
17 *River Hospital* (2003) 31 Cal.4th 709, holding that subdivision (a)  
18 provides a qualified privilege.

19 *SEC. 100. Section 13401 of the Corporations Code is amended*  
20 *to read:*

21 13401. As used in this part:

22 (a) "Professional services" means any type of professional  
23 services that may be lawfully rendered only pursuant to a license,  
24 certification, or registration authorized by the Business and  
25 Professions Code, the Chiropractic Act, or the Osteopathic Act.

26 (b) "Professional corporation" means a corporation organized  
27 under the General Corporation Law or pursuant to subdivision (b)  
28 of Section 13406 that is engaged in rendering professional services  
29 in a single profession, except as otherwise authorized in Section  
30 13401.5, pursuant to a certificate of registration issued by the  
31 governmental agency regulating the profession as herein provided  
32 and that in its practice or business designates itself as a professional  
33 or other corporation as may be required by statute. However, any  
34 professional corporation or foreign professional corporation  
35 rendering professional services by persons duly licensed by the  
36 Medical Board of California or any examining committee under  
37 the jurisdiction of the board, *the California Board of Podiatric*  
38 *Medicine*, the Osteopathic Medical Board of California, the Dental  
39 Board of California, the Dental Hygiene Committee of California,  
40 the California State Board of Pharmacy, the Veterinary Medical



Board, the California Architects Board, the Court Reporters Board of California, the Board of Behavioral Sciences, the Speech-Language Pathology and Audiology Board, the Board of Registered Nursing, or the State Board of Optometry shall not be required to obtain a certificate of registration in order to render those professional services.

(c) “Foreign professional corporation” means a corporation organized under the laws of a state of the United States other than this state that is engaged in a profession of a type for which there is authorization in the Business and Professions Code for the performance of professional services by a foreign professional corporation.

(d) “Licensed person” means any natural person who is duly licensed under the provisions of the Business and Professions Code, the Chiropractic Act, or the Osteopathic Act to render the same professional services as are or will be rendered by the professional corporation or foreign professional corporation of which he or she is, or intends to become, an officer, director, shareholder, or employee.

(e) “Disqualified person” means a licensed person who for any reason becomes legally disqualified (temporarily or permanently) to render the professional services that the particular professional corporation or foreign professional corporation of which he or she is an officer, director, shareholder, or employee is or was rendering.

*SEC. 101. Section 13401.5 of the Corporations Code is amended to read:*

13401.5. Notwithstanding subdivision (d) of Section 13401 and any other provision of law, the following licensed persons may be shareholders, officers, directors, or professional employees of the professional corporations designated in this section so long as the sum of all shares owned by those licensed persons does not exceed 49 percent of the total number of shares of the professional corporation so designated herein, and so long as the number of those licensed persons owning shares in the professional corporation so designated herein does not exceed the number of persons licensed by the governmental agency regulating the designated professional corporation. This section does not limit employment by a professional corporation designated in this section to only those licensed professionals listed under each subdivision. Any person duly licensed under Division 2 (commencing with

- 1 Section 500) of the Business and Professions Code, the  
2 Chiropractic Act, or the Osteopathic Act may be employed to  
3 render professional services by a professional corporation  
4 designated in this section.
- 5 (a) Medical corporation.
- 6 (1) Licensed doctors of podiatric medicine.
- 7 (2) Licensed psychologists.
- 8 (3) Registered nurses.
- 9 (4) Licensed optometrists.
- 10 (5) Licensed marriage and family therapists.
- 11 (6) Licensed clinical social workers.
- 12 (7) Licensed physician assistants.
- 13 (8) Licensed chiropractors.
- 14 (9) Licensed acupuncturists.
- 15 (10) Naturopathic doctors.
- 16 (11) Licensed professional clinical counselors.
- 17 (12) Licensed physical therapists.
- 18 (13) Licensed pharmacists.
- 19 (14) *Licensed midwives.*
- 20 (b) Podiatric medical corporation.
- 21 (1) Licensed physicians and surgeons.
- 22 (2) Licensed psychologists.
- 23 (3) Registered nurses.
- 24 (4) Licensed optometrists.
- 25 (5) Licensed chiropractors.
- 26 (6) Licensed acupuncturists.
- 27 (7) Naturopathic doctors.
- 28 (8) Licensed physical therapists.
- 29 (c) Psychological corporation.
- 30 (1) Licensed physicians and surgeons.
- 31 (2) Licensed doctors of podiatric medicine.
- 32 (3) Registered nurses.
- 33 (4) Licensed optometrists.
- 34 (5) Licensed marriage and family therapists.
- 35 (6) Licensed clinical social workers.
- 36 (7) Licensed chiropractors.
- 37 (8) Licensed acupuncturists.
- 38 (9) Naturopathic doctors.
- 39 (10) Licensed professional clinical counselors.
- 40 (11) *Licensed midwives.*

- 1 (d) Speech-language pathology corporation.
- 2 (1) Licensed audiologists.
- 3 (e) Audiology corporation.
- 4 (1) Licensed speech-language pathologists.
- 5 (f) Nursing corporation.
- 6 (1) Licensed physicians and surgeons.
- 7 (2) Licensed doctors of podiatric medicine.
- 8 (3) Licensed psychologists.
- 9 (4) Licensed optometrists.
- 10 (5) Licensed marriage and family therapists.
- 11 (6) Licensed clinical social workers.
- 12 (7) Licensed physician assistants.
- 13 (8) Licensed chiropractors.
- 14 (9) Licensed acupuncturists.
- 15 (10) Naturopathic doctors.
- 16 (11) Licensed professional clinical counselors.
- 17 (12) *Licensed midwives*.
- 18 (g) Marriage and family therapist corporation.
- 19 (1) Licensed physicians and surgeons.
- 20 (2) Licensed psychologists.
- 21 (3) Licensed clinical social workers.
- 22 (4) Registered nurses.
- 23 (5) Licensed chiropractors.
- 24 (6) Licensed acupuncturists.
- 25 (7) Naturopathic doctors.
- 26 (8) Licensed professional clinical counselors.
- 27 (9) *Licensed midwives*.
- 28 (h) Licensed clinical social worker corporation.
- 29 (1) Licensed physicians and surgeons.
- 30 (2) Licensed psychologists.
- 31 (3) Licensed marriage and family therapists.
- 32 (4) Registered nurses.
- 33 (5) Licensed chiropractors.
- 34 (6) Licensed acupuncturists.
- 35 (7) Naturopathic doctors.
- 36 (8) Licensed professional clinical counselors.
- 37 (i) Physician assistants corporation.
- 38 (1) Licensed physicians and surgeons.
- 39 (2) Registered nurses.
- 40 (3) Licensed acupuncturists.

- 1 (4) Naturopathic doctors.
- 2 (5) *Licensed midwives.*
- 3 (j) Optometric corporation.
- 4 (1) Licensed physicians and surgeons.
- 5 (2) Licensed doctors of podiatric medicine.
- 6 (3) Licensed psychologists.
- 7 (4) Registered nurses.
- 8 (5) Licensed chiropractors.
- 9 (6) Licensed acupuncturists.
- 10 (7) Naturopathic doctors.
- 11 (k) Chiropractic corporation.
- 12 (1) Licensed physicians and surgeons.
- 13 (2) Licensed doctors of podiatric medicine.
- 14 (3) Licensed psychologists.
- 15 (4) Registered nurses.
- 16 (5) Licensed optometrists.
- 17 (6) Licensed marriage and family therapists.
- 18 (7) Licensed clinical social workers.
- 19 (8) Licensed acupuncturists.
- 20 (9) Naturopathic doctors.
- 21 (10) Licensed professional clinical counselors.
- 22 (11) *Licensed midwives.*
- 23 (l) Acupuncture corporation.
- 24 (1) Licensed physicians and surgeons.
- 25 (2) Licensed doctors of podiatric medicine.
- 26 (3) Licensed psychologists.
- 27 (4) Registered nurses.
- 28 (5) Licensed optometrists.
- 29 (6) Licensed marriage and family therapists.
- 30 (7) Licensed clinical social workers.
- 31 (8) Licensed physician assistants.
- 32 (9) Licensed chiropractors.
- 33 (10) Naturopathic doctors.
- 34 (11) Licensed professional clinical counselors.
- 35 (12) *Licensed midwives.*
- 36 (m) Naturopathic doctor corporation.
- 37 (1) Licensed physicians and surgeons.
- 38 (2) Licensed psychologists.
- 39 (3) Registered nurses.
- 40 (4) Licensed physician assistants.

- 1 (5) Licensed chiropractors.
- 2 (6) Licensed acupuncturists.
- 3 (7) Licensed physical therapists.
- 4 (8) Licensed doctors of podiatric medicine.
- 5 (9) Licensed marriage and family therapists.
- 6 (10) Licensed clinical social workers.
- 7 (11) Licensed optometrists.
- 8 (12) Licensed professional clinical counselors.
- 9 (13) *Licensed midwives.*
- 10 (n) Dental corporation.
- 11 (1) Licensed physicians and surgeons.
- 12 (2) Dental assistants.
- 13 (3) Registered dental assistants.
- 14 (4) Registered dental assistants in extended functions.
- 15 (5) Registered dental hygienists.
- 16 (6) Registered dental hygienists in extended functions.
- 17 (7) Registered dental hygienists in alternative practice.
- 18 (o) Professional clinical counselor corporation.
- 19 (1) Licensed physicians and surgeons.
- 20 (2) Licensed psychologists.
- 21 (3) Licensed clinical social workers.
- 22 (4) Licensed marriage and family therapists.
- 23 (5) Registered nurses.
- 24 (6) Licensed chiropractors.
- 25 (7) Licensed acupuncturists.
- 26 (8) Naturopathic doctors.
- 27 (9) *Licensed midwives.*
- 28 (p) Physical therapy corporation.
- 29 (1) Licensed physicians and surgeons.
- 30 (2) Licensed doctors of podiatric medicine.
- 31 (3) Licensed acupuncturists.
- 32 (4) Naturopathic doctors.
- 33 (5) Licensed occupational therapists.
- 34 (6) Licensed speech-language therapists.
- 35 (7) Licensed audiologists.
- 36 (8) Registered nurses.
- 37 (9) Licensed psychologists.
- 38 (10) Licensed physician assistants.
- 39 (11) *Licensed midwives.*

(q) Registered dental hygienist in alternative practice corporation.

(1) Registered dental assistants.

(2) Licensed dentists.

(3) Registered dental hygienists.

(4) Registered dental hygienists in extended functions.

(r) *Licensed midwifery corporation.*

(1) *Licensed physicians and surgeons.*

(2) *Licensed psychologists.*

(3) *Registered nurses.*

(4) *Licensed marriage and family therapists.*

(5) *Licensed clinical social workers.*

(6) *Licensed physician assistants.*

(7) *Licensed chiropractors.*

(8) *Licensed acupuncturists.*

(9) *Licensed naturopathic doctors.*

(10) *Licensed professional clinical counselors.*

(11) *Licensed physical therapists.*

SEC. 102. Section 1157 of the Evidence Code is amended to read:

1157. (a) Neither the proceedings nor the records of organized committees of medical, medical-dental, podiatric, registered dietitian, psychological, marriage and family therapist, licensed clinical social worker, professional clinical counselor, pharmacist, or veterinary staffs in hospitals, or of a peer review body, as defined in Section 805 of the Business and Professions Code, having the responsibility of evaluation and improvement of the quality of care rendered in the hospital, or for that peer review body, or medical or dental review or dental hygienist review or chiropractic review or podiatric review or registered dietitian review or pharmacist review or veterinary review or acupuncturist review *or licensed midwife review* committees of local medical, dental, dental hygienist, podiatric, dietetic, pharmacist, veterinary, acupuncture, or chiropractic societies, marriage and family therapist, licensed clinical social worker, professional clinical counselor, or psychological review committees of state or local marriage and family therapist, state or local licensed clinical social worker, state or local licensed professional clinical counselor, or state or local psychological associations or societies *or licensed midwife associations or societies* having the responsibility of evaluation

1 and improvement of the quality of care, shall be subject to  
2 discovery.

3 (b) Except as hereinafter provided, a person in attendance at a  
4 meeting of any of the committees described in subdivision (a) shall  
5 not be required to testify as to what transpired at that meeting.

6 (c) The prohibition relating to discovery or testimony does not  
7 apply to the statements made by a person in attendance at a meeting  
8 of any of the committees described in subdivision (a) if that person  
9 is a party to an action or proceeding the subject matter of which  
10 was reviewed at that meeting, to a person requesting hospital staff  
11 privileges, or in an action against an insurance carrier alleging bad  
12 faith by the carrier in refusing to accept a settlement offer within  
13 the policy limits.

14 (d) The prohibitions in this section do not apply to medical,  
15 dental, dental hygienist, podiatric, dietetic, psychological, marriage  
16 and family therapist, licensed clinical social worker, professional  
17 clinical counselor, pharmacist, veterinary, acupuncture, *midwifery*,  
18 or chiropractic society committees that exceed 10 percent of the  
19 membership of the society, nor to any of those committees if a  
20 person serves upon the committee when his or her own conduct  
21 or practice is being reviewed.

22 (e) The amendments made to this section by Chapter 1081 of  
23 the Statutes of 1983, or at the 1985 portion of the 1985–86 Regular  
24 Session of the Legislature, at the 1990 portion of the 1989–90  
25 Regular Session of the Legislature, at the 2000 portion of the  
26 1999–2000 Regular Session of the Legislature, at the 2011 portion  
27 of the 2011–12 Regular Session of the Legislature, or at the 2015  
28 portion of the 2015–16 Regular Session of the Legislature, do not  
29 exclude the discovery or use of relevant evidence in a criminal  
30 action.

31 *SEC. 103. Section 11529 of the Government Code is amended*  
32 *to read:*

33 11529. (a) The administrative law judge of the Medical Quality  
34 Hearing Panel established pursuant to Section 11371 may issue  
35 an interim order suspending a license, imposing drug testing,  
36 continuing education, supervision of procedures, limitations on  
37 the authority to prescribe, furnish, administer, or dispense  
38 controlled substances, or other license restrictions. Interim orders  
39 may be issued only if the affidavits in support of the petition show  
40 that the licensee has engaged in, or is about to engage in, acts or

omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare. The failure to comply with an order issued pursuant to Section 820 of the Business and Professions Code may constitute grounds to issue an interim suspension order under this section.

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

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

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

(1) To be represented by counsel.

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

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

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

(4) To present oral argument.



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

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

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

11 (f) In all cases in which an interim order is issued, and an  
12 accusation *or petition to revoke probation* is not filed and served  
13 pursuant to Sections 11503 and 11505 within 30 days of the date  
14 on which the parties to the hearing on the interim order have  
15 submitted the matter, the order shall be dissolved.

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

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

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

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

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

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

5 *SEC. 104. Section 12529.6 of the Government Code is repealed.*

6 ~~12529.6.—(a) The Legislature finds and declares that the~~  
7 ~~Medical Board of California, by ensuring the quality and safety~~  
8 ~~of medical care, performs one of the most critical functions of state~~  
9 ~~government. Because of the critical importance of the board's~~  
10 ~~public health and safety function, the complexity of cases involving~~  
11 ~~alleged misconduct by physicians and surgeons, and the evidentiary~~  
12 ~~burden in the board's disciplinary cases, the Legislature finds and~~  
13 ~~declares that using a vertical enforcement and prosecution model~~  
14 ~~for those investigations is in the best interests of the people of~~  
15 ~~California.~~

16 ~~(b) Notwithstanding any other provision of law, as of January~~  
17 ~~1, 2006, each complaint that is referred to a district office of the~~  
18 ~~board for investigation shall be simultaneously and jointly assigned~~  
19 ~~to an investigator and to the deputy attorney general in the Health~~  
20 ~~Quality Enforcement Section responsible for prosecuting the case~~  
21 ~~if the investigation results in the filing of an accusation. The joint~~  
22 ~~assignment of the investigator and the deputy attorney general~~  
23 ~~shall exist for the duration of the disciplinary matter. During the~~  
24 ~~assignment, the investigator so assigned shall, under the direction~~  
25 ~~but not the supervision of the deputy attorney general, be~~  
26 ~~responsible for obtaining the evidence required to permit the~~  
27 ~~Attorney General to advise the board on legal matters such as~~  
28 ~~whether the board should file a formal accusation, dismiss the~~  
29 ~~complaint for a lack of evidence required to meet the applicable~~  
30 ~~burden of proof, or take other appropriate legal action.~~

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

35 ~~(d) This section does not affect the requirements of Section~~  
36 ~~12529.5 as applied to the Medical Board of California where~~  
37 ~~complaints that have not been assigned to a field office for~~  
38 ~~investigation are concerned.~~

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

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

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

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

15    ~~SEC. 105. Section 11362.7 of the Health and Safety Code is~~  
16    ~~amended to read:~~

17    11362.7. For purposes of this article, the following definitions  
18    shall apply:

19    (a) “Attending physician” means an individual who possesses  
20    a license in good standing to practice ~~medicine~~ *medicine, podiatry,*  
21    or osteopathy issued by the Medical Board of ~~California~~ *California,*  
22    ~~the California Board of Podiatric Medicine,~~ or the Osteopathic  
23    Medical Board of California and who has taken responsibility for  
24    an aspect of the medical care, treatment, diagnosis, counseling, or  
25    referral of a patient and who has conducted a medical examination  
26    of that patient before recording in the patient’s medical record the  
27    physician’s assessment of whether the patient has a serious medical  
28    condition and whether the medical use of marijuana is appropriate.

29    (b) “Department” means the State Department of Health  
30    Services.

31    (c) “Person with an identification card” means an individual  
32    who is a qualified patient who has applied for and received a valid  
33    identification card pursuant to this article.

34    (d) “Primary caregiver” means the individual, designated by a  
35    qualified patient or by a person with an identification card, who  
36    has consistently assumed responsibility for the housing, health, or  
37    safety of that patient or person, and may include any of the  
38    following:

39    (1) In any case in which a qualified patient or person with an  
40    identification card receives medical care or supportive services,

1 or both, from a clinic licensed pursuant to Chapter 1 (commencing  
2 with Section 1200) of Division 2, a health care facility licensed  
3 pursuant to Chapter 2 (commencing with Section 1250) of Division  
4 2, a residential care facility for persons with chronic life-threatening  
5 illness licensed pursuant to Chapter 3.01 (commencing with Section  
6 1568.01) of Division 2, a residential care facility for the elderly  
7 licensed pursuant to Chapter 3.2 (commencing with Section 1569)  
8 of Division 2, a hospice, or a home health agency licensed pursuant  
9 to Chapter 8 (commencing with Section 1725) of Division 2, the  
10 owner or operator, or no more than three employees who are  
11 designated by the owner or operator, of the clinic, facility, hospice,  
12 or home health agency, if designated as a primary caregiver by  
13 that qualified patient or person with an identification card.

14 (2) An individual who has been designated as a primary  
15 caregiver by more than one qualified patient or person with an  
16 identification card, if every qualified patient or person with an  
17 identification card who has designated that individual as a primary  
18 caregiver resides in the same city or county as the primary  
19 caregiver.

20 (3) An individual who has been designated as a primary  
21 caregiver by a qualified patient or person with an identification  
22 card who resides in a city or county other than that of the primary  
23 caregiver, if the individual has not been designated as a primary  
24 caregiver by any other qualified patient or person with an  
25 identification card.

26 (e) A primary caregiver shall be at least 18 years of age, unless  
27 the primary caregiver is the parent of a minor child who is a  
28 qualified patient or a person with an identification card or the  
29 primary caregiver is a person otherwise entitled to make medical  
30 decisions under state law pursuant to Sections 6922, 7002, 7050,  
31 or 7120 of the Family Code.

32 (f) “Qualified patient” means a person who is entitled to the  
33 protections of Section 11362.5, but who does not have an  
34 identification card issued pursuant to this article.

35 (g) “Identification card” means a document issued by the State  
36 Department of Health Services that document identifies a person  
37 authorized to engage in the medical use of marijuana and the  
38 person’s designated primary caregiver, if any.

39 (h) “Serious medical condition” means all of the following  
40 medical conditions:

- 1 (1) Acquired immune deficiency syndrome (AIDS).
- 2 (2) Anorexia.
- 3 (3) Arthritis.
- 4 (4) Cachexia.
- 5 (5) Cancer.
- 6 (6) Chronic pain.
- 7 (7) Glaucoma.
- 8 (8) Migraine.
- 9 (9) Persistent muscle spasms, including, but not limited to,
- 10 spasms associated with multiple sclerosis.
- 11 (10) Seizures, including, but not limited to, seizures associated
- 12 with epilepsy.
- 13 (11) Severe nausea.
- 14 (12) Any other chronic or persistent medical symptom that
- 15 either:
  - 16 (A) Substantially limits the ability of the person to conduct one
  - 17 or more major life activities as defined in the Americans with
  - 18 Disabilities Act of 1990 (Public Law 101-336).
  - 19 (B) If not alleviated, may cause serious harm to the patient's
  - 20 safety or physical or mental health.
  - 21 (i) "Written documentation" means accurate reproductions of
  - 22 those portions of a patient's medical records that have been created
  - 23 by the attending physician, that contain the information required
  - 24 by paragraph (2) of subdivision (a) of Section 11362.715, and that
  - 25 the patient may submit to a county health department or the
  - 26 county's designee as part of an application for an identification
  - 27 card.

28 *SEC. 106. Section 128335 of the Health and Safety Code is*  
29 *amended to read:*

30 128335. (a) The office shall establish a nonprofit public benefit  
31 corporation, to be known as the Health Professions Education  
32 Foundation, that shall be governed by a board consisting of nine  
33 members appointed by the Governor, one member appointed by  
34 the Speaker of the Assembly, ~~and one member appointed by the~~  
35 ~~Senate Committee on Rules.~~ *Rules, and two members appointed*  
36 *by the Medical Board of California.* The members of the foundation  
37 board appointed by the Governor, Speaker of the Assembly, and  
38 Senate Committee on Rules may include representatives of  
39 minority groups which are underrepresented in the health  
40 professions, persons employed as health professionals, and other

1 appropriate members of health or related professions. All persons  
2 considered for appointment shall have an interest in health  
3 programs, an interest in health educational opportunities for  
4 underrepresented groups, and the ability and desire to solicit funds  
5 for the purposes of this article as determined by the appointing  
6 power. The chairperson of the commission shall also be a  
7 nonvoting, ex officio member of the board.

8 (b) The Governor shall appoint the president of the board of  
9 trustees from among those members appointed by the Governor,  
10 the Speaker of the Assembly, ~~and the Senate Committee on Rules-~~  
11 *Rules, and the Medical Board of California.*

12 (c) The director, after consultation with the president of the  
13 board, may appoint a council of advisers comprised of up to nine  
14 members. The council shall advise the director and the board on  
15 technical matters and programmatic issues related to the Health  
16 Professions Education Foundation Program.

17 (d) Members of the board and members of the council shall  
18 serve without compensation but shall be reimbursed for any actual  
19 and necessary expenses incurred in connection with their duties  
20 as members of the board or the council. *The Medical Board of*  
21 *California shall reimburse the members it appointed to the*  
22 *foundation board for any actual and necessary expenses incurred*  
23 *in connection with their duties as member of the foundation board.*

24 (e) The foundation shall be subject to the Nonprofit Public  
25 Benefit Corporation Law (Part 2 (commencing with Section 5110)  
26 of Division 2 of Title 2 of the Corporations Code), except that if  
27 there is a conflict with this article and the Nonprofit Public Benefit  
28 Corporation Law (Part 2 (commencing with Section 5110) of  
29 Division 2 of Title 2 of the Corporations Code), this article shall  
30 prevail.

31 (f) This section shall become operative January 1, 2016.

32 *SEC. 107. No reimbursement is required by this act pursuant*  
33 *to Section 6 of Article XIII B of the California Constitution because*  
34 *the only costs that may be incurred by a local agency or school*  
35 *district will be incurred because this act creates a new crime or*  
36 *infraction, eliminates a crime or infraction, or changes the penalty*  
37 *for a crime or infraction, within the meaning of Section 17556 of*  
38 *the Government Code, or changes the definition of a crime within*

1 *the meaning of Section 6 of Article XIII B of the California*  
2 *Constitution.*

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# MBC TRACKER II BILLS

4/13/2017

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 12	Cooley	State Government: Administrative Regulations: Review	Asm. Approps	
AB 64	Bonta	Cannabis: Medical and Nonmedical	Asm. B&P	04/05/17
AB 77	Fong	Regulations: Effective Dates and Legislative Review	Asm. Approps	02/07/17
AB 154	Levine	Prisoners: Mental Health Treatment	Asm. Approps	
AB 183	Lackey	Bill of Rights for State Excluded Employees	Asm. PERSS	
AB 186	Eggman	Controlled Substances: Safer Drug Consumption Program	Asm. Public Safety	03/23/17
AB 207	Arambula	California State University: Doctor of Medicine Degrees	Asm. Higher Ed.	02/22/17
AB 208	Eggman	Deferred Entry of Judgment: Pretrial Diversion	Asm. Approps	03/08/17
AB 224	Thurmond	Dentistry: Anesthesia and Sedation	Asm. B&P	03/27/17
AB 242	Arambula	Certificates of Death: Veterans	Asm. Approps	03/07/17
AB 244	Cervantes	Maternal Mental Health	Asm. Health	03/21/17
AB 247	Garcia, C.	Public Health: Childhood Lead Poisoning: Lead Advisory Taskforce	Asm. Approps	03/28/17
AB 259	Gipson	Medical Cannabis and Nonmedical Cannabis	Asm. B&P	03/28/17
AB 265	Wood	Prescription Drugs: Prohibition on Price Discount	Asm. Health	03/27/17
AB 340	Arambula	Early and Periodic Screening, Diagnosis, and Treatment Program	Asm. Approps	
AB 389	Salas	Marijuana: Consumer Guide	Asm. B&P	
AB 395	Bocanegra	Substance Abuse Treatment Facilities	Asm. Approps	03/20/17
AB 401	Aguiar-Curry	Pharmacy: Remote Dispensing Site Pharmacy: Telepharmacy	Asm. Approps	03/21/17
AB 422	Arambula	California State University: Doctor of Nursing Practice Degree	Asm. Approps	
AB 447	Gray	Medi-Cal: Covered Benefits: Continuous Glucose Monitors	Asm. Health	
AB 451	Arambula	Health Facilities: Emergency Services and Care	Asm. Approps	04/06/17
AB 470	Arambula	Medi-Cal: Specialty Mental Health Services: Performance Dashboard	Asm. Approps	03/28/17
AB 492	Grayson	Public Records: Department of Consumer Affairs: Fees	Asm. Approps	03/29/17
AB 508	Santiago	Health Care Practitioners: Student Loans	Asm. Higher Ed.	
AB 514	Salas	Medical Waste: Pharmaceuticals	Asm. ES&TM	03/30/17



# **MBC TRACKER II BILLS**

**4/13/2017**

<b>BILL</b>	<b>AUTHOR</b>	<b>TITLE</b>	<b>STATUS</b>	<b>AMENDED</b>
AB 547	Chavez	California Prompt Payment Act: Disabled Veteran Businesses	Asm. J, ED&E	03/28/17
AB 613	Nazarian	Healing Arts: Clinical Laboratories	Asm. B&P	03/27/17
AB 632	Acosta	Small Business Procurement and Contract Act	Asm. A&AR	03/21/17
AB 635	Harper	Department of Consumer Affairs	Assembly	
AB 654	Maienschein	Pediatric Home Health Care	Asm. Approps	03/13/17
AB 703	Flora	Professions and Vocations: Licenses: Fee Waivers	Asm. B&P	
AB 710	Wood	Department of Consumer Affairs: Boards: Meetings	Asm. B&P	03/27/17
AB 720	Eggman	Inmates: Psychiatric Medication: Informed Consent	Asm. Judiciary	03/27/17
AB 750	Gallagher	Criminal Law: Competency: Department of State Hospitals	Asm. Health	03/30/17
AB 820	Gipson	Emergency Medical Services Authority: Task Force	Asm. Health	03/23/17
AB 826	Brough	Professions and Vocations	Assembly	
AB 827	Rubio	Department of Consumer Affairs: Task Force: Foreign-Trained Professionals	Asm. Approps	04/03/17
AB 835	Dababneh	Consumer Affairs: Licenses: Prohibited Acts	Asm. B&P	03/27/17
AB 963	Gipson	Taxation: Marijuana	Asm. B&P	04/05/17
AB 966	Chau	Public Health: Medication Assistance	Assembly	
AB 1003	Bloom	Healthy California Fund	Asm. Health	03/28/17
AB 1022	Irwin	Information Technology: Recovery Plans: Inventory	Asm. P&CP	03/28/17
AB 1098	McCarty	Child Death Investigations: Review Teams	Asm. Approps	
AB 1153	Low	Podiatry	Asm. B&P	03/28/17
AB 1188	Nazarian	Health Professions Development: Loan Repayment	Asm. Health	04/05/17
AB 1190	Obernalte	Department of Consumer Affairs: BreZE: Annual Report	Asm. B&P	
AB 1315	Mullin	Mental Health: Early Psychosis Detection and Intervention	Asm. Health	03/30/17
AB 1316	Quirk	Public Health: Childhood Lead Poisoning: Prevention	Asm. Health	
AB 1349	Daly	Diabetes: Strategy for Awareness and Prevention	Asm. Health	03/30/17
AB 1353	Waldron	Health Care Coverage: Prescription Drugs: Continuity of Care	Asm. Health	03/23/17

# **MBC TRACKER II BILLS**

**4/13/2017**

<b>BILL</b>	<b>AUTHOR</b>	<b>TITLE</b>	<b>STATUS</b>	<b>AMENDED</b>
AB 1372	Levine	Crisis Stabilization Units: Psychiatric Patients	Asm. Health	03/30/17
AB 1386	Waldron	Genomic Cancer Testing Pilot Program	Asm. Health	03/30/17
AB 1445	Reyes	Public Contracts: Small Business Participation	Asm. J, ED&E	03/28/17
AB 1466	Patterson	Patient Records	Assembly	
AB 1485	Rubio	California Health and Human Services Agency	Asm. Human Svcs.	03/20/17
AB 1488	Thurmond	Health Care: Genetic Diseases	Asm. Health	03/28/17
AB 1539	Chen	Mental Health	Asm. Health	04/04/17
AB 1643	Bonta	Health Care for All Commission	Asm. Gov. Org.	03/28/17
AB 1658	Frazier	State Agencies: Accountability	Asm. A&AR	03/27/17
AB 1685	Maienschein	Children's Mental Health	Assembly	
AB 1726	Comm. on Health	Vital Records: Confidentiality	Asm. Health	
HR 6	Burke	Relative to Women's Reproductive Health	Adopted	
SB 17	Hernandez	Health Care: Prescription Drug Costs	Sen. Health	03/14/17
SB 23	Portantino	Public Health: Umbilical Cord Blood Collection	Sen. Gov.&F	
SB 27	Morrell	Professions and Vocations: Licenses: Military Service	Sen. VA	
SB 31	Lara	California Religious Freedom Act: State Agencies	Assembly	03/27/17
SB 32	Moorlach	Public Employees Pension Reform Act of 2018	Sen. PE&R	03/02/17
SB 43	Hill	Antimicrobial-Resistant Infection: Reporting	Sen. Health	04/05/17
SB 76	Nielsen	Excluded Employees: Arbitration	Sen. Judiciary	03/22/17
SB 162	Allen	Marijuana and Medical Cannabis: Marketing	Sen. B&P	03/28/17
SB 172	Portantino	Health Care Coverage: Fertility Preservation	Sen. Health	03/07/17
SB 199	Hernandez	The California Health Care Cost, Quality, and Equity Atlas	Sen. Health	03/30/17
SB 212	Jackson	Medical Waste	Senate 3rd Reading	
SB 220	Pan	Medi-Cal Children's Health Advisory Panel	Sen. Health	03/20/17
SB 221	Wiener	Health Care Coverage: Lipodystrophy Syndrome	Sen. Health	

# MBC TRACKER II BILLS

4/13/2017

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 223	Atkins	Health Care Language Assistance Services	Sen. Health	04/05/17
SB 244	Lara	Privacy: Agencies: Personal Information	Sen. Judiciary	04/03/17
SB 294	Hernandez	Hospices: Palliative Care	Sen. Approps	03/27/17
SB 374	Newman	Health Insurance: Discriminatory Practices: Mental Health	Sen. Approps	04/03/17
SB 392	Bates	Dentistry: Report: Access to Care: Pediatric Dental Patients	Senate	04/04/17
SB 396	Lara	University of California: Medical Residency Training Pilot	Sen. Ed.	04/04/17
SB 399	Portantino	Health Care Coverage: Pervasive Developmental Disorder/Autism	Sen. Health	03/20/17
SB 432	Pan	Emergency Medical Services	Sen. Health	03/20/17
SB 454	Moorlach	Public Employees' Health Benefits	Sen. PE&R	04/06/17
SB 456	Pan	Medi-Cal Managed Care: FQHCs and Rural Health Clinics	Sen. Health	03/23/17
SB 487	Pan	Practice of Medicine: Hospitals	Sen. B&P	
SB 501	Glazer	Dentistry: General Anesthesia: Definition	Sen. B&P	
SB 510	Stone	Pharmacies: Compounding	Assembly	
SB 555	Morrell	Regulations: 5-year Review and Report	Sen. Gov. Org.	
SB 562	Lara	The Healthy California Act	Sen. Health	03/29/17
SB 572	Stone	Healing Arts Licensees: Violations: Grace Period	Sen. B&P	03/27/17
SB 575	Leyva	Patient Access to Health Records	Sen. Judiciary	04/03/17
SB 648	Mendoza	Health and Care Facilities: Private Referral Agencies	Sen. Health	04/06/17
SB 657	Bates	California Public Records Act: Reverse Public Records Actions	Sen. Judiciary	
SB 728	Newman	State Public Employees: Sick Leave: Veterans	Sen. PE&R	
SB 783	Pan	State Employment: Unused Leave Buy-Back	Senate	
SCA 8	Moorlach	Public Employee Retirement Benefits	Sen. PE&R	
SCA 10	Moorlach	Public Employee Retirement Benefits	Sen. PE&R	
SCR 18	Berryhill	Donate Life/DMV Partnership Month	Assembly	03/21/17
SCR 27	Gaines	Prostate Cancer Awareness Month	Assembly	

## **MBG TRACKER II BILLS**

**4/13/2017**

<b>BILL</b>	<b>AUTHOR</b>	<b>TITLE</b>	<b>STATUS</b>	<b>AMENDED</b>
SR 12	Atkins	Relative to Women's Reproductive Health	Adopted	
SR 26	Hernandez	Relative to the Patient Protection and Affordable Care Act	Adopted	03/09/17