MEDICAL BOARD OF CALIFORNIA - 2015 TRACKER LIST
October 13, 2015

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 159	Calderon	Investigational Drugs, Biological Products, and Devices	VETOED	No Position	7/6/15
AB 611	Dahle	Controlled Substances: Prescriptions: Reporting	2-year Bill		4/15/15
AB 637	Campos	Physician Orders for Life Sustaining Treatment Forms	Chaptered, #217	Support	
AB 679	Allen	Controlled Substances	Chaptered, #778		9/10/15
AB 684	Bonilla	Healing Arts: Licensees: Disciplinary Actions	Chaptered, #405		9/4/15
AB 890	Ridley-Thomas	Anesthesiologist Assistants	2-year Bill	Support if Amended	5/5/15
AB 1306	Burke	Healing Arts: Certified Nurse-Midwives: Scope of Practice	2-year Bill		7/1/15
ABX2 15	Eggman	End of Life	Chaptered, #1		9/3/15
ACR 29	Frazier	Donate Life California Day: Driver's License	Chaptered, #42	Support	4/20/15
SB 19	Wolk	Physician Orders for Life Sustaining Treatment Form: Electronic Registry Pilot	Chaptered, #504		9/4/15
SB 22	Roth	Residency Training	2-year Bill	Support	6/4/15
SB 277	Pan	Public Health: Vaccinations	Chaptered, #35	Support	6/18/15
SB 323	Hernandez	Nurse Practitioners	2-year Bill	Oppose	7/9/15
SB 337	Pavley	Physician Assistants	Chaptered, #536	Support	9/1/15
SB 396	Hill	Outpatient Settings and Surgical Clinics	Chaptered, #287	Strong Support	6/29/15

Pink – Sponsored Bill, Green – Chaptered, Orange - Vetoed, Blue – 2-year Bill

MEDICAL BOARD OF CALIFORNIA - 2015 TRACKER LIST
October 13, 2015

SB 408	Morrell	Midwife Assistants	Chaptered, #280	Sponsor/Support	5/6/15
SB 464	Hernandez	Healing Arts: Self-Reporting Tools	Chaptered, #387	Neutral	5/22/15
SB 482	Lara	Controlled Substances: CURES Database	2-year Bill	Support	4/30/15
SB 538	Block	Naturopathic Doctors	2-year Bill	Oppose	7/7/15
SB 622	Hernandez	Optometry	2-year Bill	Oppose Unless Amended	5/4/15
SB 643	McGuire	Medical Marijuana	Chaptered, #719		9/11/15
SB 738	Huff	Pupil Health: Epinephrine Auto-Injectors: Liability Limitation	Chaptered, #132	Support	5/13/15
SB 800	Sen. B&P	Health Omnibus	Chaptered, #426	Sponsor/Support MBC Provisions	9/3/15
SJR 7	Pan	Medical Residency Programs	Chaptered, #90	Support	4/6/15

Pink – Sponsored Bill, Green – Chaptered, Orange - Vetoed, Blue – 2-year Bill

OFFICE OF THE GOVERNOR

OCT 11 2015

To the Members of the California State Assembly:

I am returning Assembly Bill 159 without my signature.

This bill would permit a pharmaceutical manufacturer to make an investigational drug available to a patient with an immediately life-threatening disease on the recommendation of two physicians.

Patients with life threatening conditions should be able to try experimental drugs, and the United States Food and Drug Administration's compassionate use program allows this to happen. The proposed changes to this program will streamline access to these drugs. Before authorizing an alternative state pathway, we should give this federal expedited process a chance to work.

Sincerely,

Edmund G. Brown Jr.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 637
Author:	Campos
Chapter:	217
Bill Date:	February 24, 2015, Introduced
Subject:	Physician Orders for Life Sustaining Treatment Forms
Sponsor:	California Medical Association (CMA) and Coalition for Compassionate Care of California
Position:	Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow nurse practitioners (NPs) and physician assistants (PAs), under physician supervision, to sign Physician Orders for Life Sustaining Treatment (POLST) forms.

BACKGROUND

In the early 1990s, Congress passed the federal Patient Self-Determination Act and the POLST program was developed to address challenges related to advance care planning, most commonly used for frail and elderly patients. In 2008, AB 3000 (Wolk) created the California POLST, a standardized form that helps to ensure patients' wishes are honored regarding medical treatment towards the end of life. The POLST form is not an advance directive, it compliments an advance directive by identifying the patient's treatment preferences. Currently, the POLST form is a paper document and must be signed by both the patient and their physician to become actionable.

ANALYSIS

According to the author's office, there have been reported difficulties by some nursing homes in obtaining a physician's signature on a POLST form in a timely manner. Currently, patients discuss their end-of-life care wishes with all members of their health care team, including NPs and PAs. The author's office believes that expanding the number and type of healthcare providers who can assist patients in establishing their end-of-life care orders will help to ensure that patients' end-of-life care wishes are followed.

Allowing NPs and PAs, who are under the supervision of a physician, seems to be a reasonable expansion and one that will help to improve patient care. NPs and PAs are involved in providing end-of-life care to patients in California, so it makes sense to allow them to sign off on POLST forms to ensure that patients have better access to providers who can assist in establishing end-of-life care orders. This bill will further the Medical Board of California's (Board) mission of promoting access to care and the Board took a support position on this bill.

FISCAL: None to the Board

SUPPORT: California Medical Association (co-sponsor); Coalition for Compassionate Care of California (co-sponsor); AARP; Association of Northern California Oncologists; Blue Shield of California; California Assisted Living Association; California Association for Health Services at Home; California Association for Nurse Practitioners; California Chapter of the American College of Emergency Physicians; California Long-Term Care Ombudsman Association; Contra Costa County Advisory Council on Aging; Contra Costa County Board of Supervisors; LeadingAge California; Medical Board of California; Medical Oncology Association of Southern California, Inc.; and Physician Assistant Board

OPPOSITION: California Right to Life Committee

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section

Assembly Bill No. 637

CHAPTER 217

An act to amend Section 4780 of the Probate Code, relating to resuscitative measures.

[Approved by Governor August 17, 2015. Filed with Secretary of State August 17, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 637, Campos. Physician Orders for Life Sustaining Treatment forms.

Existing law defines a request regarding resuscitative measures to mean a written document, signed by an individual, as specified, and the physician, that directs a health care provider regarding resuscitative measures, and includes a Physician Orders for Life Sustaining Treatment form (POLST form). Existing law requires a physician to treat a patient in accordance with the POLST form and specifies the criteria for creation of a POLST form, including that the form be completed by a health care provider based on patient preferences and medical indications, and signed by a physician and the patient or his or her legally recognized health care decisionmaker.

This bill would authorize the signature of a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law to create a valid POLST form.

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

SECTION 1. Section 4780 of the Probate Code is amended to read:

4780. (a) As used in this part:

(1) "Request regarding resuscitative measures" means a written document, signed by (A) an individual with capacity, or a legally recognized health care decisionmaker, and (B) the individual's physician, that directs a health care provider regarding resuscitative measures. A request regarding resuscitative measures is not an advance health care directive.

(2) "Request regarding resuscitative measures" includes one, or both of, the following:

(A) A prehospital "do not resuscitate" form as developed by the Emergency Medical Services Authority or other substantially similar form.

(B) A Physician Orders for Life Sustaining Treatment form, as approved by the Emergency Medical Services Authority.

(3) "Physician Orders for Life Sustaining Treatment form" means a request regarding resuscitative measures that directs a health care provider regarding resuscitative and life-sustaining measures.

(b) A legally recognized health care decisionmaker may execute the Physician Orders for Life Sustaining Treatment form only if the individual lacks capacity, or the individual has designated that the decisionmaker's authority is effective pursuant to Section 4682.

(c) The Physician Orders for Life Sustaining Treatment form and medical intervention and procedures offered by the form shall be explained by a health care provider, as defined in Section 4621. The form shall be completed by a health care provider based on patient preferences and medical indications, and signed by a physician, or a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law, and the patient or his or her legally recognized health care decisionmaker. The health care provider, during the process of completing the Physician Orders for Life Sustaining Treatment form, should inform the patient about the difference between an advance health care directive and the Physician Orders for Life Sustaining Treatment form.

(d) An individual having capacity may revoke a Physician Orders for Life Sustaining Treatment form at any time and in any manner that communicates an intent to revoke, consistent with Section 4695.

(e) A request regarding resuscitative measures may also be evidenced by a medallion engraved with the words "do not resuscitate" or the letters "DNR," a patient identification number, and a 24-hour toll-free telephone number, issued by a person pursuant to an agreement with the Emergency Medical Services Authority.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 679
Author: Allen
Chapter: 778
Bill Date: September 10, 2015, Amended
Subject: Controlled Substances
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill amends existing law that requires all health care practitioners that are authorized to prescribe, order, administer, furnish or dispense Schedule II, III, or IV controlled substances and pharmacists to be registered with CURES by extending the date from January 1, 2016, to July 1, 2016. This bill contains an urgency clause, so it becomes effective immediately.

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. Since 2009, more than 8,000 doctors and pharmacists have signed up to use CURES, which has more than 100 million prescriptions. SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that license prescribers and dispensers, for purposes of funding and upgrading the CURES system. In addition, this bill requires all health care practitioners that are authorized to prescribe, order, administer, furnish or dispense Schedule II, III, or IV controlled substances to be registered with CURES by January 1, 2016. DOJ is currently in the process of modernizing CURES to more efficiently serve prescribers, pharmacists and entities that may utilize the data contained within the system and allow health care practitioners and pharmacists to apply for registration online. It is estimated that the new CURES 2.0 system will not be fully operational until at least October 2015.

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 amends existing law that requires all health care practitioners that are authorized to prescribe, order, administer, furnish or dispense Schedule II, III, or IV controlled substances to be registered with CURES by extending the date from January 1, 2016, to July 1, 2016. This bill contains an urgency clause, so it becomes effective immediately.

DOJ is currently in the process of modernizing CURES pursuant to SB 800. This modernization and streamlined application for CURES registration was originally expected to be completed in July 2015, and the requirement for health care practitioners and pharmacists to register was not until January 1, 2016. However, the CURES 2.0 system is not yet fully functional to allow for registration online, and this is not anticipated to be ready until at least October 2015. This bill was introduced to allow time for the new online registration process to be implemented and allow for a smooth transition to the online registration process for health care practitioners.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping". Delaying the registration requirement until the new CURES 2.0 is up and running and available to physicians to register online makes sense. The Board did not take a position on this bill as the language was put in the bill at the very end of session.

FISCAL: None to the Board

SUPPORT: California Medical Association

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s) and a boxed article to inform physicians of the delayed registration date for CURES
- Notify/train Board staff
- Send an email blast to all physicians to provide notification that the CURES registration date has been extended until July 1, 2016
- Update the Board's website to reflect the new July 1, 2016 date for required CURES registration

Assembly Bill No. 679

CHAPTER 778

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

[Approved by Governor October 11, 2015. Filed with Secretary of State October 11, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 679, Travis Allen. Controlled substances.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. Existing law authorizes the Department of Justice to provide the history of controlled substances dispensed to an individual to a licensed health care practitioner, pharmacist, or both, providing care or services to the individual. By January 1, 2016, or upon licensure in the case of a pharmacist, or upon receipt of a federal Drug Enforcement Administration registration in the case of another health care practitioner authorized to prescribe, order, administer, furnish, or dispense controlled substances, whichever respective event occurs later, existing law requires those persons to apply to the Department of Justice to obtain approval to access information contained in the CURES database regarding the controlled substance history of a patient under his or her care.

This bill would extend those January 1, 2016, deadlines to July 1, 2016.

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

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

SECTION 1. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the

Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

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

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

(i) Materially falsifying an application for a subscriber.

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

(iii) Suspended or revoked federal DEA registration.

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

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

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

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

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

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section shall be considered medical information subject to the provisions of the Confidentiality of

Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

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

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure that health care practitioners and pharmacists are not out of compliance with the requirement to apply to access data contained in the Controlled Substance Utilization Review and Evaluation System Prescription Drug Monitoring Program on January 1, 2016, it is necessary that this act take effect immediately.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 684
Author: Alejo
Chapter: 405
Bill Date: September 4, 2015, Amended
Subject: State Board of Optometry: Optometrists: Nonresident Contact Lens Sellers: Registered Dispensing Opticians
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill authorizes the establishment of landlord-tenant leasing relationships between a Registered Dispensing Optician (RDO), optometrist, and an optical company, as specified. This bill transfers the RDO Program from the Medical Board of California (Board) to the California State Board of Optometry (CBO). This bill replaces one optometrist Board Member on the CBO with an RDO Board Member and establishes an RDO Advisory Committee in the CBO. Lastly, this bill establishes a three-year transition period for companies that directly employ optometrists to transition to leasing arrangements.

BACKGROUND

The Board currently is the regulatory agency charged with overseeing the RDO Program. The RDO Program is comprised of four sections, RDOs (business location), Spectacle Lens Dispensers (SLDs), Contact Lens Dispensers (CLDs), and Non-Resident Contact Lens Dispensers (NCLDs). RDO registration is required for individuals, corporations, and firms engaged in the business of filling prescriptions of physicians licensed by the Board or optometrists licensed by CBO for prescription lenses. A registered SLD is authorized to fit and adjust spectacle lenses at any place of business holding an RDO registration, provided that the RDO certificate of registration is displayed in a conspicuous place at the place of business where the SLD is fitting and adjusting. A registered CLD is authorized to fit and adjust contact lenses at any place of business holding an RDO registration, provided that the RDO certificate of registration is displayed in a conspicuous place at the place of business where the CLD is fitting and adjusting. NCLD registration is required for individuals, partnerships, and corporations located outside of California that ship, mail, or deliver in any manner, contact lenses at retail to a patient at a California address. According to the Board's 13/14 Annual Report, there are 1,047 RDO registrants, 2,110 SLD registrants, 921 CLD registrants, and 6 NCLD registrants.

In California, there are currently two eye care service models, an optometrist's private office and a co-location office. A co-location office is where an optical retail store is co-located with a Knox-Keene plan (regulated by the Department of Managed Health Care) that provides optometry care. At co-location sites, patients receive an eye exam and can fill their

prescription for corrective eyewear during the same visit at the co-located optical retail store, some examples are Walmart and Lenscrafters. At private optometrist's offices, patients receive an eye exam and can then take their prescription elsewhere to have it filled, or have the optometrist send it out for them. California law specifies that the patient is not required to have the prescription filled on site.

Existing law, Business and Professions Code (BPC) Sections 655 and 2556, prohibits optometrists and RDOs from having any membership, proprietary interest, co-ownership, landlord-tenant relationship or any profit-sharing agreement with each other. Optometrists are also prohibited from having any membership, proprietary interest, co-ownership, landlord-tenant relationship or any profit-sharing arrangement in any form with those who manufacture, sell, or distribute lenses, frames, optical supplies, optometric appliances or devices or kindred products to physicians and surgeons, optometrists or RDOs. Existing law prohibits RDOS from advertising the furnishing of, or furnishing the services of a refractionist, an optometrist or a physician and surgeon. RDOs are also prohibited from directly or indirectly employing or maintaining on or near the premises used for optical dispensing, a refractionist, optometrist, physician and surgeon, or a practitioner of any other profession for the purpose of any examination or treatment of the eyes. RDOs are prohibited from duplicating or changing lenses without a prescription or order from a person duly licensed to issue the prescription.

There have been many lawsuits related to the Optometry Practice Act and BPC Sections 655 and 2556. However, existing law has been found to be constitutional by the courts. There are 14 United States jurisdictions that allow direct employment of optometrists by optical companies and direct landlord-tenant relationships are permitted in 47 states. In addition, 49 states allow optical companies to franchise to optometrists.

ANALYSIS

This bill will allow an optometrist, an RDO, an optical company, or a health plan to enter into a direct or indirect landlord-tenant relationship if the practice is owned by the optometrist and in every phase is under the optometrist's exclusive control, as specified. This bill allows the landlord to terminate the lease for specified reasons. This bill prohibits the RDO or optical company from interfering with the professional judgment of the optometrist.

This bill moves the RDO Program, consisting of RDO registrants, SLD registrants, CLD registrants and NCLD registrants, to the CBO effective January 1, 2016. This bill authorizes the CBO to inspect any premises where the RDO is co-located with an optometrist practice and would authorize the CBO to inspect lease agreements. This bill would replace a CBO optometrist Board Member position with an RDO Board Member to address concerns regarding conflict of interest. This bill establishes an RDO Committee to advise and make recommendations to the CBO regarding the regulation of the RDO Program. The Committee will be made up of five members, two RDOs, two public members, and one member of the CBO.

This bill is sponsored by the author, and according to the author, "Co-located vision models have existed in California for nearly three decades. They serve millions of patients annually and employ thousands of optometrists and opticians. With the conclusion of legal suits over the last few years, the state is compelled to enforce a decades old law that has found this business model to be unlawful. AB 684 is seeking a legislative solution that allows multiple models to continue to operate, while also leveling the playing field for both large and small operators, ensuring that consumers' interests are protected, and optometrists' clinical judgment is preserved. This legislation would clarify and modernize the law." This bill allows for a three year transition period for businesses to transition from the unlawful direct employment model to the leasing arrangement model.

This bill is a result of numerous stakeholder meetings convened by the Governor's office, and attended by all stakeholders, including the Board, CBO and the Department of Consumer Affairs (DCA). Board staff have attended these meetings and offered feedback and technical input. Most of the Board's staff suggestions have been taken and amended into the bill. However, there are some technical fixes and changes still needed, as this bill was being worked on until the very end of session. The Governor's Office, DCA, and CBO are all aware that further changes are needed and the Governor's Office has committed to making needed changes as the RDO Program transitions to CBO. The Board will continue to work with all interested parties, including CBO, DCA, and the Governor's Office, to provide any assistance needed during the transition of the RDO Program to CBO.

FISCAL: None to the Board

SUPPORT: None on File

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section
- Transfer all applications and case files (including pending cases) to CBO, this includes hard copies and electronic files
- Allow CBO to access RDO Program files in BreEZe
- Update the Board's RDO Program webpage, forms, and certificates
- Train CBO staff on the RDO Program, including the new staff position that will be hired to support the RDO Program
- Post a transition webpage to inform consumers and RDO Program registrants that the RDO program is moving to CBO
- Ensure that all interested parties are notified of the RDO Program moving to CBO effective January 1, 2016

Assembly Bill No. 684

CHAPTER 405

An act to amend Sections 2546.2, 2546.9, 2550.1, 2554, 2556, 2567, 3010.5, 3011, 3013 of, to add Sections 2556.1, 2556.2, 3020, 3021, 3023.1 to, and to repeal and add Section 655 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor October 1, 2015. Filed with Secretary of State October 1, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 684, Alejo. State Board of Optometry: optometrists: nonresident contact lens sellers: registered dispensing opticians.

Existing law prohibits a licensed optometrist and a registered dispensing optician from having any membership, proprietary interest, coownership, landlord-tenant relationship, or any profit-sharing arrangement in any form, directly or indirectly, with each other. Existing law prohibits a licensed optometrist from having any membership, proprietary interest, coownership, landlord-tenant relationship, or any profit-sharing arrangement in any form, directly or indirectly, either by stock ownership, interlocking directors, trusteeship, mortgage, trust deed, or otherwise with any person who is engaged in the manufacture, sale, or distribution to physicians and surgeons, optometrists, or dispensing opticians of lenses, frames, optical supplies, optometric appliances or devices or kindred products. Existing law makes a violation of these provisions by a licensed optometrist and any other persons, whether or not a healing arts licensee, who participates with a licensed optometrist, subject to a crime.

Under existing law, the Medical Board of California is responsible for the registration and regulation of nonresident contact lens sellers and dispensing opticians. Existing law requires fees collected from nonresident contact lens sellers to be deposited in the Dispensing Opticians Fund, and to be available, upon appropriation, to the Medical Board of California. Existing law requires fees collected from registered dispensing optician to be paid into the Contingent Fund of the Medical Board of California. Existing law makes a violation of the registered dispensing optician provisions a crime. Existing law, the Optometry Practice Act, makes the State Board of Optometry responsible for the licensure and regulation of optometrists. A violation of the Optometry Practice Act is a crime. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime.

This bill would repeal those prohibitions. The bill would prohibit a licensed optometrist from having any membership, proprietary interest,

coownership, or any profit-sharing arrangement, either by stock ownership, interlocking directors, trusteeship, mortgage, or trust deed, with any registered dispensing optician or any optical company, as defined, except as otherwise authorized. The bill would authorize a registered dispensing optician or optical company to operate, own, or have an ownership interest in a health plan, defined as a licensed health care service plan, if the health plan does not directly employ optometrists to provide optometric services directly to enrollees of the health plan, and would also provide for the direct or indirect provision of products and services to the health plan or its contracted providers or enrollees or to other optometrists, as specified. The bill would authorize an optometrist, a registered dispensing optician, an optical company, or a health plan to execute a lease or other written agreement giving rise to a direct or indirect landlord-tenant relationship with an optometrist if specified conditions are contained in a written agreement, as provided. The bill would authorize the State Board of Optometry, to inspect, upon request, an individual lease agreement, and the bill would require the landlord or tenant to comply. Because the failure to comply with that request would be a crime under specified acts, the bill would impose a state-mandated local program. The bill would prohibit a registered dispensing optician from having any membership, proprietary interest, coownership, or profit sharing arrangement either by stock ownership, interlocking directors, trusteeship, mortgage, or trust deed, with an optometrist, except as authorized. The bill would make a violation of these provisions a crime. By creating a new crime, the bill would impose a state-mandated local program.

This bill would instead make the State Board of Optometry responsible for the registration and regulation of nonresident contact lens sellers and dispensing opticians. The bill would direct fees collected from registered dispensing opticians and persons seeking registration as a dispensing optician to be paid into the Dispensing Opticians Fund, and to be available, upon appropriation, to the State Board of Optometry. The bill would make various conforming changes in that regard.

Existing law requires each registered dispensing optician to conspicuously and prominently display at each registered location the name of the registrant’s employee who is currently designated to handle customer inquiries and complaints and the telephone number where he or she may be reached during business hours.

This bill would instead require specified consumer information to be displayed. Because a violation of the registered dispensing provisions would be a crime, the bill would impose a state-mandated local program.

Existing law makes it unlawful to, among other things, advertise the furnishing of, or to furnish, the services of a refractionist, an optometrist, or a physician and surgeon, or to directly or indirectly employ or maintain on or near the premises used for optical dispensing, a refractionist, an optometrist, a physician and surgeon, or a practitioner of any other profession for the purpose of any examination or treatment of the eyes.

This bill, except as specified, would make it unlawful for a registered dispensing optician to, among other things, advertise the furnishing of, or to furnish, the services of an optometrist or a physician and surgeon or to directly employ an optometrist or physician and surgeon for the purpose of any examination or treatment of the eyes. The bill would authorize the State Board of Optometry, by regulation, to impose and issue administrative fines and citations for a violation of these provisions, as specified. The bill would require all licensed optometrists in a setting with a registered dispensing optician to report the business relationship to the State Board of Optometry. The bill would authorize the State Board of Optometry to inspect any premises at which the business of a registered dispensing optician is co-located with the practice of an optometrist for the purposes of determining compliance with the aforementioned written lease agreement provisions. The bill would also authorize the State Board of Optometry to take disciplinary action against a party who fails to comply with the inspection and would require the State Board of Optometry to provide specified copies of the inspection results. Because would be a crime a violation of the registered dispensing provisions would be a crime, the bill would impose a state-mandated local program

This bill, until January 1, 2019, would prohibit an individual, corporation, or firm operating as a registered dispensing optician before the effective date of the bill, or an employee of such an entity, from being subject to any action for engaging in that aforementioned unlawful conduct. Because a violation of the registered dispensing provisions would be a crime, the bill would impose a state-mandated local program. The bill would require any health plan subject to these provisions to report to the State Board of Optometry in writing that certain percentages of its locations no longer employ an optometrist by specified dates. The bill would require the State Board of Optometry to provide those reports to the Director of Consumer Affairs and the Legislature.

Under existing law, the State Board of Optometry consists of 11 members, 6 licensee members and 5 public members.

This bill would require one of the nonpublic members to be a registered dispensing optician and would require the Governor to make that appointment. The bill would establish a dispensing optician committee to advise and make recommendations to the board regarding the regulation of dispensing opticians, as provided. The bill would require the advisory committee to consist of 5 members, including 2 registered dispensing opticians, 2 public members, and a member of the State Board of Optometry.

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.

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.

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

SECTION 1. Section 655 of the Business and Professions Code is repealed.

SEC. 2. Section 655 is added to the Business and Professions Code, to read:

655. (a) For the purposes of this section, the following terms have the following meanings:

(1) "Health plan" means a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(2) "Optical company" means a person or entity that is engaged in the manufacture, sale, or distribution to physicians and surgeons, optometrists, health plans, or dispensing opticians of lenses, frames, optical supplies, or optometric appliances or devices or kindred products.

(3) "Optometrist" means a person licensed pursuant to Chapter 7 (commencing with Section 3000) or an optometric corporation, as described in Section 3160.

(4) "Registered dispensing optician" means a person licensed pursuant to Chapter 5.5 (commencing with Section 2550).

(5) "Therapeutic ophthalmic product" means lenses or other products that provide direct treatment of eye disease or visual rehabilitation for diseased eyes.

(b) No optometrist may have any membership, proprietary interest, coownership, or any profit-sharing arrangement, either by stock ownership, interlocking directors, trusteeship, mortgage, or trust deed, with any registered dispensing optician or any optical company, except as otherwise permitted under this section.

(c) (1) A registered dispensing optician or an optical company may operate, own, or have an ownership interest in a health plan so long as the health plan does not directly employ optometrists to provide optometric services directly to enrollees of the health plan, and may directly or indirectly provide products and services to the health plan or its contracted providers or enrollees or to other optometrists. For purposes of this section, an optometrist may be employed by a health plan as a clinical director for the health plan pursuant to Section 1367.01 of the Health and Safety Code or to perform services related to utilization management or quality assurance or other similar related services that do not require the optometrist to directly provide health care services to enrollees. In addition, an optometrist serving as a clinical director may not employ optometrists to provide health care services to enrollees of the health plan for which the optometrist is serving as clinical director. For the purposes of this section, the health plan's

utilization management and quality assurance programs that are consistent with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) do not constitute providing health care services to enrollees.

(2) The registered dispensing optician or optical company shall not interfere with the professional judgment of the optometrist.

(3) The Department of Managed Health Care shall forward to the State Board of Optometry any complaints received from consumers that allege that an optometrist violated the Optometry Practice Act (Chapter 7 (commencing with Section 3000)). The Department of Managed Health Care and the State Board of Optometry shall enter into an Inter-Agency Agreement regarding the sharing of information related to the services provided by an optometrist that may be in violation of the Optometry Practice Act that the Department of Managed Health Care encounters in the course of the administration of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with section 1340) of Division 2 of the Health and Safety Code.

(d) An optometrist, a registered dispensing optician, an optical company, or a health plan may execute a lease or other written agreement giving rise to a direct or indirect landlord-tenant relationship with an optometrist, if all of the following conditions are contained in a written agreement establishing the landlord-tenant relationship:

(1) (A) The practice shall be owned by the optometrist and in every phase be under the optometrist's exclusive control, including the selection and supervision of optometric staff, the scheduling of patients, the amount of time the optometrist spends with patients, fees charged for optometric products and services, the examination procedures and treatment provided to patients and the optometrist's contracting with managed care organizations.

(B) Subparagraph A shall not preclude a lease from including commercially reasonable terms that: (i) require the provision of optometric services at the leased space during certain days and hours, (ii) restrict the leased space from being used for the sale or offer for sale of spectacles, frames, lenses, contact lenses, or other ophthalmic products, except that the optometrist shall be permitted to sell therapeutic ophthalmic products if the registered dispensing optician, health plan, or optical company located on or adjacent to the optometrist's leased space does not offer any substantially similar therapeutic ophthalmic products for sale, (iii) require the optometrist to contract with a health plan network, health plan, or health insurer, or (iv) permit the landlord to directly or indirectly provide furnishings and equipment in the leased space.

(2) The optometrist's records shall be the sole property of the optometrist. Only the optometrist and those persons with written authorization from the optometrist shall have access to the patient records and the examination room, except as otherwise provided by law.

(3) The optometrist's leased space shall be definite and distinct from space occupied by other occupants of the premises, have a sign designating

that the leased space is occupied by an independent optometrist or optometrists and be accessible to the optometrist after hours or in the case of an emergency, subject to the facility's general accessibility. This paragraph shall not require a separate entrance to the optometrist's leased space.

(4) All signs and displays shall be separate and distinct from that of the other occupants and shall have the optometrist's name and the word "optometrist" prominently displayed in connection therewith. This paragraph shall not prohibit the optometrist from advertising the optometrist's practice location with reference to other occupants or prohibit the optometrist or registered dispensing optician from advertising their participation in any health plan's network or the health plan's products in which the optometrist or registered dispensing optician participates.

(5) There shall be no signs displayed on any part of the premises or in any advertising indicating that the optometrist is employed or controlled by the registered dispensing optician, health plan or optical company.

(6) Except for a statement that an independent doctor of optometry is located in the leased space, in-store pricing signs and as otherwise permitted by this subdivision, the registered dispensing optician or optical company shall not link its advertising with the optometrist's name, practice, or fees.

(7) Notwithstanding paragraphs (4) and (6), this subdivision shall not preclude a health plan from advertising its health plan products and associated premium costs and any copayments, coinsurance, deductibles, or other forms of cost-sharing, or the names and locations of the health plan's providers, including any optometrists or registered dispensing opticians that provide professional services, in compliance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(8) A health plan that advertises its products and services in accordance with paragraph (7) shall not advertise the optometrist's fees for products and services that are not included in the health plan's contract with the optometrist.

(9) The optometrist shall not be precluded from collecting fees for services that are not included in a health plan's products and services, subject to any patient disclosure requirements contained in the health plan's provider agreement with the optometrist or that are not otherwise prohibited by the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(10) The term of the lease shall be no less than one year and shall not require the optometrist to contract exclusively with a health plan. The optometrist may terminate the lease according to the terms of the lease. The landlord may terminate the lease for the following reasons:

(A) The optometrist's failure to maintain a license to practice optometry or the imposition of restrictions, suspension or revocation of the optometrist's

license or if the optometrist or the optometrist's employee is or becomes ineligible to participate in state or federal government-funded programs.

(B) Termination of any underlying lease where the optometrist has subleased space, or the optometrist's failure to comply with the underlying lease provisions that are made applicable to the optometrist.

(C) If the health plan is the landlord, the termination of the provider agreement between the health plan and the optometrist, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(D) Other reasons pursuant to the terms of the lease or permitted under the Civil Code.

(11) The landlord shall act in good faith in terminating the lease and in no case shall the landlord terminate the lease for reasons that constitute interference with the practice of optometry.

(12) Lease or rent terms and payments shall not be based on number of eye exams performed, prescriptions written, patient referrals or the sale or promotion of the products of a registered dispensing optician or an optical company.

(13) The landlord shall not terminate the lease solely because of a report, complaint, or allegation filed by the optometrist against the landlord, a registered dispensing optician or a health plan, to the State Board of Optometry or the Department of Managed Health Care or any law enforcement or regulatory agency.

(14) The landlord shall provide the optometrist with written notice of the scheduled expiration date of a lease at least 60 days prior to the scheduled expiration date. This notice obligation shall not affect the ability of either party to terminate the lease pursuant to this section. The landlord may not interfere with an outgoing optometrist's efforts to inform the optometrist's patients, in accordance with customary practice and professional obligations, of the relocation of the optometrist's practice.

(15) The State Board of Optometry may inspect, upon request, an individual lease agreement pursuant to its investigational authority, and if such a request is made, the landlord or tenant, as applicable, shall promptly comply with the request. Failure or refusal to comply with the request for lease agreements within 30 days of receiving the request constitutes unprofessional conduct and is grounds for disciplinary action by the appropriate regulatory agency. Only personal information as defined in Section 1798.3 of the Civil Code may be redacted prior to submission of the lease or agreement. This section shall not affect the Department of Managed Health Care's authority to inspect all books and records of a health plan pursuant to Section 1381 of the Health and Safety Code.

Any financial information contained in the lease submitted to a regulatory entity, pursuant to this paragraph, shall be considered confidential trade secret information that is exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(16) This subdivision shall not be applicable to the relationship between any optometrist employee and the employer medical group, or the relationship between a medical group exclusively contracted with a health plan regulated by the Department of Managed Health Care and that health plan.

(e) No registered dispensing optician may have any membership, proprietary interest, coownership, or profit sharing arrangement either by stock ownership, interlocking directors, trusteeship, mortgage, or trust deed, with an optometrist, except as permitted under this section.

(f) Nothing in this section shall prohibit a person licensed under Chapter 5 (commencing with Section 2000) or its professional corporation from contracting with or employing optometrists, ophthalmologists, or optometric assistants and entering into a contract or landlord tenant relationship with a health plan, an optical company, or a registered dispensing optician, in accordance with Sections 650 and 654 of this code.

(g) Any violation of this section constitutes a misdemeanor as to such person licensed under Chapter 7 (commencing with Section 3000) of this division and as to any and all persons, whether or not so licensed under this division, who participate with such licensed person in a violation of any provision of this section.

SEC. 3. Section 2546.2 of the Business and Professions Code is amended to read:

2546.2. All references in this chapter to the division shall mean the State Board of Optometry.

SEC. 4. Section 2546.9 of the Business and Professions Code is amended to read:

2546.9. The amount of fees prescribed in connection with the registration of nonresident contact lens sellers is that established by the following schedule:

(a) The initial registration fee shall be one hundred dollars ($100).

(b) The renewal fee shall be one hundred dollars ($100).

(c) The delinquency fee shall be twenty-five dollars ($25).

(d) The fee for replacement of a lost, stolen, or destroyed registration shall be twenty-five dollars ($25).

(e) The fees collected pursuant to this chapter shall be deposited in the Dispensing Opticians Fund, and shall be available, upon appropriation, to the State Board of Optometry for the purposes of this chapter.

SEC. 5. Section 2550.1 of the Business and Professions Code is amended to read:

2550.1. All references in this chapter to the board or the Board of Medical Examiners or division shall mean the State Board of Optometry.

SEC. 6. Section 2554 of the Business and Professions Code is amended to read:

2554. Each registrant shall conspicuously and prominently display at each registered location the following consumer information:

“Eye doctors are required to provide patients with a copy of their ophthalmic lens prescriptions as follows:

Spectacle prescriptions: Release upon completion of exam.

Contact lens prescriptions: Release upon completion of exam or upon completion of the fitting process.

Patients may take their prescription to any eye doctor or registered dispensing optician to be filled.

Optometrists and registered dispensing opticians are regulated by the State Board of Optometry. The State Board of Optometry receives and investigates all consumer complaints involving the practice of optometry and registered dispensing opticians. Complaints involving a California-licensed optometrist or a registered dispensing optician should be directed to:

California State Board of Optometry
Department of Consumer Affairs
2450 Del Paso Road, Suite 105
Sacramento, CA 95834
Phone: 1-866-585-2666 or (916) 575-7170
Email: optometry@dca.ca.gov
Website: www.optometry.ca.gov”

SEC. 7. Section 2556 of the Business and Professions Code is amended to read:

2556. (a) Except as authorized by Section 655, it is unlawful for a registered dispensing optician to do any of the following: to advertise the furnishing of, or to furnish, the services of an optometrist or a physician and surgeon, to directly employ an optometrist or physician and surgeon for the purpose of any examination or treatment of the eyes, or to duplicate or change lenses without a prescription or order from a person duly licensed to issue the same. For the purposes of this section, “furnish” does not mean to enter into a landlord-tenant relationship of any kind.

(b) Notwithstanding Section 125.9, the board may, by regulation, impose and issue administrative fines and citations for a violation of this section or Section 655, which may be assessed in addition to any other applicable fines, citations, or administrative or criminal actions.

SEC. 8. Section 2556.1 is added to the Business and Professions Code, to read:

2556.1. All licensed optometrists in a setting with a registered dispensing optician shall report the business relationship to the State Board of Optometry, as determined by the board. The State Board of Optometry shall have the authority to inspect any premises at which the business of a registered dispensing optician is co-located with the practice of an optometrist, for the purposes of determining compliance with Section 655. The inspection may include the review of any written lease agreement between the registered dispensing optician and the optometrist or between the optometrist and the health plan. Failure to comply with the inspection or any request for information by the board may subject the party to disciplinary action. The board shall provide a copy of its inspection results, if applicable, to the Department of Managed Health Care.

SEC. 9. Section 2556.2 is added to the Business and Professions Code, to read:

2556.2. (a) Notwithstanding any other law, subsequent to the effective date of this section and until January 1, 2019, any individual, corporation, or firm operating as a registered dispensing optician under this chapter before the effective date of this section, or an employee of such an entity, shall not be subject to any action for engaging in conduct prohibited by Section 2556 or Section 655 as those sections existed prior to the effective date of this bill, except that a registrant shall be subject to discipline for duplicating or changing lenses without a prescription or order from a person duly licensed to issue the same.

(b) Nothing in this section shall be construed to imply or suggest that a person registered under this chapter is in violation of or in compliance with the law.

(c) This section shall not apply to any business relationships prohibited by Section 2556 commencing registration or operations on or after the effective date of this section.

(d) Subsequent to the effective date of this section and until January 1, 2019, nothing in this section shall prohibit an individual, corporation, or firm operating as a registered dispensing optician from engaging in a business relationship with an optometrist licensed pursuant to Chapter 7 (commencing with Section 3000) before the effective date of this section at locations registered with the Medical Board of California before the effective date of this section.

(e) This section does not apply to any administrative action pending, litigation pending, cause for discipline, or cause of action accruing prior to September 1, 2015.

(f) Any health plan, as defined in Section 655, subject to this section shall report to the State Board of Optometry in writing that (1) 15 percent of its locations no longer employ an optometrist by January 1, 2017, (2) 45 percent of its locations no longer employ an optometrist by August 1, 2017, and (3) 100 percent of its locations no longer employ an optometrist by January 1, 2019. The board shall provide those reports as soon as it receives them to the director and the Legislature. The report to the Legislature shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 10. Section 2567 of the Business and Professions Code is amended to read:

2567. (a) The provisions of Article 19 (commencing with Section 2420) and Article 20 (commencing with Section 2435) of Chapter 5 which are not inconsistent or in conflict with this chapter apply to the issuance and govern the expiration and renewal of certificates issued under this chapter. All fees collected from persons registered or seeking registration under this chapter shall be paid into the Dispensing Opticians Fund, and shall be available, upon appropriation, to the State Board of Optometry for the purposes of this chapter. Any moneys within the Contingent Fund of the Medical Board of California collected pursuant to this chapter shall be deposited in the Dispensing Opticians Fund.

(b) The board may employ, subject to civil service regulations, whatever additional clerical assistance is necessary for the administration of this chapter.

SEC. 11. Section 3010.5 of the Business and Professions Code is amended to read:

3010.5. (a) There is in the Department of Consumer Affairs a State Board of Optometry in which the enforcement of this chapter is vested. The board consists of 11 members, five of whom shall be public members and one of the nonpublic members shall be an individual registered as a dispensing optician. The registered dispensing optician member shall be registered pursuant to Chapter 5.5. (commencing with Section 2550) and in good standing with the board.

Six members of the board shall constitute a quorum.

(b) The board shall, with respect to conducting investigations, inquiries, and disciplinary actions and proceedings, have the authority previously vested in the board as created pursuant to former Section 3010. The board may enforce any disciplinary actions undertaken by that board.

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

SEC. 12. Section 3011 of the Business and Professions Code is amended to read:

3011. Members of the board, except the public members and the registered dispensing optician member, shall be appointed only from persons who are registered optometrists of the State of California and actually engaged in the practice of optometry at the time of appointment or who are members of the faculty of a school of optometry. The public members shall not be a licentiate of the board or of any other board under this division or of any board referred to in Sections 1000 and 3600.

No person except the registered dispensing optician member, including the public members, shall be eligible to membership in the board who is a stockholder in or owner of or a member of the board of trustees of any school of optometry or who shall be financially interested, directly or indirectly, in any concern manufacturing or dealing in optical supplies at wholesale.

No person shall serve as a member of the board for more than two consecutive terms.

A member of the faculty of a school of optometry may be appointed to the board; however, no more than two faculty members of schools of optometry may be on the board at any one time. Faculty members of the board shall not serve as public members.

SEC. 13. Section 3013 of the Business and Professions Code is amended to read:

3013. (a) Each member of the board shall hold office for a term of four years, and shall serve until the appointment and qualification of his or her

successor or until one year shall have elapsed since the expiration of the term for which he or she was appointed, whichever first occurs.

(b) Vacancies occurring shall be filled by appointment for the unexpired term.

(c) The Governor shall appoint three of the public members, five members qualified as provided in Section 3011, and the registered dispensing optician member as provided in Section 3010.5. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.

(d) No board member serving between January 1, 2000, and June 1, 2002, inclusive, shall be eligible for reappointment.

(e) For initial appointments made on or after January 1, 2003, one of the public members appointed by the Governor and two of the professional members shall serve terms of one year. One of the public members appointed by the Governor and two of the professional members shall serve terms of three years. The remaining public member appointed by the Governor and the remaining two professional members shall serve terms of four years. The public members appointed by the Senate Committee on Rules and the Speaker of the Assembly shall each serve for a term of four years.

(f) The initial appointment of a registered dispensing optician member shall replace the optometrist member whose term expired on June 1, 2015.

SEC. 14. Section 3020 is added to the Business and Professions Code, to read:

3020. (a) There shall be established under the State Board of Optometry a dispensing optician committee to advise and make recommendations to the board regarding the regulation of a dispensing opticians pursuant to Chapter 5.5 (commencing with Section 2550). The committee shall consist of five members, two of whom shall be registered dispensing opticians, two of whom shall be public members, and one of whom shall be a member of the board. Initial appointments to the committee shall be made by the board. The board shall stagger the terms of the initial members appointed. The filling of vacancies on the committee shall be made by the board upon recommendations by the committee.

(b) The committee shall be responsible for:

(1) Recommending registration standards and criteria for the registration of dispensing opticians.

(2) Reviewing of the disciplinary guidelines relating to registered dispensing opticians.

(3) Recommending to the board changes or additions to regulations adopted pursuant to Chapter 5.5 (commencing with Section 2550).

(4) Carrying out and implementing all responsibilities and duties imposed upon it pursuant to this chapter or as delegated to it by the board.

(c) The committee shall meet at least twice a year and as needed in order to conduct its business.

(d) Recommendations by the committee regarding scope of practice or regulatory changes or additions shall be approved, modified, or rejected by the board within 90 days of submission of the recommendation to the board. If the board rejects or significantly modifies the intent or scope of the

recommendation, the committee may request that the board provide its reasons in writing for rejecting or significantly modifying the recommendation, which shall be provided by the board within 30 days of the request.

(e) After the initial appointments by the board pursuant to subdivision (a), the Governor shall appoint the registered dispensing optician members and the public members. The committee shall submit a recommendation to the board regarding which board member should be appointed to serve on the committee, and the board shall appoint the member to serve. Committee members shall serve a term of four years except for the initial staggered terms. A member may be reappointed, but no person shall serve as a member of the committee for more than two consecutive terms.

SEC. 15. Section 3021 is added to the Business and Professions Code, to read:

3021. The board shall have rulemaking authority with respect to Chapter 5.45 (commencing with Section 2546) and Chapter 5.5 (commencing with Section 2550) in accordance with Section 3025. Regulations adopted pursuant to Chapter 5.45 (commencing with Section 2546) and Chapter 5.5 (commencing with Section 2550) by the Medical Board of California prior to the effective date of this section shall continue to be valid, except that any reference to the board or division contained therein shall be construed to mean the State Board of Optometry, unless the context determines otherwise.

SEC. 16. Section 3023.1 is added to the Business and Professions Code, to read:

3023.1. (a) The nonresident contact lens seller program established under Chapter 5.45 (commencing with Section 2546) and the registered dispensing optician, spectacle lens dispensing, and contact lens dispensing programs established under Chapter 5.5 (commencing with Section 2550) are hereby transferred from the jurisdiction of the Medical Board of California and placed under the jurisdiction of the State Board of Optometry.

(b) All the duties, powers, purposes, responsibilities, and jurisdictions of the Medical Board of California under Chapter 5.45 (commencing with Section 2546) and Chapter 5.5 (commencing with Section 2550) shall be transferred to the State Board of Optometry.

(c) For the performance of the duties and the exercise of the powers vested in the board under Chapter 5.45 (commencing with Section 2546) and Chapter 5.5 (commencing with Section 2550), the State Board of Optometry shall have possession and control of all records, papers, offices, equipment, supplies, or other property, real or personal, held for the benefit or use by the Medical Board of California.

SEC. 17. The Legislature finds and declares that Section 1 of this act imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to

demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to allow the State Board of Optometry and the Department of Managed Health Care to fully accomplish its goals, it is imperative to protect the interests of those persons submitting information to those departments to ensure that any personal or sensitive business information that this act requires those persons to submit is protected as confidential information.

SEC. 18. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: ABX2 15
Author: Eggman
Chapter: 1
Bill Date: September 3, 2015, Amended
Subject: End of Life
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill establishes the End of Life Option Act (Act) in California, which will remain in effect until January 1, 2026. This Act gives a mentally competent, adult California resident who has a terminal disease the legal right to ask for and receive a prescription from his or her physician to hasten death, as long as required criteria is met.

BACKGROUND

The End of Life Option Act is modeled after Oregon law that was enacted in 1997. This medical practice is also recognized in Washington, Vermont, and Montana under the State Supreme Court's 2010 decision in the *Baxter* case. The data collected in Oregon shows that the end of life option is used in fewer than 1 in 500 deaths (60 to 70 a year out of a total of over 30,000 deaths). Comparable numbers are seen in the State of Washington.

ANALYSIS

This bill allows a competent, qualified individual, who is an adult with a terminal disease, to make a request to receive a prescription for aid-in-dying drug, if all of the following conditions are satisfied:

- The individual's attending physician has diagnosed the individual with a terminal disease. Terminal disease is defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.
- The individual has voluntarily expressed the wish to receive a prescription for aid-in-dying drug.
- The individual is a resident of California and is able to establish residency through either possession of a California driver's license or other identification issued by the State of California, being registered to vote in California, evidence that the person owns or leases property in California, or the filing of a California tax return for the most recent tax year.
- The individual documents his or her request.
- The individual has the physical and mental ability to self-administer the aid-in-dying drug.

This bill would specify that a person may not be considered a qualified individual solely because of age or disability. This bill would specify that a request for a prescription for aid-in-dying drug can only be made solely and directly by the individual diagnose with the terminal disease and shall not be made on behalf of the patient, through a power of attorney, advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decision maker.

This bill would require an individual seeking to obtain a prescription for an aid-in-dying drug to submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. The attending physician must receive all three requests required directly. A valid written request must meet all of the following conditions:

- Shall be in the form specified in this bill;
- Shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug; and
- Shall be witnessed by at least two other adult persons who, in the presence of the individual, shall attest that to the best of their knowledge and belief, the individual is personally known to them or has provided proof of identity, is acting voluntarily and signed the request in their presence, and is of sound mind and not under duress, fraud, or undue influence. This bill would specify that only one of the two witnesses may be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death; or may own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides. The attending physician, consulting physician, or mental health specialist of the individual cannot be one of the witnesses.

This bill would specify that an individual may rescind his or her request for aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual's mental state. The attending physician is required to offer the qualified individual an opportunity to withdraw or rescind the request.

This bill defines an attending physician as the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease. Before prescribing an aid-in-dying drug, the attending physician must do all of the following:

- Make the initial determination whether the requesting adult has the capacity to make medical decisions, and if there are indications of a mental disorder, refer the individual for a mental health specialist assessment. If a mental health specialist assessment referral is made, no aid-in-dying drugs can be prescribed until the specialist determines the individual has the capacity to make medical decisions and is not suffering from impaired judgment. The attending physician must determine whether the requesting adult has a terminal disease, determine if the requesting adult has voluntarily made the request for an aid-in-dying drug, and determine if the requesting adult meets the requirements of a qualified individual.

- Confirm the individual is making an informed decision by discussing his or her medical diagnosis and prognosis; the potential risks and probable result associated with ingesting the aid-in-dying drug; the possibility that he or she may choose to obtain the aid-in-dying drug but not take it; and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.
- Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the requirements of this bill. The consulting physician is independent from the attending physician and must be qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease. Before a qualified individual obtains an aid-in-dying drug from the attending physician, the consulting physician must examine the individual and his or her relevant medical records, confirm in writing the attending physician's diagnosis and prognosis, determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision. The consulting physician must fulfill the record documentation required by this bill and submit the compliance form to the attending physician.
- Confirm the individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, whether or not the qualified individual is feeling coerced or unduly influenced by another person.
- Counsel the qualified individual about the importance of having another person present when he or she ingests the aid-in-dying drug, the importance of not taking the aid-in-dying drug in a public place, the importance of notifying the next of kin of his or her request for the aid-in-dying drug, the importance of participating in a hospice program, and the importance of maintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.
- Inform the individual that he or she may withdraw or rescind the request for aid-in-dying drug at any time and in any manner.
- Offer the qualified individual the opportunity to withdraw or rescind the request for aid-in-dying drug before prescribing the aid-in-dying drug.
- Verify, immediately prior to writing the prescription for aid-in-dying drug, that the qualified individual is making an informed decision.
- Confirm that all requirements are met and all appropriate steps are carried out in accordance with this bill before writing a prescription.
- Fulfill the required record documentation pursuant to this bill.
- Complete the attending physician checklist and compliance form included in this bill and collect the consulting physician compliance form also included in this bill and include both forms in the individual's medical record and also submit both forms to the California Department of Public Health (CDPH).
- Give the qualified individual the final attestation form, included in this bill, with the instruction that the form be filled out and executed by the qualified individual within 48 hours prior to the individual choosing to self-administer the aid-in-dying drug.

If an individual is referred to a mental health specialist by the attending or consulting physician, the mental health specialist must examine the individual and his or her relevant medical records; determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision; determine that the individual is not suffering from impaired judgment due to a mental disorder; and fulfill the record documentation requirements of this bill.

This bill would require the following to be documented in the individual's medical record:

- All oral requests for aid-in-dying drugs.
- All written requests for aid-in-dying drugs.
- The attending physician's diagnosis and prognosis, determination that a qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified individual.
- The consulting physician's diagnosis and prognosis, verification that the qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified individual.
- A report of the outcome and determinations made during a mental health specialist's assessment, if performed.
- The attending physician's offer to the qualified individual to withdraw or rescind his or her request at the time of the individual's second oral request.
- A note by the attending physician indicating that the requirements in this bill have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

If the requirements are met, the attending physician may deliver the aid-in-dying drug in any of the following ways:

- Dispense the aid-in-dying drug directly if the physician is authorized to dispense medicine under California law, has a current United States Drug Enforcement Administration certificate, and has complied with any applicable administrative rule or regulation.
- With the qualified individual's written consent, the attending physician may contact a pharmacist and deliver the prescription to the pharmacist, who shall dispense the medications to the qualified individual, the attending physician, or a person expressly designated by the qualified individual.

Within 30 days of writing a prescription for an aid-in-dying drug, the attending physician must submit to CDPH, a copy of the qualifying patient's written request, the attending checklist and compliance form, and the consulting physician compliance form. Within 30 calendar days following the individual's death from ingesting the aid-in-dying drug, or any other cause, the attending physician must submit the attending physician follow up form to CDPH. Upon receiving the final attestation form from the qualified individual, the attending

physician shall add this form to the medical records of the individual.

CDPH must collect and review the information submitted by the attending physician, which shall be confidential. Beginning on July 1, 2017, and each year thereafter, based on the information collected in the previous year, CDPH is required to create a report with the information collected. The report must include the number of people for whom the aid-in-dying prescription was written; the number of known individuals who died each year that received aid-in-dying prescriptions and the cause of death; the total cumulative number of aid-in-dying prescriptions written; the total cumulative number of people who died due to use of aid-in-dying drugs; the number of people who died who were enrolled in hospice or other palliative care programs; the number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California; the number of physicians who wrote prescriptions for aid-in-dying drugs; and demographic percentages of people who died due to using an aid-in-dying drug, for age at death, education level, race, sex, type of insurance, and underlying illness.

CDPH must post on its website the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow up form. This bill allows the Medical Board of California (Board) to update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow up form. However, this bill already includes the actual forms to be used, until and unless they are updated by the Board.

This bill states that a death resulting from the self-administering of an aid-in-dying drug is not suicide, preventing health and insurance coverage from being exempt on that basis. This bill also provides that an individual's act of self-administering aid-in-dying drug may not have an effect upon a life, health, or accident insurance or annuity policy other than that of a natural death from the underlying illness. This bill prohibits an insurance carrier from providing any information in communications made about the availability of an aid-in-dying drug, unless it is requested by the individual or the individual's attending physician. This bill also prohibits any communication from including both the denial of treatment and information as to the availability of aid-in-dying drug coverage.

This bill prohibits a person from being subject to civil or criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug. This bill permits a person who is present to prepare the aid-in-dying drug (but not assist in the ingesting of the drug) without civil or criminal liability.

This bill prohibits a health care provider or professional organization or association from censoring, disciplining, suspending, or revoking licensure, privileges, membership, or administering other penalty to an individual for participating or refusing to participate in good faith compliance with this bill.

This bill specifies that a request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance with the provisions of this bill shall not be the sole basis for the appointment of a guardian or conservator.

This bill provides liability protections for providers and specifies that health care providers are not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for participating in this bill, as specified. This bill prohibits a health care provider from being sanctioned for making an initial determination that an individual has a terminal illness and informing him or her of the medical prognosis; providing information about the End of Life Option Act to a patient upon the request of the individual; providing an individual, upon request, with a referral to another physician; or, contracting with an individual to act outside the course and scope of the provider's capacity as an employee or independent contractor of a health care provider that prohibits activities under this bill.

This bill permits a health care provider to prohibit its employees, independent contractors, or other persons from participating in activities under this bill while on premises owned or under the management or direct control of that prohibiting health care provider, as specified. This bill indicates that nothing shall be construed to prevent, or to allow a prohibiting health care provider to prohibit its employees or contractor from participating in activities under this bill, as specified.

This bill specifies that notwithstanding any contrary provision in this bill, the immunities and prohibitions on sanctions of a health care provider are solely reserved for actions of a health care provider taken pursuant to this bill. Additionally, health care providers may be sanctioned by their licensing board or agency for conduct and acts of unprofessional conduct, including failure to comply in good faith with this bill. This bill provides that nothing in this bill may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia. This bill specifies that actions taken in accordance with this bill shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, homicide, or elder abuse under the law.

This bill makes it a felony to knowingly alter or forge a request for an aid-in-dying drug to end an individual's life without his or her authorization, or concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug if the act is done with the intent or effect of causing the individual's death, or to knowingly coerce or exert undue influence on an individual to request or ingest an aid-in-dying drug for the purpose of ending his or her life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without his or her knowledge or consent.

The Board, as a regulatory agency, historically has not taken positions on policy bills that affect an individual’s rights in end-of-life health care choices. As such, the Board did not to take a policy position on SB 128 (Wolk), which is very similar to this bill.

FISCAL: None to the Board

SUPPORT: Advisory Council of the Central Coast Commission for Senior Citizens; AIDS Healthcare Foundation; AIDS Project Los Angeles; American Nurses Association\California; California Association for Nurse Practitioners; California Association of Marriage and Family Therapists; California Chapter of the National Association of Social Workers; California Church IMPACT; California Commission on Aging; California Democratic Party; California Primary Care Association; California Psychological Association; California Senior Legislature; Cardinal Point at Mariner Square Residents' Association; Church Council of West Hollywood United Church of Christ; City of Cathedral City; City of Santa Barbara; Coast side Democrats; Compassion and Choices California; Conference of California Bar Associations; Democratic Party of Orange County; Democratic Party of Santa Barbara County; Democratic Service Club of Santa Barbara County; Desert Ministries United Church of Christ; Desert Stonewall Democrats; Ethical Culture Society of Silicon Valley; Five Counties Central Labor Council; Full Circle Living and Dying Collective; GLMA: Health Professionals Advancing LGBT Equality; Gray Panthers of Long Beach; Humanist Society of Santa Barbara; Humboldt and Del Norte Counties Central Labor Council; Laguna Woods Democratic Club; Lompoc Valley Democratic Club; Los Angeles LGBT Center; Mar Vista Community Council; Potrero Hill Democratic Club; Progressive Christians Uniting; Sacramento Central Labor Council, AFL-CIO; San Benito County Democratic Central Committee; San Francisco AIDS Foundation; San Mateo County Democracy for America; San Mateo County Democratic Party; San Mateo County Medical Association; Santa Barbara County Board of Supervisors; Santa Cruz City Council; Sierra County Democratic Central Committee; South Orange County Democratic Club; Tehachapi Mountain Democratic Club; Unitarian Universalist Church of the Verdugo Hills; Ventura County Board of Supervisors; and Visalia Democratic Club

OPPOSITION: Agudath Israel of California; Alliance of Catholic Health Care; Association of Northern California Oncologists; California Catholic Conference; California Disability Alliance; California Foundation for Independent Living Centers; Coalition of Concerned Medical Professionals; Communities Actively Living Independent and Free; Communities United in Defense of Olmstead; Dignity Health; Disability Action Center; Disability Rights California; Disability Rights Education and Defense Fund; FREED Center for Independent Living; Independent Living Center of Southern California; Independent Living Resource Center of San Francisco; Medical Oncology Association of Southern

California; Patients' Rights Action Fund; Placer Independent Resource Services; Rabbinical Council of California; Silicon Valley Independent Living Center; and The Arc of California

IMPLEMENTATION:

- Newsletter article(s), including one stand-alone article for physicians
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website to include information on the End of Life Option Act and links to CDPH's webpage that includes links to the forms required for attending and consulting physicians

Assembly Bill No. 15

CHAPTER 1

An act to add and repeal Part 1.85 (commencing with Section 443) of Division 1 of the Health and Safety Code, relating to end of life.

[Approved by Governor October 5, 2015. Filed with Secretary of State October 5, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 15, Eggman. End of life.

Existing law authorizes an adult to give an individual health care instruction and to appoint an attorney to make health care decisions for that individual in the event of his or her incapacity pursuant to a power of attorney for health care.

This bill, until January 1, 2026, would enact the End of Life Option Act authorizing an adult who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease, as defined, to make a request for a drug prescribed pursuant to these provisions for the purpose of ending his or her life. The bill would establish the procedures for making these requests. The bill would also establish specified forms to request an aid-in-dying drug, under specified circumstances, an interpreter declaration to be signed subject to penalty of perjury, thereby creating a crime and imposing a state-mandated local program, and a final attestation for an aid-in-dying drug. This bill would require specified information to be documented in the individual's medical record, including, among other things, all oral and written requests for an aid-in-dying drug.

This bill would prohibit a provision in a contract, will, or other agreement from being conditioned upon, or affected by, a person making or rescinding a request for the above-described drug. The bill would prohibit the sale, procurement, or issuance of any life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for any policy or plan contract, from being conditioned upon or affected by the request. The bill would prohibit an insurance carrier from providing any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. The bill would also prohibit any communication from containing both the denial of treatment and information as to the availability of aid-in-dying drug coverage.

This bill would provide a person, except as provided, immunity from civil or criminal liability solely because the person was present when the qualified individual self-administered the drug, or the person assisted the qualified individual by preparing the aid-in-dying drug so long as the person did not

assist with the ingestion of the drug, and would specify that the immunities and prohibitions on sanctions of a health care provider are solely reserved for conduct of a health care provider provided for by the bill. The bill would make participation in activities authorized pursuant to its provisions voluntary, and would make health care providers immune from liability for refusing to engage in activities authorized pursuant to its provisions. The bill would also authorize a health care provider to prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under the act while on the premises owned or under the management or direct control of that prohibiting health care provider, or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

This bill would make it a felony to knowingly alter or forge a request for drugs to end an individual's life without his or her authorization or to conceal or destroy a withdrawal or rescission of a request for a drug, if it is done with the intent or effect of causing the individual's death. The bill would make it a felony to knowingly coerce or exert undue influence on an individual to request a drug for the purpose of ending his or her life, to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without their knowledge or consent. By creating a new crime, the bill would impose a state-mandated local program. The bill would provide that nothing in its provisions is to be construed to authorize ending a patient's life by lethal injection, mercy killing, or active euthanasia, and would provide that action taken in accordance with the act shall not constitute, among other things, suicide or homicide.

This bill would require physicians to submit specified forms and information to the State Department of Public Health after writing a prescription for an aid-in-dying drug and after the death of an individual who requested an aid-in-dying drug. The bill would authorize the Medical Board of California to update those forms and would require the State Department of Public Health to publish the forms on its Internet Web site. The bill would require the department to annually review a sample of certain information and records, make a statistical report of the information collected, and post that report to its Internet Web site.

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.

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.

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

SECTION 1. Part 1.85 (commencing with Section 443) is added to Division 1 of the Health and Safety Code, to read:

PART 1.85. END OF LIFE OPTION ACT

443. This part shall be known and may be cited as the End of Life Option Act.

443.1. As used in this part, the following definitions shall apply:

(a) "Adult" means an individual 18 years of age or older.

(b) "Aid-in-dying drug" means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.

(c) "Attending physician" means the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease.

(d) "Attending physician checklist and compliance form" means a form, as described in Section 443.22, identifying each and every requirement that must be fulfilled by an attending physician to be in good faith compliance with this part should the attending physician choose to participate.

(e) "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers.

(f) "Consulting physician" means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease.

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

(h) "Health care provider" or "provider of health care" means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; any person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; any person certified pursuant to Division 2.5 (commencing with Section 1797) of this code; and any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of this code.

(i) "Informed decision" means a decision by an individual with a terminal disease to request and obtain a prescription for a drug that the individual may self-administer to end the individual's life, that is based on an understanding and acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:

(1) The individual's medical diagnosis and prognosis.

(2) The potential risks associated with taking the drug to be prescribed.

(3) The probable result of taking the drug to be prescribed.

(4) The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.

(5) The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

(j) "Medically confirmed" means the medical diagnosis and prognosis of the attending physician has been confirmed by a consulting physician who has examined the individual and the individual's relevant medical records.

(k) "Mental health specialist assessment" means one or more consultations between an individual and a mental health specialist for the purpose of determining that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

(*l*) "Mental health specialist" means a psychiatrist or a licensed psychologist.

(m) "Physician" means a doctor of medicine or osteopathy currently licensed to practice medicine in this state.

(n) "Public place" means any street, alley, park, public building, any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access.

(o) "Qualified individual" means an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of this part in order to obtain a prescription for a drug to end his or her life.

(p) "Self-administer" means a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death.

(q) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

443.2. (a) An individual who is an adult with the capacity to make medical decisions and with a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are satisfied:

(1) The individual's attending physician has diagnosed the individual with a terminal disease.

(2) The individual has voluntarily expressed the wish to receive a prescription for an aid-in-dying drug.

(3) The individual is a resident of California and is able to establish residency through any of the following means:

(A) Possession of a California driver license or other identification issued by the State of California.

(B) Registration to vote in California.

(C) Evidence that the person owns or leases property in California.

(D) Filing of a California tax return for the most recent tax year.

(4) The individual documents his or her request pursuant to the requirements set forth in Section 443.3.

(5) The individual has the physical and mental ability to self-administer the aid-in-dying drug.

(b) A person shall not be considered a "qualified individual" under the provisions of this part solely because of age or disability.

(c) A request for a prescription for an aid-in-dying drug under this part shall be made solely and directly by the individual diagnosed with the terminal disease and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decisionmaker.

443.3. (a) An individual seeking to obtain a prescription for an aid-in-dying drug pursuant to this part shall submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. The attending physician shall directly, and not through a designee, receive all three requests required pursuant to this section.

(b) A valid written request for an aid-in-dying drug under subdivision (a) shall meet all of the following conditions:

(1) The request shall be in the form described in Section 443.11.

(2) The request shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug.

(3) The request shall be witnessed by at least two other adult persons who, in the presence of the individual, shall attest that to the best of their knowledge and belief the individual is all of the following:

(A) An individual who is personally known to them or has provided proof of identity.

(B) An individual who voluntarily signed this request in their presence.

(C) An individual whom they believe to be of sound mind and not under duress, fraud, or undue influence.

(D) Not an individual for whom either of them is the attending physician, consulting physician, or mental health specialist.

(c) Only one of the two witnesses at the time the written request is signed may:

(1) Be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death.

(2) Own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides.

(d) The attending physician, consulting physician, or mental health specialist of the individual shall not be one of the witnesses required pursuant to paragraph (3) of subdivision (b).

443.4. (a) An individual may at any time withdraw or rescind his or her request for an aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual's mental state.

(b) A prescription for an aid-in-dying drug provided under this part may not be written without the attending physician directly, and not through a designee, offering the individual an opportunity to withdraw or rescind the request.

443.5. (a) Before prescribing an aid-in-dying drug, the attending physician shall do all of the following:

(1) Make the initial determination of all of the following:

(A) (i) Whether the requesting adult has the capacity to make medical decisions.

(ii) If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment.

(iii) If a mental health specialist assessment referral is made, no aid-in-dying drugs shall be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

(B) Whether the requesting adult has a terminal disease.

(C) Whether the requesting adult has voluntarily made the request for an aid-in-dying drug pursuant to Sections 443.2 and 443.3.

(D) Whether the requesting adult is a qualified individual pursuant to subdivision (o) of Section 443.1.

(2) Confirm that the individual is making an informed decision by discussing with him or her all of the following:

(A) His or her medical diagnosis and prognosis.

(B) The potential risks associated with ingesting the requested aid-in-dying drug.

(C) The probable result of ingesting the aid-in-dying drug.

(D) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it.

(E) The feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

(3) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the provisions of this part.

(4) Confirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, except for an interpreter as required pursuant to this part, whether or not the qualified individual is feeling coerced or unduly influenced by another person.

(5) Counsel the qualified individual about the importance of all of the following:

(A) Having another person present when he or she ingests the aid-in-dying drug prescribed pursuant to this part.

(B) Not ingesting the aid-in-dying drug in a public place.

(C) Notifying the next of kin of his or her request for an aid-in-dying drug. A qualified individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

(D) Participating in a hospice program.

(E) Maintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.

(6) Inform the individual that he or she may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner.

(7) Offer the individual an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing the aid-in-dying drug.

(8) Verify, immediately before writing the prescription for an aid-in-dying drug, that the qualified individual is making an informed decision.

(9) Confirm that all requirements are met and all appropriate steps are carried out in accordance with this part before writing a prescription for an aid-in-dying drug.

(10) Fulfill the record documentation required under Sections 443.8 and 443.19.

(11) Complete the attending physician checklist and compliance form, as described in Section 443.22, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to the State Department of Public Health.

(12) Give the qualified individual the final attestation form, with the instruction that the form be filled out and executed by the qualified individual within 48 hours prior to the qualified individual choosing to self-administer the aid-in-dying drug.

(b) If the conditions set forth in subdivision (a) are satisfied, the attending physician may deliver the aid-in-dying drug in any of the following ways:

(1) Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the qualified individual's discomfort, if the attending physician meets all of the following criteria:

(A) Is authorized to dispense medicine under California law.

(B) Has a current United States Drug Enforcement Administration (USDEA) certificate.

(C) Complies with any applicable administrative rule or regulation.

(2) With the qualified individual's written consent, contacting a pharmacist, informing the pharmacist of the prescriptions, and delivering the written prescriptions personally, by mail, or electronically to the pharmacist, who may dispense the drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual and with the designation delivered to the pharmacist in writing or verbally.

(c) Delivery of the dispensed drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual may be made by personal delivery, or, with a signature required on delivery, by United Parcel Service, United States Postal Service, Federal Express, or by messenger service.

443.6. Before a qualified individual obtains an aid-in-dying drug from the attending physician, the consulting physician shall perform all of the following:

(a) Examine the individual and his or her relevant medical records.

(b) Confirm in writing the attending physician's diagnosis and prognosis.

(c) Determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision.

(d) If there are indications of a mental disorder, refer the individual for a mental health specialist assessment.

(e) Fulfill the record documentation required under this part.

(f) Submit the compliance form to the attending physician.

443.7. Upon referral from the attending or consulting physician pursuant to this part, the mental health specialist shall:

(a) Examine the qualified individual and his or her relevant medical records.

(b) Determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision.

(c) Determine that the individual is not suffering from impaired judgment due to a mental disorder.

(d) Fulfill the record documentation requirements of this part.

443.8. All of the following shall be documented in the individual's medical record:

(a) All oral requests for aid-in-dying drugs.

(b) All written requests for aid-in-dying drugs.

(c) The attending physician's diagnosis and prognosis, and the determination that a qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified individual.

(d) The consulting physician's diagnosis and prognosis, and verification that the qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified individual.

(e) A report of the outcome and determinations made during a mental health specialist's assessment, if performed.

(f) The attending physician's offer to the qualified individual to withdraw or rescind his or her request at the time of the individual's second oral request.

(g) A note by the attending physician indicating that all requirements under Sections 443.5 and 443.6 have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

443.9. (a) Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician shall submit to the State Department of Public Health a copy of the qualifying patient's written request, the attending physician checklist and compliance form, and the consulting physician compliance form.

(b) Within 30 calendar days following the qualified individual's death from ingesting the aid-in-dying drug, or any other cause, the attending physician shall submit the attending physician followup form to the State Department of Public Health.

443.10. A qualified individual may not receive a prescription for an aid-in-dying drug pursuant to this part unless he or she has made an informed decision. Immediately before writing a prescription for an aid-in-dying drug under this part, the attending physician shall verify that the individual is making an informed decision.

443.11. (a) A request for an aid-in-dying drug as authorized by this part shall be in the following form:

REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER I, ..., am an adult of sound mind and a resident of the State of California.

I am suffering from ....., which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

I understand that I have the right to withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

Signed:.....

Dated:.....

DECLARATION OF WITNESSES

We declare that the person signing this request:

(a) is personally known to us or has provided proof of identity;

(b) voluntarily signed this request in our presence;

(c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and

(d) is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.
.....Witness 1/Date
.....Witness 2/Date
NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a portion of the person's estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident.

(b) (1) The written language of the request shall be written in the same translated language as any conversations, consultations, or interpreted conversations or consultations between a patient and his or her attending or consulting physicians.

(2) Notwithstanding paragraph (1), the written request may be prepared in English even when the conversations or consultations or interpreted conversations or consultations were conducted in a language other than English if the English language form includes an attached interpreter's declaration that is signed under penalty of perjury. The interpreter's declaration shall state words to the effect that:

I, (INSERT NAME OF INTERPRETER), am fluent in English and (INSERT TARGET LANGUAGE).
On (insert date) at approximately (insert time), I read the "Request for an Aid-In-Dying Drug to End My Life" to (insert name of individual/patient) in (insert target language).
Mr./Ms. (insert name of patient/qualified individual) affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.
I declare that I am fluent in English and (insert target language) and further declare under penalty of perjury that the foregoing is true and correct.
Executed at (insert city, county, and state) on this (insert day of month) of (insert month), (insert year).
X_____Interpreter signature
X_____Interpreter printed name
X_____Interpreter address

(3) An interpreter whose services are provided pursuant to paragraph (2) shall not be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the person's estate upon death. An interpreter whose services are provided pursuant to paragraph (2) shall meet the standards promulgated by the California Healthcare Interpreting Association or the National Council on Interpreting in Health Care or other standards deemed acceptable by the department for health care providers in California.

(c) The final attestation form given by the attending physician to the qualified individual at the time the attending physician writes the prescription shall appear in the following form:

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER I, ..., am an adult of sound mind and a resident of the State of California.
I am suffering from ....., which my attending physician has determined is in its terminal phase and which has been medically confirmed.
I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.
I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.
INITIAL ONE:
..... I have informed one or more members of my family of my decision and taken their opinions into consideration.
..... I have decided not to inform my family of my decision.
..... I have no family to inform of my decision.
My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.
I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed:.....
Dated:.....
Time:.....

(1) Within 48 hours prior to the individual self-administering the aid-in-dying drug, the individual shall complete the final attestation form. If aid-in-dying medication is not returned or relinquished upon the patient's death as required in Section 443.20, the completed form shall be delivered

by the individual's health care provider, family member, or other representative to the attending physician to be included in the patient's medical record.

(2) Upon receiving the final attestation form the attending physician shall add this form to the medical records of the qualified individual.

443.12. (a) A provision in a contract, will, or other agreement executed on or after January 1, 2016, whether written or oral, to the extent the provision would affect whether a person may make, withdraw, or rescind a request for an aid-in-dying drug is not valid.

(b) An obligation owing under any contract executed on or after January 1, 2016, may not be conditioned or affected by a qualified individual making, withdrawing, or rescinding a request for an aid-in-dying drug.

443.13. (a) (1) The sale, procurement, or issuance of a life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for a policy or plan contract may not be conditioned upon or affected by a person making or rescinding a request for an aid-in-dying drug.

(2) Pursuant to Section 443.18, death resulting from the self-administration of an aid-in-dying drug is not suicide, and therefore health and insurance coverage shall not be exempted on that basis.

(b) Notwithstanding any other law, a qualified individual's act of self-administering an aid-in-dying drug shall not have an effect upon a life, health, or annuity policy other than that of a natural death from the underlying disease.

(c) An insurance carrier shall not provide any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. Any communication shall not include both the denial of treatment and information as to the availability of aid-in-dying drug coverage. For the purposes of this subdivision, "insurance carrier" means a health care service plan as defined in Section 1345 of this code or a carrier of health insurance as defined in Section 106 of the Insurance Code.

443.14. (a) Notwithstanding any other law, a person shall not be subject to civil or criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug. A person who is present may, without civil or criminal liability, assist the qualified individual by preparing the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug.

(b) A health care provider or professional organization or association shall not subject an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with this part or for refusing to participate in accordance with subdivision (e).

(c) Notwithstanding any other law, a health care provider shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff

action, sanction, or penalty or other liability for participating in this part, including, but not limited to, determining the diagnosis or prognosis of an individual, determining the capacity of an individual for purposes of qualifying for the act, providing information to an individual regarding this part, and providing a referral to a physician who participates in this part. Nothing in this subdivision shall be construed to limit the application of, or provide immunity from, Section 443.16 or 443.17.

(d) (1) A request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance with the provisions of this part shall not provide the sole basis for the appointment of a guardian or conservator.

(2) No actions taken in compliance with the provisions of this part shall constitute or provide the basis for any claim of neglect or elder abuse for any purpose of law.

(e) (1) Participation in activities authorized pursuant to this part shall be voluntary. Notwithstanding Sections 442 to 442.7, inclusive, a person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized pursuant to this part is not required to take any action in support of an individual's decision under this part.

(2) Notwithstanding any other law, a health care provider is not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate in activities authorized under this part, including, but not limited to, refusing to inform a patient regarding his or her rights under this part, and not referring an individual to a physician who participates in activities authorized under this part.

(3) If a health care provider is unable or unwilling to carry out a qualified individual's request under this part and the qualified individual transfers care to a new health care provider, the individual may request a copy of his or her medical records pursuant to law.

443.15. (a) Subject to subdivision (b), notwithstanding any other law, a health care provider may prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under this part while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

(b) A health care provider that elects to prohibit its employees, independent contractors, or other persons or entities, including health care providers, from participating in activities under this part, as described in subdivision (a), shall first give notice of the policy prohibiting participation under this part to the individual or entity. A health care provider that fails to provide notice to an individual or entity in compliance with this subdivision shall not be entitled to enforce such a policy against that individual or entity.

(c) Subject to compliance with subdivision (b), the prohibiting health care provider may take action, including, but not limited to, the following, as applicable, against any individual or entity that violates this policy:

(1) Loss of privileges, loss of membership, or other action authorized by the bylaws or rules and regulations of the medical staff.

(2) Suspension, loss of employment, or other action authorized by the policies and practices of the prohibiting health care provider.

(3) Termination of any lease or other contract between the prohibiting health care provider and the individual or entity that violates the policy.

(4) Imposition of any other nonmonetary remedy provided for in any lease or contract between the prohibiting health care provider and the individual or entity in violation of the policy.

(d) Nothing in this section shall be construed to prevent, or to allow a prohibiting health care provider to prohibit, any other health care provider, employee, independent contractor, or other person or entity from any of the following:

(1) Participating, or entering into an agreement to participate, in activities under this part, while on premises that are not owned or under the management or direct control of the prohibiting provider or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the prohibiting health care provider.

(2) Participating, or entering into an agreement to participate, in activities under this part as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the prohibiting provider.

(e) In taking actions pursuant to subdivision (c), a health care provider shall comply with all procedures required by law, its own policies or procedures, and any contract with the individual or entity in violation of the policy, as applicable.

(f) For purposes of this section:

(1) "Notice" means a separate statement in writing advising of the prohibiting health care provider policy with respect to participating in activities under this part.

(2) "Participating, or entering into an agreement to participate, in activities under this part" means doing or entering into an agreement to do any one or more of the following:

(A) Performing the duties of an attending physician as specified in Section 443.5.

(B) Performing the duties of a consulting physician as specified in Section 443.6.

(C) Performing the duties of a mental health specialist, in the circumstance that a referral to one is made.

(D) Delivering the prescription for, dispensing, or delivering the dispensed aid-in-dying drug pursuant to paragraph (2) of subdivision (b) of, and subdivision (c) of, Section 443.5.

(E) Being present when the qualified individual takes the aid-in-dying drug prescribed pursuant to this part.

(3) "Participating, or entering into an agreement to participate, in activities under this part" does not include doing, or entering into an agreement to do, any of the following:

(A) Diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis, or determining whether a patient has the capacity to make decisions.

(B) Providing information to a patient about this part.

(C) Providing a patient, upon the patient's request, with a referral to another health care provider for the purposes of participating in the activities authorized by this part.

(g) Any action taken by a prohibiting provider pursuant to this section shall not be reportable under Sections 800 to 809.9, inclusive, of the Business and Professions Code. The fact that a health care provider participates in activities under this part shall not be the sole basis for a complaint or report by another health care provider of unprofessional or dishonorable conduct under Sections 800 to 809.9, inclusive, of the Business and Professions Code.

(h) Nothing in this part shall prevent a health care provider from providing an individual with health care services that do not constitute participation in this part.

443.16. (a) A health care provider may not be sanctioned for any of the following:

(1) Making an initial determination pursuant to the standard of care that an individual has a terminal disease and informing him or her of the medical prognosis.

(2) Providing information about the End of Life Option Act to a patient upon the request of the individual.

(3) Providing an individual, upon request, with a referral to another physician.

(b) A health care provider that prohibits activities under this part in accordance with Section 443.15 shall not sanction an individual health care provider for contracting with a qualified individual to engage in activities authorized by this part if the individual health care provider is acting outside of the course and scope of his or her capacity as an employee or independent contractor of the prohibiting health care provider.

(c) Notwithstanding any contrary provision in this section, the immunities and prohibitions on sanctions of a health care provider are solely reserved for actions of a health care provider taken pursuant to this part. Notwithstanding any contrary provision in this part, health care providers may be sanctioned by their licensing board or agency for conduct and actions constituting unprofessional conduct, including failure to comply in good faith with this part.

443.17. (a) Knowingly altering or forging a request for an aid-in-dying drug to end an individual's life without his or her authorization or concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug is punishable as a felony if the act is done with the intent or effect of causing the individual's death.

(b) Knowingly coercing or exerting undue influence on an individual to request or ingest an aid-in-dying drug for the purpose of ending his or her life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without his or her knowledge or consent, is punishable as a felony.

(c) For purposes of this section, "knowingly" has the meaning provided in Section 7 of the Penal Code.

(d) The attending physician, consulting physician, or mental health specialist shall not be related to the individual by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual's estate upon death.

(e) Nothing in this section shall be construed to limit civil liability.

(f) The penalties in this section do not preclude criminal penalties applicable under any law for conduct inconsistent with the provisions of this section.

443.18. Nothing in this part may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law.

443.19. (a) The State Department of Public Health shall collect and review the information submitted pursuant to Section 443.9. The information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient's family, and any medical provider or pharmacist involved with the patient under the provisions of this part. The information shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(b) On or before July 1, 2017, and each year thereafter, based on the information collected in the previous year, the department shall create a report with the information collected from the attending physician followup form and post that report to its Internet Web site. The report shall include, but not be limited to, all of the following based on the information that is provided to the department and on the department's access to vital statistics:

(1) The number of people for whom an aid-in-dying prescription was written.

(2) The number of known individuals who died each year for whom aid-in-dying prescriptions were written, and the cause of death of those individuals.

(3) For the period commencing January 1, 2016, to and including the previous year, cumulatively, the total number of aid-in-dying prescriptions written, the number of people who died due to use of aid-in-dying drugs, and the number of those people who died who were enrolled in hospice or other palliative care programs at the time of death.

(4) The number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California.

(5) The number of physicians who wrote prescriptions for aid-in-dying drugs.

(6) Of people who died due to using an aid-in-dying drug, demographic percentages organized by the following characteristics:

(A) Age at death.

(B) Education level.

(C) Race.

(D) Sex.

(E) Type of insurance, including whether or not they had insurance.

(F) Underlying illness.

(c) The State Department of Public Health shall make available the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, as described in Section 443.22, by posting them on its Internet Web site.

443.20. A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.

443.21. Any governmental entity that incurs costs resulting from a qualified individual terminating his or her life pursuant to the provisions of this part in a public place shall have a claim against the estate of the qualified individual to recover those costs and reasonable attorney fees related to enforcing the claim.

443.215. This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date.

443.22. (a) The Medical Board of California may update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, based on those provided in subdivision (b). Upon completion, the State Department of Public Health shall publish the updated forms on its Internet Web site.

(b) Unless and until updated by the Medical Board of California pursuant to this section, the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form shall be in the following form:

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

A	PATIENT INFORMATION	
	PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH
	PATIENT RESIDENTIAL ADDRESS (STREET, CITY, ZIP CODE)	

B	ATTENDING PHYSICIAN INFORMATION	
	PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
	MAILING ADDRESS (STREET, CITY, ZIP CODE)	
	PHYSICIAN'S LICENSE NUMBER	

C	CONSULTING PHYSICIAN INFORMATION	
	PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) —
	MAILING ADDRESS (STREET, CITY, ZIP CODE)	
	PHYSICIAN'S LICENSE NUMBER	

D	ELIGIBILITY DETERMINATION
	1. TERMINAL DISEASE
	2. CHECK BOXES FOR COMPLIANCE: ☐ 1. Determination that the patient has a terminal disease. ☐ 2. Determination that patient is a resident of California. ☐ 3. Determination that patient has the capacity to make medical decisions** ☐ 4. Determination that patient is acting voluntarily. ☐ 5. Determination of capacity by mental health specialist, if necessary. ☐ 6. Determination that patient has made his/her decision after being fully informed of: ☐ a) His or her medical diagnosis; and ☐ b) His or her prognosis; and ☐ c) The potential risks associated with ingesting the requested aid-in-dying drug; ☐ d) The probable result of ingesting the aid-in-dying drug; ☐ e) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

E	ADDITIONAL COMPLIANCE REQUIREMENTS

☐ 1. Counseled patient about the importance of all of the following:

☐ a) Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it;

☐ b) Having another person present when he or she ingests the aid-in-dying drug;

☐ c) Not ingesting the aid-in-dying drug in a public place;

☐ d) Notifying the next of kin of his or her request for an aid-in-dying drug. (an individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason); and

☐ e) Participating in a hospice program or palliative care program.

☐ 2. Informed patient of right to rescind request (1st time)

☐ 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.

☐ 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion

☐ 5. First oral request for aid-in-dying: _____/_____/_____ Attending physician initials:_____

☐ 6. Second oral request for aid-in-dying:_____/_____/_____ Attending physician initials:_____

☐ 7. Written request submitted: _____/_____/_____ Attending physician initials:_____

☐ 8. Offered patient right to rescind (2nd time)

F	PATIENT'S MENTAL STATUS

Check one of the following **(required)**:

☐ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

☐ I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder

Mental health specialist's information, if applicable:

MENTAL HEALTH SPECIALIST NAME
MENTAL HEALTH SPECIALIST TITLE & LICENSE NUMBER
MENTAL HEALTH SPECIALIST ADDRESS (STREET, CITY, ZIP CODE)

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

G	MEDICATION PRESCRIBED	
	PHARMACIST NAME	TELEPHONE NUMBER ( ) —

1. Aid-in-dying medication prescribed:
   - ☐ a. Name:_____
   - ☐ b. Dosage:_____
2. Antiemetic medication prescribed:
   - ☐ a. Name:_____
   - ☐ b. Dosage:_____
3. Method prescription was delivered:
   - ☐ a. In person
   - ☐ b. By mail
   - ☐ c. Electronically
4. Date medication was prescribed:_____/_____/_____

		PHYSICIAN'S SIGNATURE	DATE
	X	NAME (PLEASE PRINT)	

** "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make

****"Mental Health Specialist" means a psychiatrist or a licensed psychologist.

CONSULTING PHYSICIAN COMPLIANCE FORM

A PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

B ATTENDING PHYSICIAN

ATTENDING PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER ( ) . —

C CONSULTING PHYSICIAN'S REPORT

1. TERMINAL DISEASE	DATE OF EXAMINATION(S)

2. Check boxes for compliance. *(Both the attending and consulting physicians must make these determinations.)*

- ☐ 1. Determination that the patient has a terminal disease.
- ☐ 2. Determination that patient has the mental capacity to make medical decisions.**
- ☐ 3. Determination that patient is acting voluntarily.
- ☐ 4. Determination that patient has made his/her decision after being fully informed of:
- ☐ a) His or her medical diagnosis; and
- ☐ b) His or her prognosis; and
- ☐ c) The potential risks associated with taking the drug to be prescribed; and
- ☐ d) The potential result of taking the drug to be prescribed; and
- ☐ e) The feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.

D PATIENT'S MENTAL STATUS

Check one of the following **(required)**:

- ☐ I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.
- ☐ If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder

MENTAL HEALTH SPECIALIST'S NAME	TELEPHONE NUMBER ( ) —	DATE

E CONSULTANT'S INFORMATION

X	PHYSICIAN'S SIGNATURE	DATE
	NAME (PLEASE PRINT)	
	MAILING ADDRESS	
	CITY, STATE AND ZIP CODE	TELEPHONE NUMBER ( ) —

** "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make

****"Mental Health Specialist" means a psychiatrist or a licensed psychologist.

ATTENDING PHYSICIAN FOLLOW-UP FORM

The End of Life Option Act requires physicians who write a prescription for an aid-in-dying drug to complete this follow-up form within **30 calendar days** of a patient's death, whether from ingestion of the aid-in-dying drug obtained under the Act or from any other cause.

For the State Department of Public Health to accept this form, it must be signed by the attending physician, whether or not he or she was present at the patient's time of death.

This form should be mailed or sent electronically to the State Department of Public Health. All information is kept strictly confidential.

Date: _____/_____/_____

Patient name: _____

Attending physician name: _____

Did the patient die from ingesting the aid-in-dying drug, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink?

- ☐ **Aid-in-dying drug** (lethal dose) → Please sign below and go to page 2.
  Attending physician signature:_____
- ☐ **Underlying illness** → There is no need to complete the rest of the form. Please sign below.
  Attending physician signature:_____
- ☐ **Other** → There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death and sign
  Please specify:
  _____
  _____

Attending physician signature:_____

PART A and PART B should only be completed if the patient died from ingesting the lethal dose of the aid-in-dying drug.

Please read carefully the following to determine which situation applies. Check the box that indicates the scenario and complete the remainder of the form accordingly.

- ☐ The attending physician was present at the time of death.

→ The attending physician must complete this form in its entirety and sign Part A and Part B.

- ☐ The attending physician was not present at the time of death, but another licensed health care provider was present.

→ The licensed health care provider must complete and sign Part A of this form. The attending physician must complete and sign Part B of the form.

- ☐ Neither the attending physician nor another licensed health care provider was present at the time of death.

→ Part A may be left blank. The attending physician must complete and sign Part B of the form.

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART A: To be completed and signed by the attending physician or another licensed health care provider present at death:

1. Was the attending physician at the patient's bedside when the patient took the aid-in-dying drug?
   - ☐ Yes
   - ☐ No

If no: Was another physician or trained health care provider present when the patient ingested the aid-in-dying drug?
   - ☐ Yes, another physician
   - ☐ Yes, a trained health-care provider/volunteer
   - ☐ No
   - ☐ Unknown

2. Was the attending physician at the patient's bedside at the time of death?
   - ☐ Yes
   - ☐ No

If no: Was another physician or a licensed health care provider present at the patient's time of death?
   - ☐ Yes, another physician or licensed health care provider
   - ☐ No
   - ☐ Unknown

3. On what day did the patient consume the lethal dose of the aid-in-dying?
_____/_____/_____ (month/day/year) ☐ Unknown

4. On what day did the patient die after consuming the lethal dose of the aid-in-dying drug?
_____/_____/_____ (month/day/year) ☐ Unknown

5. Where did the patient ingest the lethal dose of the aid-in-dying drug?
   - ☐ Private home
   - ☐ Assisted-living residence
   - ☐ Nursing home
   - ☐ Acute care hospital in-patient
   - ☐ In-patient hospice resident
   - ☐ Other (specify)_____
   - ☐ Unknown

6. What was the time between the ingestion of the lethal dose of aid-in-dying drug and unconsciousness?
Minutes_____ and/or Hours_____ ☐Unknown

7. What was the time between lethal medication ingestion and death?
Minutes_____ and/or Hours_____ ☐Unknown

ATTENDING PHYSICIAN FOLLOW-UP FORM

8. Were there any complications that occurred after the patient took the lethal dose of the aid-in-dying drug?

- ☐ Yes- vomiting, emesis
- ☐ Yes-regained consciousness
- ☐ No Complications
- ☐ Other- Please describe:_____
- ☐ Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of the aid-in-dying drug?

- ☐ Yes- Please describe:_____
- ☐ No
- ☐ Unknown

10. At the time of ingesting the lethal dose of the aid-in-dying drug, was the patient receiving hospice care?

- ☐ Yes
- ☐ No, refused care
- ☐ No, other (specify) _____

Signature of attending physician present at time of death: _____

Name of Licensed Health Care Provider present at time of death if not attending physician:_____

Signature of Licensed Health Care Provider: _____

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART B: To be completed and signed by the attending physician

12. On what date was the prescription written for the aid-in-dying drug? ____/____/____

13. When the patient initially requested a prescription for the aid-in-dying drug, was the patient receiving hospice care?

- ☐ Yes
- ☐ No, refused care
- ☐ No, other (specify) _____

14. What type of health-care coverage did the patient have for their underlying illness? (*Check all that apply.*)

- ☐ Medicare
- ☐ Medi-cal
- ☐ Covered California
- ☐ V.A.
- ☐ Private Insurance
- ☐ No insurance
- ☐ Had insurance, don't know type

15. Possible concerns that may have contributed to the patient's decision to request a prescription for aid-in-dying drug Please check "yes," "no," or "Don't' know," depending on whether or not you believe that concern contributed to their request (Please check as many boxes as you think may apply)

A concern about . . .

- **His or her terminal condition representing a steady loss of autonomy**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **The decreasing ability to participate in activities that made life enjoyable**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **The loss of control of bodily functions**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **Persistent and uncontrollable pain and suffering**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **A loss of Dignity**
  - ☐ Yes
  - ☐ No
  - ☐ Don't Know
- **Other concerns** (specify): _____

Signature of attending physician: _____

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Section 443.19 to the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

(a) Any limitation to public access to personally identifiable patient data collected pursuant to Section 443.19 of the Health and Safety Code as proposed to be added by this act is necessary to protect the privacy rights of the patient and his or her family.

(b) The interests in protecting the privacy rights of the patient and his or her family in this situation strongly outweigh the public interest in having access to personally identifiable data relating to services.

(c) The statistical report to be made available to the public pursuant to subdivision (b) of Section 443.19 of the Health and Safety Code is sufficient to satisfy the public's right to access.

SEC. 3. The provisions of this part are severable. If any provision of this part or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

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

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: ACR 29
Author: Frazier
Chapter: Resolution Chapter 42
Bill Date: April 20, 2015, Amended
Subject: Donate Life California Day: Driver's License
Sponsor: Donate Life California
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This resolution would make findings and declarations regarding the importance of organ donation. This resolution would proclaim April 20, 2015, as Department of Motor Vehicles (DMV)/Donate Life California Day and the month of April 2015 as DMV/Donate Life California Month in California. This resolution would encourage all Californians to register with the Donate Life California Registry when applying for or renewing a driver's license or identification card.

ANALYSIS:

This resolution makes the following findings and declarations:

- Organ, tissue, eye, and blood donation are compassionate and life-giving acts looked upon and recognized in the highest regard. A single individual's donation of heart, lungs, liver, kidneys, pancreas, and small intestine can save up to eight lives, the donation of tissue can save and enhance lives of up to 50 others, and a single blood donation can help save three people in need.
- There are currently more than 123,000 individuals nationwide and over 22,000 Californians currently on the national organ transplant wait list. While about one-third of these patients receive a transplant each year, another one-third die while waiting due to a shortage of donated organs.
- A California resident can register with the Donate Life California Registry when applying for or renewing his or her driver's license or identification card at the DMV, which is on its tenth year as the official partner of Donate Life California.
- Nearly 12 million Californians have joined together to save lives by signing up with the state-authorized Donate Life California Organ and Tissue Donor Registry to ensure their wishes of donating their organs are recognized and honored.
- Minorities are more likely to need a life-saving transplant due to higher incidences of hypertension, diabetes, and hepatitis, which are conditions that can potentially lead to organ failure. In California, Latinos make up 39% of those waiting for life-saving transplants, Pacific Islanders make up 20%, and African Americans another 12%.

This resolution proclaims April 20, 2015, as DMV/Donate Life California Day and April 2015 as DMV/Donate Life California Month in California. This resolution

encourages all Californian to register with the Donate Life California Registry when applying for or renewing a driver's license or identification card.

The Medical Board of California (Board) voted to be the honorary state sponsor of Donate Life California's specialized license plate in 2013, because the license plate helped to increase awareness and raise money for organ and tissue donation, education and outreach. The Board has also supported similar resolutions in the past for the same reasons. This resolution will also help to raise awareness by proclaiming April 20, 2015 as DMV/Donate Life California Day and April 2015 as DMV/Donate Life California Month. For this reason, the Board voted to support this resolution.

FISCAL: None

SUPPORT: Donate Life California (Sponsor)
Medical Board of California

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter Article(s)

Assembly Concurrent Resolution No. 29

RESOLUTION CHAPTER 42

Assembly Concurrent Resolution No. 29—Relative to organ donation.

[Filed with Secretary of State May 26, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

ACR 29, Frazier. Donate Life California Day: driver's license.

This measure would designate April 20, 2015, as DMV/Donate Life California Day in the State of California and the month of April 2015, as DMV/Donate Life California Month in the State of California, and would encourage all Californians to sign up with the Donate Life California Organ and Tissue Donor Registry.

WHEREAS, Organ, tissue, eye, and blood donation are compassionate and life-giving acts looked upon and recognized in the highest regard; and

WHEREAS, More than 123,000 individuals nationwide and over 22,000 Californians are currently on the national organ transplant wait list. While about one-third of these patients receive a transplant each year, another one-third die while waiting due to a shortage of donated organs; and

WHEREAS, A single individual's donation of heart, lungs, liver, kidneys, pancreas, and small intestine can save up to eight lives, the donation of tissue can save and enhance the lives of up to 50 others, and a single blood donation can help three people in need; and

WHEREAS, Millions of lives each year are saved and enhanced by donors of organs, tissue, eyes, and blood; and

WHEREAS, The California Department of Motor Vehicles is celebrating 100 years of service to the State of California and ten years as the official partner of Donate Life California; and

WHEREAS, A California resident can register with the Donate Life California Registry when applying for or renewing his or her driver's license or identification card at the Department of Motor Vehicles; and

WHEREAS, Nearly twelve million Californians have joined together to save lives by signing up with the state-authorized Donate Life California Organ and Tissue Donor Registry to ensure that their wishes to be an organ, eye, and tissue donor are recognized and honored; and

WHEREAS, Minorities are more likely to need a life-saving transplant due to higher incidences of hypertension, diabetes, and hepatitis, conditions that can potentially lead to organ failure and placement on the national organ transplant waiting list; and

WHEREAS, Nationwide, minorities make up 58 percent of organ transplant candidates and 64 percent of those awaiting kidney transplants. In California, Latinos make up 39 percent of those waiting for life-saving

transplants, Asians and Pacific Islanders 20 percent, and African Americans another 12 percent; and

WHEREAS, Minorities make up more than one-half of the population of high school students in California, according to the State Department of Education. These high school students will have the opportunity to make a decision about saving lives and joining the state-authorized Donate Life California Registry to ensure that their wishes to be organ, eye, and tissue donors are recognized and honored; and

WHEREAS, Donate Life California has developed a comprehensive Educator Resource Guide that includes many of the health education content standards for California public schools. This Educator Resource Guide includes lesson plans and educational DVDs about organ, eye, and tissue donation, and the Donate Life California Registry created specifically for the youth population; now, therefore, be it

Resolved by the Assembly of the State of California, the Senate thereof concurring, That in recognition of April as National Donate Life Month, the Legislature proclaims April 20, 2015, as DMV/Donate Life California Day in the State of California, and April 2015 as DMV/Donate Life California Month in the State of California. In doing so, the Legislature encourages all Californians to check "YES" when applying for or renewing a driver's license or identification card, or by signing up at www.donatelifecalifornia.org or www.donevidacalifornia.org; and be it further

Resolved, that the Chief Clerk of the Assembly transmit copies of this resolution to the author for appropriate distribution.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 19
Author: Wolk
Chapter: 504
Bill Date: September 4, 2015, Amended
Subject: Physician Orders for Life Sustaining Treatment Form: Electronic Registry Pilot
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the California Physician Orders for Life Sustaining Treatment (POLST) eRegistry Pilot.

BACKGROUND

In the early 1990s, Congress passed the federal Patient Self-Determination Act and the POLST program was developed to address challenges related to advance care planning, most commonly used for frail and elderly patients. In 2008, AB 3000 (Wolk) created the California POLST, a standardized form that helps to ensure patients' wishes are honored regarding medical treatment towards the end of life. The POLST form is not an advance directive, it compliments an advance directive by identifying the patient's treatment preferences. Currently, the POLST form is a paper document.

ANALYSIS

This bill would enact the California POLST eRegistry Pilot Act. This bill was significantly amended since the Medical Board of California (Board) took a support in concept position on this bill. This bill was amended to make the POLST Registry a pilot project. This bill would require the Emergency Medical Services Authority (EMSA) to establish a pilot project, in consultation with stakeholders, to operate an electronic registry system on a pilot basis, for the purpose of collecting a patient's POLST information received from a physician or physician's designee and disseminating the information to an authorized user. This bill would define an authorized user as a person authorized by EMSA to submit information to, or receive information from, the POLST eRegistry Pilot, including health care providers and their designees. This bill would only allow EMSA to implement this bill if it determines that sufficient non-state funds are available to allow for the development of the POLST eRegistry Pilot, any related startup costs, and an evaluation of the POLST eRegistry Pilot.

This bill requires EMSA to coordinate the pilot, which could be operated by, and as part of, health exchange networks, or by an independent contractor, or a combination of both. This bill permits the pilot to operate in a single geographic area or multiple geographic areas

and may test various methods of making POLST information available electronically. This bill requires EMSA to adopt guidelines necessary for the pilot, as specified. EMSA must seek input from interested parties before adopting the guidelines. The guidelines must include the means to submit initial or subsequent POLST information, or withdraw POLST information, and must include a method for electronic delivery and the use of legally sufficient electronic signatures. The pilot must comply with state and federal privacy and security laws and regulations. This bill requires EMSA to submit a detailed plan to the Legislature that explains how the pilot will operate.

This bill provides protections for health care providers who honor a patient's request regarding resuscitative measures obtained from the POLST eRegistry and states that providers are not subject to criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the health care provider believes in good faith that the action or decision is consistent with the patient's health care decisions included in their POSLT form.

This bill requires an independent contractor approved by EMSA to perform an evaluation of the POLST eRegistry Pilot. This bill would sunset on January 1, 2020.

According to the author's office, the POLST form is currently a paper document and a key barrier to the effectiveness of the POLST is inaccessibility of the document, which is intended to guide care. The idea of making the POLST form available electronically is a good one, but many of the specific details on how this will happen are not included in this bill and it is contingent on receiving non-state funding. The Board does not have a position on the amended version of this bill.

FISCAL: None to the Board

SUPPORT: Coalition for Compassionate Care of California (Sponsor); AARP; Arc and United Cerebral Palsy California Collaboration; Alliance of Catholic Health Care: Blue Shield of California; California Accountable Physician Groups; California Assisted Living Association; California Association of Physician Groups; California American College of Emergency Physicians; California Commission on Aging; California Hospital Association; Care Like a Daughter, LLC; Long Term Ombudsman Services of San Luis Obispo County; Mission Hospital, Laguna Beach; Mission Hospital, Mission Viejo; Petaluma Valley Hospital; Providence Health and Services Southern California; Queen of the Valley Medical Center, Napa; Redwood Memorial Hospital, Fortuna; Riverside Family Physicians; Santa Rosa Memorial; St. Mary Medical Center, Apple Valley; St. Joseph Hospital, Orange; St. Jude Medical Center, Fullerton; and Vynca

OPPOSITION: California Advocates for Nursing Home Reform
California Right to Life Committee

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff

Senate Bill No. 19

CHAPTER 504

An act to add and repeal Section 4788 of the Probate Code, relating to resuscitative measures.

[Approved by Governor October 5, 2015. Filed with Secretary of State October 5, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 19, Wolk. Physician Orders for Life Sustaining Treatment form: electronic registry pilot.

Existing law defines a request regarding resuscitative measures as a written document, signed by an individual with capacity, or a legally recognized health care decisionmaker, and the individual's physician, directing a health care provider regarding resuscitative measures. Existing law defines a Physician Orders for Life Sustaining Treatment form, which is commonly referred to as a POLST form, and provides that a request regarding resuscitative measures includes a POLST form. Existing law requires that a POLST form and the medical intervention and procedures offered by the form be explained by a health care provider. Existing law distinguishes a request regarding resuscitative measures from an advance health care directive.

This bill would enact the California POLST eRegistry Pilot Act. The bill would require the Emergency Medical Services Authority to establish a pilot project, in consultation with stakeholders, to operate an electronic registry system on a pilot basis, to be known as the California POLST eRegistry Pilot, for the purpose of collecting POLST information received from a physician or physician's designee. The bill would require the authority to coordinate the POLST eRegistry Pilot, which would be operated by health information exchange networks, by an independent contractor, or by a combination thereof. The bill would require the authority to implement these provisions only after it determines that sufficient nonstate funds are available for development of the POLST eRegistry Pilot, any related startup costs, and an evaluation of the POLST eRegistry Pilot. When the POLST eRegistry Pilot is operable in the geographic area in which he or she operates or practices, a physician or physician's designee who completes POLST information would be required to include the POLST information in the patient's official medical record and would be required to submit a copy of the form to, or to enter the information into, the POLST eRegistry Pilot, unless a patient or his or her health care decisionmaker chooses not to participate in the POLST eRegistry Pilot. The bill would require the authority to adopt guidelines for, among other things, the operation of the POLST eRegistry Pilot, including the means by which POLST information would

be submitted electronically, modified, or withdrawn, the appropriate and timely methods for dissemination of POLST form information, the procedures for verifying the identity of an authorized user, and rules for maintaining the confidentiality of POLST information received by the POLST eRegistry Pilot. The bill would require that any disclosure of POLST information in the POLST eRegistry Pilot be made in accordance with applicable state and federal privacy and security laws and regulations. The bill would provide immunity from criminal prosecution, civil liability, discipline for unprofessional conduct, and any other sanction for a health care provider who honors a patient's request regarding resuscitative measures obtained from the POLST eRegistry Pilot, as specified. The bill would require an independent contractor approved by the authority to conduct an evaluation of the POLST eRegistry Pilot. The provisions of the bill would be operative until January 1, 2020.

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

SECTION 1. This act shall be known, and may be cited, as the California POLST eRegistry Pilot Act.

SEC. 2. Section 4788 is added to the Probate Code, to read:

4788. (a) For purposes of this section:

(1) "Authority" means the Emergency Medical Services Authority.

(2) "Authorized user" means a person authorized by the authority to submit information to, or to receive information from, the POLST eRegistry Pilot, including health care providers, as defined in Section 4781, and their designees.

(3) "POLST" means a Physician Orders for Life Sustaining Treatment that fulfills the requirements, in any format, of Section 4780.

(4) "POLST eRegistry Pilot" means the California POLST eRegistry Pilot Act established pursuant to this section to make electronic, in addition to other modes of submission and transmission, POLST information available to authorized users.

(b) (1) The authority shall establish a pilot project, in consultation with stakeholders, to operate an electronic registry system on a pilot basis, to be known as the California POLST eRegistry Pilot, for the purpose of collecting a patient's POLST information received from a physician or physician's designee and disseminating the information to an authorized user.

(2) The authority shall implement this section only after determining that sufficient nonstate funds are available to allow for the development of the POLST eRegistry Pilot, any related startup costs, and an evaluation of the POLST eRegistry Pilot.

(3) The authority shall coordinate the POLST eRegistry Pilot, which shall be operated by, and as a part of, the health information exchange networks, or by an independent contractor, or by a combination thereof. The POLST eRegistry Pilot may operate in a single geographic area or multiple geographic areas and may test various methods of making POLST

information available electronically. The design of the POLST eRegistry Pilot shall be sufficiently robust, based on the success of the pilot, to inform the permanent, statewide operation of a POLST eRegistry.

(4) The authority shall adopt guidelines necessary for the operation of the POLST eRegistry Pilot. In developing these guidelines, the authority shall seek input from interested parties and hold at least one public meeting. The adoption, amendment, or repeal of the guidelines authorized by this paragraph is hereby exempted from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The guidelines shall include, but not be limited to, the following:

(A) The means by which initial or subsequent POLST information may be submitted to, or withdrawn from, the POLST eRegistry Pilot, which shall include a method for electronic delivery of this information and the use of legally sufficient electronic signatures.

(B) Appropriate and timely methods by which the information in the POLST eRegistry Pilot may be disseminated to an authorized user.

(C) Procedures for verifying the identity of an authorized user.

(D) Procedures to ensure the accuracy of, and to appropriately protect the confidentiality of, POLST information submitted to the POLST eRegistry Pilot.

(E) The requirement that a patient, or, when appropriate, his or her legally recognized health care decisionmaker, receive a confirmation or a receipt that the patient's POLST information has been received by the POLST eRegistry Pilot.

(F) The ability of a patient, or, when appropriate, his or her legally recognized health care decisionmaker, with his or her health care provider, as defined in Section 4621, to modify or withdraw POLST information on the POLST eRegistry Pilot.

(6) (A) Prior to implementation of the POLST eRegistry Pilot, the authority shall submit a detailed plan to the Legislature that explains how the POLST eRegistry Pilot will operate.

(B) The plan to be submitted pursuant to subparagraph (A) shall be submitted in compliance with Section 9795 of the Government Code.

(c) The operation of the POLST eRegistry Pilot, for all users, shall comply with state and federal privacy and security laws and regulations, including, but not limited to, compliance with the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) and the regulations promulgated pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), found at Parts 160 and 164 of Title 45 of the Code of Federal Regulations.

(d) When the POLST eRegistry Pilot is operable in the geographic area in which he or she practices or operates, a physician or physician's designee who completes POLST information with a patient or his or her legally recognized health care decisionmaker shall include the POLST information in the patient's official medical record and shall submit a copy of the POLST

form to, or enter the POLST information into, the POLST eRegistry Pilot, unless the patient or the legally recognized health care decisionmaker chooses not to participate in the POLST eRegistry Pilot.

(e) When the POLST eRegistry Pilot is operable in the geographic area in which they practice or operate, physicians, hospitals, and health information exchange networks shall make electronic POLST information available, for use during emergencies, through the POLST eRegistry Pilot to health care providers, as defined in Section 4781, that also practice or operate in a geographic area where the POLST eRegistry Pilot is operable, but that are outside of their health information exchange networks.

(f) In accordance with Section 4782, a health care provider, as defined in Section 4781, who honors a patient's request regarding resuscitative measures obtained from the POLST eRegistry Pilot shall not be subject to criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the health care provider (1) believes in good faith that the action or decision is consistent with this part, and (2) has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances.

(g) An independent contractor approved by the authority shall perform an evaluation of the POLST eRegistry Pilot.

(h) This section shall remain in effect only until January 1, 2020, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2020, deletes or extends that date.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 277
Author: Pan
Chapter: 35
Bill Date: June 18, 2015, Amended
Subject: Pupil Health: Vaccinations
Sponsor: Vaccinate California
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill eliminates the personal belief exemption from the requirement that children receive specified vaccines for certain infectious diseases prior to being admitted to any private or public elementary or secondary school, or day care center.

BACKGROUND

According to the authors, in early 2015, California became the epicenter of a measles outbreak that was the result of unvaccinated individuals infecting vulnerable individuals, including children who are unable to receive vaccinations due to health conditions or age requirements. According to the Centers for Disease Control and Prevention, there were more cases of measles in January 2015 in the United States than in any one month in the past 20 years. Measles has spread through California and the United States, in large part, because of communities with large numbers of unvaccinated people. Between 2000 and 2012, the number of Personal Belief Exemptions (PBE) from vaccinations required for school entry that were filed rose by 337%. In 2000, the PBE rate for Kindergartners entering California schools was under 1%. However, as of 2012, that number rose to 2.6%. From 2012 to 2014, the number of children entering Kindergarten without receiving some or all of their required vaccinations due to their parent's personal beliefs increased to 3.15%. In certain pockets of California, exemption rates are as high as 21% which places California communities at risk for preventable diseases. Given the highly contagious nature of diseases such as measles, vaccination rates of up to 95% are necessary to preserve herd immunity and prevent future outbreaks.

According to the United States Department of Health and Human Services, when a critical portion of a community is immunized against a contagious disease, most members of the community are protected against that disease because there is little opportunity for an outbreak. Even those who are not eligible for certain vaccines, such as infants, pregnant women, or immunocompromised individuals, get some protection because the spread of contagious disease is contained. This is known as community immunity.

Existing law provides that each child between the ages of 6 and 18 years is subject to compulsory full-time education, and requires attendance at the public full-time day school or continuation school or classes for the full school day. Existing law requires parents and guardians to send the student to school for the full school day. Currently, the admission of a student to any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center is prohibited, unless, prior to the child's first admission to that institution, the child has been fully immunized. Immunizations are currently required for Diphtheria, Haemophilus influenzae type b, Measles, Mumps, Pertussis (whooping cough), Poliomyelitis, Rubella, Tetanus, Hepatitis B, Varicella (chickenpox), and any other disease deemed appropriate by the California Department of Public Health (CDPH), taking into consideration the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians.

Existing law provides that immunization is not required for admission to a school or other institution if the parent or guardian files with the school a letter or affidavit that documents which immunizations have been given and which immunizations have not been given on the basis that they are contrary to his or her beliefs (personal belief exemption). The personal belief exemption letter or affidavit must be accompanied by a form prescribed by CDPH that must include specified information, including a signed attestation from the health care practitioner that indicates that the health care practitioner provided the parent or guardian with information regarding the benefits and risks of the immunization and the health risks of the communicable diseases to the child and the community, and a written statement signed by the parent or guardian that indicates that the signer has received the information provided by the health care practitioner.

Existing law also provides that a child is exempt from immunization requirements if the parent or guardian files with the school or other institution a written statement by a licensed physician to the effect that the physical condition of the child is such, or medical circumstances relating to the child are such, that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization (medical exemption).

ANALYSIS

This bill deletes the personal belief exemption from the existing immunization requirements. This bill specifies that if CDPH adds an immunization to the list in the future, that personal belief exemptions would be allowed for that additional immunization. This bill exempts a child in a home-based private school or a pupil who is enrolled in independent study from the immunization requirements. This bill allows a child who has submitted a personal belief exemption prior to January 1, 2016 to continue to attend school or daycare under the personal belief exemption until enrollment in the next grade span. This bill defines grade span as birth to preschool, kindergarten to grade 6, or grades 7 to 12. Lastly, this bill specifies that

when issuing a medical exemption a physician must consider the family medical history of the child.

Vaccines have been scientifically proven to be effective in preventing illnesses. Ensuring that children receive the ACIP recommended vaccination schedule is the standard of care, unless there is a medical reason that the child should not receive the vaccine; this bill would still allow for a medical exemption to address these circumstances. For these reasons, the Medical Board of California (Board) took a support position on this bill.

FISCAL: None to the Board

SUPPORT: Vaccinate California (Sponsor); Insurance Commissioner Dave Jones; AIDS Healthcare Foundation; American Academy of Pediatrics; American Federation of State, County and Municipal Employees; American Lung Association; American Nurses Association; Association of Northern California Oncologists; California Academy of Family Physicians; California Academy of Physician Assistants; California Association of Nurse Practitioners; California Association of Physician Groups; California Chapter of the American College of Emergency Physicians; California Children's Hospital Association; California Coverage & Health Initiatives; California Hepatitis Alliance; California Hospital Association; California Immunization Coalition; California Medical Association; California Optometric Association; California Pharmacists Association; California Primary Care Association; California Public Health Association – North; California School Boards Association; California School Employees Association; California School Nurses Organization; California State Association of Counties; California State Parent-Teacher Association; Carlsbad High School Parent-Teacher-Student Association; Child Care Law Center; Children Now; Children's Defense Fund-California; Children's Healthcare Is a Legal Duty, Inc.: Children's Hospital Oakland; Children's Specialty Care Coalition; City of Berkeley; City of Beverly Hills; City of Pasadena; County Health Executives Association of California; County of Alameda; County of Los Angeles; County of Marin; County of Santa Clara; County of Santa Cruz; County of Santa Cruz Democratic Party; County of Yolo; Democratic Women's Club of Santa Cruz County; First 5 California; Foundation for Pediatric Health; Health Officers Association of California; Junior Leagues of California; Kaiser Permanente; Los Angeles Community College District; Los Angeles County Supervisor Sheila Kuehl; Los Angeles Unified School District; March of Dimes California Chapter; Medical Board of California; Memorial Care Health System Physician Society; National Coalition of 100 Black Women Sacramento Chapter; Osteopathic Physicians and Surgeons of California; Project Inform; Providence Health and Services

Southern California; San Diego Union High School District; San Francisco Unified School District; Santa Monica Malibu Union Unified School District; Secular Coalition for California; Silicon Valley Leadership Group; Solano Beach School District; The Children's Partnership; UAW Local 5810, Postdoctoral Researchers at the University of California; and hundreds of individuals

OPPOSITION: AWAKE California; Association of American Physicians and Surgeons; California Chiropractic Association; California Naturopathic Doctors Association; California Nurses for Ethical Standards; California Prolife Council; California Right to Life Committee, Inc.; Canary Party; Capitol Resource Institute; Educate. Advocate.; Families for Early Autism Treatment; Homeschool Association of California; National Vaccine Information Center; Pacific Justice Institute Center for Public Policy; ParentalRights.Org; Safe Minds; and hundreds of individuals

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section
- Update website to include information on new vaccine requirements and medical exemptions, including what a physician should consider before issuing a medical exemption (this is a possible enforcement issue)
- Update citation and fine regulations to include improper medical exemptions or non-compliance with the provisions of this bill

Senate Bill No. 277

CHAPTER 35

An act to amend Sections 120325, 120335, 120370, and 120375 of, to add Section 120338 to, and to repeal Section 120365 of, the Health and Safety Code, relating to public health.

[Approved by Governor June 30, 2015. Filed with Secretary of State June 30, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 277, Pan. Public health: vaccinations.

Existing law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, unless prior to his or her admission to that institution he or she has been fully immunized against various diseases, including measles, mumps, and pertussis, subject to any specific age criteria. Existing law authorizes an exemption from those provisions for medical reasons or because of personal beliefs, if specified forms are submitted to the governing authority. Existing law requires the governing authority of a school or other institution to require documentary proof of each entrant's immunization status. Existing law authorizes the governing authority of a school or other institution to temporarily exclude a child from the school or institution if the authority has good cause to believe that the child has been exposed to one of those diseases, as specified.

This bill would eliminate the exemption from existing specified immunization requirements based upon personal beliefs, but would allow exemption from future immunization requirements deemed appropriate by the State Department of Public Health for either medical reasons or personal beliefs. The bill would exempt pupils in a home-based private school and students enrolled in an independent study program and who do not receive classroom-based instruction, pursuant to specified law from the prohibition described above. The bill would allow pupils who, prior to January 1, 2016, have a letter or affidavit on file at a private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center stating beliefs opposed to immunization, to be enrolled in any private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center within the state until the pupil enrolls in the next grade span, as defined. Except as under the circumstances described above, on and after July 1, 2016, the bill would prohibit a governing authority from unconditionally admitting to any of those institutions for the first time or

admitting or advancing any pupil to the 7th grade level, unless the pupil has been immunized as required by the bill. The bill would specify that its provisions do not prohibit a pupil who qualifies for an individualized education program, pursuant to specified laws, from accessing any special education and related services required by his or her individualized education program. The bill would narrow the authorization for temporary exclusion from a school or other institution to make it applicable only to a child who has been exposed to a specified disease and whose documentary proof of immunization status does not show proof of immunization against one of the diseases described above. The bill would make conforming changes to related provisions.

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

SECTION 1. Section 120325 of the Health and Safety Code is amended to read:

120325. In enacting this chapter, but excluding Section 120380, and in enacting Sections 120400, 120405, 120410, and 120415, it is the intent of the Legislature to provide:

(a) A means for the eventual achievement of total immunization of appropriate age groups against the following childhood diseases:

(1) Diphtheria.

(2) Hepatitis B.

(3) Haemophilus influenzae type b.

(4) Measles.

(5) Mumps.

(6) Pertussis (whooping cough).

(7) Poliomyelitis.

(8) Rubella.

(9) Tetanus.

(10) Varicella (chickenpox).

(11) Any other disease deemed appropriate by the department, taking into consideration the recommendations of the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians.

(b) That the persons required to be immunized be allowed to obtain immunizations from whatever medical source they so desire, subject only to the condition that the immunization be performed in accordance with the regulations of the department and that a record of the immunization is made in accordance with the regulations.

(c) Exemptions from immunization for medical reasons.

(d) For the keeping of adequate records of immunization so that health departments, schools, and other institutions, parents or guardians, and the persons immunized will be able to ascertain that a child is fully or only partially immunized, and so that appropriate public agencies will be able

to ascertain the immunization needs of groups of children in schools or other institutions.

(e) Incentives to public health authorities to design innovative and creative programs that will promote and achieve full and timely immunization of children.

SEC. 2. Section 120335 of the Health and Safety Code is amended to read:

120335. (a) As used in this chapter, "governing authority" means the governing board of each school district or the authority of each other private or public institution responsible for the operation and control of the institution or the principal or administrator of each school or institution.

(b) The governing authority shall not unconditionally admit any person as a pupil of any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, unless, prior to his or her first admission to that institution, he or she has been fully immunized. The following are the diseases for which immunizations shall be documented:

(1) Diphtheria.
(2) Haemophilus influenzae type b.
(3) Measles.
(4) Mumps.
(5) Pertussis (whooping cough).
(6) Poliomyelitis.
(7) Rubella.
(8) Tetanus.
(9) Hepatitis B.
(10) Varicella (chickenpox).
(11) Any other disease deemed appropriate by the department, taking into consideration the recommendations of the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians.

(c) Notwithstanding subdivision (b), full immunization against hepatitis B shall not be a condition by which the governing authority shall admit or advance any pupil to the 7th grade level of any private or public elementary or secondary school.

(d) The governing authority shall not unconditionally admit or advance any pupil to the 7th grade level of any private or public elementary or secondary school unless the pupil has been fully immunized against pertussis, including all pertussis boosters appropriate for the pupil's age.

(e) The department may specify the immunizing agents that may be utilized and the manner in which immunizations are administered.

(f) This section does not apply to a pupil in a home-based private school or a pupil who is enrolled in an independent study program pursuant to Article 5.5 (commencing with Section 51745) of Chapter 5 of Part 28 of the Education Code and does not receive classroom-based instruction.

(g) (1) A pupil who, prior to January 1, 2016, submitted a letter or affidavit on file at a private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center stating beliefs opposed to immunization shall be allowed enrollment to any private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center within the state until the pupil enrolls in the next grade span.

(2) For purposes of this subdivision, "grade span" means each of the following:

(A) Birth to preschool.

(B) Kindergarten and grades 1 to 6, inclusive, including transitional kindergarten.

(C) Grades 7 to 12, inclusive.

(3) Except as provided in this subdivision, on and after July 1, 2016, the governing authority shall not unconditionally admit to any of those institutions specified in this subdivision for the first time, or admit or advance any pupil to 7th grade level, unless the pupil has been immunized for his or her age as required by this section.

(h) This section does not prohibit a pupil who qualifies for an individualized education program, pursuant to federal law and Section 56026 of the Education Code, from accessing any special education and related services required by his or her individualized education program.

SEC. 3. Section 120338 is added to the Health and Safety Code, to read:

120338. Notwithstanding Sections 120325 and 120335, any immunizations deemed appropriate by the department pursuant to paragraph (11) of subdivision (a) of Section 120325 or paragraph (11) of subdivision (b) of Section 120335, may be mandated before a pupil's first admission to any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, only if exemptions are allowed for both medical reasons and personal beliefs.

SEC. 4. Section 120365 of the Health and Safety Code is repealed.

SEC. 5. Section 120370 of the Health and Safety Code is amended to read:

120370. (a) If the parent or guardian files with the governing authority a written statement by a licensed physician to the effect that the physical condition of the child is such, or medical circumstances relating to the child are such, that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances, including, but not limited to, family medical history, for which the physician does not recommend immunization, that child shall be exempt from the requirements of Chapter 1 (commencing with Section 120325, but excluding Section 120380) and Sections 120400, 120405, 120410, and 120415 to the extent indicated by the physician's statement.

(b) If there is good cause to believe that a child has been exposed to a disease listed in subdivision (b) of Section 120335 and his or her documentary proof of immunization status does not show proof of

immunization against that disease, that child may be temporarily excluded from the school or institution until the local health officer is satisfied that the child is no longer at risk of developing or transmitting the disease.

SEC. 6. Section 120375 of the Health and Safety Code is amended to read:

120375. (a) The governing authority of each school or institution included in Section 120335 shall require documentary proof of each entrant's immunization status. The governing authority shall record the immunizations of each new entrant in the entrant's permanent enrollment and scholarship record on a form provided by the department. The immunization record of each new entrant admitted conditionally shall be reviewed periodically by the governing authority to ensure that within the time periods designated by regulation of the department he or she has been fully immunized against all of the diseases listed in Section 120335, and immunizations received subsequent to entry shall be added to the pupil's immunization record.

(b) The governing authority of each school or institution included in Section 120335 shall prohibit from further attendance any pupil admitted conditionally who failed to obtain the required immunizations within the time limits allowed in the regulations of the department, unless the pupil is exempted under Section 120370, until that pupil has been fully immunized against all of the diseases listed in Section 120335.

(c) The governing authority shall file a written report on the immunization status of new entrants to the school or institution under their jurisdiction with the department and the local health department at times and on forms prescribed by the department. As provided in paragraph (4) of subdivision (a) of Section 49076 of the Education Code, the local health department shall have access to the complete health information as it relates to immunization of each student in the schools or other institutions listed in Section 120335 in order to determine immunization deficiencies.

(d) The governing authority shall cooperate with the county health officer in carrying out programs for the immunization of persons applying for admission to any school or institution under its jurisdiction. The governing board of any school district may use funds, property, and personnel of the district for that purpose. The governing authority of any school or other institution may permit any licensed physician or any qualified registered nurse as provided in Section 2727.3 of the Business and Professions Code to administer immunizing agents to any person seeking admission to any school or institution under its jurisdiction.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 337
Author: Pavley
Chapter: 536
Bill Date: September 1, 2015, Amended
Subject: Physician Assistants
Sponsor: California Academy of Physician Assistants (CAPA)
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish alternative means for a supervising physician to ensure adequate supervision of a physician assistant (PA) for routine care and the administration, provision, or issuance of a Schedule II drug.

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 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. Existing law requires the supervising physician to select for review those cases that by diagnosis, problem, treatment, or procedure represent the most significant risk to the patient.

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 requires a supervising physician to review and countersign, within seven days, the record of any patient cared for by a PA for whom the PA's Schedule II drug order has been issued or carried out.

In October 2014, hydrocodone combination products (HCPs) were re-scheduled from a Schedule III medication to a Schedule II medication, which, according to the sponsor, significantly increased administrative responsibilities related to documentation in various practice types.

According to the sponsor, this bill recognizes the need to streamline patient care performed by PAs under the supervision of physician and surgeons. The sponsor believes this bill provides greater flexibility to medical practices by offering physicians several options to ensure adequate supervision of PA medical visits.

ANALYSIS:

This bill would add an additional mechanism, in addition to the existing five percent medical record countersignature requirement, for a supervising physician to use to ensure adequate PA supervision. This bill would define a medical records review meeting as a meeting between the supervising physician and the PA during which medical records are reviewed to ensure adequate supervision of the PA. These meetings may occur in person or by electronic communication. This bill would require the supervising physician to review a sample of at least 10 medical records per month, for at least 10 months during the year, using a combination of the existing countersignature mechanism and the new medical records review mechanism.

Existing law requires all medical charts for Schedule II drug orders to be countersigned within seven days by the supervising physician. This bill would create an additional mechanism for a supervising physician to ensure adequate supervision of the administration, provision, or issuance by a PA of a Schedule II drug order. The additional mechanism is only allowed if the PA has documentation evidencing the successful completion of an education course that covers controlled substances and meets specified standards. The mechanism would require 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.

The intent of this bill is to provide flexibility and allow for a more team-based approach in PA supervision, which the Medical Board of California (Board) believes is a laudable goal. This bill has been amended to ensure that there are minimum requirements in the mechanisms allowed to ensure adequate physician supervision, and these minimum requirements will ensure consumer protection and provide for a more team-based approach. Although this bill reduces the physician review of medical records for Schedule II drug orders, the supervising physician will be responsible for choosing the 20 percent of Schedule II drug orders that get signed, and these records could potentially be discussed at medical records review meetings with the supervising physician and the PA. For these reasons, the Board took a support position on SB 337.

FISCAL: None

SUPPORT: CAPA (sponsor)
CAPG
Medical Board of California
Pacific Pain Medicine Consultants
Pacific Southwest Pain Center
Physician Assistant Board
Planned Parenthood Affiliates of California

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s)
- Update the Board's website
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section

Senate Bill No. 337

CHAPTER 536

An act to amend Sections 3501, 3502, and 3502.1 of the Business and Professions Code, relating to healing arts.

[Approved by Governor October 6, 2015. Filed with Secretary of State October 6, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 337, Pavley. Physician assistants.

Existing law, the Physician Assistant Practice Act, provides for regulation of physician assistants and authorizes a physician assistant to perform medical services as set forth by regulations when those services are rendered under the supervision of a licensed physician and surgeon, as specified. The act requires the supervising physician and surgeon to review, countersign, and date a sample consisting of, at a minimum, 5% of the medical records of patients treated by the physician assistant functioning under adopted protocols within 30 days of the date of treatment by the physician assistant. The act requires the supervising physician and surgeon to select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient. A violation of those supervision requirements is a misdemeanor.

This bill would require that the medical record for each episode of care for a patient identify the physician and surgeon who is responsible for the supervision of the physician assistant. The bill would delete those medical record review provisions, and, instead, require the supervising physician and surgeon to use one or more of described review mechanisms. By adding these new requirements, the violation of which would be a crime, this bill would impose a state-mandated local program by changing the definition of a crime.

The act authorizes a physician assistant, while under prescribed supervision of a physician and surgeon, to administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device. The act prohibits a physician assistant from administering, providing, or issuing a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets approved standards. The act requires that the medical record of any patient cared for by a physician assistant for whom a physician assistant's Schedule II drug order has been issued or carried out to be

reviewed, countersigned, and dated by a supervising physician and surgeon within 7 days.

This bill would establish an alternative medical records review mechanism, and would authorize the supervising physician and surgeon to use the alternative mechanism, or a sample review mechanism using a combination of the 2 described mechanisms, as specified, to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances.

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.

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

SECTION 1. Section 3501 of the Business and Professions Code is amended to read:

3501. (a) As used in this chapter:

(1) "Board" means the Physician Assistant Board.

(2) "Approved program" means a program for the education of physician assistants that has been formally approved by the board.

(3) "Trainee" means a person who is currently enrolled in an approved program.

(4) "Physician assistant" means a person who meets the requirements of this chapter and is licensed by the board.

(5) "Supervising physician" or "supervising physician and surgeon" means a physician and surgeon licensed by the Medical Board of California or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant.

(6) "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant.

(7) "Regulations" means the rules and regulations as set forth in Chapter 13.8 (commencing with Section 1399.500) of Title 16 of the California Code of Regulations.

(8) "Routine visual screening" means uninvasive nonpharmacological simple testing for visual acuity, visual field defects, color blindness, and depth perception.

(9) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

(10) "Delegation of services agreement" means the writing that delegates to a physician assistant from a supervising physician the medical services

the physician assistant is authorized to perform consistent with subdivision (a) of Section 1399.540 of Title 16 of the California Code of Regulations.

(11) "Other specified medical services" means tests or examinations performed or ordered by a physician assistant practicing in compliance with this chapter or regulations of the Medical Board of California promulgated under this chapter.

(12) "Medical records review meeting" means a meeting between the supervising physician and surgeon and the physician assistant during which medical records are reviewed to ensure adequate supervision of the physician assistant functioning under protocols. Medical records review meetings may occur in person or by electronic communication.

(b) A physician assistant acts as an agent of the supervising physician when performing any activity authorized by this chapter or regulations adopted under this chapter.

SEC. 2. Section 3502 of the Business and Professions Code is amended to read:

3502. (a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

(b) (1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when that assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c) (1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the followup care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2) (A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.

(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other law, the Medical Board of California or the board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

(d) No medical services may be performed under this chapter in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

(f) Compliance by a physician assistant and supervising physician and surgeon with this section shall be deemed compliance with Section 1399.546 of Title 16 of the California Code of Regulations.

SEC. 3. Section 3502.1 of the Business and Professions Code is amended to read:

3502.1. (a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, 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. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(b) "Drug order," for purposes of this section, means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols

described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

(2) A physician assistant shall not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When

using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

(e) The supervising physician and surgeon shall use either of the following mechanisms to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances:

(1) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days.

(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations, and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall 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 physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established in Section 1399.612 of Title 16 of the California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

(g) The board shall consult with the Medical Board of California and report during its sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.

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

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 396
Author:	Hill
Chapter	287
Bill Date:	June 29, 2015, Amended
Subject:	Outpatient Settings
Sponsor:	Author
Position:	Support

DESCRIPTION OF CURRENT LEGISLATION:

SB 396 makes consumer protection enhancements that the Medical Board of California (Board) already voted to sponsor/support for accredited outpatient settings. This bill requires peer review evaluations for physicians and surgeons working in accredited outpatient settings; and it allows accredited outpatient setting facility inspections performed by Accreditation Agencies (AAs) be unannounced (after the initial inspection). For unannounced inspections, AAs must provide at least a 60-day window to the outpatient setting.

This bill also delays the report from the Board on the vertical enforcement and prosecution model from March 1, 2015, to March 1, 2016.

The bill allows an accredited outpatient setting and a "Medicare certified ambulatory surgical center" (i.e. ASC) to access 805 reports from the Board when credentialing, granting or renewing staff privileges for providers at that facility.

BACKGROUND

AB 595 (Chapter 1276) of 1994 required that certain outpatient settings (including ASCs) either be licensed by the state, Medicare certified, or accredited by an agency approved by the Division of Licensing within the Board. The intent was to "ensure that health care services are safely and effectively performed in these settings." In 2007, a September court ruling (Capen v. Shewry: 155 Cal.App.4th 378) prohibited the California Department of Public Health from issuing state licenses to physician-owned outpatient settings. As a result, the vast majority of outpatient settings are now accredited by AAs approved by the Board.

Accredited outpatient settings and Medicare certified ASCs are currently not on the list of eligible facilities that can obtain 805 reports from the Board, so these facilities are unable to ensure that physician and surgeons and others providing care in those facilities have not been denied staff privileges, been removed from a medical staff, or have had his or her staff privileges restricted.

In addition, existing law allows a physician who owns his or her own outpatient setting to choose not to have peer review of his or her practice, which means that procedures performed in outpatient settings are not subject to peer review. Lastly, routine inspections currently performed by AAs for outpatient setting accreditation are announced.

ANALYSIS

The Board believes that peer review is important to ensure consumer protection, and that procedures that are being done in outpatient settings should be subject to peer review evaluations. This bill requires physicians working in accredited outpatient settings to be subjected to the peer review process at least every two years. The findings would be given to the governing body of the outpatient setting and the findings and peer review process would be reviewed by the AAs at the next inspection of the outpatient setting.

Inspections currently performed by AAs for outpatient setting accreditation are announced. This bill allows subsequent routine inspections to be unannounced, however AAs must give a 60-day window to accredited outpatient settings for unannounced routine inspections. Allowing for unannounced inspections will help to ensure that facilities do not have time to prepare for an inspection and will be in line with inspections performed by other oversight agencies.

This bill allows an accredited outpatient setting and a "Medicare certified ambulatory surgical center" to access 805 reports from the Board to ensure patient protection when credentialing, granting or renewing staff privileges for providers at that facility. The Board already voted to support and/or sponsor these provisions.

Unrelated to outpatient settings, this bill extends the deadline for the Board's legislative report on the vertical enforcement (VE) and prosecution model by one year, to March 1, 2016. This will give the Board adequate time to assess how the VE model is working with the transfer of the investigators to the Department of Consumer Affairs, Division of Investigation. This change is needed as the report due date has passed and the Board currently has insufficient information to complete the VE report.

FISCAL: None

SUPPORT: California Ambulatory Surgery Association
Medical Board of California

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s) - a separate article may be needed geared towards physicians that work in outpatient settings

- Notify/train Board staff
- Meet with AAs to explain the bill's provisions and ensure that they understand the new outpatient setting requirements. Provide any needed guidance to the AAs.
- Update Board's website
- Work with staff on processes to allow accredited and certified outpatient settings to access 805 reports from the Board
- Draft letter for all accredited outpatient settings on the new requirements of this bill, including any guidance from the Board. Send letter to AAs for dissemination to all accredited outpatient settings.
- Work with DCA to complete the VE report by March 1, 2016

Senate Bill No. 396

CHAPTER 287

An act to amend Section 805.5 of the Business and Professions Code, to amend Section 12529.7 of the Government Code, and to amend Sections 1248.15 and 1248.35 of the Health and Safety Code, relating to health care.

[Approved by Governor September 9, 2015. Filed with Secretary of State September 9, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 396, Hill. Health care: outpatient settings and surgical clinics: facilities: licensure and enforcement.

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

Existing law provides that an outpatient setting that is accredited shall be inspected by the accreditation agency and may be inspected by the Medical Board of California. Existing law requires that the inspections be conducted no less often than once every 3 years by the accreditation agency and as often as necessary by the Medical Board of California to ensure quality of care provided.

This bill would authorize the accrediting agency to conduct unannounced inspections subsequent to the initial inspection for accreditation, if the accreditation agency provides specified notice of the unannounced routine inspection to the outpatient setting.

Existing law requires members of the medical staff and other practitioners who are granted clinical privileges in an outpatient setting to be professionally qualified and appropriately credentialed for the performance of privileges granted and requires the outpatient setting to grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting. A willful violation of these provisions is a crime.

This bill would additionally require that each licensee who performs procedures in an outpatient setting that requires the outpatient setting to be

accredited be peer reviewed, as specified, at least every 2 years, by licensees who are qualified by education and experience to perform the same types of, or similar, procedures. The bill would require the findings of the peer review to be reported to the governing body, which shall determine if the licensee continues to be professionally qualified and appropriately credentialed for the performance of privileges granted. By expanding the scope of a crime, this bill would impose a state-mandated local program.

Existing law requires specified entities, including any health care service plan or medical care foundation, to request a report from the Medical Board of California, the Board of Psychology, the Osteopathic Medical Board of California, or the Dental Board of California, prior to granting or renewing staff privileges, to determine if a certain report has been made indicating that the applying physician and surgeon, psychologist, podiatrist, or dentist has been denied staff privileges, been removed from a medical staff, or had his or her staff privileges restricted.

This bill would also require an outpatient setting and a facility certified to participate in the federal Medicare Program as an ambulatory surgical center to request that report. By expanding the scope of a crime, this bill would impose a state-mandated local program.

Existing law establishes a vertical enforcement and prosecution model for cases before the Medical Board of California, and requires the board to report to the Governor and the Legislature on that model by March 1, 2015.

This bill would extend the date that report is due to March 1, 2016.

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.

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

SECTION 1. Section 805.5 of the Business and Professions Code is amended to read:

805.5. (a) Prior to granting or renewing staff privileges for any physician and surgeon, psychologist, podiatrist, or dentist, any health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code, any health care service plan or medical care foundation, the medical staff of the institution, a facility certified to participate in the federal Medicare Program as an ambulatory surgical center, or an outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code shall request a report from the Medical Board of California, the Board of Psychology, the Osteopathic Medical Board of California, or the Dental Board of California to determine if any report has been made pursuant to Section 805 indicating that the applying physician and surgeon, psychologist, podiatrist, or dentist has been denied staff privileges, been removed from a medical staff, or had his or her staff privileges restricted as provided in

Section 805. The request shall include the name and California license number of the physician and surgeon, psychologist, podiatrist, or dentist. Furnishing of a copy of the 805 report shall not cause the 805 report to be a public record.

(b) Upon a request made by, or on behalf of, an institution described in subdivision (a) or its medical staff the board shall furnish a copy of any report made pursuant to Section 805 as well as any additional exculpatory or explanatory information submitted electronically to the board by the licensee pursuant to subdivision (f) of that section. However, the board shall not send a copy of a report (1) if the denial, removal, or restriction was imposed solely because of the failure to complete medical records, (2) if the board has found the information reported is without merit, (3) if a court finds, in a final judgment, that the peer review, as defined in Section 805, resulting in the report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, or (4) if a period of three years has elapsed since the report was submitted. This three-year period shall be tolled during any period the licentiate has obtained a judicial order precluding disclosure of the report, unless the board is finally and permanently precluded by judicial order from disclosing the report. If a request is received by the board while the board is subject to a judicial order limiting or precluding disclosure, the board shall provide a disclosure to any qualified requesting party as soon as practicable after the judicial order is no longer in force.

If the board fails to advise the institution within 30 working days following its request for a report required by this section, the institution may grant or renew staff privileges for the physician and surgeon, psychologist, podiatrist, or dentist.

(c) Any institution described in subdivision (a) or its medical staff that violates subdivision (a) is guilty of a misdemeanor and shall be punished by a fine of not less than two hundred dollars ($200) nor more than one thousand two hundred dollars ($1,200).

SEC. 2. Section 12529.7 of the Government Code is amended to read:

12529.7. By March 1, 2016, the Medical Board of California, in consultation with the Department of Justice and the Department of Consumer Affairs, shall report and make recommendations to the Governor and the Legislature on the vertical enforcement and prosecution model created under Section 12529.6.

SEC. 3. Section 1248.15 of the Health and Safety Code is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) The outpatient setting shall permit surgery by a dentist acting within his or her scope of practice under Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code or physician and surgeon, osteopathic physician and surgeon, or podiatrist acting within his or her scope of practice under Chapter 5 (commencing with Section 2000)

of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act. The outpatient setting may, in its discretion, permit anesthesia service by a certified registered nurse anesthetist acting within his or her scope of practice under Article 7 (commencing with Section 2825) of Chapter 6 of Division 2 of the Business and Professions Code.

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

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

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

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

(ii) Each licensee who performs procedures in an outpatient setting that requires the outpatient setting to be accredited shall be, at least every two years, peer reviewed, which shall be a process in which the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of a licensee is reviewed to make recommendations for quality improvement and education, if necessary, including when the outpatient setting has only one licensee. The peer review shall be performed by licensees who are qualified by education and experience to perform the same types of, or similar, procedures. The findings of the peer review shall be reported to the governing body, which shall determine if the licensee continues to meet the requirements described in clause (i). The process that resulted in the findings of the peer review shall be reviewed by the accrediting agency at the next survey to determine if the outpatient setting meets applicable accreditation standards pursuant to this section.

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

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

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

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

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

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

patient who does not meet the discharge criteria adopted pursuant to paragraph (10) of subdivision (a) shall constitute unprofessional conduct.

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

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

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

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

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

SEC. 4. Section 1248.35 of the Health and Safety Code is amended to read:

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

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

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

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

For unannounced routine inspections, the accreditation agency shall notify the outpatient setting that the inspection will occur within 60 days.

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

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

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

(2) Issue a reprimand.

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

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

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

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

voluntarily surrendering its accreditation prior to initiation of any suspension or revocation proceeding.

(e) The accreditation agency shall, within 24 hours, report to the board if the outpatient setting has been issued a reprimand or if the outpatient setting's certification of accreditation has been suspended or revoked or if the outpatient setting has been placed on probation. If an outpatient setting has been issued a license by the California State Board of Pharmacy pursuant to Article 14 (commencing with Section 4190) of Chapter 9 of Division 2 of the Business and Professions Code, the accreditation agency shall also send this report to the California State Board of Pharmacy within 24 hours.

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

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

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

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

(1) Notify the board of the action.

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

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

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

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

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 408
Author: Morrell
Chapter: 280
Bill Date: May 6, 2015, Amended
Subject: Midwife Assistants
Sponsor: Medical Board of California (Board)
Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

SB 408 ensures that midwife assistants meet minimum training requirements and sets forth the duties that a midwife assistant could perform, which should be at the same level as duties that a medical assistant can perform, technical support services only. This bill allows the Board to adopt regulations and standards for any additional midwife technical support services.

BACKGROUND

The Board licenses Licensed Midwives (LMs). It has been brought to the attention of the Board that LMs need to use assistants. As such, this issue was raised in the Board's 2012 Sunset Review Report. Currently, there is no definition for a midwife assistant in statute, nor are there specific training requirements or duties that a midwife assistant may perform. Some LMs use other LMs as assistants, while some use a midwife student who is enrolled in a recognized midwifery school and who has an official agreement with the student and midwifery school to provide clinical training to the student midwife. Other LMs use someone who may or may not have formal midwifery training and/or someone that the LM has trained. The duties that a midwife assistant performs also varies greatly from LM to LM. This unregulated practice is a serious consumer protection issue and this bill would define midwife assistants and define the services they can provide. This bill is modeled after existing law related to medical assistants, which are under the supervision of a physician and surgeon (Business and Professions Code Section 2069 - 2071).

ANALYSIS

SB 408 defines a "midwife assistant" as a person, who may be unlicensed, who performs basic administrative, clerical, and midwife technical support services in accordance with existing law for a LM, is at least 18 years of age, and has had at least the minimum amount of hours of appropriate training pursuant to standards established by the Board for a medical assistant. This bill defines "midwife technical support services" as simple routine medical tasks and procedures that may be safely performed by a midwife assistant who has

limited training and who functions under the supervision of a LM or a certified nurse midwife (CNM).

This bill allows a midwife assistant to do the following:

- Administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical support services upon the specific authorization and supervision of a LM or CNM.
- Perform venipuncture or skin puncture for the purposes of withdrawing blood upon specific authorization and under supervision of a LM or CNM if the educational and training requirements have been met.
- Perform the following midwife technical support services:
    - Administer medications orally, sublingually, topically, or rectally, or by providing a single dose to a patient for immediate self-administration, and administer oxygen at the direction of a supervising LM or CNM. The LM or CNM must verify the correct medication and dosage before the midwife assistant administers the medication.
    - Assist in immediate newborn care when a LM or CNM is engaged in a concurrent activity that precludes the LM or CNM from doing so.
    - Assist in placement of the device used for auscultation of fetal heart tones when a LM or CNM is engaged in concurrent activity that precludes the LM or CNM from doing so.
    - Collect, by noninvasive techniques, and preserve specimens for testing, including, but not limited to, urine.
    - Assist patients to and from a patient examination room, bed, or bathroom.
    - Assist patient in activities of daily living, such as assisting with bathing or clothing.
    - As authorized by the LM or CNM, provide patient information and instructions.
    - Collect and record patient data, including height, weight, temperature, pulse, respiration rate, blood pressure, and basic information about the presenting and previous conditions.
    - Perform simple laboratory and screening tests customarily performed in a medical or midwife office.
    - Perform additional midwife technical support services under regulations established by the Board.

This bill establishes training requirements in statute for midwife assistants and parameters on what services can be provided by midwife assistants, which furthers the Board's mission of consumer protection. For this reason, the Board voted to sponsor this important legislation. Amendments were taken in committee to address concerns raised by the California Medical Association and the American College of Obstetricians and Gynecologists and to add CNMs as supervisors, as requested by the CNM Association.

FISCAL: Minimal and absorbable to update regulations related to training requirements

SUPPORT: Medical Board of California (Sponsor)
American Nurses Association of California
County of Santa Cruz Board of Supervisors
Monterey County Board of Supervisors
Planned Parenthood

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section
- Hold Interested Parties Meeting regarding training requirements for midwife assistants
- Update/develop regulations to set forth the training requirements for midwife assistants, similar to what is required for medical assistants
- Update website to include information on what is required to be a midwife assistant, what duties a midwife assistant can perform and frequently asked questions. Use the medical assistant information on the Board's website as a guide for the midwife assistant information.

Senate Bill No. 408

CHAPTER 280

An act to add Section 2516.5 to the Business and Professions Code, relating to healing arts.

[Approved by Governor September 8, 2015. Filed with Secretary of State September 8, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 408, Morrell. Midwife assistants.

The Licensed Midwifery Practice Act of 1993 provides for the licensing and regulation of midwives by the Medical Board of California. The license to practice midwifery authorizes the holder 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. The Licensed Midwifery Practice Act of 1993 requires a midwife to refer to a physician and surgeon under prescribed circumstances. A violation of the Licensed Midwifery Practice Act of 1993 is a crime.

The Nursing Practice Act provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and authorizes the board to issue a certificate to practice nurse-midwifery to a person who meets educational standards established by the board or the equivalent of those educational standards. The Nursing Practice Act 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.

This bill would authorize a midwife assistant to perform certain assistive activities under the supervision of a licensed midwife or certified nurse-midwife, including the administration of medicine, the withdrawing of blood, and midwife technical support services. The bill would define terms for these purposes. The bill would prohibit a midwife assistant from being employed for inpatient care in a licensed general acute care hospital. By adding new requirements and prohibitions to the Licensed Midwifery Practice Act of 1993, the violation of which would be a crime, the bill would impose a state-mandated local program.

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

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

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

SECTION 1. Section 2516.5 is added to the Business and Professions Code, to read:

2516.5. (a) As used in this section, the following definitions apply:

(1) "Midwife assistant" means a person, who may be unlicensed, who performs basic administrative, clerical, and midwife technical supportive services in accordance with this chapter for a licensed midwife or certified nurse-midwife, is at least 18 years of age, and has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board for a medical assistant pursuant to Section 2069. The midwife assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. Each employer of the midwife assistant or the midwife assistant shall retain a copy of the certificate as a record.

(2) "Midwife technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a midwife assistant who has limited training and who functions under the supervision of a licensed midwife or certified nurse-midwife.

(3) "Specific authorization" means a specific written order prepared by the supervising midwife or supervising nurse-midwife authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising midwife or supervising nurse-midwife authorizing the procedures to be performed. A notation of the standing order shall be placed in the patient's medical record.

(4) "Supervision" means the supervision of procedures authorized by this section by a licensed midwife or certified nurse-midwife, within his or her scope of practice, who is physically present on the premises during the performance of those procedures.

(b) Notwithstanding any other provision of law, a midwife assistant may do all of the following:

(1) Administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical support services upon the specific authorization and supervision of a licensed midwife or certified nurse-midwife. A midwife assistant may also perform all these tasks and services in a clinic licensed in accordance with subdivision (a) of Section 1204 of the Health and Safety Code upon the specific authorization of a licensed midwife or certified nurse-midwife.

(2) Perform venipuncture or skin puncture for the purposes of withdrawing blood upon specific authorization and under the supervision of a licensed midwife or certified nurse-midwife, if the midwife assistant has met the educational and training requirements for medical assistants as

established in Section 2070. Each employer of the assistant shall retain a copy of any related certificates as a record.

(3) Perform the following midwife technical support services:

(A) Administer medications orally, sublingually, topically, or rectally, or by providing a single dose to a patient for immediate self-administration, and administer oxygen at the direction of the supervising licensed midwife or certified nurse-midwife. The licensed midwife or certified nurse-midwife shall verify the correct medication and dosage before the midwife assistant administers medication.

(B) Assist in immediate newborn care when the licensed midwife or certified nurse-midwife is engaged in a concurrent activity that precludes the licensed midwife or certified nurse-midwife from doing so.

(C) Assist in placement of the device used for auscultation of fetal heart tones when a licensed midwife or certified nurse-midwife is engaged in a concurrent activity that precludes the licensed midwife or certified nurse-midwife from doing so.

(D) Collect by noninvasive techniques and preserve specimens for testing, including, but not limited to, urine.

(E) Assist patients to and from a patient examination room, bed, or bathroom.

(F) Assist patients in activities of daily living, such as assisting with bathing or clothing.

(G) As authorized by the licensed midwife or certified nurse-midwife, provide patient information and instructions.

(H) Collect and record patient data, including height, weight, temperature, pulse, respiration rate, blood pressure, and basic information about the presenting and previous conditions.

(I) Perform simple laboratory and screening tests customarily performed in a medical or midwife office.

(4) Perform additional midwife technical support services under regulations and standards established by the board.

(c) (1) Nothing in this section shall be construed as authorizing the licensure of midwife assistants. Nothing in this section shall be construed as authorizing the administration of local anesthetic agents by a midwife assistant. Nothing in this section shall be construed as authorizing the board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.

(2) Nothing in this section shall be construed as authorizing a midwife assistant to perform any clinical laboratory test or examination for which he or she is not authorized under Chapter 3 (commencing with Section 1200).

(d) Notwithstanding any other law, a midwife assistant shall not be employed for inpatient care in a licensed general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because

this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 464
Author: Hernandez
Chapter: 387
Bill Date: May 22, 2015, Amended
Subject: Healing Arts: Self Reporting Tools
Sponsor: Planned Parenthood Affiliates of California
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill authorizes specified health care practitioners to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and after an appropriate examination, prescribe, furnish, or dispense self-administered hormonal contraceptives to the patient.

ANALYSIS

This bill allows a physician and surgeon, registered nurse, a certified nurse-midwife, a nurse practitioner, a physician assistant, and a pharmacist, acting within the scope of each respective license type, to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient. This bill requires an appropriate prior examination, and after that examination, the practitioner can prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. This bill allows blood pressure, weight, height, and patient health history to be self-reported using the self-screening tool that identifies patient risk factors.

The sponsors believe that the bill will help to improve preventive health services by increasing access to services in rural communities through the utilization of telemedicine by allowing patients to provide information to a health provider through self-screening tools.

A physician can already use a self-screening tool for the purposes provided for in this bill, as long as an appropriate prior exam is performed, which this bill also requires. If telehealth is used, the existing telehealth laws would also apply. The other health care practitioners named in this bill would also have to comply with their existing laws related to prescribing and can only provide services that are within their current scope. The Board would have concerns if an appropriate prior exam was not required, but since it is, the Board took a neutral position on this bill.

FISCAL: None

SUPPORT: Planned Parenthood Affiliates of California (Sponsor); California Medical Association; California Primary Care Association; Community Action Fund of Planned Parenthood of Orange and San Bernardino Counties; Icebreaker Health; NARAL Pro-Choice California; Planned Parenthood – Los Angeles, Mar Monte, Northern California, Pacific Southwest, Pasadena, San Gabriel Valley, Santa Barbara, Ventura, and San Luis Obispo Counties; and Numerous Individuals

OPPOSITION: California Catholic Conference; California Nurses Association; and California Right to Life Committee, Inc.

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section

Senate Bill No. 464

CHAPTER 387

An act to add Section 2242.2 to the Business and Professions Code, relating to healing arts.

[Approved by Governor September 30, 2015. Filed with Secretary of State September 30, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 464, Hernandez. Healing arts: self-reporting tools.

The Medical Practice Act provides for licensure and regulation of physicians and surgeons by the Medical Board of California, and authorizes a physician and surgeon to, among other things, use drugs or devices in or upon human beings. The Medical Practice Act makes it unprofessional conduct for a physician and surgeon to prescribe, dispense, or furnish dangerous drugs without an appropriate prior examination and medical indication. The act prohibits, with specified exceptions, a person or entity from prescribing, dispensing, or furnishing, or causing to be prescribed, dispensed, or furnished, dangerous drugs or dangerous devices on the Internet for delivery to a person in California without an appropriate prior examination and medical indication.

The Nursing Practice Act provides for the licensure and regulation of registered nurses, including nurse practitioners and certified nurse-midwives, by the Board of Registered Nursing within the Department of Consumer Affairs. The Nursing Practice Act authorizes a registered nurse to dispense self-administered hormonal contraceptives, as specified, in accordance with standardized procedures, including demonstration of competency in providing the appropriate prior examination comprised of checking blood pressure, weight, and patient and family health history, including medications taken by the patient. The Nursing Practice Act also authorizes certified nurse-midwives and nurse practitioners to furnish or order drugs or devices, as specified.

The Physician Assistant Practice Act provides for the licensure and regulation of physician assistants by the Physician Assistant Board within the jurisdiction of the Medical Board of California, and authorizes a physician assistant to administer or provide medication to a patient or to transmit a drug order, as specified.

The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy within the Department of Consumer Affairs, and authorizes a pharmacist to furnish self-administered hormonal contraceptives in accordance with standardized procedures and protocols. The Pharmacy Law requires the standardized procedures and protocols to require a patient to use a self-screening tool

that will identify patient risk factors for the use of self-administered hormonal contraceptives, as specified.

This bill, notwithstanding any other law, would authorize a physician and surgeon, a registered nurse acting in accordance with the authority of the Nursing Practice Act, a certified nurse-midwife acting within the scope of specified existing law relating to nurse-midwives, a nurse practitioner acting within the scope of specified existing law relating to nurse practitioners, a physician assistant acting within the scope of specified existing law relating to physician assistants, or a pharmacist acting within the scope of a specified existing law relating to pharmacists to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after an appropriate prior examination, to prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. The bill would authorize blood pressure, weight, height, and patient health history to be self-reported using the self-screening tool.

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

SECTION 1. Section 2242.2 is added to the Business and Professions Code, to read:

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

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 643
Author: McGuire
Chapter: 719
Bill Date: July 13, 2015, Amended
Subject: Medical Marijuana
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill is part of a package of three bills that establish a regulatory framework for the cultivation, sale, and transport of medical cannabis by the Bureau of Medical Marijuana Regulation in the Department of Consumer Affairs, the Department of Food and Agriculture, and other state entities. However, this analysis will only cover the portion of the bill related to the requirements on physicians recommending medical cannabis and the Medical Board of California (Board).

BACKGROUND:

In 1996, California voters approved the Compassionate Use Act (Proposition 215), which allowed Californians access to marijuana for medical purposes, and prohibited punitive action against physicians for making marijuana recommendations. SB 420 (Vasconcellos, Chapter 875, Statutes of 2003), the Medical Marijuana Program Act, included issuance of identification cards for qualified patients, and allowed patients and their primary caregivers to collectively or cooperatively cultivate marijuana for medical purposes.

In 2014, AB 1894 (Ammiano) was amended on May 23, 2014 and the amendments basically included the same language as the language included in this bill. The Board took a support position on AB 1894.

ANALYSIS:

The portions of this bill that impact the Board are very similar to the provisions in AB 26 (Jones-Sawyer), AB 34 (Bonta and Jones-Sawyer), and the previous version of AB 266 (Bonta, Cooley, Jones-Sawyer, and Lackey). The three bills related to medical cannabis were re-written and now SB 643 contains the provisions related to physicians recommending medical cannabis.

This bill includes in the Board's priorities cases that allege a physician has recommended cannabis to patients for medical purposes without a good faith prior examination and medical reason therefor.

This bill now creates a new section in law related to recommending medical cannabis, which states that physicians recommending cannabis to a patient for a medical

purpose without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. This bill prohibits a physician from recommending cannabis to a patient unless that physician is the patient's attending physician, as defined by subdivision (a) of Section 11362.7 of the Health and Safety Code (HSC). The HSC defines an "attending physician" as an individual who possesses a license in good standing to practice medicine or osteopathy issued by the Board or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient. The physician also must have conducted a medical examination of that patient before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the medical use of marijuana is appropriate.

This bill also subjects physicians recommending cannabis to the definition of "financial interest" in Business and Professions Code Section (BPC) 650.01 and does not allow a physician to accept, solicit, or offer any form of remuneration from or to a licensed dispenser, producer, or processor of cannabis products in which the licensee or his or her immediate family has a financial interest. This bill does not allow a cannabis clinic or dispensary to directly or indirectly employ physicians to provide marijuana recommendations, a violation would constitute unprofessional conduct. This bill does not allow a person to distribute any form of advertising for physician recommendations for medical cannabis unless the advertisement contains a notice to consumers, as specified.

This bill requires the Board to consult with the California Marijuana Research Program, knowns as the Center for Medicinal Cannabis Research (CMCR) on developing and adopting medical guidelines for the appropriate administration and use of cannabis.

Lastly, this bill specifies that a violation of the new section of law regulating medical cannabis recommendations is a misdemeanor and punishable by up to one year and county jail and a fine of up to five thousand dollars or by civil penalties of up to five thousand dollars and shall constitute unprofessional conduct.

This bill gives the Board some much needed enforcement tools to more efficiently regulate physicians who recommend marijuana for a medical purpose. This bill expressly requires a physician to perform an appropriate prior examination before recommending marijuana for a medical purpose. This is an important amendment because the prescribing requirements in existing law do not necessarily apply to marijuana recommendations. This bill also makes marijuana recommendation cases a priority of the Board, which will help to ensure consumer protection. Lastly, this bill prohibits physicians from being employed by cannabis clinics or dispensaries, which will help to ensure that physicians are not making marijuana recommendations for financial or employment reasons.

FISCAL: Minimal and absorbable fiscal impact to the Board

SUPPORT: California Association of Code Enforcement Officers;
California College & University Police Chiefs Association;

California League of Conservation Voters; California Native Plant Society; California Police Chiefs Association; California State Association of Counties; California State Parks Foundation; California Teamsters Public Affairs Council; California Trout; California Urban Streams Partnership; Clean Water Action; Defenders of Wildlife; League of California Cities; Pacific Forest Trust; Rural County Representatives of California; Trout Unlimited; The Nature Conservancy; The Trust for Public Land; UFCW Western States Council; and Urban Counties Caucus

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s) and a stand-alone article on the new requirements for recommending medical cannabis
- Notify/train Board staff and Department of Consumer Affairs, Division of Investigation staff and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's current statement on recommending marijuana and consult and solicit input from the CMCR on needed revisions
- Update the Board's website with the revised statement and the new requirements for recommending medical cannabis

Senate Bill No. 643

CHAPTER 719

An act to amend Sections 144, 2220.05, 2241.5, and 2242.1 of, to add Sections 19302.1, 19319, 19320, 19322, 19323, 19324, and 19325 to, to add Article 25 (commencing with Section 2525) to Chapter 5 of Division 2 of, and to add Article 6 (commencing with Section 19331), Article 7.5 (commencing with Section 19335), Article 8 (commencing with Section 19337), and Article 11 (commencing with Section 19348) to Chapter 3.5 of Division 8 of, the Business and Professions Code, relating to medical marijuana.

[Approved by Governor October 9, 2015. Filed with Secretary of State October 9, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 643, McGuire. Medical marijuana.

(1) Existing law, the Compassionate Use Act of 1996, an initiative measure enacted by the approval of Proposition 215 at the November 6, 1996, statewide general election, authorizes the use of marijuana for medical purposes. Existing law enacted by the Legislature requires the establishment of a program for the issuance of identification cards to qualified patients so that they may lawfully use marijuana for medical purposes, and requires the establishment of guidelines for the lawful cultivation of marijuana grown for medical use. Existing law provides for the licensure of various professions by the Department of Consumer Affairs. Existing law, the Sherman Food, Drug, and Cosmetic Law, provides for the regulation of food, drugs, devices, and cosmetics, as specified. A violation of that law is a crime.

This bill would, among other things, set forth standards for a physician and surgeon prescribing medical cannabis and require the Medical Board of California to prioritize its investigative and prosecutorial resources to identify and discipline physicians and surgeons that have repeatedly recommended excessive cannabis to patients for medical purposes or repeatedly recommended cannabis to patients for medical purposes without a good faith examination, as specified. The bill would require the Bureau of Medical Marijuana to require an applicant to furnish a full set of fingerprints for the purposes of conducting criminal history record checks. The bill would prohibit a physician and surgeon who recommends cannabis to a patient for a medical purpose from accepting, soliciting, or offering any form of remuneration from a facility licensed under the Medical Marijuana Regulation and Safety Act. The bill would make a violation of this prohibition a misdemeanor, and by creating a new crime, this bill would impose a state-mandated local program.

This bill would require the Governor, under the Medical Marijuana Regulation and Safety Act, to appoint, subject to confirmation by the Senate, a chief of the Bureau of Medical Marijuana Regulation. The act would require the Department of Consumer Affairs to have the sole authority to create, issue, renew, discipline, suspend, or revoke licenses for the transportation and storage, unrelated to manufacturing, of medical marijuana, and would authorize the department to collect fees for its regulatory activities and impose specified duties on this department in this regard. The act would require the Department of Food and Agriculture to administer the provisions of the act related to, and associated with, the cultivation, and transportation of, medical cannabis and would impose specified duties on this department in this regard. The act would require the State Department of Public Health to administer the provisions of the act related to, and associated with, the manufacturing and testing of medical cannabis and would impose specified duties on this department in this regard.

This bill would authorize counties to impose a tax upon specified cannabis-related activity.

This bill would require an applicant for a state license pursuant to the act to provide a statement signed by the applicant under penalty of perjury, thereby changing the scope of a crime and imposing a state-mandated local program.

This bill would set forth standards for the licensed cultivation of medical cannabis, including, but not limited to, establishing duties relating to the environmental impact of cannabis and cannabis products. The bill would also establish state cultivator license types, as specified.

(2) This bill would provide that its provisions are severable.

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

This bill would provide that with regard to certain mandates no reimbursement is required by this act for a specified reason.

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

(4) Existing constitutional provisions require that a statute that limits the right of access to the meeting of public bodies or the writings of public bodies or the writings of public officials and agencies be adopted with finding demonstrating the interest protected by the limitation and the need for protecting that interest. The bill would make legislative findings to that effect.

(5) The bill would become operative only if AB 266 and AB 243 of the 2015–16 Regular Session are enacted and take effect on or before January 1, 2016.

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

SECTION 1. Section 144 of the Business and Professions Code is amended to read:

144. (a) Notwithstanding any other provision of 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.

(6) California State Board of Pharmacy.

(7) Board of Registered Nursing.

(8) Veterinary Medical Board.

(9) Board of Vocational Nursing and Psychiatric Technicians.

(10) Respiratory Care Board of California.

(11) Physical Therapy Board of California.

(12) Physician Assistant Committee of the Medical Board of California.

(13) Speech-Language Pathology and Audiology and Hearing Aid Dispenser Board.

(14) Medical Board of California.

(15) State Board of Optometry.

(16) Acupuncture Board.

(17) Cemetery and Funeral Bureau.

(18) Bureau of Security and Investigative Services.

(19) Division of Investigation.

(20) Board of Psychology.

(21) California Board of Occupational Therapy.

(22) Structural Pest Control Board.

(23) Contractors' State License Board.

(24) Naturopathic Medicine Committee.

(25) Professional Fiduciaries Bureau.

(26) Board for Professional Engineers, Land Surveyors, and Geologists.

(27) Bureau of Medical Marijuana Regulation.

(c) For purposes of paragraph (26) of subdivision (b), the term "applicant" shall be limited to an initial applicant who has never been registered or licensed by the board or to an applicant for a new licensure or registration category.

SEC. 2. Section 2220.05 of the Business and Professions Code is amended to read:

2220.05. (a) In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its

investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing, including, but not limited to, Sections 725, 2241.5, and 2241.6 of this code and Sections 11159.2 and 124961 of the Health and Safety Code, be prosecuted for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation.

(5) Sexual misconduct with one or more patients during a course of treatment or an examination.

(6) Practicing medicine while under the influence of drugs or alcohol.

(b) The board may by regulation prioritize cases involving an allegation of conduct that is not described in subdivision (a). Those cases prioritized by regulation shall not be assigned a priority equal to or higher than the priorities established in subdivision (a).

(c) The Medical Board of California shall indicate in its annual report mandated by Section 2312 the number of temporary restraining orders, interim suspension orders, and disciplinary actions that are taken in each priority category specified in subdivisions (a) and (b).

SEC. 3. Section 2241.5 of the Business and Professions Code is amended to read:

2241.5. (a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of an addict.

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

(4) Violates Section 2242.1 regarding prescribing on the Internet.

(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

SEC. 4. Section 2242.1 of the Business and Professions Code is amended to read:

2242.1. (a) No person or entity may prescribe, dispense, or furnish, or cause to be prescribed, dispensed, or furnished, dangerous drugs or dangerous devices, as defined in Section 4022, on the Internet for delivery to any person in this state, without an appropriate prior examination and medical indication, except as authorized by Section 2242.

(b) Notwithstanding any other provision of law, a violation of this section may subject the person or entity that has committed the violation to either

a fine of up to twenty-five thousand dollars ($25,000) per occurrence pursuant to a citation issued by the board or a civil penalty of twenty-five thousand dollars ($25,000) per occurrence.

(c) The Attorney General may bring an action to enforce this section and to collect the fines or civil penalties authorized by subdivision (b).

(d) For notifications made on and after January 1, 2002, the Franchise Tax Board, upon notification by the Attorney General or the board of a final judgment in an action brought under this section, shall subtract the amount of the fine or awarded civil penalties from any tax refunds or lottery winnings due to the person who is a defendant in the action using the offset authority under Section 12419.5 of the Government Code, as delegated by the Controller, and the processes as established by the Franchise Tax Board for this purpose. That amount shall be forwarded to the board for deposit in the Contingent Fund of the Medical Board of California.

(e) If the person or entity that is the subject of an action brought pursuant to this section is not a resident of this state, a violation of this section shall, if applicable, be reported to the person's or entity's appropriate professional licensing authority.

(f) Nothing in this section shall prohibit the board from commencing a disciplinary action against a physician and surgeon pursuant to Section 2242 or 2525.3.

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

Article 25. Recommending Medical Cannabis

2525. (a) It is unlawful for a physician and surgeon who recommends cannabis to a patient for a medical purpose to accept, solicit, or offer any form of remuneration from or to a facility issued a state license pursuant to Chapter 3.5 (commencing with Section 19300) of Division 8, if the physician and surgeon or his or her immediate family have a financial interest in that facility.

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

(c) A violation of this section shall be a misdemeanor punishable by up to one year in county jail and a fine of up to five thousand dollars ($5,000) or by civil penalties of up to five thousand dollars ($5,000) and shall constitute unprofessional conduct.

2525.1. The Medical Board of California shall consult with the California Marijuana Research Program, known as the Center for Medicinal Cannabis Research, authorized pursuant to Section 11362.9 of the Health and Safety Code, on developing and adopting medical guidelines for the appropriate administration and use of medical cannabis.

2525.2. An individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of California or the Osteopathic Medical Board of California shall not recommend medical

cannabis to a patient, unless that person is the patient's attending physician, as defined by subdivision (a) of Section 11362.7 of the Health and Safety Code.

2525.3. Recommending medical cannabis to a patient for a medical purpose without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

2525.4. It is unprofessional conduct for any attending physician recommending medical cannabis to be employed by, or enter into any other agreement with, any person or entity dispensing medical cannabis.

2525.5. (a) A person shall not distribute any form of advertising for physician recommendations for medical cannabis in California unless the advertisement bears the following notice to consumers:

NOTICE TO CONSUMERS: The Compassionate Use Act of 1996 ensures that seriously ill Californians have the right to obtain and use cannabis for medical purposes where medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of medical cannabis. Recommendations must come from an attending physician as defined in Section 11362.7 of the Health and Safety Code. Cannabis is a Schedule I drug according to the federal Controlled Substances Act. Activity related to cannabis use is subject to federal prosecution, regardless of the protections provided by state law.

(b) Advertising for attending physician recommendations for medical cannabis shall meet all of the requirements in Section 651. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discounts, premiums, gifts, or statements of a similar nature.

SEC. 6. Section 19302.1 is added to the Business and Professions Code, to read:

19302.1. (a) The Governor shall appoint a chief of the bureau, subject to confirmation by the Senate, at a salary to be fixed and determined by the director with the approval of the Director of Finance. The chief shall serve under the direction and supervision of the director and at the pleasure of the Governor.

(b) Every power granted to or duty imposed upon the director under this chapter may be exercised or performed in the name of the director by a deputy or assistant director or by the chief, subject to conditions and limitations that the director may prescribe. In addition to every power granted or duty imposed with this chapter, the director shall have all other powers and duties generally applicable in relation to bureaus that are part of the Department of Consumer Affairs.

(c) The director may employ and appoint all employees necessary to properly administer the work of the bureau, in accordance with civil service laws and regulations.

(d) The Department of Consumer Affairs shall have the sole authority to create, issue, renew, discipline, suspend, or revoke licenses for the

transportation, storage unrelated to manufacturing activities, distribution, and sale of medical marijuana within the state and to collect fees in connection with activities the bureau regulates. The bureau may create licenses in addition to those identified in this chapter that the bureau deems necessary to effectuate its duties under this chapter.

(e) The Department of Food and Agriculture shall administer the provisions of this chapter related to and associated with the cultivation of medical cannabis. The Department of Food and Agriculture shall have the authority to create, issue, and suspend or revoke cultivation licenses for violations of this chapter. The State Department of Public Health shall administer the provisions of this chapter related to and associated with the manufacturing and testing of medical cannabis.

SEC. 7. Section 19319 is added to the Business and Professions Code, to read:

19319. (a) A qualified patient, as defined in Section 11362.7 of the Health and Safety Code, who cultivates, possesses, stores, manufactures, or transports cannabis exclusively for his or her personal medical use but who does not provide, donate, sell, or distribute cannabis to any other person is not thereby engaged in commercial cannabis activity and is therefore exempt from the licensure requirements of this chapter.

(b) A primary caregiver who cultivates, possesses, stores, manufactures, transports, donates, or provides cannabis exclusively for the personal medical purposes of no more than five specified qualified patients for whom he or she is the primary caregiver within the meaning of Section 11362.7 of the Health and Safety Code, but who does not receive remuneration for these activities except for compensation in full compliance with subdivision (c) of Section 11362.765 of the Health and Safety Code, is exempt from the licensure requirements of this chapter.

SEC. 8. Section 19320 is added to the Business and Professions Code, to read:

19320. (a) Licensing authorities administering this chapter may issue state licenses only to qualified applicants engaging in commercial cannabis activity pursuant to this chapter. Upon the date of implementation of regulations by the licensing authority, no person shall engage in commercial cannabis activity without possessing both a state license and a local permit, license, or other authorization. A licensee shall not commence activity under the authority of a state license until the applicant has obtained, in addition to the state license, a license or permit from the local jurisdiction in which he or she proposes to operate, following the requirements of the applicable local ordinance.

(b) Revocation of a local license, permit, or other authorization shall terminate the ability of a medical cannabis business to operate within that local jurisdiction until the local jurisdiction reinstates or reissues the local license, permit, or other required authorization. Local authorities shall notify the bureau upon revocation of a local license. The bureau shall inform relevant licensing authorities.

(c) Revocation of a state license shall terminate the ability of a medical cannabis licensee to operate within California until the licensing authority reinstates or reissues the state license. Each licensee shall obtain a separate license for each location where it engages in commercial medical cannabis activity. However, transporters only need to obtain licenses for each physical location where the licensee conducts business while not in transport, or any equipment that is not currently transporting medical cannabis or medical cannabis products, permanently resides.

(d) In addition to the provisions of this chapter, local jurisdictions retain the power to assess fees and taxes, as applicable, on facilities that are licensed pursuant to this chapter and the business activities of those licensees.

(e) Nothing in this chapter shall be construed to supersede or limit state agencies, including the State Water Resources Control Board and Department of Fish and Wildlife, from establishing fees to support their medical cannabis regulatory programs.

SEC. 9. Section 19322 is added to the Business and Professions Code, to read:

19322. (a) A person or entity shall not submit an application for a state license issued by the department pursuant to this chapter unless that person or entity has received a license, permit, or authorization by a local jurisdiction. An applicant for any type of state license issued pursuant to this chapter shall do all of the following:

(1) Electronically submit to the Department of Justice fingerprint images and related information required by the Department of Justice for the purpose of obtaining information as to the existence and content of a record of state or federal convictions and arrests, and information as to the existence and content of a record of state or federal convictions and arrests for which the Department of Justice establishes that the person is free on bail or on his or her own recognizance, pending trial or appeal.

(A) The Department of Justice shall provide a response to the licensing authority pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(B) The licensing authority shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for applicants.

(C) The Department of Justice shall charge the applicant a fee sufficient to cover the reasonable cost of processing the requests described in this paragraph.

(2) Provide documentation issued by the local jurisdiction in which the proposed business is operating certifying that the applicant is or will be in compliance with all local ordinances and regulations.

(3) Provide evidence of the legal right to occupy and use the proposed location. For an applicant seeking a cultivator, distributor, manufacturing, or dispensary license, provide a statement from the owner of real property or their agent where the cultivation, distribution, manufacturing, or dispensing commercial medical cannabis activities will occur, as proof to demonstrate the landowner has acknowledged and consented to permit

cultivation, distribution, manufacturing, or dispensary activities to be conducted on the property by the tenant applicant.

(4) If the application is for a cultivator or a dispensary, provide evidence that the proposed location is located beyond at least a 600-foot radius from a school, as required by Section 11362.768 of the Health and Safety Code.

(5) Provide a statement, signed by the applicant under penalty of perjury, that the information provided is complete, true, and accurate.

(6) (A) For an applicant with 20 or more employees, provide a statement that the applicant will enter into, or demonstrate that it has already entered into, and abide by the terms of a labor peace agreement.

(B) For the purposes of this paragraph, "employee" does not include a supervisor.

(C) For purposes of this paragraph, "supervisor" means an individual having authority, in the interest of the licensee, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them or to adjust their grievances, or effectively to recommend such action, if, in connection with the foregoing, the exercise of that authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

(7) Provide the applicant's seller's permit number issued pursuant to Part 1 (commencing with Section 6001) of Division 2 of the Revenue and Taxation Code or indicate that the applicant is currently applying for a seller's permit.

(8) Provide any other information required by the licensing authority.

(9) For an applicant seeking a cultivation license, provide a statement declaring the applicant is an "agricultural employer," as defined in the Alatorre-Zenovich-Dunlap-Berman Agricultural Labor Relations Act of 1975 (Part 3.5 (commencing with Section 1140) of Division 2 of the Labor Code), to the extent not prohibited by law.

(10) For an applicant seeking licensure as a testing laboratory, register with the State Department of Public Health and provide any information required by the State Department of Public Health.

(11) Pay all applicable fees required for licensure by the licensing authority.

(b) For applicants seeking licensure to cultivate, distribute, or manufacture medical cannabis, the application shall also include a detailed description of the applicant's operating procedures for all of the following, as required by the licensing authority:

(1) Cultivation.

(2) Extraction and infusion methods.

(3) The transportation process.

(4) Inventory procedures.

(5) Quality control procedures.

SEC. 10. Section 19323 is added to the Business and Professions Code, to read:

19323. (a) The licensing authority shall deny an application if either the applicant or the premises for which a state license is applied do not qualify for licensure under this chapter.

(b) The licensing authority may deny the application for licensure or renewal of a state license if any of the following conditions apply:

(1) Failure to comply with the provisions of this chapter or any rule or regulation adopted pursuant to this chapter, including but not limited to, any requirement imposed to protect natural resources, instream flow, and water quality pursuant to subdivision (a) of Section 19332.

(2) Conduct that constitutes grounds for denial of licensure pursuant to Chapter 2 (commencing with Section 480) of Division 1.5.

(3) A local agency has notified the licensing authority that a licensee or applicant within its jurisdiction is in violation of state rules and regulation relating to commercial cannabis activities, and the licensing authority, through an investigation, has determined that the violation is grounds for termination or revocation of the license. The licensing authority shall have the authority to collect reasonable costs, as determined by the licensing authority, for investigation from the licensee or applicant.

(4) The applicant has failed to provide information required by the licensing authority.

(5) The applicant or licensee has been convicted of an offense that is substantially related to the qualifications, functions, or duties of the business or profession for which the application is made, except that if the licensing authority determines that the applicant or licensee is otherwise suitable to be issued a license and granting the license would not compromise public safety, the licensing authority shall conduct a thorough review of the nature of the crime, conviction, circumstances, and evidence of rehabilitation of the applicant, and shall evaluate the suitability of the applicant or licensee to be issued a license based on the evidence found through the review. In determining which offenses are substantially related to the qualifications, functions, or duties of the business or profession for which the application is made, the licensing authority shall include, but not be limited to, the following:

(A) A felony conviction for the illegal possession for sale, sale, manufacture, transportation, or cultivation of a controlled substance.

(B) A violent felony conviction, as specified in subdivision (c) of Section 667.5 of the Penal Code.

(C) A serious felony conviction, as specified in subdivision (c) of Section 1192.7 of the Penal Code.

(D) A felony conviction involving fraud, deceit, or embezzlement.

(6) The applicant, or any of its officers, directors, or owners, is a licensed physician making patient recommendations for medical cannabis pursuant to Section 11362.7 of the Health and Safety Code.

(7) The applicant or any of its officers, directors, or owners has been subject to fines or penalties for cultivation or production of a controlled substance on public or private lands pursuant to Section 12025 or 12025.1 of the Fish and Game Code.

(8) The applicant, or any of its officers, directors, or owners, has been sanctioned by a licensing authority or a city, county, or city and county for unlicensed commercial medical cannabis activities or has had a license revoked under this chapter in the three years immediately preceding the date the application is filed with the licensing authority.

(9) Failure to obtain and maintain a valid seller's permit required pursuant to Part 1 (commencing with Section 6001) of Division 2 of the Revenue and Taxation Code.

SEC. 11. Section 19324 is added to the Business and Professions Code, to read:

19324. Upon the denial of any application for a license, the licensing authority shall notify the applicant in writing. Within 30 days of service of the notice, the applicant may file a written petition for a license with the licensing authority. Upon receipt of a timely filed petition, the licensing authority shall set the petition for hearing. The hearing shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the director of each licensing authority shall have all the powers granted therein.

SEC. 12. Section 19325 is added to the Business and Professions Code, to read:

19325. An applicant shall not be denied a state license if the denial is based solely on any of the following:

(a) A conviction or act that is substantially related to the qualifications, functions, or duties of the business or profession for which the application is made for which the applicant or licensee has obtained a certificate of rehabilitation pursuant to Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part 3 of the Penal Code.

(b) A conviction that was subsequently dismissed pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code.

SEC. 13. Article 6 (commencing with Section 19331) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 6. Licensed Cultivation Sites

19331. The Legislature finds and declares all of the following:

(a) The United States Environmental Protection Agency has not established appropriate pesticide tolerances for, or permitted the registration and lawful use of, pesticides on cannabis crops intended for human consumption pursuant to the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 et seq.).

(b) The use of pesticides is not adequately regulated due to the omissions in federal law, and cannabis cultivated in California for California patients can and often does contain pesticide residues.

(c) Lawful California medical cannabis growers and caregivers urge the Department of Pesticide Regulation to provide guidance, in absence of federal guidance, on whether the pesticides currently used at most cannabis

cultivation sites are actually safe for use on cannabis intended for human consumption.

19332. (a) The Department of Food and Agriculture shall promulgate regulations governing the licensing of indoor and outdoor cultivation sites.

(b) The Department of Pesticide Regulation, in consultation with the Department of Food and Agriculture, shall develop standards for the use of pesticides in cultivation, and maximum tolerances for pesticides and other foreign object residue in harvested cannabis.

(c) The State Department of Public Health shall develop standards for the production and labeling of all edible medical cannabis products.

(d) The Department of Food and Agriculture, in consultation with the Department of Fish and Wildlife and the State Water Resources Control Board, shall ensure that individual and cumulative effects of water diversion and discharge associated with cultivation do not affect the instream flows needed for fish spawning, migration, and rearing, and the flows needed to maintain natural flow variability.

(e) The Department of Food and Agriculture shall have the authority necessary for the implementation of the regulations it adopts pursuant to this chapter. The regulations shall do all of the following:

(1) Provide that weighing or measuring devices used in connection with the sale or distribution of medical cannabis are required to meet standards equivalent to Division 5 (commencing with Section 12001).

(2) Require that cannabis cultivation by licensees is conducted in accordance with state and local laws related to land conversion, grading, electricity usage, water usage, agricultural discharges, and similar matters. Nothing in this chapter, and no regulation adopted by the department, shall be construed to supersede or limit the authority of the State Water Resources Control Board, regional water quality control boards, or the Department of Fish and Wildlife to implement and enforce their statutory obligations or to adopt regulations to protect water quality, water supply, and natural resources.

(3) Establish procedures for the issuance and revocation of unique identifiers for activities associated with a cannabis cultivation license, pursuant to Article 8 (commencing with Section 19337). All cannabis shall be labeled with the unique identifier issued by the Department of Food and Agriculture.

(4) Prescribe standards, in consultation with the bureau, for the reporting of information as necessary related to unique identifiers, pursuant to Article 8 (commencing with Section 19337).

(f) The Department of Pesticide Regulation, in consultation with the State Water Resources Control Board, shall promulgate regulations that require that the application of pesticides or other pest control in connection with the indoor or outdoor cultivation of medical cannabis meets standards equivalent to Division 6 (commencing with Section 11401) of the Food and Agricultural Code and its implementing regulations.

(g) State cultivator license types issued by the Department of Food and Agriculture include:

(1) Type 1, or "specialty outdoor," for outdoor cultivation using no artificial lighting of less than or equal to 5,000 square feet of total canopy size on one premises, or up to 50 mature plants on noncontiguous plots.

(2) Type 1A, or "specialty indoor," for indoor cultivation using exclusively artificial lighting of less than or equal to 5,000 square feet of total canopy size on one premises.

(3) Type 1B, or "specialty mixed-light," for cultivation using a combination of natural and supplemental artificial lighting at a maximum threshold to be determined by the licensing authority, of less than or equal to 5,000 square feet of total canopy size on one premises.

(4) Type 2, or "small outdoor," for outdoor cultivation using no artificial lighting between 5,001 and 10,000 square feet, inclusive, of total canopy size on one premises.

(5) Type 2A, or "small indoor," for indoor cultivation using exclusively artificial lighting between 5,001 and 10,000 square feet, inclusive, of total canopy size on one premises.

(6) Type 2B, or "small mixed-light," for cultivation using a combination of natural and supplemental artificial lighting at a maximum threshold to be determined by the licensing authority, between 5,001 and 10,000 square feet, inclusive, of total canopy size on one premises.

(7) Type 3, or "outdoor," for outdoor cultivation using no artificial lighting from 10,001 square feet to one acre, inclusive, of total canopy size on one premises. The Department of Food and Agriculture shall limit the number of licenses allowed of this type.

(8) Type 3A, or "indoor," for indoor cultivation using exclusively artificial lighting between 10,001 and 22,000 square feet, inclusive, of total canopy size on one premises. The Department of Food and Agriculture shall limit the number of licenses allowed of this type.

(9) Type 3B, or "mixed-light," for cultivation using a combination of natural and supplemental artificial lighting at a maximum threshold to be determined by the licensing authority, between 10,001 and 22,000 square feet, inclusive, of total canopy size on one premises. The Department of Food and Agriculture shall limit the number of licenses allowed of this type.

(10) Type 4, or "nursery," for cultivation of medical cannabis solely as a nursery. Type 4 licensees may transport live plants.

19332.5. (a) Not later than January 1, 2020, the Department of Food and Agriculture in conjunction with the bureau, shall make available a certified organic designation and organic certification program for medical marijuana, if permitted under federal law and the National Organic Program (Section 6517 of the federal Organic Foods Production Act of 1990 (7 U.S.C. Sec. 6501 et seq.)), and Article 7 (commencing with Section 110810) of Chapter 5 of Part 5 of Division 104 of the Health and Safety Code.

(b) The bureau may establish appellations of origin for marijuana grown in California.

(c) It is unlawful for medical marijuana to be marketed, labeled, or sold as grown in a California county when the medical marijuana was not grown in that county.

(d) It is unlawful to use the name of a California county in the labeling, marketing, or packaging of medical marijuana products unless the product was grown in that county.

19333. An employee engaged in commercial cannabis cultivation activity shall be subject to Wage Order 4-2001 of the Industrial Welfare Commission.

SEC. 14. Article 7.5 (commencing with Section 19335) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 7.5. Unique Identifier and Track and Trace Program

19335. (a) The Department of Food and Agriculture, in consultation with the bureau, shall establish a track and trace program for reporting the movement of medical marijuana items throughout the distribution chain that utilizes a unique identifier pursuant to Section 11362.777 of the Health and Safety Code and secure packaging and is capable of providing information that captures, at a minimum, all of the following:

(1) The licensee receiving the product.

(2) The transaction date.

(3) The cultivator from which the product originates, including the associated unique identifier, pursuant to Section 11362.777 of the Health and Safety Code.

(b) (1) The Department of Food and Agriculture shall create an electronic database containing the electronic shipping manifests which shall include, but not be limited to, the following information:

(A) The quantity, or weight, and variety of products shipped.

(B) The estimated times of departure and arrival.

(C) The quantity, or weight, and variety of products received.

(D) The actual time of departure and arrival.

(E) A categorization of the product.

(F) The license number and the unique identifier pursuant to Section 11362.777 of the Health and Safety Code issued by the licensing authority for all licensees involved in the shipping process, including cultivators, transporters, distributors, and dispensaries.

(2) (A) The database shall be designed to flag irregularities for all licensing authorities in this chapter to investigate. All licensing authorities pursuant to this chapter may access the database and share information related to licensees under this chapter, including social security and individual taxpayer identifications notwithstanding Section 30.

(B) The Department of Food and Agriculture shall immediately inform the bureau upon the finding of an irregularity or suspicious finding related to a licensee, applicant, or commercial cannabis activity for investigatory purposes.

(3) Licensing authorities and state and local agencies may, at any time, inspect shipments and request documentation for current inventory.

(4) The bureau shall have 24-hour access to the electronic database administered by the Department of Food and Agriculture.

(5) The Department of Food and Agriculture shall be authorized to enter into memoranda of understandings with licensing authorities for data sharing purposes, as deemed necessary by the Department of Food and Agriculture.

(6) Information received and contained in records kept by the Department of Food and Agriculture or licensing authorities for the purposes of administering this section are confidential and shall not be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), except as necessary for authorized employees of the State of California or any city, county, or city and county to perform official duties pursuant to this chapter or a local ordinance.

(7) Upon the request of a state or local law enforcement agency, licensing authorities shall allow access to or provide information contained within the database to assist law enforcement in their duties and responsibilities pursuant to this chapter.

19336. (a) Chapter 4 (commencing with Section 55121) of Part 30 of Division 2 of the Revenue and Taxation Code shall apply with respect to the bureau's collection of the fees, civil fines, and penalties imposed pursuant to this chapter.

(b) Chapter 8 (commencing with Section 55381) of Part 30 of Division 2 of the Revenue and Taxation Code shall apply with respect to the disclosure of information under this chapter.

SEC. 15. Article 8 (commencing with Section 19337) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 8. Licensed Transporters

19337. (a) A licensee authorized to transport medical cannabis and medical cannabis products between licenses shall do so only as set forth in this chapter.

(b) Prior to transporting medical cannabis or medical cannabis products, a licensed transporter of medical cannabis or medical cannabis products shall do both of the following:

(1) Complete an electronic shipping manifest as prescribed by the licensing authority. The shipping manifest must include the unique identifier, pursuant to Section 11362.777 of the Health and Safety Code, issued by the Department of Food and Agriculture for the original cannabis product.

(2) Securely transmit the manifest to the bureau and the licensee that will receive the medical cannabis product. The bureau shall inform the Department of Food and Agriculture of information pertaining to commercial cannabis activity for the purpose of the track and trace program identified in Section 19335.

(c) During transportation, the licensed transporter shall maintain a physical copy of the shipping manifest and make it available upon request to agents of the Department of Consumer Affairs and law enforcement officers.

(d) The licensee receiving the shipment shall maintain each electronic shipping manifest and shall make it available upon request to the Department of Consumer Affairs and any law enforcement officers.

(e) Upon receipt of the transported shipment, the licensee receiving the shipment shall submit to the licensing agency a record verifying receipt of the shipment and the details of the shipment.

(f) Transporting, or arranging for or facilitating the transport of, medical cannabis or medical cannabis products in violation of this chapter is grounds for disciplinary action against the license.

19338. (a) This chapter shall not be construed to authorize or permit a licensee to transport or cause to be transported cannabis or cannabis products outside the state, unless authorized by federal law.

(b) A local jurisdiction shall not prevent transportation of medical cannabis or medical cannabis products on public roads by a licensee transporting medical cannabis or medical cannabis products in compliance with this chapter.

SEC. 16. Article 11 (commencing with Section 19348) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 11. Taxation

19348. (a) (1) A county may impose a tax on the privilege of cultivating, dispensing, producing, processing, preparing, storing, providing, donating, selling, or distributing medical cannabis or medical cannabis products by a licensee operating pursuant to this chapter.

(2) The board of supervisors shall specify in the ordinance proposing the tax the activities subject to the tax, the applicable rate or rates, the method of apportionment, if necessary, and the manner of collection of the tax. The tax may be imposed for general governmental purposes or for purposes specified in the ordinance by the board of supervisors.

(3) In addition to any other method of collection authorized by law, the board of supervisors may provide for the collection of the tax imposed pursuant to this section in the same manner, and subject to the same penalties and priority of lien, as other charges and taxes fixed and collected by the county. A tax imposed pursuant to this section is a tax and not a fee or special assessment. The board of supervisors shall specify whether the tax applies throughout the entire county or within the unincorporated area of the county.

(4) The tax authorized by this section may be imposed upon any or all of the activities set forth in paragraph (1), as specified in the ordinance, regardless of whether the activity is undertaken individually, collectively, or cooperatively, and regardless of whether the activity is for compensation or gratuitous, as determined by the board of supervisors.

(b) A tax imposed pursuant to this section shall be subject to applicable voter approval requirements imposed by law.

(c) This section is declaratory of existing law and does not limit or prohibit the levy or collection of any other fee, charge, or tax, or a license or service fee or charge upon, or related to, the activities set forth in subdivision (a) as otherwise provided by law. This section shall not be construed as a limitation upon the taxing authority of a county as provided by law.

(d) This section shall not be construed to authorize a county to impose a sales or use tax in addition to the sales and use tax imposed under an ordinance conforming to the provisions of Sections 7202 and 7203 of the Revenue and Taxation Code.

SEC. 17. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 18. The Legislature finds and declares that Section 14 of this act, which adds Section 19335 to the Business and Professions Code, thereby imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

The limitation imposed under this act is necessary for purposes of compliance with the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 1320d et seq.), the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), and the Insurance Information and Privacy Protection Act (Article 6.6 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code).

SEC. 19. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 20. This act shall become operative only if Assembly Bill 266 and Assembly Bill 243 of the 2015–16 Session are enacted and take effect on or before January 1, 2016.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: **S**B 738
Author: Huff
Chapter: 132
Bill Date: May 13, 2015, Amended
Subject: Pupil Health: Epinephrine Auto-Injectors: Liability Limitation
Sponsor: California Society for Allergy, Asthma and Immunology (CSAAI)
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill provides liability protection for physicians writing standing order prescriptions for epinephrine auto-injectors for school districts, county offices of education, and charter schools.

BACKGROUND

SB 1266 (Huff, Chapter 321, Statutes of 2014) was signed into law last year. This bill requires school districts, county offices of education (COE), and charter schools to provide emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered, as specified. This bill authorizes school nurses or trained personnel to use the epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction. Epinephrine is the first line of treatment for someone who is experiencing anaphylaxis, a potential lethal allergic reaction. Epinephrine is easily administered and has very little side effect.

According to the author's office, once SB 1266 took effect, many physicians began raising questions about issuing the prescription due to liability concerns. Physicians have concerns with issuing standing orders to the school, and have requested liability coverage in law, similar to what is in place for Automated External Defibrillators (AEDs) and opioid antagonists (Naloxone). In addition, recent data from the California School Nurse Organization shows that many schools cannot implement SB 1266 because they cannot obtain the necessary prescription.

ANALYSIS

This bill states that an authorizing physician and surgeon shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for the issuance of a prescription or order pursuant to existing law related to epinephrine auto injectors, unless the physician and surgeon's issuance of the prescription or order constitutes gross negligence or willful or malicious conduct.

The Board has supported bills in the past that provide this type of liability protection for physicians, including AB 635 (Ammiano) in 2013. The Board took a support position on this bill because it will help school districts obtain standing order prescriptions, so they can benefit from SB 1266 from last year.

FISCAL: None to the Board

SUPPORT: CSAAI (Sponsor); Advocacy Council – American College of Allergy, Asthma and Immunology; American Academy of Allergy, Asthma and Immunology; American College of Allergy, Asthma and Immunology; Association of Regional Centers Agencies; California Chapter of the American College of Emergency Physicians; California School Nurses Organization; Civil Justice Association of California; Los Angeles Unified School District; Medical Board of California; Rady Children's Specialists of San Diego; Sanofi; Santa Clara Office of Education; Sutter Medical Foundation; and three individuals

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section

Senate Bill No. 738

CHAPTER 132

An act to amend Section 49414 of the Education Code, relating to pupil health.

[Approved by Governor July 16, 2015. Filed with Secretary of State July 16, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 738, Huff. Pupil health: epinephrine auto-injectors: liability limitation.

Existing law requires school districts, county offices of education, and charter schools to provide emergency epinephrine auto-injectors to school nurses and trained personnel who have volunteered, as specified, and authorizes school nurses and trained personnel to use epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction. Existing law requires a qualified supervisor of health or administrator at a school district, county office of education, or charter school to obtain the prescription for epinephrine auto-injectors from an authorizing physician and surgeon, as defined, and authorizes the prescription to be filled by local or mail order pharmacies or epinephrine auto-injector manufacturers.

This bill would prohibit an authorizing physician and surgeon from being subject to professional review, being liable in a civil action, or being subject to criminal prosecution for the issuance of a prescription or order, pursuant to these provisions, unless the physician and surgeon's issuance of the prescription or order constitutes gross negligence or willful or malicious conduct. The bill would also update an entity reference.

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

SECTION 1. Section 49414 of the Education Code is amended to read:

49414. (a) School districts, county offices of education, and charter schools shall provide emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered pursuant to subdivision (d), and school nurses or trained personnel may use epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction.

(b) For purposes of this section, the following terms have the following meanings:

(1) "Anaphylaxis" means a potentially life-threatening hypersensitivity to a substance.

(A) Symptoms of anaphylaxis may include shortness of breath, wheezing, difficulty breathing, difficulty talking or swallowing, hives, itching, swelling, shock, or asthma.

(B) Causes of anaphylaxis may include, but are not limited to, an insect sting, food allergy, drug reaction, and exercise.

(2) "Authorizing physician and surgeon" may include, but is not limited to, a physician and surgeon employed by, or contracting with, a local educational agency, a medical director of the local health department, or a local emergency medical services director.

(3) "Epinephrine auto-injector" means a disposable drug delivery system with a spring-activated needle that is designed for emergency administration of epinephrine to provide rapid, convenient first aid for persons suffering a potentially fatal reaction to anaphylaxis.

(4) "Qualified supervisor of health" may include, but is not limited to, a school nurse.

(5) "Volunteer" or "trained personnel" means an employee who has volunteered to administer epinephrine auto-injectors to a person if the person is suffering, or reasonably believed to be suffering, from anaphylaxis, has been designated by a school, and has received training pursuant to subdivision (d).

(c) Each private elementary and secondary school in the state may voluntarily determine whether or not to make emergency epinephrine auto-injectors and trained personnel available at its school. In making this determination, a school shall evaluate the emergency medical response time to the school and determine whether initiating emergency medical services is an acceptable alternative to epinephrine auto-injectors and trained personnel. A private elementary or secondary school choosing to exercise the authority provided under this subdivision shall not receive state funds specifically for purposes of this subdivision.

(d) Each public and private elementary and secondary school in the state may designate one or more volunteers to receive initial and annual refresher training, based on the standards developed pursuant to subdivision (e), regarding the storage and emergency use of an epinephrine auto-injector from the school nurse or other qualified person designated by an authorizing physician and surgeon.

(e) (1) Every five years, or sooner as deemed necessary by the Superintendent, the Superintendent shall review minimum standards of training for the administration of epinephrine auto-injectors that satisfy the requirements of paragraph (2). For purposes of this subdivision, the Superintendent shall consult with organizations and providers with expertise in administering epinephrine auto-injectors and administering medication in a school environment, including, but not limited to, the State Department of Public Health, the Emergency Medical Services Authority, the American Academy of Allergy, Asthma and Immunology, the California School Nurses Organization, the California Medical Association, the American Academy of Pediatrics, Food Allergy Research and Education, the California Society of Allergy, Asthma and Immunology, the American College of Allergy,

Asthma and Immunology, the Sean N. Parker Center for Allergy Research, and others.

(2) Training established pursuant to this subdivision shall include all of the following:

(A) Techniques for recognizing symptoms of anaphylaxis.

(B) Standards and procedures for the storage, restocking, and emergency use of epinephrine auto-injectors.

(C) Emergency followup procedures, including calling the emergency 911 telephone number and contacting, if possible, the pupil's parent and physician.

(D) Recommendations on the necessity of instruction and certification in cardiopulmonary resuscitation.

(E) Instruction on how to determine whether to use an adult epinephrine auto-injector or a junior epinephrine auto-injector, which shall include consideration of a pupil's grade level or age as a guideline of equivalency for the appropriate pupil weight determination.

(F) Written materials covering the information required under this subdivision.

(3) Training established pursuant to this subdivision shall be consistent with the most recent Voluntary Guidelines for Managing Food Allergies In Schools and Early Care and Education Programs published by the federal Centers for Disease Control and Prevention and the most recent guidelines for medication administration issued by the department.

(4) A school shall retain for reference the written materials prepared under subparagraph (F) of paragraph (2).

(f) A school district, county office of education, or charter school shall distribute a notice at least once per school year to all staff that contains the following information:

(1) A description of the volunteer request stating that the request is for volunteers to be trained to administer an epinephrine auto-injector to a person if the person is suffering, or reasonably believed to be suffering, from anaphylaxis, as specified in subdivision (b).

(2) A description of the training that the volunteer will receive pursuant to subdivision (d).

(g) (1) A qualified supervisor of health at a school district, county office of education, or charter school shall obtain from an authorizing physician and surgeon a prescription for each school for epinephrine auto-injectors that, at a minimum, includes, for elementary schools, one regular epinephrine auto-injector and one junior epinephrine auto-injector, and for junior high schools, middle schools, and high schools, if there are no pupils who require a junior epinephrine auto-injector, one regular epinephrine auto-injector. A qualified supervisor of health at a school district, county office of education, or charter school shall be responsible for stocking the epinephrine auto-injector and restocking it if it is used.

(2) If a school district, county office of education, or charter school does not have a qualified supervisor of health, an administrator at the school

district, county office of education, or charter school shall carry out the duties specified in paragraph (1).

(3) A prescription pursuant to this subdivision may be filled by local or mail order pharmacies or epinephrine auto-injector manufacturers.

(4) An authorizing physician and surgeon shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for the issuance of a prescription or order pursuant to this section, unless the physician and surgeon's issuance of the prescription or order constitutes gross negligence or willful or malicious conduct.

(h) A school nurse or, if the school does not have a school nurse or the school nurse is not onsite or available, a volunteer may administer an epinephrine auto-injector to a person exhibiting potentially life-threatening symptoms of anaphylaxis at school or a school activity when a physician is not immediately available. If the epinephrine auto-injector is used it shall be restocked as soon as reasonably possible, but no later than two weeks after it is used. Epinephrine auto-injectors shall be restocked before their expiration date.

(i) A volunteer shall initiate emergency medical services or other appropriate medical followup in accordance with the training materials retained pursuant to paragraph (4) of subdivision (e).

(j) A school district, county office of education, or charter school shall ensure that each employee who volunteers under this section will be provided defense and indemnification by the school district, county office of education, or charter school for any and all civil liability, in accordance with, but not limited to, that provided in Division 3.6 (commencing with Section 810) of Title 1 of the Government Code. This information shall be reduced to writing, provided to the volunteer, and retained in the volunteer's personnel file.

(k) A state agency, the department, or a public school may accept gifts, grants, and donations from any source for the support of the public school carrying out the provisions of this section, including, but not limited to, the acceptance of epinephrine auto-injectors from a manufacturer or wholesaler.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 800
Author:	Committee on Business, Professions, and Economic Development
Chapter	426
Bill Date:	July 16, 2015, Amended
Subject:	Omnibus
Sponsor:	Committee, Medical Board of California and other affected regulatory health boards
Position:	Support provisions related to the Board

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business, Professions and Economic Development Committee. This analysis only includes the relevant sections of the bill in the Business and Professions Code (BPC) that are sponsored by and impact the Medical Board of California (Board). The omnibus language clarifies that registration is required to practice as a polysomnographic technologist, technician, or trainee in California. This bill also makes other technical, clarifying changes to fix an incorrect code section reference in existing law, delete an outdated section of statute related to a pilot project that no longer exists, and clarify that a licensee cannot call themselves "doctor", "physician", "Dr.", or "M.D.", if their license to practice medicine has been suspended or revoked.

ANALYSIS:

BPC Section 146 – Polysomnography

Existing statute does not specifically state that registration is required to practice as a polysomnographic technologist, technician, or trainee in California. Due to this ambiguity, the Board has encountered issues with pursuing action against individuals who are practicing polysomnography without being registered with the Board. This bill adds the code section related to polysomnographic technologists, technicians, and trainees to Business and Professions Code Section 146, which requires registration to engage in businesses and professions that are regulated by the code sections listed.

This bill ensures that individuals practicing as polysomnographic technologists in California are registered and subject to appropriate regulation by the Board if not. This will further the Board's mission of consumer protection.

BPC Section 2054 – Jurisdiction Language

This bill makes a technical, clarifying change in the section of law that regulates when individuals can use the words "doctor", "physician", "Dr", or the initials "M.D." Current law does not allow use if an individual has been issued a license to practice medicine in another jurisdiction and has had that license suspended or revoked. The word "another jurisdiction" in existing law leads to the interpretation that this provision

may not apply to California licensees who have had their licenses suspended or revoked, although it should. It does not protect consumers to allow licensees in California that have had their license suspended or revoked to be able to use "doctor", "physician", "Dr.", or "M.D.".

This bill clarifies that any licensee (including those licensed in California), cannot call themselves "doctor", "physician", "Dr.", or use the initials "M.D.", if their license to practice medicine has been suspended or revoked. This will help to further the Board's mission of consumer protection.

BPC 2401 – Sunsetted Pilot Program

BPC Section 2401 specifies exemptions to the ban on the corporate practice of medicine. One of these exemptions included a pilot program in 2401.1, that has since been sunsetted and repealed. This change simply cleans up the code section.

BPC 2529 – Incorrect Code Section Reference

A registered Research Psychoanalyst is an individual who has graduated from an approved psychoanalytic institution and is registered with the Board. Research Psychoanalysts may engage in psychoanalysis as an adjunct to teaching, training or research. Additionally, students who are currently enrolled in an approved psychoanalytic institution and are registered with the Board as a Student Research Psychoanalyst, may engage in psychoanalysis under supervision. B&P Code Section 2529 references code sections that define unprofessional conduct for Research Psychoanalysts. One of the code sections referenced is 725, which is the wrong code section, as Research Psychoanalysts cannot prescribe.

This bill corrects an incorrect code reference, as excessive prescribing does not apply to Research Psychoanalysts, however sexual misconduct could apply and is the correct code section that should be referred to in this section, BPC Section 726, not 725.

These statute changes were already approved by the Board to be included in the omnibus bill.

FISCAL: None to the Board

SUPPORT: Medical Board of California

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section

Senate Bill No. 800

CHAPTER 426

An act to amend Sections 28, 146, 500, 650.2, 800, 1603a, 1618.5, 1640.1, 1648.10, 1650, 1695, 1695.1, 1905.1, 1944, 2054, 2401, 2428, 2529, 2650, 2770, 2770.1, 2770.2, 2770.7, 2770.8, 2770.10, 2770.11, 2770.12, 2770.13, 2835.5, 3057, 3509.5, 4836.2, 4887, 4938, 4939, 4980.399, 4980.43, 4980.54, 4984.01, 4989.34, 4992.09, 4996.2, 4996.22, 4996.28, 4999.1, 4999.2, 4999.3, 4999.4, 4999.5, 4999.7, 4999.45, 4999.46, 4999.55, 4999.76, and 4999.100 of, to amend the heading of Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2 of, and to repeal Section 1917.2 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor October 1, 2015. Filed with Secretary of State October 1, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 800, Committee on Business, Professions and Economic Development. Healing arts.

Under existing law, the Department of Consumer Affairs is comprised of various boards that license and regulate the practice of various professions and vocations, including those relating to the healing arts:

(1) Existing law requires persons applying for initial licensure or renewal of a license as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist to have completed prescribed coursework or training in child abuse assessment and reporting. Existing law requires the training to have been obtained from an accredited or approved educational institution, a continuing education provider approved by the responsible board, or a course sponsored or offered by a professional association or a local, county, or state department of health or mental health for continuing education and approved by the responsible board.

This bill would require the responsible board to specify a continuing education provider for child abuse assessment and reporting coursework by regulation, and would permit the responsible board to approve or accept a sponsored or offered course.

(2) Existing law relating to unlicensed activity enforcement lists specified provisions that require registration, licensure, certification, or other authorization in order to engage in certain businesses or professions and, notwithstanding any other law, makes a violation of a listed provision punishable as an infraction under specified circumstances.

This bill would include in those listed provisions an existing requirement for the registration of individuals as certified polysomnographic technologists, polysomnographic technicians, and polysomnographic trainees.

The bill would also include in those listed provisions a provision of the Educational Psychologist Practice Act that makes it unlawful for any person to practice educational psychology or use any title or letters that imply that he or she is a licensed educational psychologist unless, at the time of so doing, he or she holds a valid, unexpired, and unrevoked license under that act, the violation of which is a misdemeanor. The bill would further include in those listed provisions existing requirements of the Licensed Professional Clinical Counselor Act that a person not practice or advertise the performance of professional clinical counseling services without a license and pay the license fee, as required by that act, the violation of which is a misdemeanor.

By creating new infractions, this bill would impose a state-mandated local program.

(3) The Dental Practice Act provides for the licensure and regulation of dentists by the Dental Board of California. For purposes of the act, any reference to the Board of Dental Examiners is deemed a reference to the Dental Board of California.

This bill would delete certain existing references to the Board of Dental Examiners and, instead, refer to the Dental Board of California.

(4) Existing law provides for the regulation of dental hygienists by the Dental Hygiene Committee of California, within the jurisdiction of the Dental Board of California. Existing law authorizes the committee, until January 1, 2010, to contract with the dental board to carry out any of specified provisions relating to the regulation of dental hygienists, and, on and after January 1, 2010, to contract with the dental board to perform investigations of applicants and licensees. Existing law requires a new educational program for registered dental hygienists to submit a specified feasibility study. Existing law limits the fee for each curriculum review and site evaluation for these programs to a specified amount.

This bill would require the Dental Hygiene Committee of California to create and maintain a central file of the names of licensees, to provide an individual historical record with information on acts of licensee misconduct and discipline. The bill would remove the limiting dates from the contracting provisions, thereby authorizing the committee to contract with the dental board indefinitely to carry out any of specified provisions relating to the regulation of dental hygienists, including performing investigations of applicants and licensees. The bill would additionally limit the fee for each feasibility study review to that same specified amount.

(5) The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under existing law, the board issues a physician and surgeon’s certificate to a licensed physician surgeon. The act prohibits a person who fails to renew his or her license within 5 years after its expiration from renewing it, and prohibits the license from being reissued, reinstated, or restored thereafter, although the act authorizes a person to apply for and obtain a new license under specified circumstances.

This bill would recast that renewal provision to prohibit renewal by a person who voluntarily cancels his or her license or who fails to renew it as described, and would authorize that person to apply for and obtain a license under those specified circumstances, without regard to reissuance, reinstatement, or restoration.

(6) 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 for, among other things, repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, use of diagnostic procedures, or use of diagnostic or treatment facilities.

This bill would substitute, for those described bases for suspension or revocation of the exemption, the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer.

(7) The Physical Therapy Practice Act provides for the licensure and regulation of physical therapists and physical therapist assistants by the Physical Therapy Board of California. The act establishes education requirements for a physical therapist assistant, including subject matter instruction through a combination of didactic and clinical experiences, and requires the clinical experience to include at least 18 weeks of full-time experience with a variety of patients.

This bill would delete that 18-week full-time experience requirement for physical therapist assistant education.

(8) The Nursing Practice Act provides for the licensure and regulation of registered nurses and nurse practitioners by the Board of Registered Nursing. The act, on and after January 1, 2008, requires an applicant for initial qualification or certification as a nurse practitioner who has not been qualified or certified as a nurse practitioner to meet specified requirements. Certain provisions allow the board to find registered nurses qualified to use the title of "nurse practitioner."

This bill would delete those title provisions.

The Nursing Practice Act provides for a diversion program to identify and rehabilitate registered nurses whose competency may be impaired due to abuse of alcohol and other drugs, or due to mental illness.

This bill would instead refer to the program as an intervention program.

(9) The Optometry Practice Act provides for the licensure and regulation of optometrists by the State Board of Optometry. The act prescribes license eligibility requirements, including, but not limited to, submitting proof that the person is licensed in good standing as of the date of application in every state where he or she holds a license, including compliance with continuing education requirements, submitting proof that the person has been in active practice in a state in which he or she is licensed for a total of at least 5,000 hours in 5 of the 7 consecutive years immediately preceding the date of his or her application, and has never had his or her license to practice optometry

revoked or suspended. For purposes of those provisions, "in good standing" includes the requirement that the person has not been found mentally incompetent by a physician so that the person is unable to undertake the practice of optometry in a manner consistent with the safety of a patient or the public.

This bill would delete that active practice requirement and would require that the license have never been revoked or suspended in any state where the person holds a license. The bill, with regard to making such a finding of mental incompetence, would replace a finding by a physician with a finding by a licensed psychologist or licensed psychiatrist.

(10) The Physician Assistant Practice Act requires the Physician Assistant Board to annually elect a chairperson and vice chairperson from among its members.

This bill would require the annual election of a president and vice president.

(11) Existing law relating to veterinary medicine requires a veterinary assistant to obtain a controlled substance permit from the Veterinary Medical Board in order to administer a controlled substance, and authorizes the board to deny, revoke, or suspend the permit, after notice and hearing, for any of specified causes. Existing law authorizes the board to revoke or suspend a permit for the same.

This bill would, instead, authorize the board to suspend or revoke the controlled substance permit of a veterinary assistant, after notice and hearing, for any of specified causes, and to deny, revoke, or suspend a permit for the same.

(12) The Acupuncture Licensure Act provides for the licensure and regulation of the practice of acupuncture by the Acupuncture Board. The act requires the board to issue a license to practice acupuncture to a person who meets prescribed requirements. The act requires, in the case of an applicant who has completed education and training outside the United States and Canada, documented educational training and clinical experience that meets certain standards established by the board. Existing law, commencing January 1, 2017, specifically requires the board to establish standards for the approval of educational training and clinical experience received outside the United States and Canada.

This bill would remove Canada from those provisions, thereby applying the same standards to all training and clinical experience completed outside the United States.

(13) The Board of Behavioral Sciences is responsible for administering the Licensed Marriage and Family Therapist Act, the Educational Psychologist Practice Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act.

The Licensed Marriage and Family Therapist Act provides for the licensure and regulation of marriage and family therapists by the Board of Behavioral Sciences. The act sets forth the educational and training requirements for licensure as a marriage and family therapist, including certain supervised-experience requirements whereby a prospective licensee

is required to work a specified number of hours in a clinical setting under the supervision of experienced professionals. The act requires all persons to register with the board as an intern in order to be credited for postdegree hours of supervised experience gained toward licensure. The act, with regard to interns, requires all postdegree hours of experience to be credited toward licensure, except when employed in a private practice setting, if certain conditions are met. The act limits the number of hours applicants for a marriage and family therapist license may provide counseling services via telehealth.

The bill would require postdegree hours of experience to be credited toward licensure if certain conditions are met. The bill would prohibit an applicant for licensure as a marriage and family therapist from being employed or volunteering in a private practice until registered as an intern by the board. The bill would similarly prohibit an applicant for professional clinical counselor under the Licensed Professional Clinical Counselor Act from being employed or volunteering in a private practice until registered as an intern by the board.

The bill would authorize a marriage and family therapist intern and trainee to provide services via telehealth if he or she is supervised as required by the act, and is acting within the scope authorized by the act and in accordance with any regulations governing the use of telehealth promulgated by the Board of Behavioral Sciences.

The Licensed Marriage and Family Therapist Act and the Licensed Professional Clinical Counselor Act require applicants for licensure under those acts to comply with specified educational and experience requirements, including, but not limited to, hours of supervised experience, and sets forth terms, conditions, and limitations for those hours of experience, as specified.

The bill would revise those experience requirements and provide that individuals who submit applications for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the current requirements.

The Licensed Marriage and Family Therapist Act, the Educational Psychologist Practice Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act require the Board of Behavioral Sciences to approve continuing education providers for specified educational courses relating to licensure for marriage and family therapists, educational psychologists, clinical social workers, and professional clinical counselors.

This bill would modify those acts to require the Board of Behavioral Sciences to identify, by regulation, acceptable continuing education providers.

The Licensed Marriage and Family Therapist Act and the Licensed Professional Clinical Counselor Act provide for the registration of interns and allow a maximum of possible renewals after initial registration, after which a new registration number is required to be obtained. The Clinical Social Worker Practice Act provides similarly for the registration and renewal of registration of associate clinical social workers. An applicant

who is issued a subsequent number is barred from employment or volunteering in a private practice.

This bill would revise those provisions to refer throughout to subsequent registration numbers.

(14) Existing law provides for the registration of telephone medical advice services. Existing law imposes requirements for obtaining and maintaining registration, including a requirement that medical advice services be provided by specified licensed, registered, or certified health care professionals.

This bill would expand the specified health care professionals to include naturopathic doctors and licensed professional clinical counselors. The bill would require a service to notify the department of certain business changes, and to submit quarterly reports.

(15) This bill would additionally delete or update obsolete provisions and make conforming or nonsubstantive changes.

(16) This bill would incorporate additional changes to Section 1944 of the Business and Professions Code made by this bill and AB 483 to take effect if both bills are chaptered and this bill is chaptered last.

(17) 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.

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

SECTION 1. Section 28 of the Business and Professions Code is amended to read:

28. (a) The Legislature finds that there is a need to ensure that professionals of the healing arts who have demonstrable contact with victims and potential victims of child, elder, and dependent adult abuse, and abusers and potential abusers of children, elders, and dependent adults are provided with adequate and appropriate training regarding the assessment and reporting of child, elder, and dependent adult abuse that will ameliorate, reduce, and eliminate the trauma of abuse and neglect and ensure the reporting of abuse in a timely manner to prevent additional occurrences.

(b) The Board of Psychology and the Board of Behavioral Sciences shall establish required training in the area of child abuse assessment and reporting for all persons applying for initial licensure and renewal of a license as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist. This training shall be required one time only for all persons applying for initial licensure or for licensure renewal.

(c) All persons applying for initial licensure or renewal of a license as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist shall, in addition to all other requirements for licensure or renewal, have completed coursework or training in child abuse

assessment and reporting that meets the requirements of this section, including detailed knowledge of the Child Abuse and Neglect Reporting Act (Article 2.5 (commencing with Section 11164) of Chapter 2 of Title 1 of Part 4 of the Penal Code). The training shall meet all of the following requirements:

(1) Be obtained from one of the following sources:

(A) An accredited or approved educational institution, as defined in Sections 2902, 4980.36, 4980.37, 4996.18, and 4999.12, including extension courses offered by those institutions.

(B) A continuing education provider as specified by the responsible board by regulation.

(C) A course sponsored or offered by a professional association or a local, county, or state department of health or mental health for continuing education and approved or accepted by the responsible board.

(2) Have a minimum of seven contact hours.

(3) Include the study of the assessment and method of reporting of sexual assault, neglect, severe neglect, general neglect, willful cruelty or unjustifiable punishment, corporal punishment or injury, and abuse in out-of-home care. The training shall also include physical and behavioral indicators of abuse, crisis counseling techniques, community resources, rights and responsibilities of reporting, consequences of failure to report, caring for a child's needs after a report is made, sensitivity to previously abused children and adults, and implications and methods of treatment for children and adults.

(4) An applicant shall provide the appropriate board with documentation of completion of the required child abuse training.

(d) The Board of Psychology and the Board of Behavioral Sciences shall exempt an applicant who applies for an exemption from this section and who shows to the satisfaction of the board that there would be no need for the training in his or her practice because of the nature of that practice.

(e) It is the intent of the Legislature that a person licensed as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist have minimal but appropriate training in the areas of child, elder, and dependent adult abuse assessment and reporting. It is not intended that, by solely complying with this section, a practitioner is fully trained in the subject of treatment of child, elder, and dependent adult abuse victims and abusers.

(f) The Board of Psychology and the Board of Behavioral Sciences are encouraged to include coursework regarding the assessment and reporting of elder and dependent adult abuse in the required training on aging and long-term care issues prior to licensure or license renewal.

SEC. 2. Section 146 of the Business and Professions Code is amended to read:

146. (a) Notwithstanding any other provision of law, a violation of any code section listed in subdivision (c) is an infraction subject to the procedures described in Sections 19.6 and 19.7 of the Penal Code when either of the following applies:

(1) A complaint or a written notice to appear in court pursuant to Chapter 5c (commencing with Section 853.5) of Title 3 of Part 2 of the Penal Code is filed in court charging the offense as an infraction unless the defendant, at the time he or she is arraigned, after being advised of his or her rights, elects to have the case proceed as a misdemeanor.

(2) The court, with the consent of the defendant and the prosecution, determines that the offense is an infraction in which event the case shall proceed as if the defendant has been arraigned on an infraction complaint.

(b) Subdivision (a) does not apply to a violation of the code sections listed in subdivision (c) if the defendant has had his or her license, registration, or certificate previously revoked or suspended.

(c) The following sections require registration, licensure, certification, or other authorization in order to engage in certain businesses or professions regulated by this code:

(1) Sections 2052 and 2054.
(2) Section 2630.
(3) Section 2903.
(4) Section 3575.
(5) Section 3660.
(6) Sections 3760 and 3761.
(7) Section 4080.
(8) Section 4825.
(9) Section 4935.
(10) Section 4980.
(11) Section 4989.50.
(12) Section 4996.
(13) Section 4999.30.
(14) Section 5536.
(15) Section 6704.
(16) Section 6980.10.
(17) Section 7317.
(18) Section 7502 or 7592.
(19) Section 7520.
(20) Section 7617 or 7641.
(21) Subdivision (a) of Section 7872.
(22) Section 8016.
(23) Section 8505.
(24) Section 8725.
(25) Section 9681.
(26) Section 9840.
(27) Subdivision (c) of Section 9891.24.
(28) Section 19049.

(d) Notwithstanding any other law, a violation of any of the sections listed in subdivision (c), which is an infraction, is punishable by a fine of not less than two hundred fifty dollars ($250) and not more than one thousand dollars ($1,000). No portion of the minimum fine may be suspended by the court unless as a condition of that suspension the defendant is required to

submit proof of a current valid license, registration, or certificate for the profession or vocation that was the basis for his or her conviction.

SEC. 3. Section 500 of the Business and Professions Code is amended to read:

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

SEC. 4. Section 650.2 of the Business and Professions Code is amended to read:

650.2. (a) Notwithstanding Section 650 or any other provision of law, it shall not be unlawful for a person licensed pursuant to Chapter 4 (commencing with Section 1600) of Division 2 or any other person, to participate in or operate a group advertising and referral service for dentists if all of the following conditions are met:

(1) The patient referrals by the service result from patient-initiated responses to service advertising.

(2) The service advertises, if at all, in conformity with Section 651 and subdivisions (i) and (*l*) of Section 1680.

(3) The service does not employ a solicitor within the meaning of subdivision (j) of Section 1680.

(4) The service does not impose a fee on the member dentists dependent upon the number of referrals or amount of professional fees paid by the patient to the dentist.

(5) Participating dentists charge no more than their usual and customary fees to any patient referred.

(6) The service registers with the Dental Board of California, providing its name and address.

(7) The service files with the Dental Board of California a copy of the standard form contract that regulates its relationship with member dentists, which contract shall be confidential and not open to public inspection.

(8) If more than 50 percent of its referrals are made to one individual, association, partnership, corporation, or group of three or more dentists, the service discloses that fact in all public communications, including, but not limited to, communication by means of television, radio, motion picture, newspaper, book, or list or directory of healing arts practitioners.

(9) When member dentists pay any fee to the service, any advertisement by the service shall clearly and conspicuously disclose that fact by including a statement as follows: “Paid for by participating dentists.” In print advertisements, the required statement shall be in at least 9-point type. In radio advertisements, the required statement shall be articulated so as to be clearly audible and understandable by the radio audience. In television advertisements, the required statement shall be either clearly audible and understandable to the television audience, or displayed in a written form

that remains clearly visible for at least five seconds to the television audience. This subdivision shall be operative on and after July 1, 1994.

(b) The Dental Board of California may adopt regulations necessary to enforce and administer this section.

(c) The Dental Board of California may suspend or revoke the registration of any service that fails to comply with paragraph (9) of subdivision (a). No service may reregister with the board if it has a registration that is currently under suspension for a violation of paragraph (9) of subdivision (a), nor may a service reregister with the board if it had a registration revoked by the board for a violation of paragraph (9) of subdivision (a) less than one year after that revocation.

(d) The Dental Board of California may petition the superior court of any county for the issuance of an injunction restraining any conduct that constitutes a violation of this section.

(e) It is unlawful and shall constitute a misdemeanor for a person to operate a group advertising and referral service for dentists without providing its name and address to the Dental Board of California.

(f) It is the intent of the Legislature in enacting this section not to otherwise affect the prohibitions provided in Section 650. The Legislature intends to allow the pooling of resources by dentists for the purposes of advertising.

(g) This section shall not be construed to authorize a referral service to engage in the practice of dentistry.

SEC. 5. Section 800 of the Business and Professions Code is amended to read:

800. (a) The Medical Board of California, 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.

(3) Any public complaints for which provision is made pursuant to subdivision (b).

(4) Disciplinary information reported pursuant to Section 805, including any additional exculpatory or explanatory statements submitted by the licentiate pursuant to subdivision (f) of Section 805. If a court finds, in a final judgment, that the peer review resulting in the 805 report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, the board shall include that finding in the central file. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(5) Information reported pursuant to Section 805.01, including any explanatory or exculpatory information submitted by the licensee pursuant to subdivision (b) of that section.

(b) (1) Each board shall prescribe and promulgate forms on which members of the public and other licensees or certificate holders may file written complaints to the board alleging any act of misconduct in, or connected with, the performance of professional services by the licensee.

(2) If a board, or division thereof, a committee, or a panel has failed to act upon a complaint or report within five years, or has found that the complaint or report is without merit, the central file shall be purged of information relating to the complaint or report.

(3) Notwithstanding this subdivision, the Board of Psychology, the Board of Behavioral Sciences, and the Respiratory Care Board of California shall maintain complaints or reports as long as each board deems necessary.

(c) (1) The contents of any central file that are not public records under any other provision of law shall be confidential except that the licensee involved, or his or her counsel or representative, shall have the right to inspect and have copies made of his or her complete file except for the provision that may disclose the identity of an information source. For the purposes of this section, a board may protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source or by providing a comprehensive summary of the substance of the material. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee's reputation, rights, benefits, privileges, or qualifications, or be used by a board to make a determination that would affect a licensee's rights, benefits, privileges, or qualifications. The information required to be disclosed pursuant to Section 803.1 shall not be considered among the contents of a central file for the purposes of this subdivision.

(2) The licensee may, but is not required to, submit any additional exculpatory or explanatory statement or other information that the board shall include in the central file.

(3) Each board may permit any law enforcement or regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes to inspect and have copies made of that licensee's file, unless the disclosure is otherwise prohibited by law.

(4) These disclosures shall effect no change in the confidential status of these records.

SEC. 6. Section 1603a of the Business and Professions Code is amended to read:

1603a. A member of the Dental Board of California who has served two terms shall not be eligible for reappointment to the board. In computing two terms hereunder, that portion of an unexpired term that a member fills as a result of a vacancy shall be excluded.

SEC. 7. Section 1618.5 of the Business and Professions Code is amended to read:

1618.5. (a) The board shall provide to the Director of the Department of Managed Health Care a copy of any accusation filed with the Office of Administrative Hearings pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, when the accusation is filed, for a violation of this chapter relating to the quality of care of any dental provider of a health care service plan, as defined in Section 1345 of the Health and Safety Code. There shall be no liability on the part of, and no cause of action shall arise against, the State of California, the Dental Board of California, the Department of Managed Health Care, the director of that department, or any officer, agent, employee, consultant, or contractor of the state or the board or the department for the release of any false or unauthorized information pursuant to this section, unless the release is made with knowledge and malice.

(b) The board and its executive officer and staff shall maintain the confidentiality of any nonpublic reports provided by the Director of the Department of Managed Health Care pursuant to subdivision (i) of Section 1380 of the Health and Safety Code.

SEC. 8. Section 1640.1 of the Business and Professions Code is amended to read:

1640.1. As used in this article, the following definitions shall apply:

(a) "Specialty" means an area of dental practice approved by the American Dental Association and recognized by the board.

(b) "Discipline" means an advanced dental educational program in an area of dental practice not approved as a specialty by the American Dental Association; but offered from a dental college approved by the board.

(c) "Dental college approved by the board" means a dental school or college that is approved by the Commission on Dental Accreditation of the American Dental Association, that is accredited by a body that has a reciprocal accreditation agreement with that commission, or that has been approved by the Dental Board of California through its own approval process.

SEC. 9. Section 1648.10 of the Business and Professions Code is amended to read:

1648.10. (a) The Dental Board of California shall develop and distribute a fact sheet describing and comparing the risks and efficacy of the various types of dental restorative materials that may be used to repair a dental patient's oral condition or defect. The fact sheet shall include:

(1) A description of the groups of materials that are available to the profession for restoration of an oral condition or defect.

(2) A comparison of the relative benefits and detriments of each group of materials.

(3) A comparison of the cost considerations associated with each group of materials.

(4) A reference to encourage discussion between patient and dentist regarding materials and to inform the patient of his or her options.

(b) The fact sheet shall be made available by the Dental Board of California to all licensed dentists.

(c) The Dental Board of California shall update the fact sheet described in subdivision (a) as determined necessary by the board.

SEC. 10. Section 1650 of the Business and Professions Code is amended to read:

1650. Every person who is now or hereafter licensed to practice dentistry in this state shall register on forms prescribed by the board, his or her place of practice with the executive officer of the Dental Board of California, or, if he or she has more than one place of practice, all of the places of practice, or, if he or she has no place of practice, to so notify the executive officer of the board. A person licensed by the board shall register with the executive officer within 30 days after the date of his or her license.

SEC. 11. Section 1695 of the Business and Professions Code is amended to read:

1695. It is the intent of the Legislature that the Dental Board of California seek ways and means to identify and rehabilitate licentiates whose competency may be impaired due to abuse of dangerous drugs or alcohol, so that licentiates so afflicted may be treated and returned to the practice of dentistry in a manner that will not endanger the public health and safety. It is also the intent of the Legislature that the Dental Board of California shall implement this legislation in part by establishing a diversion program as a voluntary alternative approach to traditional disciplinary actions.

SEC. 12. Section 1695.1 of the Business and Professions Code is amended to read:

1695.1. As used in this article:

(a) "Board" means the Dental Board of California.

(b) "Committee" means a diversion evaluation committee created by this article.

(c) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 13. Section 1905.1 of the Business and Professions Code is amended to read:

1905.1. The committee may contract with the dental board to carry out this article. The committee may contract with the dental board to perform investigations of applicants and licensees under this article.

SEC. 14. Section 1917.2 of the Business and Professions Code is repealed.

SEC. 15. Section 1944 of the Business and Professions Code is amended to read:

1944. (a) The committee shall establish by resolution the amount of the fees that relate to the licensing of a registered dental hygienist, a registered dental hygienist in alternative practice, and a registered dental hygienist in extended functions. The fees established by board resolution in effect on June 30, 2009, as they relate to the licensure of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions, shall remain in effect until modified by the committee. The fees are subject to the following limitations:

(1) The application fee for an original license and the fee for issuance of an original license shall not exceed two hundred fifty dollars ($250).

(2) The fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(3) The fee for examination for licensure as a registered dental hygienist in extended functions shall not exceed the actual cost of the examination.

(4) The fee for examination for licensure as a registered dental hygienist in alternative practice shall not exceed the actual cost of administering the examination.

(5) The biennial renewal fee shall not exceed one hundred sixty dollars ($160).

(6) The delinquency fee shall not exceed one-half of the renewal fee. Any delinquent license may be restored only upon payment of all fees, including the delinquency fee, and compliance with all other applicable requirements of this article.

(7) The fee for issuance of a duplicate license to replace one that is lost or destroyed, or in the event of a name change, shall not exceed twenty-five dollars ($25) or one-half of the renewal fee, whichever is greater.

(8) The fee for certification of licensure shall not exceed one-half of the renewal fee.

(9) The fee for each curriculum review, feasibility study review, and site evaluation for educational programs for dental hygienists who are not accredited by a committee-approved agency shall not exceed two thousand one hundred dollars ($2,100).

(10) The fee for each review or approval of course requirements for licensure or procedures that require additional training shall not exceed seven hundred fifty dollars ($750).

(11) The initial application and biennial fee for a provider of continuing education shall not exceed five hundred dollars ($500).

(12) The amount of fees payable in connection with permits issued under Section 1962 is as follows:

(A) The initial permit fee is an amount equal to the renewal fee for the applicant's license to practice dental hygiene in effect on the last regular renewal date before the date on which the permit is issued.

(B) If the permit will expire less than one year after its issuance, then the initial permit fee is an amount equal to 50 percent of the renewal fee in effect on the last regular renewal date before the date on which the permit is issued.

(b) The renewal and delinquency fees shall be fixed by the committee by resolution at not more than the current amount of the renewal fee for a license to practice under this article nor less than five dollars ($5).

(c) Fees fixed by the committee by resolution pursuant to this section shall not be subject to the approval of the Office of Administrative Law.

(d) Fees collected pursuant to this section shall be collected by the committee and deposited into the State Dental Hygiene Fund, which is hereby created. All money in this fund shall, upon appropriation by the Legislature in the annual Budget Act, be used to implement this article.

(e) No fees or charges other than those listed in this section shall be levied by the committee in connection with the licensure of registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

(f) The fee for registration of an extramural dental facility shall not exceed two hundred fifty dollars ($250).

(g) The fee for registration of a mobile dental hygiene unit shall not exceed one hundred fifty dollars ($150).

(h) The biennial renewal fee for a mobile dental hygiene unit shall not exceed two hundred fifty dollars ($250).

(i) The fee for an additional office permit shall not exceed two hundred fifty dollars ($250).

(j) The biennial renewal fee for an additional office as described in Section 1926.4 shall not exceed two hundred fifty dollars ($250).

(k) The initial application and biennial special permit fee is an amount equal to the biennial renewal fee specified in paragraph (6) of subdivision (a).

(*l*) The fees in this section shall not exceed an amount sufficient to cover the reasonable regulatory cost of carrying out this article.

SEC. 15.5. Section 1944 of the Business and Professions Code is amended to read:

1944. (a) The committee shall establish by resolution the amount of the fees that relate to the licensing of a registered dental hygienist, a registered dental hygienist in alternative practice, and a registered dental hygienist in extended functions. The fees established by board resolution in effect on June 30, 2009, as they relate to the licensure of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions, shall remain in effect until modified by the committee. The fees are subject to the following limitations:

(1) The application fee for an original license and the fee for the issuance of an original license shall not exceed two hundred fifty dollars ($250).

Commencing July 1, 2017, the fee for the issuance of an original license shall be prorated on the monthly basis.

(2) The fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(3) The fee for examination for licensure as a registered dental hygienist in extended functions shall not exceed the actual cost of the examination.

(4) The fee for examination for licensure as a registered dental hygienist in alternative practice shall not exceed the actual cost of administering the examination.

(5) The biennial renewal fee shall not exceed one hundred sixty dollars ($160).

(6) The delinquency fee shall not exceed one-half of the renewal fee. Any delinquent license may be restored only upon payment of all fees, including the delinquency fee, and compliance with all other applicable requirements of this article.

(7) The fee for issuance of a duplicate license to replace one that is lost or destroyed, or in the event of a name change, shall not exceed twenty-five dollars ($25) or one-half of the renewal fee, whichever is greater.

(8) The fee for certification of licensure shall not exceed one-half of the renewal fee.

(9) The fee for each curriculum review, feasibility study review, and site evaluation for educational programs for dental hygienists who are not accredited by a committee-approved agency shall not exceed two thousand one hundred dollars ($2,100).

(10) The fee for each review or approval of course requirements for licensure or procedures that require additional training shall not exceed seven hundred fifty dollars ($750).

(11) The initial application and biennial fee for a provider of continuing education shall not exceed five hundred dollars ($500).

(12) The amount of fees payable in connection with permits issued under Section 1962 is as follows:

(A) The initial permit fee is an amount equal to the renewal fee for the applicant's license to practice dental hygiene in effect on the last regular renewal date before the date on which the permit is issued.

(B) If the permit will expire less than one year after its issuance, then the initial permit fee is an amount equal to 50 percent of the renewal fee in effect on the last regular renewal date before the date on which the permit is issued.

(b) The renewal and delinquency fees shall be fixed by the committee by resolution at not more than the current amount of the renewal fee for a license to practice under this article nor less than five dollars ($5).

(c) Fees fixed by the committee by resolution pursuant to this section shall not be subject to the approval of the Office of Administrative Law.

(d) Fees collected pursuant to this section shall be collected by the committee and deposited into the State Dental Hygiene Fund, which is hereby created. All money in this fund shall, upon appropriation by the Legislature in the annual Budget Act, be used to implement this article.

(e) No fees or charges other than those listed in this section shall be levied by the committee in connection with the licensure of registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

(f) The fee for registration of an extramural dental facility shall not exceed two hundred fifty dollars ($250).

(g) The fee for registration of a mobile dental hygiene unit shall not exceed one hundred fifty dollars ($150).

(h) The biennial renewal fee for a mobile dental hygiene unit shall not exceed two hundred fifty dollars ($250).

(i) The fee for an additional office permit shall not exceed two hundred fifty dollars ($250).

(j) The biennial renewal fee for an additional office as described in Section 1926.4 shall not exceed two hundred fifty dollars ($250).

(k) The initial application and biennial special permit fee is an amount equal to the biennial renewal fee specified in paragraph (6) of subdivision (a).

(*l*) The fees in this section shall not exceed an amount sufficient to cover the reasonable regulatory cost of carrying out this article.

SEC. 16. Section 2054 of the Business and Professions Code is amended to read:

2054. (a) Any person who uses in any sign, business card, or letterhead, or, in an advertisement, the words "doctor" or "physician," the letters or prefix "Dr.," the initials "M.D.," or any other terms or letters indicating or implying that he or she is a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, or that he or she is entitled to practice hereunder, or who represents or holds himself or herself out as a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as a physician and surgeon under this chapter, is guilty of a misdemeanor.

(b) A holder of a valid, unrevoked, and unsuspended certificate to practice podiatric medicine may use the phrases "doctor of podiatric medicine," "doctor of podiatry," and "podiatric doctor," or the initials "D.P.M.," and shall not be in violation of subdivision (a).

(c) Notwithstanding subdivision (a), any of the following persons may use the words "doctor" or "physician," the letters or prefix "Dr.," or the initials "M.D.":

(1) A graduate of a medical school approved or recognized by the board while enrolled in a postgraduate training program approved by the board.

(2) A graduate of a medical school who does not have a certificate as a physician and surgeon under this chapter if he or she meets all of the following requirements:

(A) If issued a license to practice medicine in any jurisdiction, has not had that license revoked or suspended by that jurisdiction.

(B) Does not otherwise hold himself or herself out as a physician and surgeon entitled to practice medicine in this state except to the extent authorized by this chapter.

(C) Does not engage in any of the acts prohibited by Section 2060.

(3) A person authorized to practice medicine under Section 2111 or 2113 subject to the limitations set forth in those sections.

SEC. 17. Section 2401 of the Business and Professions Code is amended to read:

2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the board or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Health Care Services, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(d) Notwithstanding Section 2400, a hospital that is owned and operated by a licensed charitable organization, that offers only pediatric subspecialty care, that, prior to January 1, 2013, employed licensees on a salary basis, and that has not charged for professional services rendered to patients may, commencing January 1, 2013, charge for professional services rendered to patients, provided the following conditions are met:

(1) The hospital does not increase the number of salaried licensees by more than five licensees each year.

(2) The hospital does not expand its scope of services beyond pediatric subspecialty care.

(3) The hospital accepts each patient needing its scope of services regardless of his or her ability to pay, including whether the patient has any form of health care coverage.

(4) The medical staff concur by an affirmative vote that the licensee’s employment is in the best interest of the communities served by the hospital.

(5) The hospital does not interfere with, control, or otherwise direct a physician and surgeon’s professional judgment in a manner prohibited by Section 2400 or any other provision of law.

SEC. 18. Section 2428 of the Business and Professions Code is amended to read:

2428. (a) A person who voluntarily cancels his or her license or who fails to renew his or her license within five years after its expiration shall not renew it, but that person may apply for and obtain a new license if he or she:

(1) Has not committed any acts or crimes constituting grounds for denial of licensure under Division 1.5 (commencing with Section 475).

(2) Takes and passes the examination, if any, which would be required of him or her if application for licensure was being made for the first time, or otherwise establishes to the satisfaction of the licensing authority that passes on the qualifications of applicants for the license that, with due regard for the public interest, he or she is qualified to practice the profession or activity for which the applicant was originally licensed.

(3) Pays all of the fees that would be required if application for licensure was being made for the first time.

The licensing authority may provide for the waiver or refund of all or any part of an examination fee in those cases in which a license is issued without an examination pursuant to this section.

Nothing in this section shall be construed to authorize the issuance of a license for a professional activity or system or mode of healing for which licenses are no longer required.

(b) In addition to the requirements set forth in subdivision (a), an applicant shall establish that he or she meets one of the following requirements: (1) satisfactory completion of at least two years of approved postgraduate training; (2) certification by a specialty board approved by the American Board of Medical Specialties or approved by the board pursuant to subdivision (h) of Section 651; or (3) passing of the clinical competency written examination.

(c) Subdivision (a) shall apply to persons who held licenses to practice podiatric medicine except that those persons who failed to renew their licenses within three years after its expiration may not renew it, and it may not be reissued, reinstated, or restored, except in accordance with subdivision (a).

SEC. 19. Section 2529 of the Business and Professions Code is amended to read:

2529. (a) Graduates of the Southern California Psychoanalytic Institute, the Los Angeles Psychoanalytic Society and Institute, the San Francisco Psychoanalytic Institute, the San Diego Psychoanalytic Center, or institutes deemed equivalent by the Medical Board of California who have completed clinical training in psychoanalysis may engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts, and students in those institutes may engage in psychoanalysis under supervision, if the students and graduates do not hold themselves out to the public by any title or description of services incorporating the words “psychological,” “psychologist,” “psychology,”

"psychometrists," "psychometrics," or "psychometry," or that they do not state or imply that they are licensed to practice psychology.

(b) Those students and graduates seeking to engage in psychoanalysis under this chapter shall register with the Medical Board of California, presenting evidence of their student or graduate status. The board may suspend or revoke the exemption of those persons for unprofessional conduct as defined in Sections 726, 2234, and 2235.

SEC. 20. Section 2650 of the Business and Professions Code is amended to read:

2650. (a) The physical therapist education requirements are as follows:

(1) Except as otherwise provided in this chapter, each applicant for a license as a physical therapist shall be a graduate of a professional degree program of an accredited postsecondary institution or institutions approved by the board and shall have completed a professional education program including academic course work and clinical internship in physical therapy.

(2) Unless otherwise specified by the board by regulation, the educational requirements shall include instruction in the subjects prescribed by the Commission on Accreditation in Physical Therapy Education (CAPTE) of the American Physical Therapy Association or Physiotherapy Education Accreditation Canada and shall include a combination of didactic and clinical experiences. The clinical experience shall include at least 18 weeks of full-time experience with a variety of patients.

(b) The physical therapist assistant educational requirements are as follows:

(1) Except as otherwise provided in this chapter, each applicant for a license as a physical therapist assistant shall be a graduate of a physical therapist assistant program of an accredited postsecondary institution or institutions approved by the board, and shall have completed both the academic and clinical experience required by the physical therapist assistant program, and have been awarded an associate degree.

(2) Unless otherwise specified by the board by regulation, the educational requirements shall include instruction in the subjects prescribed by the CAPTE of the American Physical Therapy Association or Physiotherapy Education Accreditation Canada or another body as may be approved by the board by regulation and shall include a combination of didactic and clinical experiences.

SEC. 21. The heading of Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2 of the Business and Professions Code is amended to read:

Article 3.1. Intervention Program

SEC. 22. Section 2770 of the Business and Professions Code is amended to read:

2770. It is the intent of the Legislature that the Board of Registered Nursing seek ways and means to identify and rehabilitate registered nurses

whose competency may be impaired due to abuse of alcohol and other drugs, or due to mental illness so that registered nurses so afflicted may be rehabilitated and returned to the practice of nursing in a manner that will not endanger the public health and safety. It is also the intent of the Legislature that the Board of Registered Nursing shall implement this legislation by establishing an intervention program as a voluntary alternative to traditional disciplinary actions.

SEC. 23. Section 2770.1 of the Business and Professions Code is amended to read:

2770.1. As used in this article:

(a) "Board" means the Board of Registered Nursing.

(b) "Committee" means an intervention evaluation committee created by this article.

(c) "Program manager" means the staff manager of the intervention program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 24. Section 2770.2 of the Business and Professions Code is amended to read:

2770.2. (a) One or more intervention evaluation committees is hereby created in the state to be established by the board. Each committee shall be composed of five persons appointed by the board. No board member shall serve on any committee.

(b) Each committee shall have the following composition:

(1) Three registered nurses, holding active California licenses, who have demonstrated expertise in the field of chemical dependency or psychiatric nursing.

(2) One physician, holding an active California license, who specializes in the diagnosis and treatment of addictive diseases or mental illness.

(3) One public member who is knowledgeable in the field of chemical dependency or mental illness.

(c) It shall require a majority vote of the board to appoint a person to a committee. Each appointment shall be at the pleasure of the board for a term not to exceed four years. In its discretion the board may stagger the terms of the initial members appointed.

SEC. 25. Section 2770.7 of the Business and Professions Code is amended to read:

2770.7. (a) The board shall establish criteria for the acceptance, denial, or termination of registered nurses in the intervention program. Only those registered nurses who have voluntarily requested to participate in the intervention program shall participate in the program.

(b) A registered nurse under current investigation by the board may request entry into the intervention program by contacting the board. Prior to authorizing a registered nurse to enter into the intervention program, the board may require the registered nurse under current investigation for any violations of this chapter or any other provision of this code to execute a statement of understanding that states that the registered nurse understands

that his or her violations that would otherwise be the basis for discipline may still be investigated and may be the subject of disciplinary action.

(c) If the reasons for a current investigation of a registered nurse are based primarily on the self-administration of any controlled substance or dangerous drug or alcohol under Section 2762, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drug for self-administration that does not involve actual, direct harm to the public, the board shall close the investigation without further action if the registered nurse is accepted into the board's intervention program and successfully completes the program. If the registered nurse withdraws or is terminated from the program by an intervention evaluation committee, and the termination is approved by the program manager, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the board.

(d) Neither acceptance nor participation in the intervention program shall preclude the board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any registered nurse for any unprofessional conduct committed before, during, or after participation in the intervention program.

(e) All registered nurses shall sign an agreement of understanding that the withdrawal or termination from the intervention program at a time when the program manager or intervention evaluation committee determines the licentiate presents a threat to the public's health and safety shall result in the utilization by the board of intervention program treatment records in disciplinary or criminal proceedings.

(f) Any registered nurse terminated from the intervention program for failure to comply with program requirements is subject to disciplinary action by the board for acts committed before, during, and after participation in the intervention program. A registered nurse who has been under investigation by the board and has been terminated from the intervention program by an intervention evaluation committee shall be reported by the intervention evaluation committee to the board.

SEC. 26. Section 2770.8 of the Business and Professions Code is amended to read:

2770.8. A committee created under this article operates under the direction of the intervention program manager. The program manager has the primary responsibility to review and evaluate recommendations of the committee. Each committee shall have the following duties and responsibilities:

(a) To evaluate those registered nurses who request participation in the program according to the guidelines prescribed by the board, and to make recommendations.

(b) To review and designate those treatment services to which registered nurses in an intervention program may be referred.

(c) To receive and review information concerning a registered nurse participating in the program.

(d) To consider in the case of each registered nurse participating in a program whether he or she may with safety continue or resume the practice of nursing.

(e) To call meetings as necessary to consider the requests of registered nurses to participate in an intervention program, and to consider reports regarding registered nurses participating in a program.

(f) To make recommendations to the program manager regarding the terms and conditions of the intervention agreement for each registered nurse participating in the program, including treatment, supervision, and monitoring requirements.

SEC. 27. Section 2770.10 of the Business and Professions Code is amended to read:

2770.10. Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, relating to public meetings, a committee may convene in closed session to consider reports pertaining to any registered nurse requesting or participating in an intervention program. A committee shall only convene in closed session to the extent that it is necessary to protect the privacy of such a licentiate.

SEC. 28. Section 2770.11 of the Business and Professions Code is amended to read:

2770.11. (a) Each registered nurse who requests participation in an intervention program shall agree to cooperate with the rehabilitation program designed by the committee and approved by the program manager. Any failure to comply with a rehabilitation program may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.

(b) If the program manager determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the program manager shall report the name and license number, along with a copy of all intervention program records for that registered nurse, to the board's enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

SEC. 29. Section 2770.12 of the Business and Professions Code is amended to read:

2770.12. (a) After the committee and the program manager in their discretion have determined that a registered nurse has successfully completed the intervention program, all records pertaining to the registered nurse's participation in the intervention program shall be purged.

(b) All board and committee records and records of a proceeding pertaining to the participation of a registered nurse in the intervention program shall be kept confidential and are not subject to discovery or subpoena, except as specified in subdivision (b) of Section 2770.11 and subdivision (c).

(c) A registered nurse shall be deemed to have waived any rights granted by any laws and regulations relating to confidentiality of the intervention program, if he or she does any of the following:

(1) Presents information relating to any aspect of the intervention program during any stage of the disciplinary process subsequent to the filing of an accusation, statement of issues, or petition to compel an examination pursuant to Article 12.5 (commencing with Section 820) of Chapter 1. The waiver shall be limited to information necessary to verify or refute any information disclosed by the registered nurse.

(2) Files a lawsuit against the board relating to any aspect of the intervention program.

(3) Claims in defense to a disciplinary action, based on a complaint that led to the registered nurse's participation in the intervention program, that he or she was prejudiced by the length of time that passed between the alleged violation and the filing of the accusation. The waiver shall be limited to information necessary to document the length of time the registered nurse participated in the intervention program.

SEC. 30. Section 2770.13 of the Business and Professions Code is amended to read:

2770.13. The board shall provide for the legal representation of any person making reports under this article to a committee or the board in any action for defamation directly resulting from those reports regarding a registered nurse's participation in an intervention program.

SEC. 31. Section 2835.5 of the Business and Professions Code is amended to read:

2835.5. On and after January 1, 2008, an applicant for initial qualification or certification as a nurse practitioner under this article who has not been qualified or certified as a nurse practitioner in California or any other state shall meet the following requirements:

(a) Hold a valid and active registered nursing license issued under this chapter.

(b) Possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing.

(c) Satisfactorily complete a nurse practitioner program approved by the board.

SEC. 32. Section 3057 of the Business and Professions Code is amended to read:

3057. (a) The board may issue a license to practice optometry to a person who meets all of the following requirements:

(1) Has a degree as a doctor of optometry issued by an accredited school or college of optometry.

(2) Has successfully passed the licensing examination for an optometric license in another state.

(3) Submits proof that he or she is licensed in good standing as of the date of application in every state where he or she holds a license, including compliance with continuing education requirements.

(4) Is not subject to disciplinary action as set forth in subdivision (h) of Section 3110. If the person has been subject to disciplinary action, the board shall review that action to determine if it presents sufficient evidence of a violation of this chapter to warrant the submission of additional information from the person or the denial of the application for licensure.

(5) Has furnished a signed release allowing the disclosure of information from the National Practitioner Database and, if applicable, the verification of registration status with the federal Drug Enforcement Administration. The board shall review this information to determine if it presents sufficient evidence of a violation of this chapter to warrant the submission of additional information from the person or the denial of the application for licensure.

(6) Has never had his or her license to practice optometry revoked or suspended in any state where the person holds a license.

(7) (A) Is not subject to denial of an application for licensure based on any of the grounds listed in Section 480.

(B) Is not currently required to register as a sex offender pursuant to Section 290 of the Penal Code.

(8) Has met the minimum continuing education requirements set forth in Section 3059 for the current and preceding year.

(9) Has met the certification requirements of Section 3041.3 to use therapeutic pharmaceutical agents under subdivision (e) of Section 3041.

(10) Submits any other information as specified by the board to the extent it is required for licensure by examination under this chapter.

(11) Files an application on a form prescribed by the board, with an acknowledgment by the person executed under penalty of perjury and automatic forfeiture of license, of the following:

(A) That the information provided by the person to the board is true and correct, to the best of his or her knowledge and belief.

(B) That the person has not been convicted of an offense involving conduct that would violate Section 810.

(12) Pays an application fee in an amount equal to the application fee prescribed pursuant to subdivision (a) of Section 3152.

(13) Has successfully passed the board's jurisprudence examination.

(b) If the board finds that the competency of a candidate for licensure pursuant to this section is in question, the board may require the passage of a written, practical, or clinical examination or completion of additional continuing education or coursework.

(c) In cases where the person establishes, to the board's satisfaction, that he or she has been displaced by a federally declared emergency and cannot relocate to his or her state of practice within a reasonable time without economic hardship, the board may reduce or waive the fees required by paragraph (12) of subdivision (a).

(d) Any license issued pursuant to this section shall expire as provided in Section 3146, and may be renewed as provided in this chapter, subject to the same conditions as other licenses issued under this chapter.

(e) The term "in good standing," as used in this section, means that a person under this section:

(1) Is not currently under investigation nor has been charged with an offense for any act substantially related to the practice of optometry by any public agency, nor entered into any consent agreement or subject to an administrative decision that contains conditions placed by an agency upon a person's professional conduct or practice, including any voluntary surrender of license, nor been the subject of an adverse judgment resulting from the practice of optometry that the board determines constitutes evidence of a pattern of incompetence or negligence.

(2) Has no physical or mental impairment related to drugs or alcohol, and has not been found mentally incompetent by a licensed psychologist or licensed psychiatrist so that the person is unable to undertake the practice of optometry in a manner consistent with the safety of a patient or the public.

SEC. 33. Section 3509.5 of the Business and Professions Code is amended to read:

3509.5. The board shall elect annually a president and a vice president from among its members.

SEC. 34. Section 4836.2 of the Business and Professions Code is amended to read:

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

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

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

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

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

(3) The veterinary assistant to whom the permit is issued has been convicted of a state or federal felony controlled substance violation.

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

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

(e) (1) As part of the application for a veterinary assistant controlled substance permit, the applicant shall submit to the Department of Justice fingerprint images and related information, as required by the Department of Justice for all veterinary assistant applicants, for the purposes of obtaining

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

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

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

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

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

(g) This section shall become operative on July 1, 2015.

SEC. 35. Section 4887 of the Business and Professions Code is amended to read:

4887. (a) A person whose license or registration has been revoked or who has been placed on probation may petition the board for reinstatement or modification of penalty including modification or termination of probation after a period of not less than one year has elapsed from the effective date of the decision ordering the disciplinary action. The petition shall state such facts as may be required by the board.

(b) The petition shall be accompanied by at least two verified recommendations from veterinarians licensed by the board who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed. The petition shall be heard by the board. The board may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities since the license or registration was in good standing, and the petitioner's rehabilitation efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the board finds necessary.

(c) The board reinstating the license or registration or modifying a penalty may impose terms and conditions as it determines necessary. To reinstate a revoked license or registration or to otherwise reduce a penalty or modify probation shall require a vote of five of the members of the board.

(d) The petition shall not be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. The board may deny without a hearing or argument any petition filed pursuant to this section

within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 36. Section 4938 of the Business and Professions Code is amended to read:

4938. The board shall issue a license to practice acupuncture to any person who makes an application and meets the following requirements:

(a) Is at least 18 years of age.

(b) Furnishes satisfactory evidence of completion of one of the following:

(1) (A) An approved educational and training program.

(B) If an applicant began his or her educational and training program at a school or college that submitted a letter of intent to pursue accreditation to, or attained candidacy status from, the Accreditation Commission for Acupuncture and Oriental Medicine, but the commission subsequently denied the school or college candidacy status or accreditation, respectively, the board may review and evaluate the educational training and clinical experience to determine whether to waive the requirements set forth in this subdivision with respect to that applicant.

(2) Satisfactory completion of a tutorial program in the practice of an acupuncturist that is approved by the board.

(3) In the case of an applicant who has completed education and training outside the United States, documented educational training and clinical experience that meets the standards established pursuant to Sections 4939 and 4941.

(c) Passes a written examination administered by the board that tests the applicant's ability, competency, and knowledge in the practice of an acupuncturist. The written examination shall be developed by the Office of Professional Examination Services of the Department of Consumer Affairs.

(d) Is not subject to denial pursuant to Division 1.5 (commencing with Section 475).

(e) Completes a clinical internship training program approved by the board. The clinical internship training program shall not exceed nine months in duration and shall be located in a clinic in this state that is an approved educational and training program. The length of the clinical internship shall depend upon the grades received in the examination and the clinical training already satisfactorily completed by the individual prior to taking the examination. On and after January 1, 1987, individuals with 800 or more hours of documented clinical training shall be deemed to have met this requirement. The purpose of the clinical internship training program shall be to ensure a minimum level of clinical competence.

Each applicant who qualifies for a license shall pay, as a condition precedent to its issuance and in addition to other fees required, the initial licensure fee.

SEC. 37. Section 4939 of the Business and Professions Code, as added by Section 9 of Chapter 397 of the Statutes of 2014, is amended to read:

4939. (a) The board shall establish standards for the approval of educational training and clinical experience received outside the United States.

(b) This section shall become operative on January 1, 2017.

SEC. 38. Section 4980.399 of the Business and Professions Code is amended to read:

4980.399. (a) Except as provided in subdivision (a) of Section 4980.398, each applicant and registrant shall obtain a passing score on a board-administered California law and ethics examination in order to qualify for licensure.

(b) A registrant shall participate in a board-administered California law and ethics examination prior to his or her registration renewal.

(c) Notwithstanding subdivision (b), an applicant who holds a registration eligible for renewal, with an expiration date no later than June 30, 2016, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, shall, if eligible, be allowed to renew the registration without first participating in the California law and ethics examination. These applicants shall participate in the California law and ethics examination in the next renewal cycle, and shall pass the examination prior to licensure or issuance of a subsequent registration number, as specified in this section.

(d) If an applicant fails the California law and ethics examination, he or she may retake the examination, upon payment of the required fees, without further application except as provided in subdivision (e).

(e) If a registrant fails to obtain a passing score on the California law and ethics examination described in subdivision (a) within his or her renewal period on or after the operative date of this section, he or she shall complete, at a minimum, a 12-hour course in California law and ethics in order to be eligible to participate in the California law and ethics examination. Registrants shall only take the 12-hour California law and ethics course once during a renewal period. The 12-hour law and ethics course required by this section shall be taken through a continuing education provider as specified by the board by regulation, a county, state or governmental entity, or a college or university.

(f) The board shall not issue a subsequent registration number unless the registrant has passed the California law and ethics examination.

(g) Notwithstanding subdivision (f), an applicant who holds or has held a registration, with an expiration date no later than January 1, 2017, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, shall, if eligible, be allowed to obtain the subsequent registration number without first passing the California law and ethics examination. These applicants shall pass the California law and ethics examination during the next renewal period or prior to licensure, whichever occurs first.

(h) This section shall become operative on January 1, 2016.

SEC. 39. Section 4980.43 of the Business and Professions Code is amended to read:

4980.43. (a) To qualify for licensure as specified in Section 4980.40, each applicant shall complete experience related to the practice of marriage

and family therapy under a supervisor who meets the qualifications set forth in Section 4980.03. The experience shall comply with the following:

(1) A minimum of 3,000 hours of supervised experience completed during a period of at least 104 weeks.

(2) A maximum of 40 hours in any seven consecutive days.

(3) A minimum of 1,700 hours obtained after the qualifying master's or doctoral degree was awarded.

(4) A maximum of 1,300 hours obtained prior to the award date of the qualifying master's or doctoral degree.

(5) A maximum of 750 hours of counseling and direct supervisor contact prior to the award date of the qualifying master's or doctoral degree.

(6) No hours of experience may be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction.

(7) No hours of experience may be gained more than six years prior to the date the application for examination eligibility was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(8) A minimum of 1,750 hours of direct counseling with individuals, groups, couples, or families, that includes not less than 500 total hours of experience in diagnosing and treating couples, families, and children.

(9) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to marriage and family therapy that have been approved by the applicant's supervisor.

(10) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

This subdivision shall only apply to hours gained on and after January 1, 2010.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

(c) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by an intern or trainee only as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. Experience shall not be gained by an intern or trainee as an independent contractor.

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(d) Except for experience gained by attending workshops, seminars, training sessions, or conferences as described in paragraph (9) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours per week of face-to-face contact in a group.

(4) Direct supervisor contact shall occur within the same week as the hours claimed.

(5) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour.

(6) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(7) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation.

(8) The six hours of supervision that may be credited during any single week pursuant to paragraphs (1) and (2) shall apply to supervision hours gained on or after January 1, 2009.

(e) (1) A trainee may be credited with supervised experience completed in any setting that meets all of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed professional clinical counselor, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

(f) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (e), until registered as an intern.

(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.

(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee that has satisfied subdivision (g) of Section 4980.03. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.

(5) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.

(g) Except as provided in subdivision (h), all persons shall register with the board as an intern to be credited for postdegree hours of supervised experience gained toward licensure.

(h) Postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctoral degree and is thereafter granted the intern registration by the board. An applicant shall not be employed or volunteer in a private practice until registered as an intern by the board.

(i) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(j) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. For purposes of paragraph (3) of subdivision (a) of Section 2290.5, interns and trainees working under licensed supervision, consistent with subdivision

(c), may provide services via telehealth within the scope authorized by this chapter and in accordance with any regulations governing the use of telehealth promulgated by the board. Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of their employers.

(k) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered employees and not independent contractors. The board may audit applicants who receive reimbursement for expenses, and the applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(*l*) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

SEC. 40. Section 4980.54 of the Business and Professions Code is amended to read:

4980.54. (a) The Legislature recognizes that the education and experience requirements in this chapter constitute only minimal requirements to ensure that an applicant is prepared and qualified to take the licensure examinations as specified in subdivision (d) of Section 4980.40 and, if he or she passes those examinations, to begin practice.

(b) In order to continuously improve the competence of licensed marriage and family therapists and as a model for all psychotherapeutic professions, the Legislature encourages all licensees to regularly engage in continuing education related to the profession or scope of practice as defined in this chapter.

(c) Except as provided in subdivision (e), the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that he or she has completed not less than 36 hours of approved continuing education in or relevant to the field of marriage and family therapy in the preceding two years, as determined by the board.

(d) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completion of required continuing education

coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(e) The board may establish exceptions from the continuing education requirements of this section for good cause, as defined by the board.

(f) The continuing education shall be obtained from one of the following sources:

(1) An accredited school or state-approved school that meets the requirements set forth in Section 4980.36 or 4980.37. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers, as specified by the board by regulation.

(g) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision (f), shall adhere to procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(h) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of marriage and family therapy.

(2) Aspects of the discipline of marriage and family therapy in which significant recent developments have occurred.

(3) Aspects of other disciplines that enhance the understanding or the practice of marriage and family therapy.

(i) A system of continuing education for licensed marriage and family therapists shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

(j) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral Sciences Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section. For purposes of this subdivision, a provider of continuing education as described in paragraph (1) of subdivision (f) shall be deemed to be an approved provider.

(k) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 41. Section 4984.01 of the Business and Professions Code, as amended by Section 31 of Chapter 473 of the Statutes of 2013, is amended to read:

4984.01. (a) The marriage and family therapist intern registration shall expire one year from the last day of the month in which it was issued.

(b) To renew the registration, the registrant shall, on or before the expiration date of the registration, complete all of the following actions:

(1) Apply for renewal on a form prescribed by the board.

(2) Pay a renewal fee prescribed by the board.

(3) Participate in the California law and ethics examination pursuant to Section 4980.399 each year until successful completion of this examination.

(4) Notify the board whether he or she has been convicted, as defined in Section 490, of a misdemeanor or felony, and whether any disciplinary action has been taken against him or her by a regulatory or licensing board in this or any other state subsequent to the last renewal of the registration.

(c) The registration may be renewed a maximum of five times. No registration shall be renewed or reinstated beyond six years from the last day of the month during which it was issued, regardless of whether it has been revoked. When no further renewals are possible, an applicant may apply for and obtain a subsequent intern registration number if the applicant meets the educational requirements for registration in effect at the time of the application for a subsequent intern registration number and has passed the California law and ethics examination described in Section 4980.399. An applicant who is issued a subsequent intern registration number pursuant to this subdivision shall not be employed or volunteer in a private practice.

(d) This section shall become operative on January 1, 2016.

SEC. 42. Section 4989.34 of the Business and Professions Code is amended to read:

4989.34. (a) To renew his or her license, a licensee shall certify to the board, on a form prescribed by the board, completion in the preceding two years of not less than 36 hours of approved continuing education in, or relevant to, educational psychology.

(b) (1) The continuing education shall be obtained from either an accredited university or a continuing education provider as specified by the board by regulation.

(2) The board shall establish, by regulation, a procedure identifying acceptable providers of continuing education courses, and all providers of continuing education shall comply with procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(c) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of educational psychology.

(2) Aspects of the discipline of educational psychology in which significant recent developments have occurred.

(3) Aspects of other disciplines that enhance the understanding or the practice of educational psychology.

(d) The board may audit the records of a licensee to verify completion of the continuing education requirement. A licensee shall maintain records of the completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon its request.

(e) The board may establish exceptions from the continuing education requirements of this section for good cause, as determined by the board.

(f) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral Sciences Fund. The amount of the fees shall be sufficient to meet, but shall not exceed, the costs of administering this section.

(g) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 43. Section 4992.09 of the Business and Professions Code is amended to read:

4992.09. (a) Except as provided in subdivision (a) of Section 4992.07, an applicant and registrant shall obtain a passing score on a board-administered California law and ethics examination in order to qualify for licensure.

(b) A registrant shall participate in a board-administered California law and ethics examination prior to his or her registration renewal.

(c) Notwithstanding subdivision (b), an applicant who holds a registration eligible for renewal, with an expiration date no later than June 30, 2016, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, shall, if eligible, be allowed to renew the registration without first participating in the California law and ethics examination. These applicants shall participate in the California law and ethics examination in the next renewal cycle, and shall pass the examination prior to licensure or issuance of a subsequent registration number, as specified in this section.

(d) If an applicant fails the California law and ethics examination, he or she may retake the examination, upon payment of the required fees, without further application except for as provided in subdivision (e).

(e) If a registrant fails to obtain a passing score on the California law and ethics examination described in subdivision (a) within his or her renewal period on or after the operative date of this section, he or she shall complete, at a minimum, a 12-hour course in California law and ethics in order to be eligible to participate in the California law and ethics examination. Registrants shall only take the 12-hour California law and ethics course once during a renewal period. The 12-hour law and ethics course required by this section shall be taken through a continuing education provider, as specified by the board by regulation, a county, state or governmental entity, or a college or university.

(f) The board shall not issue a subsequent registration number unless the registrant has passed the California law and ethics examination.

(g) Notwithstanding subdivision (f), an applicant who holds or has held a registration, with an expiration date no later than January 1, 2017, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, shall, if eligible, be allowed to obtain the subsequent registration number without first passing the California law and ethics examination. These applicants shall pass the California law and ethics

examination during the next renewal period or prior to licensure, whichever occurs first.

(h) This section shall become operative on January 1, 2016.

SEC. 44. Section 4996.2 of the Business and Professions Code is amended to read:

4996.2. Each applicant for a license shall furnish evidence satisfactory to the board that he or she complies with all of the following requirements:

(a) Is at least 21 years of age.

(b) Has received a master's degree from an accredited school of social work.

(c) Has had two years of supervised post-master's degree experience, as specified in Section 4996.23.

(d) Has not committed any crimes or acts constituting grounds for denial of licensure under Section 480. The board shall not issue a registration or license to any person who has been convicted of any crime in this or another state or in a territory of the United States that involves sexual abuse of children or who is required to register pursuant to Section 290 of the Penal Code or the equivalent in another state or territory.

(e) Has completed adequate instruction and training in the subject of alcoholism and other chemical substance dependency. This requirement applies only to applicants who matriculate on or after January 1, 1986.

(f) Has completed instruction and training in spousal or partner abuse assessment, detection, and intervention. This requirement applies to an applicant who began graduate training during the period commencing on January 1, 1995, and ending on December 31, 2003. An applicant who began graduate training on or after January 1, 2004, shall complete a minimum of 15 contact hours of coursework in spousal or partner abuse assessment, detection, and intervention strategies, including knowledge of community resources, cultural factors, and same gender abuse dynamics. Coursework required under this subdivision may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course.

(g) Has completed a minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 1807 of Title 16 of the California Code of Regulations. This training or coursework may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course.

(h) Has completed a minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 1807.2 of Title 16 of the California Code of Regulations. This training or coursework may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course.

SEC. 45. Section 4996.22 of the Business and Professions Code is amended to read:

4996.22. (a) (1) Except as provided in subdivision (c), the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that he or she has completed

not less than 36 hours of approved continuing education in or relevant to the field of social work in the preceding two years, as determined by the board.

(2) The board shall not renew any license of an applicant who began graduate study prior to January 1, 2004, pursuant to this chapter unless the applicant certifies to the board that during the applicant's first renewal period after the operative date of this section, he or she completed a continuing education course in spousal or partner abuse assessment, detection, and intervention strategies, including community resources, cultural factors, and same gender abuse dynamics. On and after January 1, 2005, the course shall consist of not less than seven hours of training. Equivalent courses in spousal or partner abuse assessment, detection, and intervention strategies taken prior to the operative date of this section or proof of equivalent teaching or practice experience may be submitted to the board and at its discretion, may be accepted in satisfaction of this requirement. Continuing education courses taken pursuant to this paragraph shall be applied to the 36 hours of approved continuing education required under paragraph (1).

(b) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(c) The board may establish exceptions from the continuing education requirement of this section for good cause as defined by the board.

(d) The continuing education shall be obtained from one of the following sources:

(1) An accredited school of social work, as defined in Section 4991.2, or a school or department of social work that is a candidate for accreditation by the Commission on Accreditation of the Council on Social Work Education. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers, as specified by the board by regulation.

(e) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision (d), shall adhere to the procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(f) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding, or the practice, of social work.

(2) Aspects of the social work discipline in which significant recent developments have occurred.

(3) Aspects of other related disciplines that enhance the understanding, or the practice, of social work.

(g) A system of continuing education for licensed clinical social workers shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

(h) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

(i) The board may adopt regulations as necessary to implement this section.

(j) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral Sciences Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section. For purposes of this subdivision, a provider of continuing education as described in paragraph (1) of subdivision (d) shall be deemed to be an approved provider.

SEC. 46. Section 4996.28 of the Business and Professions Code is amended to read:

4996.28. (a) Registration as an associate clinical social worker shall expire one year from the last day of the month during which it was issued. To renew a registration, the registrant shall, on or before the expiration date of the registration, complete all of the following actions:

(1) Apply for renewal on a form prescribed by the board.

(2) Pay a renewal fee prescribed by the board.

(3) Notify the board whether he or she has been convicted, as defined in Section 490, of a misdemeanor or felony, and whether any disciplinary action has been taken by a regulatory or licensing board in this or any other state, subsequent to the last renewal of the registration.

(4) On and after January 1, 2016, obtain a passing score on the California law and ethics examination pursuant to Section 4992.09.

(b) A registration as an associate clinical social worker may be renewed a maximum of five times. When no further renewals are possible, an applicant may apply for and obtain a subsequent associate clinical social worker registration number if the applicant meets all requirements for registration in effect at the time of his or her application for a subsequent associate clinical social worker registration number. An applicant issued a subsequent associate registration number pursuant to this subdivision shall not be employed or volunteer in a private practice.

SEC. 47. Section 4999.1 of the Business and Professions Code is amended to read:

4999.1. Application for registration as a telephone medical advice service shall be made on a form prescribed by the department, accompanied by the fee prescribed pursuant to Section 4999.5. The department shall make application forms available. Applications shall contain all of the following:

(a) The signature of the individual owner of the telephone medical advice service, or of all of the partners if the service is a partnership, or of the

president or secretary if the service is a corporation. The signature shall be accompanied by a resolution or other written communication identifying the individual whose signature is on the form as owner, partner, president, or secretary.

(b) The name under which the person applying for the telephone medical advice service proposes to do business.

(c) The physical address, mailing address, and telephone number of the business entity.

(d) The designation, including the name and physical address, of an agent for service of process in California.

(e) A list of all health care professionals providing medical advice services that are required to be licensed, registered, or certified pursuant to this chapter. This list shall be submitted to the department on a form to be prescribed by the department and shall include, but not be limited to, the name, state of licensure, type of license, and license number.

(f) The department shall be notified within 30 days of any change of name, physical location, mailing address, or telephone number of any business, owner, partner, corporate officer, or agent for service of process in California, together with copies of all resolutions or other written communications that substantiate these changes.

SEC. 48. Section 4999.2 of the Business and Professions Code is amended to read:

4999.2. (a) In order to obtain and maintain a registration, a telephone medical advice service shall comply with the requirements established by the department. Those requirements shall include, but shall not be limited to, all of the following:

(1) (A) Ensuring that all health care professionals who provide medical advice services are appropriately licensed, certified, or registered as a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) or the Osteopathic Initiative Act, as a dentist, dental hygienist, dental hygienist in alternative practice, or dental hygienist in extended functions pursuant to Chapter 4 (commencing with Section 1600), as an occupational therapist pursuant to Chapter 5.6 (commencing with Section 2570), as a registered nurse pursuant to Chapter 6 (commencing with Section 2700), as a psychologist pursuant to Chapter 6.6 (commencing with Section 2900), as a naturopathic doctor pursuant to Chapter 8.2 (commencing with Section 3610), as a marriage and family therapist pursuant to Chapter 13 (commencing with Section 4980), as a licensed clinical social worker pursuant to Chapter 14 (commencing with Section 4991), as a licensed professional clinical counselor pursuant to Chapter 16 (commencing with Section 4999.10), as an optometrist pursuant to Chapter 7 (commencing with Section 3000), or as a chiropractor pursuant to the Chiropractic Initiative Act, and operating consistent with the laws governing their respective scopes of practice in the state within which they provide telephone medical advice services, except as provided in paragraph (2).

(B) Ensuring that all health care professionals who provide telephone medical advice services from an out-of-state location, as identified in

subparagraph (A), are licensed, registered, or certified in the state within which they are providing the telephone medical advice services and are operating consistent with the laws governing their respective scopes of practice.

(2) Ensuring that the telephone medical advice provided is consistent with good professional practice.

(3) Maintaining records of telephone medical advice services, including records of complaints, provided to patients in California for a period of at least five years.

(4) Ensuring that no staff member uses a title or designation when speaking to an enrollee, subscriber, or consumer that may cause a reasonable person to believe that the staff member is a licensed, certified, or registered health care professional described in subparagraph (A) of paragraph (1), unless the staff member is a licensed, certified, or registered professional.

(5) Complying with all directions and requests for information made by the department.

(6) Notifying the department within 30 days of any change of name, physical location, mailing address, or telephone number of any business, owner, partner, corporate officer, or agent for service of process in California, together with copies of all resolutions or other written communications that substantiate these changes.

(7) Submitting quarterly reports, on a form prescribed by the department, to the department within 30 days of the end of each calendar quarter.

(b) To the extent permitted by Article VII of the California Constitution, the department may contract with a private nonprofit accrediting agency to evaluate the qualifications of applicants for registration pursuant to this chapter and to make recommendations to the department.

SEC. 49. Section 4999.3 of the Business and Professions Code is amended to read:

4999.3. (a) The department may suspend, revoke, or otherwise discipline a registrant or deny an application for registration as a telephone medical advice service based on any of the following:

(1) Incompetence, gross negligence, or repeated similar negligent acts performed by the registrant or any employee of the registrant.

(2) An act of dishonesty or fraud by the registrant or any employee of the registrant.

(3) The commission of any act, or being convicted of a crime, that constitutes grounds for denial or revocation of licensure pursuant to any provision of this division.

(b) The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the department shall have all powers granted therein.

(c) Copies of any complaint against a telephone medical advice service shall be forwarded to the Department of Managed Health Care.

(d) The department shall forward a copy of any complaint submitted to the department pursuant to this chapter to the entity that issued the license to the licensee involved in the advice provided to the patient.

SEC. 50. Section 4999.4 of the Business and Professions Code is amended to read:

4999.4. (a) Every registration issued to a telephone medical advice service shall expire 24 months after the initial date of issuance.

(b) To renew an unexpired registration, the registrant shall, before the time at which the registration would otherwise expire, pay the renewal fee authorized by Section 4999.5.

(c) An expired registration may be renewed at any time within three years after its expiration upon the filing of an application for renewal on a form prescribed by the bureau and the payment of all fees authorized by Section 4999.5. A registration that is not renewed within three years following its expiration shall not be renewed, restored, or reinstated thereafter, and the delinquent registration shall be canceled immediately upon expiration of the three-year period.

SEC. 51. Section 4999.5 of the Business and Professions Code is amended to read:

4999.5. The department may set fees for registration and renewal as a telephone medical advice service sufficient to pay the costs of administration of this chapter.

SEC. 52. Section 4999.7 of the Business and Professions Code is amended to read:

4999.7. (a) This section does not limit, preclude, or otherwise interfere with the practices of other persons licensed or otherwise authorized to practice, under any other provision of this division, telephone medical advice services consistent with the laws governing their respective scopes of practice, or licensed under the Osteopathic Initiative Act or the Chiropractic Initiative Act and operating consistent with the laws governing their respective scopes of practice.

(b) For purposes of this chapter, "telephone medical advice" means a telephonic communication between a patient and a health care professional in which the health care professional's primary function is to provide to the patient a telephonic response to the patient's questions regarding his or her or a family member's medical care or treatment. "Telephone medical advice" includes assessment, evaluation, or advice provided to patients or their family members.

(c) For purposes of this chapter, "health care professional" is an employee or independent contractor described in Section 4999.2 who provides medical advice services and is appropriately licensed, certified, or registered as a dentist, dental hygienist, dental hygienist in alternative practice, or dental hygienist in extended functions pursuant to Chapter 4 (commencing with Section 1600), as a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) or the Osteopathic Initiative Act, as a registered nurse pursuant to Chapter 6 (commencing with Section 2700), as a psychologist pursuant to Chapter 6.6 (commencing with Section 2900), as a naturopathic doctor pursuant to Chapter 8.2 (commencing with Section 3610), as an optometrist pursuant to Chapter 7 (commencing with Section 3000), as a marriage and family therapist pursuant to Chapter 13

(commencing with Section 4980), as a licensed clinical social worker pursuant to Chapter 14 (commencing with Section 4991), as a licensed professional clinical counselor pursuant to Chapter 16 (commencing with Section 4999.10), or as a chiropractor pursuant to the Chiropractic Initiative Act, and who is operating consistent with the laws governing his or her respective scopes of practice in the state in which he or she provides telephone medical advice services.

SEC. 53. Section 4999.45 of the Business and Professions Code, as amended by Section 54 of Chapter 473 of the Statutes of 2013, is amended to read:

4999.45. (a) An intern employed under this chapter shall:

(1) Not perform any duties, except for those services provided as a clinical counselor trainee, until registered as an intern.

(2) Not be employed or volunteer in a private practice until registered as an intern.

(3) Inform each client prior to performing any professional services that he or she is unlicensed and under supervision.

(4) Renew annually for a maximum of five years after initial registration with the board.

(b) When no further renewals are possible, an applicant may apply for and obtain a subsequent intern registration number if the applicant meets the educational requirements for registration in effect at the time of the application for a subsequent intern registration number and has passed the California law and ethics examination described in Section 4999.53. An applicant issued a subsequent intern registration number pursuant to this subdivision shall not be employed or volunteer in a private practice.

(c) This section shall become operative on January 1, 2016.

SEC. 54. Section 4999.46 of the Business and Professions Code, as amended by Section 3 of Chapter 435 of the Statutes of 2014, is amended to read:

4999.46. (a) To qualify for licensure as specified in Section 4999.50, applicants shall complete experience related to the practice of professional clinical counseling under an approved supervisor. The experience shall comply with the following:

(1) A minimum of 3,000 postdegree hours of supervised experience performed over a period of not less than two years (104 weeks).

(2) Not more than 40 hours in any seven consecutive days.

(3) Not less than 1,750 hours of direct counseling with individuals, groups, couples, or families in a setting described in Section 4999.44 using a variety of psychotherapeutic techniques and recognized counseling interventions within the scope of practice of licensed professional clinical counselors.

(4) Not less than 150 hours of clinical experience in a hospital or community mental health setting, as defined in Section 1820 of Title 16 of the California Code of Regulations.

(5) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests,

writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to professional clinical counseling that have been approved by the applicant's supervisor.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

(c) No hours of clinical mental health experience may be gained more than six years prior to the date the application for examination eligibility was filed.

(d) An applicant shall register with the board as an intern in order to be credited for postdegree hours of experience toward licensure. Postdegree hours of experience shall be credited toward licensure, provided that the applicant applies for intern registration within 90 days of the granting of the qualifying degree and is thereafter granted the intern registration by the board. An applicant shall not be employed or volunteer in a private practice until registered as an intern by the board.

(e) All applicants and interns shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of professional clinical counseling.

(f) Experience obtained under the supervision of a spouse or relative by blood or marriage shall not be credited toward the required hours of supervised experience. Experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.

(g) Except for experience gained by attending workshops, seminars, training sessions, or conferences as described in paragraph (5) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting.

(1) No more than six hours of supervision, whether individual or group, shall be credited during any single week. This paragraph shall apply to supervision hours gained on or after January 1, 2009.

(2) An intern shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy is performed in each setting in which experience is gained.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour of face-to-face contact on an individual basis or two hours of face-to-face contact in a group of not more than eight persons in segments lasting no less than one continuous hour.

(4) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable, may obtain the required weekly direct supervisor

contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(h) This section shall become operative on January 1, 2016.

SEC. 55. Section 4999.55 of the Business and Professions Code is amended to read:

4999.55. (a) Each applicant and registrant shall obtain a passing score on a board-administered California law and ethics examination in order to qualify for licensure.

(b) A registrant shall participate in a board-administered California law and ethics examination prior to his or her registration renewal.

(c) Notwithstanding subdivision (b), an applicant who holds a registration eligible for renewal, with an expiration date no later than June 30, 2016, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, shall, if eligible, be allowed to renew the registration without first participating in the California law and ethics examination. These applicants shall participate in the California law and ethics examination in the next renewal cycle, and shall pass the examination prior to licensure or issuance of a subsequent registration number, as specified in this section.

(d) If an applicant fails the California law and ethics examination, he or she may retake the examination, upon payment of the required fees, without further application, except as provided in subdivision (e).

(e) If a registrant fails to obtain a passing score on the California law and ethics examination described in subdivision (a) within his or her renewal period on or after the operative date of this section, he or she shall complete, at minimum, a 12-hour course in California law and ethics in order to be eligible to participate in the California law and ethics examination. Registrants shall only take the 12-hour California law and ethics course once during a renewal period. The 12-hour law and ethics course required by this section shall be taken through a continuing education provider as specified by the board by regulation, a county, state, or governmental entity, or a college or university.

(f) The board shall not issue a subsequent registration number unless the registrant has passed the California law and ethics examination.

(g) Notwithstanding subdivision (f), an applicant who holds or has held a registration, with an expiration date no later than January 1, 2017, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, shall, if eligible, be allowed to obtain the subsequent registration number without first passing the California law and ethics examination. These applicants shall pass the California law and ethics examination during the next renewal period or prior to licensure, whichever occurs first.

(h) This section shall become operative January 1, 2016.

SEC. 56. Section 4999.76 of the Business and Professions Code is amended to read:

4999.76. (a) Except as provided in subdivision (c), the board shall not renew any license pursuant to this chapter unless the applicant certifies to

the board, on a form prescribed by the board, that he or she has completed not less than 36 hours of approved continuing education in or relevant to the field of professional clinical counseling in the preceding two years, as determined by the board.

(b) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completed continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(c) The board may establish exceptions from the continuing education requirement of this section for good cause, as defined by the board.

(d) The continuing education shall be obtained from one of the following sources:

(1) A school, college, or university that is accredited or approved, as defined in Section 4999.12. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers as specified by the board by regulation.

(e) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision (d), shall adhere to procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(f) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of professional clinical counseling.

(2) Significant recent developments in the discipline of professional clinical counseling.

(3) Aspects of other disciplines that enhance the understanding or the practice of professional clinical counseling.

(g) A system of continuing education for licensed professional clinical counselors shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

(h) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral Sciences Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section. For the purposes of this subdivision, a provider of continuing education as described in paragraph (1) of subdivision (d) shall be deemed to be an approved provider.

(i) The continuing education requirements of this section shall fully comply with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 57. Section 4999.100 of the Business and Professions Code, as amended by Section 66 of Chapter 473 of the Statutes of 2013, is amended to read:

4999.100. (a) An intern registration shall expire one year from the last day of the month in which it was issued.

(b) To renew a registration, the registrant on or before the expiration date of the registration, shall do the following:

(1) Apply for a renewal on a form prescribed by the board.

(2) Pay a renewal fee prescribed by the board.

(3) Notify the board whether he or she has been convicted, as defined in Section 490, of a misdemeanor or felony, or whether any disciplinary action has been taken by any regulatory or licensing board in this or any other state, subsequent to the registrant's last renewal.

(4) Participate in the California law and ethics examination pursuant to Section 4999.53 each year until successful completion of this examination.

(c) The intern registration may be renewed a maximum of five times. Registration shall not be renewed or reinstated beyond six years from the last day of the month during which it was issued, regardless of whether it has been revoked. When no further renewals are possible, an applicant may apply for and obtain a subsequent intern registration number if the applicant meets the educational requirements for registration in effect at the time of the application for a subsequent intern registration number and has passed the California law and ethics examination described in Section 4999.53. An applicant who is issued a subsequent intern registration number pursuant to this subdivision shall not be employed or volunteer in a private practice.

(d) This section shall become operative on January 1, 2016.

SEC. 58. Section 15.5 of this bill incorporates amendments to Section 1944 of the Business and Professions Code proposed by both this bill and Assembly Bill 483. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2016, (2) each bill amends Section 1944 of the Business and Professions Code, and (3) this bill is enacted after Assembly Bill 483, in which case Section 15 of this bill shall not become operative.

SEC. 59. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SJR 7
Author:	Pan
Chapter:	Resolution Chapter 90
Bill Date:	April 6, 2015, Amended
Subject:	Medical Residency Training Programs
Sponsor:	California Academy of Family Physicians California Medical Association
Position:	Support

DESCRIPTION OF CURRENT LEGISLATION:

This resolution urges the Congress and the President of the United States to renew funding for the Health Resources and Services Administration's Teaching Health Center and Primary Care Residency Expansion Graduate Medical Education Programs, and to lift the freeze on residency positions funded by Medicare to expand physician supply and improve access to care.

BACKGROUND

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

ANALYSIS

This resolution makes the following legislative findings:

- According to a 2014 report by the California Healthcare Foundation, although California has more than 105,000 licensed physicians, only 71,000 are actively involved in providing patient care.

- Federal funding levels for residency training programs have been frozen since 1997, while California's population has increased by more than 10% since that time.

- Medicare's rigid payment formulas for GME do not allow for the innovation needed to improve medical education to produce physicians with the appropriate training needed to meet the nation's current and future health care needs.

- Many primary care physicians, including those who have graduated from California medical schools, want to train in California, but are forced to leave the state because of the shortage in training slots at residency programs. California has been able to address only a minimal portion of primary care residency programs' funding shortfall with state funds.

- Increasing funding for primary care medical residency training programs is a critical step in addressing the physician shortage problem and improving access to medical care.

This resolution urges the Congress and the President of the United States to renew funding for the Health Resources and Services Administration's Teaching Health Center and Primary Care Residency Expansion Graduate Medical Education Programs that are set to expire this year; to lift the freeze on residency positions funded by Medicare to expand physician supply and improve access to care; and to encourage the development of primary care physician training programs in ambulatory, community, and medically underserved sites through new funding methodologies and incentives.

This resolution encourages increased funding and residency programs in California and would promote more residency positions in California. This resolution may help more physicians to receive residency training and potentially end up practicing in California. For these reasons, the Board took a support position on this resolution.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)

Senate Joint Resolution No. 7

RESOLUTION CHAPTER 90

Senate Joint Resolution No. 7—Relative to physicians.

[Filed with Secretary of State July 1, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SJR 7, Pan. Medical residency programs.

This measure would urge the Congress and the President of the United States to renew funding for the Health Resources and Services Administration's Teaching Health Center and Primary Care Residency Expansion Graduate Medical Education Programs, and to lift the freeze on residency positions funded by Medicare to expand physician supply and improve access to health care.

WHEREAS, According to a 2014 report by the California Healthcare Foundation, although California has more than 105,000 licensed physicians, only 71,000 are actively involved in providing patient care; and

WHEREAS, Certain regions of the state, such as the San Joaquin Valley and the Inland Empire, lack the recommended supply of primary care and specialty physicians and, as a result, those areas have higher populations in poor health; and

WHEREAS, California's shortage and poor distribution of physicians is likely to be exacerbated by increased levels of insured patients and projected increases in the number of physicians planning to retire; and

WHEREAS, Federal funding levels for residency training programs have been frozen since 1997, while California's population has increased by more than 10 percent since that time; and

WHEREAS, Medicare's rigid payment formulas for graduate medical education do not allow for the innovation needed to improve medical education to produce physicians with the appropriate training needed to meet the nation's current and future health care needs; and

WHEREAS, California has been able to address only a minimal portion of primary care residency programs' funding shortfall with state funds; and

WHEREAS, Many primary care physicians, including those who have graduated from California medical schools, want to train in California, but are forced to leave the state because of the shortage in training slots at residency programs; and

WHEREAS, California has the highest retention rate of physicians who complete their residency training in-state; and

WHEREAS, Increasing funding for primary care medical residency training programs is a critical step in addressing the physician shortage problem and improving access to medical care; now, therefore, be it

Resolved by the Senate and the Assembly of the State of California, jointly, That the Legislature calls upon Congress and the President of the United States to renew funding for the Health Resources and Services Administration's Teaching Health Center and Primary Care Residency Expansion Graduate Medical Education Programs that are set to expire this year; and be it further

Resolved, That the Legislature calls upon Congress and the President to lift the freeze on residency positions funded by Medicare to expand physician supply and improve access to care; and be it further

Resolved, That the Legislature calls upon Congress and the President to encourage the development of primary care physician training programs in ambulatory, community, and medically underserved sites through new funding methodologies and incentives; and be it further

Resolved, That the Secretary of the Senate transmit copies of this resolution to the President and the Vice President of the United States, to the Speaker of the House of Representatives, to the Majority Leader of the Senate, to each Senator and Representative from California in the Congress of the United States, and to the author for appropriate distribution.

O

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 11	Gonzalez	Employment: Paid Sick Days: In-Home Supportive Services	2-year Bill	03/11/15
AB 12	Cooley	State Government: Administrative Regulations: Review	2-year Bill	08/19/15
AB 19	Chang	GO BIZ: Small Business: Regulations	2-year Bill	05/06/15
AB 41	Chau	Health Care Coverage: Discrimination	2-year Bill	
AB 50	Mullin	Medi-Cal: Evidence-Based Home Visiting Program	Vetoed	09/04/15
AB 59	Waldron	Mental Health Services: Assisted Outpatient Treatment	2-year Bill	04/20/15
AB 68	Waldron	Medi-Cal	Vetoed	08/18/15
AB 70	Waldron	Emergency Medical Services: Reporting	2-year Bill	03/26/15
AB 73	Waldron	Prescriber Prevails Act	2-year Bill	05/04/15
AB 83	Gatto	Personal Data	2-year Bill	07/15/15
AB 85	Wilk	Open Meetings	Vetoed	04/15/15
AB 170	Gatto	Newborn Screening: Genetic Diseases: Blood Samples	2-year Bill	07/08/15
AB 174	Gray	UC: Medical Education	2-year Bill	06/01/15
AB 193	Maienschein	Mental Health: Conservatorship Hearings	Vetoed	09/02/15
AB 243	Wood	Medical Marijuana	Chaptered, #688	09/11/15
AB 258	Levine	Organ Transplants: Medical Marijuana: Qualified Patients	Chaptered, #51	03/25/15
AB 259	Dababneh	Personal Information: Privacy	2-year Bill	
AB 266	Bonta	Medical Marijuana	Chaptered, #689	09/11/15
AB 304	Gonzalez	Sick Leave: Accrual Limitations	Chaptered, #67	04/27/15
AB 322	Waldron	Privacy: Social Security Numbers	2-year Bill	03/26/15
AB 330	Chang	State Government	2-year Bill	
AB 333	Melendez	Healing Arts: Continuing Education	Chaptered, #360	06/24/15
AB 339	Gordon	Health Care Coverage: Outpatient Prescription Drugs	Chaptered, #619	09/04/15
AB 344	Chavez	Medi-Cal	2-year Bill	
AB 351	Jones-Sawyer	Public Contracts: Small Business Participation	2-year Bill	

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 366	Bonta	Medi-Cal: Annual Access Monitoring Report	2-year Bill	07/07/15
AB 374	Nazarian	Health Care Coverage: Prescription Drugs	Chaptered, #621	09/02/15
AB 383	Gipson	Public Health: Hepatitis C	2-year Bill	04/30/15
AB 389	Chau	Hospitals: Language Assistance Services	Chaptered, #327	09/01/15
AB 403	Stone, M	Public Social Services: Foster Care Placement	Chaptered, #773	07/07/15
AB 410	Obernolte	Reports Submitted to Legislative Committees	Vetoed	08/24/15
AB 411	Lackey	Public Contracts	2-year Bill	
AB 413	Chavez	California Disabled Veteran Business Enterprise Program	Chaptered, #513	06/30/15
AB 419	Kim	Go BIZ: Regulations	2-year Bill	05/04/15
AB 444	Gipson	Health Facilities: Epidural and Enteral Feeding Connecters	Chaptered, #198	06/01/15
AB 463	Chiu	Pharmaceutical Cost Transparency Act of 2015	2-year Bill	
AB 466	McCarty	State Civil Service: Employment Procedures	2-year Bill	07/06/15
AB 483	Patterson	Healing Arts: License Fees: Proration	Vetoed	09/02/15
AB 486	Bonilla	Centralized Hospital Packaging Pharmacies: Medication Labels	Chaptered, #241	
AB 503	Rodriguez	Emergency Medical Service	Chaptered, #362	07/07/15
AB 507	Olsen	DCA: BreEZe System: Annual Report	2-year Bill	07/09/15
AB 508	Garcia, C.	Public Health: Prenatal Care	2-year Bill	
AB 513	Jones-Sawyer	Professions and Vocations	2-year Bill	
AB 521	Nazarian	HIV Testing	Vetoed	09/04/15
AB 532	McCarty	State Agencies: Collection of Data: Race or Ethnic Origin	Chaptered, #433	09/03/15
AB 533	Bonta	Health Care Coverage: Out-of-Network Coverage	2-year Bill	09/04/15
AB 537	Allen, T.	Public Employees' Benefits	2-year Bill	
AB 546	Gonzalez	Peace Officers: Basic Training Requirements	Chaptered, #200	06/29/15
AB 570	Allen, T.	Cardiovascular Disease: High Blood Pressure	2-year Bill	
AB 572	Gaines	California Diabetes Program	2-year Bill	07/02/15

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 574	Patterson	General Acute Care Hospitals: Cardiovascular Surgical Teams	2-year Bill	03/26/15
AB 584	Cooley	Public Employee Retirement Systems	2-year Bill	04/06/15
AB 614	Brown	Health Care Standards of Practice	Chaptered, #435	06/02/15
AB 618	Maienschein	Parole: Primary Mental Health Clinicians	2-year Bill	
AB 623	Wood	Abuse-Deterrent Opioid Analgesic Drug Products	2-year Bill	05/04/15
AB 635	Atkins	Medical Interpretation Services	2-year Bill	
AB 649	Patterson	Medical Waste: Law Enforcement Drug Take back Programs	2-year Bill	06/24/15
AB 664	Dodd	Medi-Cal: Universal Assessment Tool Report	Chaptered, #367	06/25/15
AB 676	Calderon	Employment: Discrimination	Vetoed	08/31/15
AB 714	Melendez	State Employees: Health Benefits	2-year Bill	
AB 728	Hadley	State Government: Financial Reporting	Chaptered, #371	08/24/15
AB 741	Williams	Mental Health: Community Care Facilities	2-year Bill	05/04/15
AB 750	Low	Business and Professions: Retired License Category	2-year Bill	04/16/15
AB 757	Gomez	Healing Arts: Clinical Laboratories	Vetoed	06/22/15
AB 766	Ridley-Thomas	Public School Health Center Support Program	2-year Bill	04/27/15
AB 769	Jones-Sawyer	State Employees: Disciplinary Action	2-year Bill	
AB 773	Baker	Board of Psychology: Licenses	Chaptered, #336	09/01/15
AB 775	Chiu	Reproductive FACT Act	Chaptered, #700	05/04/15
AB 788	Chu	Prescriptions	2-year Bill	03/26/15
AB 789	Calderon	Contact Lens Sellers: Prohibited Practices: Fines	2-year Bill	04/22/15
AB 791	Cooley	Electronic Health Records	2-year Bill	
AB 796	Nazarian	Health Care Coverage: Autism and Pervasive Dev. Disorders	2-year Bill	
AB 840	Ridley-Thomas	Nurses and Certified Nurse Assistants	2-year Bill	
AB 843	Hadley	Controller: Internet Web Site	2-year Bill	03/26/15
AB 845	Cooley	Health Care Coverage: Vision Care	2-year Bill	04/21/15

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 848	Stone, M	Alcoholism and Drug Abuse Treatment Facilities	Chaptered, #744	08/31/15
AB 859	Medina	Medi-Cal: Obesity Treatment Plans	2-year Bill	04/30/15
AB 868	Obernolte	PERS: Contracting Agencies: Transfer of Membership	Chaptered, #86	
AB 918	Stone, M	Health and Care Facilities: Seclusion and Behavior Restraints	Chaptered, #340	08/26/15
AB 972	Jones	Ken Maddy California Cancer Registry	2-year Bill	
AB 981	Mayes	Eyeglasses	2-year Bill	
AB 993	Comm. P.E.R.S	State Employees: MOU	2-year Bill	
AB 1001	Gatto	Child Abuse: Reporting	2-year Bill	
AB 1027	Gatto	Health Care Coverage: Contracted Rates	2-year Bill	03/26/15
AB 1046	Dababneh	Hospitals: Community Benefits	2-year Bill	04/07/15
AB 1060	Bonilla	Cancer Clinical Trials	Vetoed	08/31/15
AB 1067	Gipson	Foster Children: Psychotropic Medication	2-year Bill	03/26/15
AB 1069	Gordon	Prescription Drugs: Collection and Distribution Program	2-year Bill	07/01/15
AB 1073	Ting	Pharmacy: Prescription Drug Labels	Chaptered, #784	09/04/15
AB 1092	Mullin	Magnetic Resonance Imaging Technologists	2-year Bill	05/04/15
AB 1102	Santiago	Health Care Coverage: Medi-Cal Access Program	Sen. Health	07/09/15
AB 1104	Rodriguez	Search Warrants	Chaptered, #124	06/23/15
AB 1117	Garcia, C.	Medi-Cal: Vaccination Rates	Sen. Approps	06/01/15
AB 1124	Perea	Workers Compensation: Medication Formulary	Chaptered, #525	09/04/15
AB 1125	Weber	State Agency Contracts: Small Business	2-year Bill	05/04/15
AB 1129	Burke	Emergency Medical Services: Data and Information System	Chaptered, #377	08/20/15
AB 1133	Achadjian	School-Based Early Mental Health Intervention and Prevention	2-year Bill	04/15/15
AB 1174	Bonilla	Health Research: Women's Health	2-year Bill	04/20/15
AB 1215	Ting	California Open Data Standard	2-year Bill	03/26/15
AB 1219	Baker	California Cancer Task Force	2-year Bill	

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1223	O'Donnell	Emergency Medical Services: Ambulance Transportation	Chaptered, #379	06/30/15
AB 1231	Wood	Medi-Cal: Non-Medical Transport	Vetoed	09/04/15
AB 1254	Grove	Health Care Service Plans: Abortion Coverage	2-year Bill	04/06/15
AB 1281	Wilk	Regulations: Legislative Review	2-year Bill	03/26/15
AB 1293	Holden	State Public Employment: Labor Negotiations	Vetoed	03/26/15
AB 1294	Holden	State Government: Prompt Payment of Claims	2-year Bill	03/26/15
AB 1299	Ridley-Thomas	Medi-Cal: Specialty Mental Health Services: Foster Children	2-year Bill	07/16/15
AB 1302	Brown	Public Contracts: Disabled Veterans	2-year Bill	
AB 1337	Linder	Medical Records: Electronic Delivery	Chaptered, #528	07/16/15
AB 1351	Eggman	Deferred Entry of Judgment: Pretrial Diversion	Vetoed	09/03/15
AB 1352	Eggman	Deferred Entry of Judgment: Withdrawal of Plea	Chaptered, #646	09/09/15
AB 1357	Bloom	Children and Family Health Promotion Program	2-year Bill	04/29/15
AB 1359	Nazarian	Optometry: Therapeutic Pharmaceutical Agents Certification	Chaptered, #443	06/16/15
AB 1386	Low	Emergency Medical Care: Epinephrine Auto-Injectors	2-year Bill	04/16/15
AB 1396	Bonta	Public Health Finance	2-year Bill	06/03/15
AB 1423	Stone, M	Prisoners: Medical Treatment	Chaptered, #381	04/20/15
AB 1434	McCarty	Health Insurance: Prohibition on Health Insurance Sales	2-year Bill	04/20/15
AB 1445	Brown	Public Contracts: Small Business Contracts	2-year Bill	
AB 1460	Thurmond	Hospitals: Community Benefit Plans	2-year Bill	
AB 1485	Patterson	Medi-Cal: Radiology	2-year Bill	05/05/15
ABX2 12	Patterson	Cadaveric Fetal Tissue	Assembly	
ABX2 13	Gipson	Medi-Cal: AIDS Medi-Cal Waiver Program	Assembly	
ACA 3	Gallagher	Public Employees' Retirement	2-year Bill	
ACR 38	Brown	California Task Force on Family Caregiving	Chaptered, #200	09/02/15
ACR 97	Bonilla	Medical Training: Osteopathic Students	Chaptered, #189	09/02/15

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 3	Leno	Minimum Wage: Adjustment	2-year Bill	03/11/15
SB 4	Lara	Health Care Coverage: Immigration Status	Chaptered, #709	09/10/15
SB 10	Lara	Health Care Coverage: Immigration Status	2-year Bill	09/09/15
SB 11	Beall	Peace Officer Training: Mental Health	Chaptered, #468	08/28/15
SB 24	Hill	Electronic Cigarettes: Licensing and Restrictions	2-year Bill	06/01/15
SB 26	Hernandez	California Health Care Cost and Quality Database	2-year Bill	05/05/15
SB 29	Beall	Peace Officer Training: Mental Health	Chaptered, #469	08/31/15
SB 36	Hernandez	Medi-Cal: Demonstration Project	Chaptered, #759	09/04/15
SB 43	Hernandez	Health Care Coverage: Essential Health Benefits	Chaptered, #648	08/17/15
SB 52	Walters	Regulatory Boards: Healing Arts	2-year Bill	
SB 58	Knight	Public Employees' Retirement System	2-year Bill	
SB 131	Cannella	UC: Medical Education	2-year Bill	05/12/15
SB 137	Hernandez	Health Care Coverage: Provider Directories	Chaptered, #649	09/04/15
SB 139	Galgiani	Controlled Substances	2-year Bill	08/18/15
SB 145	Pan	Robert F. Kennedy Farm Workers Medical Plan	Chaptered, #712	09/10/15
SB 190	Beall	Health Care Coverage: Acquired Brain Injury	2-year Bill	04/06/15
SB 201	Wieckowski	California Public Records Act	2-year Bill	
SB 202	Hernandez	Controlled Substances: Unfair or Deceptive Practice	2-year Bill	03/16/15
SB 214	Berryhill	Foster Care Services	2-year Bill	
SB 216	Pan	Public Employees' Retirement System	Chaptered, #244	06/03/15
SB 221	Jackson	State Public Employees: Sick Leave: Veterans	Chaptered, #794	07/09/15
SB 238	Mitchell	Foster Care: Psychotropic Medication	Chaptered, #534	09/04/15
SB 243	Hernandez	Medi-Cal: Reimbursement: Provider Rates	2-year Bill	05/12/15
SB 251	Roth	Disability Access: Civil Rights: Income Tax Credit	Vetoed	09/04/15
SB 253	Monning	Dependent Children: Psychotropic Medication	2-year Bill	08/31/15

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 275	Hernandez	Health Facility Data	2-year Bill	
SB 280	Stone, J	Public Employees: Compensation	2-year Bill	04/15/15
SB 282	Hernandez	Health Care Coverage: Prescription Drugs	Chaptered, #654	09/02/15
SB 289	Mitchell	Telephonic and Electronic Patient Management Services	2-year Bill	05/04/15
SB 291	Lara	Mental Health: Vulnerable Communities	Vetoed	09/04/15
SB 293	Pan	Public Employees: Retirement	2-year Bill	
SB 296	Cannella	Medi-Cal: Specialty Mental Health Services: Documentation	2-year Bill	08/28/15
SB 299	Monning	Medi-Cal: Provider Enrollment	Chaptered, #271	05/18/15
SB 315	Monning	Health Care Access Demonstration Project Grants	2-year Bill	08/31/15
SB 319	Beall	Child Welfare Services: Public Health Nursing	Chaptered, #535	09/03/15
SB 346	Wieckowski	Health Facilities: Community Benefits	2-year Bill	04/23/15
SB 349	Bates	Optometry: Mobile Optometric Facilities	2-year Bill	04/06/15
SB 354	Huff	California Public Employees Pension Reform Act	Chaptered, #158	04/06/15
SB 370	Wolk	Immunizations: Disclosure of Information: TB Screening	2-year Bill	
SB 375	Berryhill	Public Employees' Retirement	2-year Bill	
SB 376	Lara	Public Contracts: UC	Vetoed	08/18/15
SB 402	Mitchell	Pupil Health: Vision Examinations	2-year Bill	05/04/15
SB 407	Morrell	Comprehensive Perinatal Services Program: Licensed Midwives	Chaptered, #313	07/07/15
SB 435	Pan	Medical Home: Health Care Delivery Model	2-year Bill	07/07/15
SB 447	Allen	Medi-Cal: Clinics: Enrollment Applications	2-year Bill	06/01/15
SB 453	Pan	Prisons: Involuntary Medication	Chaptered, #260	07/08/15
SB 459	Liu	State Government: Data	2-year Bill	
SB 467	Hill	Professions and Vocations	Chaptered, #656	09/03/15
SB 484	Beall	Juveniles	Chaptered, #540	09/03/15
SB 492	Liu	Coordinate Care Initiative: Consumer Ed. & Info. Guide	2-year Bill	06/25/15

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 525	Nielsen	Respiratory Care Practice	Chaptered, #247	06/16/15
SB 547	Liu	Long-Term Care	2-year Bill	
SB 560	Monning	Licensing Boards	Asm. Approps	07/09/15
SB 563	Pan	Workers' Compensation: Utilization Review	2-year Bill	04/30/15
SB 570	Jackson	Personal Information: Privacy: Breach	Chaptered, #543	09/01/15
SB 571	Liu	Long-Term Care: CalCareNet	2-year Bill	04/21/15
SB 573	Pan	Statewide Open Data Portal	2-year Bill	07/09/15
SB 579	Jackson	Employees: Time Off	Chaptered, #802	07/16/15
SB 587	Stone, J	Pharmacy: Drug Regimens: Hypertension and Hyperlipidemia	2-year Bill	04/09/15
SB 609	Stone, J	Controlled Substances: Narcotic Replacement Treatment	2-year Bill	04/21/15
SB 613	Allen	Public Health: Dementia Guidelines: Workgroup	Chaptered, #577	07/06/15
SB 614	Leno	Medi-Cal: Mental Health Services	2-year Bill	08/31/15
SB 644	Hancock	LEAP: Persons with Developmental Disabilities	Chaptered, #356	08/28/15
SB 658	Hill	Automated External Defibrillators	Chaptered, #264	06/15/15
SB 671	Hill	Pharmacy: Biological Product	Chaptered, #545	07/16/15
SB 729	Wieckowski	Consumer Complaints	2-year Bill	
SB 744	Huff	Pupil Health: Epinephrine Auto-Injectors	2-year Bill	
SB 779	Hall	Skilled Nursing Facilities: Certified Nurse Assistants	2-year Bill	05/04/15
SB 780	Mendoza	Psychiatric Technicians and Assistants	2-year Bill	
SB 792	Mendoza	Day Care Facilities: Immunizations: Exemptions	Chaptered, #807	09/04/15
SCR 4	Pan	Physician Anesthesiologist Week	Chaptered, #3	
SCR 13	Jackson	American Heart Month and Wear Red Day in California	Chaptered, #22	01/29/15
SR 17	Jackson	California Health Care Decisions Day	Adopted	03/16/15